DOMESTIC HOMICIDE REVIEW
OVERVIEW REPORT

Report into the death of Steve, who died in April 2021.

Independent Chair and Author: Mark Wolski

Date of Completion: 30th April 2024

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GLOSSARY

A & E	Accident & Emergency
AAFDA	Advocacy After Fatal Domestic Abuse
ACE	Adverse Childhood Experience
ADHD	Attention deficit hyperactivity disorder
ASB	Anti-social behaviour
BMJ	British Medical Journal
BCSC	Bristol Children's Social Care
CAMHs	Child and adolescent mental health services
CSEW	Crime Survey England and Wales
DASH	Domestic Abuse Stalking & Harassment
DHR	Domestic Homicide Review
ED	Emergency Department
GP	General Practitioner
ICB	Integrated Care Board
IDVA	Independent domestic violence advocate
IMR	Individual Management Review
IPV	Interpersonal violence
KBSP	Keeping Bristol Safe Partnership
MAM	Multi agency meeting
MARAC	Multi Agency Risk Assessment Conference
NICE	National Institute for Health and Care Excellence
OASys	Offender assessment system
PSR	Pre-sentence report
ROSH	Risk of serious harm
VIP	Victim information pack
VLO	Victim liaison officer
VS	Victim Support

1. INTRODUCTION

1.1 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004.

1.2 This report of the DHR (hereafter 'the review') examines agency responses and support given to Steve (not real name), a resident of Bristol prior to the point of taking his own life in April 2021.

1.3 Emergency services were called to Steve's home where he had been found hanging in his bedroom by his mother and two flatmates. Earlier in the evening he had sent texts to his mother saying, 'he could not do it anymore'. There was an extensive history of domestic abuse incidents between Steve and his father David. It is for this reason that this review was commissioned.

1.4 This review was commissioned by the Keeping Bristol Safe Partnership (KBSP) to consider agencies contact/involvement with Steve from **1st *April 2017 to April 2021*** when he died. In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse before Steve took his own life. The period was selected to encompass the period of his relationship with his former partner and mother of his child.

1.5 The primary purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person died because of domestic violence and abuse. In this case, where Steve had taken his own life, a history of domestic abuse gave rise to a concern that a review should be undertaken, even though no one was charged with homicide. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand the circumstances leading up to Steve taking his own life, what happened when agencies had involvement during the relevant period, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

1.6 This review process does not take the place of the criminal or coroner's courts, nor does it take the form of a disciplinary process.

1.7 With regret this report is unable to reflect the views and thoughts of Steve's family who declined to take part in this review.

2. TIMESCALES

2.1 Keeping Bristol Safe Partnership commissioned this review in accordance with 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'. The Home Office were notified of the decision in writing on 13/10/2021.

2.2 The initial review panel meeting took place on 19th May 2022 where the terms of reference were discussed and a timeframe for completion within months was set out.

2.3 Some delays have been incurred for the following reasons.

- Delays in receipt of IMRs.
- Identifying contact details for family members and attempts to engage with them.
- Research and follow up enquiries in relation to IMRs.
- Detailed consideration by and with probation service of policy changes

3. CONFIDENTIALITY

3.1 Details of confidentiality, disclosure and dissemination were discussed and were agreed between Panel Member Agencies at the first Panel Meeting.

3.2 All information discussed was agreed as strictly confidential and was not to be disclosed to third parties without the agreement of the responsible agency's representative.

3.3 All agency representatives agreed to be personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

3.4 The KBSP provided a secure information platform for the purposes of sharing information that was supported by a comprehensive information sharing protocol provided at the first meeting.

3.5 To protect the identity of family members, with the agreement of family members, the following anonymised terms and pseudonyms have been used throughout this review.

Table 1

Pseudonym	Relationship	Age at the time of the incident	Ethnicity
Steve	Deceased	24	White British
David	Father	58	White British
Samantha	Partner		White British
Drew[1]	Child		White British

4. TERMS OF REFERENCE

4.1 The full terms of reference are set out at **Appendix A**. This review aims to identify the learning from the homicide, and for action to be taken in response to that learning with a view to preventing homicide and ensuring that individuals and families are better supported.

4.2 The Review Panel comprised of agencies from the Bristol City area, as the victim and his father were living in that area at the time of the incident. Agencies were contacted as soon as possible after the review was established to inform them of the review, their participation, and the need to secure their records.

4.3 The timeframe for this DHR was agreed as from **1st April 2017 to April 2021,** as it allowed for an in-depth consideration of their relationship in recent years. Where appropriate, information outside of this period is included to provide context and to explore noteworthy events prior to the relevant period.

5. METHODOLOGY - REVIEW PROCESS

5.1 Legal Framework

5.1.1 The Review has been conducted in accordance with Statutory Guidance under S9(3) Domestic Violence, Crime and Victims Act (2004) and the expectation of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016.

5.2 Methodology Overview, Panel Meetings, IMRs and Chronologies

5.2.1 Avon and Somerset Police Major and Statutory Crime Review team referred the case to the Keeping Bristol Safe Partnership on 11th May 2021. The matter was considered by the SAR/DHR sub-group, and the decision was taken to undertake a review on 2nd July 2021.

5.2.2 Comprehensive initial scoping of Agencies involved was undertaken by the KBSP.

5.2.3 A combined chronology was produced that was supplied to the chair that enabled the identification of key events and areas for consideration. These were discussed at the first panel meeting and the terms of reference were agreed.

[1] Gender neutral name

5.2.4 The chair gave a bespoke IMR briefing to authors, providing an overview of the DHR process, and writing an IMR, in line with Home Office guidance (Home Office 2016).

5.2.5 Agencies who had contact were:

Table 2

Agency	Trace of	Input
University Hospitals Bristol and Weston NHS Foundation Trust	Steve, David	Chronology and IMR
Avon and Somerset Police	Steve, David	Chronology and IMR
North Bristol NHS Trust	Steve,	Chronology
Bristol City Council Housing and Landlord Services	Steve, David	Chronology and IMR
Bristol City Council Children's Social Care	Steve, David,	Chronology and IMR
Local nursery	Samantha, Drew	Chronology and IMR
GP Practice	Steve, David	Chronology and IMR
Probation Service	Steve, David	Chronology and IMR

5.2.6 In addition to the IMRs, documents reviewed during the review process have included:

- Avon and Somerset Domestic Abuse Procedure v7 (Police)
- Bristol City Suicide Prevention Strategy and Plan
- Bristol Domestic Abuse Safe Accommodation Strategy 2022-2025
- Bristol Suicide Prevention Strategy
- Covid – Equalities Impact Assessment Form for Bristol
- Domestic abuse and the criminal justice system (ONS)
- GP Safeguarding Adult Policies
- Joint Strategic Needs Assessment (JSNA)
- Local "Violence Against Women and Girls" strategy
- Local ward profile.
- Multi agency meeting (MAM) protocol for Anti-social behaviour cases
  Probation guidance: - Risk of serious Harm Guidance (National Probation Service), - Risk and OASys Practice Improvement (November 2023), - 4 step guide, - OASys changes April 2023 FAQ, - Revalidation: Risk of recidivism tools.
- Southwestern Ambulance Service: Mental Health and Capacity Considerations in Patients Who Present as Having Self-Harmed or Attempted Suicide (October 2020)
- Vulnerability Knowledge and Practice Programme (VKPP) Domestic Homicides and Suspected Victim Suicides 2021-2022 Report

5.2.7 Five panel meetings took place, together with several one-to-one meetings between the chair with panel representatives, including the ICB panel representative, housing, police, Victim Support, and Probation Service. Keeping Bristol Safe Partnership (KBSP) also facilitated meetings after panel 4, between the local MARAC co-ordinator, police and KBSP panel representatives.

6. FAMILY INVOLVEMENT

6.1 At the start of the Review Process, the panel were informed that David had been a victim of a serious assault and that a trial was due to take place. Owing to concerns for his welfare, the decision was taken to delay contact with him and any wider family members.

6.2 A schedule of contact with family members is shown at **Appendix B.**

7. CONTRIBUTORS

7.1 Individual Management Reviews or Factual Reports were requested from agencies as shown at table 2 above.

7.2 Factual reports were completed by the police and ambulance service owing to the limited nature of contact with those agencies.

8. REVIEW PANEL

8.1 The Review Panel consisted of:

Table 3

Agency	Job Title
Avon and Somerset Police	Head of Major and Statutory Crime Review Team, Detective Chief Inspector
Avon and Wiltshire Mental Health Partnership	Head of Safeguarding
BNSSG ICB on behalf of GP	Interim Designated Professional/Nurse for Safeguarding Adults
Bristol City Council Childrens and Families Services	Head of Safeguarding and Area Services
Bristol City Council Housing and Landlord Services	Housing Safeguarding Reviews & Improvement Officer
Bristol City Council Public Health	Senior Public Health Specialist
Drug and Alcohol Services	Specialist Social Work Lead - ROADS Advice and Liaison Service
ManKind Initiative	Charity Manager
Probation Service	Senior Probation Officer
Bristol City Council Safeguarding in Education team	School Safeguarding Advisor
University Hospitals Bristol and Weston NHS Trust	Head of Safeguarding

8.2 The review panel met a total of 5 times, with the first meeting 19th May 2022 with subsequent meetings on the 28th of September, 4th of November, 23rd of March 2023 and 10th October 2023.

8.3 Agency representatives were of appropriate level of expertise and were independent of the case.

8.4 The chair of the review wishes to thank everyone who contributed their time, patience, and cooperation to this review.

9. AUTHOR AND INDEPENDENT CHAIR

9.1 The Chair of the Review was Mark Wolski. Mark has completed his Home Office approved Training, has attended subsequent Training by Advocacy After Fatal Domestic Abuse, and is an approved Offensive Weapon and Homicide Review chair.

9.2 Mark is a former Metropolitan police officer with 30 years operational service, retiring in February 2016. He served mainly as a uniformed officer, holding the role as Deputy Borough Commander across several London boroughs at the Specialist Operations command of Aviation Security. Subsequently he has acted as a consultant in the field of community safety and has experience of leading the strategic response to violence against women and girls, including the commissioning of VAWG services and development of strategy across several authorities. He has also had a number of DHR's published from across England.

9.3 During and since his MPS service Mark has had no personal or operational involvement with Bristol City Community Safety Partnership.

10. EQUALITIES AND DIVERSITY

10.1 The protected characteristics as defined by the Equality Act 2010 have been considered; they are age, disability, sex, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief and sexual orientation.

10.2 One of the protected characteristics considered to have relevance to this DHR was Steve's gender, a male victim of domestic abuse. For the year ending March 2022, the Crime Survey for England, and Wales (CSEW) estimated that 1.7 million women and 699,000 men aged 16 years and over experienced domestic abuse in the last year. This is a prevalence rate of approximately 7 in 100 women and 3 in 100 men.[2] The panel remained vigilant to unconscious bias that may result from the knowledge of such statistics and remained mindful to consider barriers to men disclosing abuse.

10.3 Steve's gender was also material in so far as males are statistically more likely to take their own life. The most recent report from the office of national statistics reports "Around three-quarters of suicides were males".[3]

11. DISSEMINATION

11.1 Once finalised by the review panel, the Executive Summary and Overview Report will be presented to the Keeping Bristol Safe Partnership for approval. Once agreed, they will be sent to the Home Office for quality assurance.

11.2 The recommendations will be owned by the Keeping Bristol Safe Partnership, which will be responsible for disseminating learning through professional networks locally, as well as receiving reports on the progress of an action plan. The full list of recipients and agencies is shown below.

Table 4

Agency
DHR Panel members
KBSP DHR sub-group
KBSP Domestic Abuse and Sexual Violence Delivery Group
Keeping Bristol Safe Partnership Executive Group
Keeping Bristol Safe Partnership - Independent Chair
Bristol City Council - Chief Executive

[2] Source: Domestic abuse victim characteristics, England and Wales - Office for National Statistics (ons.gov.uk) (accessed March 2023)

[3] Source: Suicides in England and Wales - Office for National Statistics (ons.gov.uk) (Accessed September 2022)

Bristol City Council - Deputy Mayor with responsibility for Children's Services, Education and Equalities
Bristol City Council - Cabinet Member with responsibility for Public Health, Communities and Bristol One City
Bristol City Council - Cabinet Member with responsibility for Adult Social Care and Integrated Care System
Bristol City Council - Executive Director of People
Bristol City Council - Director: Children, Families and Safer Communities
Bristol City Council - Director of Public Health and Community Safety
Bristol City Council - Director: Housing and Landlord Services
Avon and Somerset Police - Bristol Police Commander
Avon and Somerset Police - Chief Constable
Office of the Police and Crime Commissioner for Avon and Somerset Police - Police and Crime Commissioner
Bristol, North Somerset South Gloucestershire Integrated Care Board - Director of Nursing
Bristol, North Somerset South Gloucestershire Integrated Care Board – Head of Safeguarding
Domestic Abuse Commissioner

12. PARALLEL REVIEWS AND RELATED PROCESSES

12.1 An inquest hearing was held at Bristol Coroner's Court on 23rd July 2021. The conclusion of the coroner as to the cause of death was 'suicide'. The medical cause of death was recorded as 'hanging'.

13. BACKGROUND INFORMATION - THE FACTS

Contextual Information relating to the locality.

13.1 Steve rented accommodation in a Bristol ward whose characteristics are unremarkable across a range of indicators including health and wellbeing, jobs and economy, and population including deprivation. Crime levels are marginally below the average.

Events of Steve's death

13.2 Steve was 24 at the time of his death, staying in lodgings with a couple at an address in the same ward as his father, where he had previously resided.

13.3 A few months prior to his death, Steve lived in the family home with his father. Steve's grandmother had also lived at the same address but had passed away a few years prior to this incident.

13.4 Police were called to Steve's rented accommodation by the ambulance service, where he had been found hanging in his room by two housemates and Steve's mother who had attended following several text messages from Steve asking to be picked up. It was reported at the time by those present including the live-in landlord, that Steve had lost his job and was having custody problems regarding his child. It was also reported by the landlord that Steve had been in rent arrears and was a heavy drinker.

13.5 Avon and Somerset Police conducted a comprehensive investigation into the circumstances of Steve's death that included interviewing and taking statements from friends and family. As there was no evidence of third-party involvement, the matter was passed to the coroner, and the inquest concluded death by suicide as outlined at 12.1.

13.6 The review was commissioned based on the recorded events of domestic abuse by his father during the relevant period prior to Steve's death.

14. CHRONOLOGY

14.1 Background History of Family

14.1.1 The background history of Steve has sadly not benefitted from the accounts of family or friends who felt unable to take part in the review process. Reliance has been placed on information made available from the GP's records.

14.1.2 Steve was an only child who grew up locally, who at around aged twelve moved in with his father and grandmother.

14.1.3 Steve has one child Drew, with his ex-partner Samantha.

14.1.4 He was a scaffolder.

Family contact

14.1.5 The chair has sought the views of Steve's mother, father, uncle, the mother of his child and landlord. With regret he has only been able to speak with the landlord (John).

Landlord

14.1.6 Steve had stayed as a private lodger in private accommodation for about three months prior to taking his own life, though he was recorded as an occupant at his father's address at the time of his death. He was one of three lodgers who had lived at the address with the private landlord and his wife.

14.1.7 John said that usually, he does not get too friendly with his tenants, but in Steve's case, they had formed a friendship and would often sit watching football together whilst having a beer.

14.1.8 He explained that when Steve had arrived, he had lacked confidence, asking permission to make use of the facilities such as kitchen and bathroom. In hindsight this struck him as unusual, but he had responded saying to him words to the effect, "this is your home mate, help yourself, you can do what you want".

14.1.9 From conversations between John and Steve, the landlord (his words), explained he thought Steve had been "controlled and abused", physically and through actions such as Steve having had to ask to use the toilet or even to eat.

14.1.10 On enquiring about Steve's lifestyle, John explained Steve had often been intoxicated and that his room was 'quite a state', with discarded wine bottles and beer cans. He further explained that Steve had been in trouble with local drug dealers, owing them money.

14.1.11 Asked about other worries, he explained that he knew Steve had a difficult relationship with his partner, made worse by the coincidental fact that she (Samantha), was now seeing another lodger at the same lodgings. This along with Steve not having access to his child had been difficult for Steve.

14.1.12 He also explained that prior to taking his life, Steve had spoken about his money worries, not only in terms of drug dealers, but also owing to having been receiving letters from HMRC, as he had owed them money.

14.1.13 John explained that in the weeks running up to the incident, Steve had been late paying his rent and had told John that he had another job lined up. John says he had said not to worry about this.

14.1.14 He said that he knew things were very difficult, and his wife had said that she had often heard Steve crying at night, such as the evening that Steve had taken his own life.

14.1.15 On the evening of the incident, he recalls that Steve's mother and her partner had come to see Steve, and he further recalls that he had seen text messages to his mother pleading for help. It was John, another lodger and family, that had entered his room, taken Steve down, tried to resuscitate Steve, and called paramedics.

14.2 Narrative Chronology – Key Contacts with Agencies

14.2.1 The following section summarises contact between Steve and David with agencies. To assist the reader, the table below summarises the names of the organisations and their role in this case. The paragraphs within the narrative chronology are prefaced with the lead agency to identify the primary source of information and assist the reader.

Table 5

University Hospitals Bristol and Weston NHS Foundation Trust	Local hospital where Steve had attended the emergency department	Hospital (UHBWFT)
Avon and Somerset Police	Police force who had contact with Steve and David	Police
North Bristol NHS Trust	Infrequent contact only with Steve	n/a
Bristol City Council Housing & Landlord Services	Local council housing provider	Housing
Bristol City Council Children's Social Care	Children's Service who assessed Drew (Steve's child)	Children's Social care
Local nursery	Nursery for Steve's child	Nursery
GP Practice	GP for Steve	GP
Avon and Wiltshire Mental Health Trust	Local secondary care provider for mental health	Mental Health
Probation Service	Supervised David following conviction	Probation

Pre-Relevant Period

GP

14.2.2 Notable GP contacts for Steve during his childhood include that he had febrile convulsions[4] between 1997-2002 (aged 1 to 5) and following investigations no causal factors were identified. Between 2002/3 (aged 6 to 7) Steve was diagnosed by community paediatricians as having attention deficit hyperactivity disorder (ADHD) and responded to medication prescribed that were

[4] **Febrile seizures (febrile convulsions) are fits that can happen when a child has a fever. They most often happen between the ages of 6 months and 3 years.**It can be frightening and distressing to see your child having a seizure, particularly if it's their first seizure.However, these seizures are usually harmless and almost all children make a complete recovery afterwards Febrile seizures - NHS (www.nhs.uk)

stopped in 2008 with no ill effect. School exclusions and behaviour concerns were reported in 2009 (aged 13) and a referral to Child and adolescent mental health services (CAMHs) was made. Steve moved to live with his father and grandmother at this time with advice given on establishing clear parenting boundaries instead of use of medication for his ADHD. In 2011 (aged 15) he moved back to live with his mother following disruptive behaviour and two school moves. The paediatrician at this time identified Steve had low self-esteem, and possible communication and learning needs. Advice was again given around parenting boundaries.

14.2.3 In April 2014 (aged 17) Steve had an appendectomy and visited A&E and the GP regularly from July 2014 to February 2015 with nonspecific abdominal pains and through 2015 he underwent full abdominal and bowel screening investigations with normal results. Records indicate use of codeine with regular A&E attendance to obtain morphine rather than attending reviews by GP. It was noted in August 2015 he had attended A&E (Royal University Hospital Bath) 47 times for IV morphine. Further investigations were undertaken, and no causal factors identified. An A&E support plan was put in place for Steve's frequent attendances where he continued to attend reporting abdominal, urinary, or testicular pain and requested intravenous morphine and allegedly became aggressive if challenged. Steve was also reported as using alias names to obtain morphine, but multiple hospital attendances and investigations had not found any underlying cause for his pain.

Police

14.2.4 Prior to the timeframe of this review there are 4 recorded contacts with Steve. Two related to anti-social/bullying behaviour in school and between students. There is one record from December 2009 of police attending Steve and his father's home following Steve threatening to run away from home. It was reported that Steve and David argued frequently.

Bristol City Children's Social Care

14.2.5 An isolated notification was submitted 2009 (Steve aged 13) highlighting on going arguments between David and Steve. At this time no additional concerns were noted by partner agencies or additional notifications submitted thereafter. The safeguarding threshold at this time was not met and therefore the task of understanding Steve's lived experiences of a child via the lens of a social work assessment was not initiated.

Royal University Hospital Bath

14.2.6 Steve was a frequent attender at the emergency department, with presentations related to abdominal pain. Investigations were undertaken and was usually prescribed with oral or intravenous pain relief including codeine, morphine, tramadol, and Entonox. In 2015, he attended on 55 occasions and was assessed by the pain clinic psychologist in respect of medication seeking behaviour. In 2016, he was seen on 22 occasions between January and May. He was referred for further investigations but was discharged following non-attendance at appointments in August 2017.

2017

14.2.7 ***Police:*** On 13th July a neighbour called police to report a domestic argument between Steve and an unrelated female. Steve reported feeling unwell resulting in him feeling stressed, and an argument resulted. Neither party wanted to make any allegations, and a DASH was completed that was rated as standard risk. The matter was closed with no further action.

14.2.8 ***University Hospitals Bristol and Weston NHS Foundation Trust (UHBWFT)***: Steve attended the hospital on four occasions seeking pain relief.

2018

14.2.9 ***Police:*** On 4th August, a neighbour called police to report a disturbance at Steve's girlfriend's (Samantha – mother of their child) house. Samantha, Steve, David, and the child (5 months old) had been in the pub and on return to Samantha's house an argument ensued between David and Steve about Steve's behaviour in the pub when Steve suggested Samantha had been looking at other men. Samantha said that Steve continued the argument with her and became aggressive, pushing her several times and hitting her head with his hand. Steve and David started physically fighting with Steve reporting David pushed him over causing him to hit his head as he fell on the floor. Steve was arrested, but before being taken to the police station he was assessed at the Bristol Royal Infirmary Emergency Department. Following investigation, he was charged and subsequently pleaded guilty to battery and a protection from harassment order (for Samantha against Steve) was put in place for 2 years until 19th August 2020.

14.2.10 On the same date, Steve explained in his initial account that he and David started fighting when David intervened in the argument with Samantha. During this fight, David had his hands around Steve's throat, after which he fell and hit his head. The investigating officer notes that David was defending and supporting Samantha. This case of assault by Steve on David was closed with no further action due to CPS decision not to proceed due to insufficient evidence.

14.2.11 ***Hospital (UHBWFT):*** On 5th August Steve attended hospital following an overdose of Naproxen. He was seen by the emergency mental healthcare team and later discharged following treatment. These details were passed to Steve's GP.

14.2.12 During the consultation with the mental health service, Steve explained that his mental health had deteriorated following an assault, where his ear had been bitten. He explained that despite medical consultations, they had been unable to 'repair' his ear, and he was becoming very frustrated, causing relationship difficulties. Following the incident, the day before, he said that he was missing his partner and child. He said he felt he would benefit from counselling, and he was provided with details of the 'Bristol Wellbeing Team' and 'Off the Record', as well as given details of the Bristol Crisis number. These agencies have no trace of contact from Steve.

14.2.13 ***Children's Services (CS):*** (6th August) Social care received alerts from police and ambulance service. These summarised the events of the assault for which Steve was arrested, as well as the assault where Steve's ear was bitten. They describe Steve's jealousy when he has been drinking, and the notes conclude that this was a high-risk domestic abuse case and alleged purposeful attempts to harm the child by pushing Samantha down the stairs.

14.2.14 ***GP:*** On 14th August, Steve attended his GP who removed sutures from a head wound.

14.2.15 ***Housing:*** On the 15th & 18th August, housing sent rent arrears letter to David and his mother.

14.2.16 ***Children's Services:*** By the 12th of October the social care assessment had been completed, with Samantha and Drew living with Samantha's parents. The reports noted that there was an order in place preventing Samantha and Steve living together, though recognising it was likely their relationship would resume in the future. The assessment concluded with a recommendation that they would both be written to, with advice and information on support services, as it is likely their relationship will resume in the future. It was made clear that any further incidents / concerns may require further Children's Services involvement.

14.2.17 ***Housing:*** Further letters concerning rent arrears were sent to David and on the 5th of November 3rd and 12th December.

14.2.18 ***Hospital (UHBWFT):*** On the 23rd of December, Steve was brought into the hospital by ambulance with a head injury, following him being assaulted outside a pub. He was discharged following scans and treatment.

14.2.19 ***Police***: On 26th December, David called police to report Steve was being aggressive and causing damage to the house. Officers attended the property and Steve had become angry that Samantha had changed access arrangements for Drew. Steve admitted punching a door during the

argument and agreed to stay at this mother's house that evening. David confirmed he did not support any further action and was happy for his son to remain living at the property. The incident was not tasked to the Lighthouse Safeguarding Unit[5] (LSU). During this incident, it appeared that David had been acting as a facilitator for child-care arrangements.

14.2.20 ***Police:*** On 29th December, David called police to report that Steve had told him he had bitten Drew's finger when they tried to take a chip. An argument followed between David and Steve with Steve punching David in the back several times. On police attendance, both David and Steve appeared very intoxicated, having been drinking in the pub whilst caring for Drew, who had no visible injuries. Steve denied injuring Drew and was arrested for battery against David. A BRAG was completed for Drew rated as Amber. David declined a DASH risk assessment and described the incident as father/son fighting. Samantha collected Drew from the scene and the investigation later determined Drew had not been assaulted. This matter was referred to Child Health and CSC, noting this was the second incident within three days. When spoken to the following morning, David did not want to pursue an investigation and observed that Steve's demeanour had changed since the assault when his ear was bitten in July 2018. The case was closed with no further action; there were no injuries, insufficient evidence and David did not wish to proceed.

14.2.21 ***Hospital (UHBWFT):*** On the 31st of December, Steve attended hospital with abdominal pains and didn't wait to be seen/ self-discharged later.

14.2.22 ***GP:*** On the 31st of December, the GP received information from NHS111 that Steve had called, needing to talk to someone. This resulted in a GP appointment early in the new year.

2019

14.2.23 ***GP:*** Steve attended his GP on 3rd January in relation to depression, anxiety, and pain. Steve explained things were gradually getting worse since breaking up with partner approximately 6 months previously and he was not allowed to see his child (9 months old) since an incident last summer when he pushed ex-partner. He explained feelings of being upset and angry, and a comprehensive history covered matters of suicidal ideation, and denied current thoughts of self-harm, though explained he had almost taken an overdose twice. He acknowledged being angry towards his partner, and an unknown man who had assaulted him in 2018. He denied thoughts of harming anyone and denied any recreational drug use. Safety netting advice included advice about self-referral to 'Lift' for talking therapy and attendance at A & E, if any feelings of self-harm or suicide. The consultation further dealt with pain related to a matter not relevant to the review.

14.2.24 ***Children's Services:*** Following the incident on 26th December, CS contacted Samantha who had already decided not to allow either Steve or David see Drew, but that David could visit them at Samantha's address only. She explained she would not allow Steve any contact unless he went through court to achieve this. The case was closed with no further action.

14.2.25 ***Police:*** On 13th January, Steve was punched by another male in the town centre. On attendance, the suspect admitted the offence and it was agreed he would voluntarily attend the police station. Steve attended the hospital and following examination was discharged. Information was shared from the hospital to the GP.

14.2.26 ***Children's Services:*** On 7th February, Steve contacted CS in respect of access to Drew. He was advised that following the incident in January, Samantha would not allow unsupervised contact unless this went through the court. He was advised to seek legal advice and no action was required by CS.

14.2.27 ***Housing:*** On 4th March, records show that David became the sole tenant at his address, following the death of his mother. Steve is listed as an occupant at this address. Later in May, two letters were sent about rent arrears to David and his mother.

[5] LSU - joint team was launched in September 2018 with a joint function of supporting victims and witnesses of crime (including onward referral to other agencies and, where appropriate, being a point of contact during a Criminal Justice System processes) alongside safeguarding overview.

14.2.28 ***Children's Services***: On 22nd May, CS received an anonymous letter stating that on Saturday night all the adults in Samantha's mother's house had been drinking, and that Steve had been abusive and threatening towards Samantha in the street. The records showed that there was still an order in place, preventing Steve having contact with them. CS spoke to Samantha over the phone who vehemently denied the allegation and was not having any contact with Steve. Enquiries were made with local services who had seen Samantha and Drew in May, and at that point Steve was not living with them. The case was closed at this point.

14.2.29 ***Hospital (UHBWFT):*** On 8th August Steve attended the emergency department with abdominal pains. He was discharged. Information was shared with the GP.

14.2.30 ***Housing***: In October, there were several calls between David and the housing service regarding erratic rental payments. This resulted in a rent payment plan being agreed.

14.2.31 ***Police:*** On 26th November, police were called to a domestic incident between Steve and David after Steve ate a pie belonging to David. Steve called the police to report that David became angry and verbally aggressive, which escalated to Steve being pushed and hit in the ribs. During the call Steve said he was scared of David. Officers attended and spoke to Steve who said the situation had resolved itself, and he did not want David to be aware of the police having been called and wanted this incident logged only. He then said he would stay at his uncle's address. The case was closed with no further action due to insufficient evidence as Steve declined to support further action.

2020

14.2.32 ***Police***: On 3rd January, David called police to report that, during an argument, Steve pushed him to get a reaction and spat in his face. David reported that Steve had previously wrecked his house, had broken two TVs, and was constantly drinking. He reported that the Christmas period was terrible as was the prior Christmas. Steve was interviewed under caution and provided an alternative explanation saying that he was spitting unintentionally whilst speaking angrily. Officers had considered arresting Steve, but he agreed to go to his mother's house. David refused to provide a statement or support prosecution. David refused to answer questions for the DASH and an officer observed DASH was assessed as medium with the officer noting previous incidents and that both parties aggravated the other. LSU attempted to contact David but were unsuccessful. The case was closed with no further action due to insufficient evidence and David not supporting further action.

14.2.33 ***Police and Hospital:*** On the 12th of January, Steve had been admitted to hospital with stomach pains. At the hospital, his account to health staff changed a number of times, and his father David explained that his black eye was owing to Steve getting into trouble with cocaine dealers. Whilst in hospital he called police to report David had punched him in the face earlier that day, sustaining a black eye. The hospital informed the GP of this medical occurrence.

14.2.34 Police were unable to attend that evening and eventually spoke to him on the 23rd of January at his place of work. Steve alleged that David was a manipulative bully who made false allegations against him when drunk. Steve said he was afraid of David but was concerned about the impact on him, his relationship with his dad and the wider family if he physically defended himself. Steve raised concerns about access to his child as he believed police involvement in his relationship with David, even if as a victim, would be looked at negatively by Drew's mother and social services. Steve was insistent that the police did not speak to David as this would put him at risk and stated he was planning to move out and wanted to keep things calm until then. Steve refused to answer questions for the DASH risk assessment, and the officer observed DASH was assessed Standard. The officer gave Steve words of advice that domestic abuse was not just about stereotypical male/female domestic violence. A supervisory review endorsed the officer's approach noting that Steve declined to provide evidence and believed police involvement would antagonise the situation. The supervisor agreed that Steve moving out would reduce risk. LSU

completed background checks and attempted contact with Steve but were unsuccessful. A follow up text was sent offering support.

14.2.35 ***Police:*** On 2nd February Steve called police to report that David had assaulted him several times with a cricket bat, injuring his upper body and head with lacerations, and threatened to stab him with the broken bat. On police attendance, Steve explained that David came home intoxicated and was angry that Steve had not ordered a takeaway. David admitted the offence and was arrested and taken into custody. Steve reported that assaults were a frequent occurrence (although this was the first time a weapon was used) but that David usually accused Steve of assault when speaking to police. Steve acknowledged their relationship was toxic and they frequently argued and physically fought. This was confirmed during house-to-house enquiries, with reports of Steve being a compulsive liar and the main aggressor.

14.2.36 Whilst Steve declined to give a formal statement at the scene, wanting time to think about it, David was arrested and during the interview David admitted assaulting Steve and expressed remorse. He was charged and given bail on condition that he did not return home. On the 17th of February, he pleaded guilty in court, was fined, and required to attend a rehabilitation activity.

14.2.37 ***Probation:*** On 17th February, the probation service began engagement with David, following his sentence of a 12- month community order and a requirement to undertake 10 days of rehabilitation activity. At the first meeting, David put the offence in the context of a build-up of grievance and anger towards his son over the preceding months, whom he described as abusing his good nature by making a mess in the house, failing to clear it up and being generally lazy and disagreeable. He explained that his son had returned to live with him when he was evicted from his last place of residence due to a Restraining Order being imposed against Steve. He explained that he felt obliged to have him live with him as he knew his son had nowhere else to go. However, he described his son's behaviour, as focused on drug and alcohol use, often funded by David and that his son did nothing to help with the upkeep of the property.

14.2.38 It appears that resentment built and on the night in question he had "had enough" and when Steve refused or ignored his pleas to help tidy up, he became more insistent on making his son take notice of him. He states that his son then squared up to him and this resulted in a violent confrontation. David recognised that this use of violence was unacceptable and excessive and could have resulted in far more serious injuries.

14.2.39 Later in February, induction paperwork was completed, and it was noted that David was in denial about some aspects of the offence and that he denied alcohol was a problem.

14.2.40 ***Housing***: On 17th February, housing services received a complaint about the behaviour of Steve and David. The complaint alleges constant fighting between father and son, drunken fights and breaking up the property. Notes on the file acknowledge police involvement, and the complainant stated that the incidents occur when Steve is intoxicated. Two days later a housing officer calls David who explained that incidents occur when Steve returns home drunk, and that he has spoken to his son about getting his own place. David was warned that if the behaviour continues then he would be served an anti-social behaviour contract.

14.2.41 ***Probation:*** Later in March (date unclear), an initial sentence plan was completed, including attendance at an Emotional Resilience program and an objective was set around the increased recognition of link between alcohol misuse and offending that would be measured by David's willingness to discuss and acknowledge alcohol misuse and a willingness to moderate his consumption.

14.2.42 The probation service conducted an interview with David on the phone owing to Covid on the 25th of March. David explained that Steve was still living at home, but that he was finding it hard to get by. He was not claiming benefits and did cash in hand jobs. He was advised to ensure that he claimed benefits to which he was entitled. The offender manager also spoke to Steve, who said that his father was not drinking, and that things were much better between them. Following these conversations, it was agreed they made fortnightly contact.

14.2.43 ***Housing:*** On 1st of April, the rent management team received a call from David's sister, saying that David was really isolated at the moment owing to Covid 19, having no work, and was trying to claim universal credit. The rent management team also received a call from David who said that he was not entitled to universal credit. The records show an application for Universal credit was made on the 9th of April.

14.2.44 ***Police:*** On the 12th of April, David called police requesting assistance to de-escalate an argument during which Steve had become aggressive, pushing David and threatening violence. When officers arrived both Steve and David denied assault and said the other had been drinking. Steve left to stay with a friend. David said he did not want him back at the address and remarked that he was disrespectful by leaving the house in a mess. David was advised to seek a long-term solution to prevent the continuation of the incidents. The police log noted that David relied on Steve for financial support. A DASH was completed assessed medium during which David advised that Steve had a problem with drugs and alcohol. The police LSU contacted David on the 17th and were advised that Steve was back living at home. David declined support for domestic abuse and reported that tension had risen due to the lockdown. The case was closed with no further action.

14.2.45 ***Housing:*** On 17th April, a housing officer called David to enquire about his application for universal credit. He said yes but had not asked for an advanced payment. The housing advisor advised him he must apply for that as he said he has no income, and his family gave him a bit of money to buy food. He said that he would contact Universal Credit to request this as he has no access to internet. A note later that day reports that David had requested an advance payment, and he will receive £330 on 21/4/2020 and would pay this via swipe card onto his rent account.

14.2.46 ***Probation:*** A series of planned telephone appointments took place with David, on 14th of May, 28th of May and 10th of June that referenced Steve having moved out, and that David had applied for benefits. They also describe an issue with a neighbour, and that David was having problems trying to contact the court to pay his fine.

14.2.47 ***Housing:*** Steve presented as homeless on the 26th of June, having been assaulted by his father. Steve described his assault a few months previously, and that he had not spoken to his father for about 2 months. He claimed to still be paying David £120 per week, but that if he wanted to use the bathroom or make food, he had to sneak in. He said that his father threw him out the previous night, and said he had an injunction that Steve had not seen. He further explained that he was a scaffolder but was on furlough from his scaffolding job. He was advised to bring in a copy of the injunction and was added to the rough sleepers list.

14.2.48 ***Housing:*** On the 18th of August, housing received a complaint about the behaviour of David and Steve and diary sheets were submitted.

14.2.49 ***Police:*** On the 30th of August, two incidents were reported to the police. The first incident, Steve called police reporting that, 2 hours previously, David had assaulted him during an argument about money, resulting in swelling and large bruises to his cheeks. After the assault Steve left for his uncle's and was unable to enter his home on his return as David had since left. Steve made further calls, first to chase police attendance, and then to withdraw the allegation. On one of these subsequent calls, David's partner took the phone from him and spoke to the call handler. She advised that earlier Steve and David had a scuffle and later when they returned home, they found Steve on the floor foaming at the mouth and called an ambulance. Owing to the Threat Harm Risk assessment at the time (and volume of other outstanding incidents), police did not attend until the 9th of September. Steve had no visible injuries and did not want to pursue the complaint, remarking that both parties assaulted each other, and he was as bad as his dad. David was also spoken to by the officer, but it is not documented if he was asked about the alleged assault. David is described as polite, friendly, and engaging in the log. There is no complete BRAG and no BWV of attendance. The case was requested to be closed with no further action.

14.2.50 The LSU spoke to Steve on 13th September and Steve said he lied about the incident to officers. He explained he had a fit as David had smacked his head on the wall but did not tell anyone. Steve reported he was being abused financially, emotionally, and physically by David and that it was getting worse. Steve disclosed David was out of work and demanded a constantly changing amount of money from him. He feared David and wanted to leave but had nowhere to go and felt trapped. He disclosed he was depressed. Steve confirmed he wanted support from IDVA and consented to referral. LSU assessed the risk level to be higher than low and referred Steve to Victim Support.

14.2.51 The case was reviewed by a supervisor on 14th September and requested that officers contact Steve again. Following a number of failed attempts, they spoke to him on the 25th of September when Steve explained he felt he was living on the edge with constant disagreements. Steve asked the officers to speak with David as he could not communicate with him. Officers spoke with David in person, who admitted he and Steve did not get on and disclosed that Steve took drugs. Both David and Steve were given words of advice by the officers about wasting police time as they are adults and need to go their separate ways. The case was filed with no further action due to insufficient evidence.

14.2.52 The second incident was not linked to the first described above. On the same date, 30th August, The ambulance service called Police requesting assistance. It was reported Steve had taken drugs, was foaming at mouth and was being aggressive to David and his partner. David reported Steve had earlier stolen £50 and following a confrontation Steve left the house, returning intoxicated. Officers spoke with David and his partner. David confirmed he did not want to make statement about the theft, commenting that Steve had nowhere else to go. David admitted his relationship with Steve was tense and they did not get on. He remarked that Steve's aggressive behaviour was becoming more frequent, and they argued approximately once per week. David believed Steve was using drugs. Further follow up calls were attempted by the LSU, but they were unable to speak to David and the case of theft was closed with no further action due to insufficient evidence.

14.2.53 ***Hospital***: On 31st August (linked to the above two incidents), Steve was taken by ambulance to the emergency department. Steve had been allegedly assaulted by his father and presented with a facial injury. Steve had suffered a seizure and his father had called 999. Steve had also had a further seizure in the ambulance. His injuries were deemed as minor, and it was observed he was intoxicated, and his pupil dilation indicated drug usage. Steve acted inappropriately towards female staff and self-discharged against advice. He was referred to the seizure clinic in line with usual practice. The details of medical treatment and circumstances were relayed to the GP.

14.2.54 ***Housing:*** On 3rd September, housing received a complaint about incidents that occurred on the 20th of August, alleging an altercation between Steve and his father. Housing advised that they contact David regarding his son's behaviour and although not enough evidence to seek legal intervention will consider serving and anti-social behaviour contract.

14.2.55 **Victim Support**: On 14th September, the chronology shows Victim Support receiving the referral regarding Steve. The case was closed on the 16th of October as they were unable to make contact.

14.2.56 ***GP*****:** On 1st October 2020, Steve Attended the out of hours service in relation to an injury at work, when a pole had fallen off a board and hit his head. A laceration was treated, advice given, and he was discharged.

14.2.57 ***Police:*** On the 5th of December, Police and ambulance were called by David to his house as Steve had attempted suicide by suffocation. Steve reported that David had also punched him in the face. Steve then returned home twice but David refused entry and called the police.

14.2.58 On arrival at the first call, Steve was intoxicated and reported he had tried to harm himself because he was upset after David punched him twice in the face. David denied the allegation and countered that he was in bed when he heard Steve shouting on the phone to his ex-girlfriend

(Samantha), after which he asked Steve not to cause a disturbance and returned to bed. David then heard Steve struggling to breathe and found him in the hall with an extension lead around his neck. After removing the lead, David slapped Steve to rouse a response. Steve then walked out of the property stating David had assaulted him. Officers spoke to witnesses who stated she did not hear a fight, only raised voices and David shouting 'breathe, breathe.' A BRAG was assessed Amber noting that Steve was now homeless as David no longer wanted him to stay.

14.2.59 An ambulance attended, and Steve refused medical treatment. The ambulance staff determined he had capacity. David refused to allow Steve back into the house. Officers attempted to find accommodation for Steve for 2 hours, offering to drop him at another address, local B&Bs or A&E but he was intoxicated and uncooperative and requested to leave. Officers permitted this as there was no reason to detain Steve.

14.2.60 Steve twice returned to the house and David refused entry and called police. Steve was less intoxicated and agreed he needed to seek help with regards to his mental health. Officers took him to BRI so could obtain a mental health assessment. The second time Steve returned he then left with his cousin after officers attended. Further DASHs were completed for David assessed standard risk.

14.2.61 These incidents were considered by the LSU who referred Steve to Victim Support without consent, as the risk had been rated as High. The case was not automatically referred to the MARAC and awaited the assessment from Victim Support.

14.2.62 This incident and full details were referred to children's social care, but not adult social care.

14.2.63 ***Hospital***: Steve was taken to hospital by the police for assessment. He was kept in overnight for observation, but Steve was keen to go home and declined a face-to-face review with the psychiatry liaison service. He said he no longer felt suicidal. The GP practice was informed of this incident.

14.2.64 ***Victim Support***: On the 10th of December, following the referral by the LSU, VS attempted to make contact. They were unable to make contact and VS referred the case to the MARAC.

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14.2.65 ***Victim Support***: On the 7th January, VS notes that the case was discussed at the MARAC and a number of actions arose, including; -ASB housing officer to invite VS IDVA to meetings to link in; -GP to call Steve in for contact around his mental health and encourage him to engage with DVA support; - Probation to explore David's contact with Drew and whether Steve remains at home and refer to First Response if appropriate.

14.2.66 ***GP:*** On the same date, the GP receives the request to contact Steve. The practice called Steve on the 28th of January, and the call was not answered, and a message wasn't left. Steve had a number of other appointments with the practice, for unrelated matters before his death, including 9th and 16th March a telephone and face to face consultation with an Advance nurse practitioner. No further discussion took place around the MARAC action to discuss his mental health.

14.2.67 ***Probation***: On 23rd February, a planned telephone appointment took place. David told probation about the allegations made by Steve regarding the incidents in December. Despite having no contact with Steve, he said that he maintained contact with Steve's partner and his grandchild. It was acknowledged that a lot had happened over a short space of time, including issues with his son, being unable to work, and some medical matters. The meeting concluded with the current order having been completed and terminated.

14.2.68 ***GP and Hospital***: Over the period March through to the April, Steve was undergoing tests regarding some lumps on his neck. Following urgent tests, cancer was eliminated, and he underwent treatment for an unrelated matter that concluded on the 27th April.

14.2.69 ***Police:*** In April, the police were called by the ambulance service reporting that Steve had been found hanging in his room in an HMO. Police attended and interviewed those present. The live in property owner reported that Steve had informed him he had lost his job and had custody problems with his child. He also disclosed that Steve was in rent arrears and was a heavy drinker. Police determined there were no suspicious circumstances and the matter was reported to the coroner.

15. OVERVIEW

15.1 CCG – GP

15.1.1 Steve was well known to the practice as a child diagnosed with ADHD, referrals to CAMHs and working with his father and grandmother on parenting boundaries. Aged 17, Steve had an appendectomy and thereafter reported unexplained abdominal pains, to which the records show him having attended A & E to obtain morphine as opposed to attending primary care.

15.1.2 During the relevant period, most information on record relates to information received by hospitals, two from NHS111 and a MARAC enquiry by police. He was seen on four occasions and had one telephone consultation. The analysis will show that information received included references to domestic abuse including being the perpetrator towards his partner on one occasion, and victim on two occasions. The information from other agencies includes two incidents of self-harm from A & E, the first in 2018 having taken an overdose following an altercation with his partner, and the second on 2020, following an attempt to take his own life. Records show one comprehensive consultation in early January, having phoned NHS111, when Steve had said he needed someone to talk to.

15.1.3 He was seen on four occasions during the relevant period.

15.2 Avon and Somerset Police

15.2.1 The police attended seventeen incidents involving Steve during the relevant period. Some of the incidents that were recorded included counter allegations between Steve and David, hence two incidents relating to one police attendance, though there was an occasion when police were called to the address twice on the same day.

15.2.2 The majority of incidents were of a domestic nature between Steve and David, though there was one incident (20/07/2018) where Steve was assaulted in a pub and had part of his ear bitten off and an assault in the street on 13/01/2019.

15.2.3 There was also one allegation of domestic assault (04/08/2018) perpetrated by Steve against his partner Samantha that resulted in Steve being arrested and charged. Because of this and the subsequent judicial restraint, Steve's access to his child was restricted as the analysis will show.

15.2.4 On one occasion David (02/02/2020) was arrested, charged, and convicted for an assault against Steve, resulting in David being supervised by probation for a period. Notwithstanding the conviction, Steve remained living in the same house as David.

15.2.5 The contacts with police were frequently typified by alcohol consumption, and on several occasions, mention was made of Steve's substance misuse as a further aggravating factor.

15.3 UHBWFT - Hospital

15.3.1 Steve had fifteen contacts with the Trust during the relevant period and there was an alert on his file regarding him being a regular attender seeking opiate medication. Three of his contacts during the relevant period related to abdominal pain (31/12/2018, 08/08/2019, 21/03/2021), associated with drug seeking behaviour. Six attendances related to head injuries, of which one related to an injury after drinking (23/12/2018), one to an assault by a stranger (13/01/2019), three related to

assaults by his father *(04/08/2018, 12/01/2020, 31/08/2020)*, and one related to a work injury. Two attendances related to self-harm, an overdose *(05/08/2018)* and an attempted hanging *(05/12/2020).* Further contact in April 2021 related to a course of treatment regarding an unrelated matter.

15.4 Bristol Children's Social Care

15.4.1 Bristol City Council Children's Social Care first became involved after an allegation of assault (04/08/2018) by Samantha against Steve that required statutory involvement. A social care assessment was completed with further contact being limited such as an allegation that Steve had bitten his child's finger (29/12/2018). Following assessment, no further action was taken. (There was no evidence of the child's finger having been bitten).

15.4.2 Social care only had one contact with Steve when he sought information about seeing his child, and he was advised to seek legal advice.

15.5 Education Services (Nursery)

15.**5**.1 Education services was not involved with Steve. They did not have any contact details for him, and having been made aware of Steve's conviction and subsequent restraining order worked on the assumption that Samantha was responsible for the care of Drew.

15.6 Bristol City Council Housing & Landlord Services (Housing)

15.6.1 Steve's home address at the time of his death was not managed by Bristol City Council Housing & Landlord Services (BCC H&LS). He was living in private rented accommodation. However, he was recorded as an occupant at his father's (David) address which is owned and managed by BCC H&LS until the date of his death in April 2021.

15.6.2 The housing records note that he was not always living at the address, and that David asked Steve to leave the address (April 2020) and Steve presenting as homeless (June 2020).

15.6.3 There are over 45 entries on the chronology provided by BCC H&LS. Many relate to routine maintenance, though there are a significant number relating to rent arrears that suggest a degree of financial pressure within the household, along with reported anti-social behaviour associated with Steve.

15.7 Probation Service

15.7.1 David was supervised by Probation Service following his conviction on 17/02/2020 for an offence against Steve of Assault occasioning actually bodily harm for which he received a 12 month community order with a "Rehabilitation Activity Requirement" to comply with any instructions of the responsible officer (probation officer) to attend appointments with the responsible officer or someone else nominated by them, or to participate in any activity as required by the responsible officer up to a maximum of 10 days.

15.8 North Bristol NHS Trust

15.8.1 Steve had two contacts 21/07/2018 and 07/10/2020. These contacts were unremarkable in nature and did not merit further exploration.

16. ANALYSIS

The analysis of this Domestic Homicide Review explores the reasons why events occurred, how and whether information was shared and, subsequently, whether the sharing informed decisions and actions taken. This section is broken down into three parts, the definition of domestic abuse, an analysis overview, and a detailed analysis against the lines of enquiry.

16.1 Domestic Abuse Definition

16.1.1 The Government definition of Domestic Abuse is: - Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence, or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited, to the following types of abuse: psychological, physical, sexual, financial, emotional.

16.1.2 Controlling behaviour is defined as: - A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

16.1.3 Coercive behaviour is defined as: - An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

16.1.4 In April 2021, the Domestic Abuse Act received Royal assent and provided a statutory definition of domestic abuse that is shown at appendix A, but otherwise summarised as: - *Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if A and B are each aged 16 or over and are personally connected to each other, and the behaviour is abusive. Behaviour is abusive if it consists of any of the following; (a) physical or sexual abuse, (b) violent or threatening behaviour, (c) controlling or coercive behaviour, (d) economic abuse, (e)psychological, emotional or other abuse; and it does not matter whether the behaviour consists of a single incident or a course of conduct.*

16.2 Analysis Overview

16.2.1 The chronology shows that during the relevant period, Steve had contacts with several agencies that has allowed detailed consideration against the terms of reference. Sadly, the review has not benefited from family insight. The themes below became apparent from early analysis and show the complexity of Steve's situation and presence of multiple risk factors that provides a useful lens through which to consider the agency analysis. Recent research also provides a useful lens through which to consider this review that may influence local strategic approaches.

Childhood Experience

16.2.2 Whilst Steve's childhood is outside the relevant period, agencies have recorded relevant background material. The IMR from primary care shines a light on Steve's characteristics that are relevant to the review. These include, that he was diagnosed with ADHD, and that he was prescribed medication in relation to this. It was reported that a paediatrician had advised that parenting boundaries would be preferable to medication in treating ADHD. This was considered noteworthy as Steve's journey through primary care and attending hospitals would show that he would consistently seek medication in relation to undiagnosed pain. The report also observed that there had been concerns regarding his behaviour and following exclusions at school he was referred to CAMHs. Low mood had been observed, and comments suggested an unsettled home life with frequent home and school moves. Additionally, Steve disclosed to housing that he had been beaten as a child and therefore the panel kept in mind links between adverse childhood experiences and suicide such as stated in a United States article on the subject that reported "ACEs are a well-documented and understood risk factor for suicidality",[6] and an NHS article reporting "show a strong association between childhood adversity, such as neglect or physical abuse, and suicide in adulthood".[7]

[6] Source: Adverse Childhood Experiences and Suicide Risk: Toward Comprehensive Prevention - PMC (nih.gov) (Accessed June 2023)

[7] Source: Adverse Childhood Experiences as Predictors of Self-harm and Suicide - Health Research Authority (hra.nhs.uk) (accessed June 2023)

Suicide and ADHD

16.2.3 According to a variety of sources, the review learned of the links between ADHD and suicide, with the National library of medicine declaring "A review of the current literature focusing on this issue provides strong evidence that ADHD patients are at a significant risk for experiencing suicidal ideations and committing suicide".[8] A further report concluded, "There is a positive relationship between ADHD and risk to self. More focused research needs to take place on younger populations and those without comorbidity. This review highlights the importance of thorough risk assessment in the attention-deficit population"[9] An article in the British Journal concluded, "This study underlines the link between ADHD and an elevated rate of suicidal behaviour, which is significantly elevated by comorbid psychiatric disorders. In sum, these results suggest that persons with ADHD and comorbid psychiatric disorders are targets for suicide preventive interventions."[10] Steve was in this group.

Substance Misuse

16.2.4 The IMRs showed two features relating to substance misuse, the first being Steve's use of drugs to control pain, either as a learned behaviour and/or a habit. He would frequently attend hospital complaining of stomach pains, seeking morphine to control his pain, to the extent that there were flags on his medical records. Linked to this, it became clear that he was believed to be taking illegal drugs.

Suicide and Demographic Groups

16.2.5 It is understood that males are more likely to take their own lives, though Steve was not in the age group with highest prevalence of suicide. However, in an all-party parliamentary report, entitled "Tackling Male Suicide", it reported "Men in the building trades are nearly four times (see the Mates in Mind presentation) more likely to take their own lives than the average UK man, with almost nine tragedies a week".[11]

Covid Lockdown and Mental Health

16.2.6 Steve took his life during the Covid pandemic. The analysis of events will show that Steve and David lived in the same house for an extended time during the relevant period, and the number of police incidents clearly showed tension within the household. There are now several academic studies that reported increased problems with mental health in this period. The World health Organisation commented "for some COVID-19 has sparked or amplified much more serious mental health problems. A great number of people have reported psychological distress and symptoms of depression, anxiety, or post-traumatic stress. And there have been worrying signs of more widespread suicidal thoughts and behaviours, including among health care workers".[12] At the time of writing, this has not been translated into detailed analysis and report by the Office for National Statistics and some other reports that suicide rates did not change, with the BBC reporting in April 2021 "The number of suicides in England did not rise following the first national lockdown in 2020, research has found".[13]

Reported Domestic Incidents

16.2.7 The volume of incidents, and roles played will show that Steve was reportedly the victim on more occasions than David. Moreover, the in-depth analysis within the police IMR has enabled the panel to scrutinise in some depth matters such as the breadth of police investigations; temporal

[8] Source: Adult ADHD and suicide - PubMed (nih.gov) (Accessed November 2022)

[9] Source: Completed suicide, ideation and attempt in attention deficit hyperactivity disorder - PubMed (nih.gov) (Accessed November 2022)

[10] Source Suicidal behaviour among persons with attention-deficit hyperactivity disorder | The British Journal of Psychiatry | Cambridge Core

[11] Source: APPG-MB-Male-Suicide-Report-9-22.pdf (Accessed October 2022)

[12] Source: The impact of COVID-19 on mental health cannot be made light of (who.int) (Accessed November 2022)

[13] Source: Covid-19: Suicide rate 'did not rise during first lockdown' - BBC News (Accessed November 2022)

analysis and repeat nature of incidents and potential referral to MARAC; potential unconscious bias in dealing with male victims.

16.2.8 Moreover, the police incidents show that alcohol was frequently a significant feature in disputes between Steve and David, that along with alleged substance misuse contributed to a volatile relationship between father and son.

Domestic Abuse and Male Victims

16.2.9 The analysis that follows considers the widely recognised facts in respect of the gendered nature of domestic abuse but has attempted to view the circumstances from Steve's perspective. An article 'Domestic abuse during Covid-19; What about the boys', provides a useful perspective from which to start, suggesting that a considerably lower number of men confide in someone about their experience.[14] A further research study[15] bringing together academic research, and structured interviews with call handlers identified several matters to consider as reflective of Steve's experience:

- *Recognising and accepting. This theme relates to men's denial of their abuse. The issue of abused men being unable (or unwilling) to recognize and accept their victimization featured heavily in participant accounts. In part, this was accounted for by the lack of knowledge or awareness by men as to what constitutes DVA victimization, fear of not being believed, and shame of admitting being abused:*
- *Outcomes and impact of abuse. Participants referred to the extensive impact of abuse experienced by men. This included isolation, long-term physical problems, poor mental health (including feeling suicidal), and loss of contact with their children:*
- *Outcome and impact of disbelief and expectations. This theme depicts the consequences of men not being readily accepted as victims of abuse by others (e.g., police and family courts). Disbelief that men can experience abuse, notions of what a victim is, a reluctance or inability to see themselves as victims/claim victim status, coupled with societal expectations of men may mean that men face further victimization when they seek help:*
- *Barriers and challenges. The overarching Theme 3, Barriers, and Challenges, is supported by two subthemes: For men and for service providers. Participant accounts highlighted numerous barriers and challenges within the context of male domestic abuse: those specific to male victims and those specific to providing services for men.*

16.2.10 These findings reflect the existence of rigid gender role expectations placed upon men, commonly referred to as hegemonic masculinity that may be characterised by independence and stoicism. An article in Science Direct quotes how in Western Societies such masculinity is synonymous with a 'macho' identity that includes '*stoic in the face of adversity. It is thereby viewed as associated with behaviours that display courage and strength and that include refusal to acknowledge weakness or to be overcome by adverse events'*.[16]

16.2.11 The panel noted a recent comment by the domestic abuse commissioner," *We know that men face specific challenges when it comes to* domestic *abuse. Harmful gender norms, shame or honour, and stereotypes of masculinity and sexuality can act as barriers for male victims and survivors to seek support and can impact on reporting*".[17] Evidence of the additional barriers men are confronted with may be drawn from the 2018 crime survey for England and Wales that reported just over half of male victims of partner abuse (50.8%) reported telling anyone personally about abuse experienced in the previous year. This compares to the 81.3% of female victims.[18]

Domestic Abuse and Suicide

16.2.12 In 2018, Refuge and The University of Warwick published research that investigated the link between domestic abuse and suicide that was commissioned to fill gaps in the knowledge about

[14] Source: Domestic Abuse during COVID-19: What about the boys? - PMC (nih.gov) (Accessed March 2023)
[15] Source: "I Have Guys Call Me and Say 'I Can't Be the Victim of Domestic Abuse'": Exploring the Experiences of Telephone Support Providers for Male Victims of Domestic Violence and Abuse (sagepub.com) (Accessed March 2023)
[16] Source: Hegemonic Masculinity - an overview | ScienceDirect Topics (Accessed August 2023)
[17] Source: Our support for male victims - Domestic Abuse Commissioner (Accessed November 2022)
[18] Source: Partner abuse in detail, England and Wales - Office for National Statistics (ons.gov.uk) (Accessed June 2023)

factors that might predict, contribute to or mitigate against the risk of victims taking their own lives.[19] This report found 'Almost a quarter (24%) of refuge clients had felt suicidal at one time or another'. The findings of this report provide a useful lens through which to consider agency analysis and the terms of reference. The report's key findings were;

- Damaging *gaps and delays* were observed by staff who referred clients to community services;
- Short term *risk management* approaches were often cited as inadequate to address suicidality, particularly when facilitating its disclosure;
- Limitations of existing *tools* to assess risk of harm from the client to herself particularly over a broad timescale were highlighted;
- The need for *trauma-informed approaches* to practice, for clients and for the workforce were identified.

16.2.13 The importance of this lens is highlighted by a further recent study conducted by Kent and Medway. They found that "30% of all suspected suicides locally are individuals who have been impacted by domestic abuse (either as a victim or perpetrator)".[20]

Bristol Suicide Rates

16.2.14 The latest JSNA Health and Wellbeing Profile (2021/22) shows there were 142 deaths between 2018 and 2020, and the rate of 12.3 per 100,000 versus 10.4 for England.[21] In other words the local rate is 20% higher than the national average.

16.2.15 The local JSNA Chapter on Suicide Prevention and Self-Harm[22] reflects some of the observations above.

- Misuse of Drugs: The misuse of drugs and alcohol is strongly associated with suicide in the general population. Drugs, alcohol, and suicide thoughts can be a lethal combination. Alcohol affects suicide risk in multiple ways.
- Under care of Mental Health and those with self-harm history: People under the care of mental health services, especially those in psychiatric hospitals or under crisis teams and those who self-harm are at increased risk.
- Specific occupational groups: such as low-skilled workers e.g. construction workers and carers. For males working in skilled trades, the highest risk was among building finishing trades particularly plasters, Bristol JSNA Chapter 2018 – Suicide Prevention and Self-harm 5 painters and decorators.

16.2.16 The chronology and analysis that follows will show that Steve fell into these groups.

16.2.17 The local Bristol Suicide Prevention Strategy and Plan, sets out a comprehensive ambition "Bristol will be a city where people do not consider suicide to be a solution to the challenges they face, and individuals are supported by friends, colleagues, and services at times of crisis".[23] An examination of the strategy references domestic violence and domestic abuse separately in the context of A & E departments and support in respect of women respectively. A diagram within the strategy shows links to various partnership groups, but not to domestic abuse. Given the links between suicide and domestic abuse described at 16.2.10 & 11, there is an opportunity to strengthen this comprehensive strategy.

16.2.18 In December 2022, the Home Office in conjunction with the College of Policing published, "Vulnerability Knowledge and Practice Programme (VKPP) Domestic Homicides and Suspected Victim Suicides 2021-2022" that contains a series of recommendations. Given the evidence at 16.2.9 and 16.2.10, it is suggested that Recommendation 12 merits consideration.

[19] Source: WRAP-Domestic-abuse-and-suicide-Munro-2018.pdf (warwick.ac.uk) (Accessed January 2022)
[20] Source: Article: Why are people impacted by domestic abuse dying by suicide? (nspa.org.uk) (Accessed November 2022)
[21] Source: JSNA 2021.22 - Suicide deaths (bristol.gov.uk) Accessed November 2022)
[22] Source file (bristol.gov.uk) (Accessed November 2022)
[23] Source: file (bristol.gov.uk) (Accessed January 2023)

- We recommend that, in developing local and national suicide prevention activities, health agencies should consult domestic abuse specialists to ensure that appropriate measures relating to domestic abuse victims are included. At a local level, Local Health Partnerships should consider the risk of suicide following domestic abuse in their Domestic Homicides and Suspected Victim Suicides 2021-2022 suicide prevention strategies. At a national level, the Department for Health and Social Care should ensure that domestic abuse is reflected in national suicide prevention strategies.[24]

Learning Opportunity (LO1): Within the Bristol Suicide Prevention Strategy and Plan, an opportunity to recognise domestic abuse as a vulnerability/characteristic for those who may take their own lives. **Recommendation 1**: Bristol City Council (Public Health) is to ensure that the link between all victims of domestic abuse and suicide is strengthened and plans to reduce suicide are embedded into partnership work on domestic abuse.
Outputs/Outcomes: Domestic abuse is recognised as a vulnerability for those who take their own lives and embedded into the work of professionals working in that field.

Equalities

16.2.19 Two matters arise within the analysis, the first being agencies recognising that there is a risk of unconscious bias by professionals, when dealing with a male victim of domestic abuse. Several academic reports, support this notion such as a study by the University of Cumbria that found "it is clear that even within the more recent research, there is still a strong influence of gendered stereotypes within service and practice". [25] The second linked challenge of professionals recognising what was happening to Steve as being 'domestic abuse'. Arguably this contributes to the barriers that male survivors experience when seeking help and support for domestic abuse as summarised in the same study above that found barriers include, "fear of legal and administrative aggression from their partners (e.g., through false allegations, parental alienation), fear of not being believed, and barriers relating to socially constructed masculine gender role".[26]

16.3 GP

Background

16.3.1 Steve registered at the GP practice in 1997. Notable GP contacts for him during his childhood include febrile convulsions between 1997-2002. He was seen by a pediatrician with investigations, including EEG with no causal factors identified. Between 2002/3 he was diagnosed by Community Pediatricians as having ADHD and responded to medication prescribed. Medication was reduced and stopped in 2008 with no ill effect following concerns relating to withdrawn mood and behaviour.

16.3.2 School exclusions and behaviour concerns were reported in 2009 at a GP contact when the GP made a referral to CAMHs (child and adolescent mental health services). He moved to live with his father and grandmother at this time with agreement between his father, and advice was given on establishing clear parenting boundaries instead of use of medication for his ADHD.

16.3.3 In 2011 he moved back to live with his mother following disruptive behaviour and two school moves. The Pediatrician at this time identified Steve had low self-esteem and possible communication and learning needs but due to complexity and possible impact on Steve of frequent home and school moves parenting boundaries were advised, reportedly with a good response.

16.3.4 Aged 17 years old in April 2014 Steve had an appendectomy and visited A&E and the GP regularly from July 2014 to February 2015 with nonspecific abdominal pains. In February 2015 Steve underwent full abdominal and bowel screening investigations with normal results.

[24] Source: *[Title] (vkpp.org.uk) (Accessed January 2023)
[25] Source Bates_MensExperience.pdf (cumbria.ac.uk) (accessed December 2022)
[26] IBID

16.3.5 Records indicate use of codeine with regular A&E attendance to obtain morphine rather than attending reviews by GP. In June 2015 he was reported by Southwest Ambulance Service as living in Somerset so advised to change GP Practices. It was noted in August 2015 Steve had attended A&E (RUH Bath) forty-seven times for IV Morphine. He was referred and reviewed under pain clinic with colonoscopy completed with normal result. An A&E support plan was put in place for Steve's frequent attendances where he continued to attend reporting abdominal, urinary, or testicular pain and requested IV morphine and allegedly became aggressive if challenged. He was also reported to use alias names to obtain Morphine, but multiple hospital attendances and investigations had not found any underlying cause for his pain.

16.3.6 This background provides an invaluable insight, suggesting that he lived with a substance misuse dependency before the relevant period under consideration. An article on the government website entitled, 'Opioids: Risk of dependence and addiction' reports, "*For all patients, prolonged use of opioids may lead to drug dependence (and in some patients addiction/opioid use disorder), even at therapeutic doses (see resources from the Faculty of Pain Medicine). The risks are increased in individuals with current or past history of substance use disorder (including alcohol misuse) or mental health disorder (for example, major depression*)".[27] A BMJ best Practice article 'Opioid use disorder' when considering causes comments, "*Comorbid psychiatric disorders such as bipolar disorder, ADHD, major depression, anxiety disorders, personality disorders, PTSD, and psychosis increase the risk of substance abuse, including opioid abuse".*

16.3.7 The GP had over 25 entries on the chronology, the majority of which were alerts regarding contact with other health professionals such as A & E, NHS111 and one alert in respect of a MARAC enquiry. These alerts did include incidents where the subject of domestic abuse was apparent, or in some cases related to his state of mind. The table below shows when these alerts were made, and when the GP next either saw or contacted Steve. He was seen on only four occasions during the relevant period.

Table 6

Date	Summary	DA/MH	Alert Source	Notes
3/8/2018	Altercation with girlfriend and his overdose	DA, MH	A & E	
5/8/2018	Overdose		A & E	
6/8/2018	Assault, persons unknown		A & E	
10/1/2018	Did not attend GP			
14/8/2018	Attended GP: Sutures removed			Seen
31/12/2018	Needed someone to talk to		NHS111	
3/1/2019	Attended GP: Comprehensive assessment			Seen
7/2/2019	Did not attend medical appointment		Hospital	
13/1/2019	Assault, persons unknown		A & E	
21/03/2019	Telephone consult: Unrelated medical matter			Telephone
8/8/2019	Abdominal Pains		A & E	
25/8/2019	GP out of hours: Unrelated medical matter			
12/1/2020	Alleged assault versus Steve	DA	A & E	
31/5/2020	Unrelated medical matter.		NHS111	
30/08/2020	Alleged assault versus Steve	DA	A & E	
01/10/2020	Out of hours GP: Unrelated matter			Seen
07/10/2020	Unrelated medical matter		A & E	
05/12/2020	Attempted suicide	DA, MH	A & E	
08/01/2021	MARAC enquiry		MARAC	
28/01/2021	Attempted contacts			
09/03/2021	Unrelated physical complaint matters			Seen
21/03/2021	Abdominal Pain		A & E	

Key Line of Enquiry A: Communication and Co-operation Between Agencies

[27] Source: Opioids: risk of dependence and addiction - GOV.UK (www.gov.uk) (Accessed December 2022)

16.3.8 There is clear evidence of health agencies such as A&E and NHS111 notifying the GP of their contact with Steve. These include matters relating to Steve's state of mind and/or domestic abuse as shown at table 1. They also include alerts for unrelated medical matters, and attendance at A & E seeking pain relief.

Key Line of Enquiry B: Risk of Domestic Abuse and Self-Harm

Routine Screening and Enquiry for Domestic Abuse

16.3.9 Steve was seen infrequently by his GP during the relevant period. He was seen within two weeks following an altercation with his girlfriend (03/08/2018) and overdose, and in March (09/03/2021) when GP records show alerts regarding domestic abuse (12/01/2020, 30/08/2020), an attempted suicide linked to DA (05/12/2020) and a MARAC enquiry (08/01/2021). These may have provided an opportunity to explore how things were at home, as he was attending the GP with an injury that had occurred in relation to that incident. There is a body of evidence suggesting the benefits, such as an article by the British Journal of General Practice that says, "Evidence suggests that routine or universal healthcare screening for DA improves levels of victim identification in primary care settings".[28]

16.3.10 Other attendances at the GP were not proximate in time, to matters overtly related to potential domestic abuse. For example, Steve called NHS111 on the 31st of December 2018 wanting someone to talk to. Therefore, on the 3rd of January 2019 his GP carried out a comprehensive assessment of medical and social matters, where Steve disclosed his own low mood and anxiety following the breakup with his girlfriend, and not being able to see his child. The records reflect detailed consideration of both medical and social causes of his low mood and show curiosity in respect of his risk to self and from others. Whilst he denied any suicidal ideation, as part of his safety netting, he was advised to attend A & E if he was feeling acutely agitated or suicidal. However, Steve did not disclose two incidents reported (on 26th and 29th December) where he had been the alleged perpetrator.

16.3.11 On considering Quality Standard 116 of NICE guidelines relating to asking about domestic violence and abuse, it is noted that a list of symptoms or conditions of possible domestic violence and abuse commence with; - symptoms of depression, anxiety, post-traumatic stress disorder, sleep disorders; - suicidal tendencies or self-harming and alcohol or other substance misuse. During this consultation, Steve also spoke about anxiety and difficulty sleeping, though suggested he had stopped drinking as a New Year's resolution. Arguably, this consultation provided an opportunity to recognise potential indicators of domestic abuse and make an enquiry.

16.3.12 Other contacts with the GP occurred several months after having received information about being a victim of assault. He was seen on the 1st of October 2020 regarding a head injury by the out of hours GP, when the most recent incident alerts of having been assaulted by his father was dated 30th August 2020. (Having been alerted to this incident by the hospital). Steve explained the injury occurred whilst at work as a scaffolder, and whilst there is nothing in the chronology to suggest any linked domestic incident, there is also nothing to suggest he was asked about domestic abuse. Similarly, as outlined at 16.3.9, information was on file about domestic abuse when seen in March 2021. Given the recent history of abuse, arguably these contacts merited improved professional curiosity.

Learning Opportunity (LO2): To improve the recognition and response to signs of domestic abuse, demonstrating improved professional curiosity and asking about domestic abuse. **Recommendation 2**: The ICB is to improve the ability of GPs to identify signs of domestic abuse and respond with appropriate professional interest that provides opportunities for survivors to disclose abuse.
Outputs/Outcomes: - Improved staff awareness and ability to recognise indicators of domestic abuse. -Increased identification of victims of domestic abuse, and signposting of victims to appropriate specialist support.

[28] Source: Routine screening for domestic abuse | British Journal of General Practice (bjgp.org) (accessed February 2022)

16.3.13 The GP practice received a MARAC enquiry on the 8th of January 2021 but was not seen until the 9th of March 2021. The IMR author notes that there was no documented evidence in the record if the recommended GP action from the MARAC meeting was received by the GP or the action completed. This was further explored with the Safeguarding link GP who confirmed receipt of the request and confirmed a colleague GP attempted contact on the 28th of January, but there was no reply. Due to the sensitive nature of the call and a standard voicemail not confirming Steve's name, a message was not left. The documentation in the records of this phone contact on the 28/01/2021 is unclear on how the DVA risk and any follow up action required was recorded (coded) from the missed phone call contact or whether any follow up plan for contact was put in place. There was no further reference to how this MARAC enquiry and/or follow up with Steve would be made in subsequent contact with him.

16.3.14 It is noted as positive that agencies can ask GPs to follow up with MARAC enquiries, but noted the subsequent contact was a missed opportunity to follow up on the initial request from the MARAC. Arguably, this links with the earlier alerts to Steve having been a victim of domestic abuse, and an individual agency recommendation is welcomed in this regard.

Learning Opportunity (LO3): To recognise and follow up on domestic abuse alerts.
Response and Individual Agency recommendation: To ensure that DVA risk is documented and coded in GP records

Risk assessment for Self-Harm

16.3.15 The link between suicidal ideation, suicide and domestic abuse is well recognised as outlined at 16.2.9 and 16.2.10.

16.3.16 There are also several articles that link attention-deficit hyperactivity disorder (ADHD) and suicide. The National Library of Medicine, a US site reports, "A review of the current literature focusing on this issue provides strong evidence that ADHD patients are at a significant risk for experiencing suicidal ideations and committing suicide. For daily clinical practice, it is therefore essential to incorporate this aspect into the diagnostic and therapeutic process and to take preventive measures".[29] Similarly the British Journal of Psychiatry reported, "Persons diagnosed with attention-deficit hyperactivity disorder (ADHD) have been found to have an increased risk of suicidal behaviour, but the pathway remains to be thoroughly explored".[30] Given Steve's reported adolescent history, it seems important that any additional vulnerability is noted when considering risk and response to suicide/self-harm.

16.3.17 The matter of self-harm came to notice on three occasions during the relevant period.

a) The first incident was in August 2018, though there does not appear to have been any reference to this overdose when he came into the surgery and had sutures removed on the 14th of August.
b) The second incident followed Steve calling NHS111 on 31st January 2018, before he attended his GP on the 3rd of January 2019, when he underwent a thorough consultation.
c) The third related to an attempted hanging on 5th December 2020. He was not seen by his GP until March 2021, and no reference is made to the attempted suicide.

16.3.18 Whilst he underwent a comprehensive examination regarding the second incident, neither the first or third prompted any contact from the GP, or professional curiosity at the first opportunity that he was seen.

16.3.19 Steve was only seen on one more occasion before he took his own life, when he saw an advance practitioner nurse at the practice regarding an unrelated matter. It is not recorded whether he was asked about his state of mind. On the one hand he was seen regarding physical ailments, on the other hand it is possible worries around physical ailments may have raised his anxiety. The BMJ

[29] Source: Adult ADHD and suicide - PubMed (nih.gov) (Accessed December 2022)
[30] Source: Suicidal behaviour among persons with attention-deficit hyperactivity disorder | The British Journal of Psychiatry | Cambridge Core (Accessed December 2022)

Best Practice Guidance Suicide risk management recommends "It is important to consider asking all patients about suicidal thoughts even if this is not their primary reason for presentation".

16.3.20 The panel explored flagging of patients with suicidal ideation and learned GPs use SNOMED (how GPs code problems) in their patient records and there is a code named "suicidal ideation or thoughts of self-harm". Use of the code is reliant on practitioner choice of code. The panel agree that the use of such codes may prompt GPs and nurses to explore with patients how they are, in other words enhance their professional curiosity for patients who have a history of self-harm.

Learning Opportunity (LO4): Use of flagging a history of suicidal ideation to prompt improved professional curiosity. **Recommendation 3**: The GP practice seeks assurance that it has a system in place that demonstrates the recording of "suicidal ideation or thoughts of self-harm" using the codes as per the system of software in place for patient records.
Outputs/Outcomes: - Enhance staff awareness of codes that encourage routine professional curiosity for patients with a history of suicidal ideation, - More regular routine professional curiosity for patients who have a history of suicidal ideation.

16.3.21 Steve had an in-depth consultation for the second incident, where he detailed that his low mood and anxiety had been getting worse since breaking up with his partner. He explained that he had a low mood, was not socialising and that he was struggling to sleep and having bad dreams about not seeing his child. He denied any current thoughts of self-harm/suicide, and when asked about the first incident (August 2018), he said he had almost taken an overdose on two other occasions. An assessment was undertaken using the 'patient health questionnaire (PHQ9). His safety plan included advice about attending A & E in the event of feeling agitated or suicidal.' He was also signposted to talking therapies and prescribed an anti-depressant.

16.3.22 On considering the available tools for assessing risk, the panel learned that risk assessment in relation to self-harm and suicidal ideation is problematic, with the BMJ reporting "Risk assessment is challenging for several reasons, not least because conventional approaches to risk assessment rely on patient self-reporting and suicidal patients may wish to conceal their plans. Accurate methods of predicting suicide therefore remain elusive and are actively being studied"[31] Conversely, the department of Health in its publication 'Best Practice in Managing Risk'[32] cites 6 tools for assessing risk of suicide. In Steve's case the PHQ9 was used as a means of assessing his mood. This tool is described as, "The **9-question Patient Health Questionnaire** (**PHQ-9**) is a diagnostic tool introduced in 2001 to screen adult patients in a primary care setting for the presence and severity of depression. It rates depression based on the self-administered Patient Health Questionnaire (PHQ)".[33] This tool provides a scalar to assess depression that varies from, "Depression Severity: 0-4 none, 5-9 mild, 10-14 moderate, 15-19 moderately severe, 20-27 severe."[34] Steve scored 22/27, in other words severe.

16.3.23 As the review was progressing, the panel's attention was drawn to the recently published NICE guideline (NG225) regarding 'Self-harm: assessment, management and preventing recurrence'[35]. This article provides clear advice as to the use of risk assessments, clarifying what had been an ambiguous position for the panel, with section 1.6 of this article specifically stating, "Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm."

Key Line of Enquiry C: Response to Domestic Abuse and Self-Harm

Domestic Abuse

[31] Source: studied Suicide risk assessment and intervention in people with mental illness | The BMJ (Accessed February 2022)
[32] Source: Best Practice Managing Risk Cover (publishing.service.gov.uk) (accessed March 2022)
[33] Source: PHQ-9 - Wikipedia (Accessed December 2022)
[34] Source: PHQ-9 Depression Test Questionnaire | Patient (Accessed December 2022)
[35] Source: Recommendations | Self-harm: assessment, management and preventing recurrence | Guidance | NICE (Accessed April 2023)

16.3.24 Domestic abuse was neither identified nor asked about, and therefore comments on response to domestic abuse is limited to the learning opportunities identified above. *(16.3.14 and 16.3.15)*

Self-Harm

16.3.25 The national strategy 'Preventing Suicide in England' has 6 key areas for action, that includes; - reducing the risk of suicide in key high-risk groups; - tailor approaches to improve mental health in specific groups; - reduce access to the means of suicide; - providing information and support to those bereaved or affected by suicide; - support the media in delivering sensitive approaches to suicide and support research, data collection and monitoring. Whilst these may be seen as high-level strategic aims, they provide helpful context.

16.3.26 BMJ Best Practice Guidance Suicide risk management[36], provides a useful summary of risk factors, that includes a section on self-harm, where it reflects on several academic articles.

- Although most people who self-harm may not intend to end their life, self-harm is associated with a 50- to 100-fold increased risk of future suicide.
- An approximately 30-fold increase in risk of suicide, compared with the general population, was observed for the whole cohort.[37]
- Repetition of deliberate self-harm is associated with an increased risk of suicide in males and females.[38]
- Continued use of weak analgesics to self-poison is a particularly strong indicator of future suicide.

These risk factors were apparent for Steve. This does not suggest him taking his own life was predictable, rather matters of reflection to consider in considering the response to him.

16.3.27 Steve was provided advice as described at 16.3.19. It is not clear whether a formal safety plan was documented, as described in BMJ Best Practice Guidance Suicide risk management.[39] There are various descriptions of what a safety plan is such as; - A Safety Plan provides a blueprint for coping when suicidal thoughts and feelings are overwhelming,[40] - A suicide safety plan is a written set of instructions that you create for yourself as a contingency plan should you begin to experience thoughts about harming yourself [41]. The key feature of these plans is that they are written down. The BMJ reference a useful website (Staying Safe) for this purpose that enable people to refer to written answers for coping. (See Appendix X). This safety plan requires answers to the following questions: - Getting through now: - Making situation safer; - Things to lift or calm your mood; - Things to distract you; - People to support you; - List of who you can talk to if distressed or thinking about suicide; - Emergency professional support. In other words, an immediate reference point for an individual in crisis. Interestingly, the same article also references smartphone apps that may be utilised, in recognition of developing technology that may assist in these circumstances. In discussion with the panel representative, it was clear that GPs have very limited time with patients, and completion of these generic 'safety plans' would be problematic for practices.

16.3.28 As the review progressed, the panels attention was drawn to a number of research articles on the subject of suicide prevention such as "Suicide mitigation: a compassionate approach to suicide prevention" that quotes "*clinicians should routinely ask patients with depression or emotional distress about thoughts of suicide and self-harm and suicidal behaviour (Cole-King*

[36] Source: https://bestpractice.bmj.com (Accessed December 2022)
[37] Source: Suicide After Deliberate Self-Harm: A 4-Year Cohort Study | American Journal of Psychiatry (psychiatryonline.org)
[38] Source: Repetition of deliberate self-harm and subsequent suicide risk: long-term follow-up study of 11,583 patients - PubMed (nih.gov)
[39] Source: https://bestpractice.bmj.com (Accessed December 2022)
[40] Source: How to Develop a Suicide Safety Plan | Psychology Today (Accessed December 2022)
[41] Source: How to Create a Suicide Safety Plan (verywellmind.com) (Accessed December 2022)

2011)[42]" and a further article in the Lancet that suggests a need for "*a compassionate and alternative to the so called management of suicide*"' and continues the need to go "*beyond the checklist approach*"[43].

16.3.29 Following discussions outside the panel with panel representatives from the ICB and Public Health, the panel concur that the use of safety plans was an important point of reflection for professionals meriting further exploration by public health in their future development of suicide prevention strategies.

Learning Opportunity (LO5): Consideration as to the merits of using safety planning tools to mitigate the risk of suicide. **Recommendation 4:** Public health to explore the evidence-base for the routine use of 'safety planning' tools for those who express suicidal ideation and/or have attempted to take their own lives within the suicide prevention strategy. .
Outcome: A better informed understanding as to the efficacy of 'safety planning' that informs local policy and practice options.

Key Line of Enquiry D: Access to specialist domestic abuse agencies

16.3.30 The local practice refers and signpost to the locally commissioned provider Victim Support, having their contact details along with ManKind Initiative available for male victims of domestic abuse.

Key Line of Enquiry E: Policies, procedures, and training

16.3.31 The chair was provided with two Safeguarding policies, and it is apparent there has been a significant updating in respect from the first to second version last reviewed in 2017. That said, the most recent policy refers to domestic violence, and its definition would benefit from updating in accordance with the Domestic Abuse Act 2021.

16.3.32 The policy does not provide specific guidance as to recognising and responding to domestic abuse, and in all cases recommends reporting to a senior manager and/or safeguarding lead. Having regard to the comments at 16.3.12, it appears there is an opportunity to further update the policy in respect of recognising, enquiring, and responding to domestic abuse.

Learning Opportunity (LO5): To update the safeguarding policy in accordance with change in definition to domestic abuse, and regarding the recognition of and response to Domestic Abuse. **Response**: See Recommendation 2. The action plan will include changes to policy.

16.3.33 Whilst reassured that staff complete training and have access to a variety of training resources, the policy states, "All Practice staff must be trained and competent…." and continues that the practice will enable staff to participate in training, and that the practice will keep a training database, it does not set a standard for training. Linking this with policy amendments suggested above, this may provide an opportunity to refresh training requirements in terms of focus and frequency. It may be helpful to consider a framework for training, based upon a tiered system utilised in Wales, ranging from Group 1 - e-learning through to Group 2 – ask and act, Group 3 – ask and act champions through to more strategic roles. [44]

Learning Opportunity (LO7): To strengthen the approach to training, to ensure staff are able to recognise and respond to domestic abuse. **Response**: See Recommendation 2. The action plan will include work in relation to training and awareness.

[42] Source: *suicide mitigation a compassionate approach to suicide prevention.pdf (cambridge.org) (Accessed November 2023)

[43] Source: Alys Cole-King: a pioneer of suicide mitigation in the UK - The Lancet (Accessed November 2023)

[44] Source: National Training Framework on violence against women, domestic abuse and sexual violence | GOV.WALES (Accessed March 2022)

Key Line of Enquiry F: Seeking help, as well as considering what might have helped or hindered access to help and support.

16.3.34 Steve was able to access medical services and his GP as required.

Key Line of Enquiry G: Extent to which Covid affected agency involvement with Steve.

16.3.35 Steve continued to contact the GP or access GP advice via NHS111 throughout the Covid-19 pandemic period.

Key Line of Enquiry H: Substance Misuse and financial pressures

16.3.36 Whilst prior to the relevant period he had frequently sought pain relief at A & E departments, during the relevant period the matter of abdominal pain being reported was less frequent, (August 2019, January 2020, and March 2021). Possible opioid dependency is noted at 16.3.6. and he was asked about and denied any recreational drug use at his consultation on 3rd January 2019.

16.3.37 The UHBWFT IMR has made an individual agency recommendation regarding this observation.

- *High Impact User team will be asked to ensure that personal support plans for opiate seeking presentations to E.D include a prompt to offer a referral to the drug team and signposting to relevant service for support is considered.*

Further key lines of enquiry

16.3.38 No specific comments are made in respect of, child access, housing situation, familial abuse, or gender.

16.4 Avon and Somerset Police

16.4.1 Table 7 below summarises the incidents and some features involving Steve. These include seven allegations of assault by Steve against his father David, and four allegations of assault on David by Steve. Other incidents include an allegation of assault by Steve against his former partner and mother of his child; one where it was alleged that Steve had bitten the finger of his child; and two property related crimes, a theft and criminal damage where David is the victim.

16.4.2 The table shows the degree of complexity with cross allegations, and presence of vulnerability factors, such as alcohol as a feature in over 50% of contacts, and substance misuse and mental health on several occasions. The chronology also shows that the ambulance service was called on two of these incidents, one where Steve had been found foaming at the mouth, the second where he had attempted to take his own life.

16.4.3 Temporal analysis of the incidents shows that police had contact (with Steve and David) on three occasions in 2018, one occasion in 2019, nine relevant occasions in 2020 of which three occurred over a seven-hour period in one day. The longest period without police contact was January 2019 through to November 2019, suggesting a period of stability. Arguably the frequency of contact in 2020, suggest that circumstances were becoming more challenging for Steve and David.

16.4.4 There also appears to be two periods of 'clustered events' that suggest periods of heightened tension within the household.

- One cluster of four events, 26/11/2019, 03/01,2020, 12/01/2020,02/02/2020
- One cluster of four events, the third of which had an additional two calls (30/08/2020 x 2, 05/12/2020, 15/01/2021)

16.4.5 It is against this background that the key lines of enquiry were considered. It should be noted that the volume of contact posed questions as to the efficacy of the MARAC. Comments in relation to the MARAC are included within the police section, but it is acknowledged that the MARAC is a partnership responsibility to which police play a vital role.

Table 7

Date	Type of Call	DASH	BRAG	BWV[45]	Neighbour Enquiry	999 listened to	Features	Outcome
04/08/18	Assault S v S	Y (H)	No	yes	Yes,	U/K	**A, S**	Arrest & charge
04/08/18	Assault D v S S v D	Yes (St)	U/K	yes yes	Yes,	U/K	**A, S, M**	NFA CPS decision
26/12/18	Verbal argument / criminal damage	Yes (St)	U/K	U/K	U/K	U/K		NFA. S remains at house
29/12/18	Assault v child & S v D	Yes (St)	Yes	Yes	U/K	U/K	**A**	NFA. D did not substantiate
26/11/19	Assault D v S	Yes (St)	U/K	U/K	U/K	U/K		NFA
03/01/20	Assault S v D	Yes (M)	U/K	U/K	U/K	U/K		NFA
12/01/20	Assault D v S	Yes (St)	No	U/K	U/K	U/K		NFA
02/02/20	Assault D v S	Yes (M)	Yes (Amber)	Yes	Yes	U/K	**A**	Charged, convicted
12/04/20	Assault S v D	Yes (M)	U/K	Yes	U/K	U/K	**A, S**	NFA
30/08/20	Assault D v S	Yes (St)	No	U/K	U/K	U/K	**A**	NFA
30/08/20	Theft S v D	Yes (M)	U/K	U/K	N/A	U/K	**A, S**	NFA
05/12/20 **X 3**	Assault D v S (for 1st incident)	No (S) Yes (D) (St)	Yes (Amber)	Yes	Yes	U/K	**A, M**	NFA
15/01/21	Threats & historic strangulation	Yes (H))	Yes (Amber)	Yes	U/K	Yes		NFA

A – alcohol, S- substance misuse, M-mental health

Key Line of Enquiry A: Communication and Co-operation Between Agencies

16.4.6 Police were called to multiple incidents involving Steve either as a perpetrator or as a victim. Police involvement and opportunity to work with other agencies regarding domestic abuse was limited, dependent upon either Steve consenting for his details to be shared, or whether the police assessed the level of risk as being high that would have necessitated a referral to DA Support Service or the MARAC that would have involved a multi-agency discussion across agencies.

16.4.7 The chronology showed that the first time Steve was referred to specialist advocacy services was following the incident on 30th August 2020, when the LSU spoke to Steve on the 13th of September, and he disclosed financial, emotional, and physical abuse. The LSU escalated the risk from low to medium and referred him to Victim Support. It wasn't until the incidents on December 2020, that Steve and David's situation was referred to the MARAC for multi-agency discussion.

[45] It is noted that Body Worn Video (BWV) is only shown as 'yes' below if it was committed to police records as there was material of evidential value and is not retained if there was no evidential value.

16.4.8 Therefore it was only at the point of the risk having been assessed as high via the completion of DASH[46] and BRAG[47] respectively, that there was a multi-agency discussion that is explored later.

16.4.9 Notwithstanding the comments about communication and co-operation between agencies regarding Steve and David, the chronology shows that police made appropriate referrals such as to Child Health and Education and Safeguarding (04/08/2018), and to Child Health and Education (03/01/2020).

Key Line of Enquiry B: Risk of Domestic Abuse and Self-Harm

DASH

16.4.10 DASH risk checklists were completed consistently during police contacts, the majority of which were on professional judgement, as rarely did Steve or David co-operate. However, where there were cross allegations, the DASH was not completed for both parties such as on 4th August 2018 when no DASH was completed for Steve and the 5th of December 2020, following a suicide attempt, a DASH was completed in respect of David, but not in respect of Steve. Upon exploring compliance rates, as of May 2023 DASH non-compliance rates had fallen from 14.4% for the past six quarters, to 8.5%. this follows a wide ranging cultural and awareness training programme across the force (See 16.4.24). This mitigates the need for a recommendation.

Learning Opportunity (LO8): To ensure that DASH checklists are completed for all domestic abuse incidents, and where there are cross allegations, complete for both parties.
Response: Police programme of training and awareness and evidence of improvement provided.

16.4.11 Only on one occasion (15th January 2021) was the risk assessed as high by officers dealing with Steve and David. Conversely, when police dealt with an allegation of assault by Steve versus his partner (4th August 2018) the rating for her was high. This raises a question as to whether attending officers recognised the risk of familial domestic abuse of father versus adult son, in the same way that they may between intimate partners when the perpetrator is male, and the victim female.

16.4.12 The panel concur with the IMR author's observations, "*It would appear from the chronology that often each incident between Steve and David was managed in isolation. Prior to the incident on the 12th of August 2020, no broad picture of the relationship and its dynamics and complexities appears to have been understood. In response to some incidents, there seems to be a perception that resorting to violence has been normalised in Steve and David's relationship and that Steve antagonised David.*" The author continued, "*This translated on some occasions into a lack of professional curiosity. There may have been a lack of understanding and recognition that Steve as a young, fit, scaffolder, could be the victim of abuse, including controlling and coercive behaviour, by his father, as a result of a possible unconscious confirmation bias towards a more stereotypical domestic abusive relationship*". In this case considering 'confirmation bias' as; "the conscious or unconscious tendency to affirm theories, opinions, or outcomes or findings. It is a specific kind of bias in which information and evidence are screened to include those things that confirm a desired position",[48] the effect was that risk to Steve was not assessed as high.

16.4.13 In September 2022 Avon and Somerset launched DA Matters, '*a cultural change programme designed by domestic abuse charity SafeLives. This programme, which is being delivered to 3,000 of our officers and staff who respond to domestic abuse, aims to transform our response*

[46] **Domestic Abuse, Stalking and harassment and Honour based abuse (DASH) Toolkit –** A nationally implemented tool used to assess victim risk in cases of domestic abuse. It enables officers to assess level of risk of serious harm for the victim to support safeguarding decisions. Ideally it will be victim led but where a victim declines to answer the series of questions it will be based on an officer perceived level of risk based on what is known about the victim and the perpetrator.

[47] **BRAG Tool –** A tool introduced in 2018 to objectively risk assess and record all forms of vulnerability or safeguarding concerns. The outcome of the BRAG assessments helps determine immediate action as well as helping LSU to triage and signpost or refer to appropriate partner agencies. It should be used alongside other assessment tools (such as the DASH), and its use is subject to continual compliance monitoring via the Qliksense App

[48] Source: Confirmation Bias - an overview | ScienceDirect Topics (Accessed November 2022)

and ensure the voice of the victim is at the centre of the way we deal with such cases'.[49] This programme seeks to transform understanding of all domestic abuse, irrespective of the gender of victims, type of abuse, and is currently been augmented by other initiatives outlined at 16.4.24. The learning from this review has informed the roll out of this programme and will be further shared as a point of reflection in the delivery of future training and shared learning.

Learning Opportunity (LO9): Professionals (officers) to be alert to the potential for unconscious bias, recognising father versus adult son as domestic abuse**.**
Response: DA Matters programme rolled out incorporated domestic abuse and was delivered between September 2022 and March 2023.

16.4.14 Whilst we know that neither Steve nor David volunteered to complete the DASH assessments, an examination of the checklist in hindsight did show that several markers may have been answered with a positive indication but may not have been sufficient to have reached the threshold of 14 out of 24 to justify a high-risk rating and automatic referral to MARAC. These markers are - injury, - fear; - depression or suicidal thoughts; - conflict over child contact; - abuse happening more often; - abuse escalating; - use of weapons; - attempted strangulation. Each of the features were apparent at points in time, such as a reported attempted strangulation in October 2020 (reported in January 2021). Therefore, in the absence of achieving 14 from 24 to be referred to MARAC, one would have been reliant on professional judgement of high risk such as in January 2021, or another means such as automatically referring repeat calls over a certain threshold to MARAC.

Professionals Judgement- Assessment of vulnerability – BRAG

16.4.15 Frequently, the expression 'professional curiosity' is applied to seeking further information. The BRAG tool was introduced in 2018 to assist with the assessment of vulnerability. Whilst a BRAG is not routinely required for a DA victim where a DASH has been completed it can be helpful if additional vulnerabilities are identified by attending officers and should be completed if there are other vulnerable parties present at the scene. The IMR identified two incidents on 12th January and 30th August 2020 when a BRAG in addition to the DASH could have been considered. The panel concur with the IMR's observations on this incident, that 'A BRAG would have been an opportunity to highlight Steve's housing situation and concern about his possible alcohol dependency'. In other words, provide an insight into apparent vulnerabilities, and potential pathways to support and/or a rate the risk differently on professional judgement.

Learning Opportunity (LO10): Encourage professional curiosity through use of BRAG to provide insight into vulnerability.
Response: Police programme of training and awareness and evidence of improvement provided.

Further information – Intelligence checks

16.4.16 Police also have additional means of securing further information. They are provided relevant information by dispatchers when responding to an incident and can view the STORM call log to see details of the incident they are attending. They also have access to NICHE to review previous occurrences for the victim/suspect to provide information on previous call history.

Repeat Calls. (Handling and MARAC)

16.4.17 On the 30th of August 2020, there were two calls to police. The first by Steve at 4.56pm alleging a domestic assault by David against Steve, that Steve chased at 5.41pm and 6.30pm. Whilst the call was listed for attendance, they did not attend until the 9th of September 2020, citing call operational demands in accordance with the THR matrix. However, they did attend a call (*which was not related to the first*) at 8.10pm on the 30th of August at the request of Ambulance to assist with Steve who was being aggressive. The panel understands that it was the 'request for assistance' that resulted in attendance, and that a subsequent allegation of theft made by David

[49] Source: The decisive action Avon and Somerset Police is taking on culture and standards | Avon and Somerset Police (accessed September 2023)

happened during the attendance and after Steve was in the ambulance. The two calls on the 30th were not linked by either the call centre or officers who attended the second call. This was explored outside panel meetings with the police communications and STORM technical team, who advised the system does 'automatically populate' similar calls to alert call handlers to potentially linked calls. The actual linking/cross referencing of calls is a manual process, and that this was a call handler error on the 30th of August. The panel concur with the individual agency recommendation noted below and note the efforts of the IMR author in progressing this learning opportunity during the review with the Police communications team and force STORM team.

Learning Opportunity (LO10): To ensure that police deal with all outstanding calls to a location where there is more than one call. **Recommendation 5:** Avon and Somerset Police are to ensure that call handling policies and protocols ensure that all outstanding calls to a location are dealt with by the first attending police unit.
Outcome/Outputs: All outstanding calls to same location are dealt with by attending police units / Policies and protocols reflect the outcome, and how this outcome is achieved

16.4.18 SafeLives defines a 'repeat' as ANY instance of abuse between the same victim and perpetrator(s), within 12 months of the last referral to MARAC.[50] This pre-supposes that a case is heard at the MARAC. We know that Steve and David's circumstances were only referred to the MARAC on one occasion. The panel learned that there is no local policy in respect of 'repeat incidents' resulting in automatic referrals, though if a case has been heard at MARAC, and there is a further incident it will be heard again. Conversely, we know that in many parts of the UK that multiple calls in a 12-month period are automatically referred to the MARAC, whether that is three, four or a higher threshold. This is in accordance with an HMIC publication "Everyone's business: Improving the police response top domestic abuse', that said *"reviewing standard and medium risk cases following a pattern of repeat incidents, but where the number of incidents that have to occur before a review is triggered is unacceptably high. Even more concerning is where forces have no policy of review after repeat incidents"* [51]

16.4.19 HMICFRS in their update report made further comment about identifying repeat victims; *"Victims of domestic abuse are more likely to be repeat victims than are victims of any other crime type. Forces need to identify repeat victims as early as possible. This will help them to spot patterns of abuse"*. [52]

16.4.20 Of note, when HMICFRS reviewed domestic abuse against the background of the pandemic, they found that Avon and Somerset had the second lowest rate of cases discussed per 10,000 adult females in the year to 31st March 2020. It showed a rate of around 20 cases per 10,000 population against SafeLives recommended levels of just below 40, suggesting an opportunity to explain the differential. This could in part be attributed to local data which the panel were informed of by police that domestic incidents account for around 16% of the demand where some forces are closer to 30%.

16.4.21 Further to observations at 16.4.4 about clusters of events the IMR author reported "on the 2nd of February there had been four calls in 2 months, and there was clear escalation in violence from previous incidents, and Steve and David living together presented a risk of serious harm; and that by the 12th of April 2020, there had been eight incidents in under 2 years". By this time, there were several vulnerabilities apparent, including alcohol, potential drugs misuse, potential mental health issues, and an accommodation challenge for Steve. The chair agrees with the authors observation that there was a lack of insight into the overall situation, and consideration as to escalating the case to MARAC. This links to the discussion around whether there should be a policy about repeat calls. After all such a policy would have automatically resulted in multi-agency research and discussion at the MARAC and avoided reliance on professional judgement around high-risk.

[50] Source: Repeat Definition - A Briefing for Maracs 2018.pdf (safelives.org.uk)
[51] Source: improving-the-police-response-to-domestic-abuse.pdf (justiceinspectorates.gov.uk) (Accessed October 2022)
[52] Source: The police response to domestic abuse: An update report (justiceinspectorates.gov.uk) (Accessed October 2022)

16.4.22 The chair explored the matter further outside the review panel at a meeting with police representatives, the local MARAC co-ordinator and council. It was learned that in 2018, a review had been undertaken that resulted in local practices being introduced where if a survivor were already working with an agency, and there was a need for a multi-agency discussion, that could take place outside the MARAC process. This may in part explain the low numbers locally.

16.4.23 In Steve's case, he was not working with an agency, and so this would not have impacted on his situation. Whilst an individual agency recommendation is welcomed, the panel agree that Steve's experience lends weight to HMICFRS comments noted at 16.4.17 requiring partnership consideration.

16.4.24 In conversation with the MARAC representative, she supported the need to ensure repeat cases were identified and referred, but nervous of the impact of increased demand. She acknowledged that the current repeat rates sit at 20%, versus a recommended level of 28-40%. However, it struck the chair that the good practice of weekly MARAC meetings would better cope with a percentage increase as opposed to monthly MARAC meetings.

Learning Opportunity (LO12): To improve identification of repeat/multiple domestic abuse incidents between the same two parties, refer to MARAC thereby improving overall MARAC referral rates.
Individual agency recommendation: To review the feasibility of implementing a process to identify multiple domestic abuse incidents between the same two parties regardless of their victim/suspect status in order to better consider referrals for cross agency support.
+
See 16.4.52-54

Key Line of Enquiry C: Response to Domestic Abuse and Self-Harm

Investigation

16.4.25 The chair wishes to thank the police for their comprehensive analysis of police contact with the family, that is recognised as being complex, and difficult to unpick and understand. Below provides comments about four incidents that the police IMR found that showed not all reasonable lines of enquiry had been pursued and that there should have been greater effort on engaging with Steve in different ways as well as focused attempts to alleviate any concerns he had to encourage Steve to provide a statement and support further investigation. The IMR states '*There was a need to make thorough efforts to engage with Steve early at the first opportunity and to exhaust opportunities to collect non-independent evidence such as hearsay or circumstantial and use BWV to improve the prospect of a successful evidence led prosecution*'.

16.4.26 Whilst most investigations did show that, neighbour enquiries were conducted, BWV was used, and that 999 initial calls were listened to, these lines of enquiry were not consistently undertaken, and the IMR identified four incidents.

- **4th August 2018**: *An allegation of assault by Steve against his former partner, for which he was arrested. During the incident, Steve alleged that he had been assaulted by David. There was no investigation into this allegation and that there could have been greater professional curiosity in understanding the circumstances and document a careful and detailed review to determine who the primary aggressor was. A DASH was not completed for Steve.*

- **12th January 2020:** *Whilst in hospital for an unrelated matter, Steve made an allegation of assault that was not proceeded with. Despite attempts, officers were unable to speak with him until the 23rd. The IMR notes there could have been greater emphasis on building an evidence-led prosecution, through neighbour enquiries, and discussing special measures to secure a statement and medical evidence. It was noted a BRAG should have been completed and this had been the third incident in two months.*

- **30th August 2020**: *Steve alleged that following an argument about money, he had been assaulted causing bruising to his face. Steve called twice later, to chase attendance, and then to withdraw the allegation. Police were unable to attend that evening and did not attend until 9th September,*

when no visible injuries were apparent. Steve did not want to pursue the investigation. An officer perceived DASH was completed. The IMR observed; - it was not clear whether BWV was used; - that Steve and David were not spoken to separately; - David's partner was not spoken to as a witness; - not pursuing house to house enquiries; - considering an ABE interview; - securing medical records.

The LSU followed this matter up, and owing their assessment of the risk being higher, they referred Steve to advocacy services without consent. Officers were directed to re-attend by the supervising sergeant. On so doing, Steve said he was living on the edge, and David disclosed that Steve was taking drugs. The attending officers told both Steve and David to stop wasting police time and go their own ways and the matter was closed with no further action. It was recommended the officers who responded review their response for personal learning.

- **5th December 2020**: *This incident relates to Steve's attempted suicide, and subsequent allegation of David having assaulted him. Steve had refused medical treatment and having left the location twice returned before leaving with a cousin. A BRAG was completed in respect of Steve, and a DASH completed in respect of David, but not Steve.*

  The IMR noted that a more detailed investigation of circumstances would have been expected; - consideration given to the ongoing nature of the familial domestic abuse; - reviewing history before closing the case; - no statement taken, nor attempt to when less intoxicated. Further observations include, that it would have been best practice to have signposted Steve to domestic abuse services. It was recommended that the officers who responded to the incident review their response for personal learning.

16.4.27 The chair enquired about minimum standards of investigation for domestic abuse and learned that there is no set procedure for minimum standards of investigation in Avon and Somerset Police, nor advised by the College of Policing. Officers are expected to approach all incidents with an evidence-led investigative mind set, investigating all reasonable lines of enquiry, and obtaining all necessary and proportionate evidence, applying professional curiosity.

16.4.28 On further discussion at the panel, the police reviewed all the incidents again and no further additional concerns were highlighted, with attention being drawn to the current range of initiatives that will mitigate the inconsistencies identified by seeking to change attitudes to domestic abuse within the service. These include:

- ***DA Matters programme****. This is an evidence based cultural, attitudinal and practice transformation programme, provided by SafeLives specifically for police forces.*
- ***DA Influencers.*** *This network of individuals, both staff and officers, from ASC will champion and promote the force's domestic abuse approach to influence, change and initiate improvement activities.*
- ***DA Victims Pledge*** *This is an approach, unique to ASC, that recognises domestic abuse does not discriminate and that a proportion of ASC staff are likely to be affected by domestic abuse.*
- ***DA procedural guidance*** *has recently been published with a greater emphasis that anyone can be a victim or perpetrator of domestic abuse. Specific procedural guidance relating to controlling and coercive behaviour is also in the final stages of development.*

16.4.29 ASC is congratulated for the breadth and ambition of these initiatives that demonstrate the services commitment to tackling domestic abuse. The police provided the chair with a copy of the DA procedural guidance and would cite the scope and existence as good practice. This document includes sections on definitions, practice, investigation, and roles of investigating and supervisory ranks, along with hyper-links to useful information.

16.4.30 The panel sought to understand the outcome of these initiatives and were provided information in April 2023 on; - DASH completion rates (noted at 16.4.10); - an increase in arrest rates from 18.7% for previous 6 quarters to 22.6%; - positive outcome rates up from 9.7% for previous six quarters to 10.7%; - no further action rates where a suspect has been identified stand at 54.1% versus an average of 59.4% for previous six quarters. The panel recognise these indicators as evidence of improvement.

16.4.31 However, risking the lens of perfection that is hindsight, it remains that the lines of enquiry pursued were inconsistent, and therefore it may not be possible to determine whether additional enquiries would or would not have added weight to any investigation.

16.4.32 Considering the example of neighbourhood enquiries, a neighbour called the police on the 4th of August 2018, enquiries were made on the 2nd of February 2020, and again on the 5th of December 2020. On the 2nd of February call, David was arrested and charged. On the third occasion "Officers spoke to the neighbour who stated she did not hear a fight, only raised voices (which was unlike previous occasions when she could clearly hear fighting)". It is therefore possible that had neighbours been spoken to about other incidents, they may (if at home) have been able to add useful information for an investigation, that either they did or did not hear anything. One clear example is the incident on the 30th August, when the housing records show community awareness of incidents. Police did not speak to neighbours on this occasion.

16.4.33 The panel mindful of relying on one example of a missed opportunity to extrapolate and conclude poor investigative standards, agree that the four examples highlighted by the police IMR is a significant proportion, and therefore sought to explore this further.

16.4.34 The chair drew the panels attention to another DHR in Somerset that concluded in 2019 that also related to a young man that took his own life. (Somerset reference DHR020[53]). This review noted a specific learning opportunity; *"The review shows an improvement of the standards of investigation over time and that opportunities to ensure the consistency of high standards is now being driven by a rigorous compliance regime*". The same review referenced "*an evolving quality assurance programme including supervisory review of DA investigations every 7 days and by an Inspector rank every 28 days; quarterly Directorate performance meetings; quarterly assurance meetings; further quality assurance at the Police Crime Board by the Police and Crime Commissioner"*. The question therefore arises as to outcomes of that rigorous compliance regime.

16.4.35 The panel learned that the performance measures for Investigative Standards, applied across all crime types are: -Supervisor review timeliness (within 7 days), - Supervisor review timeliness (within 28 days). Furthermore, the procedure guidance states that it is vital that supervisors conduct an early review of the incident using the Niche supervisor review template, but there does not appear to be an associated performance measure, such as supervision by the end of the shift or within 24 hours.

16.4.36 Upon exploring ownership of DA investigations, it was learned they remain with the incident response officers and are not passed to specialist domestic abuse investigators. Arguably, this makes the case for early robust supervision, to ensure investigative opportunities are pursued in a timely fashion as well as minimising the risk of such opportunities being missed.

16.4.37 As a consequence, the police IMR author and panel representative re-examined the police response to the four incidents (16.4.26), producing a further detailed analysis of each incident. It found that three of the four incidents were subject to a supervisory review within 24 hours. The one incident that was not subject to a supervisory review (4th August 2018) was however subject to oversight of CPS decision making to take no further action within 20 hours of the incident.

16.4.38 In further discourse between chair and police, the question of the status of domestic abuse investigations when compared to other crime was raised, and further relevant service developments came to notice.

Domestic Abuse Cases – Victim does not want to support.

16.4.39 Since October 2022, new guidance requires all such cases to be coded (allowing greater measurement), and for details of what prevented evidence led prosecution being pursued. The effect will be two-fold, (a) at a strategic level information will allow the police to understand and improve evidence led prosecutions and (b) require officers to describe why such prosecutions are not feasible.

[53] Source: DHR020-Executive-Summary-V2-redacted-PUBLICATION.pdf (somersetsurvivors.org.uk) (Accessed November 2020)

Supervisor Review Template

16.4.40 At around the same time, quarter 3 of 2022, supervisors are now required to use a new "supervisor review template". The chair was provided with a copy of the template, that contains hyper-links specifically for domestic abuse crime that refer to the investigative opportunities that should be pursued and guidance to safeguard the victim.

16.4.41 Further evolution has taken place, such as the introduction of a new supervisor template (Quarter 3 of 2022), that provides guidance on gathering evidence and safeguarding the victim. This guidance reinforces review timeliness within 7 and 28 days.

No Further Action (NFA) – Scrutiny Panel

16.4.42 The introduction of a no further action scrutiny panel, a joint day between the police and CPS, examines NFA cases enabling identification of lessons that is believed to contribute to improvements in outcome data described at 16.4.26.

16.4.43 Whilst acknowledging the initiatives above, the IMR author and panel representative identified that not all NFA decisions had been authorised by an Inspector in accordance with policy guidance and suggested a recommendation described below.

Learning opportunity (LO13): To ensure all decisions to take no further action in domestic abuse cases are overseen by an Inspector in accordance with policy. **Response**: The range of initiatives; - rationale for decisions to NFA to be recorded, - use of supervisor's template with links to domestic abuse focused investigative opportunities, - NFA scrutiny panel. **Recommendation 6:** A&S Police should conduct assurance work around Domestic Abuse NFA authorisations to check for adherence to current policy. The audit should inform the next steps to be taken to address the findings.
Outputs/Outcomes: Better, improved, and consistent standards of investigation contributing to improved positive outcome rates such as evidence-based prosecutions

Key Line of Enquiry D: Access to specialist domestic abuse agencies

Support Services

16.4.44 Steve's situation was beset with multiple vulnerabilities, that include domestic abuse, alcohol, suspected substance misuse, accommodation need, as well as child access arrangements. The IMR noted these challenges writing *"One of the challenges Steve seems to have in distancing his relationship with his father is his accommodation options. It is suggested that the panel consider how the local authority and housing are engaged in multi-agency forum to support domestic abuse victims with housing difficulties. Police reports mention Steve excessively consuming alcohol. Police do not have a direct referral for substance misuse support, and it is not documented if Steve or David were given advice on available support services"*. This observation adds weight to the discussion points in respect of repeat domestic abuse cases and MARAC, where a multi-agency discussion would have been possible. It is noted Housing is a standing member of the MARAC. Accommodation needs are subject to further analysis at 16.8.

16.4.45 However, this links with an earlier discussion point at 16.4.14, in the signposting and/or referral in respect of a range of vulnerabilities including housing, but also alcohol and substance misuse. After all, we know from table 7, matters of alcohol, substance misuse or mental health featured on 8 of the contacts.

16.4.46 Whilst recognising the opportunities to complete assessments such as a BRAG at the time, the panel also recognised the complexity of situation that police frequently found themselves dealing with. The circumstances of three calls on the 5th of December 2020, show patience on behalf of officers, dealing with a suicide attempt, by a young man clearly intoxicated, eventually persuading him to seek help with his mental health at the hospital. In effect ensuring support for his mental health needs was catered for.

IDVA (Domestic Abuse)

16.4.47 It seems that Steve only had one fleeting conversation with IDVA services. An examination of the chronology and IMR shows a variety of reasons.

- No offer on 04/08/2018, 12/01/2020, 12/04/2020
- Declined on 26/11/2019, 02/02/2020.

16.4.48 However, the incident on the 12th of January 2019 provides a useful insight into Steve's view and perhaps a reason as to why support was declined, when he stated he did not see the situation as 'domestic abuse', suggesting a need to enhance male and community awareness of what constitutes domestic abuse, in this case interfamilial domestic abuse. The panel explored various reasons as to why he may not have acknowledged domestic abuse including 'hegemonic masculinity' that sees men as dominant and upheld by society. If this were the case, acknowledging domestic abuse may have been embarrassing for Steve. Other theories relate to his concern about this adversely affecting his child contact arrangements. Nevertheless, a partnership response is required.

Learning Opportunity (LO14): To improve on understanding in the community of what constitutes domestic abuse, including interfamilial abuse of adult parent versus adult child.
Response: See Recommendation 8 below.

16.4.49 He was however subsequently referred without consent by the LSU to Victim Support IDVA services following the incidents on 30th August 2020, 5th December 2020, and 15th January 2021. The police IMR shows that he had said he wanted IDVA support in September 2020, but subsequent entries show that when police spoke to advocacy services, they advised he was not open to them.

16.4.50 The chair agrees with the IMR authors opinion that following the incident on 26th November 2019 that whilst Steve did not want details of support organisations, this should have been followed up by the LSU, against a backdrop of recent incidents between Steve and David. Afterall, by the 12th of April 2020, there had been eight incidents in under 2 years, and no referral to domestic abuse services had been made. An individual agency recommendation has been made to improve the consistency of how the LSU contact and offer support to victims of domestic abuse.

16.4.51 A further examination of events and IMR commentary provides a further point of reflection. The IMR comments on the events of the 5th of December 2020, note that it would have been best practice to have signposted Steve to men's domestic abuse charities such as ManKind Initiative or Men's advice line. "By this point at least eight incidents between Steve and David had occurred, and no reference to specialist to male support services. One explanation is that there is a reliance on Victim Support as the specialist domestic abuse provider. Given the volume of calls and the absence of mention of such providers, it would seem there is an opportunity to highlight the work of such specialist agencies, thereby providing men like Steve with options". On a positive note, the panel were informed that following a recommissioning process, since October 2022 there was now (a) a male IDVA that links to specialist male accommodation and (b) a specialist support worker for men within the advocacy pathway.

Learning Opportunity (LO15): To ensure male victims are appropriately informed of specialist domestic abuse services/advice lines as well as generic providers.
Individual agency recommendation: LSU to increase supervisory oversight through audits and dip samples.
+
Response: Avon and Somerset Police are developing a 'Victim information pack (VIP)'. See LO15 below

16.4.52 Steve was referred to domestic abuse support services on 30th August 2020, following an intervention by the LSU who assessed the risk as higher than low, and who followed up with Steve. At this point in time, Steve explained to officers that he was being abused financially, emotionally, and physically by David and that it was getting worse. He spoke about his fear, that he was depressed and wanted to leave, but had no-where to go. Arguably, at this point, a MARAC referral could have been made to ensure a holistic discussion on the multiple vulnerabilities

disclosed. Failing that, it seems that Steve was not at that point signposted for any other support, in respect of accommodation needs or his depression, or at least no reference is made to such referrals.

16.4.53 On 10th December the LSU in this case, also referred him to IDVAs without his consent, but did not refer him to MARAC, relying on the IDVAs response and determination about risk. It would seem in hindsight, if there were sufficient concern to refer Steve to IDVAs, then he should also have been referred to MARAC at the same time. The panel explored this point and learned that the local policy is that IDVAs make the referral to MARAC. In Steve's case he was referred to MARAC by the IDVAs on the 16th, and the case was scheduled for the 7th of January that is discussed below. Whilst the local policy of IDVAs completing the referral to MARAC worked in this case (within 6 days), it is observed that a policy relying on IDVAs to do the referral does in effect build in a delay to high-risk cases being heard at MARAC. Arguably this practice could risk a case not reaching MARAC if IDVAs were unable to speak to a client.

16.4.54 Given the findings of 'Learning Opportunity (LO11)' in respect of repeat incidents, the panel agree there is a need for the partnership to review MARAC policies in respect of 'repeats' and route to MARAC referral.

Learning Opportunity (LO12): To improve identification of repeat/multiple domestic abuse incidents between the same two parties, refer to MARAC thereby improving overall MARAC referral rates. + **Learning Opportunity (LO16):** Recognising that the current policy of IDVA referring to MARAC builds in a system delay to cases being heard at the MARAC. **Recommendation 7:** The Bristol City MARAC steering group set a threshold for repeat domestic incidents that results in automatic referral to MARAC, reassures itself that there are no unnecessary delays in referral of cases to MARAC and makes necessary policy adjustments.
Outputs/Outcomes: - Threshold for repeat incidents set, - MARAC policy adjusted in respect of repeat incidents, - MARAC policy requiring referrals via IDVA services reviewed and adjusted if required, - Increased referral of repeat victims, - Timelier referral of cases to MARAC, increased MARAC referral rates.

16.4.55 In relation to the broader subject of signposting and referral, the panel learned that Avon and Somerset Police is developing a victim information pack (VIP), for officers to hand out. Considering Steve's multiple vulnerabilities, domestic abuse, accommodation, and substance misuse, such a pack is welcomed, and the police have agreed to ensure the learning opportunity from this review informs the new VIP.

Learning Opportunity (LO17): To ensure that the multiple vulnerabilities of the victim in this case, inform the development of the victim information pack currently under development. **Response:** The specific vulnerabilities and relevant support services will be included in the new pack (such as the male support services described at 16.4.38).

<u>MARAC</u>

16.4.56 The chair has been provided with notes from the MARAC meeting in January, where the following agencies contributed. (Police, IDVA, Health Agencies, Probation). The situation was not known to AWP, Adult Social Care nor Drug & Alcohol services. Notably, the extensive history of incidents was presented, housing reported that an incomplete housing application had been made, David had ten days rehabilitation left on his sentence and finally the IDVAs had been unable to engage, with one fleeting telephone conversation.

16.4.57 At this stage, and by reference to the chronology, the following were apparent vulnerabilities; (i) <u>Accommodation, (ii) Mental Health and suicide risk, (iii) alcohol and potential substance misuse</u>. It was also known that (iv) Steve was not engaging. Three actions arose as follows: (a) ASB housing officer to invite Victim Support IDVA to meetings to 'link in' (b) GP to call Steve in for contact around his MH and encourage him to engage with IDVA support, (c) Probation to explore David's contact with the grandchild and whether Steve remains at home and refer to First Response if appropriate.

16.4.58 From the perspective of the chair of the MARAC, the accommodation concern was being handled by housing, though arguably the action could have been more specific, setting a timeframe for contact rather than saying this was an ongoing matter. Arguably, points (ii) and (iii) were covered by the requested action to the GP to make contact within 2 weeks. A check with the GP confirms attempts were made. Using the GP in this way is recognised as positive practice. The panel recognise the actions as proportionate to a case being heard for the first time.

16.4.59 Within two weeks of the MARAC having been heard, on 15th January, police attended owing to an allegation that Steve would not leave the family home. During this incident, he disclosed an historic strangulation and spoke about some money that he had given David that potentially indicated a degree of financial control/coercion. He also made it clear that he was focused on finding alternative accommodation. Also, within the IMR, it was reported that the officer asked him why he still lived with David, and he replied that he was 'scared to be on his own'. A DASH was completed rated High and a without consent referral was made to VS IDVA. This interaction provides a unique insight into Steve's situation, the fear, financial dependency, and power and control that David held over Steve, as well as posing the question as to why a further referral was not made into the MARAC by the IDVA service.

Housing

16.4.60 Steve's accommodation needs were clearly an issue, as noted above, and highlighted by the IMR author. A question arose as to the provision of male survivor accommodation locally, that was explored by the panel (See 16.4.38). However, whatever the availability of such accommodation, his pathway to such support would have been by signposting him to housing, or through advocacy services.

Key Line of Enquiry E: Policies, procedures, and training

16.4.61 The DA Procedural Guidance discussed at 16.4.25 is noted as good practice. This review and other DHRs inform the regular review of this guidance.

16.4.62 The police recognise the need to continue to work to change attitudes towards Domestic Abuse having invested resources into the DA Matters programme, and initiatives such as DA Influencers and the DA Victims Pledge. This work is overseen by a force wide domestic abuse strategy group with partner organisations to inform policy and to help foster a multi-agency approach to dealing with domestic abuse. This includes planning communication strategies and supporting/promoting each other's publicity campaigns.

16.4.63 As part of this programme of activity, as the review is being conducted, SafeLives are delivering training to all first responders on domestic abuse (3,000). This is recognised as a positive development.

Key Line of Enquiry F: Seeking help, as well as considering what might have helped or hindered access to help and support.

16.4.64 The review documents Steve called police on several occasions to report domestic incidents, suggesting Steve did not have barriers to reporting incidents, but then declined to provide statements or accept referrals to advocacy services.

16.4.65 The panel agree with the IMR comment, "*There was a need to make thorough efforts to engage with Steve early at the first opportunity and to exhaust opportunities to collect non independent evidence such as hearsay or circumstantial and use BWV to improve the prospect of a successful evidence led prosecution. From reviewing police records, it is not known if Steve was given the opportunity to consider a planned ABE interview to document the full history of this relationship with David or if special measures were discussed. This may have supported Steve to overcome his past resistance to providing statements and would have allowed officers to ask more explicit questions to understand why Steve continued to live with David and to signpost Steve to possible solutions*".

16.4.66 On exploring 'Achieving Best Evidence' interviews, the panel considered the 'Guidance on Interviewing Victims and Witnesses, and Guidance on Using Special Measures'[54] that is applicable to intimidated witnesses. This makes the presumption that a witness is recognised as being intimidated, that the guidance describes as "intimidated witnesses are those whose quality of evidence is likely to be diminished by reason of fear or distress". One could argue that all victims of domestic abuse are intimidated, but in this review, Steve clearly stated that he was fearful or scared on three occasions. (26th November 2019, 30th August 2020, and 15th January 2021).

16.4.67 It is unclear from police records whether special measures were discussed. One hypothesis for Steve not having been considered/offered an ABE interview was that his vulnerability was not recognised, linking with the subject of 'unconscious bias', discussed earlier. A further hypothesis may be a lack of experience and knowledge, that would have benefitted from earlier oversight and supervision of the investigative response. As such the panel agree it is a broad learning reflection, and that earlier comments about supervision apply and decisions to take no further action apply.

Learning Opportunity (LO18): To consider the extent to which special measures are used in respect to intimidated victims of domestic abuse. **Response**: The range of initiatives; - rationale for decisions to NFA to be recorded, - use of supervisor's template with links to domestic abuse focused investigative opportunities, - NFA scrutiny panel. **Recommendation 6:** A&S Police should conduct assurance work around Domestic Abuse NFA authorisations to check for adherence to current policy. The audit should inform the next steps to be taken to address the findings.
Outputs/Outcomes: Better, improved, and consistent standards of investigation contributing to improved positive outcome rates such as evidence-based prosecutions

16.4.68 Whilst it was clear that Steve feared his father, there were also other elements of concern to Steve that were in effect barriers to him seeking and/or progressing support. These include child access and accommodation.

Child Access

16.4.69 On 12th January 2020, Steve raised concerns about access to his child, as he believed his relationship would be viewed negatively even as a victim. He was insistent police did not speak to David as this would put him at risk and stated he was planning to move out and wanted to keep things calm until then. ManKind Initiative notes, "This fear, which is common with female victims, is compounded for men because of the poor reputation and bias within the family court system against equal parenting. They feel that if they flee the family home, they will never see their children again." [55] This is recognised as a broad learning reflection from this review for sharing when the review is published.

Learning Opportunity/Reflection (LO19): Recognising the impact of parental responsibility on male victims of domestic abuse.

Accommodation

16.4.70 Steve's accommodation needs were a constant theme in dealings with the police, such as on 2nd February 2020, he disclosed difficulties with his accommodation and on 30th August 2020 when he said he had nowhere else to go. Whilst a male victim, housing is recognised as a significant challenge for survivors, with women's aid reporting a specific challenge as 'fears homelessness and being forced to live in unsuitable or unsafe housing'.[56] In Steve's case the IMR notes it was unclear whether he had been signposted for support regarding accommodation needs.

[54] Source: Achieving Best Evidence in Criminal Proceedings (publishing.service.gov.uk) (Accessed December 2022)
[55] Source: THE SEVEN CHALLENGES MALE VICTIMS FACE (mankind.org.uk) (Accessed December 2022)
[56] Source: The Domestic Abuse Report - Women's Aid (womensaid.org.uk) (Accessed December 2022)

16.4.71 Whilst we know that Steve frequently declined support from advocacy services who would have been well placed to advise on these matters, it is unclear whether he was signposted to other support agencies, such as support for male victims, national domestic abuse helpline and his local housing service. The development of the Victim Information Pack described at 16.4.45 that will also include information on housing will help ensure timely provision of information to victims.

16.4.72 The concerns over accommodation added another level of worry to Steve, adding to the physical abuse, control, and coercion, as well as his worries about seeking police help adversely effecting his child access. This is recognised as a broad learning reflection from this review for sharing when the review is published.

Learning Opportunity (LO20): Recognition of the intersection of multiple vulnerabilities between accommodation needs, financial control and coercion and concerns over child access and impact on a victim's state of mind.

Key Line of Enquiry G: Extent to which Covid affected agency involvement with Steve.

16.4.73 The review has not identified any impact of Covid on the police response.

Key Line of Enquiry H: Substance Misuse and financial pressures

16.4.74 It is widely accepted that alcohol can lead to poor decision making and impulsive behaviour and the frequent mention of excessive alcohol consumption (see table 1) tends to support the notion that it was an aggravating factor in Steve and David's circumstances. There is less frequent mention of substance misuse and Steve taking illegal drugs, though the health agency analysis will show that Steve frequently sought prescribed pain killers.

16.4.75 There are numerous studies that show a correlation between alcohol consumption and domestic abuse. One study entitled "Roles of Alcohol intimate partner abuse" found 'Two-thirds of 'domestic' incidents known to the police were found to involve at least one of the couples concerned being 'under the influence' of alcohol'.[57] There is no information from police records to indicate whether Steve or David were in receipt of any professional support in relation to alcohol or other substance misuse. Given the part that alcohol played as an aggravating factor suggests an opportunity to provide information on relevant support services.

16.4.76 The subject of money featured in three incidents. On the 30th of August 2020, an alleged assault followed an argument about money, when Steve explained that David was out of work and changed the amount of money he wanted from Steve. On the 5th of December that year, the date of three calls to the police, Steve alleged that David's partner had been stealing money and on the 15th of January 2021, Steve referenced money he had given to David. This provides a point of reflection, recognising that financial/economic abuse as a risk factor in relation to domestic abuse.

Key Line of Enquiry I: Child Access

16.4.77 See 16.4.69.

Key Line of Enquiry J: Housing Situation

16.4.78 Steve frequently mentioned to police of his intention to move out and often said this was going to happen soon. It is possible that had he moved out then several of the incidents would not have occurred. This raises an issue of what advice he was given in respect of housing. It is not documented whether he was signposted to housing support agencies by officers or LSU, although it should be noted that Steve only spoke to LSU twice and on one occasion, he confirmed he was due to move out. The only other occasion that the police had potential to assist with housing was at the only MARAC discussion, that took place in early 2021. The notes show at that point he did

[57] Source: Roles of Alcohol in Intimate Partner Abuse | Alcohol Change UK (Accessed December 2022)

have an incomplete application for housing that was opened in June 2020, which is after several incidents as shown at Table 1.

16.4.79 The Domestic Abuse Act received Royal ascent in April 2021, making council obligations far clearer in recognising those fleeing domestic abuse as being in priority need. This is discussed within the analysis section for Bristol City Housing. Nevertheless, the learning point herein is to ensure that victims are informed of their rights and signposted to present at their local housing office. This links closely with a planned victim information pack described earlier.

Key Line of Enquiry K & L: Familial Abuse and Gender

16.4.80 The gendered nature of domestic abuse was recognised by the panel as noted at 10.2. This equates to a prevalence rate of approximately 5.0% of adults (6.9% women and 3.0% men).[58] Less well recognised, but significant is familial abuse with a prevalence rate of 2.1%.

16.4.81 It was observed at 16.4.12, that unconscious bias may have been a barrier for professionals in recognising familial domestic abuse from father to adult son. One explanation relates to how domestic abuse being framed as a woman's issue. "*Intimate partner violence (IPV) or domestic violence (DV) is often framed as a "woman's issue" or "violence against women" generating the perception of males involved in violent relationships as the aggressor and more capable of inflicting injury or causing harm to their partner*.[59]

16.4.82 At 16.2.9, the subject of domestic abuse and male victims was explored, with one piece of research suggesting a considerably lower number of men confide in their experience, and another research articles suggesting men may not recognise or accept their abuse. In Steve's case, he did reach out to police and report, and therefore arguably he recognised the need for help, even though he had said in January 2019 that he did not see the situation as 'domestic abuse' (16.4.3x), a factor the domestic abuse commissioner has made comment on" *We know that men face specific challenges when it comes to domestic abuse. Harmful gender norms, shame or honour, and stereotypes of masculinity and sexuality can act as barriers for male victims and survivors to seek support and can impact on reporting*".[60]

Learning Opportunity (LO21): The intersection of unconscious bias by officers, and Steve not recognising his circumstances as being domestic abuse risked the gravity of his circumstances being recognised and being appropriately signposted and willing to engage with support. **Recommendation 8.** Keeping Bristol Safe Partnership is to coordinate a broad communication campaign targeting professionals and communities to raise awareness of domestic abuse and male victims, and to ensure male survivors know where to go for support.
Outputs/Outcomes: Improved community awareness of male victimisation resulting in improved confidence of males in reporting domestic abuse and seeking support from specialist agencies**.**

16.5 University Hospitals Bristol and Weston NHS Foundation Trust

16.5.1 Steve had several contacts with the Trust, ranging from opiate seeking behaviour, through to having been assaulted, two incidents of self-harm and before his death, treatment for an unrelated matter. Table 8 summarises contact during relevant period.

Table 8

Date	Unit	Summary

[58] Source: Domestic abuse in England and Wales overview - Office for National Statistics (ons.gov.uk) (Accessed March 2023)
[59] Source: Male Victims of Domestic Violence. By Don Dutton and Katherine White | NCFM, Australia (Accessed March 2023)
[60] Source: Our support for male victims - Domestic Abuse Commissioner (Accessed November 2022)

04/08/2018	Emergency Dept (ED)	Assaulted girlfriend and father retaliated and punched him in the head, police involved, and safeguarding raised for child. Had been drinking alcohol. Taken into custody by police. Safeguarding for child, as 5 months old and was being carried by mother when Steve to assaulted her
05/08/2018	(ED)	Had taken an overdose – referred to mental health services
23/12/2018	(ED)	Head injury after drinking – CT head normal discharged
31/12/2018	(ED)	Presented with abdominal pain – self discharged
13/01/2019	(ED)	Alleged assault, punched to head and right shoulder – all exam normal - discharged
08/08/2019	(ED)	Presented with abdominal pain, discharged
12/01/2020	(ED)	Alleged assault from father says his father punched him causing black eye, but changing his story multiple times, father says arrested over Christmas and black eye was because of this and that he gets into trouble with cocaine dealers. Advised to attend eye hospital if visual problems
31/08/2020	(ED)	Alleged assault by father presented to ED with facial injury, had seizure so father called 999, had seizure in ambulance. Minor injuries and he was unsure how these happened. Intoxicated and pupil large indicating drug usage. Inappropriate behaviour recorded towards female staff – self discharged against advice.
05/12/2020	(ED)	Attempted hanging at home. Had an argument with father, drank a lot of alcohol night before. Father called the police. No longer feels suicidal but days home life is unstable. To discharge with Mental health liaison – who offered to see Steve, or he could take phone number to ring as an outpatient, Steve keen to go home. Given strict return advice from clinician
21/03/2021	(ED)	Presented with abdominal pain, drug seeking behaviour. Alcohol advice provided, with GP follow up for endoscopy
08/04/2021 to 27/04/2021		Steve had a series of appointments not relevant to the review on 8th, 9th, 14th, 20th and 27th, one of which was conducted over the phone.

Key Line of Enquiry A: Communication and Co-operation Between Agencies

16.5.2 All incidents were reported to Steve's GP via an automated letter system. This is noted as having been effective in this review.

Key Line of Enquiry B: Risk of Domestic Abuse and Self-Harm

16.5.3 On considering the attendance of Steve and opportunities to identify domestic abuse, the panel has considered best practice and study but were keen to ensure the challenges that have been confronting the NHS, and that have become more acute recently are considered when making recommendations. They recognise this does not preclude the identification of learning opportunities. In 2018, the Care Quality Commission in an article entitled 'Under Pressure' wrote, "England's health care and adult social care services face a formidable challenge. Demand is increasing inexorably not only from an ageing population but from the increasing number of people living with complex, chronic, or multiple conditions, such as diabetes, cancer, heart disease and dementia. The total number of years people can expect to live in poorer health is steadily growing. This rising demand is manifested as pressure on emergency departments that is increasing year on year, further exacerbated by spikes in activity driven by seasonally related conditions".[61] Fast forward, to March 2020, when the first covid lockdown was imposed, the impact on the health system at full stretch is well documented without reference to academic studies or reports. Fast forward to the autumn/winter of 2022, the demands upon the NHS have continued to grow, with reports of the NHS in crisis.

16.5.4 There were multiple attendances at hospital, where staff may have used their professional curiosity to explore attendance at the hospital. The missed opportunities to explore potential signs of domestic abuse, add weight to a report by SafeLives that examined the domestic abuse response within health settings in London entitled "We only do bones here". This report found that "Survivors have experienced a lack of understanding, awareness and support from the health

[61] Source: 20180716_underpressure-winterpressures.pdf (cqc.org.uk) (Accessed December 2022)

system, perpetuating the impact on their physical and mental health". [62] The examples highlighted by the IMR author suggest similar learning locally. Indeed, another local hospital the Bristol Royal Infirmary reports identifying between 300-350 cases per annum, via the provision of a hospital advocacy service.[63]

16.5.5 These attendances include three occasions when Steve had been assaulted by his father:

- 4th August 2018: Assaulted girlfriend and father retaliated and punched him in the head.
- 12th January 2020 Alleged assault from father says his father punched him causing black eye, but changing his story multiple times, father says arrested over Christmas and black eye was because of this and that he gets into trouble with cocaine dealers.
- 31st August 2020: Alleged assault by father presented to ED with facial injury, had seizure so father called 999, had seizure in ambulance. Minor injuries and he was unsure how these happened. Intoxicated and pupil large indicating drug usage. Inappropriate behaviour recorded towards female staff – self discharged against advice.

16.5.6 A number of explanations arise, including not recognising abuse from father to adult son as domestic abuse, or potentially an unconscious confirmation bias as outlined at 16.4.12. A further explanation in relation to the first incident on the 4th of August 2018 may have been as Steve was also a perpetrator against his partner and because of that context, it was thought to have been in retaliation or protective act to Steve assaulting his girlfriend.

16.5.7 The subject of 'routine enquiry' was subject to discourse in the panel and attention was drawn to Quality Standard 116 of the National Institute for Health and Care Excellence, that sets out expectations that includes "ensure that health and social care practitioners are trained to recognise the indicators of possible domestic violence and abuse". [64] This quality standard also notes other presentations that may be indicative of domestic abuse including: - Suicidal tendencies or self-harming. It is noted that Steve attended on two occasions during the relevant period where he had self-harmed. The first when he had taken an overdose on 5th August 2018, and the second on the 5th of December 2020 where he had attempted to hang himself.

16.5.8 On considering why staff may not have shown enhanced professional curiosity to ask questions about potential abuse, or not identified the signs, the British Journal of Nursing posed the question as to what the barriers were and concluded, *"Several barriers to screening by health professionals were identified, including lack of training, education, time, privacy, guidelines, policies and support from the employer, with the most prevalent of these being a lack of training and education"*.[65]

16.5.9 On considering attendance at emergency departments during the relevant period, the panel considered the impact of the coronavirus pandemic. His third attendance on 20th August 2020 relating to an assault occurred within the Covid lockdown period, when the NHS was under considerable strain. Whilst Steve was able to attend unhindered, and the hospital did not report any effect owing to covid, it is considered important in respect of context at the time.

16.5.10 The chair was provided with a copy of the Trust's local domestic abuse policy, that explicitly states.
"Health professionals must make appropriate assessments of everyone attending for health care using the indicators described below as a framework. If staff suspects DVA they must investigate further and keep accurate records of their enquiry". The policy then continues with a comprehensive list of signs and symptoms of abuse.

[62] Source: 'We Online Do Bones Here' - Why London needs a whole-health approach to domestic abuse_0.pdf (safelives.org.uk) (Accessed March 2022)
[63] Source: A day in the life of a hospital Idsva service | Safelives (Accessed March 2023)
[64] Source: Quality statement 1: Asking about dometic violence and abuse | Domestic violence and abuse | Quality standards | NICE (Accessed March 2022)
[65] Source: What barriers prevent health professionals screening women for domestic abuse? A literature review | British Journal of Nursing (magonlinelibrary.com) (Accessed March 2022)

16.5.11 The panel agree that further professional interest should have been applied and welcome the IMR author identifying learning opportunities and a recommendation pertinent to the discussion points above.

Learning Opportunity (LO22): To improve the recognition and response to signs of domestic abuse, demonstrating improved professional curiosity and asking about domestic abuse.
Response (Single Agency recommendations):
(a) To complete a focused piece of work to promote the 'Think Family' agenda across all emergency departments.
(b) To encourage ED staff to be professionally curious in relation to the history given for assaults, including Domestic Violence/non- intimate partner / familial domestic violence and male victims. To include signposting for on-going support from other agencies, including reporting to Police.

16.5.12 On considering the domestic abuse policy and list of signs and symptoms, it includes depression and mental health. Whilst one may contend that self-harm and suicidal ideation are synonymous with mental health, it is suggested there is an opportunity to review the list of indicators in the policy to specifically state self-harm and suicide. After all, the research papers noted at 16.2.9-11 do show the links between domestic abuse and suicide.

Learning Opportunity (LO23): To update the local domestic abuse policy lists of signs and symptoms to include self-harm and suicide.
Response: See Recommendation 9 below

16.5.13 The domestic abuse policy is also clear in respect of expectations when domestic abuse is suspected or known, stating, "*Whenever DVA is either suspected or known an opportunity must be provided for discussions about individual circumstance in a quiet and private environment, and where the person can be seen alone".* The same policy continues, "*If domestic violence and abuse is suspected the Safe Lives Risk Assessment tool (previously known as the CAADA-DASH) should be completed to ensure a consistent and robust approach*." However, this pre-supposes that DA is suspected/apparent, but does not deal with routine enquiry on presentation of signs or symptoms of DA. In other words, if safe to do so, ask the question on all presentations. Whilst routine enquiry is actively encouraged in emergency departments, sexual health and midwifery, the expansion of enquiry is actively being considered by the Safeguarding Operational Group as this review progressed.

Learning Opportunity (LO22): To improve the recognition and response to signs of domestic abuse, demonstrating improved professional curiosity and asking about domestic abuse on presentation of indicators of domestic abuse.
Response (Single Agency recommendation): To encourage ED staff to be professionally curious in relation to the history given for assaults, including Domestic Violence/non- intimate partner / familial domestic violence and male victims. To include signposting for on-going support from other agencies, including reporting to Police.

Self-Harm

16.5.14 Steve presented on two occasions following self-harm, the 5th of August 2018, and the 5th of December 2020. The first was an overdose, and the second was an attempted hanging. A self-harm template was completed by the Psychiatric Liaison Team regarding the overdose, but not regarding the attempted hanging, as he didn't want to be seen. Given that there is a body of evidence demonstrating a link between self-harm/suicide and domestic abuse it was noted that there was no reference to domestic abuse or familial abuse in the self-harm template. One such article entitled, "Intimate partner violence, suicidality, and self- harm: a probability sample survey of the general population in England", that concluded," IPV *is common in England, especially among women, and is strongly associated with self-harm and suicidality. People presenting to services in suicidal distress or after self-harm should be asked about IPV".*[66] As the review progressed, this observation has been raised with the Psychiatric Liaison Team (PLT). Clearly this presents a learning opportunity linked with LO20 above, but relevant to the PLT.

[66] Source: Intimate partner violence, suicidality, and self-harm: a probability sample survey of the general population in England - The Lancet Psychiatry (Accessed May 2023)

Learning Opportunity (LO24): To adapt the self-harm template to reference domestic abuse, to improve the recognition and response to signs of domestic abuse, demonstrating improved professional curiosity and asking about domestic abuse on presentation of indicators of domestic abuse.
Response: See Recommendation 9 below

Key Line of Enquiry C: Response to Domestic Abuse and Self-Harm

Domestic abuse

16.5.15 Given that domestic abuse was not identified, it is not possible to assess the response but acknowledge the learning opportunities above.

Self-Harm

16.5.16 Steve attended the Trust on two occasions following self-harm. The first incident on the 5th of August 2018, following an overdose, and the second on 5th December 2020 following an attempted hanging.

16.5.17 On the first presentation, he was seen by Mental Health Services, and he explained that his mental health was deteriorating following a few factors; - a recent assault where his ear had been partially bitten off, that effected his confidence, - an incident with his partner that had resulted him being bailed away from his partner. He had said that he would benefit from counselling, and he was discharged following two agreed actions. The first that he would contact either Bristol Wellbeing team or Off the Record. He was also provided with the Bristol Crisis contact number. Enquiries with these agencies show that Steve did not contact them.

16.5.18 NICE guidelines regarding discharge following an episode of self-harm recommend that, "Before discharging a person who has self-harmed from a general hospital, ensure that:

- psychosocial assessment has taken place.
- a plan for further management has been drawn up with all appropriate agencies and people.
- a discharge planning meeting with all appropriate agencies and people has taken place and
- arrangements for aftercare have been specified, including clear written communication with the primary care team[67]

16.5.19 The actions undertaken were in accordance with these guidelines.

16.5.20 On his second presentation, there were no concerns about his mental capacity, and he was keen to get home, therefore he did not engage with Mental Health services and was provided with their details to engage as an outpatient.

16.5.21 Whilst working to the guidelines, it is unclear whether he was provided with a written safety plan. The discussion points at 16.3.35 for GP practices are relevant here and an overarching recommendation has been made in this regard.

16.5.22 Following discussions outside the panel with panel representatives from the ICB and Public Health, the panel concur that the use of safety plans was an important point of reflection for professionals meriting further exploration by public health in their future development of suicide prevention strategies.

Learning Opportunity (LO25): Seek assurance that safety plans are completed.
Recommendation 4 refers: Public health to explore the merits of the routine use of 'safety planning' tools for those who express suicidal ideation and/or have attempted to take their own lives.

Key Line of Enquiry D: Access to specialist domestic abuse agencies

[67] Source: Recommendations | Self-harm: assessment, management and preventing recurrence | Guidance | NICE (Accessed November 2022)

16.5.23 The IMR author reported that there may have been unconscious bias due to male-on-male assault, not recognising Steve as a victim of a domestic assault on the three occasions noted above at 16.5.1. The hospital has IDVAs embedded in the emergency department that provide training and advice to staff and whom may be directly referred to with consent when on duty or within two days of the referral. The chair's attention was also drawn to a report by SafeLives entitled, 'A cry for Health, why we must invest in domestic abuse services in hospitals'[68], that links closely with comments made at 16.5.4. This report sets out in some detail the benefits of hospital IDVAs, such as being more likely to reach victims with complex needs (mental health difficulties, alcohol misuse, drugs misuse and financial difficulty). The panel therefore note the good practice of having hospital based IDVAs.

16.5.24 It is expected that victims will also be provided with a leaflet or letter with details of domestic abuse support services, or lip balms with Next Links telephone number embedded into bar code (single point of contact for all DA support services). Given the possibility of unconscious bias, the trust agrees there is a need to incorporate training on this phenomenon into local training.

Learning Opportunity (LO26): Professionals to be alerted to the possibility of unconscious bias. **Recommendation 9**: Seek to improve the identification of domestic abuse victims by, - emending policy to incorporate self-harm/suicidal ideation as an indicator of abuse, - by adapting the self-harm template to incorporate enquiry about domestic abuse and deliver training on unconscious bias.
Outputs/Outcomes: Emendation of local DA Policy and self-harm template together with training on unconscious bias contributing to improved screening and identification rates for all domestic abuse victims, and males in particular.

Key Line of Enquiry E: Policies, procedures, and training

16.5.25 (See 16.5.13) The Trust has a detailed policy for domestic abuse that provides explicit expectations where abuse is suspected or disclosed. As acknowledged earlier that whilst there were signs of domestic abuse, these were not identified and nor does the policy require routine enquiry or follow the notion of having 'a duty to ask', though the benefits of routine enquiry are promoted in high-risk areas of the Trust such as Emergency Departments, Sexual Health, and Midwifery.

16.5.26 As the review progressed, the trust agreed to explore options to strengthen, expand and implement routine enquiry, and that this matter was on the agenda of the internal Safeguarding Operational Group.

Key Line of Enquiry F & H: Seeking help, as well as considering what might have helped or hindered access to help and support AND Substance Misuse and financial pressures.

16.5.27 It is clear from Steve's history that he was a frequent attender at hospital, seeking pain relief that may have indicated an opioid dependency, as well as attending whilst intoxicated from alcohol. Furthermore, he also made comment about being in trouble with cocaine dealers (12/01/20) and when he had a telephone consultation regarding an unrelated matter (08/04/2021), that further adds weight to concerns about his substance misuse. Clearly, together this created a toxic mix for Steve, reportedly being aggressive and being warned about his behaviour to female staff. Nevertheless, the IMR author has noted that substance misuse was not noted on his file.

16.5.28 The Trust has specialist drugs and alcohol teams within the hospital, and it is not clear from records if he was signposted for support to specialist drugs services in the hospital, though it is recorded that a referral was made to the alcohol specialist nurse. There are a few aspects to substance misuse for Steve, including, potential opiate dependencies as well as Steve having admitted to hospital staff that he used class A drugs (apparent in conversation with a specialist on 8th April 2021). The IMR author notes there may have been an opportunity to explore the nature and degree of substance misuse and potential signposting to the in-house drugs team. The IMR notes a specific learning opportunity and associated recommendation.

[68] Source: SAFJ4993_Themis_report_WEBcorrect.pdf (safelives.org.uk) (Accessed March 2023)

- ❖ Electronic alerts and Personal Support Plans are accurate in relation to drug/opiate seeking behaviours and include advice to signpost to services for support with drug dependence/misuse.

Learning Opportunity (LO27): To have identified (a) frequent attendance at hospital seeking opiate pain killers as indicative of substance misuse and (b) admitted class A drug use, as requiring further professional curiosity and signposting for support.
Response (Single Agency Recommendation): Medway alerts and Personal Support Plans to include prompt for staff to sign post to other services

16.5.29 In discussion, the panel learned that staff are asked to complete an internationally recognised assessment tool known as HEADSS used to structure the assessment of an adolescent patient aged 10-23, encompassing Home, Education/Employment, Activities, Drugs, Sex and relationships, Self-harm and depression, Safety and abuse.[69] However, whilst common in children's departments, the panel learned it is difficult to complete this tool in an emergency department or out of hours setting owing to operational demands. Whilst not used at the time, promotion of this assessment in the Emergency Department is now underway and would have been relevant for Steve and others in this transitional group. This initiative is welcomed, as a holistic assessment of multiple vulnerabilities for young people and recognising that Steve was a young person with a variety of complex challenges.

Learning Opportunity (LO28): Mainstreaming of HEADSS recognised as a positive initiative.
Response: The Trust is embedding the HEADSS tool into Emergency department Settings

Key Line of Enquiry G: Extent to which Covid affected agency involvement with Steve.

16.5.30 The Covid pandemic did not impact his attendance at hospital.

Key Lines of Enquiry I - Child Access

16.5.31 It was apparent from Steve's conversation with the Mental Health team, that being bailed away from his partner and not having access to his child was distressing to him, adding to his anxieties and personal stress. This appears to have been dealt with sensitively, though ultimately would not have been something for an emergency department to offer advice on.

Key Lines of Enquiry J - Housing Situation

16.5.32 Steve did not present as homeless, and concerns were not apparent that may have enabled appropriate signposting. The mainstreaming of HEADSS may assist in identifying such challenges with future patients in the transitionary group from child to adult.

Key Line of Enquiry K – Familial Abuse

16.5.33 This does not appear to have been recognised. (See 16.5.11)

Key Line of Enquiry L – Steve's Gender and Key Line of Enquiry M - Equalities

16.5.34 The panel agree with the IMR authors observation that Steve's status as a perpetrator of domestic abuse may have obscured his vulnerability such as on the occasion, he attended hospital after having assaulted his partner, then having been assaulted by his father (4th August 2018). On other occasions he presented in different states of intoxication, giving accounts that varied, that presented staff with challenges recognising Steve's overall vulnerability. After all, Steve was a young fit man, and therefore, the same risks of bias identified by the police may have applied to how Steve was dealt with.

16.5.35 The panel were informed by the ManKind Initiative representative that some trusts have commissioned full day training sessions in respect of recognising and responding to male victims

[69] Source: HEADSSS Assessment - TeachMePaediatrics - Home - Education (Accessed December 2022)

of domestic abuse. The panel discussed this, initiative and considering the current situation in respect of the NHS including ongoing industrial action, increased waiting lists, any such recommendation would not be achievable. Hence the linked recommendation from 16.5.23 is agreed as proportionate.

Learning Opportunity (LO26): Professionals to be alert to the possibility of unconscious bias in dealing with male victims.
Recommendation 9 refers: Seek to improve the identification of domestic abuse victims by, - emending policy to incorporate self-harm/suicidal ideation as an indicator of abuse, - by adapting the self-harm template to incorporate enquiry about domestic abuse and deliver training on unconscious bias.

16.6 Bristol Children's Social Care (BCSC)

Key Line of Enquiry A: Communication and Co-operation Between Agencies

16.6.1 The communication of events following police contact were swift and contained detailed accounts of the incidents that occurred, such as the allegations of assault by Steve against his partner (06/08/2018), and an allegation that he had bitten his child's hand (04/01/2019).

16.6.2 The referral on the 6th of August 2018 did make a request for a strategy meeting, and the police chronology shows that they were briefed about the intention for social care to visit a few days later and were notified that a strategy meeting would not be required. This shows good co-operation between agencies.

16.6.3 The IMR author notes that the assessment was compiled through parental enquiry, and via the allocated health visitor, showing a degree of professional curiosity.

16.6.4 Children's Services were also notified of Steve having attempted to take his own life in December 2020. Whilst providing Children's services further information as his child was linked and may be useful for considering future child safeguarding concerns, a referral was not submitted to adult services.

Key Line of Enquiry B: Risk of Domestic Abuse and Self-Harm

16.6.5 The early childhood experiences of Steve were not known to BCSC. The indication of a fractious relationship with his birth father had been notified in 2009 and did not meet the safeguarding threshold at the time and therefore task of understanding Steve's lived experiences as a child via the lens of a social work assessment was not initiated. There were no subsequent concerns throughout his teenage years.

16.6.6 The notifications of Steve assaulting his partner (6th December 2018), biting his child (4th January 2019) and a report of self-harming were considered in isolation, with a focus upon the welfare of the child and the actions taken by the child's mother, such as an intention to separate. The IMR author notes, *"*
The opportunity to be more domestic abuse informed and move away from failure to protect narratives, increasing understanding and accountability on Steve as the person causing harm were not sufficiently explored or undertaken." At the time of these incidents 2018/2019, Steve was around 22 years old, only ten years after children's social care had been notified about his own difficult relationship with his father. This alert may have been indicative of Steve having experienced adverse childhood experiences, that research increasingly demonstrates having an adverse impact on long term 'health and wellbeing.' One adverse outcome cited by SafeLives is *"There is a cumulative impact of ACEs. Compared to someone with no ACEs, someone with 4 or more is more likely to experience a range of negative outcomes in adulthood. For example, they are 16 times more likely to perpetrate violence"*.[70] The inference herein, as noted by the IMR author, "The professionals could have shown more curiosity and explored how patterns of

[70] Source: Living with domestic abuse as an ACE (adverse childhood experience) | Safelives (Accessed January 2023)

violence in the family home may link to physical abuse of Steve's child" This has resulted in an individual agency recommendation.

> **Learning Opportunity (LO29):** To show more professional curiosity, seeking to understand experience of violence may link to child abuse.
> **Individual agency recommendation:** Increase use of family functioning and life story exploration in social work assessments with fathers who are causing harm through domestic abuse.

Key Line of Enquiry C: Response to Domestic Abuse and Self-Harm

16.6.7 See above.

Key Line of Enquiry D: Access to specialist domestic abuse agencies

16.6.8 Domestic abuse professionals are now embedded in children's social care.

Key Line of Enquiry E: Policies, procedures, and training

16.6.9 BCSC have recently formulated policies and practice procedures and training to support practitioners to understand and develop ideas to address issues of domestic violence. This includes the practical measure of co-locating Advanced Domestic Abuse Practitioners in all child protection services. They were not in place at the time-of-service involvement with Steve's child.

16.6.10 In 2021, BCSC and the wider partnership have begun piloting the 'Safe and Together'™ Model. The model is an internationally recognised suite of tools and interventions designed to help child and family-serving systems become domestic violence-informed.[71]

16.6.11 The practice model and use of signs of safety[72] now used by local professionals encourages social workers to consider the family history of the parents and the causes and complicating factors leading to the behaviour or situation, to enable meaningful change and a trauma-informed plan. There is limited evidence of Steve's own history or experience of violence being explored in assessing and planning the response to the child, that would have been expected now through the use of tools to explore perpetrator patterns of behaviour within social care assessments and understanding the causes of violence in a family. The social care practice at the time demonstrated a linear focus on the mother's ability to protect herself and her child in the absence of a more intensive understanding of the wider parental functioning. This may have led towards the formulation of a more structured and realistic plan with a focus on achieving stability for the family and moving away from the onus being on mum protecting the children and herself from dad. This may have led to more targeted support for Steve about the factors, including his own experiences of violence, which were contributing to his behaviour.

16.6.12 The chair is aware that the funding for 'Safe and Together' is time limited and a study by 'What works for Childrens Social Care' entitled 'Domestic Abuse Interventions in Children's Social Care'[73] is due to report on domestic abuse interventions linked to children's outcomes. This may help inform future effective practice and evaluation.

> **Learning Opportunity (LO30):** To have explored the family history of Steve, to inform an improved trauma informed approach.
> **Response:** Bristol Children's social care is piloting 'Safe and Together' and has embedded Advanced Domestic abuse Practitioners in the child protection service.

[71] Source: Safe & Together™: An Introduction to the Model (safeandtogetherinstitute.com) (accessed January 2023)

[72] The Signs of Safety® approach is a relationship-grounded, safety-organised approach to child protection practice, created by researching what works for professionals and families in building meaningful safety for vulnerable and at-risk children. What Are Signs of Safety? - Signs of Safety (Accessed January 2023)

[73] Source: Domestic abuse interventions in children's social care - What Works for Children's Social Care (whatworks-csc.org.uk) (Accessed June 2023)

16.6.13 Training is also delivered into the wider partnership via the KBSP by a dedicated trainer. There are currently two tiers of training. The chair has been provided with a synopsis of Tier 1 training that includes identification of all types of abuse and features familial abuse. Within the 'living agenda', it also provides space for learning from DHRs. The intention is to commission Tier 2 training which is effect, advanced training that will focus on familial abuse and coercion and control, that are clearly features of this review. Without detailing the whole package, the panel agree that it is comprehensive in nature.

Key Line of Enquiry F: Seeking help, as well as considering what might have helped or hindered access to help and support.

16.6.14 See comments under KLoE B & E.

Key Line of Enquiry G: Extent to which Covid affected agency involvement with Steve.

16.6.15 Covid had no impact on agency involvement. The agency did not engage or seek to engage with Steve.

Key Line of Enquiry H: Substance Misuse and financial pressures

16.6.16 The agency did not engage or seek to engage with Steve. Comments in respect of recent service developments 'Safe and Together' would have provided an improved understanding had the current working practices been in place at the time.

Key Line of Enquiry I: Child Access

16.6.17 The records reflect an understanding that there was court order preventing direct contact between Steve and his partner following the domestic assault in 2018, though the details of this are unclear. There is no evidence that the arrangements for contact between Steve and his child was formalised through the process of a private law order, though there is reference in social care records of a 'civil' order applying to the restriction of contact between Steve and his child. However, details and a copy were not sought by professionals involved as would have been expected. In other words, to either secure a copy of any such order and/or details of what the injunction stated.

Learning Opportunity (LO31): To remind professionals of the need to seek and record accurate records of court orders/injunctions in relation to private law proceedings and civil orders.
Response: Bristol Children's social care will remind professionals of the need to seek and record accurate records of court orders/injunctions in relation to private law proceedings and civil orders

16.6.18 It is notable that the maternal grandmother indicated to Steve that his child would be removed by children's social care should he resume contact. Steve contacted the service to seek clarification on this issue and was signposted to seek independent legal advice. There is no evidence to indicate that he pursued this resource.

16.6.19 Steve was clearly concerned about the restrictions imposed on him regarding contact with his child. This no doubt would have caused him a level of distress and frustration. This was evident in his attempt to contact children's services in an attempt to seek clarification. Contact was not initiated by the service with Steve, arguably leaving him in the dark, not understanding his own situation regarding access to his child and preventing the service from getting a more comprehensive understanding of the risk he may have presented. The subsequent service developments of 'Safe and Together' are noted.

Key Line of Enquiry J: Housing Situation

16.6.20 The agency contact with Steve was limited to when he contacted them, and there is no evidence to suggest that his housing situation was considered or to sign post him to the relevant housing agent. The focus of the work undertaken was primarily on the mother's ability to protect herself and her child. Greater integration of adult services with children's social care

(i.e. Family safeguarding model) seen elsewhere could have enabled a more trauma-informed response and recognised his ongoing needs as a non-resident father to enable him to have a safe relationship with his child.

Key Line of Enquiry K: Familial Abuse

16.6.21 The police notification in December 2020 explicitly identified Steve as a victim, though it is unclear as to what services he had been signposted to, with a comment made this was a referral 'more suited to adult social care'. However, Adult Social Care were not notified, nor was there evidence whether this was checked.

16.6.22 Given that Steve's child was not open to services at this time, no further action would have been expected. Had the child been open to services and had the same information come to notice now, a more holistic approach under the 'Safe and Together' model would have been adopted.

Key line of Enquiry L: Gender

16.6.23 The experiences of Steve within the paternal home were not understood or analysed in the context of the family functioning as the agency did not engage with him.

16.7 Education Services

16.7.1 The nursery's involvement was limited to working with Steve's young child and his former partner. There was no contact with Steve, as the work of the nursery focused on the child's welfare, and because the registration paperwork did not include Steve's details. The comments below are therefore based on the nursery's dealing with his child and mother alone. Chronology entries were routine in nature, with no recorded entries relating to Steve, his situation with his former partner, nor anything regarding his circumstances.

16.7.2 The nursery was aware of Steve's history of domestic abuse towards his former partner and were aware of a historic restraining order against Steve, and that social care and police had been involved.

Key Line of Enquiry A: Communication and Co-operation Between Agencies

16.7.3 The nursery was notified of Steve's situation through Police Safeguarding Notifications and MARAC. The nursery was aware of Steve's history of domestic abuse and were aware of a historic restraining order against Steve, and that social care and police had been involved. The sharing of information via Operation Encompass is noted as good practice.

Key Lines of Enquiry B to M

16.7.4 The agency was not involved with Steve, and therefore analysis is not possible, though the chair acknowledges their active reflection on this case.

Good Practice

16.7.5 The nursery has an Alert Board and password system for supporting safe pick up and drop off with parents/carers. The agency was not involved with Steve, and therefore analysis is limited, though the chair acknowledges their active reflection on this case.

Reflections and Recommendations

16.7.6 Whilst the nursery did not have contact with Steve, the Safeguarding in Education Team has reflected on this review and reported recommendations as follows.

- Development of knowledge within the Education Workforce around the Domestic Abuse Act 2021 and the application of the Statutory guidance 2022.
- Development of training and support for the workforce around tackling parental conflict.
- Secure resource for the Police Safeguarding Notification Scheme from the statutory Local Safeguarding Partnership.

16.8 Bristol City Council Housing & Landlord Services (Housing)

16.8.1 The home address recorded for Steve at the time of his death was not owned or managed by Bristol City Council Housing & Landlord Services (BCC H&LS) and therefore BCC H&LS was not the landlord for him. However, he was recorded as an occupant at his father's address which is owned and managed by BCC H&LS until the date of his death in April 2021.

16.8.2 The Housing Management System entitled Civica Cx (where cases are recorded and managed) has reference to Steve not always living at the address and living at his girlfriends. Case notes record that David asked Steve to leave the address (April 2020) and Steve presenting as homeless (June 2020).

16.8.3 It is important to note that David is the tenant and within the tenancy agreement he is responsible for his occupants and has the right to ask occupants to leave. Specifically pertinent are:

i. You will be responsible for any breach of these tenancy conditions by members of your household, including lodgers and sub-tenants, and your visitors.

ii. You must not harm, intimidate, threaten, or act in any manner that causes or is likely to cause nuisance, annoyance, alarm, harassment, or distress to any person living in, visiting, or otherwise engaging in lawful activity in or in the locality of, the property. You will be held responsible if anyone else is involved in such behaviour on your behalf or for your benefit.

iii. You must not use threatening behaviour, domestic violence, or abuse (including but not restricted to physical, psychological, sexual, financial, or emotional) towards anyone living in the property or anyone with whom you currently have or have previously had a personal relationship. This includes but is not restricted to spouses, partners, girlfriends, boyfriends, and any member of your family. You will be held responsible if anyone else is involved in such behaviour on your behalf or for your benefit.

16.8.4 There are over 45 entries on the chronology provided by BCC H&LS. These may be summarised as follows.

- Routine maintenance
- Nineteen entries that relate to rent arrears, suggesting financial pressure within the household, and one specific entry from David's sister regarding his isolation, and trying to apply for universal credit.
- Reported anti-social behaviour that link directly to Steve.
- Administrative entries regarding the death of David's mother in 2019, and subsequent transfer of tenancy to him in 2020
- Steve presenting as homeless in June 2020

<u>Financial Concerns/Rent arrears</u>

16.8.5 The relevant period up until February 2020, is unremarkable, save for eleven entries related to David and his mother about rent arrears. After March 2019, David succeeded to the tenancy, when his mother passed away. Steve was listed as an occupant throughout. There is nothing to indicate that further action was being considered in relation to rent arrears during this point, until in April 2020, when David's sister contacted housing seeking advice about his rent situation.

16.8.6 On 1st April 2020 the rent management team received a call from David's sister to inform them that David is '*really worried and isolated now due to covid 19, has been laid off and is trying to apply for Universal Credit and she has told him to contact us.'* Later that day, David called and as a result, the rent management team liaised further with his family to help claim universal credit

(UC). On 9th April he applied for UC, and on the 17th of April a housing officer encouraged David to seek an advance to help pay rent and buy food. By the 20th he had received his first payment. By June he was no longer in rent arrears and no further concerns about rent arrears came to light.

16.8.7 This period of interaction with housing over financial worries shows effective working practices between David and the wider family to problem solve the issue of rent arrears and applying for UC.

16.8.8 This period also shines a light on the impact of Covid in isolating David, that along with financial worries provides an insight into the pressure within the household.

Anti-social behaviour (ASB) & Domestic Abuse

16.8.9 During this same period of concern about rent arrears, on the 17th of February 2020, housing received an online complaint about ASB. It reported, father and son fighting, loud smashing and breaking up property and alleged drug taking.

16.8.10 David was contacted within 2 days who explained that incidents occurred when Steve gets drunk, and the housing officer informs David that if the behaviour continued, he may consider serving an anti- social behaviour contract. This could involve all parties, including Steve and David.

16.8.11 It is apparent that this incident was seen through the lens of ASB and does not appear that the alleged fighting between father and son, was recognised as domestic abuse, or whether the matters of other criminality (stealing), or vulnerabilities such as drug taking, or alcohol fuelled trouble were subject of further advice nor intervention. However, at this initial stage, it was an isolated report, and by the 20th of April there had been no further reports and Steve had moved out.

16.8.12 There were no further complaints of ASB until further report on the 18th of August 2020, when it was alleged that Steve had returned to the address and that there was constant slamming of doors and suspected drug taking, and on 20th August with reports of Steve and David fighting. Housing services gave appropriate advice in relation to ASB such as completion of diary sheets an encouraged that concerns were reported to the police. Again, these complaints were seen through the lens of ASB management as opposed to domestic abuse.

16.8.13 Housing did seek further information from the police via email to the beat officers (on 28th August), but the records do not show if a response was received. They also contacted the neighbour via email on the same date providing information regarding diary sheets and where to send them. This is recognised as good standard practice.

16.8.14 Housing contacted David, who outlined police involvement around this time. The housing officer documents that housing was concerned for David's welfare. David agreed that Steve needed some form of intervention such as support around substance misuse or an injunction etc. The housing officer also explained to David that BCC can revoke Steve's licence to go to the address, but David didn't want this to happen at the time as he would have nowhere to go. The housing officer further explained that if Steve was to return and further incidents were reported then housing would serve ASB on both David and Steve. David understands this and agrees that this is what is needed.'

16.8.15 The IMR author has spoken to the housing officer, and she explained that she had offered to help signpost Steve to support services for drug and alcohol misuse, but that David had declined this offer.

16.8.16 However, these events were not recognised as domestic abuse terms for Steve against David or vice versa. The focus was on ASB even though the housing records show that David had been witnessed hitting Steve, but that this was '*because he was hitting himself'*. It is possible that the interplay of Steve and David was seen as mutually abusive and anti-social, focusing on

supporting victims of ASB as opposed to a more nuanced trauma-informed approach that may have prompted signposting Steve/David to appropriate support.

16.8.17 On considering opportunities to exchange information and work in partnership, the IMR author noted the email requesting information from the police but also drew attention to the existence of a "locality neighbourhood multi-agency meeting (MAM)". This is a meeting chaired by the police ASB co-ordinators, that deals with 'high risk individuals' and 'problem locations'. The focus is on anti-social behaviour, not domestic abuse, or safeguarding. Specifically, the focus of the ASB may be; Personal – where ASB is targeted at individuals or groups; Nuisance – where incidents affect the community rather than someone specific; Environmental – incidents having an impact on surroundings. The circumstances surrounding Steve were not discussed at this forum.

16.8.18 The chair was provided with the referral protocol for the MAM. Given that the meetings take place monthly, a cluster of complaints (18.08.2020, 20.08.2020, 03.09.2020) and that the ASB described may have fallen within the categories of 'Personal ASB', it is recognised that there may have been an opportunity to have considered a partnership discussion through the lens of ASB, though the main learning was that the incidents were not recognised as domestic abuse.

Case Management

16.8.19 The IMR author has identified that the original housing officer handed this case over on 25th September 2020 owing to maternity leave. The records show that the case was reviewed on 29th September, 22nd October, and 13th November, but there is no detail as to what the review entailed. The records show that the housing officer contacted the neighbour on 14th January 2021 who explained that Steve had tried to hang himself four weeks previously and that it had been quiet since. The housing officer said she would seek an update from the police and do a welfare check. However, there are no records of these actions having been completed.

16.8.20 Whilst the housing officer was not receiving any reports of ASB, there were reports of domestic incidents to the police (not shared with Housing) in December and in January. The panel are grateful for the IMR author's intrusion and the housing officer's honesty in acknowledging a 4-month gap in contact with the complainant and not following up on the actions due to other case priorities. These omissions are recognised as missed opportunities, and whilst recognising the prevailing circumstances of being mid-Covid, the circumstances do show the importance of sound case management and supervision.

Steve presenting as Homeless

.16.8.21 The analysis above shows a relatively quiet period that is explained by Steve not living at the address. On the 26th of June 2020, he presented as homeless having been excluded from his father's address. A homelessness assessment is completed, and the following is the summary from the records made by the homeless officer triaging Steve which was over the phone rather than face to face due to Covid.

Steve *has lived with his dad for most of his life at (an address). He says he hasn't been speaking to his dad for about a week. About 2 months ago his dad was drunk and beat him up with a cricket bat. His dad was arrested and charged (is on probation) and since then he has not spoken to Steve. Steve says that if he wants to use the bathroom or make any food he has to sneak about in the house, even though he pays £120 per week to live there. His dad threw him out last night and told him he has an injunction to stop him from going anywhere near the house. Steve slept outside the property last night. Steve has not seen an injunction and his dad has refused to show it to him. Steve has said that his dad has hit him throughout his childhood. Steve is currently on furlough from his job as a scaffolder. He does not claim any benefits. He has no health issues. Steve is homeless tonight. (Supervisor) advised we need to see the injunction and so I have told Steve to contact the courts to find out if it exists and get a copy. In the meantime, he can be added to the rough sleeper list.*

16.8.22 This summary provides a unique insight / account of Steve's lived experience, in terms of the response to a victim of domestic abuse, as well as his account of his own childhood.

16.8.23 Steve's homelessness case was closed in September, as Steve had not re-presented or contacted housing, which may in part be explained by the response he received. He was not identified as a victim of domestic abuse, or if he was this wasn't shared with the supervisor as his priority need based on the DA he reported, and support services and accommodation were not identified for Steve at this time. It is unclear why this occurred; the impact of Covid may be relevant due to the pressures on services especially homeless in terms of 'everyone in' initiative etc.

16.8.24 The Homelessness Code of Guidance for Local Authorities states "person who is homeless as a result of being a victim of domestic abuse has a priority need as set out in section 189 of the 1996 Act. Section 193(2) of the 1996 Act which requires housing authorities to secure accommodation that is available for occupation for applicants who have a priority need for accommodation, and as set out in section 176 of the 1996 Act, the accommodation must be available for occupation by the applicant together with any other person who normally resides with them as a member of the family, or might reasonably be expected to reside with them.[74] This guidance was published in 2018, and has been updated in 2022 in accordance with the Domestic Abuse Act would clearly have put Steve in the category of priority need if he presented now. The panel learned that Bristol City Council has, since 2018, treated domestic abuse cases as having priority need, and this is recognised as positive practice.

16.8.25 The panel agree with the IMR authors observation that the advice for a homeless person to get a copy of an injunction from the courts was inappropriate and not practical.

MARAC

16.8.26 Steve's case was discussed at MARAC on 7th January 2021. An action was recorded for the "ASB housing officer to invite VS IDVA to meetings to link in". In discussion with agencies outside the panel, it was agreed that the action and ownership could have been clearer, and Victim Support suggest that this action should have been owned by them and have agreed a learning opportunity (LO40) and recommendation (R11) described below. There is insufficient involvement with the MARAC meeting itself to draw a conclusion as to the quality of actions generated from MARAC requiring a broader recommendation regarding the quality of MARAC actions.

16.8.27 It is also noted that as the agency seeks DAHA accreditation, the new DAHA processes require all cases discussed at MARAC involving a housing tenant will result in a DA case being opened. The resultant additional layer of intrusion would ensure actions are followed up.

Key Line of Enquiry A: Communication and Co-operation within and between Agencies

16.8.28 There is no evidence to suggest that the information in relation to reported ASB was searched and considered when Steve made an application for housing. Similarly, his homeless application made was not shared with the estate management team. If the notes that were recorded from Steve's homelessness assessment were shared in June 2020 with the housing officer, then they may have been able to further ask for details as to the incident which he mentioned to Police being '*About 2 months ago his dad was drunk and beat him up with a cricket bat. His dad was arrested and charged (is on probation) and since then he has not spoken to Steve.'* Estate management service within H&LS were never informed of this or an injunction to which Steve also mentions by Homelessness services within H&LS. This was in effect two missed opportunities to signpost Steve to the relevant support services for his disclosure of domestic abuse from his father at this point (at homelessness assessment and passing to housing officer). An individual agency recommendation has been made regarding the sharing of information.

[74] Source: Homelessness code of guidance for local authorities - Chapter 21: Domestic abuse - Guidance - GOV.UK (www.gov.uk) (Accessed December 2022)

Learning Opportunity (LO32): To improve the sharing between the homelessness team and estate management teams.
Individual agency recommendation: Review the current homelessness duty process from triage-closure.

16.8.29 There is evidence of housing having sought information from neighbourhood policing via email, but not having received a response (16.8.13), though the police can find no trace of any reports made to them.

16.8.30 This case of reported anti-social behaviour, including disturbances, allegations of assault were not recognised as domestic abuse (See 16.8.28 below) or subject to a local multi-agency meeting through the lens of ASB. The police report that there were no reports of ASB made to them.

16.8.31 Housing is a standing member of MARAC and there is clear evidence of information sharing and co-operation.

Key Line of Enquiry B: Risk of Domestic Abuse and Self-Harm

16.8.32 There were missed opportunities to identify domestic abuse, including the reported ASB (August/September 2020) and Steve presenting as homeless. On the 26th of June 2020, Steve gave detail that shed a light on the control David exercised on him, such as - asking permission to use the bathroom; - speaking about the assault with the cricket bat, and that his father had hit him throughout his childhood. On neither occasion was domestic abuse identified. Steve was seen as a perpetrator of nuisance behaviour, and the domestic abuse he was experiencing was entwined in this narrative. The opportunity for housing staff from various parts of the organisation to recognise domestic abuse has been the subject of an individual agency recommendation.

Learning Opportunity (LO33): Improve the recognition of interfamilial domestic abuse especially between father and son (males) and how to support disclosure/ accessing support services.
Individual agency recommendation: Training to refresh identifying the signs of interfamilial Domestic Abuse.

Key Line of Enquiry C: Response to Domestic Abuse and Self-Harm

16.8.33 Given that domestic abuse was not identified, it is not possible to assess the response but acknowledge the learning opportunities above.

Key Line of Enquiry D: Access to specialist domestic abuse agencies

16.8.34 BCC H&LS can refer into specialist domestic abuse agencies and Housing have recently recruited a Housing IDVA who can offer advice and guidance to staff and link services to support victims.

16.8.35 According to the 'Bristol Domestic Abuse Safe Accommodation Strategy 2022-2025', "Bristol has more units of refuge space than the estimated capacity required. The Council of Europe (COE) estimate that one family refuge space is required per 10,000 residents in the community."[75] However in panel discussions there did not appear to be any locally accessible accommodation for male victims of domestic abuse. The strategy noted above also notes "Overall, 76% of homeless applicants experiencing domestic abuse were female. Our prevalence estimates in the previous section suggest that around 32% of victims are likely to be male which would mean they are underrepresented within the homelessness pathway". However, as the review progressed, the panel learned that in October 2022, Bristol City Council had commissioned the provision of a male IDVA, and a shared safe house for male victims of domestic abuse. This is recognised as a positive development and good practice.

16.8.36 Male victims may be referred to local Victim Support services, who are the local domestic abuse advocacy provider, and there are good links on local websites for male support.

[75] Source: *Safe Accommodation Strategy (bristol.gov.uk) (Accessed December 2022)

Key Line of Enquiry E: Policies, procedures, and training

16.8.37 Bristol City Council H&LS have recently refreshed their domestic abuse policy and standard operating procedures following the Domestic Abuse Act 2021 with training given on the new legislative definition and powers. The chair was provided with a copy that provides a comprehensive framework with very clear expectations of the approach to abuse. This is recognised as good practice. Training has occurred and continues to occur across services. A Housing IDVA has been in post for 6 months and is working across H&LS with staff and clients which is a great benefit to the service to share expertise and join up services utilizing their knowledge and supporting staff and victims. This is recognised as good practice and will assist housing professionals to see complaints of ASB through a different lens, that of domestic abuse that will more likely result in an individual such as Steve benefitting from a trauma-informed approach.

16.8.38 The panel were also informed that Bristol City Council intend to secure DAHA accreditation, are currently writing the job specification for a DAHA manager and intend to achieve accreditation within two-years (by March 2025). This is recognised as a significant positive development.

Key Line of Enquiry F: Seeking help, as well as considering what might have helped or hindered access to help and support.

16.8.39 Please see 16.8.25.

Key Line of Enquiry G: Extent to which Covid affected agency involvement with Steve.

16.8.40 The Covid pandemic affected both Steve and David, with neither being able to work owing to covid. It is unclear whether Steve had benefitted from furlough payments as it has not been possible to determine if he was on a company payroll related to his scaffolding. Records show that David claimed universal credit.

16.8.41 It is believed that Steve had returned to his father's address (16.7.8), owing to the risks of Covid. In other words, a decision was taken by Steve that the risk presented by Covid was greater than the risks of him staying with his father.

16.8.42 The IMR author reports that Bristol City Council's policy during the pandemic was that home visits were for essential services only e.g., emergency repairs and as a result all interactions were completed over the telephone. The practical effect being that David and Steve were never met in the locality by the officer. It is not possible to determine whether this impeded opportunities for housing officers to observe the physical environment and/or have better involvement with Steve. It is noteworthy that at the time, there was a significant response and focus on street homelessness at the time which impacted on the system.

Key Line of Enquiry H: Substance Misuse and financial pressures

16.8.43 Steve did not share any drug and alcohol dependencies/ misuse directly with housing but there is reference to his substance misuse by the complaints to housing and David agreed verbally with the housing officer that Steve needed an intervention for his substance misuse in September 2020.

16.8.44 When Steve sought help with housing he said *'currently on furlough from his job as a scaffolder & does not claim any benefits',* though it has not been possible to confirm whether he received furlough payments (16.8.36). He also said of his current accommodation arrangements, *'that if he wants to use the bathroom or make any food he has to sneak about in the house, even though he pays £120 per week to live there.'* This shows a self-awareness of his own financial situation and suggests he felt he was being exploited by his father financially for his living arrangement. The analysis above at 16.7.3 to 16.7.6 shows that there were clearly financial pressures within the household.

Learning Opportunity (LO33): Improve the recognition of interfamilial domestic abuse especially between father and son (males), including financial abuse, and how to support disclosure/ accessing support services.
Individual agency recommendation: Training to refresh identifying the signs of interfamilial Domestic Abuse.

16.8.45 The chronology and analysis (16.8.5-16.8.8) shows that there was financial strain within the household, and effective working between housing and David in securing universal credit and advanced payments to alleviate these pressures. This is a point of reflection in recognising how contextual circumstances add weight to family discord.

Key Line of Enquiry I: Child Access/concern

16.8.46 The only reference to Steve's child is by the neighbour on one of his reports about ASB referencing Steve not supporting his new-born child, when he was describing the father (David) fighting with Steve over his constant stealing, lying and drug use.

Key Line of Enquiry J: Housing Situation

16.8.47 See 16.8.20 to 16.8.23. Steve was not recognised as a victim of domestic abuse, and as such having a priority need. The IMR also recognises that asking Steve to provide a copy of an injunction to support his housing application was not practical and nor was he signposted for any support in relation to the injunction or domestic abuse services. Whilst these are significant in this case, the work in place to secure DAHA accreditation are recognised as positive and will help prevent missing such opportunities in the future.

Learning Opportunity (LO33): Improve the recognition of interfamilial domestic abuse especially between father and son (males), including financial abuse, and how to support disclosure/ accessing support services.
Individual agency recommendation: Training to refresh identifying the signs of interfamilial Domestic Abuse +
Response: Work in place to secure DAHA accreditation

Key Line of Enquiry K: Familial Abuse

16.8.48 See 16.7.23: Key Line of Enquiry B: Risk of Domestic Abuse and Self-Harm

Key Line of Enquiry L/M: Gender & Equalities

16.8.49 Steve was not recognised as a victim of domestic abuse with the overt symptoms being entwined with complaints of anti-social behaviour, where Steve was seen as the perpetrator. One view considered as to why domestic abuse was not 'seen' relates to a society value of masculinity, where the behaviour was viewed with greater tolerance in comparison to any such behaviour in a male-female relationship. Had the anti-social behaviour been between a man and woman, the panel agree that the matter of domestic abuse would more likely have been explored. This is supported in some academic reports, where one reported "*A variety of studies have demonstrated similar findings including that IPV perpetrated against women is seen as more serious*".[76]

Learning Opportunity (LO34): The need to recognise abuse by family members on male victims as domestic abuse.
Individual agency recommendation: Training to refresh identifying the signs of interfamilial Domestic Abuse
+
Response: Work in place to secure DAHA accreditation

16.9 Probation Service

[76] Source: Impelling and Inhibiting influences of Men's and Women's use of Aggression towards Partners and Same-Sex Non-Intimates: A test (cumbria.ac.uk) (Accessed December 2022)

16.9.1 David's case was allocated to a Community Rehabilitation Company which was the privatised part of the Probation Service, which held responsibility for cases assessed as low or medium risk of serious harm to others. It is noted that the private company that was awarded this contract went into administration in 2020 and passed onto another private company.

16.9.2 Following his conviction and prior to sentencing, a pre-sentence report (PSR) was written on David that included, a summary of offence, an analysis of the offence and pattern of offending. The purpose of a PSR is to complete a risk assessment of an individual and propose a sentence to the court. This should consider relevant personal factors such as: Accommodation, Finance, Employment, Substance Misuse, Relationships, Thinking and Behaviour, Physical and Mental Health, Experience of Trauma and Caring responsibilities. The PSR would examine a variety of information sources such as interview records, police information such as domestic abuse and previous convictions.

16.9.3 At the time of completing the PSR, David only had historic convictions that were unrelated to the offence for which he was convicted.

16.9.4 It was noted that the probation practitioner to whom this case was assigned, did not explore antecedent history in relation to domestic abuse, even though in the pre-sentence interview David spoke about other incidents. The chronology shows that there had been several domestic abuse incidents *(3rd and 12th January 2020)* within the relevant period, prior to the index offence (2nd February 2020) for which David was convicted. The PSR author is no longer working for the organisation, so it has not been possible to ascertain the reasons. The IMR author reports that current practice is that the PSR author would ask for police intel and complete safeguarding checks with CYPS. If those are not received by the time of the court appearance, then the PSR author will ask for an adjournment.

Learning Opportunity (LO35): Probation practitioners to follow up appropriate lines of enquiry with improved levels of professional curiosity.
R**esponse**: Practice changes have taken place.

16.9.5 A clear issue to the panel was how it was practical for the victim of a domestic assault to remain living with the perpetrator. The probation records do show the PSR author had explored this challenge, reporting that David explained that Steve had returned to live with him when he was evicted from his last place of residence due to a restraining order being imposed protecting his partner at the time and their little girl. David had said he felt somewhat obliged to have Steve live with him as he knew his son had nowhere else to go. However, his son's behaviour which he describes as centring around drug and alcohol use often funded by the defendant (David) was problematic. Notwithstanding the actual index offence, no action was considered to mitigate the accommodation issue, nor was consideration given to signpost Steve to support regarding the risk factors for alcohol and substance misuse. The PSR author did note that David had reported a supportive family and David still had the option to stay elsewhere if tensions rose.

16.9.6 Whilst the circumstances were unique, a domestic abuse victim was residing at the same address as the perpetrator, it is arguable that a case be made for closer working with the victim when these circumstances occur. The panel learned there would have been more regular contact if the offence was a 'Victim Qualifying Offence'. This relates to offences such as a serious violence or sexual offences where the offender was sentenced to 12 months or more in custody or detained under the Mental Health Act. Had these criteria been met, a victim liaison officer (VLO) would have engaged with the victim and advocated on his behalf for alternative accommodation.

16.9.7 A further question arose as to the probation service being alerted to incidents that took place and learned that subsequent systems change now result in Probation Service being informed daily of the arrests of offenders under probation supervision and any safeguarding (including domestic abuse) incidents. This would alert the probation officer who would be expected to contact the supervised subject and assess the risk of the domestic circumstances (in this case, David, and Steve living at the same address) and take appropriate action to mitigate risk and safeguard others.

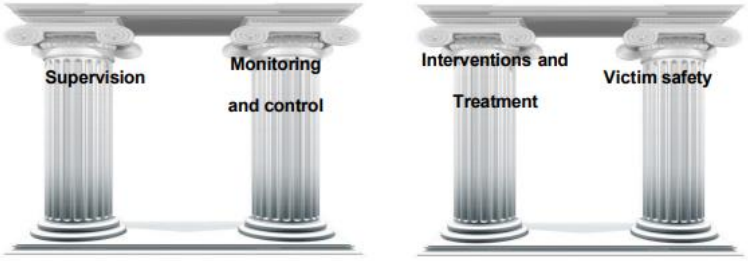
16.9.8 It was also noted in the IMR that the initial sentence plan written by the probation practitioner contained scant detail and very limited professional curiosity and was not countersigned by a senior probation officer that would happen now under the auspices of the National Probation Service.

16.9.9 Whilst the accommodation issue was noted as being a Risk of Re-offending (ROR) and Risk of Serious Harm (ROSH), there is limited detail other than the offence that took place in the home and that the victim and perpetrator still lived together. Areas that would have been expected to be explored include; - whilst alcohol use was assessed as being linked to ROR and ROSH the information is limited as it was noted that at that time David was not willing to admit to alcohol issues and the probation practitioner could have explored this further in subsequent appointments; - a section on relationships stated the facts of a difficult relationship, but does not explore why, family relationships, and seek to understand the dynamics of the relationship.

16.9.10 The IMR author has attempted to examine policies and procedures in place at the time, but it has not been possible to locate these as the company went into administration. Moreover, in February 2022 the National Probation Service introduced a new Countersigning Framework. This required certain criteria to be met before the practitioner is assigned a role that may or may not result in their assessments being countersigned. Linked to this countersigning framework, the panel learned that levels of supervision have also been enhanced that ensures supervision of cases every 4 to 6 weeks, and the introduction of a dashboard that highlights when offenders have not been seen. In other words, a significantly tighter regime of supervision.

16.9.11 The IMR author also reports that in completing the risk assessment, whilst describing the nature of the risk, it did not describe imminence. The risk was assessed as Medium.[77] Considering what was known and recorded by the probation practitioner at the time, the panel would agree that a medium rating was appropriate. However, if one considers the domestic abuse call outs that were 'knowable' during the relevant period, a stronger case for a 'high' rating would have been justified. After all, David was sentenced in relation to an incident on 2nd February, but there were nine calls between July 2017 and 12th January 2020. One explanation may be a telephone conversation between the officer and Steve who reportedly said, 'things were fine between him and his dad'. What is unclear is whether David was present at the time, but given Covid restrictions at the time, this is likely. However, we know the system of alerts (16.9.7) now ensures probation service are alerted to such incidents.

16.9.12 Upon further review of the ROSH guidance, a section on risk management plans is described as a four pillars approach.



16.9.13 Under 'victim safety planning', the guidance says, 'plans to keep the current and/or potential victims safe and ensure that the victim has a voice in the management of risk to them'. It is

[77] **Low risk of serious harm** - *current evidence does not indicate likelihood of serious harm.*
Medium risk of serious harm - *there are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse.*
High risk of serious harm - *there are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious.*
Very High risk of serious harm - *there is an imminent risk of serious harm. The potential event is more likely than not to happen imminently, and the impact would be serious*.

apparent that Steve's voice was absent, and whilst linking with observations around VLO above, the panel agree that engagement with the victim would have been desirable in circumstances such as Steve's and David, where the victim lives with the perpetrator.

16.9.14 In March 2022, new guidance was introduced on assessing domestic abuse on probation systems. There are several relevant sections that the IMR author drew the panels attention to including the importance of the victim's voice.

- *The victim's voice is an essential component of the assessment: evidence shows that where a victim is in fear for their safety, their concerns should be seen as a reliable predictive risk factor. Contrastingly, victims may minimise / mask their own level of risk or continue to return to abusive relationships. These decisions present a challenge in assessing risk and should not always be taken at face value: they may be influenced by manipulation or intimidation and should not necessarily be taken as an indication of risk reduction. Additionally, a child who is exposed to domestic abuse is also a victim and include them in your analysis.*

Learning opportunity (LO36): To improve the quality of risk management, through supervisory oversight and adherence to policy requirements.
Response:
(1) The structure of the Probation Service has changed, with Community Rehabilitation Company having been integrated into the national probation service.
(2) In February 2022, a new Countersigning Framework was introduced that ensures oversight of the assessment and risk management planning, along with a rigorous regime of supervision.
(3) In March 2022, revised guidance was put in place regarding domestic abuse.

Key Line of Enquiry A: Communication and Co-operation Between Agencies

16.9.15 Whilst under Probation Service supervision, police were involved with further domestic abuse related calls (12/04/2020, Assault with David as victim; 30/08/2020, Assault with Steve as victim; 05/12/2020, Assault and attempted suicide – Steve as victim; 15/01/2021, Assault with Steve as victim). The service was only aware of the final incident following a police alert, and service involvement ended on the 23rd of February 2021.

16.9.16 The panel were informed that practice has subsequently changed, with Probation Service now receiving daily arrest reports that includes domestic abuse, that would alert the service of any incidents. There are also new systems in place allowing Probation Service access to police systems. These developments are welcome.

Learning opportunity (LO37): Ensuring that Probation Service is alerted to arrests involving clients under probation supervision.
Response: Systems changes ensure Probation are alerted to arrests of clients under supervision.

Key Line of Enquiry B: Risk of Domestic Abuse and Self-Harm

16.9.17 Whilst the Probation Services interaction was primarily in relation to David, the management of risk was more complex in this situation owing to perpetrator and victim living together. The risk management plan is acknowledged as not being as robust as would be expected, and under current arrangements the 'one Probation Service' would have been returned for further work and details. Several opportunities for enhanced professional curiosity and supervision have been highlighted.

16.9.18 Whilst management of offenders now sits within one Probation Service, there have been significant changes in policy that would ensure better risk management planning as well as supervisory oversight (see comments above).

16.9.19 The chair had several meetings with the panel representative who also consulted with the national lead following consideration of "Risk of Serious Harm Guidance 2022". What became clear was that there are numerous actuarial tools used for the assessment of risk, designed for specific

types and gravity of offences. A document 'Revalidation: Risk of recidivism tools'[78] describes five types of reoffending and ten risk predictor tools. The chair considered some of the guidance and raised a concern that the ROSH guidance within one section stated "*The RSR (Risk of serious recidivism) tool predicts serious offending. This could include domestic abuse, but the tool is not specifically designed to predict all behaviours associated with domestic abuse, such as coercive control, stalking and common assault level violence."* Having stated this, it was clarified by the panel representative that RSR guidance is for offences of GBH and above. David did not fit into this category. Further discourse with the probation service provided reassurance in that Oasys systems had significantly changed in November 2021 and now deal with familial abuse. The chair explored these with the panel representative and examined linked guidance on domestic abuse risk. There are several subsections that include the following: - current relationship with close family members, - experience of childhood, - current relationship status, - previous experience of close relationships, - is there evidence of current or recent domestic abuse? With reference to sub-sections on family relationships, a series of questions are then asked covering a broad spectrum of abuse from physical to emotional abuse. On researching further, a probation service publication entitled 'IT Systems Training Guide for OASys and NDelius', also contains a hyper link to a '4 Step Quick Guide Domestic Abuse – Oasys'.[79] Further guidance in November 2023 (Risk and OASys Practice Improvement Suite) also demonstrably sets out the expectations within the countersigning framework as to satisfaction that risk management plans are sufficient to manage domestic abuse and risk of serious harm.

16.9.20 In summary, there are now policies and toolkits on how domestic abuse is considered and other sources of support for staff to access. Staff also are required to update their learning and be up to date with current trends and research and have access to external events to further enhance their understanding. Whilst the focus had been on intimate relationships, familial relationships have also been covered more recently.

Key Line of Enquiry C: Response to Domestic Abuse and Self-Harm

16.9.21 While assault / domestic abuse was the index offence, there is no evidence of any referrals, work undertaken in respect of David as a perpetrator. As part of the sentence plan objectives, David was intended to have attended an emotional resilience programme, and to undertake one-to-one work to explore alcohol misuse and the disinhibiting effects which is linked to offending behaviour. Owing to lockdown this work was not undertaken.

16.9.22 The IMR author also acknowledges that the emphasis within the Probation Service in terms of training had related to intimate partner violence as opposed to familial violence. Arguably this suggests an opportunity to explore how the needs of familial domestic abuse perpetrators are best met, after all the Crime Survey of England and Wales suggests that just less than 2% of the adult population have experienced such abuse within a year.[80] However, the counter argument to this comment was found within the linked guidance on domestic abuse that posed a number of questions in relation to familial domestic abuse and the risk assessment tool OASys has now changed.

Learning opportunity/reflection (LO38): Probation to have an improved focus on familial domestic abuse.
Response: There have been subsequent policy and guidance changes to systems such as OASys risk assessment that provide reassurance as to the risk assessment of all domestic abuse including familial abuse.

Key Line of Enquiry D: Access to specialist domestic abuse agencies

16.9.23 Probation Service is aware of relevant agencies who provide support and advice in respect of all domestic abuse, including specialist services for men.

[78] Source: revalidation-risk-recidivism-tools.pdf (publishing.service.gov.uk) (Accessed April 2024)
[79] Source: PowerPoint Presentation (hmppsintranet.org.uk) (Accessed November 2023)
[80] Source: Domestic abuse prevalence and trends, England and Wales - Office for National Statistics (ons.gov.uk) (Accessed January 2023)

Key Line of Enquiry E: Policies, procedures, and training

16.9.24 See 16.9.17 to 16.9.21.

Key Line of Enquiry F: Seeking help, as well as considering what might have helped or hindered access to help and support.

16.9.25 The level of inquiry and professional curiosity shown by the service at pre-sentence reporting stage was poor, resulting in a limited understanding of the history of abuse and overall family situation (history of domestic abuse, Steve's substance misuse, Steve's reported dependency on David to finance his drug habit). Undoubtedly this was exacerbated by a lack of oversight, the providing company going into administration, and the fact that during the 12 months of supervision covid prevented face to face supervision, and David taking part in planned programmes. These matters are mitigated by policy developments.

16.9.26 Furthermore, the IMR noted that in the 12 months of supervision he had 5 officers overseeing his case, that would have been a barrier to gaining a comprehensive understanding of the circumstances. The panel were informed and are aware of the current difficulties in recruitment and retention into public service, including the Probation Service, with significant vacancy rates. Whilst acknowledging the best practice of having a consistent probation officer, the Probation Service are unable to deliver this in the present climate.

16.9.27 The panel acknowledge that many of these barriers result directly to the structural challenges and changes confronting the 'Probation Service' at the time, as well as the impact of Covid.

Key Line of Enquiry G: Extent to which Covid affected agency involvement with Steve.

16.9.28 At the time of the pandemic, an exceptional delivery model was in place meaning that a very limited number of staff were able to be in the office for Face-to-Face appointments and those appointments were with those who posed the most concerns in terms of (Risk of serious harm) ROSH along with those who were particularly vulnerable due to homelessness or mental health issues. Aside from the initial induction appointment, all contact with David was conducted via telephone. Consequently, David did not undertake programmes of activity as planned.

16.9.29 If there were a further pandemic, the service would once again consider how it may safely supervise people on probation, that would be driven by public health guidance. This may include doorstep home visits as opposed to telephone only contact.

Key Line of Enquiry H: Substance Misuse and financial pressures

16.9.30 David denied problems around alcohol misuse. However, there are notes that Steve's behaviour centred around drug and alcohol use that David often funded. There is nothing to indicate that this was considered as a risk factor, nor to suggest any intervention or advice to mitigate the risk. Practically one may argue enquiries may have been made as to the extent of Steve's challenges, that could have enabled signposting of Steve for support to have taken place. One may also argue that the service should have made enquiries with the police to consider the extent of the risk of Steve's behaviours and drug taking putting David's probation at peril. Given what the IMR described as being 'scant' detail on the available assessments, there was a missed opportunity to consider the role of drugs and alcohol in the family home, where Steve and David lived together.

16.9.31 However, the panel are satisfied that the introduction of various changes summarised at 16.9.14 will ensure that the four pillars of risk management are subject to far closer scrutiny and supervision.

Learning opportunity (LO39): Improved professional curiosity and consideration of the impact of problematic drug use within the family on the person subject to probation supervision.

Response: Significant changes in probation structures, and changes in policy will ensure far closer scrutiny and adherence to the four pillars of risk management**.**

Key Line of Enquiry I: Child Access

16.9.32 The Probation Service was alerted to the fact that David's grandchild came to stay every weekend and he supervised contact between his grandchild and his son. It is acknowledged that safeguarding checks and a referral to children's services ought to have been made following David's conviction and the continued tension between David and his son. The panel agree this is a broad learning reflection.

Key Line of Enquiry J: Housing Situation

16.9.33 See below.

Key Line of Enquiry K: Familial Abuse

16.9.34 Familial abuse was recognised and noted in all assessments. However, the IMR author candidly acknowledges the previous emphasis on intimate relationships when considering domestic abuse, though risk assessment, policy and training has evolved to consider wider familial abuse. This suggests an opportunity for the Probation Service to reassure itself that the response to familial domestic abuse is understood which will in turn aid formulation of risk management plans for supervised clients.

See Learning opportunity (LO38)

Key Line of Enquiry K and L (Gender and Equalities)

16.9.35 The service acknowledges an historic emphasis on intimate partner relationships when considering domestic abuse, that is now subject to updated mandatory training and ongoing training that has taken place since the Domestic Abuse Act 2021. It is not possible to determine the extent to which this impacts / detracts on the Probation Service approach to familial abuse, suggesting an opportunity to understand whether needs are appropriately met in respect of familial abuse. The recommendation noted at 16.9.23 is relevant in this regard.

16.10 Victim Support

16.10.1 Victim Support received two referrals for Steve, on 14th September 2020 and 10th December 2020 before further records reference discussion at the MARAC on 7th January 2021.

16.10.2 The records show attempted contact in accordance with VS policy. On the 14th September calls were made and went through to voicemail before a call was answered and Steve said he was going to work in Bournemouth. Arrangements were made for a conversation the following day. He did not answer a call on the 15th and a wellbeing text was sent outlining support available. Steve did not respond, and further contact was attempted in October before the case was closed with a recorded rationale that Steve had been provided with contact details and knew how to contact Victim Support.

16.10.3 A similar pattern took place in December 2020, but on this occasion, Steve sent a text asking who was trying to call him. VS replied, identifying themselves and asking if he wanted a call back. Steve did not reply. The case was then referred to MARAC that was heard in January 2021.

16.10.4 The MARAC minutes of 7th January summarises efforts made in December as follows, "VS IDVA-Tried to contact Steve on several occasions with no luck. The first contact made Steve said he was on his way into work so he could not speak but he hasn't answered since." A later entry logged in relation to housing records, "David and Steve are joint tenants at the named address. There is an open ASB case (informal) regarding drunken incidents, shouting and screaming and Steve also has an incomplete housing application that he needs to complete."

16.10.5 The actions suggest that the chair identified an opportunity for VS to work with housing to engage with Steve, recording an action for housing, "ASB housing officer to invite VS IDVA to meetings to link in". The chair met with the VS manager who suggested this was an enquiry (and a missed opportunity) that should have been followed up by VS, rather than waiting for the other agency to call them. The manager agrees that responsibility sits with the agencies in receipt of such actions and not MARAC, though it reflects the MARAC chair has responsibility for monitoring completion of actions.

Learning opportunity (LO40): To ensure that MARAC actions mentioning VS (even if not owned) by VS are followed up. **Recommendation 10:** Victim Support is to ensure that all MARAC actions mentioning VS are followed up.
Outcome: (a) VS follow up and ensure MARAC actions are completed, maximising opportunities for engagement. (b) Joint agency action completion improves communication and co-operation between agencies

16.10.6 More broadly, VS noted that having a dedicated male IDVA enables focused support and advocacy for male victims where they indicate a preference as to the gender of their IDVA.

16.10.7 The lack of engagement with Steve precludes full commentary against all lines of enquiry, though analysis shows that Covid did not impeded agency involvement with Steve having attempted telephone calls and text messages, and because Steve had on one occasion called VS back, as well as being provided details of support via text.

17. CONCLUSIONS AND LESSONS LEARNED

17.1 Conclusions

17.1.1 The chair and panel are mindful of avoiding the counsel of perfection that is 'Hindsight Bias'. The review panel has attempted to view as broadly as possible what happened, to understand the circumstances of Steve's life to help explain his death. The panel has reflected on local service developments and initiatives, and wider academic studies. Regrettably, the panel has not benefitted from family insight but has the perspective of a friend with whom Steve lodged with at the time of his death.

17.1.2 There are several factors in this case that contribute to an understanding of Steve's vulnerability. It is clear from the account of his friend and the friend's wife, that Steve was unhappy, in some despair, having been heard to be crying on the evening he died by suicide. Whilst the panel could not identify a 'trigger event', it is arguable his death was not 'out of the blue' given some of the factors below.

17.1.3 Steve was an only child and a young man who had a disjointed upbringing, living between his mother at times and father/grandmother. He had been treated for ADHD as a child and may have had undiagnosed learning difficulties and there were reports of concerns regarding his behaviour. There was limited agency involvement prior to the relevant period, but when aged 13, a report regarding running away resulted in brief social care contact, and it was noted there were arguments between Steve and his father. Cross referencing with comments by Steve to housing about how his father treated him as a child, it is likely that adverse childhood experiences has affected his vulnerability and wellbeing as an adult. This background was not considered by agencies when considering the circumstances of agency involvement.

17.1.4 There is no background of reported abuse before the relevant period (April 2017), and Steve's arrest for domestic abuse against his partner and mother of his only child is significant. Thereafter, there was a history of domestic abuse between father and son, that shows David as the primary aggressor. The abuse took a number of forms, predominantly physical, but also alluding to controlling behaviour and financial abuse.

17.1.5 There were several cross allegations of assault, many where alcohol was an aggravating factor, and frequently arising from minor arguments such as eating one another's food or keeping the house tidy. Whilst neither party substantiated allegations, it is clear David was the primary aggressor and that his conviction for an assault on Steve was based on his admission as opposed to Steve supporting a prosecution (January 2020). Notwithstanding this conviction, Steve remained in the same house as David, and his accommodation needs are noted as important in this review. After all Steve had said he had 'no-where else to go' (16.4.61).

17.1.6 There is evidence of controlling behaviour from father to son through conversations with professionals such as through a conversation with housing (June 2020) where Steve said that he had to ask permission to use the bathroom or make food. This was corroborated in a similar account provided by his friend with whom he lodged. It was also reported by police when Steve had been asked by police why he remained at the address, and he had replied that he was 'scared to be on his own', that indicates his own isolation and deprivation of independence. This shows a clear relationship between the need for accommodation and control.

Vulnerabilities & Worries (Steve's perspective)

17.1.7 The intersection of multiple vulnerabilities and worries is apparent over the relevant period. Each incident of self-harm, an overdose (05/08/2018) and attempted suicide by strangulation (05/12/2020) followed significant incidents. The panel were unable to identify a trigger event proximate to Steve's death.

Victim of Assault

17.1.8 Steve had been a victim of assault, where he incurred a significant injury to an ear. This featured in discussions following incidents of self-harm and following a comprehensive assessment of his mental wellbeing by his GP a year later.

Substance Misuse

17.1.9 Steve had formed a substance use (Opioid) dependency with prolific contacts with Emergency Departments on record prior to the relevant period (RP), flags having been placed on his medical record and sporadic presentations during the RP seeking medication. It is highly likely from Steve's own accounts of being in trouble with cocaine dealers, as well as of others, that he was using illegal drugs. Steve was not signposted to substance misuse support services.

Child Access

17.1.10 The imposition of a restraining order on Steve that afforded protection for his former partner and restricted access to his child. It is clear from disclosures to professionals that Steve found the restricted access to his child difficult.

17.1.11 Worries about child access also formed a barrier to Steve seeking help from the police, as he was worried how his former partner, and social services would view police involvement.

17.1.12 At the time of his death, Steve was lodging in a house with others, one of whom was in a relationship with the mother of his child. This is recognised as a 'stressor' for Steve, owing to the separation from his former partner, and because this new boyfriend could see Steve's child more freely than he could.

Covid and Mental Health

17.1.13 Covid lockdown that commenced on 16th March 2020[81] had a significant impact at the time, isolating Steve and David, preventing them from working, getting out of the house and adding tension to the household. Steve's experience reflects academic research of people reporting psychological distress and symptoms of depression related to Covid.

Accommodation

[81] Source: timeline-coronavirus-lockdown-december-2021 (instituteforgovernment.org.uk) (Accessed June 2023)

17.1.14 A secondary effect was that it forced them to remain together, with no other easy option for Steve to live elsewhere. When he did present to housing, he was not treated as having priority need as a victim of domestic abuse and was put on a rough sleeping list.

Financial pressure and financial abuse

17.1.15 Money was a worry for Steve. Neither were able to work during Covid, David had to be advised about claiming Universal Credit, and Steve spoke about the reliance of David on him and mentioned financial abuse to the police (14.2.43 and 14.2.49).

17.1.16 Steve was also worried about other debts, with reports of correspondence from HMRC that had concerned him, and the frequent references to being in trouble with cocaine dealers.

17.2 Learning

17.2.1 This review has benefitted from detailed chronologies, candid IMR's and open conversations with panel representatives and other professionals that has helped inform the identification of 'learning opportunities' summarised at Appendix D.

Vulnerability

17.2.2 The intersection of multiple vulnerabilities and worries as summarised above is apparent in this review.

Suicide Prevention

17.2.3 The research conducted during the review demonstrated links between domestic abuse and suicide, adverse childhood experience and suicide, and demographic groups such as labourers. Steve fell into these categories. The review identified an opportunity to strengthen the local suicide prevention strategy by seeing suicide prevention through the lens of domestic abuse in accordance with recent research.

17.2.4 The review also highlighted a dichotomy in respect of BMJ advice on 'safety planning' and of suicidal ideation and its practical application that will be taken forward by Public Health.

Multi-agency working - Communication and Co-operation and MARAC

17.2.5 The absence of a multi-agency appreciation of the situation is one of the most important lessons learned from this review. Information was shared between agencies in a linear fashion of agency to agency, but no overall picture of the relationship was available or sought. Escalating risk was not identified and the absence of a partnership policy on repeat domestic abuse incidents in accordance with previous HMIFCRS findings, proved to be a barrier to a multi-agency (MARAC) conversation that would have brought agencies together to secure a holistic overview of the circumstances. Linked to not recognising repeats as a barrier, is the current pathway for MARAC referrals going through IDVAs to refer, that creates another barrier and possible delay to multi-agency discussion.

Recognition, response, and professional curiosity

17.2.6 The review identified the need to promote professional curiosity across all agencies to help recognise and respond to domestic abuse. Intrinsic to this, remains the need to maintain comprehensive training and awareness, - in healthcare improvements to recognition and response to domestic abuse can be made through routine enquiry and reference to NICE guidelines health indicators of domestic abuse (QS116) that includes suicidal tendencies or self-harming , - through the improved use of coding to record suicidal ideation/self-harm in medical practice, - in the police through effective use of DASH/ BRAG tools and recognising the need to deal with cross allegations appropriately, - in children's services by developing the approach on the whole family.

17.2.7 Whilst recognising the subsequent cultural change programme undertaken by police, the review identified missed investigative opportunities and the opportunity to enhance the status of domestic abuse investigations by more timely supervision of crimes (within one day) that applies to all crime (seven and twenty-eight days). After all evidence gathering for domestic abuse is particularly time sensitive.

Unconscious bias

17.2.8 The potential for unconscious bias was apparent across multiple agencies. The police recognise the risk of domestic abuse being seen as a women's issue, not recognising familial abuse as domestic abuse. The fact that Steve himself did not recognise the circumstances as being domestic abuse may have impeded him securing the help he needed, suggesting a need for a wider piece of work to raise awareness. This potential for unconscious bias was similarly reflected by the UHBWFT and by housing.

Call handling

17.2.9 The review identified assurance opportunities in respect of police handling of calls to specific localities and to ensure that policies regarding decisions to take no further action are adhered to.

Risk Management

17.2.10 The review shone a light on unusual circumstances of a victim living with the perpetrator under probation supervision, and owing to the gravity of offence, Steve as the victim did not qualify for a victim liaison officer. It found that there had been deficiencies in the quality of risk management and planning, but that revised frameworks/policy and the National Probation Service now managing all offenders has resulted in improved supervision.

17.2.11 There was an acknowledgement by Probation Service that risk guidance is not specifically designed to predict all behaviours associated with domestic abuse. The IMR author acknowledges that the emphasis is on intimate partner violence, not interfamilial abuse indicating a gap in service guidance on DA.

17.3 Good Practice Identified and Significant Developments

17.3.1 GP

- Communication between MARAC and GP that alerts the practice to high-risk cases.

17.3.2 Avon and Somerset Police

- The significant cultural change programme, aligned with a performance and quality assurance framework.
- DA Procedural Guidance

17.3.3 UHBWFT

- The Mainstreaming of HEADSS (Home, Education/Employment, Activities, Drugs, Sex and relationships, Self-harm and depression, Safety) initiative into hospital practice is seen as good practice that will assist in identifying vulnerable people such as Steve.
- Hospital IDVAs

17.3.4 Bristol City Council Children's Social Care

- The embedding of domestic abuse practitioners and use of 'signs of safety' model within the service is recognised as good practice.

17.3.5 Bristol City Council Housing and Landlord Services

- A housing IDVA embedded into service.
- Seeking DAHA accreditation will transform practice.

17.3.6 Education services

- Operation Encompass to alert schools of domestic incidents
- Alert Board and password system for supporting safe pick up and drop off with parents/carers.

18. RECOMMENDATIONS

18.1 Local Recommendations (Individual Agency)

18.1.1 GP Practice

- To ensure DVA risk is documented and coded in GP records.

18.1.2 Police

- LSU to increase supervisory oversight through audits and dip sampling.
- LSU to review the feasibility of implementing a process to identify multiple domestic abuse incidents between the same two parties regardless of their victim/suspect status.

18.1.3 UHBWFT

- To complete a focused piece of work to promote the Think Family agenda across all ED's.
- Think Family approach to raise awareness of non- intimate partner abuse.
- Medway alerts and Personal Support Plans to include prompt for staff to sign post to other services.

18.1.4 Education services

- Development of knowledge within the Education Workforce around the Domestic Abuse Act 2021 and the application of the Statutory guidance 2022.
- Development of training and support for the workforce around tackling parental conflict.
- Secure resource for the Police Safeguarding Notification Scheme from the statutory Local Safeguarding Partnership.

18.1.5 Childrens Social Care

- Increase use of family functioning and life story exploration in social work assessments with fathers who are causing harm through domestic abuse.

18.1.6 Partnership

- Commissioning of a male only domestic abuse service.
- Commissioning of male only Refuge accommodation.

18.2 Panel Recommendations

R1	Bristol City Council (Public Health) is to ensure that the link between all victims of domestic abuse and suicide is strengthened and plans to reduce suicide are embedded into partnership work on domestic abuse.	Public Health
R2	The ICB is to improve the ability of GPs to identify signs of domestic abuse and respond with appropriate professional interest that provides opportunities for survivors to disclose abuse.	ICB
R3	The GP practice seeks assurance that it has a system in place that demonstrates the recording of “suicidal ideation or thoughts of self-harm” using the codes as per the system of software in place for patient records.	ICB
R4	Public health to explore the evidence-base for the routine use of ‘safety planning’ tools for those who express suicidal ideation and/or have attempted to take their own lives within the suicide prevention strategy.	Public Health
R5	A&S Police are to ensure that call handling policies and protocols ensure that all outstanding calls to a location are dealt with by the first attending police unit.	Police
R6	A&S Police should conduct assurance work around Domestic Abuse NFA authorisations to check for adherence to current policy. The audit should inform the next steps to be taken to address the findings.	Police
R7	The Bristol City MARAC steering group set a threshold for repeat domestic incidents that results in automatic referral to MARAC, reassures itself that there are no unnecessary delays in referral of cases to MARAC and makes necessary policy adjustments.	Keeping Bristol Safe Partnership
R8	Keeping Bristol Safe Partnership is to coordinate a broad communication campaign targeting professionals and communities to raise awareness of domestic abuse and male victims, and to ensure male survivors know where to go for support.	Keeping Bristol Safe Partnership
R9	Seek to improve the identification of domestic abuse victims by, - emending policy to incorporate self-harm/suicidal ideation as an indicator of abuse, - by adapting the self-harm template to incorporate enquiry about domestic abuse and deliver training on unconscious bias.	UHBWFT
R10	Victim Support is to ensure that all MARAC actions mentioning VS are followed up.	Victim Support
R11	The learning from this review is shared across the partnership to raise awareness of domestic abuse including interfamilial abuse, links to suicide and all the learning opportunities raised.	Keeping Bristol Safe Partnership

APPENDIX A

DOMESTIC HOMICIDE REVIEW TERMS OF REFERENCE:

CASE OF STEVE

This Domestic Homicide Review is being completed to consider agency involvement with **Steve** and **David** following the death of Steve in **April 2021.** The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose of DHR

1. To review the involvement of each individual agency, statutory and non-statutory, with **Steve** and **David** during the relevant period of time **01.04.2017** to **April 2021**.
2. To summarise agency involvement prior to **01.04.2017**.
3. To 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.
4. To 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.
5. To apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
6. To 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.
7. To contribute to a better understanding of the nature of domestic violence and abuse.
8. Identify good practice.

Key Lines of Inquiry

A. Analyse the **communication and co-operation** which took place within and between agencies regarding **Steve**.
B. Analyse the opportunity for agencies to identify and **assess the risk of domestic abuse** or **self-harm**, including what would have enabled or hindered disclosure.
C. Analyse agency **responses to any identification of domestic abuse or self-harm** issues. (*Including referrals, treatment, safety, and crisis planning*)
D. Analyse organisations' **access to specialist domestic abuse agencies**.
E. Analyse the **policies, procedures, and training** available to the agencies involved in domestic abuse issues.

F. Analyse any evidence of **seeking help**, as well as considering what might have **helped or hindered access to help and support**.
G. The extent to which **Covid-19** effected agency involvement with Steve.
H. The extent to which **substance misuse** and **financial pressures** impacted/effected Steve's circumstances.
I. The extent to which **'child access'** effected the circumstances of Steve.
J. Consider (a)Steve's **housing situation** had been considered by agencies and (b) whether they considered any obligations to signpost or refer him in respect of his housing situation.
K. The extent to which '**familial abuse'** was recognised as domestic abuse.
L. Analyse whether **Steve's gender** as a male victim had played a part in him being able to access services, and whether he was also seen as a perpetrator.
M. Linked to L. above**, Equalities**: The Review Panel will consider all protected characteristics as noted at paragraph 13.

Role of the DHR Panel, Independent Chair and the KBSP

9. The Independent Chair of the DHR will:
   a) Chair the Domestic Homicide Review Panel.
   b) Co-ordinate the review process.
   c) Quality assure the approach and challenge agencies where necessary.
   d) Produce the Overview Report, Executive Summary and collate action plan by critically analysing each agency involvement in the context of the established terms of reference.

10. The Review Panel:
   a) Agree robust terms of reference incorporating those terms of reference that wish to be included by family and friends of the victim.
   b) Ensure appropriate representation of your agency at the panel: panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.
   c) Prepare Individual Management Reviews (IMRs) and chronologies through delegation to an appropriate person in the agency.
   d) Discuss key findings from the IMRs and invite the author of the IMR (if different) to the IMR meeting.
   e) Agree and promptly act on recommendations in the IMR Action Plan.
   f) Ensure that the information contributed by your organisation is fully and fairly represented in the Overview Report.
   g) Ensure that the Overview Report is of a sufficiently high standard for it to be submitted to the Home Office, for example:
      - The purpose of the review has been met as set out in the ToR;
      - The report provides an accurate description of the circumstances surrounding the case; and
      - The analysis builds on the work of the IMRs and the findings can be substantiated.

h) To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.
i) On completion present the full report to the Keeping Bristol Safe Partnership.
j) Implement your agency's actions from the Overview Report Action Plan.

Keeping Bristol Safe Partnership working with the DHR Chair:

a) Submit the Executive Summary, Overview Report and Action Plan to the Home Office Quality Assurance Panel.
b) Working with the Chair of the DHR forward Home Office feedback to the family, Review Panel and KBSP.
c) Agree publication date and method of the Executive Summary and Overview Report.
d) Notify the family, Review Panel and KBSP of publication date.

Definitions: Domestic Violence and Coercive Control

11. The Overview Report will make reference to the term's domestic violence and coercive control. The Review Panel understands and agrees to the use of the cross-government definition (amended March 2013) as a framework for understanding the domestic violence experienced by the victim in this DHR. The cross-government definition states that domestic violence and abuse is:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence, or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.
Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."
This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group."

12. The overview report will make reference to the term domestic abuse and the statutory definition as per the Domestic Abuse Act.

(1) This section defines "**domestic abuse**" for the purposes of this Act.

(2) Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if—

(a) **A and B** are each **aged 16 or over** and are **personally connected** to each other, and

(b) the behaviour is abusive.

(3) Behaviour is **"abusive"** if it consists of any of the following—

(a) physical or sexual abuse;

(b) violent or threatening behaviour;

(c) controlling or coercive behaviour;

(d) economic abuse (see subsection (4));

(e) psychological, emotional, or other abuse;

and it does not matter whether the behaviour consists of a single incident or a course of conduct.

(4) "**Economic abuse**" means any behaviour that has a substantial adverse effect on B's ability to—

(a) acquire, use, or maintain money or other property, or

(b) obtain goods or services.

(5) For the purposes of this Act A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child).

Equality and Diversity

13. The Review Panel will consider all protected characteristics (as defined by the Equality Act 2010) of both **Steve** and **David** (age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation) and will also identify any additional vulnerabilities to consider.

Parallel Reviews

14. Coronial proceedings continue in parallel. The inquest is scheduled for the 15th December 2021 and the coroner's officer has been appraised of this review

Membership

15. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.
16. The following agencies are to be on the Review Panel:

Agency
Avon and Somerset Police
Avon and Wiltshire Mental Health Partnership
BNSSG ICB on behalf of GP
Bristol City Council Childrens and Families Services
Bristol City Council Housing and Landlord Services
Bristol City Council Public Health

Drug and Alcohol Services
ManKind Initiative
Probation Service
Bristol City Council Safeguarding in Education team
University Hospitals Bristol and Weston NHS Trust

DHR Chair Role and the Panel

17. **Mark Wolski** has been commissioned to independently chair this DHR. His contact details will be provided to the panel and you can contact them for advice and support during this review.

Collating information to support the review.

18. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted and secure all relevant records.
19. Chronologies and Individual Management Review (IMRs) will be completed by the following organisations known to have had contact with **Steve** and **David** during the relevant time period:
20. Each IMR will:
    - Set out the facts of their involvement with **Steve** and **David**
    - Critically analyse the service they provided in line with the specific terms of reference (key lines of enquiry).
    - Identify any recommendations for practice or policy in relation to their agency.
    - Consider issues of agency activity in other areas and review the impact in this specific case.

Development of an action plan

21. Individual agencies to take responsibility for establishing clear action plans for the implementation of any recommendations in their IMRs with clear owners and completion dates of those actions. The Overview Report will make clear that agencies should report to Bristol City KBSP on their action plans within 3 months of the Review being completed.

Liaison with the victim's family and [alleged] perpetrator and other informal networks

22. The review will sensitively attempt to involve the family of Steve in the review. The chair will lead on family engagement.

23. **Steve's** father **David** will be invited to participate in the review.
24. Family liaison will be coordinated in such a way as to aim to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.
25. The Review Panel discussed involvement of other informal networks of the Steve and David and will consider such involvement as the review progresses.

Media handling

26. Any enquiries from the media and family should be forwarded to BCKBSP who will liaise with the chair and associated agencies communications leads. Panel members are asked not to comment if requested. The BCKBSP and its Chair will make no comment apart from stating that a review is underway and will report in due course.
27. The BCKBSP are responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

28. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.
29. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.
30. It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Documents will be password protected.
31. If an agency representative does not have a secure email address, then their non-secure address can be used but all confidential information must be sent in a password protected attachment. The password used must be sent in a separate email.
32. If you are sending password protected document to a non-secure email address it must be a recognisable work email address for the professional receiving information. Information from DHR should not be sent to a gmail / hotmail or other personal email account unless in rare cases when it has been verified as the work address for an individual or charity.
33. No confidential content should be in the body of an email to a non-secure email account. That includes names, DOBs and address of any subjects discussed at DHR.

Disclosure

34. Disclosure of facts or sensitive information will be managed and appropriately so that problems do not arise. The review process will seek to complete its work in a timely fashion in order to safeguard others.

35. The sharing of information by agencies in relation to their contact with the victim and/or the alleged perpetrator is guided by the following:
    a) The Data Protection Act 1998 governs the protection of personal data of living persons and places obligations on public authorities to follow 'data protection principles'.
    b) The 2016 Home Office Multi-Agency Guidance for the Conduct of DHRs (Guidance) Section 10 outlines data protection issues in relation to DHRs (Par 98).

c) Data Protection Act and Living Persons: The Guidance notes that in the case of a living person, for example the perpetrator, the obligations do apply. However, it further advises in Par 99 that the Department of Health encourages clinicians and health professionals to cooperate with domestic homicide reviews and disclose all relevant information about the victim and where appropriate, the individual who caused their death unless exceptional circumstances apply.

d) Where record holders consider there are reasons why full disclosure of information about a person of interest to a review is not appropriate (e.g. due to confidentiality obligations or other human rights considerations), the following steps should be taken:
    - The review team should be informed about the existence of information relevant to an inquiry in all cases; and
    - The reason for concern about disclosure should be discussed with the review team and attempts made to reach agreement on the confidential handling of records or
    - partial redaction of record content.

e) Human Rights Act: information shared for the purpose of preventing crime (domestic abuse and domestic homicide), improving public safety, and protecting the rights or freedoms of others (domestic abuse victims).

f) Common Law Duty of Confidentiality outlines that where information is held in confidence, the consent of the individual should normally be sought prior to any information being disclosed, with the exception of the following relevant situations – where they can be demonstrated:
    i) It is needed to prevent serious crime.
    ii) there is a public interest (e.g., prevention of crime, protection of vulnerable persons)

APPENDIX B – CONTACT WITH FAMILY

Date and time of contact (or attempt)	Name and relationship to victim of individual contacted	Mode of contact (Phone, email, text etc.)	Outcome of contact
26.10.2022	Mother	Letter from KBSP	No response
26.10.2022	Former Partner	Letter from KBSP	No response
26.10.2022	Uncle (brother of David)	Email to uncle	
08.11.2022	Uncle (brother of David)	Email from uncle to KBSP	Declines to take part and explains brother unwell
12.11.2022	Uncle (brother of David)	Email from chair to uncle	As below
12.11.2022	Uncle (brother of David)	Email from uncle to chair	Declines to take part as above.
03.01.2023	Mother	Letter from chair	No response
03.01.2023	Former Partner	Letter from chair	No response
10.10.2023	Uncle (brother of David)	Email from chair	No response
27.12.2023	Mother	Letter from chair	No response
27.12.2023	Former Partner	Letter from chair	No response
27.12.2023	Uncle (brother of David)	Email from chair to uncle (brother of David)	No response

APPENDIX C – STATUTORY DEFINITION FOR DOMESTIC ABUSE

Domestic Abuse Statutory Definition.

(1) This section defines "**domestic abuse**" for the purposes of this Act.

(2) Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if—

(a) **A and B** are each **aged 16 or over** and are **personally connected** to each other, and

(b) the behaviour is abusive.

(3) Behaviour is **"abusive"** if it consists of any of the following—

(a) physical or sexual abuse;

(b) violent or threatening behaviour;

(c) controlling or coercive behaviour;

(d) economic abuse (see subsection (4));

(e) psychological, emotional, or other abuse;

and it does not matter whether the behaviour consists of a single incident or a course of conduct.

(4) "**Economic abuse**" means any behaviour that has a substantial adverse effect on B's ability to—

(a) acquire, use, or maintain money or other property, or

(b) obtain goods or services.

(5) For the purposes of this Act A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child).

Controlling and Coercive behaviour

(1)A person (A) commits an offence if—

(a)A repeatedly or continuously engages in behaviour towards another person (B) that is controlling or coercive,

(b)at the time of the behaviour, A and B are personally connected,

(c)the behaviour has a serious effect on B, and

(d)A knows or ought to know that the behaviour will have a serious effect on B.

(2)A and B are "personally connected" if—

(a)A is in an intimate personal relationship with B, or

(b)A and B live together and—

(i)they are members of the same family, or

(ii)they have previously been in an intimate personal relationship with each other.

Note: On 29 April 2021, the Domestic Abuse Act 2021 (the 2021 Act) received Royal Assent. Section 1(3)(c) of the 2021 Act created a statutory definition of domestic abuse, which encompasses a range of abusive behaviours, including controlling or coercive behaviour. Section 2 of the 2021 Act defines the term "personally connected" for the purpose of the relationship criteria in section 1(2)(a) of the 2021 Act. Under section 68 of the 2021 Act, the definition of "personally connected'' was amended in section 76 of the 2015 Act. This removed the "living together'' requirement for the controlling or coercive behaviour offence, which means that as of April 2023, the offence applies to intimate partners, ex-partners or family members, regardless of whether the victim and perpetrator live together.[82]

[82] Source: controlling or coervice behaviour statutory guidance consultation response. (publishing.service.gov.uk) (Accessed Sept 2023)

APPENDIX D – LEARNING OPPORTUNITIES

Learning Opportunity	R.'tion Y/N	Agency R.'tion or Response	Agency
Learning Opportunity (LO1): Within the Bristol Suicide Prevention Strategy and Plan, an Opportunity to recognise domestic abuse as a vulnerability/characteristic for those who may take their own lives.	R1		Public Health
Learning Opportunity (LO2): To improve the recognition and response to signs of domestic abuse, demonstrating improved professional curiosity and asking about domestic abuse.	R2	N	ICB
Learning Opportunity (LO3): To recognise and follow up on domestic abuse alerts.	n/a	Y	ICB
Learning Opportunity (LO4): Use of flagging a history of suicidal ideation to prompt improved professional curiosity.	R3		ICB
Learning Opportunity (LO5): Seek assurance that safety plans are completed.	R4		ICB
Learning Opportunity (LO6): To update the safeguarding policy in accordance with change in definition to domestic abuse, and regarding the recognition of and response to Domestic Abuse.	R2		ICB
Learning Opportunity (LO7): To strengthen the approach to training, to ensure staff are able to recognise and respond to domestic abuse.	R2		ICB
Learning Opportunity (LO8) : To ensure that DASH checklists are completed for all domestic abuse incidents, and where there cross allegations, complete for both parties.	**n/a**	Y	Police
Learning Opportunity (LO9): Professionals to be alert to the potential for unconscious bias, recognising father versus adult son as domestic abuse. .	n/a	**N – (DA Matters programme)**	Police
Learning Opportunity (LO10): Encourage professional curiosity through use of BRAG to provide insight into vulnerability.	n/a	**N – (T & A programme in place)**	Police
Learning Opportunity (LO11): To ensure that police deal with all outstanding calls to a location where there is more than one call.	R5		Police
Learning Opportunity (LO12): To improve identification of repeat/multiple domestic abuse incidents between the same two parties, refer to MARAC thereby improving overall MARAC referral rates. (or MARAC review)	n/a	Y	Police
Learning opportunity (LO13): To ensure all decisions to take no further action in domestic abuse cases are overseen by an Inspector in accordance with policy.	R6	**Plus other initiatives**	Police
Learning Opportunity (LO14): To improve on understanding in the community of what constitutes domestic abuse, including interfamilial abuse of adult parent versus adult child**.**	R8		Police
Learning Opportunity (LO15): To ensure male victims are appropriately informed of specialist domestic abuse services/advice lines as well as generic providers.	n/a	Y + VIP pack	Police
Learning Opportunity (LO16): Recognising that the current policy of IDVA referring to MARAC builds in a **system delay** to cases being heard at the MARAC.	R7		Police
Learning Opportunity (LO17): To ensure that the multiple vulnerabilities of the victim in this case, inform the development of the victim information pack currently under development.	n/a	VIP	Police
Learning Opportunity (LO18): To consider the extent to which special measures are used in respect to intimidated victims of domestic abuse.	R6	+ Other ongoing work	Police
Learning Opportunity (LO19): Recognising the impact of parental responsibility on male victims of domestic abuse.	R11		Police
Learning Opportunity (LO20): Recognition of the intersection of multiple vulnerabilities between accommodation needs, financial control and coercion and impact on a victim's state of mind.	R11		Police
Learning Opportunity (LO21): The intersection of unconscious bias by officers, and Steve not recognising his circumstances as being domestic abuse risked the gravity of his circumstances being recognised and being appropriately signposted and willing to engage with support.	R8		Police
Learning Opportunity (LO22): To improve the recognition and response to signs of domestic abuse, demonstrating improved professional curiosity and asking about domestic abuse	n/a	Y	UHBWFT
Learning Opportunity (LO23): To update the local domestic abuse policy lists of signs and symptoms to include self-harm and suicide.	R9	N	UHBWFT
Learning Opportunity (LO24): To adapt the self-harm template to reference domestic abuse, to improve the recognition and response to signs of domestic abuse, demonstrating improved professional curiosity and asking about domestic abuse on presentation of indicators of domestic abuse	R9	N	UHBWFT
Learning Opportunity (LO25): Seek assurance that safety plans are completed.	**R4**		UHBWFT
Learning Opportunity (LO26): Professionals to be alerted to the possibility of unconscious bias	R9	N	UHBWFT
Learning Opportunity (LO27): To have identified (a) frequent attendance at hospital seeking opiate pain killers as indicative of substance misuse and (b) admitted class A drug use, as requiring further professional curiosity and signposting for support.	n/a	Y	UHBWFT
Learning Opportunity (LO28): Mainstreaming of HEADSS recognised as a positive initiative	n/a	n/a	UHBWFT
Learning Opportunity (LO29): To show more professional curiosity, seeking to understand experience of violence may link to child abuse.	n/a	Y	Childrens
Learning Opportunity (LO30): To have explored the family history of Steve, to inform an improved trauma informed approach.	n/a	Y	Childrens

Learning Opportunity (LO31): To remind professionals of the need to seek and record accurate records of court orders/injunctions in relation to private law proceedings and civil orders.	**n/a**	**Y**	Childrens
Learning Opportunity (LO32): To improve the sharing between the homelessness team and estate management teams.	n/a	Y	Housing
Learning Opportunity (LO33): Improve the recognition of interfamilial domestic abuse especially between father and son (males) and how to support disclosure/ accessing support services.	n/a	Y	Housing
Learning Opportunity (LO34): The need to recognise abuse by family members on male victims as domestic abuse	n/a	Y	Housing
***Learning* Opportunity (LO35):** Probation practitioners to follow up appropriate lines of enquiry with improved levels of professional curiosity.	n/a	Y	Probation
Learning Opportunity (LO36): To improve the quality of risk management, through supervisory oversight and adherence to policy requirements.	n/a	Agency changes	Probation
Learning opportunity (LO37): Ensuring that probation service is alerted to arrest involving clients under probation supervision.	n/a	Agency changes	Probation
Learning opportunity (LO38): Probation to have an improved focus on familial domestic abuse.		Agency changes	Probation
Learning opportunity (LO39): Improved professional curiosity and consideration of the impact of problematic drug use within the family on the person subject to probation supervision.	n/a	Agency changes	Probation
Learning opportunity (LO40): To ensure that MARAC actions mentioning VS (even if not owned) by VS are followed up.	**R10**		Victim Support

APPENDIX E – LIVE DHR ACTION PLAN

Recommendation	Scope	Action to take	Lead Agency	Key Milestones achieved	Target Dates	Date of completion and outcome
R1: Bristol City Council (Public Health) is to ensure that the link between all victims of domestic abuse and suicide is strengthened and plans to reduce suicide are embedded into partnership work on domestic abuse.	Local	(i)Ensure accessing mental health support is included in the upcoming Domestic Abuse and Sexual Violence Strategy for Bristol; improving access for victims, support navigating the system and being aware of what is available. (ii)Suicide to be included in the upcoming delivery/action plan that has oversight from the MADASV Delivery Group (iii) Improve links with unexpected death surveillance to identify trends (iv)Explore avoidable death approach with other local authorities and implement relevant learning/recommendations	BCC Public Health	Inclusion of related outcomes/ambitions in published strategy.	May 2025	(i)Strategy published in Dec 2024 includes following ambition: *4Aii) Enhance access to mental health support for victims of domestic abuse and sexual violence by developing a streamlined system that simplifies navigation. Implement strategies to improve awareness among victims and services ensuring they have comprehensive information on the mental health resources* accessible *to them.* (ii)Action plan currently in development (iii) Links have been made with unexpected deaths surveillance team and invited to sit on SAR/DHR sub group. (iv) Met with Plymouth to understand their avoidable approach in February 2024.
R2: The ICB is to improve the ability of GPs to identify signs of domestic abuse and respond with appropriate professional interest that provides opportunities for survivors to disclose abuse.	Local	For the GP practice to review current safeguarding polices and training for Domestic Abuse and routine enquiry. To bring the DA policy up to date in respect of DA Act, and routine enquiry	ICB/GP	Review Complete. Policy updated.	January 2025	Completed: January 2025 Outcome: Improved staff awareness and ability to recognise indicators of domestic abuse.

		To ensure that staff within practice are trained in alignment with Level 1, level 2 and level 3 expectations, and that this is monitored by the safeguarding practice lead. Bring the learning of this review to practice staff		Staff trained. Review learning shared.		Increased identification of victims of domestic abuse, and signposting of victims to appropriate specialist support.
R3: The GP practice seeks assurance that it has a system in place that demonstrates the recording of "suicidal ideation or thoughts of self-harm" using the codes as per the system of software in place for patient records.	Local	The Practice will apply a system of audit, to examine a sample of adult records six-monthly to check the quality of summarising and coding. To encourage the use of coding of medical records using a consistent system the practice has in place as per the system of software in place.	ICB/GP	Audit in place. Coding used routinely.	March 2025 March 2025	Completed: March 2025 1: The practice will now run 6 monthly audits and pick a random consultation from each clinician to be audited by the Partners. 2: They have always had a monthly Child safeguarding meeting – this has now changed to an "All Safeguarding meeting" which will cover all ages of safeguarding, which will start April 2025. Our clinical staff will be made aware of cases to be raised at this meeting, which will include those where a deliberate self-harm attempt has been made. During our meeting on 7/2/25 we were assured this already happens using EMIS codes as needed for problems/ diagnosis. Outcome: Enhance staff awareness of codes that encourage routine professional curiosity for patients with a history of suicidal ideation. More regular routine professional curiosity for patients who have a history of suicidal ideation.

R4: Public health to explore the evidence-base for the routine use of 'safety planning' tools for those who express suicidal ideation and/or have attempted to take their own lives within the suicide prevention strategy	Local	Review the available evidence on safety planning and similar interventions to make recommendations.	BCC Public Health	Suicide safety planning interventions reviewed.	December 2025	Not yet in progress. Outcome: A better-informed understanding as to the efficacy of 'safety planning' that informs local policy and practice options.
R5: A&S Police are to ensure that call handling policies and protocols ensure that all outstanding calls to a location are dealt with by the first attending police unit.	Force wide	Review polices and call handling /dispatch procedures for clarity Communicate expectations with staff (call handlers, dispatch teams, response officers	Avon and Somerset Police	Policy/procedures updated Staff communications complete.	April 2025	In progress: Update Jan '25: Discovery work ongoing to get details on costs for Salesforce CRM. Decision to be made soon on which way we are going around technology for C&C. Tech being considered: an interface which will pull back data in NICHE and a CRM which will join dots in policing. Outcome: Outstanding calls to same location are dealt with by attending police units. Policies and protocols reflect the outcome, and how this outcome is achieved.
R6: A&S Police should conduct assurance work around Domestic Abuse NFA authorisations to check for adherence to current policy. The audit should inform the next steps to be taken to address the findings.	Force wide	The force will complete an audit to review adherence to current policy.	Avon and Somerset Police	Review complete. Steps to take identified by audit findings. Relevant action taken.	August 2024	Completed: August 2024: As well as supervisor reviews, we now have a regular force scrutiny panel auditing adherence to policy. Assurance in place so Rec closed. Outcome: Better, improved, and consistent standards of investigation contributing to improved positive outcome rates such as evidence-based prosecutions
R7: The Bristol City MARAC steering group set a threshold for repeat domestic incidents that results in automatic referral to MARAC, reassures itself that there are no unnecessary delays in referral of cases to MARAC and makes necessary policy adjustments.	Local	Membership of MARAC steering group to be re-reviewed and TOR to be refreshed. MARAC Steering Group to review current arrangements including threshold for repeat incidents and referral criteria	KBSP MARAC Steering Group	MARAC Steering Group re-established. Revised and updated MARAC referral policy. New guidance will be widely circulated	December 2025	In progress: Steering group has been re-established and is meeting quarterly. The Terms of Reference and all other documentation work will be underway in 2025. Outcome: Revised MARAC thresholds to reduce delays.

				and communicated to all agencies.		
R8: Keeping Bristol Safe Partnership is to coordinate a broad communication campaign targeting professionals and communities to raise awareness of domestic abuse and male victims, and to ensure male survivors know where to go for support.	Local	The KBSP team will develop a communications plan to detail how the findings of the report will be shared professionals and the public, prior to publication. The KBSP team will publish the report and a professional learning briefing, enacting its comms plan	Keeping Bristol Safe Partnership	Communication plan created. Communication plan enacted. Report published.	April 2025	Completed: April 2025 Outcome: Partnership is provided with information on learning opportunities presented by this review.
R9: Seek to improve the identification of domestic abuse victims by, - emending policy to incorporate self-harm/suicidal ideation as an indicator of abuse, - by adapting the self-harm template to incorporate enquiry about domestic abuse and deliver training on unconscious bias.	Local	To review the Liaison Psychiatry proforma and ensure it has a clear focus on self-harm & harm reduction and includes a section relating to safeguarding (including domestic abuse and suicide). To ensure that all psychiatric liaison team staff at induction & team education events are aware of the different forms of abuse including 'domestic abuse.' To identify how the psychiatric liaison team are trained in relation to unconscious bias.	University Hospitals Bristol and Weston NHS Foundation Trust	Liaison Psychiatry proforma reviewed. Domestic Abuse Training included in Inductions. Unconscious bias training.	February 2024	Completed: February 2024. The Liaison Psychiatry proforma has a clear focus on self-harm & harm reduction and includes a section relating to safeguarding. At induction & team education events the different forms of abuse including 'domestic' are discussed as part of a comprehensive bio-psycho-social assessment. The outcomes from the DHR were shared with the Teams at the 'Integrated Governance Meeting in 2023.' The Team has also had discussions on 'conscious inclusion' as part of the Divisional Equality, Diversity and Inclusion work. There is also 'conscious inclusion' training available.
R10: Victim support is to ensure that all actions mentioning VS are followed up.	Local / National	Check current local practice re MARAC actions where VS are named. Local VS procedure to be reviewed for any improvements that could be made to ensure robust system across the team for ensuring MARAC actions are completed.	Victim Support	Local practice has changed since this incident and MARAC actions where VS are named are recorded on our case management	February 2024	Completed: February 2024. More robust practice already in place.

		VS National DA Lead to be made aware to assess whether any changes required to wording of national VS DA policy regarding MARAC actions where VS is named as well as those where we are deemed to be owner. Once in post, new VS Senior IDVA will attend DHR training session with New Era, VS' large DA service in Staffordshire in March to ensure best practice is shared at an early stage.		system as well as those, we 'own'. Exploration underway of ways to use new case management system to facilitate this. Change proposed to DA Lead regarding alteration of wording of VS DA policy.		
R11: The learning from this review is shared across the partnership to raise awareness of domestic abuse including interfamilial abuse, links to suicide and all the learning opportunities raised.	Local	The KBSP team will develop a communications plan to detail how the findings of the report will be shared professionals and the public, prior to publication. The KBSP team will publish the report and a professional learning briefing, enacting its comms plan	Keeping Bristol Safe Partnership	Communication plan created. Communication plan enacted. Report published	April 2025	Completed: April 2025 Outcome: Partnership is provided with information on learning opportunities presented by this review.
Single Agency (SA) Action Plan						
SA.1: To ensure DVA risk is documented and coded in GP records.	Local	GP Practice to ensure GP follow up actions from MARAC meetings are documented and coded in patients' records with follow up plans clearly stated.	ICB/GP	DVA risk recorded and coded in patient records. Follow ups clearly stated.	January 2025	Completed: Jan '25: MARAC meeting information and actions clearly documented and coded in patients records to enable all GPs to be fully informed regarding potential domestic abuse risks, to review risk at all subsequent contacts and contribute to individual patients MARAC action plans.
SA.2: LSU to increase supervisory oversight through audits and dip sampling	Local	LSU to develop procedure.	LSU (Avon and Somerset Police)	Consistency in contacting DA victims where a crime is recorded.	December 2024	Completed: Dec '24 - a task & finish group has been set up within the LSU to review performance frameworks with the priority being supervisory and 121 frameworks for first-line managers. Remains within existing priorities.

SA.3: LSU to review the feasibility of implementing a process to identify multiple domestic abuse incidents between the same two parties regardless of their victim/suspect status	Local	To be reviewed as part of the current LSU Service Delivery Review.	LSU (Avon and Somerset Police)	Process reviewed to ensure timely and appropriate referrals for cross agency support.	December 2024	Completed: Dec '24 - part of the LSU review. Automation and Robotics is a workstream relating to the LSU Implementation Board, and this activity has been picked up within it.
SA.4: To complete a focused piece of work to promote the Think Family agenda across all ED's.	Local	Re circulate safeguarding posters/prompts for staff in E.D, raise through the E.D governance group & APOG, ED Matrons and IDSVA .To disseminate the learning from this DHR to E.D, via training and safety briefings.	University Hospitals Bristol and Weston NHS Foundation Trust	Safeguarding posters/prompts circulated. Learning disseminated.	December 2022	Completed: All staff in E.D have had a reminder on the Think Family agenda. We have an IDVA team based in ED to support with safeguarding issues. We are also intending to relaunch our safeguarding link professionals where we can update on training like this.
SA. 5: Think Family approach to raise awareness of non- intimate partner abuse.	Local	As above Learning form this DHR will inform practice. Training packages to inform staff of the victim/perpetrator interface	University Hospitals Bristol and Weston NHS Foundation Trust	Learning disseminated. Training updated	December 2022	Completed as above: We have an IDVA team based in ED to support with safeguarding issues. We are also intending to relaunch our safeguarding link professionals where we can update on training like this.
SA.6: Medway alerts and Personal Support Plans to include prompt for staff to sign post to other services	Local	High impact user team and Mental health liaison teams to be briefed to add request for sign posting when possible (Medway alerts and Personal Support Plans)	University Hospitals Bristol and Weston NHS Foundation Trust	Request for signposting included for all alerts and Personal Support Plans	December 2022	Completed: This has been actioned by the high impact user team / MH liaison.
SA.7: Development of knowledge within the Education Workforce around the Domestic Abuse Act 2021 and the application of the Statutory guidance 2022.	Local	Ensure that there is appropriate 'Tackling domestic abuse in Education' training which is reviewed and accessible to the education workforce.	Bristol City Council Safeguarding in Education Team.	Ensure that all education practitioners can expand their role and duties towards recognising domestic abuse beyond the traditional abuse that happens in intimate relationships.	August 2025	Not yet in progress.

SA.8: Development of training and support for the workforce around tackling parental conflict.	Local	Ensure that a post can strategically and operationally utilise secured funding from the Early Intervention Foundation.	Bristol City Council Early Intervention Services	Develop and deliver training for families and professionals where conflict has not met the threshold for domestic abuse services.	August 2025	Not yet in progress.
SA.9: Secure resource for the Police Safeguarding Notification Scheme from the statutory Local Safeguarding Partnership	Local	Education settings need access to information in a timely manner. The work needs appropriate levels of resourcing that meets Bristol's needs and the volume of notifications that need to be shared with Bristol's education settings.	Bristol City Council Safeguarding in Education Team /The Keeping Bristol Safe Partnership Executive	Ensure that education settings are able to receive information around where domestic abuse may be present and ensure that they are able to put in place early intervention and/or make referrals to statutory agencies where the impact on the child can be evidenced.	March 2025	Completed: March 2025 Operation EMCOMPASS is now statutory.
SA.10: Increase use of family functioning and life story exploration in social work assessments with father who are causing harm through domestic abuse	Local	Bristol City Council Children's Services to share the learning from this case through the Domestic Abuse Advanced Practitioners to social workers – reinforcing the need to engage with fathers who harm others to explore their own experiences of violence	Bristol City Council Children's Services	Assessments are more nuanced and identify the holistic experiences of violence impacting parenting functioning improving interventions and capacity for meaningful change	December 2022	Domestic Abuse advanced practitioners no longer in post and so the delivery of this action needs to be reconsidered – possibly a DHR learning event for social workers.
SA.11: Commissioning of a male only domestic abuse service.	Local	Male domestic abuse services to be commissioned using a full open tender process as part of the wider commissioning of Domestic Abuse services.	The Keeping Bristol Safe Partnership	Provider commissioned.	October 2023	Completed. Victim Support are sub-contracted to commission a male only Domestic Abuse Service which is part of the Next Link Plus Partnership. Next Link staff also work with male victims in some settings, for example hospitals.
SA.12: Commissioning of male only Refuge accommodation.	Local	Male Safe House to be included in the service specification for the provision of safe accommodation for victims of Domestic Abuse.	The Keeping Bristol Safe Partnership	Male Safe House commissioned.	October 2022	Completed. October 2022. Under Support in Safe Accommodation contract which

						began in October 2022 there is now a Male Safe House.

APPENDIX F – MY SAFETY PLAN

My Safety Plan

CONNECTING WITH PEOPLE

Getting through right now
Making your situation safer
Things to lift or calm your mood
Things to distract you
People to support you
List who you can talk to if you are distressed or thinking about self-harm or suicide
Emergency professional support

APPENDIX G – ONE PAGE SUMMARY

1. Domestic Homicide Review

The Keeping Bristol Safe Partnership commissioned this DHR following Steve taking his own life in April 2021.

2. Case Summary

Steve was aged 24 at the time of his death. In April 2021, police were called by the ambulance service to Steve's rented accommodation where he had been found hanging in his room by two housemates and Steve's mother.

The police conducted a comprehensive investigation and, as there was no third-party involvement, the matter was passed to the coroner and the inquest concluded death by suicide.

The review was commissioned based on the recorded events of domestic abuse by his father during the relevant period prior to Steve's death.

3. The Facts – an overview

Steve was staying in lodgings with a couple at the time of his death, having lived in the family home with his father until a few months previously.

Steve had a disjointed upbringing, living with his father and grandmother for a period, during which he had been diagnosed with ADHD, possible low self-esteem and potential communication and learning needs. Aged 15, Steve moved back in with his mother following disruptive behaviour and two school moves.

Aged 17, following medical procedures and undiagnosed abdominal pains Steve developed a dependency on medication.

As a young adult, Steve moved back in with his father and took up work as a scaffolder. He had a partner with whom he had a child but had restricted access following one reported incident of domestic abuse (*August 2018*).

During the relevant period, police attended seventeen incidents involving Steve (including the incident above). Most incidents were of a domestic nature between Steve and his father. On one occasion his father was arrested, charged, and convicted for an assault against Steve. His father was then supervised by the Community Rehabilitation Company prior to the re-integration into the Probation Service. Steve remained resident with his father in the same accommodation (Father's house) and when he sought housing he was not identified as having priority need (victim of DA).

The practical effect of Covid at the time was also to isolate Steve and his father from others and require them to remain in the same household.

Other linked incidents also included attempts by Steve to take his own life (*Overdose August 2018, and attempted hanging December 2020*).

The review highlighted elements of controlling behaviour by Steve's father (*reportedly having to seek permission to use the kitchen and bathroom*) and potential financial abuse (*in respect of rent paid to father*) in addition to physical abuse.

Steve's drug habit also extended to illegal drugs, reportedly being in debt to drug dealers, and that with reported letters from HMRC proximate to his death added to Steve's worries.

4. Learning Points

Vulnerabilities: The intersection of multiple vulnerabilities *(substance misuse, mental health)* and worries *(child access, covid)* is apparent from this review.

Suicide Prevention: The review identified opportunities to strengthen the local strategic approach to suicide prevention by seeing it through the lens of domestic abuse and to consider the merits / practicalities of suicide safety planning.

Recognition & response (R&R): There remains a need for improved R&R of DA via professional curiosity, training, routine enquiry and recognising suicide/self-harming links to DA.

Unconscious bias: The risk of unconscious bias was apparent, not recognising familial abuse as DA, and thinking a young fit scaffolder could be at risk of such abuse.

4. Learning Points (Continued)

Partnership working: Steve's circumstances did not benefit from a multi-agency perspective of the relationship between father and son where escalating risk was not identified, with the case being heard only once at MARAC despite multiple domestic abuse related contacts.

Call Handling: Opportunities to seek assurance around police call handling to the same location and decisions to take no further action being in accordance with policy.

Risk Management: An opportunity to strengthen the development of probation risk management regarding domestic abuse in the planned redesign of risk tools in the redesign of systems.

5. Good Practice

GP: Communication between MARAC and GP

Police: Significant cultural change programme together with performance and quality assurance regime plus DA procedural guidance.

Hospital: Mainstreaming of HEADSS (Home, Education/ Employment, Activities, Drugs, Sex and relationships, Self-harm and depression, Safety) initiative for patients plus IDVA provision.

Children's Services: embedding of domestic abuse practitioners and use of 'signs of safety' model within the service.

Housing: Seeking DAHA accreditation plus a housing IDVA embedded into service.

Education services: Operation Encompass and use of an 'Alert Board' for supporting safe pick up and drop off for parents/carers.

6. Recommendations

R1: Bristol City Council (Public Health) is to ensure that the link between all victims of domestic abuse and suicide is strengthened and plans to reduce suicide are embedded into partnership work on domestic abuse.

R2: The ICB is to improve the ability of GPs to identify signs of domestic abuse and respond with appropriate professional interest that provides opportunities for survivors to disclose abuse.

R3: The GP practice seeks assurance that it has a system in place that demonstrates the recording of "suicidal ideation or thoughts of self-harm" using the codes as per the system of software in place for patient records.

R4: Public health to explore the evidence-base for the routine use of 'safety planning' tools for those who express suicidal ideation and/or have attempted to take their own lives within the suicide prevention strategy.

R5: A&S Police are to ensure that call handling policies and protocols ensure that all outstanding calls to a location are dealt with by the first attending police unit.

R6: A&S Police should conduct assurance work around Domestic Abuse NFA authorisations to check for adherence to current policy. The audit should inform the next steps to be taken to address findings.

R7: The Bristol MARAC steering group set a threshold for repeat domestic incidents that results in automatic referral to MARAC, reassures itself that there are no unnecessary delays in referral of cases to MARAC and makes necessary policy adjustments.

R8: KBSP to coordinate a broad communication campaign targeting professionals and communities to raise awareness of domestic abuse and male victims, and to ensure male survivors know where to go for support.

R9: UBHWT: Seek to improve the identification of domestic abuse victims by, - emending policy to incorporate self-harm/suicidal ideation as an indicator of abuse, - by adapting the self-harm template to incorporate enquiry about domestic abuse and deliver training on unconscious bias.

R10: Victim support is to ensure that all MARAC actions mentioning VS are followed up.

R11: The learning from this review is shared across the partnership to raise awareness of domestic abuse including interfamilial abuse, links to suicide and all the learning opportunities raised.

APPENDIX H – HOME OFFICE FEEDBACK LETTER

Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848
www.homeoffice.gov.uk

Statutory Review Officer Keeping Bristol
Safe Partnership KBSP Business Unit
(City Hall) Bristol City Council
PO Box 3399
Bristol BS1 9NE

17th December 2024

Dear the Keeping Bristol Safe Partnership,

Thank you for submitting the Domestic Homicide Review (DHR) report (Steve) for Bristol Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 20th November 2024. I apologise for the delay in responding to you.

The QA Panel noted that this was a strong and sensitively written report. They noted that the report was reflective of the victim, despite a lack of family engagement, and praised the inclusion of a male domestic abuse panel representative from Mankind.

The report was supported by academic references and the research cited was very helpful and evidence based.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

AREAS FOR FINAL DEVELOPMENT:

- All identifiable information in the report should be removed. For example, the report should not include the sex of Steve's child.
- The dissemination list (section 11) needs to include the Domestic Abuse Commissioner.
- There is an opportunity to further explore the lack of professional curiosity of agencies and how this impacted their ability to share information with each other, including why Victim Support did not complete a repeat MARAC referral (paragraph 16.10).
- The Action Plan is promising but it only includes the DHR Panel's actions and not the individual agency actions, which should be added.

- This report would benefit from a thorough proofread ahead of publication.

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 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 Panel feedback letter 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 Panel, 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 Panel