Domestic Homicide Review
into the death of ‘Tony’ in June 2017
Overview Report
June 2023

Independent Reviewer: Deborah Jeremiah

Contents

1. Introduction

1.1 This report of a Domestic Homicide Review (DHR) examines how agencies responded to and supported Tony, a 62-year-old resident of Bristol prior to his death in June 2017. Tony was murdered by Paul, his 38-year-old stepson.

1.2 In addition to agency involvement, the review will also examine the past to identify any relevant background or any trail of abuse before the homicide; whether support was accessed within the community and whether there were any barriers to support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

1.3 The key purpose in undertaking this DHR is to ensure that learning can be identified following the death. Most importantly the purpose is to ensure the review achieves the fullest understanding possible both of what happened but also why, to identify improvements and contribute to the prevention of future similar tragedies.

1.4 The panel offer its sincere condolences to Tony's family.

2. Timescales

2.1 In October 2017, the Safer Bristol Partnership (now known as the Keeping Bristol Safe Partnership) identified the circumstances of Tony's death as meeting the criteria for undertaking a Domestic Homicide Review (DHR) under Section 9 (3) of the Domestic Violence, Crime and Victims Act 2004.

> (1) In this section "domestic homicide review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by:
>
> (a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
>
> (b) a member of the same household as himself, with a view to identifying the lessons to be learnt from the death[1].

2.2 The review has taken much longer to complete than the Chair or review panel would have liked. There are multiple reasons why this review has taken a considerable time to complete, including challenges around constituting a review panel, obtaining the Internal Management Reviews, the fact that it was important the family were supported to input when they felt able, and challenges around some organisations providing their action

[1] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews: Home Office (December 2016:5)

plans. Furthermore, it initially took some time to make a decision to commission a DHR because it was believed that the Probation Serious Further Offence investigation would capture the learning from this incident. Further conversations with Probation revealed that their investigation would only focus on the internal processes and there was no assurance that this would include the domestic abuse context, and on that basis, it was decided to commission a DHR. The first Overview Report was produced in 2019 and the next versions in early 2021 but then there a was delay in the police agreeing recommendations. The police panel member was unable to sign off the recommendations and was then on long term sick leave. The matter was eventually escalated within that agency and the matter resolved. The Covid Pandemic also played a considerable part in delaying progress. The report was presented to the local safety partnership in October 2022 who made a decision to make further amends to the report internally as they felt that the recommendations needed to be strengthened. This resulted in several recommendations needing further amendments and sign off by their relevant organisations. The Executive Summary was not provided by the Chair, so this was drafted by the KBSP team based on the Overview Report. The Chair was sent the report in June 2023 before it was submitted to the Home Office.

2.3 The main timeframe for the review was identified as June 2015 to the death in June 2017. This timeframe was identified as it was agreed it represented enough of a period to look at the relationship and events between Tony and Paul. Nevertheless, there was also significant relevant information prior to this point, which has been included as this gives important context. The time period does encapsulate some relationships Paul had with women where he harassed and harmed.

2.4 The DHR was presented to the Keeping Bristol Safe Partnership on 11th October 2022 and concluded by the Keeping Bristol Safer Partnership on 29th June 2023 when it was sent to the Home Office.

3. Confidentiality

3.1 The content and findings of this review were strictly confidential during the review process. Information provided was only available to the identified participating officers and professionals and their line managers until the overview report was approved for publication by the Home Office Quality Assurance Group.

3.2 Until the report is published it is marked confidential to comply with Official Sensitive Government Security Classifications April 2014.

3.3 Tony's stepdaughter wished to be part of the review and was seen during the process by the Chair. Her contribution to the review appears as appropriate.

3.4 Pseudonyms are used throughout. Tony for the victim and Paul for the perpetrator. Both are white British males. Tony was 62 and Paul 38 at the time of the index offence.

4. Terms of Reference

4.1 The terms of reference were agreed upon the panel. At this point the family were not engaged in the review but when they did contribute in 2019, the terms of reference were discussed with them, and it was felt that it covered the appropriate issues. These are set out below.

4.2 The purpose of the Domestic Homicide Review is to:

4.2.1) 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.

4.2.2) 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.

4.2.3) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

4.2.4) 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.

4.2.5) contribute to a better understanding of the nature of domestic violence and abuse; and

4.2.6) highlight good practice.

4.3 It is not the role of a DHR to act as an inquiry into how the victim died, or who is culpable. These are matters for the Criminal and Coroners courts. Neither is it the role of the DHR to initiate disciplinary or other employment procedures, as these remain the responsibility of the employing organisation.

4.4 **Main Terms of Reference** for the review were established as follows:

4.4.1. Decide whether in all the circumstances at the time, any agency or individual intervention could have potentially prevented Tony's death.

4.4.2. Review current responsibilities, policies, and practices in relation to victims of domestic abuse – to build up a picture of what should have happened to support the victim and review national best practice in respect of protection of individuals from domestic abuse.

4.4.3. Consider whether there are issues of race, gender, religion, disability, or other individual needs that were significant in the circumstances and how services responded.

4.4.4. Examine the roles of the organisations involved in this case; the extent to which the victim or perpetrator had involvement with those agencies, and the appropriateness of single agency and partnership responses to the case to draw out the strengths and weaknesses and to assess whether there are any gaps in support.

4.4.5. Establish whether there are lessons to be learnt from this case about the way in which organisations and partnerships carried out their responsibilities to safeguard the wellbeing of Tony and any other relevant others,

4.4.6. Identify clearly what those lessons are.

4.4.7. Identify whether, as a result, there is a need for changes in organisational and/or partnership policy, procedures, or practice to improve practice to better safeguard victims of domestic abuse.

4.4.8. To examine whether there were signs or behaviours exhibited by the perpetrator in his contact with services which could have indicated he was a risk to the victim directly or indirectly.

4.4.9. To assess whether agencies have domestic abuse policies and procedures in place, whether these were known and understood by staff, are up to date and fit for purpose in assisting staff to practice effectively where domestic abuse is suspected or present.

4.5 The following **specific terms of reference** which have been agreed by the panel:

4.5.1. What can this review tell us about the multi-agency response to domestic abuse concerning non-intimate but interfamilial relationships?

4.5.2. What does this review tell us about the multi-agency effectiveness of managing risk where a family member may be exposed to harm from a family member coming out of prison?

4.5.3. What does this review tell us about the multi-agency system's response for those who may be vulnerable to financial exploitation or duress from another family member?

4.5.4. What does this review tell us about information sharing of any relationships the perpetrator had/has involving domestic abuse including coercive control?

5 Methodology

5.1 The review takes as its starting point the government definition of domestic abuse as follows:

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*
- *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.

5.2 The methodology of this Domestic Homicide Review is in accordance with Home Office Guidance. This review examines the responses of all the relevant agencies that had contact with Tony and Paul and considers whether there were gaps in services or wider learning about domestic abuse. In line with the expectations of a DHR, full consideration was given to the involvement and potential contribution of key family members and friends.

5.3 The review panel determined which agencies were required to submit written information and in what format. Those agencies with any substantial

contact were asked to produce individual management reviews and the others, short reports. Some agencies interviewed staff involved in the case to gain a better understanding of how and why decisions were made. The written material was distributed to panel members and used to inform their deliberations. During these deliberations, additional queries were identified, and auxiliary information sought.

5.4 Thereafter, a draft overview report was produced which was discussed and refined at panel meetings before being agreed.

6 Involvement of family, friends, neighbours, and the wider community

6.1 The family were sent letters advising them of the review and inviting them to contribute from the outset. Also delivered at the same time was the Home Office domestic homicide leaflet for families and the Advocacy After Fatal Domestic Abuse leaflet[2].The family liaison officer from Avon and Somerset Constabulary was also used to liaise with the family. There were two main groups to Tony's family, namely his children from his first marriage and then the stepchildren group. It became apparent that there was some contention within the family which complicated liaison. For some considerable time, the family were not inclined to engage with the DHR. It was important to permit the family time and space to do so. Two of Tony's sons and a friend had given statements to the police, and these were accessed for the review after the trial was concluded.

6.2 In the absence of contact from most of Tony's family the panel chair was, after some time, able to engage Tony's stepdaughter in late 2019. She provided useful background information as included in this report.

6.3 Two friends and a neighbour of Tony's were also approached to contribute to the review. One friend and one neighbour declined, and the other friend did not respond.

6.4 The panel chair wrote to Paul's solicitor informing them about the review and inviting Paul to contribute. There was no response despite chasing this several times.

7 Contributors to the Review

7.1 Numerous agencies provided information into the review primarily through Individual Management Reviews (IMR). This is a templated document setting out the agency's involvement with the subjects of the review. These were received from:

[2] www.aafda.org.uk

- Avon and Somerset Constabulary
- Bristol Clinical Commissioning Group
- General Practitioner
- Bristol City Council
- Probation (On June 26, 2021, the National Probation Service and the Community Rehabilitation Company (Seetec) reunified to form the Probation Service.)

7.2 The Individual Management Reviews contained a declaration of independence by their authors and the style and content of the material indicated an open and self-analytical approach together with a willingness to learn, apart from one IMR which required further consideration, and this was redone appropriately. This did cause some delay, however. None of the authors of the IMRs had management of the case or direct managerial responsibility for the staff involved.

7.3 There was also input from NextLink Support, a domestic abuse support organisation into the review. The Review Panel met on five occasions.

8 Review Panel Members

8.1 A review panel consisting of the Independent Chair and representatives of the following agencies was established. It should be noted that the Safety Partnership faced some real challenges in convening a panel for this DHR as they had several DHRs ongoing at the same time as well as other statutory reviews. This was compounded by the Covid Pandemic in 2020/21. All agencies and professionals needed to prioritise around that. While this is was not ideal several of the panel brought expertise around domestic abuse. The panel members had the requisite knowledge, expertise and seniority. They are independent from the case and line management of practitioners involved.

Agency/Organisation	**Role**
Independent	Independent Chair
Avon and Somerset Constabulary	Detective Sergeant
Probation	Senior Probation Officer
Public Health	Senior Public health Specialist
Bristol Clinical Commissioning Group	Safeguarding Lead

NextLink (Domestic Abuse Service)	CEO (advisory panel member)

9 Chair and Author of the Overview Report

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 sets out the requirements for review chairs and authors. In this case, the Chair and author are the same person. Deborah Jeremiah is an independent practitioner who has chaired and written previous Domestic Homicide Reviews, Child Serious Case Reviews, and Safeguarding Adults Reviews and was judged to have the experience and skills for the task. Deborah has also had involvement with national domestic abuse initiatives and supports a number of organisations that work with families around domestic abuse. Deborah also has academic links with two universities researching in this field.

10 Parallel Reviews

10.1 Her Majesty's Coroner for Bristol opened and adjourned an inquest into Tony's death pending the outcome of the criminal trial. HM Coroner confirmed the inquest later concluded on the basis of a suspension under Schedule 1 of the Coroners and Justice Act 2009 given the outcome of the criminal trial. Therefore, a full inquest was not necessary due to the evidence that was heard during the criminal proceedings. Avon and Somerset Constabulary completed a criminal investigation and prepared a case for the Crown Prosecution Service and the court. Paul was convicted of the murder of Tony in 2018. He is now serving a sentence of 20 years and 4 months.

11 Equality and Diversity

11.1 Tony was a white man who was UK resident living in one of the more deprived areas of the city. English was Tony's first language. Paul is white British with English being his first language. He is not known to have been in a relationship at the time of the homicide. Paul has no children.

11.2 Section 4 of the Equality Act 2010 defines protective characteristics as age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation.

11.3 There is no information to indicate that any act by Paul was motivated or aggravated by any factors relevant to the protective characteristics under the Equality Act 2010.

11.4 Tony had a physical disability but was mobile and fully independent. Tony had a longstanding neurological condition (neurofibromatosis) diagnosed in 1986 and this was managed by his GP. He had a disability badge but was mobile and able to go out and socialise with friends and family. Tony had no communication barriers, and he was able to contact others easily and drove a car.

11.5 Section 6 of the Equality Act defines 'disability' as:

(1) A person has a disability if:
(a) they have a physical or mental impairment, and
(b) the impairment has a substantial and long-term adverse effect on the individual's ability to carry out normal day-to-day activities

11.6 No agency held information that indicated Tony or Paul lacked capacity and there is no indication from the material seen by the review panel that a formal assessment of capacity was ever required for either of them. The DHR panel did not see any information that identified that Tony or Paul had any mental health impairment.

11.7 It was believed that at times Paul took and supplied drugs. It is unknown to what degree. The Equality Act 2010 [Disability] Regulations 2010 [SI 2010/2128] specifically provides that addiction to alcohol, nicotine, or any other substance [except where the addiction originally resulted from the administration of medically prescribed drugs] is to be treated as not amounting to an impairment for the purposes of the Equality Act 2010. Paul's misuse of drugs is not, therefore, covered by the Act.

12 Dissemination of the Report

12.1 On completion, the report will be sent to the Keeping Bristol Safe Partnership.

12.2 The following agencies will also receive copies of this report:

- Avon and Somerset Constabulary
- Bristol City Council
- Bristol Clinical Commissioning Group
- GP
- Probation
- PCC
- Domestic Abuse Commissioner

12.3 The report will also be shared with Tony's family to those who wish to see it and to comment.

13 Background Information (the facts)

13.1 Tony was murdered at his home, a council property where he had lived for many years alone. Tony had three sons from his first marriage. He married again and his second wife had two sons and one daughter to whom he became a stepfather when they were in their teens. He was murdered by one of his stepsons, Paul.

13.2 Tony had a longstanding neurological condition (neurofibromatosis) diagnosed in 1986 and this was managed by his GP. He had a disability badge but was mobile and able to go out and socialise with friends and family and have hobbies. Tony's second wife was disabled, and he was her carer until she died in 2014.

13.3 Paul was a difficult teenager and became involved in crime as a youth. He has an extensive history of offending over a 20-year period. This includes 101 offences, 30 convictions and 2 cautions. Paul was 38 years-old when he murdered his stepfather. He had spent much of his adult life in and out of prison. He was a managed by the Impact Offender Team for theft and fraud, but he did not work well with this service and was non-compliant. The review discovered that Paul was also a perpetrator of domestic abuse upon women. Within the time period of this review, there were four victims of domestic abuse. There was another known victim of domestic abuse, however this was outside of the review period.

13.4 On a number of occasions when he was out of prison, Paul would visit Tony and request money from him. He would also want to stay at Tony's address which Tony resisted. Tony had very limited contact with Paul once he was an adult. The police had never been called to the address and no other agencies were ever involved with Tony, but Paul would turn up making demands several times over the years. Tony was aware that Paul may have been involved with drugs and others involved in drugs and he had a CCTV camera set up to ensure he could protect his property generally. CCTV footage was not available on the day Tony was murdered as it is believed that Paul removed this evidence.

13.5 Paul states he went to Tony's on the day of the murder to collect tools he had in the shed that belonged to him. He also intended to collect some of his deceased mother's possessions. While at the house an altercation occurred between Paul and Tony in the kitchen and Paul attacked Tony with a hammer. It is believed that the attack started in the kitchen but continued in the sitting room, fatally wounding Tony. Tony had no defence wounds. Paul then left the property stealing valuable property from the house which has never been recovered. Tony was later found dead behind the sofa in his sitting room initially by a neighbour. Paul was arrested and charged with the murder and subsequently convicted.

13.6 At the time of the murder, Paul had just been released on licence from prison for theft offences and due to report to probation. However, Paul failed to attend the probation office on Friday 2nd June 2017. Failure to attend breaches conditions of the licence which prompts a review of the circumstances and known risks and a consideration of enforcement up to and including recall. Subsequently, the Offender Manager had a case discussion with his line manager, but the decision was made to allow Paul a window of time to report, and recall would be initiated if he failed to make contact after the weekend. It was on that weekend that Paul murdered Tony. While making this decision, the Offender Manager could not have predicted that Tony was at risk; although this review has found that they did not realise Paul had given Tony's address as where he would be staying after release. It has also become apparent that probation did not appreciate Paul's domestic abuse history with women.

14 Key events

14.1 Chronologies were requested by the agencies thought to be involved with Tony and Paul with the IMRs. However, Tony had very little contact with any agencies. He had repeat prescriptions from his GP and his disability was well managed. The key relevant events for this DHR within the time period was the failure of Paul to report to probation on Friday 2nd June 2017 after his release on licence and then his visit to his stepfather in June 2017 when Paul murdered Tony. Consequently, there is no integrated chronology for this review. Tony's health condition was well managed, and the attack was considered by the panel to be unforeseeable.

15 Overview

15.1 The information gathered during the police investigation from Tony's friends and family do paint a picture of Paul at times seeking to coerce money from Tony. This was not a regular occurrence but three or four times over many years. Paul is described by his sibling, (Tony's stepdaughter) who we will call Ann, as being very dishonest from an early age and would even steal from those close to him. Ann describes their mother struggling to deal with Paul's anti-social behaviour and that he was always in trouble with the police. Paul moved away from the family home at the age of 18. Following this, contact between Paul and Tony was very minimal and there were considerable periods of time with no contact. Ann describes their contact as distant.

15.2 Ann decided not to have contact with Paul, and she also moved away from the family home and now has a family of her own, but Ann stayed close to Tony and visited often with her partner and children. She describes the family as very fragmented, and she does not see other family members

often. None of Tony's natural children or his other stepson wished to engage in the DHR.

15.3 In approximately 2009, Ann visited Tony and found he had two black eyes and a swollen nose. He told Ann this was a result of an altercation with Paul over money. Tony had told him to leave, and Paul become aggressive and head-butted Tony. The police were not involved. Paul was still writing to his mother but after this incident she decided to cut all ties with him. Their mother died in 2014. Before she died, Tony had become her full-time carer. When Paul murdered Tony, this information was not known by any agency as Ann says Tony did not wish to report this. She is unsure why but doesn't think Paul's mother would have been a barrier to this and that Paul's mother had decided to cut ties after this incident, and they didn't see Paul. Tony was a middle-aged man who had been assaulted by his sick wife's son, but it appears from the family account that the couple decided to manage this by fully cutting ties with Paul rather than involving the police.

15.4 Ann would hear of Paul's offences and behaviours through the community but last saw Paul in 2016 when he had stolen money and a car from others. He was verbally abusive toward her in a supermarket carpark. Ann describes her brother as someone with no morals, a con man and a bully. Ann reports Paul had a character that was arrogant, and he was confident he would persuade others to do his bidding or give him want he wanted. Ann was never physically harmed by Paul and her mother and Tony were protective factors, but she believed that Paul could "turn nasty." Ann was not aware of him being violent to others other than the one event as described above.

15.5 Tony's natural children did give statements to the police and describe Paul as contacting their father on various occasions as if he was owed something from Tony. They did not have contact with Paul but were aware of his criminal lifestyle which was public knowledge. They describe Tony loaning Paul £2000 many years before the murder, which Paul never repaid. They were also aware that Paul would ring Tony from prison over the years making demands. They were aware that Paul had some property in the garden shed at their father's and that their father was not happy about this as it was an excuse for Paul to return to the house, albeit rarely. He had asked Paul to remove the items, mainly tools, several times. The family cannot recall exact times and years when Paul had contact with Tony. It was not regular occurrence and Paul spent considerable time in and out of prison.

15.6 Tony also told them that on one occasion men had come to the door looking for Paul saying that Paul owed money. They cannot recall exactly when this was, but it was some years prior to Tony's death. They encouraged their father to cut all ties with Paul as he was a criminal and

they felt Paul would always bring trouble to their father's door. They saw the main problem as Paul wanting to take money from Tony rather than concerns around violence, though they were concerned that the people Paul associated with could potentially come to the house to look for Paul and that Tony could get hurt. After the incident of the men coming to Tony's home, Tony did report this to the police and later installed CCTV which he could check and access on his phone.

15.7 On the Saturday before his death, Tony told his son that Paul has been pestering him about bank statements. Tony was quite stressed about this, but it was not clear to his son what this was about exactly. He then saw his father he next morning but went straight out. When he returned to see his father in the afternoon, he discovered his dead body behind the sofa. There were blood stains in the kitchen which had been partially cleaned up. He raised the alarm with others and the police were called.

15.8 Tony is described by a friend as a kind and uncomplaining man who kept himself to himself. He had long retired and enjoyed seeing friends and had a routine of going to the pub at the end of the week with a friend. He also had a female friend with whom he spent time. He saw his natural children intermittently but only saw Ann of his stepchildren and he lived alone. He was mobile and independent and was able to go out into the community and enjoy activities and socialise. Tony did not speak of Paul to his friends and Paul was not in his life regularly. Paul spent stretches of time in prison and also never lived with Tony after he left at 18.

15.9 When Tony met his second wife, her children were already teenagers and he tried to raise them with his second wife, but Paul showed anti-social behaviours and a leaning towards a criminal life at an early stage, and he went on to be a career criminal. On the minimal occasions he did have contact with Tony over the years after he left the family home, Paul always wanted something from Tony and their relationship was not a loving relationship but one where Paul had a sense of entitlement and wanted to exploit Tony for money. That appears to be the extent of the relationship.

16. Analysis and Appraisal of Practice

16.1 The Terms of Reference of this review direct us to consider the significance and potential for learning in relation to non-intimate partner abuse. The national narrative around domestic abuse has changed to explore more openly non-intimate relationship abuse. This extends to parental and adolescence abuse but there is less research around adult, children and parental abuse and this is more commonly seen as a factor to be managed within safeguarding systems and managed more commonly under the umbrella of elder abuse. Legislation, statutory guidance, and definitions of

domestic abuse recognise that it does not only take place in intimate partner relationships but can also be a feature of other family relationships. However, research tells us that the majority of domestic homicides do involve intimate partner relationships, but that a smaller number include other family members.

16.2 The statutory guidance and much of the research, therefore, is in relation to 'intimate partner violence'. What guidance and information there is regarding 'non-intimate partner' domestic abuse from other family members tends then to be weighted towards violence from an adolescent to a parent.

16.3 There is evidence of some financial exploitation and coercion by Paul to Tony and one previous historic incident where it is reported that Paul physically assaulted him by head butting Tony. This was not known or reported to the police at the time. It is unknown why Tony did not report this assault. Had this been reported, the police could have dealt with this as an assault, or a domestic abuse incident and risk assessed using a DASH. This may have afforded Tony the opportunity to share further information with the police around Paul's behaviours. It would have also raised the possibility of Tony being seen as a vulnerable adult from a safeguarding and Care Act perspective.

16.4 The DASH form is the tool by which professionals, including the police, identify the level of risk to a victim, which in turn impacts on the response of agencies. The risk management framework of the DASH is based on there being three levels of risk to the victim:

- **Standard:** current evidence does not indicate likelihood of causing serious harm.

- **Medium:** 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 of circumstances.

- **High:** there are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be risk of serious harm.

16.5 The risk assessment is achieved by asking a series of closed questions requiring a 'yes' or 'no' answer, although there is also space to record the victim's response. If the number of 'yes' answers reaches a total of 16 or more, the case will automatically be referred to MARAC. If a total of 14, it is discussed in a pre-MARAC meeting which decides if it should be subject to a full MARAC. However, where the points threshold is not met, but a professional is sufficiently concerned about the level of risk, they can nevertheless refer this directly to the MARAC.

16.6 The panel gave considerable thought to the history of Paul's offending and any indicators that he would murder a family member. Probation records date back to 1999 and Paul is heavily convicted with a total of 30 convictions. His convictions were mainly for fraudulent and theft offences (28 in total). Of particular interest to the review, the three offences against a person are as follows: Battery dated 2009 & 2010 and on 17/12/16 he received a deferred sentence for Disclosing Private Photographs, Harassment and using Threatening Words (domestic abuse toward his ex-partner). Paul has been subject to supervision by Probation for several past community and custodial sentences.

16.7 Paul was supervised by an experienced Probation Officer, and he was also a registered Impact/IOM (Integrated Offender Management) case. As a result, he was subject to an Integrated Offender Management scheme involving close supervision and support provided jointly by police and probation. The impact of this resulted in the Offender Manager in this case being able to plan home visits/prison visits and to share police intelligence thus informing their risk assessment and management of this case. There is also evidence that the Offender Manager and police involved with Paul's management had a significant awareness of his behaviour and traits. They comment on his tendency to be deceitful, avoid intervention and be of poor compliance.

16.8 There is no evidence on file of the Offender Manager actively seeking information regarding police domestic abuse call-outs, which may have better informed risk assessment and risk management. However, in this case, it is stated by probation that sight of past police call-outs is unlikely to have altered the risk assessment of Paul and the harm he posed to other known adults, namely family members. A significant learning point, however, is the omission to explicitly risk assess the level of harm Paul posed to other known adults. Risk assessments focused on the potential harm posed to female partners/ex-partners. It has been identified that it is necessary for offender managers to embrace the concept of domestic abuse beyond that of intimate partners and ensure that this is assessed and managed as a potential risk to other groups within assessments.

16.9 It is noted that the intensive supervision and joint working arrangements for both prison and home visits is considered as good practice. Paul presented as complex and non-compliant. Manager oversight is evidenced. Enforcement in particular (revocation of licence) was used swiftly and consistently in accordance with practice guidelines but was open to professional judgement rather than any rigid policy. When Paul breached his licence on 2nd June, the judgement was made to wait until after the weekend. The manager making that decision could not have foreseen that Paul would go on to murder his stepfather that weekend. A weak point

however in the probation system in this case, is that the offender must be released to a known address, and this was not checked nor followed up in this case. Paul had suggested he may be with an ex-partner (who he had previously abused) or his stepfather. No check was made on either address or their suitability, so any risk assessment was not considered.

16.10 A thread that runs through this review is an absence of specific assessments and subsequent management of the risk of inter-familial harm. Further investigation into the coercive and threatening element of Paul's behaviours to others may have shed light on the potential harm he posed to others beyond that of intimate partners/ex-partners. If a decision had been made to revoke Paul's licence immediately following his failure to report on the day of release (Friday 2nd June 2017), it is extremely unlikely that the revocation would have been processed and the police could have arrested him prior to the commission of the murder. It is important to outline that immediate revocation of a licence for failure to report would only implemented in 'emergency recall' situations involving high or very high risk of serious harm offenders. As such, this action would not have been expected in this case given the absence of imminent risk factors indicating the high risk of serious harm.

16.11 As stated the police worked closely with probation but interestingly Paul was seen as a fraudster, manipulator, and con man rather than a perpetrator of domestic abuse or a violent offender. Through this review, it has transpired that Paul was abusive in previous relationships with women.

16.12 The first victim (V1) who had been in a relationship with Paul for a short time had her card stolen and used by him. She later received harassing texts but decided not to proceed with the police. Officers attended in good time and obtained a statement for the theft. A DASH was taken from V1 which included details of her young children at the address. The risk was recorded as 'Standard' and a good rationale was provided detailing the victim as having ended the relationship, stating that no physical violence had been disclosed and that she was not in fear of Paul at that time. However, a further incident occurred, V1 contacted police in June 2017 to report an incident when she had arranged to meet her ex-partner Paul in order to collect her laptop and he had started shouting at her. He then followed her to her car, got in and refused to leave. V1 eventually got Paul to leave the car. No physical violence was disclosed.

16.13 The Call Handler correctly identified this as a domestic incident and this produced the appropriate script which ensured that the risks were assessed, identified whether the perpetrator was still at the location, if the victim was hurt/safe and whether any children were present amongst other questions which were answered satisfactorily, and no immediate risk identified.

16.14 Live Cell, a 24/7 Intelligence Team, completed background checks and identified that Paul had been involved in previous domestic incidents where he had a Protection from Harassment Order in relation to another victim. This information was recorded on the log and provided the rationale for assessing the Threat/Harm/Risk (THR).

16.15 Officers were unable to attend due to 30 outstanding logs and all units being heavily committed with Threat to Harm and Risk (THR) incidents with a higher level. A decision was made and V1 was contacted, and details recorded over the phone. This is against national domestic abuse policy but an option that is increasingly being used due to the demand on Policing for 'low' risk domestic incidents which are verbal only.

16.16 A resolution team has now been introduced in the communications department in order to assist in dealing with outstanding logs and help reduce demand. One feature is to contact victims of domestic abuse where the risk is considered 'low', and the offence is 'verbal' only.

16.17 The second victim (V2) called the police stating that she had been in a relationship with Paul who had just been released from prison. V2 said that she had received a Facebook message asking for a vehicle back which the owner believed Paul had stolen. V2 reported that she did not have anything to do with it and that she had contacted him about it and an argument started via text/voice calls. V2 reported that Paul had threatened her to tell her to leave the address as he was "coming for her." However, V2 refused to give a statement.

16.18 This was correctly identified as domestic abuse and the Threat/Harm/Risk tag was added requesting an attendance by officers based upon the rationale that the informant was the victim and that she believed the threats to be true. V2 was described as being frightened of Paul. The officer listened to/read the messages but did not believe them to be threatening; they noted that Paul had requested that his belongings be returned. Advice was given to V2 to inform Paul that the relationship was over and that she wanted nothing more to do with him.

16.19 Good practice was followed, and the DASH was recorded with V2 at the scene with her consent being obtained for support services/referrals. V2 informed the DASH that she was not in fear of physical violence from Paul but that she felt manipulated by him. The officer recording described her as being 'on edge' whilst talking. The DASH was assessed as medium risk. V2 called the police again to report that her ex-partner Paul kept calling her and was threatening to put indecent images of her on social media. V2 reported that he had also threatened to go to her nan's address and drive his van through it in order to collect his belongings. V2 later

reported further threats from Paul in which he stated he would put her in his van. Paul was subsequently arrested and charged. This matter was also referred to MARAC[3]. V2 called police stating that Paul had on two occasions posted naked photographs of her on to Instagram which caused her distress. Paul was charged with disclosing private sexual photographs with intent to cause distress.

16.20 During this incident, Paul's Impact IOM Police Manager raised his case to 'Red' as he was to be recalled to prison. Paul was on licence at the time and outstanding for several fraud offences. A pathways assessment was completed but no reference was made to domestic abuse as Paul would not be open to this as a perpetrator. Paul was described as a habitual liar with no known drug/alcohol issues and no diagnosed mental health illness. The general opinion was that he did not engage in any services offered through Impact/IOM.

16.21 Paul was recalled to prison on other matters. He was charged and convicted with harassment and disclosing private sexual photographs with intent to cause distress. He was found guilty on 17/12/2016 and given 6 months imprisonment and a Protection from Harassment Order with an indefinite term.

16.22 To further reduce the risk posed to V2, she was asked to send one message to Paul stating that the police had taken his belongings to his stepdad's (Tony's) address and that he should not contact her any further. However, no DASH was completed as officers were called away. The officer should have also tasked for Lighthouse[4] to review as V2 fits the criteria for the enhanced service as a victim of domestic abuse. Lighthouse carried out a search of incidents in order to eliminate the risk of not being tasked by an officer. The search highlighted this incident, and they recorded the risk as 'high' and requested the officer to complete the DASH as soon as possible and to task the Safeguarding Co-ordination Unit (SCU) in relation to a MARAC referral.

16.23 V2 was correctly identified as a 'high-risk' victim in relation to the ongoing harassment and 'revenge' private photographs that Paul uploaded to social media. Despite there being no DASH initially, a MARAC referral and DASH risk assessment form was completed. In line with policy, an IDVA was correctly tasked to contact and support V2. The DASH was eventually completed by the officer who recorded it as 'high' stating that V2 was petrified of Paul.

[3] A MARAC is a regular local meeting to discuss how to help victims at high risk of murder or serious harm.

[4] Lighthouse is a team of staff from the police and victim support organisations, working together to guide, advise and support victims and witnesses.

16.24 A MARAC case was discussed on 05/01/2017. There was an ongoing action for the IDVA to continue to support V2 and report back to MARAC if necessary.

16.25 It is not known whether the offence of “Controlling or Coercive Behaviour” according to Section 76 of the Serious Crime Act 2015 was considered. However, Home Office Guidance relating to this offence stipulates that the pattern of behaviour has to occur ‘during’ the intimate relationship. V2 and Paul were no longer in a relationship. Had they have still been together a pattern of behaviour was certainly emerging and this offence could have been considered.

16.26 V2 called police again in March 2017 stating that she had been receiving fake accounts added to her Snapchat and Instagram accounts, all of which were named after friends and family. V2 stated that she had blocked them but was concerned they were related to her ex-partner Paul who she believed was obsessed with her. V2 stated that she wanted this logged but did not want the police to do anything else. Paul had been released from prison that month.

16.27 Safeguarding was considered and actioned with Lighthouse providing support and referring V2 back to her previous IDVA. Markers were placed against the addresses and V2 was highlighted as a repeat victim and a MARAC referral was made.

16.28 V2 was discussed at a pre-MARAC meeting on 01/06/2017 and it was noted that Paul had been recalled to prison on unrelated offences and not due to be released until 22/08/2017 further eliminating any risk to V2.

16.29 Consideration was given by the Head of Impact as to whether the fortnightly risk meeting held by joint agencies presents an ideal opportunity to share information in respect of Impact Nominals as Domestic Abuse Perpetrators and in particular risks posed to victims upon release from prison. However, after consultation with the current Head of Impact, assurance was given that now the fortnightly migration meeting where offenders are discussed as to suitability to enter or leave the scheme would discuss domestic abuse risks as a matter of routine. They would not routinely discuss the safeguarding of any victims but if risks were newly evident they would (and do) make suitable referrals to other agencies as appropriate. In addition, the Community Rehabilitation Company covering Bristol, North Somerset and South Gloucestershire now receives (but did not in 2017), a daily report of all domestic incidents involving offenders currently subject of Community Rehabilitation Company intervention (so not just Impact nominals). This is regardless of whether the offender is a victim, suspect or mentioned party.

16.30 There were no specific interventions available for domestic abuse perpetrators via the police in the focus period of this review, but Impact have now embarked on a new pilot to manage around ten domestic abuse perpetrators in South Bristol via the existing Impact multi-agency process. This new cohort is being built from MARAC, Impact, Children and Young People's Services, Probation, and Community Rehabilitation Company lists. This new work may result in the sourcing of a new intervention, but it is too early to evaluate.

16.31 A third victim emerged (V3) with a report that she had previously been sexually assaulted by Paul and she had gone to the home address of Paul's partner and had been thrown out from the address by Paul. V3 was intoxicated and difficult to understand and her account kept changing throughout with V3 informing that she no longer wanted the police involved. The communications log is correctly identified as sexual offences. This triggered the requirement for a FRO (First Response Officer) which is in accordance with policy and enables best evidence to be achieved whilst supporting the victim of a serious sexual assault by a specifically trained officer.

16.32 V3 called police on another occasion to report that she had been assaulted by Paul and was at the hospital. V3 stated that she had gone to her friend/partner of Paul's address to explain why she had slept with Paul previously, but he had become violent and pushed her over. V3 had two breaks and shattered bones in her right arm. V3 went to a relative following the discharge from hospital. Initial contact was made with the victim by the police and details taken. However, V3 was under medication and unable to provide a statement. The officer in the case was unable to later contact the victim and the incident was subsequently filed with no further action.

16.33 The incident was correctly recorded as an assault, but the attending officer identified the previous sexual contact with Paul and took preventative measures, treating the incident as domestic related. In doing so, they completed a DASH and DA Toolkit in order to assess and record the risk to the victim.

16.34 When responding to domestic incidents, Avon & Somerset Constabulary has introduced a Domestic Abuse (DA) Toolkit which enables officers to ask a series of questions to assess the risk level appropriately. It also considers children and whether they are present during any incidents and includes the recent offence of 'controlling or coercive behaviour.' The DA Toolkit is compulsory, as is the DASH, and best practice is for completion by the attending officer at the scene. The incident was reallocated to a Detective Constable due to the nature of the injuries and

previous incident. A timely Supervisory Review took place with actions set to ensure evidence was obtained and victim safeguarding took place.

16.35 V3 did initially make good contact requesting updates and attempting to speak with the officer in the case. There are three entries on the system from the victim asking when the officer will be taking a statement and providing different contact numbers due to phones being broken. The officer is then unable to make any further contact with the victim and leaves voicemail messages on the phone numbers that she provided.

16.36 A review took place between the officer and their supervisor which stated that due to the whereabouts of the victim not being known and messages left and not returned the incident would be filed until the victim got back in touch. A decision was made not to arrest the suspect and rationale recorded was because it could make matters worse and without the victim contact, it was difficult to understand what her wishes were. The victim had initially said she was willing to give a statement but had stated that she was afraid of the offender and afraid of repercussions from him. No referrals were made, and the incident was filed. Lighthouse had reviewed the incident but as it was linked to the sexual assault, their policy is to await a victim contact strategy by the officer in the case which had not taken place and the officer could no longer reach the victim in order to do this.

16.37 A further victim (V4) called Police to state that some of her jewellery had been stolen by her ex-partner (Paul). She stated that he had returned most of it except a solid gold lighter of sentimental value; he had told her that he had taken the jewellery to teach her a lesson. The victim did not want police to attend but the call handler perceived her to be very upset and potentially vulnerable. V4 would only provide details for a DASH, she informed police that the relationship had ended, and she had changed her locks. There were no previous recorded incidents between V4 and Paul.

16.38 The call handler identified the victim as being potentially vulnerable and although she had not wanted police to attend, the call handler liaised with a supervisor and after speaking with the victim again, a decision was made to attempt to dispatch an officer to her address that evening. Officers subsequently attended in good time ensuring the welfare of the victim. Although V4 did not want to provide details for a statement, officers were able to record a DASH with her which was standard.

16.39 Good contact was made with the victim over the following weeks and a further visit to support her and attempt to take a statement. V4 explained that she could not emotionally cope with the process. Officers spent some time with her but respected her wishes not to pursue the complaint. The report was sent to an Inspector for review which took place shortly later

with the decision to file due to lack of evidence or victim co-operation. The DASH was recorded by the officers as standard. V4 recorded that she was not in fear of Paul but did state that she was feeling very low and had attempted suicide in the past. There was no further information recorded to ascertain whether this was due to the relationship or unrelated and no support services were documented as being discussed. Lighthouse reviewed the report and completed background checks of which there were none between the victim and Paul. No children identified. There is only one recorded attempt by Lighthouse to contact the victim and offer services. It is unclear whether any follow-up took place.

Other relevant information

16.40 The Police National Database (PND) has been searched and one incident of domestic abuse was found for Dorset Police. Details within PND are limited and provide that**,** a partner of Paul's was kept inside a hotel room by him and punched several times causing bruising to her arm and face. This was reported historically so the date is unclear.

16.41 While there was a history of theft, harassment and violence toward women there was no report of these behaviours by Tony to the police. Tony did report that an unknown male approached his front door asking for Paul. Tony advised that Paul did not live there, and he did not know where he was. The unknown male then threatened Tony that if Paul was not there when he returned, he would 'take it out' on him. Initial enquiries took place to identify the male without fruition. A warning marker was placed against the address to indicate that a 'priority' attendance was required and the reasons why, should Tony call Police again. This prompted Tony to use CCTV outside his property.

16.42 Paul was supervised by an experienced Probation Officer, and he was also a registered Impact/IOM (Integrated Offender Management) case. As a result, he was subject to an Integrated Offender Management scheme involving close supervision and support provided jointly by police and probation. The impact of this resulted in the Offender Manager in this case being able to plan home visits/prison visits and to share police intelligence thus informing their risk assessment and management of this case. There is clear evidence of the benefits of the IOM scheme linked to this case. There is also evidence that the Offender Manager and Police involved with the management of Paul had a significant awareness of his behaviour and traits. They comment on his tendency to be deceitful, avoid intervention and be of poor compliance. The joint management of this case between Probation and Police is considered as good practice.

16.43 Formal risk assessments were carried out in a timely manner with risk of harm and risk of reoffending being reassessed at significant events (re-

release and start of a sentence). However, these were pulled through from old assessments and did not include fresh assessments considering recent updating criminal activity. There was no contact with the police domestic violence unit as per organisational policy. This did not afford an open consideration of whether Paul presented a risk to others including family members.

16.44 The most recent address Paul gave was a release address which was in fact that of an ex-partner he had abused. There are also indications that he may have been thinking of staying with Tony on release. No contact was made with Tony as to the suitability of that address. Probation advise an assessment would be done of the address Paul offered not one he may go to.

16.45 Enforcement decisions made by the Offender Manager and their line manager in this case are considered as sufficient. The case records confirm that Paul presented as an individual who regularly failed to comply with community orders and licence condition and was subsequently sanctioned appropriately. Between the period of June 2016 and May 2017, Paul had been recalled to prison for breaching his licence on three occasions and during this period; he also served a 3-month period in custody. Each of the recalls were fixed term (automatic re-release after 14/28 days) and this is considered as a correct course of action and in line with Probation Instruction. Probation recommend fixed term or standard but are not the final decision maker. The panel is aware that Paul failed to attend the probation office on the day of his latest release (02/06/17). Subsequently, the Offender Manager had a case discussion with their line manager and a decision was made to allow Paul a window to report and recall would be initiated if he failed to make contact after the weekend. This decision is considered as appropriate and in accordance with that agency's practice guidelines on recall. There was no information that probation was aware that Paul posed an imminent risk of harm to a known person or a member of the public.

16.46 Health professionals comprise one of the most significant groups in identifying domestic abuse. Tony had regular contact with his GP and the practice regarding his health. There is no evidence that Tony reported any financial coercion or domestic abuse or that Tony had any concerns for his welfare from any family members. There are no regular attendances to health services, and he did not present with any injuries sustained from contact with Paul or otherwise.

16.47 It should be noted that no concerns were raised in the community, by neighbours or Housing and Landlord Services as to any anti-social behaviours from Paul towards Tony. However, housing plays an increasingly important role in safeguarding and community safety, but they

were not aware of the fact that Tony may be vulnerable. Currently there is no real communication link between probation and housing, and this is a gap in safeguarding terms. There was no information sharing between probation to housing at that point and so any steps to offer alternative accommodation if a resident such as Tony is at risk or being harassed is not currently managed.

17 Concluding Remarks and Learning points

17.1 The review has raised learning points around how the police and probation risk assess when a persistent offender is released on licence considering the spectrum of his offences and the nature of these. This could add to probationary management when and if the perpetrator then defaults on the licence.

17.2 The review also raises issues around how we work with perpetrators who repeatedly show abusive behaviours toward partners, though the review panel realise that in this case the victim was not an intimate partner. It is apparent that more research on familial abuse outside the intimate partner or adolescent to parent dynamic would be welcomed and this will be fed back to those academics and institutions that do important work in domestic abuse.

18 Recommendations

18.1 The recommendations are as follows:

Recommendation 1: After arrest and start of investigations, the whole offence history is to be considered as far as possible to better understand behaviours and level of risk and where appropriate this information shared with other agencies.

Recommendation 2: Probation risk assessments should include all current and historic information relevant to risk. This may include convicted and unconvicted matters

Recommendation 3: Probation services should ensure that enforcement decisions are clearly recorded on case management systems and risk assessed. In particular, if a decision is made not to recall following a breach the rational should be clearly recorded

Recommendation 4: Probation should ensure that address checks are completed as per guidance particularly in cases with a known history of domestic violence.

Recommendation 5 Domestic abuse history checks should be done by probation on all cases where there is knowledge of previous domestic abuse

and that the individual being released on licence is not going to be accommodated by a person potentially or actually vulnerable.

Recommendation 6: In Impact Offender Management cases, police Offender Managers ensure that all recorded information related to the individual being processed is passed to the probation Offender Manager to inform risk assessments.

APPENDIX A: Action Plans

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
Recommendation 1: After arrest and start of investigations the whole offence history is to be considered as far as possible to better understand behaviours and level of risk and where appropriate this information shared with other agencies.	Local	Practice has moved on considerably since 2017; our information sharing practices have adapted to become more comprehensive and collegiate with local safeguarding processes. The Head of Victim Care is satisfied that the police do routinely review the whole offence history in order to better understand behaviours and levels of risk – and that this is shared with other agencies, either via DIRM/DAT or MASH processes.	Avon and Somerset Police	Assurance activity will need to be commissioned to ensure that this is the case.	December 2021	Completed and will be monitored

Recommendation 2: Probation risk assessments should include all current and historic information relevant to risk. This may include convicted and unconvicted matters.	Local	All Staff to undergo mandatory training and ongoing development covering Risk Assessments to include Risk of Serious Harm summary and Risk Management Plans As part of the assessment, and in addition to assessing risk relevant to the index offence the assessment should cover the behaviour, predisposing factors and situational hazards concerning ***previous*** behaviour / offences.	Probation Service	Training Records are kept on staff to ensure they have completed the training and issues around risk and risk assessments are routinely discussed in supervision.	December 2021	Completed and continually assess as part of Assessment Quality Assurance
Recommendation 3: Probation services should ensure that enforcement decisions are clearly recorded on case management systems and risk assessed. In particular if a decision is made not to recall following a breach the rational should be clearly recorded	Local	A new national standardised process has been developed and implemented for the issuing of letters to individuals who breach their licence conditions predicated on the recall thresholds. This also outlines clear recording instructions regarding recall decision making on Delius and moving	Probation Service	There is a step-by-step guide in how to use the new process. Additionally, staff have attended briefing sessions on the new process and Management Oversight recording is now incorporated into various performance measures.	October 2021	Complete. Policy Framework was implemented nationally.

		away from the language of 'warnings'. Line Management oversight is required during enforcement decision being made.				
Recommendation 4: Probation should ensure that address checks are completed as per guidance particularly in cases with a known history of domestic violence.	Local	To review guidance with all staff and ensure they are implementing the requirements around address checks. To review in supervision / case audits with individual probation practitioners	Probation Service	Assurance from case audits and touch points model.	June 2021	Completed 25th June 2021
Recommendation 5: Domestic abuse history checks should be done by probation on all cases where there is knowledge of previous domestic abuse and that the individual being released on licence is not going to be accommodated	Local	To re-visit guidance and ensure this is being implemented during individual supervision and case audits with Probation Practitioners.	Probation Service	Guidance has been given to staff to ensure that the police checks are much more specific in relation to the information being sought and within certain timeframes	June 2021	Completed 25th June 2021 NOTE - during the sign off of the report the partnership proposed adding a further action *'Dependent on risk profile housing to be informed if*

by a person potentially or actually vulnerable.				Assurance from case audits and touch points model.		*individual being released intend to stay with any person actually or potentially vulnerable'* but this was later removed. After further discussion with housing and probation partners, it was determined that the action was not achievable. The probation service now carry out address checks and safeguarding checks through police and CYPS before someone is released from prison; therefore, there should not be a situation in which a person is being released to the home of a vulnerable person. The action would not be fully effective as it only applies to BCC tenants and would not apply to private tenants, housing association tenants and people who own their home. To aid better communication between the services, BCC housing & landlord services have shared a patch list which probation can use to determine

						which housing officer is working with an individual.
Recommendation 6: In impact offender management cases, police offender managers ensure that all recorded information related to a nominal is passed to the probation offender manager to inform risk assessments	Local	The Government has recently released national guidance about how Integrated Offender Management (IOM) Units should operate. This was after feedback that some IOM Units in other Police Forces had 'lost their way'. This guidance recommends co-locating with our key partners including Probation and having fortnightly risk and migration meetings to share information and ensure we are managing the most appropriate offenders.	Avon and Somerset Police	This has already been completed.	This has already been completed.	Completed - Avon and Somerset have adopted all the recommendations from the Government's guidance which includes the DHR recommendation of this board. I would add that the police and probation see each other on a daily basis. I have been on the IOM for approximately 6 months, and it is my view that information sharing is good. Fortunately, the Offender Manager in this case is still working on the IOM. I have asked for his personal opinion, and he is in agreement that

						information with probation is good and is a two-way process.

APPENDIX B: 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

23rd May 2024

Dear KBSP,

Thank you for resubmitting the report (Tony) for Bristol Community Safety Partnership to the Home Office Quality Assurance (QA) Panel. The report was reassessed in May 2024.

The QA Panel felt it was positive that condolences were offered to the family of the victim and an effort had been made to include the victim's friends and family within the report.

The QA Panel noted that most of the issues raised in the previous feedback letter following the first submission have now been addressed.

The view of the Home Office is that the DHR may now be published.

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