Safer Somerset Partnership

Multi- agency Domestic Abuse Death Review

Executive Summary

Into the death of Mr D (pseudonym) in April 2017

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Independent Domestic Homicide Review Chair and Report Author

Report Completed: 31st July 2018

1. Preface

1.1 Domestic Homicide Reviews (DHRs) came into force on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

a) A person to whom she was related or with whom she was or had been in an intimate personal relationship or
b) A member of the same household as herself; held with a view to identifying the lessons to be learnt from the death.

1.2 Throughout the report, the term 'domestic abuse' is used in reference to 'domestic violence' as this is the term, which has been adopted by the Safer Somerset Partnership.

1.3 The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and agencies work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply those lessons to service response, including changes to policies and procedures as appropriate, and identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.4 This death was not caused by a homicide but a suicide. However, following the Revised DHR guidance published in December 2016 it is now mandatory for a statutory review to be undertaken where an individual has committed suicide and it is believed this could have been connected to domestic abuse. This review examines the circumstances surrounding the death of Mr D (pseudonym) in the Taunton Deane area in April 2017. The principles underpinning the review process have been followed in accordance with the Home Office Multi-Agency Statutory Guidance on the Conduct of Domestic Homicide Reviews- Revised Version-December 2016.

1.5 The Independent Chair and the DHR Panel members offer their deepest sympathy and condolences to Mr D's family. The Chair would also like to thank the Review Panel who have contributed to the deliberations of the Review, for their time, honesty, transparency and cooperation.

1.6 The Chair of the Panel possesses the qualifications and experience required of an Independent DHR Chair, as set out in section 5.10 of the Home Office Multi- Agency

Statutory Guidance. She is not associated with any of the agencies involved in the Review nor has she had any dealings with either Mr D or Miss E and she is totally independent.

2. Domestic Homicide Review Panel

- Faye Kamara LLB, MSc- Independent Chair
- Suzanne Harris, Somerset County Council
- Melanie Thomson, Formerly known as Knightstone, now known as Liverty from 19th March 2018 (SIDAS- Somerset Integrated Domestic Abuse Service)
- Joanna Mines, Avon and Somerset Constabulary
- Punita Bassi, Avon and Somerset Constabulary (IMR Author)
- Julia Burrows, Somerset Partnership NHS Foundation Trust (SomPar)
- Andrew Tresidder, Somerset Clinical Commissioning Group
- Ben Judd, Somerset Drug and Alcohol Service
- Alex Chapman, Somerset Drug and Alcohol Service
- Darryl Northover, Taunton Association for the Homeless
- Charlotte Coker, Community Rehabilitation Company (Probation)
- Duncan Marrow, Taunton and Somerset NHS Foundation Trust

3. Introduction

3.1. This review examines the circumstances surrounding the death of Mr D (pseudonym) who was 36 years of age and had lived in Taunton, Somerset for many years but at the time of his death he was of no fixed abode.

3.2 Mr D was a bisexual gentleman who had had relationships with men in the early 2000s however more latterly with a female named Miss E. He was an opiate drug user and had been for a number of years. He was known to the Somerset Drug and Alcohol Service and had been released from Her Majesty's Prison on license in January 2016.

3.3 Mr D and Miss E had been in relationship since January 2016 following his release from prison. We understand they both knew one another in 2012 when they were

both living in accommodation provided by Taunton Association for the Homeless, albeit different properties. Miss E has two children, however both of these reside with grandparents and the latest position is that Miss E has had infrequent contact with her children for some time. There had been a number of third party reports to the police between January 2016 and April 2017, all from Miss E's address, some categorised as domestic abuse related and others anti-social behaviour. None of the reported incidents involved children present at her address. Miss E was also known to the Somerset Drug and Alcohol Service, however in August 2018 she had successfully completed a suspended sentence order whilst being managed by the Bristol, Gloucestershire, Somerset and Wiltshire Community Rehabilitation Company for a drug related offence.

3.4 As a result of Mr D's drug use he was also known to the police, his GP, and local hospital trust because of his poor health. Mr D did not disclose to any agencies that his girlfriend Miss E was abusing him, however there was one occasion in January 2017 where Mr D reported he had been assaulted by Miss E. Domestic incidents were identified by agencies, however not all possible action was taken.

3.5 Incident summary:

3.5.1 In early April 2017, a third party reported to the police that they could hear violence and banging coming from Miss E's flat, the caller also added that they could hear the female being violent and shouting. Police attended the address and it was reported by Mr D to the officer that they had been arguing about Mr D's drug use. He advised that he had tried to leave however, Miss E didn't want him to. No physical violence was reported by neither Mr D or Miss E. Mr D was advised by the officers to leave the address for a 'cooling off' period.

3.5.2 The next day following the events described in 3.5.1 Mr D's body was found hanging from a tree. The police were called and shortly after their attendance, Miss E and her friend appeared. Miss E advised officers that Mr D had used a recipe of drugs that day including heroin and 'base' and that they had had an argument the previous day but after a walk around the block he usually returns but hadn't on this occasion.

3.5.3 It was concluded by the Coroner that Mr D's death was caused by 'deliberately suspending himself by the neck whilst under the influence of heroin, his intentions at the time were not clearly established'.

3.5.4 The police continue to investigate whether any other persons were present prior to and during his death.

3.6 The key purpose of this review is to enable lessons to be learned from Mr D's death. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened, and most importantly, what needs to change in order to reduce the risk of such a tragedy happening in the future.

3.7 The Review considers all contacts/involvement agencies had with Mr D and Miss E during the period January 2012-April 2017, as well as any events, prior to 2012, which are relevant to mental health, violence and abuse.

3.8 The DHR Panel consists of senior managers, from both the statutory and voluntary sector, listed in section 2 of this report. All of the agencies who have been part of the Review have assisted in the identification of lessons and committed to implementing action plans to address the lessons.

3.10 The agencies participating in this Domestic Homicide Review are:

- Somerset County Council
- Somerset Partnership NHS Foundation Trust
- Somerset Clinical Commissioning Group
- Avon and Somerset Constabulary
- Knightstone Housing now known as Liverty (SIDAS- Somerset Integrated Domestic Abuse Service)
- Turning Point (SDAS- Somerset Drug and Alcohol Service)
- Community Rehabilitation Company
- Taunton and Somerset NHS Foundation Trust
- Taunton Association for the Homeless.

3.11 As per the Home Office guidance a letter together with the Leaflet on 'Domestic Homicide Reviews' was sent to Mr D's family and Miss E asking both whether they wished to engage in this review. Unfortunately, neither replied to this invitation and therefore this review has been solely based on the records held by agencies as opposed to opinions and intelligence from family members and friends.

3.12 Sanctuary Housing Group were also invited to be part of this Review and provided some initial information at the beginning of the process. This was because the property in which Miss E lived was owned and managed by Sanctuary Housing. However, they did not fully engage with this review and therefore there is no learning to be shared for this agency.

4. Parallel Reviews

4.1 There were and are no other statutory parallel reviews ongoing.

4.2 There was a Coroner's Inquest for Mr D. Conclusion recorded above in paragraph 3.5.3

5. Confidentiality

5.1 As recommended within the 'Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' to protect the identity of the deceased, and her family, the following pseudonyms have been used throughout this report.

5.2 The name Mr D is used for the deceased, who was 36 years at the time of his death and the name Miss E for his most recent partner; both of these names were all agreed by the DHR/DSR Panel. The other pseudonyms used included Mr F, Mr G Miss H and Mr J; these were all neighbours, acquaintances or friends of Mr D or Miss E.

6. Dissemination

6.1 Each of the Panel members (see list at the beginning of report), the Chair and members of the Safer Somerset Partnership have received copies of the full Overview Report.

7. Methodology

7.1 The Overview Report has been compiled using information and facts from the following:

- IMR presentations from the following agencies;
  - Avon and Somerset Constabulary
  - BGSW Community Rehabilitation Company
  - Somerset Clinical Commissioning Group
  - Somerset Drug and Alcohol Service
  - Taunton and Somerset NHS Foundation Trust
  - Somerset Partnership NHS Foundation Trust
  - Taunton Association for the Homeless

- A chronology of events leading to the suicide of Mr D, coordinated and produced by Safer Somerset Partnership

- Discussions during the Review Panel Meetings;

- Consultations with Safe Lives, a national agency leading on the development of MARACs and also Sanctuary Housing, a housing association/provider where Miss E resides.

8. Overview

8.1 The Panel have been committed to the Review, within the spirit of the Equalities Act 2010, and have demonstrated an ethos of fairness, equality, openness and transparency. The Panel have worked as a partnership in ensuring that the Review has been conducted in line with the Terms of Reference. The Review has been cognisant of the Mr D's family and their privacy. Mr D's parents and Miss E were both contacted as part of this Review to ascertain their views about Mr D's lifestyle, interaction with agencies and his relationship. Unfortunately, there was not a response to this

invitation and therefore the Overview Report has been written in the context of information held by agencies only.

8.2 The practices of agencies were carefully considered to ascertain if they were sensitive to the nine protected characteristics of the Equality Act 2010 i.e. Age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, face and religion and belief, sex or sexual orientation. In line with the Terms of Reference, the Panel considered these protected characteristics and concluded that although Mr D was a bisexual individual; it was believed by the Panel that his sexual orientation has been acknowledged as part of the review and this was added to the complexity of how to engage and how to access services throughout the review process.

9. Analysis

9.1 The Panel has considered the individual management reviews (IMRs) through the viewpoints of both Mr D and Miss E, to ascertain if the agencies' contacts were appropriate and whether they acted in accordance with their set procedures and guidelines. Where they have not done so, the panel has discussed whether the lessons have been identified and appropriately actioned.

9.2 The authors of the IMRs have followed the Review's Terms of Reference and addressed the points within it. The agencies undertook the IMRs in an honest, thorough and transparent fashion, ascertaining information from a number of sources. The following is the Review Panel's view on the appropriateness of the intervention undertaken by each agency.

Somerset Drug and Alcohol Service

9.3 In the opinion of the IMR author, it is recognised that this agency had a considerable amount of contact with both parties, however particularly Mr D following his release from prison in January 2016. The challenges faced by this organisation with Mr D's chaotic drug use and lack of stability to remain on a script resulted in his treatment being escalated to an internal Complex case review, and this happened on more than one occasion. Despite best efforts actioned following these reviews Mr D still did not engage with the service for a long enough period to begin any psychosocial treatment.

9.5 With reference to the points raised above, the IMR also considered what else could be developed when the service is finding some individuals difficult to engage with who meet the threshold for a complex case review. It was found that consideration should be given to what emergency contacts and useful advice is available for these service users in the event of serious distress.

9.6 It is noted in the IMR that Mr D did disclose that he had been subjected to violence and had a bite mark. SDAS appreciate that this disclosure was not explored thoroughly enough at the time to establish whether it was domestic abuse and that

this was potentially a missed opportunity to learn more about how he was feeling and his situation.

9.7 The Panel were advised as part of the IMR presentation and discussion that both Mr D and Miss E were known to the service at the same time and that their relationship was known. The Panel sought assurance from this organisation on what would have happened should any disclosures from either party had been made. In addition, it was discussed whether joint treatment would ever be considered. The outcome was that joint treatment can be considered where both parties request it and all parties agree that this is in the best interest of each individual's treatment. In the case of Miss E and Mr D, this was not requested.

9.8 The final point that was raised by this organisation in relation to lessons learnt related to Mr D's risk assessment, which was not completed in his absence and was significantly out of date at the time of his death. It was clear from his records held by the service that he had a history of poor mental health and suicidal ideation, intent and attempts. Therefore, it was found as part of this review that 'past' risks identified in the risk assessment were not actively managed.

Somerset Partnership NHS Foundation Trust

9.9 As previously articulated in this report, the contact this organisation had with Mr D was limited and related only to an incident in January 2017 where he was detained under the Mental Health Act 1983. It was noted in the IMR that the Policy and Protocol was followed as per standard and an assessment was undertaken which found that Mr D did not need to be admitted to secondary psychiatric care and that it was more critical he engaged with the drug and alcohol service locally.

9.10 However, as part of the assessment Mr D disclosed that he often felt suicidal when he had arguments with his girlfriend and that this was the reason for his behaviour on this occasion. Within the IMR and Panel discussion, it was highlighted that this could have been an opportunity to explore his situation and feelings further and establish whether he was experiencing domestic abuse from his girlfriend, who we believed to be Miss E although Mr D did not disclose her name to this organisation.

9.11 The Panel discussed 'professional curiosity' and how this tends to only feature where the workforce understand in detail the dynamics of abuse and are confident in being able to ask those sensitive questions. This was a shared concern for many of the organisations taking part in this review.

9.12 In addition to the above, the IMR author also highlighted another concern where the risk screening and risk information regarding Mr D's disclosure of feeling suicidal was not adequately recorded within his notes.

Somerset Clinical Commissioning Group

9.13 It was reported within the IMR and by the author as part of the Panel meeting that Mr D had many contacts with his GP surgery, not always seeing the same GP. Mr D's drug and alcohol use was known by the surgery and how he had a history of experiencing low mood and depression. Suicidal ideation was not disclosed by Mr D to his GP and therefore this was never acknowledged as a risk factor.

9.14 The IMR also highlighted that there was often correspondence between secondary care services and the GP practice informing this organisation of the attendances made by Mr D at the local hospital; often accident and emergency for drug related accidents. This is regarded as good practice and enabled health professionals to be kept informed of Mr D's care.

9.15 As part of this review, both Miss E and Mr D's contact with agencies was considered, however there was considerable uncertainty and debate as a Panel in relation to whether Miss E's information could be shared. This was of particular relevance to Miss E's health records owing to whether information could be shared without the living person's consent. The Panel concluded that it was essential we seek further guidance from the Home Office about this issue, suggesting that they should discuss this with the Medical Defence Organisations.

Taunton and Somerset NHS Foundation Trust

9.16 This IMR was extremely transparent and actions taken at the time with Mr D were critiqued well. Consideration was given to how Mr D was treated by staff clinically as well as a patient and therefore his general wellbeing. In the opinion of the IMR author, more robust questions could have been asked of Mr D when he attended the Emergency department with suspected or actual injuries resulting from assaults, in order to establish whether he was experiencing domestic abuse. Panel members supported this suggestion and a more detailed discussion was had in relation to what the policy and protocol is in relation to staff within the Trust exploring these questions with patients.

9.17 With particular reference to the policy held by the Trust, it was found that there could be some improvements made to the policy which would aim to strengthen the response medical professionals, working in the Emergency Department, can give to the patients attending. These included clearer advice on when to complete a risk assessment, what questions could be asked when a patient discloses a difficulty in a relationship, and the reminder that victims can be males or females etc.…

9.18 It was highlighted by the Panel that where appropriate this organisation did share information with others, for example the Somerset Drug and Alcohol Service and the GP. However, to the contrary it was also found within the IMR that where another agency was involved there was a sense of complacency amongst the staff to deal with the issue because there was an assumption that the other organisation had already undertaken a risk assessment and made any necessary referrals.

9.19 The IMR author also advised in the report that the Trust is currently seeking to employ a Homeless Health Support Worker with local services. This post will aim to support homeless people who attend the Emergency Department. It was discussed and agreed by the Panel that should this post have been in place when Mr D was being seen by this service then additional support may have been available to him which may have also teased out further information about his current situation.

Avon and Somerset Constabulary

9.20 This IMR was also very thorough and each contact with Mr D had been considered in detail. There were in excess of 20 incidents reported to the police regarding Mr D and Miss E and therefore this organisation was critical to understanding what was known about the couple and the status of their relationship.

9.21 Within the IMR, each contact was scrutinised and the Panel considered each contact. There were a number of contacts which were categorised correctly as a 'domestic incident' however despite neighbours reporting Miss E as the primary aggressor; shouting and reportedly throwing items, Mr D was often seen as the perpetrator and therefore there were missed opportunities to undertake a DASH risk assessment with him as the victim.

9.22 Similarly to the point above, Mr D was not referred to the local specialist support service for domestic abuse or victim support team because he was not recognised as the victim. Mr D had a nickname on police systems of 'Gay [redacted]' yet he was not recognised as being bisexual. In addition, what interestingly transpired from the Panel discussions was that when Miss E was recognised as a victim in a number of incidents, a referral was not always made to the Lighthouse Victim and Witness Care service to offer support. This did not provide assurance to the Panel that there was a robust victim support process in place following reported domestic incidents to the police.

9.23 With reference to the Lighthouse Victim and Witness Care Service, this services aims to provide a comprehensive coordination function following police attendance at an incident. The team works closely with other agencies including local specialist domestic abuse support services to refer victims onto for advice and support and an another team called the Safeguarding Coordination Unit screen and re-assess for safeguarding actions and referrals to MARAC. It is clear that the lighthouse team did thoroughly research these incidents, however on occasion the follow up actions were not taken. At the time of this case, the lighthouse team would only follow up actions where there is a crime. Unfortunately, a number of the incidents reported and attended by the police for this case did not equate to a crime and therefore did not fall into the remit of the lighthouse team.

9.24 In the opinion of the IMR Author there was also a missed opportunity to use the neighbourhood beat teams to review and follow up with Mr D and Miss E following repeated domestic abuse calls. It was also highlighted by this author that some additional guidance on domestic abuse screening techniques to avoid colluding with

the perpetrator, providing services to someone who doesn't need them and equipping a perpetrator of domestic abuse (who presents as a victim) with information that may be used to further abuse their partner.

9.25 The Panel agreed that there was some good practice shown by a number of officers when attending Miss E's property following a domestic incident because where a DASH was refused by either party, often officers would attempt to complete one afterwards to understand the severity of the risk and issues. This provided assurance that the officers recognised the importance of risk assessing domestic incidents. In addition to this, the Panel also felt that one officer in particular should be commended for their efforts to escalate their concerns based on poor mental health of both parties, drug misuse and regular police attendance at Miss E's address. The officer used their professional judgement which displayed a good understanding that a different intervention or action was needed.

Taunton Association for the Homeless

9.26 This IMR was commissioned because both parties had been known to this organisation. It transpires from the IMR that there was no evidence to suggest that they were in a relationship and knew one another well prior to January 2016 when we know their relationship began. However, in the opinion of the IMR author and Panel this review has been a useful process to the organisation in raising the awareness of domestic abuse as a safeguarding issue of its own.

9.27 By considering what policies, protocols and training are in place to deal with domestic abuse cases for this small, local organisation has highlighted a number of gaps and therefore these opportunities can be taken forward to improve this agency's response to domestic abuse.

Bristol Gloucester Somerset Wiltshire (BGSW) Community Rehabilitation Company

9.28 This IMR has provided the review with a significant amount of background information on Mr D because he was known to this service before his custodial sentence in 2015, which has been extremely valuable. Mr D disclosed long term issues with depression in 2012 when he first became known to this service and it was highlighted following a thorough analysis that the case management assessment skills for identifying vulnerability and working with service users with long term mental health issues requires significant improvement. This was because his only vulnerability which was recognised and flagged related to his drug use.

9.29 Another theme which has been emphasised in this case was that case managers meeting Mr D on a relatively frequent basis were focussed on his drug misuse and offending and therefore did not take more holistic approach to his situation and wellbeing. The IMR author noted that this organisation is undertaking a programme of work called Skills for Effective Engagement and Development (SEEDs) which aims to develop practitioner's skills and practices in working with offenders more holistically and increase their confidence to be more investigative in their approach.

9.30 This IMR also highlighted to the Panel Mr D's sexuality, following a disclosure of a same sex relationship in 2012 to this organisation. Following the exploration of how Mr D was dealt with by this organisation at this time, the IMR author found that greater work was needed to seek assurance that case managers are more responsive to the needs of LGBT service users. This was because it appeared from the case records that his sexuality and other vulnerabilities were not risk- assessed (given it is a protected characteristic) and therefore there was not an adequate plan to protect and support him sufficiently. Instead, contacts Mr D had with this service were more often reactive.

9.31 This IMR did also highlight some good practice whereby this organisation attended a meeting with the prison, Mr D and his parents following Mr D's completion of a programme whilst in prison. Attendance at the meeting enabled the case manager to learn what Mr D had completed during this period so that the same learning could be reinforced following release from prison.

9.32 There was also some discussion by the Panel in relation to Mr D's behaviour (failing drug tests) following his release from prison and what actions were and were not taken by this service. It is acknowledged in the IMR that at various stages a review of the initial sentence plan and his licence conditions should have been undertaken and that case managers should be reminded to comply with Probation Instruction on Recall.

9.33 Another learning point which was raised by the IMR author related to the policies held by this organisation for safeguarding and domestic abuse. Both Miss E and Mr D were known to this service albeit not at the same time during 2016-17, however this review has raised the concern that where case managers become aware of service users forming relationships with others that have violence, mental health or substance misuse in their profile that safeguarding action should be taken in some form, underpinned by a clear policy and process.

9.34 Finally, a Panel discussion was had in relation to the disconnect between the reported police incidents and this agency because this information was not shared with the case managers. The Panel felt that had this information been shared, given Mr D had to attend regular appointments with this organisation a conversation could have been explored about his relationship. The Panel agreed that a recommendation should be considered to address this issue.

10 Themes from the Review

10.1 There were a number of other themes, which were discussed by the Panel as part of this review. These were the following;

10.1.1 Situational Couple Violence
10.1.2 Recognition and support locally for male victims
10.1.3 Shared learning across the whole system for complex cases

10.2 Situational Couple Violence (SCV) was defined by Johnson (2008) as a type of intimate partner violence which is enacted as a means of controlling a specific situation or context and is often a disagreement that escalates into violence, as opposed to being about exerting power and control from one person onto another. SCV is relevant here because there is little evidence from the risk assessments undertaken to suggest that the intimate partner violence/abuse experienced by Mr D or Miss E was about power and control. To the contrary, the evidence suggests it was an unhealthy relationship where abuse occurred in the context of conflict about drug misuse. We understand from the reported incidents to the police that Miss E was perhaps the primary aggressor, however without any understanding of how Mr D felt about many of the reported incidents it is unclear to categorise whether one individual was the victim.

10.3 There have been a number of pieces of research undertaken to understand more about what the difference is between the power and control model of intimate partner violence and SCV, as well as the impact. A study by Leone, Johnson and Cohan (2007) found that those experiencing SCV are more likely to seek help from family and friends informally, in the hope that they can 'fix' the problem which causes the conflict and remain in the relationship. This is fundamentally different to an abusive relationship focussed on a power and control phenomenon where victims seeking help are often looking for an escape route to leave the relationship due to fear of violence, abuse and sometimes death. This is useful to note in this review because without engagement from family members we are unsure whether Mr D sought to find help for this situation and his relationship with Miss E. However, this does highlight the importance of how raising the awareness about how friends and family can support others in situations of intimate partner violence is critical to preventing further harm.

10.4 All organisations that were part of the Panel for this review recognised this theme and many have incorporated this into their recommendations to improve how they can respond to this type of intimate partner violence as Johnson describes.

10.5 The next theme which was considered by the Panel related to the awareness of male victims of domestic abuse. This was recognised at numerous points during the Panel discussions for example, where upon attendance at Miss E's address by the police she was identified as a victim on the majority of occasions due to preconceived ideas as opposed to what had been reported by third parties. In addition, the domestic abuse policy created by Taunton and Somerset NHS Foundation Trust also did not acknowledge well enough that men can be victims of domestic abuse too. The Panel understands the statistics for domestic abuse and how it is more prevalent for women to be victims, however this review and the responses given by organisations highlighted a training and awareness gap.

10.6 The Chair reminded all organisations to re-consider their policies and training schedules to ensure that the message is clear how males can be victims too. The Panel were assured that support services are available locally for those male victims

who do disclose and wish to seek support; this is via Somerset Integrated Domestic Abuse Service (SIDAS). Somerset Integrated Domestic Abuse Service supports individuals experiencing abuse regardless of gender or sexuality. However ManKind and Men's Advice Line, two national organisations who specialise in supporting male victims of domestic abuse also are known in Somerset and therefore Panel members were aware of these services.

10.7 Finally, the last theme which was considered as part of the review related to sharing learning across the system in particular the health system. This was emphasised as a concern when consideration was given to the effective learning required for health professionals, with particular regard to practicing professional curiosity and therefore the importance of where one part of the health system e.g. The acute provider decides to embed this as a recommendation how the community provider and mental health provider should also consider the same. This is so that victims of domestic abuse receive a consistent level of service and response to this safeguarding issue in the same health system.

10.8 Following a comprehensive discussion about this concern held by the Panel it was agreed that the governance for embedding consistent learning across the systems in a coordinated fashion was held by the Adults Safeguarding Boards and therefore the Panel was content to support a recommendation which reflected this.

11 Conclusions

11.1 In reaching their conclusions the Review Panel have focussed on the following questions;

- Has the Panel fulfilled the Terms of Reference for this review by undertaking a variety of lines of enquiry, including discussing the drat chronology and entering broader more strategic discussions about cross authority working?
- Will the actions and suggestions for improvement improve the response domestic abuse victims have in the future?
- What are the key themes or learning points from this review?

11.2 The Review Panel are satisfied that the Terms of Reference have been fulfilled and that discussions did take place at the Panel meeting to consider what was known prior to Mr D's death in April 2017.

11.3 The Panel is of the opinion that the agreed recommendations appropriately address the points raised throughout the review, particularly in relation to the lessons learnt and the themes discussed.

11.4 The Panel felt that there were a number of key issues which were fundamental to the discussion and therefore key learning points. Firstly, the fact that Mr D was not regarded as the victim, despite third party reports, did not enable conversations and appropriate risk assessments to be undertaken with him. The Panel also felt that because he was a male there was an assumption made that he was the perpetrator of

abuse for the domestic incidents reported to the police, therefore summarising that gender stereotypes were most probably at play during this time.

11.5 Another key learning point which the Panel felt was replicated across a number of organisations was that of professional curiosity. It was felt that at most contacts Mr D had with agencies it was surface level conversations about his offending, drug use or clinical needs; not investigative or holistic in seeking further information about the situation and life he was leading. This resulted in the Panel concluding that more awareness raising and training was required by practitioners on how to engage with individuals with complex needs and ask sensitive questions.

11.6 Lastly, despite the complexities which Mr D had; poor mental health, chaotic drug use, involvement in repeated domestic incidents reported to the police, homelessness and his licence conditions from prison there was no coordination of information held by all of the agencies to discuss and agree what additional actions/support could be offered to Mr D. Mr D was a vulnerable individual as a result of these complexities and should all of the information been shared, there may have been a greater chance of one agency being able to engage with him and support him with some positive steps forward. However, he did not fit an obvious multi agency strategy discussion process therefore this would have had to has been a bespoke complex case needs meeting.

12 Recommendations

12.1 Somerset Drug and Alcohol Service

12.1.1 Additional training to be provided to all this agency's staff in relation to identifying Domestic Abuse and Violence and making appropriate referrals

12.1.2 This agency to ensure risk assessments are reviewed and completed in absence of the service user if they continually fail to engage in treatment and risk management plan to consider and address "past" issues as well as "present".

12.1.3 This agency to consider developing "Crisis, Relapse & Contingency Plans" with details of emergency contacts and useful advice to use in the event of serious distress. This has now been implemented and is operational.

12.2 Somerset Partnership NHS Foundation Trust

12.2.1 Information volunteered re relationship difficulties should stimulate further questioning / "professional curiosity" by staff involved to gain fuller understanding of what client is experiencing at that time. This could be fulfilled by emphasising the importance in safeguarding adults training and the Trust's newsletter as a reminder.

12.2.2 Risk screen and information to be completed in relation to all MHA assessments to include recording current suicide risk. This would be achieved by monitoring this practice through supervision and caseload management.

12.3 **Somerset Clinical Commissioning Group**

12.3.1 This agency, with the support of the Chair, to seek further guidance and clarity to be sought from the Home Office in relation to sharing information about an 'alleged perpetrator' following a suicide.

12.4 **Taunton and Somerset NHS Foundation Trust**

12.4.1 In all cases of assault that attend the Emergency Department, the nature of the assault should be documented and the victim should be asked who the perpetrator of the assault was. This should be clearly documented. If domestic abuse is identified staff should act in line with Trust policy.

12.4.2 This agency to continue with plans to employ a Homeless Health Support Worker for the Trust to assist with co-ordinating multi-agency intervention (including where domestic abuse identified) when required following attending the Emergency Department

12.4.3 Review if improvements can be made to the Emergency Department's response to domestic abuse e.g. Routine enquiry.

12.4.4 This agency to share the overall findings of the DHR with Emergency Department Staff

12.4.5 This agency to add a slide to the Emergency department training presentation outlining the issues raised by this case.

12.4.6 Learning from this review report to be shared with the Trust Safeguarding Committee

12.4.7 All referrals to the Safeguarding team to be consider for flagging on the MAXIMS system. Flags to be added for medium risk cases (alongside current high risk flagging) and to use professional judgment when considering flagging other cases.

12.4.8 This agency to change wording on front page of Domestic Abuse policy from 'Women should be regularly asked if they are experiencing domestic abuse' to 'Ask any individuals whose attendance could be related to Domestic Abuse (such as assaults of physical injuries) if they are a victim of Domestic Abuse and to use more consistent terminology in the policy; using the term Domestic Abuse rather than Domestic Violence.

12.5 **Avon and Somerset Constabulary**

12.5.1 Situational couple violence' recognised as an issue and to be added to the current DA procedural guidance, to include information on screening techniques. In addition, this guidance will need to be disseminated through training.

12.5.2 This agency to ensure that there is a process in place across the force where repeated DA reporting (including reports by third parties) are tasked for review and followed up by Neighbourhood Beat teams.

12.6 **Taunton Association for the Homeless**

12.6.1 This agency to revise their safeguarding policy ensuring that domestic abuse is covered in detail with regards to spotting the signs of abuse, and steps that can be taken to help safeguard a victim from harm.

12.6.2 This agency to forge closer links with the domestic abuse specialist service in Taunton; Somerset Integrated Domestic Abuse Support Service to ensure that staff feel confident in signposting and making referrals to this agency.

12.7 BGSW Community Rehabilitation Company

12.7.1 BGSW CRC case managers to receive training in order to identify and take appropriate actions when there is potential domestic abuse in cases they manage.

12.7.2 This agency to ensure that staff demonstrate they clearly understand and adhere to BGSW CRCs approach to managing potential domestic abuse

12.7.3 Staff to clearly understand and adhere to BGSW CRCs approach to safeguarding

12.7.4 Case managers to develop an investigative approach when working with service users. With a particular emphasis on identifying potential domestic abuse, safeguarding, vulnerability and protected characteristics.

12.7.5 Case managers to develop effective information gathering/sharing practice with police and other key partner agencies.

12.7.6 Somerset Integrated Domestic Abuse Service

12.7.7 To promote their services to all individuals who maybe experiencing abuse regardless of gender or sexuality.

12.8 **Additional Panel recommendations**

12.8.1 SSAB to lead on sharing learning from DHR19 in relation to professional curiosity across health economy in Somerset and gain assurance that this learning is embedded across all NHS Trusts and change is implemented.

12.8.2 All Panel members to raise awareness of male victims of domestic abuse amongst their organisation.

12.8.3 Police and BGSW CRC to consider how they could improve communication channels where an individual is on licence and repeated involved in domestic incidents or similar.

12.8.4 Home Office to consider mandating housing associations to become part of DHR Panels where they have had some involvement in order to improve awareness and responses for domestic abuse victims.