Domestic Homicide Review
Executive Summary

Keeping Bristol Safe Partnership

Report Into the Death of Nevaeh in April 2019

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Version	Final
Date of Completion:	14th September 2023

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1. INTRODUCTION AND METHODOLOGY

1.1 The Review Process

In September 2020, the Keeping Bristol Safe Partnership (KBSP) considered the case of Nevaeh, who had died by suicide in her own home. She was known to a number of services and at the time of her death was being supported having disclosed that she was a victim of domestic abuse committed by her previous partner Colin, from whom she had recently separated. The safeguarding partnership recognised the potential to improve the way agencies worked together to protect persons reporting domestic abuse and commissioned this Domestic Homicide Review[1].

The review aimed to use the experiences of Nevaeh to identify learning and to improve the way that agencies support persons reporting domestic abuse. A wide number of agencies from the
safeguarding partnership took part and three key findings were identified. These are detailed in this report as follows:

a) Multi-Agency Planning and Information Sharing.
b) Housing Providers and Domestic Abuse Procedures.
c) The Police Response to Nevaeh's Reports of Domestic Abuse.

This executive summary has been prepared to outline the key findings of the review and to provide context for the recommendations. Further information about the review process and the information considered in the review may be found in the main overview report. Within the reports, pseudonyms have been used to protect the identity of persons involved.

Following the Home Office quality assurance process, this report, in addition to the main overview report, will be published by the KBSP and may be widely disseminated. This will include Nevaeh's family and AAFDA advocate, all agencies taking part in the DHR, the wider KBSP membership, and publication on the KBSP website.

1.2. Methodology

An independent chair and author was appointed to work alongside a panel of local professionals to undertake the review. See appendix A for full details of the review panel, contributors, and independent chair. Terms of reference (see appendix B) were provided, identifying a number of issues for the review to examine. Chronologies and single organisation reviews[2] were provided by each agency, analysing practice events and considering how changes to practice may deliver future improvement.

Practitioners and senior representatives from each agency met for the further analysis of events and to identify the systemic reasons as to why better outcomes were not achieved. All were then involved in identifying potential improvements for consideration by the KBSP.

[1] https://aafda.org.uk/domestic-homicide-reviews (Explanation of DHR)

[2] Individual Management Reviews

Nevaeh's family were actively involved in the review, meeting with the independent reviewer to ensure that their views were considered and the voice of Nevaeh captured. The KBSP is very grateful for their participation and their valuable contribution.

A detailed DHR overview report was then prepared, detailing the analysis and findings, which has passed a quality assurance process by the review panel.

1.3 The Review Panel and Contributors

A list of the agencies contributing to the review[3] is provided at Appendix C of this report, which details the method of their contribution. Each of the IMR authors and the panel members were independent of Nevaeh's case.

Nevaeh's family contributed fully to the review and identified two of Nevaeh's friends who were also able to provide a contribution, in addition to Nevaeh's previous employer. Nevaeh's ex-partner, Colin, willingly engaged with the review. A full list of contributors and the method of their contribution is provided within Appendix A.

2. BACKGROUND INFORMATION – AN OVERVIEW OF NEVAEH

Nevaeh had been in a long term relationship with her ex-partner Colin since 2008, living together in Bristol and living in accommodation rented from the local authority. The relationship came to an end in December 2018, after which Nevaeh made a series of disclosures that she had been the subject of domestic abuse in their relationship. These were made to a number of different agencies.

At the time of the relationship coming to an end, Nevaeh made a complaint of harassment to the Avon and Somerset Constabulary, explaining that Colin had returned to their home and had taken property from it. This was determined to be a civil dispute over a joint tenancy housing agreement and the ownership of joint property. Following this, both Nevaeh and Colin contacted Bristol City Council Housing and Landlord Services in an attempt to change the tenancy agreement to a sole tenancy in Nevaeh's name.

In February 2019, Nevaeh made a further complaint of harassment to the police, at which time she also disclosed that she had been the victim of domestic abuse throughout the relationship with Colin. The officer who recorded details of her report identified that she was extremely distressed and vulnerable. A decision was therefore made that it would be more appropriate to secure Nevaeh's evidence in a video 'ABE' interview, rather than taking a written statement. A referral was submitted to the domestic abuse services and Nevaeh was signposted to further agencies for support. The domestic abuse complaint was recorded as a crime and sent for allocation to a different officer for investigation, following the procedures existing at that time.

[3] Appendix C – The review panel and contributors

Following this disclosure to the police, Nevaeh was supported by a number of different agencies and made a series of disclosures about the domestic abuse she had suffered. Whilst she received support for her mental health and wellbeing, the risk of Nevaeh taking her own life was not identified.

In April 2019, Nevaeh was found at her home having taken her own life. At this time the police had not arranged her video interview to obtain evidence of the domestic abuse and the criminal allegations had not been investigated.

Nevaeh had told professionals different parts of her story and due to the absence of information sharing, and her police interview not having been completed, the full details of the abuse she had suffered was never known. As a result this made it difficult to effectively support Nevaeh and safeguard her from further harm.

3. SUMMARY CHRONOLOGY – KEY EVENTS

1) In early November 2018, Nevaeh and Colin had a review appointment following their unsuccessful fertility treatment, which coincided with Nevaeh spending a greater amount of time at work and away from home. Whilst Colin believed that this was connected to the fertility treatment, Nevaeh's family believe that this was due to the relationship breaking down and the domestic abuse that she had suffered from him.
2) On the 8th November 2018, Angela, a vulnerable person who was receiving social care services, moved into supported accommodation at Nevaeh's place of work. In her role as a supervisor with her company, Nevaeh had conducted an assessment with Angela prior to her placement commencing and was then involved in supporting her care needs.
3) On the 15th November 2018, Angela attempted to take her own life in her accommodation. Nevaeh was the first person to find her and provided immediate assistance. This included contacting the ambulance service and remaining with Angela as she received medical support. Nevaeh contacted her manager, who despite being off duty returned to work to support Nevaeh. She noted that Nevaeh was shaken by what had happened and ensured that additional support was put into place. Daily welfare meetings commenced and Nevaeh was offered the chance to take some time off, which she declined to do. After this incident Angela remained in her supported living accommodation and her friendship with Nevaeh developed. The extent of this developing friendship was not known to her manager.
4) On the 20th November 2018, Nevaeh contacted her GP practice to explain that she had witnessed a traumatic incident at work and that she was struggling with the memory. Following a GP telephone consultation, she was provided a face to face appointment with a mental health nurse attached to the practice. Support was provided, which included advice to contact her occupational health unit and being signposted to the Bristol Wellbeing Primary Mental Health Service. This was a self-referral service providing primary mental health support. A monthly GP review appointment was scheduled.
5) Later that day, on the 20th November 2018, Nevaeh had a welfare meeting with her manager. When it was identified that she was struggling emotionally as a result of the incident with Angela, a referral was made to the human resources department to facilitate

additional occupational health services. Nevaeh was again provided the opportunity to take some time off work. All further support discussed with the HR department and the opportunity to take some time off was declined by Nevaeh. On the 25th November Nevaeh had a further meeting with her manager and explained that she was starting to feel much better.

6) During the evening of the 28th November 2018, Nevaeh went out on a social event with work colleagues and it was reported to Nevaeh's employer that Angela had accompanied them. This was immediately addressed by her managers, who the following day met with Nevaeh to explore whether any professional boundaries had been crossed. This was intended to be a supportive meeting and Nevaeh was again asked if she needed any support or time off work. During the meeting Nevaeh denied any inappropriate relationship and became upset in the way the matter had been raised. She felt that she had been treated unfairly and later that evening resigned her employment. Her employer describes how they felt that Nevaeh had acted out of character in relation to the incident itself and also when they had spoken to her about it. They outlined how in dealing with the situation they acted in accordance with their policies and were surprised at Nevaeh's reaction and resignation. Having left her employment, Nevaeh's friendship with Angela developed and they subsequently commenced a relationship after her relationship with Colin had concluded.

7) On the 4th December 2018, Colin and Nevaeh's relationship came to an end. Colin moved out of the flat and whilst doing so removed items of property.

8) Later that day, Nevaeh contacted Avon and Somerset Constabulary reporting harassment by Colin and was visited by a police officer. Nevaeh explained that she had separated from Colin and that having initially moved out of their flat, he had returned and removed property belonging to them both. She explained that she did not want Colin prosecuted, but wanted him to be prevented from going to the flat. She was asked about any violence in the relationship, to which she stated that she had not been the victim of violence and was not afraid of him. The incident was determined to be a civil matter and recorded as a non-crime incident. A DASH risk assessment was completed[4] to assess Nevaeh's risk from domestic abuse, a process which determines a person's risk as either standard, medium, or high. Nevaeh was assessed as a standard risk. The following day the police contacted Nevaeh by telephone to check on her welfare and during this call she did not raise any further concerns. The incident was subsequently reviewed by staff within the constabulary's 'Lighthouse' victim care unit, who concluded that there was no role for them as a crime had not been committed.

9) On the 5th December 2018, Nevaeh contacted housing services to report that her relationship with Colin had come to an end and that he'd moved out of their flat. She wanted to discuss tenancy options and how she could change to a sole tenant. She was provided advice about the legal status of joint tenancy agreements and advised to seek independent legal advice for any change of names on the tenancy agreement[5]. Nevaeh was not asked if domestic abuse was a factor in the tenancy change and it was not raised by Nevaeh.

[4] https://safelives.org.uk/practice-support/resources-identifying-risk-victims-face

[5] Property adjustment order – made by the courts.

10) On the 23rd January 2019, Nevaeh had a review appointment with her GP having not attended the initial review on the 17th December. It was identified that she had not yet sought support from the Bristol Wellbeing service and was reminded how to self-refer.

11) On the 24th January 2019, Colin contacted housing services to say that he was no longer living at the flat and wanted to remove his name from the joint tenancy agreement. He was advised that he should complete an 'assignment form' relinquishing tenancy, which Nevaeh would also need to sign.

12) On the 28th and the 29th January 2019, Colin again contacted housing services to request removal from the tenancy agreement. He subsequently spoke with a housing officer and explained that whilst he had completed the assignment form, Nevaeh had refused to sign it. He was advised that he could submit notice to terminate the tenancy which would effectively end the agreement for both parties. He explained that he did not want to do this as he didn't want to end the tenancy for Nevaeh. He was advised to seek independent legal advice.

13) On the 5th February 2019, Nevaeh had a further appointment with the GP practice mental health nurse and she explained that she was having flash backs about Angela attempting to take her own life. Post traumatic distress disorder (PTSD) was identified and comprehensive support was provided. This included a review of Nevaeh's medication, the consideration of providing therapy for PTSD, discussing options for further mental health support services, and providing a back dated statutory sickness form to help with Nevaeh's financial situation. During this consultation Nevaeh disclosed that she was frightened of being alone in her flat as Colin still had access. She disclosed that she had been the victim of domestic abuse in the relationship, which had included being the victim of sexual assault, and in response to this the nurse signposted Nevaeh to other support agencies[6]. Nevaeh also outlined that she had been inflicting harm upon herself by making small cuts to her stomach, but when asked denied that she had any suicidal thoughts.

14) On the 9th February 2019, Nevaeh contacted the police to report domestic abuse and harassment committed by Colin. The police contact centre completed a risk assessment and having determined that Nevaeh was not at immediate risk she was provided an appointment to attend a police station on the 15th February. This was part of the Response Appointments Scheme, a system introduced to manage the demand of crimes and incidents that did not require an immediate police attendance.

15) On the 15th February 2019, Nevaeh attended the scheduled appointment and spoke with a police officer. She reported that Colin was harassing her over the tenancy and a crime of harassment was recorded. She explained that she was frightened of Colin and that she feared he would break into the flat. A DASH risk assessment was completed, during which Nevaeh disclosed incidents of previous domestic abuse. The DASH assessed Nevaeh as being at medium risk of harm. The officer described Nevaeh as appearing tense, withdrawn, and suffering from mental health issues. She believed that her behaviour indicated significant mental health trauma and signposted Nevaeh to further support, including a recommendation to contact her GP. The incident was additionally flagged to ensure that the Lighthouse Unit reviewed the incident to provide any necessary additional support. As a result of Nevaeh's distress, a decision was taken to arrange a video

[6] Sexual Assault Services / Mental Health Employment Team

interview (ABE)[7] to capture her evidence, which due to her vulnerability would be more appropriate than a written statement. The ABE interview was arranged for the 3rd March, but was subsequently cancelled as the officer tasked to conduct it did not feel sufficiently trained.

16) On the 19th February 2019, the police crime report was reviewed by a supervisor and allocated to an officer for investigation. They made a number of attempts to contact Nevaeh, however were not successful in establishing contact with her. Initial attempts to contact Nevaeh were made on the 20th and the 25th February. The ABE interview was never rearranged and as a result Nevaeh's full disclosure of domestic abuse was never captured.

17) On the 19th February 2019, Nevaeh attended a follow up face to face appointment with her mental health nurse who noted that Nevaeh was anxious and nervous. During this consultation Nevaeh told the nurse that she was now living with Angela and continued to have worries that she would attempt to take her own life again. As an outcome of the appointment a referral was submitted to Adult Social Care outlining that Nevaeh was vulnerable from domestic abuse, affected by PTSD, and that her housing situation had made her fearful for her safety. A referral was also submitted to the IRIS scheme, which is a GP practice based support service for victims of domestic abuse. In Bristol this service was provided by Next Link. Nevaeh explained that she had arranged an appointment with the sexual support services and it is recorded that she was pleased with the support she was being provided.

18) On the 20th February 2019, an IRIS worker from Next Link unsuccessfully attempted to contact Nevaeh by telephone following the GP practice referral.

19) On the 21st February 2019, a social worker received the referral from the GP surgery and spoke with Nevaeh directly. Nevaeh confirmed that the domestic abuse had been reported to the police but explained that she was now considering what action she wanted to take. During the interview, housing was identified as the support most needed and with Nevaeh's consent housing services were informed of the referral and the disclosures of domestic abuse. Housing services agreed to provide Nevaeh enhanced support and as a result of this and the fact that Nevaeh had reported the domestic abuse to the police, it was determined that no further social care support was required.

20) On the 21st February 2019, housing services opened a domestic abuse support case. Nevaeh was provided additional support and regular contact was maintained with her. She was again advised to seek legal advice to obtain a property adjustment order.

21) On the 28th February 2019, Colin contacted housing services to say that he now wished to remain on the joint tenancy agreement. He also requested a key to the property as he was unable to gain access and an item of his property was being withheld from him. The housing officer explained that Nevaeh was seeking a property adjustment order to remove him from the tenancy which is what he had wanted. The housing officer also

[7] Achieving Best Evidence interview - Used to capture the evidence of vulnerable and intimidated witnesses. https://www.cps.gov.uk/sites/default/files/documents/legal_guidance/best_evidence_in_criminal_proceedings.pdf

made attempts to assist Colin in recovering the item he wished for. A new set of keys was not provided to Colin.

22) On the 5th March 2019, Nevaeh had a review appointment with her mental health nurse. She explained that she was now living back at her flat, whilst also at times staying with her mother. She also said that she had missed a call from the Lighthouse Unit, but would return their call. No additional risk to Nevaeh was identified in the appointment.

23) Later on the 5th March 2019, the constabulary's Lighthouse Unit made successful contact with Nevaeh, having been unsuccessful on two previous occasions. The purpose being to identify what further support she may need. Nevaeh explained that she had not heard anything about her criminal complaint and was assured that the investigating officer would be asked to contact her. She was provided safeguarding advice and a referral was submitted to the Next Link domestic abuse service.

24) On the 5th March 2019, an IRIS support worker[8] from Next Link spoke with Nevaeh in response to the referral submitted by the GP surgery and a face to face meeting took place on the 11th March. During this meeting Nevaeh disclosed that she had been the victim of domestic abuse over a ten year period, which had included physical assaults. Nevaeh discussed her mental health and her need of financial support to pay her rent. A DASH risk assessment was completed, which assessed her as being at medium risk of harm. During the risk assessment Nevaeh disclosed that she felt pressurised into having sexual intercourse with Colin, but did not believe this to be rape. The support worker recognised that sexual abuse may have existed in the relationship and referrals to sexual offence support services and to the police were discussed, but were declined by Nevaeh. A support plan was put into place supporting Nevaeh with her financial circumstances, her housing situation, and provided options and advice in relation to counselling services. Regular contact with Nevaeh was maintained by telephone calls, text messages, and physical meetings. This included seven contacts during the following three weeks.

25) On the 13th March 2019, Nevaeh missed her appointment with the Bristol Wellbeing Therapy service.

26) On the 19th March 2019, Nevaeh had a face to face review appointment with her GP practice mental health nurse. It was recorded that Nevaeh was engaging well with support services and that she was sleeping and feeling better. Nevaeh's condition seemed to be improving and a risk assessment did not find any sign that she may be at risk to herself.

27) On the 20th March 2019, the police investigating officer attempted to contact Nevaeh on her mobile telephone. There was no reply.

28) On the 27th March 2019, the Next Link IRIS worker submitted a referral to Housing Services by email, requesting that additional support was provided to find Nevaeh a new housing tenancy. This was submitted to the 'Home Choice Bristol' team, which is responsible for new housing requests and was not copied to the housing officer who had been supporting Nevaeh. The email was received and forwarded to a manager for their consideration.

[8] Provides a similar role to that of an Independent Domestic Violence Advisor (IDVA) – An overview of the IDVA role may be found on the following weblink - https://safelives.org.uk/sites/default/files/resources/National definition of IDVA work FINAL.pdf

Due to an administrative issue this referral was not opened by the manager or acted upon. The lack of response to the referral was not escalated by the IRIS worker.

29) On the 29th March 2019, Colin again contacted housing services to request that his name be removed from the tenancy agreement. He was advised that he would need a court order, or an assignment form signed by Nevaeh.

30) On the 30th March 2019, the police investigating officer attended Nevaeh's flat in an attempt to contact her. There was no reply and a calling card was left asking Nevaeh to contact them. She replied to this message a few days later, however the investigating officer was not available. She left a message explaining that she had changed her mobile phone number and provided her new contact details.

31) On the 4th April 2019, Nevaeh attended the Unity Sexual Health clinic, a service provided by University Hospitals Bristol and Weston NHS Foundation Trust. During her appointment Nevaeh disclosed that she had been raped by a recent partner who she did not name. She explained that the incident had occurred in November 2018 and that she had reported it to the police. Nevaeh also disclosed that she had been the victim of domestic violence and was being supported by the domestic abuse support services.

32) On the 10th April 2019, Nevaeh attended her phone consultation with the Bristol Wellbeing service. She disclosed that she was suffering from anxiety in relation to a number of issues following the breakdown of a recent relationship. This included her housing situation, financial debt, and previous domestic abuse. Nevaeh also outlined how during her relationship with Colin she had suffered a number of miscarriages and discussed how her pregnancy losses had affected her. Nevaeh described how she had feelings of not wanting to be around anymore, but denied having any intent to end her life. She also said that she did not feel at risk of harm from anyone. Nevaeh discussed that she would self-harm by making small cuts to her stomach and that when very stressed would bang her head. As an outcome of the meeting further support was provided, with Nevaeh being allocated a place on a six week course to support her in managing a low mood. This was due to start on the 1st May 2019. Nevaeh was also signposted to the Willow Tree Centre, who provide specialist support for pregnancy loss.

33) Whilst it was organisational policy for a DASH risk assessment to be completed following disclosure of domestic abuse, this was not done with Nevaeh. The domestic abuse issues were however explored and support provided. The health professional signposted Nevaeh to other support services and also liaised with the mental health nurse from Nevaeh's GP practice, to seek assurance that Nevaeh was receiving support in relation to her housing situation and from domestic abuse services.

34) On the 10th April 2019, the police investigating officer unsuccessfully attempted to contact Nevaeh on her phone and it was noted that a further attempt would be made on the 12th April. There is no record to say that this further attempt was made.

35) On the 15th April 2019, the investigating officer returned to Nevaeh's flat in an attempt to contact her. There was no reply and a further calling card was left asking for Nevaeh to contact them.

36) On the 17th April 2019, Nevaeh's Next Link IRIS worker was unsuccessful in contacting her. This had followed an unsuccessful attempt at contact on the 8th April.

37) On the 18th April 2019, Nevaeh contacted the police expressing concerns that Angela was intending to self-harm. The police attended Angela's home and after speaking with all parties recorded that there were no apparent concerns for anyone's safety.

38) A small number of days later, the police investigating officer went to Nevaeh's flat in an unsuccessful attempt to contact her. A calling card was left. Later that day, Angela went to Nevaeh's flat and found her deceased. She had apparently died by suicide.

4. CRITICAL ANALYSIS AND LEARNING

In examining Nevaeh's case, the review identified three key thematic areas which may have improved the way services were delivered to Nevaeh and which provide the opportunity to improve the way services are delivered in the future. They are dealt with in this report under the following headings.

i) Multi-agency planning and information sharing

ii) Housing providers and domestic abuse procedures

iii) The police response to Nevaeh's report of domestic abuse

Finding 1: Multi-Agency Planning and Information Sharing

Learning:

The quality of services provided to Nevaeh was affected by the lack of a coordinated multi-agency response to her needs. This included a lack of information sharing, the joint assessment of risk, and multi-agency planning. If future improvements are to be made, then a trauma informed and needs based approach to supporting victims of domestic abuse will be needed.

During the review it was evident that whilst Nevaeh was being supported by a wide number of agencies, the services were delivered independently and not as part of a coordinated multi-agency response. Whilst individual professionals were committed in doing their best for Nevaeh, the efficacy of this support was reduced by the lack of coordination, information sharing, and multi-agency planning.

At one time Nevaeh was supported by at least seven key agencies, all receiving different parts of her story about domestic abuse and the state of her mental health. Whilst there was evidence of good communication between some professionals, this did not extend to the full sharing of information. As such, a complete picture of Nevaeh was never developed and she was never really understood. This made it impossible to fully assess the risk to Nevaeh, especially the risk that she may go on to harm herself. Had a formal process to share information existed then a holistic picture of Nevaeh may have been developed and a joint risk assessment completed. This would have been more effective than individual agencies assessing risk based solely on the information known to them.

In not developing this holistic picture of Nevaeh, the opportunity to provide additional support in her relationship with Angela was also missed. Angela was herself vulnerable with a number of care needs and Nevaeh clearly felt responsible for supporting her. Nevaeh's friends describe how she was fearful of leaving Angela alone in case she harmed herself and

this meant that she spent less time with her friends. This in effect removed a key pillar of support from Nevaeh, which she had always previously enjoyed. Had this issue been identified, then Nevaeh could have been provided additional support in caring for Angela and managing her feelings about the relationship. The fact that Nevaeh had been unable to resolve her housing situation added pressure to this relationship, as she became more dependent on Angela for a safe place to spend the night.

The lack of coordination and multi-agency planning also had a significant effect on the efficacy of services being delivered by the individual agencies. This was particularly evident in relation to the support Nevaeh was receiving from health agencies, in helping her to manage anxiety and low mood. Until Nevaeh felt secure in her housing situation and safe from Colin, it was unlikely that any health support for her mental wellbeing would be successful.

What may have made the most difference to Nevaeh, would have been for one agency to have taken a responsibility in coordinating the other services. This could have involved arranging professional meetings to share information and develop multi-agency plans, whilst then holding agencies to account in delivering their safeguarding actions. Had agencies not progressed their actions in a timely way, then this could have been challenged through the partnership escalation process. A single lead agency would also have provided support to Nevaeh in her engagement with the different services, the DHR had the sense that Nevaeh felt overwhelmed by events and as a result had difficulty in engaging with the many agencies who were working with her.

Whilst the Next Link IRIS service will coordinate services if a need is identified, this is only done through individual discussions by telephone and email, which does not provide a forum to effectively share information and develop multi-agency planning. Whilst the MARAC process exists to enable multi-agency planning for high risk domestic abuse cases, this does not routinely support people who may have complex needs but who are not assessed as being at high risk.

If the provision of services to people in Nevaeh's situation is to be improved, then a change of approach to multi-agency working is needed. Any future change should involve working in partnership to deliver a person's self-defined needs, regardless of their risk level. In order to achieve this, it is recommended that Next Link develops a responsibility to coordinate the services being provided to victims of domestic abuse who have complex needs and are being supported by a number of agencies. This should involve the use of professional meetings, attended by those directly involved in a case, which should aim to share information and develop joint planning. For any such change in practice to be successful, all agencies within the Keeping Bristol Safe Partnership will need to support the new multi-agency working arrangements regardless of the identified risk level.

Recommendation 1:	*Next Link staff, providing services within the IRIS scheme or any other Next Link service, should consider a need to coordinate the provision of services to victims with complex needs and those who are being supported by a number of agencies. This coordination should consider the use of professional meetings to share*

	information and develop joint planning, which should be supported by all agencies regardless of the level of identified risk.

Finding 2: Housing Providers and Domestic Abuse Procedures

Learning:

It was not immediately identified that Nevaeh's request to change her tenancy agreement related to domestic abuse. Once it had been identified, the existing policy and procedures were not effective in providing a quick outcome. A change to policy and developing closer working arrangements with domestic abuse support services, would improve the support provided to victims of domestic abuse.

Having sought assistance for her housing situation, staff from housing services supported Nevaeh in accordance with their policy and procedure. Having examined this issue, the DHR identified two areas where a change to these procedures will offer the potential to improve future practice. These relate to:

a) The time taken to identify that Nevaeh was a victim of domestic abuse
b) Processes for supporting victims of domestic abuse with joint tenancies

At the time of contacting housing services in December 2018, Nevaeh did not disclose that she was suffering harassment over the joint tenancy. This was understandable as it would have been a difficult and sensitive subject to volunteer over the telephone. Housing services only became aware that domestic abuse was an issue when they were informed by Adult Social Care in late February 2019. Had Nevaeh disclosed this at the first point of contact, then the enhanced levels of support could have been provided immediately, preventing a two month delay. To address this issue and to develop future good practice, there is an opportunity to introduce a proactive policy for the identification of domestic abuse. This could involve always asking if domestic abuse is a factor in any request for a change in tenancy agreements. This may be further supported by providing information following a change of tenancy request, explaining how to report domestic abuse and outlining the housing providers policy to support victims.

The second issue related to the request made by Nevaeh and Colin, to change their joint tenancy agreement to a sole tenancy in Nevaeh's name. Both Nevaeh and Colin wanted the same outcome and had contacted housing services a number of times in an attempt to achieve this. This was not successful and caused additional anxiety for both parties.

In the first instance they were advised to jointly sign a housing assignment form, which would have allowed housing services to make the change. Asking victims of domestic abuse to do this, does however create two issues. Firstly, victims of domestic abuse may be reluctant to contact the perpetrator and ask them to sign the form. Secondly it provides the abuser the opportunity to exert further control over their victim. In Nevaeh and Colin's case the assignment form was not completed as Nevaeh did not engage with Colin to sign it. The Housing Services representative on the review panel explained that the advice to complete an assignment form was not actually correct, as this process is no longer used to change a joint tenancy in any circumstance.

In this case, it may have been more supportive for housing services to find a way of working with both parties to quickly change the tenancy arrangement. For example, a management decision may have been taken to end the joint tenancy and then to start a new sole tenancy in Nevaeh's name, as in the early stages of the tenancy change discussions both parties wanted to achieve this outcome. This would be a useful and supportive policy when dealing with future similar cases.

When the assignment form was not completed, both parties were advised to seek independent legal advice to obtain a property adjustment order. Neither party felt that they had the financial means to do this and it was not progressed. At this time Nevaeh was vulnerable and overwhelmed by events. Having to obtain a court order to change the tenancy agreement was likely to increase her anxiety and place additional pressure upon her. Housing providers have the ability to commence legal action to exclude a perpetrator from the home and in cases of domestic abuse it would be more supportive for the provider to do this, rather than advising a vulnerable victim of abuse to do it themselves.

In light of Nevaeh's case, it is recommended that Bristol City Council Housing and Landlord Services review their policy and procedures in relation to supporting victims of domestic abuse.

In considering how future improvements may be achieved, the Domestic Abuse Housing Alliance partnership (DAHA)[9] is an excellent resource. Its 'Whole Housing Approach' provides extensive guidance in relation to the early identification and intervention for domestic abuse, aiming to keep victims safely in their home. It includes a perpetrator management toolkit[10], providing guidance for a change to joint tenancy and how the housing provider may commence legal action to remove a preparator of abuse from the premises. The principles of this guidance may have made a difference to Nevaeh, particularly in removing the onus from the victim to progress any necessary legal action. Other guidance in the toolkit considers multi-agency working, such as supporting the police with information to obtain Domestic Violence Prevention Notices and Protection Orders[11].

During the review it was identified that the KBSP have recently developed new proposals to integrate housing services with the domestic abuse support services provided by Next Link. This involves embedding an IDVA within Bristol City Council Landlord and Housing Services to improve the sharing of information and multi-agency working. This will also allow domestic abuse expertise to be shared with staff working in housing services and for best practice to be developed. This is an excellent initiative and embraces the principles of the

[9] https://www.dahalliance.org.uk/about-us/who-we-are-why-we-do-it/

[10] https://www.dahalliance.org.uk/media/10662/16_-wha-perpetrator-management.pdf

[11] https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010

good practice developed by the DAHA whole housing approach. It is recommended that this initiative is commissioned and implemented in Bristol.

Since Nevaeh's DHR, the UK Government has launched a consultation on the impacts of joint tenancies on victims of domestic abuse. The scope of this consultation includes the themes that were identified in Nevaeh's case and the agencies involved in this DHR intend to contribute to the consultation process.

Recommendation 2:	*It is recommended that Bristol City Council Housing and Landlord Services review their policies for supporting victims of domestic abuse. In particular this should include a policy for the proactive identification of domestic abuse and the development of a perpetrator toolkit.*

Recommendation 3:	*It is recommended that the current proposals to integrate housing and domestic abuse support services are commissioned and implemented.*

Finding 3: Police Response to the Reports of Domestic Abuse

Learning:

The use of a scheduled appointment system to manage incidents of domestic abuse, is not an effective method of delivering a victim focussed and needs based service.

The lack of police officers and staff trained to conduct Achieving Best Evidence (ABE)[12] witness interviews, reduces the ability of the police to address domestic abuse and keep victims safe.

At the time of Nevaeh's report to the police in February 2019, Avon and Somerset Constabulary were using a system of scheduled appointments[13] to manage the demand of calls requiring the presence of a police officer. This was not designed for serious or complex crime, or where the immediate attendance of a police officer was necessary. Guidance was provided to call centre staff as to the type of incidents which may be included in the appointments scheme. This included domestic abuse offences if the incidents were reviewed and authorised by an Inspector. Each appointment was for a maximum of 90 minutes and following a crime being recorded it would be allocated to a different officer if a further investigation was necessary.

Nevaeh contacted the police contact centre on the 9th February 2019 and reported that she was receiving harassment from Colin in the form of text messages. The report was risk assessed and determined that it should be managed by the response appointments scheme.

[12] Achieving Best Evidence interview - Used to capture the evidence of vulnerable and intimidated witnesses. https://www.cps.gov.uk/sites/default/files/documents/legal_guidance/best_evidence_in_criminal_proceedings.pdf

[13] The Avon and Somerset Constabulary Response Appointments Scheme

An appointment was provided for her to meet a police officer a week later and the process of dealing with Nevaeh's report complied with the policy and procedures at that time.

At Nevaeh's scheduled appointment on the 15th February, the officer identified that the matters being reported were more complicated than initially thought at the point of first contact. It was decided that Nevaeh's evidence should be obtained through an ABE video interview and this was arranged to be completed three weeks later. The interview did not however take place, due to a lack of trained staff to complete it. The lack of trained officers to conduct ABE interviews was identified by the police representative on the DHR panel as a key issue for the constabulary and forms a recommendation of this review.

At the conclusion of the scheduled appointment the crime investigation was forwarded for allocation to an investigating officer who worked on the response team, a team involved in shift working to deliver 24 hour policing. It was allocated on the 19th February and the first recorded attempt to contact Nevaeh by the officer in the case was the following day. After this there were a number of attempts to contact Nevaeh, which included leaving messages at her home. There were also unsuccessful attempts made by Nevaeh to contact the officer. Contact was not however established before Nevaeh died in April.

Whilst individual officers appeared committed in doing their best for Nevaeh, the use of the appointment scheme caused a number of issues. It affected the service provided to her and the constabulary's ability to respond to the allegations of domestic abuse. The key issues are outlined as follows:

a) The use of a scheduled appointment caused a systematic delay in recording and responding to Nevaeh's complaint of harassment. At the time of reporting the harassment she just wanted it to be stopped. Even if the ABE interview had progressed as scheduled, it would have been four weeks from the time of reporting the abuse to her evidence being recorded. Failing to address this conduct with Colin provided a lengthy time frame where abuse could continue. It would not be unreasonable to expect this delay to have reduced Nevaeh's confidence in the police to keep her safe.

b) Until the full details of Nevaeh's complaint had been explored, the risk to her could not be fully assessed. The delay in speaking with Colin would also have made it difficult to identify and manage any escalating risk, which may have occurred whilst waiting for Nevaeh's interview to be completed.

c) Reporting domestic abuse to the police must have involved great bravery and the need for Nevaeh to overcome a fear as to what may happen as a consequence. To maintain her confidence, quick action was needed to secure Nevaeh's evidence and address the matter with Colin. As time passed without any positive action, Nevaeh started to disengage from the police. This resulted in her evidence never being captured and the allegations of abuse against Colin never being investigated.

d) The failure to capture the full details of Nevaeh's disclosure was a critical issue in this case. It meant that an informed risk assessment could not be developed and in turn affected the multi-agency support for Nevaeh. For example if Nevaeh had been assessed as being at high risk of harm, then a MARAC referral and a multi-agency response may have followed. Additionally, if Colin had been arrested, then police bail conditions or a domestic violence protection order may have been used to exclude him from the

premises. This would have supported housing services in any further work to end the joint tenancy.

During the DHR, the police informed the review panel that the response appointment scheme was no longer in operation. This had been replaced with an enhanced Incident Assessment Unit which deals with non-attendance crimes and incidents. This unit includes specialist investigators whose remit includes the investigation of domestic abuse harassment. As these staff are not involved in the delivery of front line policing, their capacity to engage with victims and partnership agencies is greater than would be the case for a police officer working in the response teams.

The use of a scheduled appointment system for managing incidents is not a suitable response to the report of domestic abuse. It does not provide a person centred service and reduces the ability of the police service to tackle domestic abuse and protect victims. It is positive that the response appointments scheme has now been replaced by a more victim focussed approach and as such there is no requirement for the DHR to make any recommendations in relation to a change of system approach. There is a need however, for the constabulary to ensure that the Incident Assessment Unit is providing an effective victim focussed service to reports of domestic abuse. It is therefore recommended that a quality audit should be undertaken on the new procedures. The audit should focus on the quality of service and quality of investigation, including timeliness of investigation, timeliness of completing ABE interviews, and compliance with the victims' codes of practice.

As mentioned earlier in this section of the report, the lack of staff trained to conduct ABE interviews with vulnerable witnesses was an issue highlighted in Nevaeh's case. This remains a current issue for Avon and Somerset Constabulary and is likely to be a wider issue for the police service in general. It is recommended that this is reviewed by the constabulary and that plans are developed to address the issue. This should include how police teams involved in the investigation of domestic abuse, such as the Incident Assessment Unit, access trained staff in future cases.

Recommendation 4:	*It is recommended that Avon and Somerset Constabulary audit the Incident Assessment Unit to ensure that it is providing a victim focussed response to reports of domestic abuse.*

Recommendation 5:	*It is recommended that Avon and Somerset Constabulary develop plans to address the lack of staff trained to conduct ABE interviews with vulnerable witnesses.*

5. SUMMARY OF RECOMMENDATIONS AND RESPONSE PLAN

5.1. Summary of Recommendations

Recommendation 1:	Next Link staff, providing services within the IRIS scheme or any other Next Link service, should consider a need to coordinate the

	provision of services to victims with complex needs and those who are being supported by a number of agencies. This coordination should consider the use of professional meetings to share information and develop joint planning, which should be supported by all agencies regardless of the level of identified risk.
Recommendation 2:	It is recommended that Bristol City Council Housing and Landlord Services review their policies for supporting victims of domestic abuse. In particular this should include a policy for the proactive identification of domestic abuse and the development of a perpetrator toolkit.
Recommendation 3:	It is recommended that the current proposals to integrate housing and domestic abuse support services are commissioned and implemented.
Recommendation 4:	It is recommended that Avon and Somerset Constabulary audit the Incident Assessment Unit to ensure that it is providing a victim focussed response to reports of domestic abuse.
Recommendation 5:	It is recommended that Avon and Somerset Constabulary develop plans to address the lack of staff trained to conduct ABE interviews with vulnerable witnesses.

5.2. DHR Response Plan

The KBSP partnership has developed a response plan to this DHR which can be found in Appendix C.

Appendix A – Review Panel, Contributors and Independent Chair

1. Review Panel

Agency	Representative	Job Title / Role	IMR Provided
North Bristol NHS Trust	Claire Foster	Named Nurse for Safeguarding	No – Not required
University Hospitals Bristol NHS Foundation Trust (Including Unity Sexual Health)	Carol Sawkins	Senior Nurse Safeguarding	Yes
Bristol City Council Housing and Landlord Services	Krystal Presland	Policy & Practice Officer	Yes
	Martin Owen	Project Manager	
Avon and Somerset Constabulary	Andrew Sparks	D/ Inspector	Yes
	Lee Jones	D/ Inspector	
Next Link Bristol	Jayne Whittlestone	Senior Services Manager	Yes
Avon and Wiltshire Mental Health Partnership NHS Trust	Danielle Rowan	Domestic Abuse Lead	Yes
Bristol City Council Adult Social Care	Claudine Mignott	Service Manager	Yes
Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group	Paulette Nuttall	Head of Adult Safeguarding	Yes
Public Health, Bristol County Council	Sue Moss	Senior Public Health Specialist	No – Not required
	Lizzie Henden	Senior Public Health Specialist	
Womankind Bristol	Kyra Bond	Chief Executive Officer	No – Not required

2. Other Contributors

Contributor	Comment
Nevaeh's Family	Personal interview with the independent reviewer. Provided supporting documents.
Colin	Personal interview with the Independent Reviewer.
Nevaeh's Friends	Individual interviews with the independent reviewer.
Nevaeh's Employer	Personal interview with the independent reviewer and provided supporting documents.

3. The Independent Chair and Author

The independent chair and author of this report, Mark Power, is independent of the KBSP and all of the agencies involved in the review. Mark previously worked in the police service, serving with both Wiltshire Police and the Gloucestershire Constabulary. In addition to being an accredited senior investigating officer for homicide investigations, he specialised in protecting vulnerable people and led the police safeguarding teams for both children and adults. Through this work he developed extensive experience in multi-agency public protection and chaired a number of strategic partnership forums. Relevant experience in the context of this DHR includes being the strategic lead for the investigation of serious sexual offences and providing strategic oversight of the Multi-Agency Safeguarding Hub, which encompassed a multi-agency response to domestic abuse.

Mark is now an independent reviewer conducting a variety of safeguarding reviews. In addition to conducting DHRs, he is a published author for safeguarding adult reviews and child safeguarding practice reviews. He has completed the Home Office training to undertake DHRs and completes regular continuous professional development, including attendance at AAFDA seminars.

Appendix B – DHR Terms of Reference

DOMESTIC HOMICIDE REVIEW
TERMS OF REFERENCE

1. Introduction

These terms of reference have been produced to guide a Domestic Homicide Review commissioned by the Keeping Bristol Safe Partnership (KBSP). The review follows the death of Nevaeh who died in April 2019.

The decision to undertake this review was taken in accordance with the Home Office statutory guidance. An independent author has been appointed to lead the review and a multi-agency review panel has been formed by a number of agencies from the Safeguarding Partnership.

2. Purpose of Review

The purpose of this review is to support the development of safeguarding practice and services in Bristol. In particular it aims to:

- Establish what lessons are to be learned from Nevaeh's death, regarding the way in which professionals and agencies work individually and together to safeguard victims of domestic abuse.
- Identify how and within what timescales those lessons are to be acted on, and what is expected to change as a result.
- Apply these lessons to service responses including changing policies and procedures as appropriate.
- Prevent domestic homicide and improve the way services respond to all victims of domestic abuse, and their children, through improved partnership working.
- The overriding principle of the review is to prevent and reduce the risk of future harm. It is not conducted to hold individuals, organisations, or agencies to account, as there are other processes for that purpose.

3. Scope of Review

3.1 Persons Subject of the Review

- Nevaeh (Deceased)

3.2 Other Relevant Parties

- Colin (Nevaeh's ex-partner)
- Angela (Nevaeh's partner prior to her death)

3.3 Date Parameters

The review will examine all relevant information during the period of Nevaeh's relationship with Colin and Angela. Information will be deemed relevant as follows:

- 01/01/08 – Nevaeh's death in April 2019 – Details of all information in relation to domestic abuse between Nevaeh and either Colin or Angela.
- 01/01/08 – 01/11/18 – A summary of contact with Nevaeh and any relevant information relating to Colin or Angela.
- 01/11/18 – Nevaeh's death in April 2019 – Detailed chronology of involvement with Nevaeh and a detailed chronology of relevant contact with Colin or Angela.

3.4 Key Questions / Themes for Examination
Whilst the review will address any relevant theme found during the analysis of information, it will specifically examine the following:

1. The response to reports of domestic abuse reported by Nevaeh in the context of her relationships with Colin and Angela. Examining how different agencies responded in terms of risk assessment and planning, including how information was shared with other services.
2. How Nevaeh's mental health and wellbeing was considered and responded to.
3. Policies and procedures to support staff who may themselves be vulnerable, in their work supporting vulnerable service users with complex needs.
4. The potential role of the Multi-Agency Risk Assessment Conference (MARAC) arrangements in Nevaeh's case.

4. Methodology

Voice of Nevaeh
Nevaeh's family will have an integral role in the review, to ensure that events in Nevaeh's life are accurately reflected and the effects upon her fully considered. They will be supported by the charitable organisation Advocacy After Fatal Domestic Abuse (AAFDA).

Review Panel
A multi-agency review panel will be formed to deliver the review. This will involve key agencies from the Bristol Safeguarding Partnership. The role will be to critically analyse information and make recommendations for improved practice. This will be led by an independent reviewer and author. An organisation not forming part of the review panel may still be requested to produce information to the independent reviewer.

Individual Management Reviews
Each participating agency will produce Individual Management Reviews. The format will be a detailed chronology including a critical analysis of events. Authors will be assisted by an initial briefing and ongoing support.

Overview Report for Publication
An overview report will be prepared, suitable for publication following Home Office quality assurance. This will include an action plan endorsed by the KBSP and outlining how any improvements to safeguarding practice will be implemented.

5. Timescales

A Domestic Homicide Review should where possible be completed within a six month period. In this case six months from December 2020 when the review commenced.

Due to the current COVID-19 situation, which has an immediate impact upon many agencies participating in this review, the Home Office recognises that these timescales will need to be extended. Whilst there is no fixed date for completion of the review it will be conducted as expeditiously as possible in the circumstances.

Appendix C – DHR Action Plan

Recommendation	**Scope of recommendation** *Local/ Regional/ National*	**Action to take** *What specific actions will be taken to fulfil this recommendation? Ensure the actions are SMART: Specific, Measurable, Achievable, Realistic, and Timely*	**Lead Agency**	**Key milestones achieved in enacting recommendation** *What are the key milestones within the plan for completing these actions which can be measured for progress reporting?*	**Target Date** *When will these actions be completed?*	**Progress Monitoring** *To be completed throughout the action progress, including dates.*
1. Next Link staff, providing services within the IRIS scheme or any other Next Link service, should consider a need to coordinate the provision of services to victims with complex needs and those who are being supported by a number of agencies. This coordination should consider the use of professional meetings to share information and develop joint	Regional - The learning will be applied regionally across the organisation.	a) Review the process map for all Next Link staff to consider the need for wider agency meetings on cases b) Proactive identification of partners working with domestic abuse cases c) Process review of request for multiagency meeting d) Partners to agree to be part of these meetings	Next Link	a) Process map changed b) Staff briefed c) Meetings held d) Review in supervisions with staff Measure outcome: Performance framework to be developed for the monthly management review of performance measures. Performance measures to include: 1.Percentage of Next Link cases that include a multi-agency discussion.	The new processes and staff training to be completed by April 2022.	a) completed b) completed c) completed d) completed: May 2023

planning, which should be supported by all agencies regardless of the level of identified risk.				2.Percentage of Next Link cases that are referred to the MARAC meeting. 3.Quarterly quality audit, to include a dip sample of case files. Consideration for this to be a multi-agency audit.		
2.It is recommended that Bristol Housing and Landlord Services review their policies for supporting victims of domestic abuse. In particular this should include a policy for the proactive identification of domestic abuse and the development of a perpetrator toolkit.	Local – To address the issues outlined in the recommendation. National - To engage with a national consultation in relation to joint tenancy and domestic abuse.	a) Review DA policy b) Develop a proactive identification of domestic abuse and perpetrator toolkit c) Review training re joint tenancies d) Review process of request for tenancy change for joint tenancies, add DA enquiry/ advice part to the online web form and CSC scripting to proactively identify DA e) To engage with the national consultation in relation to joint	Bristol City Council Housing and Landlord Services	a) DA policy signed off and adopted by BCC H&LS b) Proactive identification and perpetrator toolkit developed and live c) Training for Estate Services reviewed d) online web form amended with prompt for DA and CSC scripting discussion in line with details of DHR for proactive identification of DA linked to joint to sole request e) Engaged with national consultation in relation to joint tenancy and DA Measure of outcome:	a) complete b) Spring 2023 c) Spring 2023 d) Spring 2023 e) complete	a) completed b) completed c) completed d) completed e) completed: May 2023

		tenancy and domestic abuse to highlight the learning as a national issue		A performance framework to be developed, for the regular management review of how H&LS are supporting victims of domestic abuse. This will develop an understanding of how people are identified as victims of abuse and how effective the measures are within the perpetrator toolkit. Specific measures will include: 1. Report developed to show percentage of DA cases (estate management) that include a referral to other relevant support agencies, for example Next Link. People experiencing DA can rightfully decline this offer but the offer needs to be made with the target set as being 100% - to show support is being offered by H&LS to all known victims. 2. New performance measures developed in line with the pro-active identification of domestic abuse guidance. For example, to audit/ refresh publication of DA services annually within communal		

				notice boards in housing blocks to educate and proactively promote ways of seeking support 3. Report to evidence actions undertaken by H&LS in relation to DA perpetrators in line with the introduction of the perpetrator toolkit		
3.It is recommended that the current proposals to integrate housing and domestic abuse support services are commissioned and implemented.	Local	IDVAs from the commissioned specialist domestic abuse service to be co-located in the Bristol City Council Housing team working in the Housing Options and Estates teams.	Bristol City Council	a) Funding agreed b) Job descriptions developed c) Recruitment process undertaken d) IDVA begins work Measure outcomes: Effectiveness reviewed via quarterly monitoring and 6-month presentation at Multiagency Domestic Abuse and Sexual Violence delivery group	a) Nov 2021 b) Nov 2021 c) Jan 2022 d) Feb 2022	a) completed b) completed c) completed d) completed In April 2023 one IDVA was appointed to work across housing, landlord and homelessness services. This has been found to be very positive approved until 2027
4.It is recommended that Avon and Somerset Constabulary audit the Incident Assessment Unit to	Local	To conduct an audit of the Incident Assessment Unit (IAU) examining the quality of investigation and the quality of service	Avon and Somerset Constabulary	1. Terms of reference to be completed for the audit. 2. Completion of the audit and production of an overview report to summarise findings.	1st September 2022	Complete The IAU have been conducting relevant audits to ensure that DA incidents are receiving

ensure that it is providing a victim focussed response to reports of domestic abuse.		provided to victims. Including: • Timeliness of investigations. • Timeliness of ABE Interviews conducted during investigations. • Compliance with investigative standards. • How the level of risk is affected following allocation of a case to the IAU. • The re- allocation of investigations in response to changing risk levels. The audit will be managed by key staff to provide a victim's perspective and a specific DA perspective.		3. Presentation of the overview report and any action plan to safeguarding partnership for scrutiny. 4. Share findings of the audit and the action plan with the family.		same level of service / protection as those where they had attendance. Every morning 3 random domestic tagged crimes are reviewed by the IAU and all followed the same assurance process. The Inspector will feedback to the line managers of the OICs (officer in the case). The Sergeants have been extremely receptive to this and we have already seen improvements regarding investigative action plans being adapted to ensure that all points are covered at the earliest point of the investigations. We are seeing a positive increase in the quality of investigations and also the recording of work on the Occurrence Enquiry Logs (OEL). For example, some officers would

						always consider victimless prosecutions, but would never actually write on the OEL's what there rationale for not pursuing was.
5. It is recommended that Avon and Somerset Constabulary develop plans to address the lack of staff trained to conduct ABE interviews with vulnerable witnesses.	Local	a) To train student Officers within the PEACE interview course, including a specific module of ABE witness interviewing. b) To provide specialist investigative staff with refresher and further enhanced training in relation to ABE witness interviewing.	Avon and Somerset Constabulary	a) students trained in PEACE interview course b) refresher training and enhanced training delivered to specialist investigative staff	April 2022	Complete Following a review, ASC now believes there to be a sufficient resilience of ABE trained staff within the core patrol team to maintain an effective investigative ability. Since 2017 ASC have provided all student officers (472) with 1.5 days training as part of their PEACE interview course. The training provides the student officers with the knowledge and awareness to identify those people who need ABE interviewing. It also provides them with the skills to obtain evidence

						using ABE skills for those minor offences. ASC continue to train specialist officers in ABE. Since Jan 2021 the following courses have been delivered with an intention to deliver more: • ABE Refresher 24 • ABE Basic 14 • ABE Bluestone 10 • Adult ABE 14 • PIP 2 Interviewing 47 There are now approx. 300 officers who have undertaken the formal ABE or SCAIDP training (PIP2 trained) and this provides them with the skills to manage the most vulnerable of witnesses.