



Domestic Homicide Review Executive Summary

Review into the death of Robert, who died in
January 2023 in Bristol

Review Panel Chair and Report Author:

Liz Cooper

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2025

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EXECUTIVE SUMMARY CONTENTS

Section	Page No.
The DHR Review Process	4
Contributors to the Review	5
DHR Review Panel Members	5
Chair of the DHR and Author of the Report	6
Terms of Reference	7
Summary of the Chronology	7-10
Conclusion/Key issues arising from the review	10
Lessons to be learnt	11-12
DHR Recommendations	12-13
Single Agency Recommendations	13-14
Appendix One Terms of Reference	15-18
Appendix Two Live DHR Action Plan	19-22
Appendix Three Home Office Feedback Letter	23-26

Keeping Bristol Safe Partnership and the Domestic Homicide Review Panel wish to express their sincere condolences to the family and friends of Robert.

Pen Portrait

Robert was a kind, loving and loyal person, his personality would see him be able to make friends wherever he went and he did frequently, which was later obvious at his funeral with the huge turnout of people who came to pay their respects and share stories of how he had impacted their lives.

He was a loving son, brother, husband, father and grandfather who fell in love all over again when his children, then grandchildren were born. Our fondest memories as a family were the time he would put into arranging fun days for his children, then grandchildren one being turning the garden into a huge water slide! The working extra hours to save enough money to take them on days out, and holidays with the grandchildren.

Robert loved music, he would enjoy many nights singing karaoke, Elvis being a particular favourite and he even learned to play the guitar which as a family we would have to listen to over and over again. He had a passion for cooking and could whip up the most delicious of meals with no recipe, just the ability to be able to know what would work, it was a skill we as a family most appreciated to come home to the most wonderful meals. He was also an amazing artist who even had one of his drawings of Bob Marley become a poster, one that we all have in our own homes now.

His number one priority was always his family; there was nothing he wouldn't do for them. Robert has left a space in each of our lives that will never be replaced or forgotten.

Words by Robert's family

1.0 THE REVIEW PROCESS

1.1 This Executive Summary outlines the process and findings of a Domestic Homicide Review (DHR) undertaken by the Keeping Bristol Safe Partnership (KBSP) into the death of Robert. All the names in this review have been anonymised for the purpose of confidentiality.

1.2 The following pseudonyms have been used in this review to protect the identities of the victim and perpetrator.

Name	Relationship to Robert
Robert	N/A (Victim)
Helen	Girlfriend of Robert, known victim of domestic abuse and perpetrator of Robert's death

1.3 Robert died in January 2023, and the police notified the KBSP of his death. The KBSP concluded that Robert's death met the criteria for a DHR¹ on 5 June 2023. The DHR commenced in July 2023 following the recruitment of an Independent Chair, Liz Cooper, and concluded with submission to the Home Office in May 2025. The Home Office guidance states that a DHR should be completed within six months of the initial decision to establish one. This timeframe was extended for the following reasons:

- The completion of the criminal trial.
- To allow the Independent Chair considerable time to engage with the victim's family.

1.4 In the early hours of the morning in January 2023, the police and ambulance service attended the home of Helen after reports that a male (Robert) had been stabbed. Robert was found at Helen's home with a single stab wound, and he died at the scene. Helen was arrested on suspicion of murder. During the police interview, Helen was asked what had happened and she stated that "me and my partner had a fight. A massive fight and I stabbed him with a knife and he's dead, it was not my intention to kill him".

1.5 Following a criminal investigation, Helen was convicted of murder by a jury at a crown court. Helen was jailed for life with a minimum of fifteen years with the judge saying, "you acted in a moment of rage".

1.6 Following the criminal trial and conviction, the full inquest was suspended under Schedule 1 of the Coroners and Justice Act 2009 given the outcome of the criminal trial. Once the trial was concluded, a death certificate was issued for Robert.

¹ DHR-Statutory-Guidance-161206.pdf(publishing.service.gov.uk)

1.7 All agencies that potentially had contact with Robert and Helen prior to Robert's death were contacted and asked to confirm any involvement with the case. The DHR commenced in **July 2023**.

2.0 CONTRIBUTERS TO THE REVIEW

2.1 This DHR has followed the statutory guidance issued following the implementation of Section 9 of the Domestic Violence Crime and Victim Act 2004 as well as the local DHR protocol developed by the KBSP.

2.2 The following agencies submitted Individual Management Reviews (IMRs) detailing their contact with Robert and Helen:

- Avon and Somerset Constabulary (the Police)
- Bristol City Council - Children Social Care (BCC CSC)
- University Hospital Bristol and Weston NHS Trust (UHBW)
- Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)
- Next Link Plus
- Bristol City Council - Housing and Landlord Services

2.3 The IMRs were completed by senior staff who had no direct management or involvement with Robert, Helen or any family members.

2.4 The Panel gave detailed consideration and professional challenge to the IMRs submitted by these agencies including inviting IMR authors to present their IMRs at a Panel meeting.

2.5 In addition, the South Western Ambulance Service NHS Foundation Trust and Avon Fire and Rescue Service provided information in a manner which was proportional to their involvement with Robert and Helen.

2.6 The Independent Chair engaged with the Victim Support Homicide Workers and several letters including the Home Office leaflet for family members were sent directly to Robert's family. Robert's family contacted the Independent Chair and explained that they would like to engage with the review. The contribution from the family has been reflected in this Executive Summary.

2.7 The Independent Chair spoke with Helen via a video link from her prison location. Helen provided some background information about Robert, their relationship and her life.

3.0 THE REVIEW PANEL MEMBERS

3.1 Panel Membership

3.1.1 The Panel consisted of senior representatives from the following agencies. All Panel members were independent of any involvement with Robert and Helen.

Liz Cooper	Independent DHR Chair / Overview Report Author
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Statutory Review Officer	Keeping Bristol Safe Partnership
Senior Public Health Specialist	Bristol City Council Public Health
Detective Chief Inspector	Avon and Somerset Constabulary – Major and Statutory Crime Review Team
Through Care Services Placements Manager	Bristol City Council Children and Families Services
Safeguarding Lead for Children in CAMHS and AWP Domestic abuse Lead	Avon and Wiltshire Mental Health Partnership
Senior Service Manager	Next Link Plus Domestic Abuse Service
Deputy Designated Nurse (Safeguarding for all Ages)	Bristol, North Somerset and South Gloucestershire Integrated Care Board
Housing Safeguard Reviews and Improvement Officer	Bristol City Council Housing and Landlord Services
Deputy Head of Safeguarding	University Hospital Bristol and Weston NHS Foundation Trust
Area manager	Victim Support (sub-contracted by Next Link Plus to provide domestic abuse services to males living in the Bristol area)
Vulnerable Adults Manager & Joint Safeguarding Lead	Avon Fire & Rescue Service
Named Safeguarding Specialist for Adults	South Western Ambulance Service NHS Foundation Trust
Administrator	Independent

3.1.2 The Review Panel met on six occasions, all virtually, and agency representatives were of the appropriate level of expertise.

4.0 CHAIR OF THE DHR AND AUTHOR OF THE OVERVIEW REPORT

4.1 The Chair and author of the review is Liz Cooper, formerly Assistant Chief Executive at Spelthorne Borough Council (Surrey). Liz has a wide range of expertise in services for vulnerable adults and children, housing and domestic violence. Liz has conducted several Domestic Homicide Reviews for the Home Office and has attended Home Office Independent Chair training for DHRs and further DHR Chair training with Advocacy After Fatal Domestic Abuse (AAFDA). Liz has completed her (Level 3) Certificate in Chairing a Domestic Homicide Review. Liz is a member of the AAFDA DHR Chairs Network and has also been involved with several Safeguarding Adult Reviews. Liz has no connection with any of the agencies in this case.

4.2 The DHR administrator had no connections with any of the individuals or agencies involved in this DHR.

5.0 TERMS OF REFERENCE

5.1 The Terms of Reference (TOR) were agreed by the DHR Panel in December 2023 and were regularly reviewed and amended as further details of events in Robert and Helen's life emerged. The full TOR is included in Appendix One. The DHR aims to identify the learning from this case and for actions to be taken from that learning, with a view to preventing unexpected deaths and ensuring that individuals and families are better supported. The key lines of enquiry are:

- To identify barriers for male victims of domestic abuse disclosing and seeking support from agencies, locally and nationally.
- Do professionals and the wider community understand what the impact of excessive substance or alcohol use has within a relationship?
- Do professionals understand the impact of bidirectional / mutually abusive relationships and what support there is available for the male and the female in the relationship?
- Gender and assumptions about perpetrators of domestic abuse.
- Do professionals and the wider community understand the correlation of mental health and domestic abuse and the impact on a victim and a perpetrator?
- To identify what support is available for a male/female victim/perpetrator of domestic abuse.

5.2 There was very little agency information about Robert, but Helen had been in contact with several agencies prior to her meeting Robert in 2022. All the organisations involved with Robert and Helen were asked to review how their agency responded to the key lines of enquiry.

5.3 The timeframe for this DHR was agreed as January 2022 until January 2023 when Robert died. This period represented the known relationship between Robert and Helen. Agencies were also requested to include any significant events prior to this timeframe if information added to the narrative or had a significant impact on Robert or Helen.

6.0 SUMMARY CHRONOLOGY

6.1 Background Information relating to Robert and Helen

6.1.1 Robert owned his own business, along with a friend. Robert loved his music, his football and cooking for his family.

6.1.2 Robert had been previously married and had adult children and grandchildren who he kept in contact with. The marriage broke down in 2022, as Robert had started to drink more, following the death of his brother. Although Robert tried to give up drink

and sought support from Alcoholics Anonymous², the relationship ended. Robert also had a sister and a brother (deceased).

6.1.3 Robert and Helen met online in mid-2022. Robert was living with his mother but began to spend more time at Helen's home. According to Helen, Robert's business was struggling and as Helen was not working, they spent most of their time together in Helen's home. Robert and Helen, both had anxiety and were feeling "low". Helen reported that she and Robert were both drinking unhealthily which began to impact on their relationship.

6.1.4 During the relationship the police responded to seven incidents relating to Robert and Helen, prior to Robert's death. Robert was identified as experiencing domestic abuse on two occasions; food being thrown at him and swelling on the eye, although in most of the reported incidents, Robert was seen as the perpetrator of the domestic abuse.

6.2 Key Practice Episodes

6.2.1 The Independent Chair used the SCIE model "Learning Together"³ to identify the key practice episodes (KPE) in the lives of Robert and Helen.

6.3 KPE One: Known relationship between Robert and Helen and the first domestic abuse incident.

6.3.1 In June 2022, Helen called the police to say that Robert, her partner, was refusing to leave her home following a verbal argument. The police attended Helen's home and spoke with Robert and Helen separately. The police did not identify any visible injuries or damage to Helen's home and Robert agreed to go back to his mother's home. Helen said she did not want to pursue anything further with the police. The police completed an officer-led Domestic Abuse, Stalking and Honour-based Violence model risk assessment (DASH)⁴ but as this was the first incident between Robert and Helen, no further action was taken.

6.3.2 Early August 2022, Helen went to the Accident and Emergency (A&E) department at her local hospital with a bruised shoulder and ongoing pain. Helen said she had fallen and hit her shoulder on a door whilst moving a cooker. Helen saw a fracture professional who gave advice but there was no routine enquiry about domestic abuse.

6.4 KPE Two: Second recorded incident of domestic abuse between Robert and Helen.

6.4.1 Mid-August 2022, Helen called the police to say that Robert was refusing to leave her home. The police went to Helen's home and Helen had taken several tablets and an ambulance had been called. Helen told the police that she was happy for Robert to

² www.alcoholics-anonymous.org.uk

³ www.scie.org.uk/children/learningtogether

⁴ www.dashriskchecklist.com - Domestic abuse, stalking and honour-based abuse checklist

stay, and the police completed a safeguarding check for Helen which did raise concerns about the overdose that Helen had taken. The ambulance crew also attended Helen's home, and they completed a safeguarding referral for Helen and sent it to the police, BCC CSC and Helen's GP.

6.5 KPE Three: Robert assaulted by Helen

6.5.1 September 2022, Helen called the police and said that there had been an incident between her and Robert. The police went to Helen's home and Helen said that nothing physical had occurred but that she had thrown food over the home. When the police spoke to Robert, he told officers that there had been a verbal argument and that Helen had thrown food over him. Robert also disclosed that a month earlier Helen had punched him in the face multiple times. The police arrested Helen for assault but Robert stated that he did not wish to engage with the police or support a prosecution. A DASH was completed for Robert and rated standard and a Domestic Violence Protection Order⁵ (DVPO) was considered to protect Robert, however it was felt that it was not proportionate or appropriate. A Treat As Urgent (TAU)⁶ notice was added to Helen's property.

6.6 KPE Four: Robert receives a Domestic Abuse Violence Protection Notice and further deterioration of Helen's mental Health and concerns over her alcohol use.

6.6.1 Late September 2022, Helen's GP referred Helen to the AWP Single Point of Access (SPA) saying she was having a mental health crisis. After several attempts, the AWP SPA managed to speak with Helen, however Helen went on to explain that she did not wish to have mental health support but that she had been given details of support services including Next Link⁷ (the domestic abuse support service).

6.6.2 Early in November 2022, Helen's neighbour called the police as they heard a female shouting "get off me". The police attended and spoke with Helen and Robert. Helen said that there had been an argument and Robert had pulled her hair and banged her head against the wall. The police noted swelling on Helen's head. It was also noted that Robert had an injury under his eye. Robert was arrested, and a Domestic Violence Protection Notice (DVPN) was authorised against Robert followed by a DVPO, which was applied for in mid-November 2022 and was granted for 28 days by a magistrate's court.

⁵ <https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010> - Domestic Violence Protection Notice (DVPN) gives the police powers to make an abusive partner leave the premises and not to contact a victim for 48 hours. This can be extended for up to 28 days by magistrates, who issue a Domestic Violence Protection Order (DVPO). Survivors can use the time to consider their options and seek support.

⁶ TAU means that the police or other emergency services will respond quicker to a 999 call.

⁷ www.nextlinkhousing.co.uk

6.7 KPE Five: Further domestic abuse incident between Robert and Helen resulting in Robert breaching his Domestic Violence Protection Notice.

6.7.1 Early December, the police received an abandoned 999 call from Helen's address, and shouting could be heard in the background. As a TAU had been placed on the property, the police attended and Helen said that she and Robert had had an argument but that he had left the home and gone to his mother's home. The police searched Helen's home and found Robert hiding. This was in breach of his DVPN and Robert was prosecuted for the breach.

6.8 KPE Six: Death of Robert

6.8.1 In January 2023, Robert was stabbed by Helen. Ambulance crews tried to resuscitate Robert but despite several attempts, Robert was confirmed dead at the scene.

7.0 CONCLUSION/ KEY ISSUES ARISING FROM THE REVIEW.

7.1 The Panel felt that Robert's death and this DHR raised several learning points. This DHR highlights the complex dynamics of domestic abuse. Robert was primarily identified by the police as the perpetrator of domestic abuse, although on two occasions, Robert was seen as a potential victim where he also disclosed further incidents of abuse.

7.2 Alcohol played a significant role in the relationship between Robert and Helen and most of the known incidents involved alcohol use. Despite alcohol being an issue for both Robert and Helen, there was no known referral to any specialist drug and alcohol use organisation, although with such little agency contact with Robert, this may have been difficult. Professionals highlighted their concerns about Helen and her alcohol use but despite these concerns and agency involvement with Helen, there appears to have been no referral or support offered to help her to use alcohol more responsibly.

7.3 Helen had contact with a number of agencies and her mental health appears to decline.

7.4 In the judge's words and Helen's, the relationship between Robert and Helen was "toxic" and unhealthy, although loving at certain times. Robert and Helen spent a significant amount of time together in Helen's home due to home working and Helen not being in work. Robert and Helen both had financial issues, and Helen was trying to keep her home and struggling to pay the household bills with no contribution from Robert, according to Helen. The criminal trial transcript detailed the volatility within the relationship and alcohol fuelled arguments which often led to physical abuse.

7.5 The police attended several domestic abuse incidents, gave advice and arrested Robert and Helen on separate occasions. The police also considered a DVPN to protect Robert and instigated a DVPO against Robert to protect Helen. The police may not have had a full understanding of Robert and Helen's living arrangements as, according to Helen, they lived together so Robert spent very little time elsewhere and this may have impacted on the assessment of risk within the relationship.

8.0 LESSONS TO BE LEARNT

8.1 Gender/unconscious bias and not seeing Robert as a victim of domestic abuse

8.1.1 Everyone has their own unconscious bias. Even for people who are open minded and only observe the facts before concluding, it is likely that some bias will shape their opinion. Professionals can exhibit unconscious bias which means that they look for evidence to support their pre-held views and this can lead to poor decision making.⁸

8.1.2 Evidence within this DHR indicates that Robert was predominately identified as the perpetrator of domestic abuse and Helen, apart from one incident, was described as the victim. Although research and data shows that females are more likely to experience domestic abuse than men, this can impact on decision making by professionals. It is important that professionals understand their own unconscious bias and that decisions should be made based on fact and challenge.

8.1.3 Liz Harper and Dr Liz Bates identified in their research that although there is a prevalence of bi-directional, mutual violence in Interpersonal Violence (IPV), it has been understudied compared to unidirectional violence. It is important that professionals understand the concept, so they are in a better position to understand and challenge what is happening in a relationship and therefore provide the appropriate support.⁹

8.2 Professionals to understand the impact of alcohol within a relationship

8.2.1 Alcohol was a precursor for the verbal and physical arguments between Robert and Helen. The police identified on several of their visits that both Robert and Helen had been drinking and as both were at home all day, the alcohol intake would start due to boredom. Alcohol alone is not a cause of domestic abuse, however there are many ways in which alcohol and domestic abuse are related. Alcohol Change UK¹⁰ highlights that:

- Drinking and domestic abuse often occur at the same time.
- When alcohol is involved, abuse can become more severe.
- Controlling access to alcohol can become part of the abuse.
- People who experience domestic abuse may drink to try to cope.

8.2.2 It is important that professionals and the wider community understand the impact of alcohol not only on someone's health, but also the relationship between alcohol and domestic abuse. Professionals and the community need the knowledge to understand the links but also to have the knowledge of local support services. Bristol City Council's

⁸ www.ed.ac.uk - The University of Edinburgh, Equality, Diversity and Inclusion - Unconscious bias

⁹ <http://elizabethbates.co.uk> - Why we need to investigate experiences of Bi-directional Intimate Partner Violence (Liz Harper and Dr Liz Bates, July 2021)

¹⁰ www.alcoholchange.org.uk - Alcohol and Domestic Abuse

website had clear links to support provided by Developing Health and Independence (DHI) who were the provider of drug and alcohol support services at the time. DHI was the first call for all referrals and assessments. Bristol City Council have procured a new drug and alcohol service¹¹. As this new contract is awarded, professionals should be notified about the new referral process. In addition, awareness should be raised with the local community about the support available if they are using alcohol excessively and how to self-refer.

8.3 Understanding by professionals of the complex dynamics of domestic abuse

8.3.1 As already highlighted in this summary, there was evidence that Robert experienced abuse as identified by the police. Robert had marks around his eyes and Helen stated that she threw food at Robert following an argument. The DHR Panel spent significant time reflecting on the dynamics within the relationship between Robert and Helen including bidirectional violence and retaliatory violence, which highlights the complex nature of domestic abuse.

8.3.2 If professionals only see a victim and perpetrator then the support provided may not resolve the situation as both may be perpetrators and victims. Professionals and the wider community need to understand that the dynamics of domestic abuse can be complex, and practitioners should use their professional curiosity to better understand these complexities within a relationship in order to provide the most appropriate support to the person they are working with.

8.4 Raising awareness that males can experience domestic abuse

8.4.1 Robert did disclose to the police that he experienced physical abuse by Helen, which sometimes men feel that they are unable to. The ManKind Initiative has highlighted that 21% of male victims (2022/23) did not tell anyone they are a victim of partner abuse which is an improvement from 2017/18, where 49% chose not to disclose. This would indicate that males are becoming more able to disclose. Nevertheless, this DHR provides the opportunity to continue to raise awareness within Bristol that males can experience domestic abuse and what services are available to support them.

8.4.2 For males living in the Bristol area, there is a specific domestic abuse service provided by Victim Support as part of the Next Link Plus Partnership. This DHR provides an opportunity to remind professionals who may come into contact with male victims of domestic abuse about the specific male service and how to refer to the service.

9.0 DHR RECOMMENDATIONS

9.1 Local Partnership Recommendations

¹¹ [Support for Drug and Alcohol Recovery | Horizons Bristol | Horizons Bristol](#)

Recommendation One

1a) Bristol City Council Public Health and KBSP to raise awareness to professionals to highlight the impact of excessive alcohol use within a relationship and the support and resources available in the area to address excessive alcohol use.

Ownership; Bristol City Council Public Health and Keeping Bristol Safe Partnership

1b) Bristol City Council Public Health to update KBSP partners on the new substance use and alcohol support service and referral pathways, once in place.

Ownership; Bristol City Council Public Health

Recommendation Two

2a) KBSP to raise awareness of male domestic abuse services and referral pathways with all KBSP partners.

2b) Agencies within the KBSP to embed within domestic abuse training bidirectional and situational couples' violence to ensure professionals understand the dynamic nature of domestic abuse.

Ownership - Keeping Bristol Safe Partnership

9.2 Individual agency recommendations

9.2.1 Avon and Somerset Police

No recommendations.

9.2.2 Bristol City Council Children Social Care

No recommendations.

9.2.3 University Hospital Bristol and Weston

a) UHBW A&E Staff will complete initial triage and assessment of all cases presenting. If there are any safeguarding concerns, or any cases showing red flags, staff will proceed with targeted enquiries, especially cases noting delayed presentation, or where domestic violence is suspected or disclosed.

9.2.4 Avon and Wiltshire Mental Health NHS Partnership

No recommendations.

9.2.5 Bristol City Council Housing and Landlord Services

No recommendations.

9.2.6 Next Link Plus

No recommendations.

Domestic Homicide Review for Robert

Terms of Reference

Legal Framework

As defined in the Domestic Violence, Crime and Victims Act 2004, a Domestic Homicide Review (DHR) is 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 he was related or with whom he was or had been in an intimate relationship, or
- (b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

In cases of suicide

The Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) states further that:

'Where a victim took their own life and the circumstances give rise to concern, for example, if it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.'

Purpose and aim of the review

The purpose of a DHR is to:

- a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- b) 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;
- c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- e) contribute to a better understanding of the nature of domestic violence and abuse; and
- f) highlight good practice.

Methodology

The review will follow the process outlined in the [Home Office DHR Statutory Guidance 2016](#).

Operating principles

- a. The aim of this review is to identify and learn lessons as well as identify good practice so that future safeguarding services improve their systems and practice for increased safety of potential and actual victims of domestic abuse, as defined in the Domestic Abuse Act 2021
- b. The aim is not to apportion blame to individuals or organizations, rather, it is to use the study of this case to provide a window on the system.
- c. A forensic and non-judgmental appraisal of the system will aid understanding of what happened, the context and contributory factors and what lessons may be learned.
- d. The review findings will be independent, objective, insightful and based on evidence while avoiding 'hindsight bias' and 'outcome bias' as influences.
- e. The review will be guided by humanity, compassion and empathy with the victim's 'voice' at the heart of the process.
- f. It will take account of the protected characteristics listed in the Equality Act 2010
- g. All material will be handled within Government Security Classifications at 'Official - Sensitive' level.

Specific Terms of Reference

- To identify barriers for male victims of domestic abuse disclosing and seeking support from agencies, locally and nationally.
- Do professionals and the wider community understand what the impact of excessive substance or alcohol use has within a relationship.
- Do professionals understand the impact of bidirectional / mutually abusive relationships and what support there is available for the male and the female in the relationship.
- Gender and assumptions about perpetrators of domestic abuse.
- Do professional and the wider community understand the correlation of mental health and domestic abuse and the impact on a victim and a perpetrator.
- To identify what support is available for a female victim/perpetrator of domestic abuse.

Time period under review

The period under review is January 2022 – January 2023, except for any other relevant information relating to domestic abuse prior to this date.

DHR Chair and Panel Membership

Liz Cooper-Borthwick has been appointed as the Independent Chair and Author of the review panel and agreed to commence these duties in July 2023.

Panel members are independent of any line management of staff involved in the case and sufficiently senior to have the authority to commit on behalf of their agency to decisions made during the review. The following agencies and individuals constitute the DHR panel:

Liz Cooper	Independent DHR Chair / Overview Report Author
Statutory Review Officer	Keeping Bristol Safe Partnership
Senior Public Health Specialist	Bristol City Council Public Health
Detective Chief Inspector	Avon and Somerset Constabulary – Major and Statutory Crime Review Team
Through Care Services Placements Manager	Bristol City Council Children and Families Services
Safeguarding Lead for Children in CAMHS and AWP Domestic abuse Lead	Avon and Wiltshire Mental Health Partnership
Senior Service Manager	Next Link Plus Domestic Abuse Service
Deputy Designated Nurse (Safeguarding for all Ages)	Bristol, North Somerset and South Gloucestershire Integrated Care Board
Housing Safeguard Reviews and Improvement Officer	Bristol City Council Housing and Landlord Services
Deputy Head of Safeguarding	University Hospital Bristol and Weston NHS Foundation Trust
Area manager	Victim Support (sub-contracted by Next Link Plus to provide domestic abuse services to males living in the Bristol area)
Vulnerable Adults Manager & Joint Safeguarding Lead	Avon Fire & Rescue Service
Named Safeguarding Specialist for Adults	South Western Ambulance Service NHS Foundation Trust
Administrator	Independent

Chronologies, individual management reviews (IMR) and other reports

A chronology will be requested from the following organisations:

The deadline to complete and submit the chronology is 14/09/2023.

An IMR will be requested from the following organisations:

- Avon and Somerset Constabulary
- Bristol City Council Children Social Care
- Next Link Plus
- Bristol City Council Housing Services
- BNSSG Integrated Care Board
- Avon and Wiltshire Mental Health Partnership
- Avon Fire and Rescue Service
- University Hospital Bristol and Weston NHS Trust

The deadline to complete and submit the IMR is 11 December 2023.

Family involvement

The DHR will seek to involve the family of the subject of the review in the process, considering who the family wishes to be involved as lead members and identifying other people they think are relevant to the DHR process.

We will seek to agree a communication strategy that keeps the family informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

Media and communications

All media enquiries must be managed by the Communications Advisor to the KBSP in consultation with the KBSP Independent Chair.

Publication

Publication of overview reports and executive summaries will take place after agreement from the Home Office Quality Assurance Panel. The panel and family members will be consulted as part of the publication planning. The reports will be published on the Keeping Bristol Safe Partnership and Bristol City Council website.

Terms of reference agreed

The panel agreed upon these terms of reference via correspondence in December 2023.

The terms of reference will be kept under review by the panel throughout the review.

Appendix Two: Live DHR Action Plan

	Recommendation	Scope	Action	Lead Agency	Outcomes	Target Date	RAG rating
1.	<p>Recommendations One</p> <p>A. Bristol City Council Public Health and KBSP to raise awareness to professionals to highlight the impact of excessive alcohol use within a relationship and the support and resources available in the area to address excessive alcohol use.</p> <p>B. Bristol City Council Public Health to update KBSP partners on the new substance use and alcohol support service</p>	Local	<p>1A.1. BCC Public Health and Bristol Horizon's to launch the new alcohol pathway with consideration of the impact of excessive alcohol use within a relationship.</p> <p>1A.2. BCC to develop a professionals' campaign and support resources for practitioners to understand the impact of excessive alcohol use within a relationship including domestic abuse and for this to be promoted through various mediums.</p> <p>1B.1. Learning brief to be produced for professionals about the arrangements for the provision of support for</p>	<p>1A.1 & 1A.2. BCC Public Health and KBSP</p> <p>1B.1. Public Health and</p>	<p>1A.1 & 1A.2. Professionals are better informed about alcohol use and domestic abuse.</p> <p>1B.1. Professionals across the Partnership have knowledge of organisations who</p>	<p>1A.1. February 2026.</p> <p>1A.2. June 2026.</p> <p>1B.1. April 2026.</p>	<p>1A.1. Complete. 26/02/2026: The new alcohol pathway has now gone live within the Horizons treatment service, discussions taking place about domestic abuse training for Horizons staff.</p> <p>1A.2. Not yet started. 26/02/2026: Professional's campaign still to be developed and promoted.</p> <p>1B.1. In progress. 26/02/26: Horizons have been delivering webinars to a range of different professionals across Bristol about the support available for</p>

	Recommendation	Scope	Action	Lead Agency	Outcomes	Target Date	RAG rating
	and referral pathways, once in place.		people experiencing alcohol use.	new provider	can provide support to people who may be experiencing alcohol use/domestic abuse or both.		people experiencing alcohol use. A Learning Brief is to be developed now that the alcohol pathway has launched.
2.	<p>Recommendation Two</p> <p>A. KBSP to raise awareness of male domestic abuse services and referral pathways with all KBSP partners.</p> <p>B. Agencies within the KBSP to embed within domestic abuse training</p>	Local	<p>2A.1. KBSP to raise awareness of the specific male domestic abuse support provider in Bristol promoted through various mediums.</p> <p>2B.1. KBSP partner agencies provide assurance that their domestic abuse</p>	<p>2A.1. KBSP</p> <p>2B.1. All agencies with KBSP</p>	<p>2A.1. Professionals know and feel confident to signpost and refer male victims of domestic abuse to their specific support provider in Bristol.</p> <p>2B.1. Professionals understand that males can suffer</p>	<p>2A.1. May 2026.</p> <p>2B.1. June 2026.</p>	<p>2A.1. In progress. 03/03/2026: Next Link and South Gloucestershire Council are leading on the development of the campaign to highlight the support available to male victims. This will be shared on the KBSP website and social media pages when launched in Spring 2026.</p> <p>2B.1. In progress. The KBSP Training Offer is complete. This covers</p>

	Recommendation	Scope	Action	Lead Agency	Outcomes	Target Date	RAG rating
	bidirectional and situational couples' violence to ensure professionals understand the dynamic nature of domestic abuse.		training offer includes examples of male victims, bidirectional and couples' violence.		domestic abuse and that the dynamics of domestic abuse can be complex and needs professional curiosity.		examples of male victims of domestic abuse and other domestic abuse typologies including violent resistance and situational couples' violence. The KBSP and BCC Public Health Teams will also produce a professional's resource covering these topics which can be published on the KBSP website.
3.	Agency recommendation A. UHBW A&E Staff will complete initial triage and assessment of all cases presenting. If there are any safeguarding	Local	3A.1. Safeguarding lead to discuss with the UHBW Matron and Divisional Director of Emergency Departments the current level of use of targeted domestic abuse enquiry and documentation by	3A.1. University Hospital Bristol and Weston - Deputy Head of	3A.1 For the Safeguarding team to produce an audit tool that aims to measure current use and documentation of targeted domestic abuse enquiry in	3A.1 February 2026.	3A.1. Completed on 23/02/2026.

	Recommendation	Scope	Action	Lead Agency	Outcomes	Target Date	RAG rating
	concerns, or any cases showing red flags staff will proceed with targeted enquiries, especially cases noting delayed presentation, or where domestic violence is suspected or disclosed.		Emergency Department staff (with a focus on patients presenting with injury and delay in presentation)	Safeguarding	UHBW Emergency Departments. This will allow the Emergency Department to identify any gaps and improve the use and documentation of the targeted Domestic Abuse enquiry. ED /safeguarding team to set up 6 monthly audits within the ED.		

Appendix Three: Home Office Feedback Letter

Interpersonal Abuse Unit

Tel: 020 7035 4848

London
SW1P 4DF



Home Office

2 Marsham Street

www.homeoffice.gov.uk

KBSP Business Unit (City Hall)

Bristol City Council
PO Box 3399
Bristol
BS1 9NE

15 January 2026

Dear KBSP Business Unit,

Thank you for submitting the Domestic Homicide Review (DHR) report (Robert) for Bristol Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Board. The report was considered at the QA Board meeting on 3rd December 2025. I apologise for the delay in responding to you.

Please find the QA Board's feedback in the form below. On completion of the changes suggested the DHR may be published.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter and the feedback form is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Board letter and feedback form should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Board, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Board

DHR QA Board Feedback for the Community Safety Partnership

TITLE OF DHR	Robert
COMMUNITY SAFETY PARTNERSHIP	Bristol
DATE REVIEWED BY QA BOARD	03 December 2025
DECISION	Publish with amendments
GOOD PRACTICE COMMENDED	<ul style="list-style-type: none">• This is a succinct but comprehensive report.• There is good citing of relevant research about male victims of domestic abuse.• It is positive to see that engagement was undertaken with the perpetrator.• It is clear that several attempts were made to engage with the family and friends of Robert in order to include his voice within the review.• It is helpful to see instances of good practice from agencies identified within the DHR.
FEEDBACK FOR FUTURE DHRs	

	DHR SECTION	DHR QA BOARD FEEDBACK (improvements required before publication)
	Title Page	The date the report was completed by Chair is missing from the title page. Please add this.
1	Contents Page	No amendments required.
2	Pen Portrait	It has been difficult to build up a voice for Robert as the family felt unable to participate in the review. The Chair and the DHR Panel considered other contacts in order to ensure Robert's voice was heard. Please consider including a pen portrait with the information that is known.
3	Condolences	No amendments required.
4	Confidentiality and Anonymity	No amendments required.

5	Terms of Reference	<ul style="list-style-type: none"> • Please amend to Home Office DHR/DARDR Quality Assurance Board (not Panel). • The full terms of reference are in the appendix. The statutory guidance outlines that they should be included in the body of the report. Please consider moving accordingly.
6	Equality and Diversity	No amendments required.
7	Background Information	No amendments required.
8	Combined Chronology	In the overview report, at section 3.6.1 it states: 'a victimless prosecution was considered by the police and house-to-house and CCTV enquiries were conducted, but this provided no further information.' Please consider changing the term 'victimless prosecution' to 'evidence led prosecution' throughout the report.
9	Overview	No amendments required.
10	Analysis	No amendments required.
11	Conclusions	No amendments required.
12	Lessons learnt and recommendations	In the overview report, at section 3.7.6, there is a missed opportunity for Avon and Somerset to be included in a recommendation regarding call handlers' access to intelligence that provides information regarding a Domestic Violence Protection Order. ¹²
13	Timescales	No amendments required.
14	Involvement of family / friends / community	Please clarify if the Home Office leaflet was made available to the victim's ex-wife.
16	DHR contributors	No amendments required.
17	DHR Panel	No amendments required.

¹² Avon and Somerset Police response: A recommendation is not feasible at this time based on the following:

- Call handlers within Avon and Somerset Constabulary do not currently have automatic access to all safeguarding or intelligence information at the first point of contact. This includes information relating to DVPNs/DVPOs. This is because the force does not yet operate a Customer Relationship Management (CRM) system that brings together information from multiple databases.
- At present, call handlers would only become aware of a DVPO if they undertook manual checks on systems such as LEDS or Niche, or if such information was disclosed by the reporting person during the call. Call handlers do routinely ask whether any court orders are in place, which can prompt further safeguarding enquiries.
- The force is currently in the process of procuring a CRM system, which is intended to provide call handlers with an integrated view of relevant information, including safeguarding history and the existence of court orders.
- The issue is entirely system based, and as Comms have outlined, nothing further can be actioned until the CX platform is in place.

18	DHR Author	No amendments required.
19	Parallel Reviews	No amendments required.
20	Dissemination	No amendments required.

21	Action Plan	<ul style="list-style-type: none"> • Please consider adding the recommendation referenced above about Avon and Somerset Police. • Please ensure the actions are RAG rated before publication.
22	<p>Has there been a request to withhold publication?</p> <p><i>If Yes, include the reason for the request. Is it proportionate and appropriate?</i></p>	No requests to withhold publication.
23	Any other comments	The relevant timeframe was one year. Please consider using this as a case study to show the trajectory that can occur.