Domestic Homicide Review Overview Report

Review into the death of Lauren, who died in March 2022 in Bristol

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Preface

The Independent Chair and Review Panel send their deepest condolences to all those impacted by Lauren's untimely death and thank them for their involvement and support in this process.

Lauren, her family and friends, and the alleged perpetrator, as accepted by her father, Luke, are pseudonymised. Only the independent chair and review panel are named.

The primary goal of a Domestic Homicide Review (DHR) is to facilitate learning from the death of an individual in a relationship where domestic abuse was suspected. For these lessons to be fully and effectively assimilated, professionals must understand the events in each instance and determine the most effective modifications to reduce the likelihood of domestic abuse-related deaths.

The chair thanks the panel and persons who submitted chronologies and materials for their time and cooperation.

Lauren's tutors commented warmly on her and spoke of the kindness and generosity that they observed in the short time that they knew Lauren. (University Two)

Lauren was an empathetic, selfless, and good person (Lauren's Housemate, Daniel)

Lauren was the most caring and loving person; she always bought something for others and wrote cards to tell the family how much she loved them.

1.1 Introduction

1.1.1 The report was written following the tragic suicide of Lauren, aged twenty-two, in March 2022. In October 2021, Avon and Somerset Constabulary (ASC) received the initial report of domestic abuse. James, Lauren's partner, was the perpetrator.

1.1.2 As a statutory requirement under Section 9 of the Domestic Violence, Crime and Victims Act (2004):[1]

"domestic homicide review" means a review of the circumstances in which the death of a person aged sixteen 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,

held to identify the lessons to be learnt from the death

1.1.3 This review was conducted following the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews[2] (referred to in the report as 'Guidance').

1.1.4 Section 2 of the Guidance emphasises the circumstances under which a DHR should be conducted concerning suicides:

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

1.1.5 Lauren was living in shared student accommodation in Bristol at the time of her death.

1.1.6 This review evaluates the agency's responses and support to Lauren during her final years, specifically from **March 2018 until March 2022**.

1.1.7 Lauren moved alone from her hometown to Bristol in September 2017 to pursue her academic goals. In August/September 2021, she initiated an intimate

[1] https://www.legislation.gov.uk/ukpga/2004/28/section/9
[2] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

relationship with James. Consequently, the scoping period encompasses an examination of the abusive relationship.

1.1.8 The review assessed the community support available, the challenges faced, and the history of abuse involving Lauren. It also examined strategies to reduce similar risks in the future through a comprehensive approach.

1.1.9 This review is not intended to replace criminal or coroner's court proceedings or resemble a disciplinary hearing.

1.2 Case Summary

1.2.1 Lauren was found hanged in her bedroom by Daniel, her housemate in March 2022. James had phoned Daniel after becoming concerned about his inability to contact her.

1.2.2 No suicide note was found, but several blue tablets, believed to be diazepam (a benzodiazepine drug, which are prescription-only medications used to treat various conditions, including anxiety[3]) and a half-empty bottle of wine were discovered in her bedroom.

1.2.3 Lauren's friends suggested that James's suicidal thoughts and domineering behaviour may have influenced Lauren's actions.

1.2.4 In September 2017, Lauren enrolled in a full-time course at the University of Bristol (UOB) and graduated in July 2021 with a 2:1 degree.

1.2.5 Lauren was registered at a University GP Practice from October 2018 to March 2022. Lauren disclosed a history of self-harm to UOB.

1.2.6 Lauren contacted ASC in November 2018 to report that the boyfriend of a friend had raped her in October 2018. In November 2018, she self-referred to the Student Counselling Service (SCS).

1.2.7 In March 2019, her GP referred her to the Student Health Emotional Regulation Pathway (SHERPA[4]). In March 2020, she received support from the Bristol Wellbeing and Counselling Services.[5]

1.2.8 Lauren attended University Two In October 2021.

[3] https://www.nhs.uk/medicines/diazepam/

[4] https://studenthealthassociation.co.uk/pconf/Loughborough_2017/Student%20Health%20Assoc%20SHERPA%20Talk%2029%20June%20(2).ppt

[5] https://www.bristol.ac.uk/students/support/wellbeing/request-support/services/

1.2.9 Lauren's last interaction with ASC occurred in October 2021, concerning an allegation of rape by James. The allegation was filed due to the lack of evidence, and Lauren declined to support the ASC investigation.

1.2.10 During the investigation into the alleged rape, Lauren informed ASC about her two-month relationship with James. She reported that they had spent nearly every day together and that she was rarely alone. Lauren had skipped university classes, quit her job, and stopped her gym visits to spend more time with him. Additionally, he often picked her up unexpectedly from university.

1.2.11 Lauren informed ASC that James had asked her to record their conversation so he could listen to it later. She recorded the initial part of the discussion and then turned off the recording.

1.2.12 Lauren said James had suggested a suicide pact twice, the first time by overdosing with 100 Xanax (a benzodiazepine not available from the NHS; it can be obtained privately or illegally[6]) and the second with razor blades.

1.2.13 Lauren disclosed that James frequently threatened to take his own life to manipulate her and discourage her from leaving him to pursue university or work. She reported that James had been diagnosed with borderline personality disorder (BPD) and that his behaviours aligned with the traits of this condition.[7]

1.2.14 Lauren had visited Clifton Suspension Bridge on numerous occasions due to James's threat to end his life if she did not stop him.

1.2.15 Lauren informed ASC that she had a diagnosis of BPD, talked to the Samaritans[8] regularly, had the mental health crisis team number (Avon and Wiltshire Mental Health Partnership NHS Trust, AWP) in case of an emergency, and had a care coordinator (a key point of contact for patients who are receiving mental health services) from the Bristol Assessment and Recovery Team (AWP) whom she met weekly.

1.2.16 Lauren described her mental health at the time of officers' attendance as *"as bad as it's ever been,*" and she had self-harmed six times during the brief relationship with James (she had not self-harmed for an extended period before their relationship). James had encouraged her to engage in self-harm and had shown her where he stored razor blades in his home if *she "needed to self-harm."*

[6] https://ukhsa.blog.gov.uk/2018/07/30/alprazolam-xanax-what-are-the-facts/
[7] https://www.nhs.uk/mental-health/conditions/borderline-personality-disorder/sympJamess/
[8] https://www.samaritans.org/how-we-can-help/contact-samaritan/?gad_source=1&gclid=Cj0KCQiAvbm7BhC5ARIsAFjwNHt5jfzgWYbjAHeDkXpu1z5ahXtdOsS8nKzv2fNrxZjOb1_GXrcmmUsaAiSoEALw_wcB

1.2.17 After her death, one of Lauren's housemates said that Lauren had told him James had cut his arm in front of her, blamed her for it, and told her to take her own life.

1.3 Background information about Lauren

1.3.1 Lauren died at the age of twenty-two. In 2017, she relocated to Bristol at 18 to pursue a language degree and successfully concluded her undergraduate degree in 2021.

1.3.2 Lauren lived abroad with her parents from age five to thirteen. Lauren's father left the family home when she was ten, and they became estranged. She reconnected with him in the UK four years before her death.

1.3.3 Lauren disclosed to SCS that she had endured bullying during her childhood and continued to experience persistent issues with her body image, particularly about her weight. She disclosed that she attempted suicide for the first time at the age of fifteen.

1.3.4 Lauren had a close relationship with her older sister and younger brother, with whom she expressed considerable concern.

1.3.5 Daniel described Lauren as a selfless, empathetic, and good person. He noted that Lauren was lonely at university, had few friends, and had *"weird relationships with men."*

1.3.7 Lauren concluded her secondary education at a state comprehensive high school and attended a sixth-form college before attending university. Her University and College Admissions Service[9] (UCAS) application reflected her affection for learning a language because of her residency abroad from ages five to thirteen. Additionally, she demonstrated an interest in mental health in her statement, referencing her experience as a school "health champion" and fundraising for Papyrus[10].

1.3.8 In October 2018, Lauren disclosed that she had been raped by a colleague (ASC report indicated that the alleged perpetrator was a friend's boyfriend) to her university tutor, who referred Lauren to SCS. Lauren declined assistance at this time and was referred to a local sexual violence service and directed to her GP.

[9] https://www.ucas.com/
[10] https://www.papyrus-uk.org/aboutus/

1.3.9 Initially, SCS declined to accept the referral because it assessed the risk as too high. Nevertheless, Lauren received their assistance after the referral was reviewed, and a senior well-being advisor/sexual violence liaison officer[11] (SVLO) assumed responsibility for her case.

1.3.10 Lauren reported the alleged rape to ASC in November 2018, which concluded in September 2020 with no further action.

1.3.11 In November 2018, Lauren sought counselling from UOB, citing her struggles with anxiety and depression. She was prescribed sertraline (an antidepressant) and pregabalin for anxiety. She disclosed that she frequently engaged in self-harm, often taking *"dangerous risks with her health,"* abused Xanax, and occasionally entertained suicide plans. However, she identified her family as the reason she did not wish to end her life, as she felt she needed to live for them.

1.3.12 Lauren was referred to AWP by her GP in January 2019. The referral noted that Lauren had experienced anxiety, depression, and emotional instability for five years and that these symptoms had worsened since an alleged sexual assault in October 2018.

1.3.13 Lauren's initial contact with AWP was in January 2019, during which they recognised her exceptional motivation to excel academically. Lauren disclosed that she maintained a complex relationship with her mother, that her father resided abroad, and that she had recently visited him. The dosage of pregabalin was increased after a review of her medication. For several months, she had been abusing Xanax and was unable to discontinue. Additionally, she consumed alcohol and cannabis and had experienced symptoms of bulimia nervosa (eating disorder[12]).

1.3.14 Lauren was referred to Safe Link (Avon and Somerset-wide independent support for rape and sexual abuse victims[13]) by The Bridge, a Sexual Assault Referral Centre (SARC[14]). Lauren was allocated an independent sexual violence advisor (ISVA) from May 2019 to January 2021.

1.3.15 In 2021, Lauren started a master's in creative writing at University Two and was due to complete it in September 2022.

1.3.16 Lauren and James were in an intimate relationship from August/September 2021 until her death in March 2022.

[11] https://reportandsupport.bristol.ac.uk/support/sexual-violence-liaison-officer-support
[12] https://www.nhs.uk/mental-health/conditions/bulimia/
[13] https://safelinksupport.co.uk/services/independent-sexual-violence-advisors/
[14] https://www.lighthousevictimcare.org/organisation/the-bridge-sarc/

1.4 Timescales

1.4.1 The Keeping Bristol Safe Partnership (KBSP) received a referral from ASC in March 2022. Twenty-four agencies that potentially had contact with Lauren and James before the point of death were contacted and asked to confirm whether they had involvement with them. Eight agencies contacted confirmed contact with Lauren and were asked to secure their files. The case was discussed at the KBSP meetings convened in March 2022 and June 2022. The DHR criteria was determined to have been satisfied by the Safeguarding Adult Review and DHR sub-group.

1.4.2 KBSP commissioned the DHR in response to a decision to proceed with a review in July 2022.

1.4.3 The independent DHR chair/author was commissioned in September 2022.

1.4.4 The first panel meeting was held on 4 October 2022.

1.4.5 A second panel meeting was held to review the agencies' chronologies. Three agencies completed individual management reviews (IMR), while four, with minimal contact with Lauren, completed summary reports.

1.4.6 The report was presented to the KBSP on 29 November 2023, and the final report was accepted on 23 April 2024.

1.4.7 The Guidance mandates that reviews, including the overview report, should be completed within six months of their commencement whenever feasible. The chair agreed that the panel required additional time to generate their reports and review and agree on the recommendations for the overview report.

1.4.8 The family was grieving and required time to ensure they could participate.

1.4.9 Subsequently, the conclusion of the review was delayed.

1.5 Confidentiality

1.5.1 This review is confidential until the Home Office Quality Assurance Panel approves the release of the overview report for publication. Only contributing professionals and their line managers had access to the confidential information.

1.5.2 The following pseudonyms have been used throughout the report to preserve the victims' families and alleged perpetrators' identities. The date of death has also been removed.

Role	Pseudonym	Support offered
Victim	Lauren	N/A
Mother	Sophie	Sophie was provided with information on an advocacy service. The Home Office DHR leaflet was sent to Sophie with an introductory letter from the KBSP to inform her that a review was taking place and introduce the review chair/author. Sophie shared with the review author that she was grieving and had reported feeling overwhelmed by the review process, her ongoing family responsibilities, and the large amount of paperwork she needed to manage. Therefore, the priority was to ensure she had access to the advocacy service, which was emphasised during the calls with the chair.
Father	Luke	The Home Office DHR leaflet was sent to Luke with an introductory letter from the KBSP to inform him that a review was taking place and introduce the review chair/author. Luke declined the offer of advocacy or any other support service.
Housemate	Daniel	Links to Daniel's local support services were provided, and a link to the Home Office DHR leaflet was sent via text message.
Ex Partner	Adult A	N/A
Alleged perpetrator	James	No contact was made; the panel knew he had mental health struggles, and it was unclear how this would impact him and what support he had available. In addition, no contact details were available for James.

1.6 Terms of Reference/Key Lines of Enquiry

1.6.1 This review intends to identify the lessons learned from Lauren's tragic death and respond to those lessons to prevent domestic abuse-related deaths and ensure that individuals and families are supported effectively.

1.6.2 The agreed Terms of Reference:

1. Identify good practices where responses may have exceeded the required standards.
2. Were service responses to Lauren affected by the COVID-19 pandemic (review relevant contact/response with current impact at that time)?
3. Does your organisation have any information, such as knowledge of Lauren's history, adverse childhood experiences (ACEs), or trauma, which helps to understand the possible 'triggers' that existed in her life that may have led to her death by suicide?
4. How accessible were the services for Lauren?
5. Were local domestic abuse and adult safeguarding procedures followed by agencies who had contact with Lauren?
6. What knowledge/information did your agency have that indicated that those involved might be victims or perpetrators of domestic abuse, and how did your agency respond to this information?
7. Were any perpetrator disruption or victim safety planning options available to your agency/agencies during this review? If so, were they considered, or were there barriers to using them?
8. Did your agency have policies and procedures for identifying domestic abuse and dealing with those concerns? Were these assessment tools, procedures and policies considered effective?
9. Was information shared promptly and to all appropriate partners during the period covered by this review?
10. Were joint assessments taking place to assess factors such as mental ill-health and domestic violence abuse?
11. What were the key points or opportunities for assessment and decision-making in this case? Do reviews and decisions have been reached in an informed and professional way and in keeping with organisational and multi-agency policies and procedures?
12. Was there any additional action that could have been taken, and would it have made a difference? (Missed opportunities?)
13. Were there issues about capacity or help in your agency that impacted the ability to provide services to the victim, the alleged perpetrator(s), or any other relevant others? If so, did these issues affect the agency's ability to work effectively with other agencies?
14. Are there lessons to be learned from Lauren's death relating to how your agency works to safeguard victims and promote their welfare or the form that it identifies, assesses, and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management, and supervision, as well as working in partnership with other agencies and resources?
15. Are there areas where agencies can identify where national or local improvements could be made to the existing legal and policy framework?
16. The reports should consider any equality and diversity issues, including social status that is pertinent to the victim and alleged perpetrator, e.g.

age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

1.6.3 The Domestic Abuse Act (2021) specifies the following legal definition of domestic abuse:

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

(a) A and B are each aged 16 or over and are personally connected, and
(b) the behaviour is abusive.
Behaviour is "abusive" if it consists of any of the following—
(a) physical or sexual abuse;
(b) violent or threatening behaviour;
(c) controlling or coercive behaviour;
(d) economic abuse;
(e) psychological, emotional, or other abuse; it does not matter whether the behaviour consists of a single incident or a course of conduct.
"Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to—
(a)acquire, use, or maintain money or other property, or
(b)obtain goods or services.
(5) For the purposes of this Act A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child).

Two people are "personally connected" to each other if any of the following applies:

(a) they are, or have been, married to each other;
(b) they are, or have been, civil partners of each other;
(c) they have agreed to marry one another (whether or not the agreement has been terminated);
(d) they have entered into a civil partnership agreement (whether or not the agreement has been terminated);
(e) they are, or have been, in an intimate personal relationship with each other;
(f) they each have, or there has been a time when they each have had, a parental relationship concerning the same child;
(g) they are relatives.

1.7 Methodology

1.7.1 The Guidance outlines the procedure for conducting a DHR.

1.7.2 Lauren was a resident of Bristol at the time of her death; consequently, Bristol agencies comprised the review panel. Additionally, agency documents from her hometown were sourced. These agencies were not obligated to participate in the review, as no significant agency interactions existed.

1.7.3 At the first meeting of the review panel, panellists shared their agency engagements for Lauren.

1.7.4 Within the agreed timeframe, agencies submitted a chronology of their contact with Lauren. The chronology determined which agencies would be required to conduct an IMR or a summary report.

1.7.5 To ensure appropriate independence and quality, IMRs and summary reports were written by professionals not involved in direct case management or service delivery for Lauren. The reports allowed the panel to analyse agency interactions with Lauren and compile the lessons learned.

1.7.6 The authors of the IMRs and summary reports made seventeen recommendations concerning single-agency improvements, and the panel made eight multi-agency recommendations.

1.7.7 The panel met a total of five times.

1.7.8 The chair spoke to Lauren's family and friends to gain a holistic view of her experience.

1.8 Involvement of Family, Friends, Neighbours and Wider Community

1.8.1 The chair of the review and the review panel acknowledged the vital role Lauren's family and friends could play in the review.

1.8.2 **The chair contacted Lauren's mother, Sophie, by telephone on 3 November 2022**.

1.8.3 Sophie learnt of Lauren's relationship with James in November 2021. She believed that Lauren had met James online. Lauren had reported James' abusive behaviour to Sophie and encouraged her to contact ASC. Sophie shared that Lauren identified James as controlling and coercive at a meeting with the ASC officer (October 2021), whom Lauren regarded very supportive.

1.8.4 Sophie stated that Lauren's housemates did not want James back at the house because he had caused damage to the property. Lauren had promised her mother that she would end the relationship, and Sophie discovered in Lauren's diary after her death that she intended to do so.

1.8.5 Sophie regarded Lauren as lonely due to her mental illness. Before her relationship with James, she had been in a two-and-a-half-year relationship [with Adult A] that Sophie considered supportive. According to Sophie, Lauren desired a reconciliation; however, Adult A did not.

1.8.6 Sophie last spoke with Lauren the day before she died; the conversation was positive, and they laughed. Lauren requested that her mother refrain from calling her while she was studying, indicating that she would contact her mother instead. Sophie stated that Lauren had always aimed for grade As and worked hard to obtain them.

1.8.7 Sophie informed the chair that the inquest was set for the following week and that she would be better positioned to discuss Lauren then. She agreed to email the chair a picture of Lauren to share with the panel.

1.8.8 Sophie spoke about feeling frustrated and saddened about how she learnt of Lauren's death, which occurred many days after Lauren died. She requested that the panel explore this matter. Sophie was encouraged to pursue this matter further with the help of advocacy, as it was outside the scope of the terms of reference. The chair provided her with the details of Advocacy After Fatal Domestic Abuse[15] (AAFDA).

1.8.9 **The chair spoke with Lauren's father, Luke, on 17 November 2022**. He remarked that he could not discuss Lauren at length as her death continued to upset him.

1.8.10 Luke was aware of James, whom he said was significantly different from Adult A, whom he regarded as *"level-headed."* Luke believed Lauren was still recovering from ending this relationship and was vulnerable when she began seeing James.

1.8.11 Lauren had informed him that James would become aggressive after he drank too much alcohol. As a result, Luke requested that Lauren refrain from bringing James to their home during her visits.

1.8.12 Luke suspected Lauren consumed too much alcohol and was under the influence of *"something else."* These assumptions stemmed from Lauren's social media posts.

1.8.13 Luke was aware that Lauren was seeing a counsellor and taking medication for her stomach, which he assumed was due to the stress of university.

[15] https://aafda.org.uk/

1.8.14 Luke revealed that he had been estranged from Lauren's mother for thirteen to sixteen years. Luke did not enter Lauren's life until she contacted him four years before her death. He stated that Lauren had been informed that her father had moved to another continent, which was incorrect.

1.8.15 Luke stated that he and Lauren had grown close in the last four years and that he only had fond memories of her.

1.8.16 **On 3 January 2023, the chair contacted Lauren's housemate, Daniel, by telephone**. He had discovered Lauren's body.

1.8.17 Lauren had been Daniel's friend since they started university in 2017. He felt her mental health had deteriorated in the last year of her life. He described her as an *"alcoholic;"* she would drink first thing in the morning, and he could not recall her being sober in the previous six months of her life. He reported that she drank gin and wine and took diazepam for anxiety. He believed Lauren always had an issue with alcohol.

1.8.18 Daniel knew that Lauren had been dating James since August or September 2021 and that they had met online. He stated Lauren was isolated, did not have many friends at university, and was challenging to live with because of her ill mental health and relationship with James. He stated that the other housemates only met Lauren in October 2021.

1.8.19 Daniel recalled an incident whereby he heard James in Lauren's room throwing things around. Lauren had told Daniel about the difficulties in her relationship with James. Daniel had also seen text messages James sent Lauren in which James threatened to harm himself if she did not answer the phone.

1.8.20 Lauren informed Daniel that James had taken some pills and suggested that she and James do this together. He also alleged that James had knives in his van and had cut himself; Daniel had seen James with bandages on his arms.

1.8.21 In October 2021, Daniel stated that Lauren awoke to discover James raping her, and when she ordered him to stop, he refused.

1.8.22 Daniel stated he was compelled to call ASC on James as he had threatened to *'cut'* him. As a result, Daniel banned James from visiting the house.

1.8.23 Daniel was hesitant about whether Lauren wanted to leave James, and James would threaten to kill himself if she did. Daniel believed Lauren depended on James. Lauren would be with James for extended periods when Daniel would not see her.

1.8.24 Daniel was aware Lauren received mental health support from a community support worker who would visit her at home, and she also attended counselling. He added that Lauren informed him that she had a difficult childhood. He felt Lauren's parents were unaware of Lauren's alcohol and drug addiction.

1.8.25 Daniel was made aware (unclear how he learnt this) of James's prior girlfriend, whom he had abused. He believed ASC should undertake a comprehensive investigation into this matter. Consequently, he harboured concerns that another woman might initiate a relationship with James and be exposed to a level of risk comparable to Lauren.

1.8.26 Daniel knew one person close to Lauren from her hometown but did not have her contact information.

1.8.27 The report was shared with Sophie and Luke to allow them to comment on and discuss the findings with the chair. Unfortunately, neither Sophie nor Luke responded after receiving the report.

1.9 Contributors to the Review

1.9.1 The following agencies and their contributions to this review:

Agency and Profile	**Contribution- Chronology/IMR/Summary/Other**
Avon and Somerset Constabulary (ASC)	Chronology and Summary Report
Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) Provides inpatient and community-based mental health services to 1.6 million people in the region.	Chronology and IMR
Bristol North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB) This includes councils, NHS hospitals, GP practices, and community and mental health services. They are working to enhance health and well-being, decrease inequities, and offer services to the one million Bristol, North Somerset, and South Gloucestershire residents.	N/A
GP	Chronology and IMR
Safe Link (Specialist Sexual Violence and Domestic Abuse Service) Provides domestic abuse support, mental health care for women, men and children and independent support for rape and sexual abuse victims.	Chronology and Summary Report
North Bristol NHS Trust	Chronology and Summary Report

A hospital and community healthcare facility for Bristol, South Gloucestershire, and North Somerset residents, it is also a regional centre for neurosciences, plastics, burns, orthopaedics, and renal.	
University Hospital Bristol and Weston NHS Trust includes Bristol Royal Infirmary (BRI) Provides services from the neonatal intensive care unit to care for the elderly and the residents of Bristol, Weston, and the southwest from birth to death.	Chronology and Summary Report
University of Bristol (UOB) Focused on addressing future global challenges through exceptional education, world-class research, and an entrepreneurial mindset.	Chronology and IMR
University Two Higher education institution Due to confidentiality and the institution's size, which could expose Lauren, the name is withheld.	Chronology and IMR

1.10 The Review Panel Members

1.10.1 The independent panel members for this review were the following:

Role	Organisation
Detective Chief Inspector	Avon and Somerset Police
Head of Safeguarding All Ages	Avon and Wiltshire Mental Health Partnership NHS Trust
University Representative	University Two
Designated Professional/Nurse for Safeguarding Adults	BNSSG Integrated Care Board
Head of Service	GP
Senior Public Health Specialist	Bristol City Council Public Health
Senior Services Manager	Safe Link/ Next Link (Specialist Sexual Violence / Domestic Abuse Service)
Head of Safeguarding	North Bristol NHS Trust
Interim Operational Lead- Adult Learning Disability and/or Autism Services	University Hospital Bristol and Weston NHS Trust
Head of Complex Student Casework and Safeguarding	University of Bristol

1.11 Chair and Author of the Overview Report

1.11.1 Parminder Sahota is an independent reviewer who has worked in Safeguarding and Domestic Abuse for eleven years and obtained DHR Chair training in 2021

from AAFDA. She has worked in the NHS for over twenty years as a Mental Health Nurse with a particular focus on crisis work and working with persons diagnosed with a personality disorder. She was employed as the Director of Safeguarding, Prevent (counterterrorism) and the Domestic Abuse Lead for an NHS Trust.

1.11.2 Before this review, Parminder had no contact with Lauren's family or friends and is independent of all participating agencies. However, she had previously undertaken a Safeguarding Adult Review for the KBSP.

1.12 Parallel Reviews

1.12.1 In November 2022, a Coronial Inquest established the medical cause of death as hanging, concluding that the death was suicide.

1.13 Equality and Diversity

1.13.1 During the review process, the review chair and panel reviewed all protected characteristics under the Equality Act (2010).

1.13.2 Lauren was a female of white British heritage and was twenty-two years old at the time of her death.

1.13.3 The relevant characteristics are age, disability, and sex.

1.13.4 The Office of National Statistics[16] released data on domestic abuse, including victim characteristics.

1.13.5 According to the data, domestic abuse victims were significantly more likely to be female than male. For instance, 53% of the victims of domestic abuse-related violence were female, whereas 26% were male. In addition, 57% of victims aged 30-34 were female, while 34% of victims aged seventy-five and older were male. According to the data, 53% of victims in Lauren's age group were female, while 25% were male.

1.13.6 According to Refuge[17], every thirty seconds, the police receive a report of domestic abuse, though it is estimated that this represents just a quarter of all actual instances of domestic abuse. In addition, the research highlighted by

[16] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2021
[17] https://refuge.org.uk/what-is-domestic-abuse/the-facts/

Hestia[18] suggested domestic abuse is related to depression and estimated that three women each week take their own lives because of domestic abuse.

1.13.7 A study by the University of Warwick and Refuge presented extensive and substantial evidence on the incidence of suicidal ideation among domestic abuse victims. This study is the first of its kind, suggesting this is an under-researched area. The study emphasised risk factors such as depression, psychological distress, despair, hopelessness, difficulties with drugs or alcohol, childlessness, and cumulative experiences of abuse, particularly sexual abuse.

1.13.8 The data identifies domestic abuse as a gendered crime; although men are abused, women are more likely to face recurrent and severe abuse.[19]

1.13.9 Lauren had no children, her parents were estranged, and she shared a home with housemates. Lauren was reported to be a victim of rape in two separate incidents in 2018 and 2021.

1.13.10 Lauren was diagnosed with BPD; characteristics of this disorder include a disturbed thinking style, impulsive behaviour, and difficulties managing mood. People with BPD may also have intense but unstable relationships.[20] Lauren had detailed an intense relationship with James with the ASC, who she reported had had BPD and wanted to spend every moment with her.

1.13.11 There is anecdotal evidence from domestic abuse services that some victims with personality disorder characteristics have been held culpable for domestic abuse, and the disorder has been utilised as a form of victim blaming.

1.13.12 The National Institute of Mental Health England[21] issued guidance in 2003 titled "*Personality Disorder: No Longer an Exclusion Diagnosis,"* emphasising how persons with this diagnosis are inappropriately admitted to mental health units.

1.13.13 Despite the 2003 guidance, personality disorder remains stigmatised, with opposing opinions among some healthcare professionals and the public. In addition, a personality disorder is also associated with criminality and danger in the public mind.[22]

1.13.14 The examination of mental health issues, domestic abuse, and coercive control is facilitated by the application of an intersectional perspective.

[18] https://www.hestia.org/blog/domestic-abuse-suicide
[19] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/domestic-abuse-is-a-gendered-crime/
[20] https://www.nhs.uk/mental-health/conditions/personality-disorder/
[21] http://personalitydisorder.org.uk/wp-content/uploads/2015/04/PD-No-longer-a-diagnosis-of-exclusion.pdf
[22] https://www.candi.nhs.uk/sites/default/files/Documents/practitionerguide_0.pdf

1.13.15 A social issue cannot be viewed through the lens of a single identity, such as race or gender, as per an intersectional approach. Focussing exclusively on a single identity marker, such as gender or ethnicity, can obscure the full extent to which oppressive institutions influence individuals' identities.[23]

1.13.16 The unique intersectional factors identified for Lauren included poor mental health, alcohol and substance misuse, being a student away from her family and home network, and a lack of social support while in Bristol, as noted by Daniel.

1.13.17 Acknowledging these unique factors enhances the understanding of Lauren's vulnerability and potential responses to domestic abuse, highlighting the need for agencies to frame coercive control within an intersectional perspective. The factors are further explained within the terms of reference.

1.13.18 The factors may enable abusers to exploit and manipulate situations, which may inhibit effective interventions or prevention.

1.13.19 To understand how abusers exploit these factors, it is necessary to understand their protected characteristics. The chair acknowledged that consent had not been obtained from James, who was alleged to have perpetrated domestic abuse towards Lauren. The panel, however, was aware of his mental health issues.

1.13.2 According to an analysis of DHRs[24], most domestic abuse suicide victims were female. At the same time, the alleged perpetrators were male and, most commonly, partners or ex-partners. Mental health issues were recorded in 94% of the reviews, and in almost half of the reviews, there was evidence of self-harm. In addition, 40% of the victims were aged 25–34. James was reported to have engaged in self-harm and, according to Lauren's friends, would motivate Lauren to do so.

1.13.20 Coping responses of victims-survivors may be affected by domestic abuse, and experiences of coercive control may create barriers to seeking support and engaging with services and affect their relationships with others.[25]

1.13.21 The analysis of DHRs published in England and Wales was conducted in a 2023 study that reviewed the mental health service use of perpetrators of domestic homicides.[26]

[23] https://www.genesisshelter.org/intersectionality-and-domestic-violence/
[24] http://wrap.warwick.ac.uk/174206/1/WRAP-learning-legacies-analysis-domestic-homicide-reviews-cases-domestic-abuse-suicide-2023.pdf
[25] https://education.gov.scot/media/kwilejb4/da-trauma-companion-pack.pdf
[26] MacInnes P, Calcia MA, Martinuzzi M, Griffin C, Oram S, Howard LM. Patterns of mental health service use among perpetrators of domestic homicide: descriptive study of Domestic Homicide Reviews in England and Wales. BJPsych Bulletin. 2024;48(6):341-349. doi:10.1192/bjb.2023.91

1.13.22 The research revealed a high prevalence of mental health issues among perpetrators of domestic homicides. Furthermore, 43.5% of the perpetrators reported a history of self-harm or suicidal ideation or behaviour before the homicide, and 21.5% of the homicides were followed by suicide attempts or death by suicide. According to Lauren's friends, James was alleged to have a history of substance misuse and would threaten suicide if Lauren did not respond to his messages or visit him.

1.13.23 The research also found that comorbid substance misuse or personality disorder increased the risk of intimate partner homicide by males with a psychiatric diagnosis. Lauren disclosed that James shared her diagnosis.

1.13.24 The study stressed the significance of conducting routine domestic abuse enquiries for individuals who are seeking mental health services for substance misuse, self-harm, suicidality, anxiety and mood disorders. Healthcare services are also suggested to play a critical role in identifying perpetrators of domestic abuse who may be seeking assistance with relationship difficulties.

1.14 Dissemination

1.14.1 After the Home Office grants permission to publish, this report will be widely disseminated, including, but not limited to:

- Members of the Keeping Bristol Safe Partnership.
- Agencies represented.
- Local Police and Crime Commissioner.
- The report will also be published on the Keeping Bristol Safe Partnership and Bristol City Council Website.

2.1 The Facts

2.1.1 Lauren shared a house with students from UOB. In August/September 2021, she began a relationship with James, which she described as intense. She received counselling while at UOB and reported having a diagnosis of BPD. Lauren reported ongoing self-harm whilst at UOB, and the relationship she described with James made her feel depressed more than ever before.

2.1.2 Lauren was accepted on a master's course at University Two, which commenced in October 2021.

2.1.3 Lauren received input from AWP from January 2019 to her death. Her communication with them in October 2021 revealed that she was suicidal and cutting herself.

2.1.4 In December 2021, she travelled to see her father and reported experiencing a breakdown that included misuse of benzodiazepines and excessive alcohol. AWP assessed her in December 2021, reviewed her prescription, and made plans to assist her in lowering her benzodiazepine and alcohol consumption.

2.1.5 In January 2022, Lauren requested access to counselling from University Two.

2.1.6 AWP last saw Lauren in February 2022; she presented with a low mood and recurring suicidal ideation. However, she reported that her studies were going well. She reported to have stayed out of the county with James because her housemates bullied her. AWP determined that Lauren was at a low risk of intentional self-harm and suicide, and they advocated for more face-to-face contact.

2.1.7 Lauren was discovered hanged in her shared home in Bristol by Daniel in March 2022.

2.2 Combined Chronology March 2018 to March 2022

2.2.1 The panel agreed to incorporate additional context to enhance the understanding of Lauren's experiences and challenges.

October 2017

2.2.2 During Lauren's initial GP registration, a comprehensive assessment of her physical and mental health was completed, including a medication review. Her history of depression, anxiety, Child and Adolescent Mental Health Services (CAMHS) involvement, and antidepressant use were discussed, and domestic and emotional abuse were enquired about.

October 2018 to January 2019

2.2.3 Lauren received mental health support from her GP and the student well-being team. She was referred to AWP as an emergency in January 2019 due to mental health deterioration.

October 2018

2.2.4 UOB's student services learned of Lauren in October 2018 when she told her senior tutor about a serious sexual assault by a colleague unrelated to the university (the report to ASC identified the alleged suspect as a friend's

boyfriend). The tutor notified SCS, and Lauren declined further support. She was referred to a local sexual violence service and directed to her GP.

November 2018

2.2.5 SCS initially declined the referral due to high risk but revised their decision later that month and offered counselling. However, her first session occurred in February 2019 due to the waiting list and scheduling conflicts. Lauren reported that after confronting her colleague and losing her job the same month, she reported the sexual assault to ASC.

2.2.6 Lauren informed ASC that she, her friend and the friend's boyfriend (suspect) had been drinking together. The friend invited her to the home, which she shared with the suspect. All three eventually retired to the same bed in the early morning hours. Lauren subsequently disclosed that the suspect subjected her to sexual assault, which included penetration for a period of approximately four to five hours. In the ASC interview, the suspect denied sexual assault. He claimed that he had cuddled Lauren, thinking it was his girlfriend, but then realised and stopped. He denied rape.

December 2018

2.2.7 Lauren informed UOB that she felt suicidal when the suspect allegedly assaulted his girlfriend, and he expressed a wish to end his life. In addition, she expressed feelings of self-hatred and was smoking cannabis.

January 2019

2.2.8 Lauren informed UOB that her relationship with her mother was strained because of her reconnection with her father.

2.2.9 First contact with AWP following a referral from Lauren's GP. Lauren had seen her father abroad and described the experience as emotional and challenging. She reported experiencing body image issues and indicated she is a size eight but considered herself overweight. She believed her mother had left out specific information about her father.

February 2019

2.2.10 Lauren attended AWP for a mental health assessment with Adult A. She informed AWP that she used Xanax to cope with her emotional difficulties, which had increased due to family stress. She did not believe she was addicted to Xanax and declined input from the Bristol Drugs Project[27] (BDP). Her medication was reviewed.

[27] https://www.bdp.org.uk/?gad_source=1&gclid=Cj0KCQiAvbm7BhC5ARIsAFjwNHvtN6Uu9FDXp1RCHRhnIN9KZgXDTtv4_x5ngmY5uy525x3JE55lSVcaAsXLEALw_wcB

March 2019

2.2.11 Lauren disclosed to her GP that she had stopped taking benzodiazepines and continued using sertraline and pregabalin. She had also been prescribed an antipsychotic medication, Quetiapine[28], for use during emotional crises. The GP referred Lauren to SHERPA.

2.2.12 UOB: Lauren reported self-harming and using Xanax as an incentive for completing her assignments. Lauren's senior tutor observed that Lauren was *"in a state"* and distraught with grief at her SCS counselling coming to an end.

2.2.13 The AWP consultant psychiatrist reviewed Lauren. They reported that Lauren's main difficulties continued to be ongoing emotional dysregulation on the background of a history of psychosocial stress within the family dynamics and her early development.

2.2.14 She had experienced mental health difficulties throughout the period from early adolescence that included the emergence of a disorder of her personality that led to episodes of acute emotional crisis, suicidal ideation and deliberate self-harm.

2.2.15 She was diagnosed with Emotional Unstable Personality Disorder – Borderline type. "*These are traits only and include the clusters of symptoms around emotional dysregulation, distress intolerance and deliberate self-harm. It should be noted that Lauren can maintain strong personal and professional relationships and continues to function despite significant emotional dysregulation."* They also stated that her underlying borderline personality traits were likely to become more apparent when she was under stress and less overt during periods of relative stability.

2.2.16 In line with NICE guidance[29], the primary component of Lauren's treatment was psychological therapy, with a particular emphasis on emotion regulation skills therapy. AWP requested that her GP refer Lauren to SHERPA to evaluate her eligibility to participate in psychological therapy.

May 2019

2.2.17 GP: Lauren consumed an excessive quantity of both prescription and over-the-counter medications. She was seen in the emergency department (ED, BRI) and subsequently referred to AWP.

2.2.18 UOB: SHERPA declined the referral, as they determined that Lauren could manage her emotions and would require counselling for *"deeper issues."*

[28] https://www.nhs.uk/medicines/quetiapine/
[29] https://www.nice.org.uk/guidance/cg78

Lauren had expressed concerns regarding the safety of her upcoming study abroad and reported that her relationship with her parents had deteriorated

2.2.19 AWP: Lauren was due to study abroad for one year for her degree program. Consequently, crisis planning and short-term initiatives were implemented to alleviate stress and negative emotions.

2.2.20 Adult A called AWP to report that Lauren had overdosed on 16 x diazepam, 12 x pregabalin, and 8 x paracetamol. Adult A told Lauren to vomit, as she refused to attend ED. He told AWP that a similar occurrence occurred on Christmas Day when she was younger, and the paramedic told her she had ruined Christmas. Lauren described Adult A as supportive.

2.2.21 Lauren attended BRI; she was admitted overnight and referred to the mental health liaison team (AWP).

2.2.22 AWP reviewed Lauren in ED; she reported battling her mental health for years, had a difficult upbringing, and viewed her relationship with her mother as poor. Lauren reported she had vomited because she believed she was gaining weight and punished herself by not eating. Lauren was admitted to the Crisis Team[30] and received daily visits at home for one week.

2.2.23 Referral received by Safe Link regarding the sexual assault from a colleague (ASC confirmed this was not a colleague).

2.2.24 Lauren presented to AWP with a labile mood; she had increased the dosage of pregabalin and had acquired “street” diazepam. She described Adult A as supportive. AWP and Lauren expressed concerns about her travelling abroad.

2.2.25 Safe Link completed a triage assessment, and Lauren accepted the allocation of a Safe Link ISVA.

June 2019

2.2.26 Lauren informed the ISVA via text message that she intended to travel abroad in three weeks and would address support upon her return.

July 2019

2.2.27 UOB: The external psychiatrist recommended that Lauren be assessed as fit to study, and as a result, a ‘fitness-to-study assessment’ and panel meeting were conducted. The fitness to study panel recommended that Lauren receive five trauma treatment sessions before her study trip, in addition to attending bi-

[30] https://www.awp.nhs.uk/patients-and-carers/leaflets-and-resources/patient-and-carer-information-leaflets/service-information/bristol-central-crisis-team-1

weekly phone calls with her care coordinator and completing a Dialectical Behaviour Therapy[31] (DBT) skills booklet.

August 2019

2.2.28 Lauren was discharged from AWP in preparation for her travels.

2.2.29 Lauren was admitted to ED with abdominal pain due to making herself sick, and there was concern that she was developing an eating disorder. Lauren reported struggling with the end of her involvement with her AWP care coordinator due to her year of study abroad.

2.2.30 Later that month, Lauren began her year abroad. Throughout her studies, she maintained contact with her senior tutor and SVLO.

October 2019

2.2.31 Lauren contacted UOB while still abroad to enquire about the local Samaritans' contact numbers. She reported that she had returned to the UK temporarily as her brother experienced a seizure. She stated that she was engaging in an inordinate amount of physical activity.

December 2019

2.2.32 UOB: Lauren reported experiencing insomnia and needed sleeping pills.

January 2020

2.2.33 UOB: Lauren reported a worsening of her mental health; she felt hopeless and had posted self-harm photographs on social media. Her antidepressant was increased.

March 2020

2.2.34 GP: Due to the COVID-19 outbreak, Lauren returned from abroad. She had taken an overdose of non-prescription drugs and was living with Adult A in Bristol.

April 2020

2.2.35 Lauren authorised ASC access to her social media account to investigate the sexual assault allegation.

May 2020

2.2.36 Lauren's dependence on the SVLO, the SVLO/wellness adviser, and the SCS counsellor was becoming increasingly concerning. Lauren had written a suicide note and attempted suicide by cutting her wrists and overdosing on her

[31] https://www.nhs.uk/mental-health/conditions/borderline-personality-disorder/treatment/

medication. She was hesitant to use mental health services and wanted to rely on UOB's support.

2.2.37 AWP: Lauren returned early from her study abroad due to the COVID-19 pandemic. Four days earlier, she had cut herself superficially with a razor and reported feeling mentally ill. Lauren's sister contacted AWP. Lauren had sent a text message to her sister in the early morning, apologised for being a poor sister, and explained that her sister deserved much better and did not wish to burden her with her mental health and self-harm. Due to the COVID-19 pandemic, telephone assessments were conducted. Lauren was discharged after twelve days to her GP with advice to signpost Lauren to drug and alcohol services.

June 2020

2.2.38 GP: Due to the forthcoming trial concerning the alleged rape, Lauren reported suffering anxiety. Although she continued to self-medicate with diazepam and Xanax, she did not want to stop or receive support for this.

2.2.39 Lauren informed Safe Link that she was shielding with Adult A. She reported no suicidal thoughts and was sleeping better. She had also relocated to live with her father outside of Bristol. Safe Link confirmed that ASC was still assessing her social media platforms.

July 2020

2.2.40 Lauren informed her GP that she was engaging with BDP and had ceased using diazepam. Lauren disclosed that her familial relationships had been enhanced. Nevertheless, her weight perceptions were causing her to restrict her food intake.

2.2.41 Because of her profound emotional connection to the SVLO/wellness advisor, they determined that she would no longer work with them. However, an alternative advisor could be consulted if required. According to their reports, she was still using diazepam.

August 2020

2.2.42 Lauren was concerned that the criminal allegations might not result in a conviction, as reported by Safe Link. Nevertheless, she was happy to return to university and was employed.

September 2020

2.2.43 Lauren disclosed to her GP that she was adhering to her prescribed medication regimen and had refrained from the consumption of illicit substances. Nevertheless, she had consumed a substantial quantity of alcohol. She was diagnosed with Emotionally Unstable Personality Disorder - Borderline type,

moderate severity, Generalised Anxiety Disorder, and Recurrent Depressive Disorder by AWP.

2.2.44 UOB: Lauren pursued counselling on her initiative. ASC informed her that the criminal case had been dismissed, which prompted her to take multiple overdoses, and she had refused to visit the ED. She had spoken with the SCS on one occasion, and the service had, in turn, called an ambulance. Lauren had discharged herself from the hospital and was admitted to the Crisis Team.

2.2.45 Safe Link: Lauren faced challenges with her finances, mental health, and the bereavement of a family member. Considering the outcome of the rape allegation, an email was sent to ASC by Safe Link to inform them of the potential need for safeguarding.

2.2.46 Lauren's knowledge that the alleged rape would not be prosecuted, interpersonal issues, and estrangement between her mother and father prompted the GP to refer her to AWP. Lauren reported feeling intensely suicidal.

2.2.47 Safe Link: Lauren was experiencing difficulties and was taking an excessive amount of medication, which resulted in an inadvertent overdose. She sought support from her GP and SCS. She stated that she comprehended the rationale behind dismissing the criminal case; however, she had lost her employment and was experiencing financial hardship.

2.2.48 Lauren arrived at BRI after calling 999. She had taken an overdose of diazepam at home to treat anxiety symptoms; she did not want to end her life.

October 2020

2.2.49 Following five unsuccessful phone calls and Lauren's missed appointment, AWP notified Lauren in writing that a new appointment had been arranged. Should she not attend, they would presume she no longer wanted their services. The GP was also notified.

2.2.50 Lauren was recorded as having attended nine out of her fifteen SCS counselling sessions. She had either cancelled or did not attend the other appointments.

2.2.51 AWP: No modifications to diagnoses or medications. Psychological therapy and risk assessment were discussed.

November 2020

2.2.52 At the second Fitness to Study panel meeting, the external psychiatrist assessment recommended that Lauren was fit to study, and the panel agreed. One of the panel's recommendations was to engage with Disability Services.

The Disability Service later sent Lauren a list of available appointments, but she did not respond. Her case was closed to Student Wellbeing, and it was agreed that the SCS would provide ongoing support.

2.2.53 Lauren contacted UOB to report that she had endured some difficult days and cut and bandaged her legs.

2.2.54 AWP: Lauren had experienced some challenging days and revealed increased suicidal ideation and plans. She had purchased fifty diazepam tablets and disclosed this to Adult A, who took them from her.

2.2.55 Safe Link: Lauren reported that she experienced suicidal ideation and withdrawal symptoms from diazepam after two weeks of abstinence. Additionally, she disclosed difficulties with her family and Adult A.

December 2020

2.2.56 AWP: Lauren reported misusing street-purchased diazepam and was informed that she would need support from BDP, which provided online services in response to the COVID-19 pandemic. Lauren was issued a prescription for diazepam for two weeks.

January 2021

2.2.57 Due to BDP's online operations, AWP agreed to support the reduction of diazepam.

March 2021

2.2.58 AWP: Lauren agreed to a two-week stabilisation period, consented to the cessation of diazepam dosage reduction, and reported experiencing stress. Lauren had relocated to a student residence and no longer lived with Adult A. She had taken an insignificant overdose and had self-inflicted wounds on her arms. She expressed concerns regarding her brother's vulnerabilities.

April 2021

2.2.59 UOB: Lauren's relationship with Adult A had terminated. She felt she was coping and was pleased with her recent marks.

2.2.60 Adult A contacted AWP and stated that their relationship was strained, and Lauren was living with her father.

May 2021

2.2.61 UOB: Adult A phoned the accommodation services to request emergency housing. He shared a one-bedroom flat with Lauren, who had threatened to hurt herself if he did not leave. Given her past, he perceived this as a genuine threat.

Unfortunately, the accommodation services could not provide him with an alternative, and he had no option but to remain in the flat.

2.2.62 AWP: Lauren reported struggling with low mood and increased suicidal ideation. She intended to complete her degree to prove she could and then take her own life in June 2021. Family issues, relationship breakdown, and housing issues were viewed as the most stressful aspects of her life.

2.2.63 AWP: Today was the first day in the past week that Lauren had not experienced suicidal ideation and was feeling marginally better. She was effectively managing her time, and her relationship with her family had improved. In addition, her living situation, eating, and drinking had improved.

June 2021

2.2.64 AWP: Lauren disclosed that she had experienced a difficult week, a low mood, and a sexual assault attempt at a pub. Furthermore, Adult A had relocated to a new residence. Lauren disclosed that she was stockpiling co-codamol (a painkiller consisting of paracetamol and codeine[32]) to overdose. She stated that she had initiated the process but subsequently stopped and had experienced a sense of security while living with her father.

July 2021

2.2.65 Lauren completed her degree and achieved a 2:1.

August 2021

2.2.66 Lauren filed her application directly to University Two for the Master's in Creative Writing programme. The application was for a programme lasting one year.

August/September 2021

2.2.67 Lauren started dating James.

September 2021

2.2.68 Lauren received an email informing her that her application to UOB had been rejected. She stated she had applied to University Two through the 'clearing process,' and her senior tutor at UOB provided her with a reference.

October 2021

2.2.69 Care Program Approach Meeting[33] with AWP. Lauren continued to experience difficulties with her mood. Upon her return from her holiday abroad, she had intended to take her own life and purchased 100 Xanax tablets. She had

[32] https://www.nhs.uk/medicines/co-codamol-for-adults/about-co-codamol-for-adults/
[33] https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/

planned to take an overdose and proceed to the bridge; however, she refrained from doing so due to her wish for *'perfection'* and the *'right conditions.'* She reported that James had been supportive and had assisted her in managing her moods. She had self-harmed by cutting herself forty-nine times with a razor and described a complex familial relationship.

2.2.70 Daniel called ASC to report that James had raped Lauren. Lauren informed Daniel that James had sex with her while she was under the influence of drugs, and she did not believe she had consented to the act. Lauren detailed James's controlling and coercive nature to Daniel: James would routinely self-harm and ask Lauren to bring a first aid kit. They had forged a suicide pact, and he told her where he stored razors in case she wanted to self-harm. On another occasion, he emptied 100 Xanax tablets and recommended they end their lives together.

2.2.71 Lauren formally accepted the offer of study at University Two.

November 2021

2.2.72 AWP: Lauren smoked cannabis and consumed over 0.5 litres of gin daily. She self-medicated with alcohol or additional substances and experienced suicidal ideation for one hour daily.

January 2022

2.2.73 AWP: Lauren disclosed that she experienced emotional dysregulation, self-harm, and chronic mental health issues. Subsequently, she increased her daily consumption of cannabis and alcohol. Furthermore, she used MDMA (ecstasy[34]) and ketamine.[35] Lauren experienced suicidal thoughts daily and used alcohol or additional medication to alleviate her symptoms. She did not intend to end her life and reported her boyfriend [James], and her conviction that she would recuperate were identified as protective factors.

February 2022

2.2.74 Lauren sent an email requesting counselling services from University Two.

2.2.75 AWP: Lauren reported that she was experiencing persistent suicidal thoughts and was experiencing a depressed mood. Nevertheless, she stated that her academic pursuits were proceeding smoothly. She had discontinued her drug and alcohol use; however, she had consumed alcohol in recent days. She was residing with James, who reported having BPD and lived outside the county. She reported having sought trauma therapy from a student counsellor.

[34] https://www.talktofrank.com/drug/ecstasy
[35] https://www.talktofrank.com/drug/ketamine

March 2022, one day before Lauren died

2.2.76 Lauren spoke with her mother on the phone.

3.1 Analysis of Agency Involvement

3.1.1 This section explores the agencies' involvement with Lauren.

Avon and Somerset Constabulary

3.1.2 Lauren contacted ASC about three crimes:

1. Alleged rape in 2018
2. Alleged rape in 2021
3. Coercion and control in 2021.

The latter two crimes were related to James.

Allegation of rape in 2018

3.1.3 Lauren was informed that the investigation into the alleged rape in October 2018 was being filled in September 2020. The allegations were thoroughly investigated, which included taking statements, voluntarily interviewing the suspect, and reviewing Lauren's medical records. However, no physical evidence was collected since Lauren declined a physical examination at The Bridge and reported the incident to ASC after the forensic window had closed (within seven days of the assault[36]).

3.1.4 The suspect's phone could not be looked at due to its loss. Lauren was allocated an ISVA (May 2019), and most communication was made through the ISVA in the latter part of the investigation in line with force procedures for victims of sexual assault.

3.1.5 The case took longer than expected due to the following factors: the suspect's relocation from Bristol, Lauren's stay abroad in 2019, both parties' refusal to submit their phones for examination, the officer's annual leave, the change of the officer involved in the case, and the delay in the provision of medical records.

3.1.6 A Detective Inspector decided not to pursue the case, citing Lauren's counselling notes, indicating that she had acknowledged *"dramatising, acting*

[36] https://www.england.nhs.uk/south/2024/11/22/joint-advice-on-getting-help-after-rape-and-sexual-assault-and-the-use-of-self-swab-kits/

impulsively," and *"exaggerating"* events. This was perceived to undermine her integrity in court due to an evidentially weak case.

3.1.7 The counselling notes suggest that Lauren is 'victim blamed.' Victim blaming creates the idea that the victim is responsible or partially responsible for their vulnerable condition.

3.1.8 The College of Policing discovered this was common among victims of domestic violence and major sexual crimes. As a result of many incorrect assumptions, blame and judgment were examined concerning the victims' behaviour, attributes, and circumstances.[37]

3.1.9 The Crown Prosecution Service (CPS) provides information regarding the progression of offences. The CPS implements a two-stage test[38] to establish whether a prosecution may be initiated. The first relates to evidence: *'Is there enough evidence against the suspect to provide a realistic prospect of conviction?'* ASC reported a lack of evidence. Consequently, CPS cannot progress to the second stage, and the suspect will not be prosecuted.

3.1.10 Rape Crisis[39] reported that the number of such crimes is overwhelming, as revealed by the following:

- *One in four women has been raped or sexually assaulted as an adult.*
- *One in six children have been sexually assaulted.*
- *One in twenty men has been raped or sexually assaulted as an adult.*
- *In March 2022, 70,330 rapes were recorded, with only 2,223 cases where charges were brought.*

3.1.11 End Violence Against Women[40] discovered that women's rights were violated, noting that only 1.3% of documented rapes in the year ending September 2021 resulted in a charge.

3.1.12 Operation Bluestone is the specialised rape investigation team. It was founded in September 2019 and Introduced to ASC in June 2021 in response to the city's low rape detection rate and high victim refusal to prosecute rate.[41]

3.1.13 An analysis of Operation Bluestone investigations revealed a higher percentage of charges than comparable investigations (35.5% vs 31.5%), and

[37] https://assets.college.ASC.uk/s3fs-public/2021-11/Recognising-responding-vulnerability-related-risks-REA.pdf
[38] https://www.cps.gov.uk/about-cps/how-we-make-our-decisions
[39] https://rapecrisis.org.uk/get-informed/statistics-sexual-violence/
[40] https://www.endviolenceagainstwomen.org.uk/wp-content/uploads/EVAW-snapshot-report-FINAL-030322.pdf
[41] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/97739/operation-bluestone-tilley11.pdf

a slightly more significant proportion of Bluestone cases reached court (29.8% vs 27.3%).[42]

Allegations against James: October 2021

3.1.14 Daniel informed ASC that James had allegedly raped Lauren. Lauren told ASC she did not intend to support police action, as she did not believe James had raped her, and the act was not against her will. The decision was not to proceed, as Lauren declined to pursue prosecution.

3.1.15 Lauren disclosed her relationship with James to the ASC officer. She described it as intense, highlighting his coercive and controlling behaviour, which included a threat to take his life if she did not respond to his messages to meet him. James had also suggested a suicide pact on two separate occasions.

3.1.16 ASC conducted a domestic abuse, stalking and 'honour'- based abuse (DASH) risk assessment[43] and they determined Lauren was at medium risk. (Medium risk means that there is indicators of risk for serious harm. The perpetrator may cause harm but is unlikely to do so unless circumstances change, such as a relationship breakdown or substance misuse.)

3.1.17 Lauren was designated as amber after completing a comprehensive BRAG (Blue, Red, Amber, and Green) assessment, a tool used to evaluate vulnerability. Consent was not obtained, and subsequent attempts to obtain consent were unsuccessful. Consequently, no referrals to domestic abuse services were made.

3.1.18 ASC only refer to Next Link[44] (a domestic abuse service), without consent if the risk is high (DASH score of 14 or higher, which states there are clear indicators of serious harm risk, with potential events that could occur anytime and have a severe impact) or based on professional judgment.

3.1.19 The ASC IMR author stated that no evidence had been gathered from Daniel, the housemate who had reported the crime. ASC was due to speak with James; however, this did not occur.

3.1.20 When reflecting on their response to this incident, the ASC IMR author found they had missed the opportunity to adequately investigate the allegation of rape and controlling and coercive behaviour and to support and safeguard Lauren as a victim.

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[42] https://www.researchgate.net/publication/314949484_A_Comparative_Analysis_of_Operation_Bluestone_A_Specialist_Rape_Investigation_Unit_-_Summary_Report

[43] https://safelives.org.uk/sites/default/files/resources/Dash%20for%20IDVAs%20FINAL_0.pdf

[44] https://nextlinkhousing.co.uk/

3.1.21 The individual attending officers did not adhere to the policy and procedure. The records indicate that the attending officers and supervisory reviews disregarded the allegation of rape after Lauren stated that she believed the act was consensual.

3.1.22 The guidance on the classification of sexual offences states that a victim's lack of recollection or uncertainty regarding the occurrence of intercourse does not necessarily imply that rape did not take place. Furthermore, the attending officers should have recognised that Lauren's account was being taken within the context of a controlling relationship (Lauren recorded the initial half of the account per James's instructions).

3.1.23 The case's narrative was altered from one in which Lauren was unaware of, an offence against her in the context of a controlling relationship, to one in which the offence did not occur, which resulted from an absence of professional curiosity, poor decision-making, and failure to seek expert advice from investigations. This narrative change influenced the subsequent supervisor reviews, LSU response, and rationale for filing the case.

3.1.24 The case was not classified as high risk due to the altered narrative; consequently, Operation Bluestone was not contacted. Additionally, referrals to an ISVA, witness, or perpetrator interviews were not considered.

3.1.25 The supervisor's decision was that it was not appropriate to arrest James due to the relatively low (perceived) risk, no need for forensic evidence to be collected, and the fact that Lauren did not believe this was a rape offence.

3.1.26 The supervisor set an action to give James advice about contacting Lauren, but this did not happen. When the OIC contacted Lauren in November 2021, she stated that James' current contact was manageable and not excessive and made no representations that she did not want contact with him. Therefore, the OIC felt it inappropriate to advise James not to contact Lauren.

3.1.27 Advice from Operation Bluestone recommended that had they taken primacy in this case, James would likely have been arrested, Lauren’s housemates approached for evidence, and referrals to The Bridge, Next Link, and other support agencies would have been pursued more robustly.

3.1.28 Although the DASH and BRAG were completed according to the ASC protocol, Lauren’s allegation of rape, evidence of controlling and coercive behaviour, and suicidal ideation may have indicated an increase of risk where a referral without consent could have been considered.

3.1.29 The ASC IMR author stated that Body Worn Video (BWV) should have been used during the response. However, the ASC report presented conflicting national and local BWV directives concerning its use in cases of domestic abuse, rape, and serious sexual offences. Therefore, the interim recommendation was to revise the guidance to align with the National Police Chief's Council's (NPCC) interim recommendations.

Sudden Death

3.1.30 The final call to ASC was about the sudden death of Lauren. No suspicious circumstances were discovered, and the case was forwarded to the Coroner.

3.1.31 There is no police record of any consideration by ASC to prosecute Lauren's boyfriend/partner for events leading up to her suicide or controlling and coercive behaviour.

3.1.32 The OIC did not believe that she had been directly coerced into the suicide. Officers seized Lauren's phone at the scene, though messages were not downloaded. Lauren's laptop was left in her room. The OIC assumed that both would be password protected, and the Police would only look to attempt to access them if there was enough suspicion that a 3rd party had directly coerced Lauren into suicide (which, in this case, there wasn't). No suicide note was found, though there may have been one on Lauren's laptop or phone.

3.1.33 According to ASC, accessing Lauren's next of kin was difficult. Lauren's friend provided ASC with Lauren's mother's incorrect mobile number.

3.1.34 ASC received the contact details of Lauren's father; subsequently, Lauren's father called ASC and was informed of Lauren's death on the phone. This was contrary to the *'Sudden Death policy'* at that time, which stipulated that *a 'death message'* should be delivered in person and only in extraordinary cases over the telephone.

3.1.35 ASC did not document and could not confirm whether any efforts were made to determine whether Lauren's father would inform her mother of their daughter's death. This also contradicted the guidelines, which specifies that the next of kin *'should be asked directly whether anyone else qualifies as a next of kin or equivalent which they deem notifiable in addition to themselves.'*

3.1.36 ASC have observed several developments since the review period:

1. All responding ASC officers are aware of their obligations to victims of rape and serious sexual assault offences.

2. The Criminal Investigation Department (CID) and Response staff received interim crime allocation guidance in November 2022. This direction explicitly stated, *'all offences of sexual assault under clothing and any which are penetrative offences will be allocated to CID.'*
3. Following a previous DHR recommendation, Specific Controlling and Coercive Behaviour Procedural Guidance was drafted, finalised and disseminated across the ASC force in November 2022.
4. To ensure Operation Bluestone is embedded within investigations. Operation Bluestone provides a specialised investigative section to handle rape and serious sexual assault offence cases and much-increased victim support.
5. ASC has requested and been granted funding to implement the Domestic Abuse Matters programme[45], acknowledging the need to continue efforts to alter perceptions of domestic abuse. This training has taken place.
6. Additionally, ASC has established a force-wide network *called 'Domestic Abuse Influencers,'* which champions and promotes the response to domestic abuse, initiating and supporting improvement efforts.
7. ASC will implement a novel strategy: the 'Domestic Abuse Victims Pledge.' The commitment affirms that colleagues will be heard, believed in, supported, assured of confidentiality, and assisted in feeling safe.
8. Since this period, Safe Link has funded three ISVAs in Operation Bluestone, and they work directly with CID officers.

3.1.37 In addition to the recommendations made in previous DHRs, ASC have issued two more.

3.1.38 ASC have been open and committed to improving their response to domestic abuse and rape reports.

3.1.39 The ASC IMR author acknowledged the exhaustive investigation into the initial crime (allegation of rape in 2018), which resulted in no action. A lack of evidence was given as justification.

Avon and Wiltshire Mental Health Partnership

3.1.40 Lauren received support from AWP from January 2019 until her death.

3.1.41 She was assigned a Specialist Recovery Practitioner (responsible for assessing, planning, delivering, and reviewing activities and interventions for identified health and well-being needs, acting as care coordinators for a specific group of service users) in May 2019. She reported a complex childhood, non-

[45] https://safelives.org.uk/training/ASC

prescription drug use, and emotional dysregulation. Using the DBT skills workbook, the practitioner assisted Lauren in managing distress, difficult emotions, and crises.

3.1.42 AWP planned to discharge Lauren in September 2019 as she intended to study abroad for one year. Instead, she was discharged in August 2019.

3.1.43 Lauren returned from abroad and was accepted back under the care of AWP in May 2020.

3.1.44 During interactions with Lauren, she frequently presented with suicidal ideation and substance and alcohol misuse.

3.1.45 Her general disposition remained depressed, and she experienced emotional dysregulation related to her trauma experiences. AWP stated that she was ineligible for psychological therapy since she was not regarded as stable enough to benefit from a structured approach.

3.1.46 On average, Lauren was reviewed every two weeks; however, appointments were sometimes scheduled more frequently or longer at her and AWP's request. The care coordinator and the consultant psychiatrist provided her with care. Lauren's patient records also revealed efficient communication between the SCS and her GP.

3.1.47 In her last contact with AWP in February 2022, Lauren reported decreased alcohol and substance misuse. However, her mood did not improve. She told them that her housemates were bullying her and that she was experiencing problems with her boyfriend [James], who she said had BPD. AWP acknowledged that they did not explore this with Lauren and how it impacted her.

3.1.48 The NICE guidance states that people with BPD should be under a Care Program Approach, which Lauren was under. The guidelines also state that brief psychological intervention of fewer than three months should not be used. AWP worked briefly with Lauren, utilising the DBT skills workbook; however, this was planned to be brief due to Lauren's planned trip abroad.

3.1.49 AWP considered DBT before Lauren's departure abroad. This is the only treatment backed by empirical evidence for those diagnosed with BPD.[46] DBT targets behaviour and teaches skills to people experiencing unstable relationships, fear of abandonment, emotional lability, and impulsivity. The

[46] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6007584/

NICE guidelines[47] recommend that women who self-harm should be offered DBT.

3.1.50 AWP made two recommendations.

GP

3.1.51 In 2017, Lauren relocated to Bristol to study and registered with the UOB-affiliated GP practice in 2018. She continued with the practice until her death in March 2022.

3.1.52 Lauren had an excellent rapport with her GP and could discuss her emotional concerns, including her alcohol and benzodiazepine misuse, club drug use (MDMA and ketamine), and recreational drug use (cannabis).

3.1.53 Lauren told her GP she experienced daily suicidal ideation and would self-harm by cutting. She reported that when she was fifteen, she had attempted suicide by overdose. She had been under the care of CAMHS and received Cognitive Behavioural Therapy (CBT, a talking therapy[48]). Lauren was already taking antidepressants, and her GP prescribed pregabalin to help her manage her anxiety.

3.1.54 Lauren disclosed to her GP that she had been raped. Lauren reported this to ASC, and the GP supported her during and beyond this period.

3.1.55 Lauren was referred to AWP by her GP due to her deteriorating mental health and increased risk of self-harm and suicide ideation.

3.1.56 The GP IMR author concurs with the GP's judgement and found evidence that they were sensitive to Lauren's requirements and coordinated with specialists to continue to support her during her time in Bristol.

3.1.57 The GP knew Lauren was not living at home and was supported by the university's well-being service.

3.1.58 Next Link has an IRIS[49] service that works with clients who visit the GP and have been referred by them to Next Link.

[47] https://www.nice.org.uk/guidance/cg78/ifp/chapter/what-treatment-should-i-be-offered-for-borderline-personality-disorder
[48] https://www.nhs.uk/mental-health/talking-therapies-medicine-treatments/talking-therapies-and-counselling/cognitive-behavioural-therapy-cbt/overview/
[49] http://www.bristol.ac.uk/research/impact/iris-training-helps-victims-of-domestic-abuse/

3.1.59 The GP was informed of emotional abuse by Lauren's family in October 2018; this did not progress to a referral to domestic abuse services, or a DASH risk assessment being completed.

3.1.60 The practice made three recommendations.

North Bristol NHS Trust

3.1.61 Lauren attended the hospital once during the review period. The attendance was in response to Lauren's report of continuous abdominal pain and gastrointestinal/bowel problems for seven to ten days. In addition, she reported a lack of appetite and vomiting.

3.1.62 Lauren described her mental health as poor and admitted to misusing benzodiazepines and alcohol, which she was weaning off. She was advised to limit her alcohol consumption and seek mental health treatment.

3.1.63 Alcohol and benzodiazepines both have sedative effects and combining them can exacerbate the effects of both. Mixing these substances may also raise the risk of self-harm, overdose, and other health issues like liver, heart, and lung difficulties.

3.1.64 Alcohol can result in gastritis and the symptoms Lauren described she was experiencing. Lauren notified the hospital that she was a dependent drinker, but it was not recorded whether she was informed that her drinking might be a likely reason for her abdominal pain.

Safe Link

3.1.65 Lauren was referred to Safe Link in early 2019 after a sexual assault by a colleague (ASC confirmed it was not a colleague) that occurred in October 2018.

3.1.66 Lauren worked with an ISVA from May 2019 to January 2021. An ISVA assists victims in navigating the criminal justice system and obtaining the necessary recovery services.

3.1.67 Lauren disclosed to the ISVA that she was experiencing poor mental health and suicidal ideation and was receiving mental health support, including assistance from her university. Lauren denied the ISVA's request to call mental health services or the university.

3.1.68 Safe Link noted one recommendation.

3.1.69 The Safe Link IMR author found evidence of regular and supportive work with Lauren throughout.

University of Bristol

3.1.70 Lauren achieved a 2:1 in her degree. She mentioned wanting a sufficient grade to access a Master of Arts in Creative Writing.

3.1.71 Lauren received extensive and detailed support from several university services. The intricacy of her case is reflected in the length of time she spent working with the SVLO and Senior Wellbeing Advisor, which was longer than is typical for the service model.

3.1.72 The university identified training on how to work with, set and maintain boundaries with students diagnosed with personality disorders as an area for service enhancement.

3.1.73 Four recommendations were presented and made by UOB.

3.1.74 The chair noted evidence of engagement and follow-up from UOB. Despite the obstacles of working with Lauren, they persevered and established communication with specialists to ensure that Lauren's mental health needs were met.

University Hospitals Bristol and Weston NHS Trust

3.1.75 Lauren visited the BRI four times, twice for an overdose and twice for abdominal pain.

3.1.76 At the first presentation, Lauren was admitted overnight for observation following an overdose and referred to AWP.

3.1.77 When patients are seen by AWP mental health service, it is not always recorded in BRI hospital notes. AWP confirmed that the crisis team only sometimes document within the BRI notes. The Liaison Psychiatry Services (AWP), on the other hand, frequently records in both systems. In addition, BRI hospital staff do not have access to mental health records.

3.1.78 The chair and panel noted a risk and significant deficiency in this area that needs resolution. The panel recognised a risk of duplication, which could be a better use of time. However, the risks of not documenting are significantly worse.

3.1.79 BRI proposed one recommendation.

University Two

3.1.80 In October 2021, Lauren began her Master's in Creative Writing. She disclosed a mental health condition, and her academic references acknowledged challenging personal circumstances.

3.1.81 The university routinely sends questionnaires to all applicants, encouraging them to disclose a disability, make early contact, and agree on reasonable adaptations and other supportive measures. It is entirely an applicant's choice whether to complete the questionnaire. The university did not have a record of this being received.

3.1.82 Lauren's course included peer reviews and workshops. The workshops are described as sensitive and safe environments, and it is common for the students (who may already be published authors and poets) to incorporate sensitive issues in their work. However, academic staff are careful not to presume that a students' work is autobiographical.

3.1.83 Following Lauren's request for access to counselling, the student well-being service was contacted through email. They sent Lauren an email with instructions on receiving mental health support. A confirmation email was also sent to ensure receipt of the communication.

3.1.84 During her interview admission at the university, she was regarded as being *"over-amplified."* However, while her presentation was unusual compared to other applicants, the discussion did not raise any concerns.

3.1.85 Lauren was noted as having a *'colourful personality;'* she frequently talked during the workshops, had a commanding presence, and appeared well-liked by her peers.

3.1.86 Lauren was a compassionate person who comforted others in the class. Although she was the group's youngest member, she participated actively in the workshop.

3.1.87 Lauren characterised her life as *'chaotic,'* with a lengthy commute causing her to miss or arrive late to class, yet she attempted to make up the time and submit her work.

3.1.88 The tutors suggested that Lauren did not intend to include *"challenging"* components. For example, Lauren requested that her peers use *'trigger*

warnings' when discussing anorexia-related information, but she did not do so herself. In addition to addressing destructive relationships, Lauren's writing focused on sexual abuse and trauma. However, she gave no clear response when asked if this was based on personal experience.

3.1.89 Lauren was enthusiastic about the course and *"couldn't believe her luck"* she was attending. She was noted as unusually enthusiastic about the course, although her sporadic attendance contradicted her enthusiasm.

3.1.90 The death of Lauren occurred around five months after she began her studies.

3.1.91 Following Lauren's death, a peer group member claimed Lauren brought alcohol to class and questioned whether she was using drugs.

3.1.92 Their IMR highlighted the following:

- Identify additional methods for communicating support information to students who have declared a disability on their application.
- To further develop guidance for staff and students involved in the Master's in Creative Writing programme (and other programmes, as appropriate) to assist in better framing the context of workshop spaces so that participants are aware of how to raise concerns about the content or emotional impact of their academic work and the writing process.
- Even though implementing the "Protocol for the death or serious injury of a student" is an infrequent occurrence at the University, it is always vital to provide appropriate assistance for personnel (primarily academic staff who knew the student in question) when this is initiated.

3.1.93 The university has determined that its processes and protocols were always followed appropriately and identified three recommendations as part of its commitment to continuous improvement.

3.2 Analysis of Terms of Reference

3.2.1 The terms of reference (TOR) have been analysed in this section to confirm that they have been addressed and met.

3.2.2 **TOR 1**: Identify good practices where responses may have exceeded the required standards.

3.2.3 Lauren received compassionate and person-centred support throughout her time with UOB, AWP, Safe Link, University Two and her GP. It was unknown to any of these agencies that she was a victim of domestic abuse.

3.2.4 AWP continued to support Lauren despite determining that drug and alcohol support services could better meet her requirements. However, as BDP moved to online services, they assisted Lauren in reducing her diazepam dosage.

3.2.5 The AWP consultant was the liaison between the UOB health services and AWP.

3.2.6 **TOR 2**: Were service responses to Lauren affected by the COVID-19 pandemic (review relevant contact/response with current impact at that time)?

3.2.7 During the pandemic, UOB teaching moved to an online platform instead of face-to-face. This did not affect the continuous support Lauren received from the university's well-being service.

3.2.8 Due to the pandemic, AWP visits with Lauren were initially conducted through telephone or video contact. However, due to revisions in COVID-19 regulations, AWP met Lauren face-to-face and went on socially distant walks with her from November 2020.

3.2.9 Lauren's attendance was irregular at online and in-person University Two sessions.

3.2.10 Safe Link emphasised how the pandemic and subsequent shift to online services affected Lauren, isolating her at times because she could not leave her home and they could not meet in person. However, they stated that face-to-face visits would have been made if Lauren had requested one; however, she declined and indicated she was shielding.

3.2.11 **TOR 3:** Does your organisation have any information, such as Lauren's history, ACEs, or trauma, which helps to understand the possible 'triggers' in her life that may have led to her death by suicide?

3.2.12 AWP notified UOB and the GP that Lauren's estrangement from her mother and father was a significant stressor. In addition to taking prescribed medication and acquiring it without a prescription, Lauren was also using club drugs, recreational substances, and alcohol. She declined assistance from BDP, and AWP supported her in reducing her diazepam usage.

3.2.13 Lauren disclosed to AWP that her interactions with her parents were challenging. However, no specific incidents were documented.

3.2.14 AWP acknowledged that they did not consider using the DASH risk assessment to explore these relationships.

3.2.15 Lauren moved to Bristol at eighteen to attend university, having just completed college. Lauren reported a mental health condition to UOB and University Two. As a result, she received support at UOB. However, she did not access the support offered at University Two.

3.2.16 The Office of National Statistics[50] published data concerning the number of suicides among higher education students compared to the general population between 2017 – 2020. The findings revealed that the rates were significantly higher among the general population. While this is reassuring, it is crucial to remember the potential stress of moving away from home, becoming independent for the first time, and the loneliness of not knowing anyone. In addition, this demographic may consume more drugs and alcohol than the average population.[51]

3.2.17 A further contributor was the sexual assault in 2018, which resulted in no further action in 2020 and significantly impacted Lauren.

3.2.18 Recently, the reporting rate of rape and sexual assault has increased[52]. The Home Office estimates that only one in seventy cases will result in charges. In addition, ASC reported concerns regarding Lauren's character being undermined in court. This suggests the victim's credibility is essential to understanding how this can be hampered in a court of law.

3.2.19 A report[53] examined how credibility is further influenced by the victim's race, age, religion, sex, identity, migrant status, socioeconomic background, disability, and sexual orientation. The findings suggest that the criminal justice system should develop a broader and more in-depth comprehension of the wide-ranging, intersecting, and systemic characteristics that drive it.

3.2.20 Lauren's unique factors were:

1. Mental Illness
2. Alcohol and substance misuse
3. Being a student away from her family and home network
4. Lack of social support while in Bristol

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50 https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/estimatingsuicideamonghighereducationstudentsenglandandwalesexperimentalstatistics/2017to2020#comparison-of-suicides-among-higher-education-students-and-general-population

51 https://www.uwhc.org.uk/health-information/students-smoking-alcohol-and-drugs/#:~:text=Studies%20show%20that%20students%20are,drugs%20than%20the%20general%20population.

52 https://www.endviolenceagainstwomen.org.uk/wp-content/uploads/C-Decriminalisation-of-Rape-Report-CWJ-EVAW-IMKAAN-RCEW-NOV-2020.pdf

53 https://www.endviolenceagainstwomen.org.uk/wp-content/uploads/C-Decriminalisation-of-Rape-Report-CWJ-EVAW-IMKAAN-RCEW-NOV-2020.pdf

Mental Illness

3.2.21 Safe Lives emphasised that domestic abuse victim-survivors who also experience mental illness are more likely to have complex needs. This highlights the importance of understanding the complete situation of each victim-survivor and their families so everyone can live their desired lives.[54]

3.2.22 Health services and Safe Link were aware of Lauren's mental illness and diagnosis, and she received treatment for them. However, aside from her initial assessment with her GP, the services did not enquire about domestic abuse.

3.2.23 Safe Lives also reported that the relationship between mental health and domestic abuse is bidirectional. Research suggests that individuals who have experienced abuse are at a higher risk of developing mental health conditions, and conversely, having a mental health condition can increase an individual's susceptibility to abuse. Individuals diagnosed with conditions such as anxiety and depression are at a higher risk of experiencing domestic abuse.[55]

3.2.24 Isolation because of mental illness was identified as one such obstacle to disclosure by Safe Lives. Daniel had reported that Lauren was challenging to live with due to her mental health and had few friends. Sophie had also reported that Lauren was lonely because of her mental illness.

3.2.25 Although Lauren had obtained assistance for her mental health, it was observed that she had been unable to attend all her scheduled appointments. Her study abroad and the COVID-19 pandemic further isolated her from services.

3.2.26 Lauren's GP practice and AWP were aware of the trauma that resulted from her formative experiences. Nevertheless, trauma therapy was not accessible to her, and AWP determined that she would not benefit from psychological services because of her unstable mental health.

3.2.27 ASC was aware of Lauren's poor mental health during their response to the alleged rape in October 2021. Nevertheless, this did not lead to external referrals due to the absence of consent. Nonetheless, this awareness of her mental health may have enabled ASC to notify Adult Social Care of the attendance and the safeguarding request that Safe Link initially submitted in September 2020.

3.2.28 As previously mentioned, it is imperative that services that provide care and treatment for individuals with mental illness consider their entire circumstance to offer opportunities for disclosure.

[54] https://safelives.org.uk/resources-for-professionals/spotlights/spotlight-domestic-abuse-and-mental-health/
[55] https://safelives.org.uk/wp-content/uploads/Practice-briefing-mental-health.pdf

Alcohol and substance misuse

3.2.29 The chair and panel recognised that alcohol and substance misuse may be used as a coping mechanism to manage the effects of domestic abuse and to regulate the symptoms of mental illness.

3.2.30 Lauren had notified the health services that she had acquired street diazepam, and they increased her prescription due to her inability to manage her symptoms.

Being a student away from her family and home network

3.2.31 Lauren had disclosed to health services her parents' complex relationships, which had intermittently improved. Nevertheless, she identified ignoring her mother as a coping mechanism for the relationship.

3.2.32 The review revealed that the agencies she had informed of the complex relationship had not thoroughly explored her family relationships.

Lack of social support while in Bristol

3.2.33 Lauren informed the health services that Partner A was supportive. It was unclear what support she had in Bristol when this relationship ended.

3.2.34 Daniel informed the chair that Lauren had limited social support. She had informed ASC that she spent most of her time with James, who she had also reported was controlling.

3.2.35 Lauren received support from health services about her mental health and the misuse of benzodiazepines. Nonetheless, the causal factors were not adequately addressed.

3.2.36 To enhance understanding, the chair examined Jane Monkton Smith's suicide timeline, which consists of the following stages[56]:

Stage One: History of the perpetrator: A history of coercive control, stalking, Intimate partner abuse or violence	The allegations of rape and controlling behaviour towards Lauren were reported to ASC. Additionally, Daniel had reported James's abuse of a former girlfriend. It was unclear whether Lauren knew this. According to ASC records, James had no previous history of domestic abuse.

[56] https://twitter.com/JMoncktonSmith/status/1495129374886174728

Stage Two: Early relationship: a relationship that often begins and Progresses rapidly	Lauren disclosed that James desired to devote all his time to her, and due to his attention, Lauren had missed university lectures and the gym.
Stage Three: Relationship: A relationship dominated by controlling tactics	Lauren had recognised several flags with James, such as coercion and control, and had told ASC.
Stage Four: Disclosure: Disclosing abuse to family and friends	Lauren disclosed domestic abuse to Daniel.
Stage Five: Help-seeking	Lauren reported James's controlling behaviour exclusively to ASC; no other agencies knew or received information about this.
Stage six: Suicidal Ideation: Increasing move towards Seeing suicide as the answer to resolve the issues	Lauren had taken overdoses and self-harmed by cutting before and during her relationship with James. She received support from AWP, BRI, GP and UOB.
Stage Seven: Entrapment	James had threatened to harm himself and end his life if Lauren left him. Lauren told Daniel she felt she had to attend to him to prevent him from ending his life.
Stage Eight: Suicide	

3.2.37 **TOR 4:** How accessible were the services for Lauren?

3.2.38 All agencies were accessible, with AWP filling in for the online-only BDP.

3.2.39 ASC noted that during their October 2021 contact with Lauren, she did not have access to officers with specialised experience and was not directed to an ISVA or domestic abuse services. However, the ASC officer added that they advised Lauren to contact the domestic abuse service via Next Link. Lauren's mother remarked that she heard from Lauren that the ASC officer was friendly and attentive and that the interaction was positive.

3.2.40 **TOR 5** Were local domestic abuse and adult safeguarding procedures followed by agencies who had contact with Lauren?

3.2.41 The GP conducted a routine enquiry for domestic abuse. Lauren discussed the problems in her relationship with her parents. She was receiving support from the services, and there was no indication that a referral was necessary.

3.2.42 Safe Link emailed the ASC following safeguarding concerns related to the alleged rape in 2018 to ensure Lauren was supported following the decision not to pursue the allegation.

3.2.43 AWP cited that professional curiosity was not employed following Lauren's disclosure of experiencing abuse by her parents and bullying by her housemates. The AWP panel member reported that they would expect consideration of safeguarding.

3.2.44 The Care Act 2014 highlights the criteria for Safeguarding Adults[57]:

- *An adult needs care and support*
- *Is experiencing, or is at risk of, abuse or neglect, and*
- *As a result of those needs, they are unable to protect themselves against the abuse or neglect or the risk of it.*

3.2.45 The chair concurs with AWP that safeguarding should have been considered to determine what safety precautions were in place.

3.2.46 In 2021, when ASC visited Lauren's house, they discovered she was a victim of domestic abuse, explicitly controlling and coercive behaviour. They have acknowledged that processes were not adhered to, and as a result, these have been investigated, and recommendations for improving practice have been made.

3.2.47 **TOR 6:** What knowledge/information did your agency have that indicated that those involved might be victims and perpetrators of domestic abuse, and how did your agency respond to this information?

3.2.48 ASC knew Lauren was a victim of domestic abuse from James. However, according to the author of the ASC IMR, inadequate measures were taken. They have identified recommendations to strengthen their response to domestic abuse.

3.2.49 The GP asked Lauren about domestic abuse during their initial contact; she reported strained relations with her parents and described her boyfriend (Adult A) as supportive.

3.2.50 AWP recognised that Lauren's statement of a complex relationship with her family did not elicit consideration of domestic abuse or further investigation.

3.2.51 It was evident that Lauren was unaware she was in a controlling and coercive relationship with James, which was highlighted following ASC attendance at her home in October 2021.

[57] https://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuse-or-neglect/enacted

3.2.52 The Domestic Abuse Act 2021[58] and Women's Aid[59] state: '*Domestic abuse is not always physical. Coercive control is an act or pattern of assault, threats, humiliation, intimidation, or other abuse used to harm, punish, or frighten the victim. This controlling behaviour is designed to make a person dependent by isolating them from support, exploiting them, depriving them of independence and regulating their everyday behaviour.'*

3.2.53 **TOR 7:** During this review, were any perpetrator disruption or victim safety planning options available to your agency/agencies? If so, were they considered, or were there barriers to using them?

3.2.54 The alleged perpetrator was unknown to any other agencies.

3.2.55 Lauren described managing her strained relationship with her mother, which included avoiding her.

3.2.56 **TOR 8:** Did your agency have policies and procedures for identifying domestic abuse and dealing with those concerns? Were these assessment tools, procedures and policies considered effective?

3.2.57 All agencies involved in the DHR have established policies and procedures.

3.2.58 ASC completed the DASH and BRAG during their encounter with Lauren in October 2021. However, it was noted that Lauren was not referred to Operation Bluestone, which is the protocol for cases of rape and serious sexual assault.

3.2.59 AWP discovered that domestic abuse and safeguarding policies were not employed.

3.2.60 AWP have revised the domestic abuse procedure to incorporate routine and selective inquiries regarding relationships and domestic abuse. All employees who pass the Level 2 Safeguarding Adults training are now provided with an internal e-learning course on domestic abuse. This package assists staff in recognising and responding to domestic abuse.

3.2.61 Since Lauren's death, new tools, such as a safety planning toolkit and DASH advice, have also been available to AWP staff to assist them in completing the assessment and making professional judgements regarding how to best protect the victim.

3.2.62 **TOR 9:** Was information shared promptly and to all appropriate partners during the period covered by this review?

[58] https://www.legislation.gov.uk/ukpga/2021/17/part/6/crossheading/controlling-or-coercive-behaviour
[59] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/coercive-control/

3.2.63 UOB, the GP, and AWP shared exceptional information about Lauren's mental health, ensuring that Lauren received the necessary support.

3.2.64 According to the ASC IMR, Lauren's case should have been assigned to Operation Bluestone. In addition, consideration should have been taken when contacting the university, but it is vital to emphasise that consent was neither provided nor requested.

3.2.65 Other services that were involved with Lauren were unaware of the domestic violence she had experienced at the hands of James due to the absence of consent and/or consideration from ASC regarding a referral to Adult Social Care. Consequently, her disclosure to ASC of James's controlling and coercive behaviour was not addressed.

3.2.66 **TOR 10:** Were joint assessments taking place to assess factors such as mental ill-health and domestic abuse?

3.2.67 Other than ASC, no other organisations were aware of the domestic abuse perpetrated by James.

3.2.68 **TOR 11:** What were the key points or opportunities for assessment and decision-making in this case? Have reviews and decisions been reached in an informed and professional way and in keeping with organisational and multi-agency policies and procedures?

3.2.69 Review and conclusions were taken after a thorough assessment and consultation with professionals.

3.2.70 **TOR 12:** Was there any additional action that could have been taken, and would it have made a difference in missed opportunities)?

3.2.71 ASC highlighted a missed opportunity during their October 2021 visit to Lauren.

3.2.72 Safe Link stated that should they have been informed of Lauren's hospitalisation and they would have been able to collaborate with mental health services and partners.

3.2.73 The chair concurs that collaboration with all concerned agencies has been regularly emphasised in previous reviews. In this instance, AWP, UOB, and the GP collaborated and were aware of the alleged rape in 2018 and its outcome.

3.2.74 However, AWP acknowledged a missed opportunity regarding investigating domestic abuse and safeguarding.

3.2.75 **TOR 13:** Were there issues about capacity or help in your agency that impacted the ability to provide services to the victims, the alleged perpetrator, or any other relevant others? If so, did these issues affect the agency's ability to work effectively with other agencies?

3.2.76 Agencies were unaware of the domestic abuse from James towards Lauren.

3.2.77 Resources in all areas are nationally recognised as insufficient. For example, ASC published a report[60] highlighting potential problems resulting from dwindling budgetary resources, rising criminal complexity, and operational demand.

3.2.78 **TOR 14**: Are there lessons to be learned from Lauren's death relating to how your agency safeguards victims and promotes their welfare or the form that it identifies, assesses, and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management, and supervision, as well as working in partnership with other agencies and resources?

3.2.79 All agencies have noted learning and put recommendations in place for improvement in practice.

3.2.80 **TOR 15:** Are there areas where agencies can identify national or local improvements to the existing legal and policy framework?

3.2.81 After Operation Soteria[61] has researched BWV, the NPCC's procedural guidance on employing Body Worn Video for the first response to rape and serious sexual assault cases will be amended in June 2023. The "interim" policy is that response officers should use their BWV when responding to incidents of domestic abuse, rape and/or serious sexual assault.

3.2.82 This recommendation is now closed to ASC. The new guidance regarding using BWV for the first disclosures of Rape or Serious Sexual Offences (RASSO) is now current and has been published. It is based on Op Soteria findings and 2024 NPCC Guidance as follows:

3.2.83 The College of Policing have published within their Briefing note for Police First responders to a rape or sexual assault that BWV can be used to record initial accounts only where the victim has consented and has the capacity to consent. Although consent isn't usually required to use/not use BWV, this is one exception where the needs and wishes of the victim should be discussed and

[60] https://www.avonandsomerset.ASC.uk/media/29964806/safe-sustainable-policing-report.pdf
[61] https://www.college.ASC.uk/research/projects/operation-soteria-bluestone

considered. Therefore, if the victim wishes for their account to be recorded on BWV and feels more comfortable with it during this process, then their wishes should take precedence.

3.2.84 As such, the ASC procedure now reads:

3.2.85 'The explicit and informed consent of victims of serious sexual offences should be obtained and recorded in writing before their initial accounts are recorded on a BWV. Where the emotional or physical condition of a victim to a serious sexual offence is such that there is any doubt about their capacity to give informed consent, BWV should not be used.'

3.2.86 AWP noted the need for staff to improve their knowledge of the context of domestic abuse beyond intimate relationship abuse.

3.2.87 **TOR 16:** The reports should consider any equality and diversity issues, including social status that is pertinent to the victim and alleged perpetrator, e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

3.2.88 During the review process, the review chair and panel reviewed all protected characteristics under the Equality Act, see section 1.13. Equality and Diversity.

4.1 Conclusion

4.1.1 The purpose of the review is to determine the circumstances behind the death of Lauren in March 2022 and *'articulate life through the eyes of the victims.'*[62]

4.1.2 Lauren was twenty-two when she ended her life by suicide. At the age of eighteen, she moved to Bristol to pursue university. She lived abroad from age five to thirteen and adored her younger brother.

4.1.3 Lauren was raised in a single-parent household. Her father left the family when she was young, and Lauren reconnected with him four years before her death. In the main, she described her relationship with her father as positive and reported feeling safe when staying with him.

4.1.4 Lauren received mental health services as both a child and an adult. She was diagnosed with Borderline-type Emotionally Unstable Personality Disorder, moderate severity, Generalized Anxiety Disorder, and Recurrent Depressive

[62] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

Disorder. In addition, Lauren self-medicated with medication, non-prescription medication, illegal substances, and alcohol.

4.1.5 Lauren frequently engaged in self-harm through self-inflicted cuts; she had overdoses of prescribed and non-prescribed medications and did not always attend ED.

4.1.6 Lauren recognised she required assistance and sought it mainly through UOB counselling and her GP. Time-limited therapy sessions were offered, and AWP explored DBT. However, Lauren only attended some sessions and was not provided DBT after returning from studying abroad.

4.1.7 DBT is based on CBT, which Lauren received when under CAMHS. However, DBT is adapted for people experiencing intense emotions, such as suicidal thoughts and self-harm. This is because the creator, Marsha Linehan, who had experienced these emotions, noted CBT was ineffective for these symptoms.

4.1.8 DBT is evidence-based and was found to be more effective than treatment as usual; the research also included those with co-morbidities of substance abuse.[63] Therefore, this was the most appropriate treatment for Lauren. Although she was given a workbook to complete while abroad, following through without guidance and feedback may have been challenging.

4.1.9 Before Lauren met James, her mother and father described Adult A as level-headed and positively influenced her. However, Lauren's parents recall that Adult A reported that the relationship was strained; Lauren's emotions were dysregulated at this time, and she was experiencing familial problems.

4.1.10 Lauren met James in August/September 2021 online; she reported he, too, had BPD and was engaging in self-harm by cutting.

4.1.11 Lauren struggled with regulating her mood and self-harming behaviours, which can disrupt relationships. Consequently, it is expected that being in a relationship with someone with the same diagnosis will be difficult.

4.1.12 In addition to reporting James' coercive and controlling behaviour, Lauren informed Daniel that James would urge her to self-harm and that they had established a suicide pact.

4.1.13 Lauren's mental health, substance use, alcohol abuse, self-harming behaviour, her relationship with James, and isolation put her at an increased risk of self-harm than the general population.

[63] https://www.dbt-training.co.uk/what-is-dbt/development-of-dbt/

4.1.14 It is recorded that suicide is a particular risk for people diagnosed with BPD, with one in ten dying by suicide.[64] DBT was offered before Lauren studied abroad but was not provided due to the one-year commitment.

4.1.15 As discovered by the ASC IMR, there were missed opportunities which may have affected Lauren accessing domestic abuse support. However, this may not have affected the outcome.

4.1.16 Agencies have identified areas for practice improvement, reflected in the recommendations.

5.1 Lessons to be Learnt

5.1.1 The review identified the following themes:

Working with people diagnosed with Personality Disorder

5.1.2 UOB and the GP emphasised the challenges in their IMRs, highlighting boundaries and Lauren's dependency on professionals.

5.1.3 The Knowledge and Understanding Framework (KUF) is a nationally recognised programme for all health, social care, criminal justice, and voluntary services personnel.[65] It is a national training programme designed to develop the skills, competence, and confidence of staff working across the health, criminal justice, and voluntary sectors. It enables staff to work more effectively with people with complex emotional needs, often associated with a diagnosis of *'personality disorder'*.

Information Sharing

5.1.4 Safe Link and ASC identified information sharing as an issue that needed improvement.

5.1.5 The UK Caldicott Guardian Council has developed an information-sharing decision-making template[66].

5.1.6 ASC could not refer Lauren to Next Link without her consent or a high-risk DASH assessment. However, ASC officers overlooked the potential influence of coercion and control on Lauren's decision not to pursue the allegation.

[64] https://www.nice.org.uk/guidance/cg78/documents/personality-disorders-borderline-final-scope2
[65] https://www.kuftraining.org.uk/
[66] https://www.ukcgc.uk/domestic-violence#:~:text=A%20template%20to%20support%20decision,not%20just%20those%20involving%20DVA.

Additionally, they neglected their safeguarding duty to inform Adult Social Care, given Lauren's care and support needs under the Care Act (2014[67]). This would have ensured that relevant agencies were aware of her as a victim of domestic abuse.

Agencies' Response to Disclosures of Domestic Abuse

5.1.7 Lauren disclosed she had a challenging relationship with her parents, felt bullied by her housemates and experienced coercive and controlling behaviour from her boyfriend, James.

5.1.8 The Department of Health and Social Care published guidance[68] in April 2022 to strengthen the response to domestic abuse. It states: '*Domestic abuse is a serious health and criminal issue. Practitioners are in a key position to identify and help interrupt domestic abuse.'*

5.1.9 And: *'Health professionals are responsible for addressing the health impacts on people directly or indirectly affected by domestic abuse. They also must ensure that other agencies are engaged to address the social, environmental, and broader impacts. People experiencing domestic abuse may choose to disclose it to health professionals, including GPs.'*

5.1.10 According to the ASC IMR author, the police did not contact James, and the investigation was insufficient. Consequently, the matter of ensuring that Lauren was informed of her *"Right to Know"* through the Domestic Violence Disclosure Scheme[69] was not addressed, nor was there any background information provided about James to confirm Daniel's claim that he had abused a previous girlfriend.

Professional Curiosity

5.1.10 Professional curiosity is where a practitioner explores and proactively tries to understand what is happening within a family or for an individual rather than making assumptions or taking a single source of information and accepting it at face value.

5.1.11 ASC and AWP discussed the absence of professional curiosity in their interactions with Lauren.

[67] https://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/assessing-needs
[68] https://www.guidelines.co.uk/public-health/responding-to-domestic-abuse-guideline/456939.article
[69] https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/domestic-violence-disclosure-scheme-factsheet

5.2 Single Agency Recommendations

5.2.1 Recommendations for specific agencies, as detailed in their management reviews.

Avon and Somerset Constabulary

A recommendation was made following a recent DHR (KBSP DHR Steve):

5.2.2 Lighthouse Safeguarding Unit to increase supervisory oversight of Witness and Victim Care Officer through audits and dip sampling to improve consistency in decisions to contact victims of domestic abuse where a crime is recorded. The author believes this recommendation will address the abovementioned concerns, so there is no need to duplicate the recommendation.

A recommendation open to ASC from North Somerset DHR 5:

5.2.3 The ASC Mental Health Theme Lead, AWP and CAMHS to work to review and deliver improved current pathways into Mental Health Services.

Recommendation One

5.2.4 ASC to conduct a deep dive analysis of cases in Spring 2023 that involve both rape and serious sexual assault cases and controlling and coercive behaviour to check and test that these cases are dealt with appropriately about both types of offence.

Recommendation Two

5.2.5 Three connected recommendations have also been proposed to improve force guidance using Body Worn Videos.

- ASC should revise and update the Body Worn Video ASC Force Procedure to ensure it reflects current best practice, the interim guidance offered by NPCC, and aligns appropriately with ASC Domestic Abuse Procedure and Rape and Serious Sexual Offences Guidance.
- ASC should effectively disseminate the revised guidance to First Response Officers.
- ASC should reflect any changes in Body-Worn Video policy that arise from Operation Soteria research when published in 2023, within their guidance, and disseminate them as soon as possible.

Avon and Wiltshire Mental Health Partnership

Recommendation One

5.2.6 Improve staff knowledge regarding identifying potential abusive behaviours and improve staff confidence in completing the DASH risk assessment to establish risk and context.

Recommendation Two

5.2.7 Awareness raising around considering domestic abuse outside of intimate partner relationships.

Recommendation Three

5.2.8 Domestic abuse and suicide prevention lead to working collaboratively to inform staff of the risk of suicide and domestic abuse and promoting awareness among staff.

Integrated Care Board

Recommendation One

5.2.9 GPs to be provided with guidance on recording identifiers on patient records to support distinguishing between different relationships in the patient's social network.

Recommendation Two

5.2.10 GPs to be provided training and resources concerning the NICE indicators of domestic abuse to support them with recognising when domestic abuse needs to be a consideration for their patients.

Recommendation Three

5.2.11 GPs are to be provided training to improve confidence and understanding of domestic abuse, the usefulness of DASH assessment forms, and the Multi-Agency Risk Assessment Conference[70] (MARAC) process.

Safe Link

Recommendation One

5.2.12 At Safe Link, we always consider the need to contact mental health support for any high-risk cases who have suicide attempts. Still, it has since been agreed that this will be an additional focus when anyone decides that the case will not proceed to court for sexual assault. We will explore in more detail why clients do not want us to contact their mental health services and explain how this may assist their support.

Recommendation Two

[70] https://safelives.org.uk/resources-for-professionals/marac-resources/

5.2.13 Multi-agency meetings/reviews with mental health services are to be considered for cases Safe Link supports and not solely rely on the client saying they have support in place.

Recommendation Three

5.2.14 Safe Link is now working closely with universities and holds a drop-in for clients to get support, so we will ensure that any university students can access our services and that we can work collaboratively with the well-being services within the university.

University Hospitals Bristol and Weston

Recommendation One

5.2.15 Staff to be able to access AWP mental health records on a need-to-know basis when the patient is under the care of University Hospitals Bristol and Weston.

University of Bristol

Recommendation One

5.2.16 The university will consider providing training for students in well-being/residential life, working with students diagnosed with personality disorders.

Recommendation Two

5.2.17 When interacting with external agencies in similar situations, assumptions should not be made about individuals according to roles such as next of kin. Instead, individual identification of all relevant contacts should be provided, particularly for separated parents.

Recommendation Three

5.2.18 The university should consistently use the term ‘emergency contact’ instead of ‘next of kin’ to avoid conflation with legal definitions that do not apply in this context.

Recommendation Four

5.2.19 All information relevant to students should be appropriately recorded on their case records, including after they left the university and after their death.

University Two

Recommendation One

5.2.20 **Student Communications**: To explore options for enhancing communication methods with students, e.g., the capacity to send SMS messages to students who have yet to respond to University Two emails.

Recommendation Two

5.2.21 **Guidance for workshop spaces**: To develop guidance for participants in dealing effectively with sensitive topics (especially in workshop spaces on the Master's in Creative Writing programme).

Recommendation Three

5.2.22 **Staff support**: To ensure academic staff who taught the student receive personal and direct contact and support in the event of a student's death.

5.3 Multi-Agency Recommendations

5.3.1 Recommendation One: Working with people diagnosed with poor Mental Health

Health and Social Care

1.a The KBSP will seek assurance from partners that a patient's mental health needs, specifically discharge preparations, are included in all care plans and that relevant agencies supporting the individual in the community are notified before the discharge date.

Post-16 Educational Settings

1.b The KBSP should work with the Safeguarding in Education Team to provide post-sixteen educational settings with literature and resources to assist young people in learning about mental health and where they can access help.

All Agencies

1.c All agencies and Post-16 Educational establishments to source and provide all frontline practitioners access to training such as level 1 Zero Suicide Alliance Level 2 Half-Day Suicide Prevention Course Training—No More Suicides[71].

1.d Staff to be provided with training opportunities and resources to identify risk factors, including coercion and control as an enabler for potential self-harm and

[71] https://no-more.co.uk/training/

suicide, to support individuals in accessing help and referring them to specialist services as appropriate.

5.3.2 Recommendation Two: Information Sharing

All Agencies

2.a To assure the partnership that their information-sharing policies comply with Bristol City Council Information Sharing Protocols.

5.3.3 Recommendation three: Agencies' responses to disclosures of Domestic Abuse

Health

3.a In accordance with NICE recommendations, all health providers should ensure that they have systems to raise awareness of domestic abuse.

3.b Avon & Wiltshire Mental Health Partnership NHS Trust, the GP, University Hospital Bristol and Weston NHS Trust are tasked with reviewing the existing measures that enable routine inquiry.[72]

5.3.4 Recommendation Four: Professional Curiosity

All Agencies

4.a The partnership will offer training for partners in Professional Curiosity to increase the confidence of staff talking sensitively to potential victims of domestic abuse.

4.b KBSP to promote Think Family to agencies providing services to children, young people, and adults with care and support needs and ensure that it is reflected in assessments.

4.c Agencies should explore the current tools to aid in their comprehension of the interrelationships between the risk of abusive relationships and suicide ideation and to ensure practitioners know the need to consider the risk of self-harm and suicide when depression and low mood are reported.

The KBSP will establish an action plan to implement the recommendations and share the review's findings with partners.

[72] https://www.lse.ac.uk/research/research-for-the-world/politics/new-tech-can-help-tackle-domestic-violence-improving-the-uk-governments-domestic-abuse-bill

Appendix 1: Acronyms

AAFDA	Advocacy After Fatal Domestic Abuse
ACEs	Adverse Childhood Experiences
ASC	Avon and Somerset Constabulary
AWP	Avon and Wiltshire Mental Health Partnership NHS Trust
BDP	Bristol Drugs Project
BNSSG	Bristol North Somerset and South Gloucestershire
BPD	Borderline Personality Disorder
BRI	Bristol Royal Infirmary
BWV	Body Worn Video
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CID	Criminal Investigation Department
CPS	Crown Prosecution Service
DASH	Domestic Abuse, Stalking and 'Honour'- Based Abuse
DBT	Dialectical Behaviour Therapy
DHR	Domestic Homicide Review
ED	Emergency Department
ICB	Integrated Care Board
IMR	Individual Management Review
ISVA	Independent Sexual Violence Advisor
KBSP	Keeping Bristol Safe Partnership
KUF	Knowledge and Understanding Framework
MARAC	Multi-Agency Risk Assessment Conference
NPCC	National Police Chief's Council
RASSO	Rape or Serious Sexual Offences
SARC	Sexual Assault Referral Centre
SCS	Student Counselling Service
SHERPA	Student Health Emotional Regulation Pathway
SVLO	Sexual Violence Liaison Officer
TOR	Terms Of Reference
UCAS	Universities and Colleges Admissions Service
UOB	University of Bristol

Appendix 2: Live 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 recommendations What are the key milestones within the plan for completing these actions that** *can be measured for progress reporting?*	**Target Date** *When will these actions be completed?*	**Date of Completion and Outcome** *To be completed upon completion of actions.*
1a) The KBSP will seek assurance from partners that a patient's mental health needs, specifically discharge preparations, are included in all care plans and that relevant agencies who will support in the community are notified in advance of the discharge date.	Local	1.1.1. Partners to provide assurance that they review care and support plans, which incorporates a patients mental health need, in advance of discharge so that they are able to share details to community-based services.	Health and Social Care providers	Partners share policy/guidance which stipulates that a patients mental health need is recorded and reviewed in all care and support plans	July 2025	*In progress.* Outcome: Mental health needs are recorded in discharge plans and shared with relevant agencies who are supporting the individual in the community.
		1.1.2. KBSP to conduct a quality assurance activity on discharge planning.	KBSP – QA and Policy Officer	Discharge planning to be quality assured by the partnership.	July 2025	*Not started.* Outcome: Discharging planning checked by the partnership and improvements made to any gaps identified.

1b) The KBSP should work with Safeguarding in Education Team to provide post-16 educational settings with literature and resources to assist young people to learn about mental health and where they can access help.	Local	1.2.1. Safeguarding in Education team to share/develop resources specifically aimed at raising awareness of mental health for post-16 educational settings. 1.2.2. Training opportunities developed to promote mental health and suicide amongst post-16 educational settings.	Safeguarding in Education Team	Resources shared. Training for post-16 educational settings.	July 2025 September 2025	*Not started* Outcome: Accessible mental health support resources for post-16 educational settings. *Not started* Outcome: Post-16 settings trained on mental health and suicide awareness.
1c) All agencies and Post-16 Educational establishments to source and provide all frontline practitioners access to training such as: level 1 Zero Suicide Alliance Level 2 Half-Day Suicide Prevention Course Training—No More Suicides[73].	Local	1.3.1. All agencies and post 16 educational settings to provide assurance that Mental Health and Suicide First Aid training is promoted regularly and accessible to all staff.	All agencies involved in this review and Safeguarding in Education Team	All agencies to evidence promotion of Mental Health First Aid and Suicide awareness training.	July 2025	*In progress.* Completed by: **NBT:** NBT has the attached courses running for staff, some are for specific roles. For groups of staff with specific roles/departments. Mental Health Awareness in the Emergency Department – run by the Mental Health Liaison Team for ED staff. Perinatal Mental Health for Midwives – run by the mental health and bereavement midwifery team. **UHBW:** UHBW have suicide awareness training. This is available to all staff trust wide.

[73] https://no-more.co.uk/training/

						Our safeguarding team are also doing outreach within our wards and will raise the profile of this. Training: Suicide Awareness Training (Zero Suicide Alliance): Suicide Awareness Training (Zero Suicide Alliance). Please find the list of courses for UHBW: Preventing Suicide by Ligature Training – face-to-face training. Suicide Awareness Training (Zero Suicide Alliance) – eLearning. There are four active programmes relating to mental health staff can also access: eLearning: Mental Health Problems in Veterans - an eLfH module added as part of the NHS Healthcare for the Armed Forces programme. Narrowing Health Inequalities in Severe Mental Illness (SMI) – an eLfH module that's part of a course titled Health Inequalities Face-to-face: Day 1: Introduction to Infant feeding – part of an infant feeding course for paediatric hospitals. This has a description of

						"Understanding normal infant feeding; Maintaining lactation; Challenges, barriers and gaps; Maternal motivation and mental health; Parent stories" Safeguarding and Paediatric Mental Health - Safeguarding Children L3 Themed Update - part of the range of safeguarding themed update titles for level 3 staff but any staff member can book. **UOB:** The following are on our online training platform and are routinely promoted to all staff, as well as being included in induction plans: Develop - University of Bristol - Recommended Training: ZSA Suicide Awareness Training, Develop - University of Bristol - Recommended Training: Supporting student mental health & wellbeing, Develop - University of Bristol - Recommended Training: Mental health awareness at work. **AWP**: AWP have mandatory E learning • Mental Health Act e-learning

						• Safety Ax and Suicide prevention in /mental Health Outcome: Suicide awareness and prevention training completed by frontline staff.
1d) Staff to be provided with training opportunities and resources to identify risk factors, including coercion and control as an enabler for potential self-harm and suicide, to support individuals in accessing help and referring them to specialist services as appropriate.	Local	1.4.1. KBSP to offer training to professionals to identify the links between domestic abuse and coercion and control as an enabler for potential self-harm and suicide. 1.4.2. KBSP to survey attendees after 3 – 6 months to record impact.	Keeping Bristol Safe Partnership – Training and Development Officer	Training plan includes this for 2024/25 programme. Training rolled out. Number of agency attendees tracked/outcomes recorded.	November 2024	Completed. Domestic abuse and links to coercion and control and included in the KBSP Domestic Abuse and Safeguarding Training Offer. *In progress:* Post training survey to be sent out by May 2025.
2a) To assure the partnership that their information-sharing policies comply with Bristol City Council Information Sharing Protocols.	Local	2.1.1. All agencies to provide assurance to the KBSP that their information sharing policies align with Bristol City Council Information Sharing ASCs	Keeping Bristol Safe Partnership	Assurance provided from the following agencies on their information sharing policies	July 2025	*In progress.* *Completed by:* **NextLink:** Yes our policies (Adult and child Safeguarding policies and all our Data protection and confidentiality policies including consent and permission to share forms)

						comply with KBSP Information and Data Sharing Agreements. **ICB:** The BNSSG ICB can provide assurance their information sharing policy is in alignment with KBSP information and data sharing agreement. Outcome: Partner agencies compliant with KBSP Information-sharing policies.
3a) In accordance with NICE recommendations, all health providers to assure the partnership they have systems in place to raise awareness of domestic abuse.	Local	3.1.1 For the GP practice to review current safeguarding ASCs and training for GPs for Domestic Abuse and routine enquiry in accordance with the NICE guidance. 3.1.2. To review Remedy Website to ensure the ICB Primary Care DA Guidance is up to date in respect of DA Act 2021 and routine enquiry. Link to be shared appropriately with GP Surgery. 3.1.3. ICB Primary Care Safeguarding Team to contact the surgery requesting evidence of	ICB/GPs	There will be improved staff awareness and ability to recognise indicators of domestic abuse and increased identification of victims of domestic abuse, and signposting of victims to appropriate specialist support. ICB Guidance updated. HHHC Safeguarding Practice lead to provide evidence of safeguarding training compliance. Evidence of feedback meeting completed	December 2024	3.1.1. Completed in November 2024. All policies up to date and reviewed annually. Resources on Remedy utilised 3.1.2. Completed in November 2024. Information review and shared with the surgery. 3.1.3. Completed in November 2024. Reviewed prior to and assurance gained.

		compliance with safeguarding training as per the intercollegiate document (RCGP guidance). 3.1.4. Learning of this DHR to be shared with the practice safeguarding lead, practice manager and named GP involved in case.		with GP practice staff. Evidence of a lunch and learn accessible to all primary care staff in BNSSG footprint.		3.1.4. Completed in November 2024. Shared actions and recommendations. Once published links to reports will be shared with practice.
		3.1.5. Confirm with KBSP the system in place to raise awareness of Domestic abuse	University Hospitals Bristol and Weston	Domestic abuse is included in the induction training packages delivered to all UHBW staff and has a training package in place that provides domestic abuse training for all staff that require level 3 training (as per Intercollegiate document guidance) This domestic abuse training offer includes delivery of sessions by IDVAs. UHBW have a domestic abuse policy available to all staff. This policy is reviewed and updated annually	September 2024	3.1.5. Completed in April 2024. Domestic Abuse induction training delivered to all UHBW staff.

				to meet local and national requirement. All wards/departments have a copy of the Safeguarding information which includes a page on domestic abuse (Nextlink contact details).		
			Avon and Wiltshire Mental Health Partnership	Provision of internal and external (to partners) domestic abuse and suicide awareness training looking at high risk flags for DA and how these interlink with victim and perp suicide risks. Development of the suicide safety assessment (previously risk assessment) to include consideration for domestic abuse when risk of suicide is identified. If this is ticked on the assessment it prompts	Complete	3.1.6. Completed. Domestic Abuse and Suicide awareness training delivered to staff.

				staff to complete the DASH and links to DASH guidance. DASH risk assessment training offered to teams on an ad hoc basis/ on request AWP have a directory of domestic abuse services by locality to improve staff signposting to neighbouring local authority services and national charities. This document also includes how to refer to MARAC. Trust has DASH guidance which looks at the statistics and figures surrounding the red flag questions and to help staff provide rationale on MARAC referrals should there be multiple red flags present.		

				The Trust continues to partake in awareness raising during domestic abuse campaigns throughout the year to support staff with recognising the signs and knowing how to appropriately respond- e.g. 2023- Day of Honour June- HBV, Suicide awareness day- sept- included details about DA as a risk factor to suicide, 16 days of action November		
3b) Avon & Wiltshire Mental Health Partnership NHS Trust, the GP, University Hospital Bristol and Weston NHS Trust are tasked with reviewing the existing measures that enable routine inquiry.	Local	3.2.1. Safeguarding lead to discuss with the UHBW Divisional Director of Emergency Departments the current level of use of routine domestic enquiry and documentation by Emergency Department staff (with a focus on patients presenting with injury and delay in presentation)	UHBW – Deputy Head of Safeguarding	For the Safeguarding lead to achieve a baseline understanding for current use of domestic abuse enquiry in UHBW Emergency Departments to identify any actions required by the UHBW Safeguarding team to support increase in its use and ensure its documentation in patient records (with a focus on those patients	September 2024	3.2.1. Completed. Increased identification of victims of domestic abuse, and signposting of victims to appropriate specialist support.

				with injury and delayed presentation).		
		3.2.2. AWP to add routine enquiry regarding domestic abuse in the suicide risk assessment.	Avon and Wiltshire Mental Health Partnership	AWP are working to add routine enquiry re domestic abuse in the suicide risk assessment/ safety assessment. A question will be added to the suicide risk assessment asking specifically about whether there are concerns about domestic abuse- if the answer is yes this will prompt DASH risk assessment and link to guidance.	December 2024	3.2.2. Completed. Routine enquiry is part of our risk assessment. In the safety assessment staff are asked: 'Is there any concern about domestic abuse' If the clinician answers yes, another box pops up asking: 'Have you completed DASH' and next to that is the hyperlink to the DASH risk assessment and guidance. In addition. the Domestic abuse lead and Suicide prevention lead jointly created a guide to DA and suicide and this is accessible directly from a hyperlink in the safety assessment. DA and suicide is included in all suicide prevention training.

4a) The partnership will offer training for partners in Professional Curiosity to increase confidence of staff talking sensitively to potential victims of domestic abuse.	Local	4.1.1. KBSP will include professional curiosity within its 2024/25 training programme, e.g. Safeguarding Adults course, MA Domestic Abuse course. 4.1.2. Evaluate impact via survey 3-6 months after 4.1.3. Professional curiosity to feature as a theme in the upcoming Learning Webinar	Keeping Bristol Safe Partnership – Training and Development Officer Keeping Bristol Safe Partnership – Statutory Review Officer	KBSP to include within its 2024/25 training programme. Evaluations three and six months after attendance to check impact. Webinar recorded and uploaded to KBSP Website.	November 2024 December 2024	4.1.1. Completed. Professional Curiosity is a thread throughout the core training offer. 4.1.2. *In progress:* Post training survey to be sent out by May 2025. 4.1.3. Completed. Professional Curiosity was the theme of a Stop Adult Abuse Week Bristol webinar that has been published on the KBSP YouTube.
4b) KBSP to promote Think Family to agencies providing services to children, young people, and adults with care and support needs and ensure that it is reflected in assessments.	Local	4.2.1. KBSP to work with practice leads in First Response to develop a webinar to launch the new Bristol guidance for supporting CYP thresholds document and promote the Think Family approach in undertaking assessments. 4.2.2. Webinar launched, recorded and uploaded to KBSP Website.	First Response Keeping Bristol Safe Partnership	Webinar developed. Webinar recorded and uploaded to KBSP Website.	July 2024 September 2024	4.2.1. Not started. Outcome: Webinar delivered to partners launching the new Bristol guidance for supporting CYP thresholds. 4.2.2.Not started.

						Outcome: Webinar accessible to all partners on the KBSP website.
4c) Agencies should explore the current tools to aid in their comprehension of the interrelationships between the risk of abusive relationships and suicide ideation to ensure practitioners know the need to consider the risk of self-harm and suicide when depression and low mood are reported.	Local	4.3.1. KBSP to develop a dedicated resource page for domestic abuse which will promote the following tools: • Victim Support/Jane Monckton Smith – VS 5 critical questions, • Stalking DA combined suicide timeline risk assessment & DASH, • DA combined homicide timeline risk assessment & DASH 4.3.2. KBSP to promote resource page via the KBSP Domestic Abuse groups and in the KBSP Quarterly newsletter.	Keeping Bristol Safe Partnership	The KBSP to develop a dedicated resource page for domestic abuse including the uploading of these resources and promotion of the page when launched through the KBSP Quarterly Newsletter	July 2024 September 2024	4.3.1. Completed. The KBSP website has a dedicated resource page for Domestic Abuse. During Stop Adult Abuse week in November, resources and services for Domestic Abuse was promoted. 4.3.2. Completed. The KBSP website has a dedicated resource page for Domestic Abuse. During Stop Adult Abuse week in November, resources and services for

						Domestic Abuse was promoted via the newsletter, Adults and Domestic Abuse sub-groups.
SA.1) Avon and Somerset Constabulary to conduct a deep dive analysis of cases in Spring 2023 that involve both rape and serious sexual assault cases and controlling and coercive behaviour to check and test that these cases are dealt with appropriately about both types of offence.	Local	1. Scrutiny panel set up for rape and DA and CCB, plus stalking and harassment	Avon and Somerset ASC	New scrutiny panel to scrutinise rape, DA, CCB, and talking and harassment cases to ensure that they are delt with appropriately.	January 2024	Scrutiny panel being set up for rape and DA and CCB plus stalking/harassment – This is a longer term and more satisfactory solution to this recommendation. Recommendation completed and closed: 04/01/2024
SA.2) Three connected recommendations have also been proposed to improve force guidance using Body Worn Videos. • Avon and Somerset Constabulary should revise and	Local	1. Review Body Worn Video ASC Force Procedure. 2. Update and disseminate revised guidance 3. Implement guidance following Op Soteria research.	Avon and Somerset ASC	Await Op Soteria research findings Align force guidance using Body Worn Videos	June 2023	Completed. Op Soteria research concluded that, against prediction, it is better NOT to use BWV when taking first accounts of Rape or Serious Sexual Offences (RASSO). Therefore, A&S policy needs to reflect this.

update the Body Worn Video ASC Force Procedure to ensure it reflects current best practice, the interim guidance offered by NPCC, and aligns appropriately with ASC Domestic Abuse Procedure and Rape and Serious Sexual Offences Guidance. • Avon and Somerset Constabulary should effectively disseminate the revised guidance to First Response Officers. • Avon and Somerset Constabulary should reflect any changes in Body Worn Video policy, which arise from Operation Soteria research when published in 2023, within their guidance, and						Update from Force Lead for Body Worn Video: We have agreed our force position with the Bluestone team in terms of RASSO and the use of BWV which is included in the new policy. There is no consistent national direction on this from the NPPC BWV portfolio and as we are the national lead force for RASSO the view/steer from our own team is entirely appropriate. The policy does not mandate recording but does give officers options based on the particular circumstances of the incident. Review of policy and FLO booklets took place and was published June 2024.

disseminate as soon as possible.						
SA.3) Improve staff knowledge regarding identifying potential abusive behaviours and improve staff confidence in completing the DASH risk assessment to establish risk and context.	Local	1. Training rolled out to the trust to improve staff confidence when completing DASH risk assessments.	Avon and Wiltshire Mental Health Partnership	Improved accessibility and availability of DASH Risk Assessment training for all staff.	Complete	Completed. DASH risk assessment training available to teams on request, or if concerns identified. DASH guidance has been developed to support staff in the completion of DASH risk assessment and providing context and rationale for their risk assessments/ referrals to MARAC- particularly professional judgement referrals.
SA.4) Awareness raising around considering domestic abuse outside of intimate partner relationships.	Local	1. Training rolled out to the trust that considers domestic abuse outside of intimate partner relationships.	Avon and Wiltshire Mental Health Partnership	Increased awareness of domestic abuse outside intimate partner relationships.	Complete	Completed. Level 2 safeguarding domestic abuse training emphasises that domestic abuse can occur outside the intimate partner triad. This is also a permanent feature of the DASH risk assessment update training.

SA.5) Domestic abuse and suicide prevention lead to working collaboratively to inform staff of the risk of suicide and domestic abuse and promoting awareness among staff.	Local	1. Training rolled out for the trust that informs staff about the risks of suicide and domestic abuse.	Avon and Wiltshire Mental Health Partnership	Training rolled out. Evaluated impact.	Complete	Completed. Training rolled out trust wide looking at high risk cluster DA behaviours and risk profiles for those presenting with suicidal thinking. This training received positive feedback and was also extended to partner agencies including North Somerset partnership day and DRIVE practitioners. The findings and associated links were also shared at strategy level with partners for sharing within their organisations.
SA.6) Learning from this DHR to be shared with the practice	Local	1. Arrange meeting to share themes	BNSSG ICB – Safeguarding Team	Meet with Safeguarding Link GP	2 months from publication	Completed in November 2024. Learning shared with Safeguarding Link GP and 12 clinicians in the surgery.
SA.7) GPs to be provided with guidance on recording identifiers on patient records to support distinguishing between different relationships in the patient's social network.	Local	1. Guidance to be provided which details a recommendation on recording and identifying partners/significant others onto the patient record in the ICB Newsletter sent to GP Surgeries.	BNSSG ICB – Safeguarding Team	GPs will have access to guidance on recording patient's social network.	6 months	The ICB Named GPs are presenting this topic and documenting partner details on records at safeguarding link GP meeting on 5th March 2025 and information added to newsletter.

SA.8) GPs be provided training and resources in relation to the NICE indicators of domestic abuse to support them with recognising when domestic abuse needs to be a consideration for their patients.	Local	1. Included in Level 3 training that supports GPs to identify signs of domestic abuse.	BNSSG ICB – Safeguarding Team	Staff awareness raised of NICE indicators for DA.	Ongoing	Completed March 2025: Safeguarding Training- the Practice have staff training log for recording safeguarding training which is reviewed each year by practice Safeguarding Leads.
SA.9) GPs to be provided training to improve confidence and understanding of DA, the usefulness of DASH assessment forms and the MARAC process.	Local	1. Included in level 3 training which supports GPs to be professionally curious around domestic violence to make it easier for patients to disclose, and awareness of onward services to support and reduce risks to victims of DA following disclosures.	BNSSG – Safeguarding Team	Staff awareness raised of need to address and assess all potential victims of DA.	Ongoing	Completed March 2025: Practice staff utilise resources and guidance from REMEDY to support Safeguarding practice which includes professional curiosity. They have now adopted 'Think Family' approach to considering wider issues for family home of students presenting with Safeguarding concerns.

SA.10) At safe link, we always consider the need to contact MH support for any high-risk cases who have suicide attempts. Still, it has since been agreed that this will be an additional focus when anyone decides that the case will not proceed to court for sexual assault. We will explore in more detail why clients do not want us to contact their MH services and explain how this may assist their support.	Local	1. Guidance to be provided to ISVA's which details a recommendation to Contact MH Support for any high-risk victims who have identified Struggles with this Mental Health; including suicide ideation or attempts. This will be an additional Focus for Victims who make the decision to no longer proceed through the Criminal Justice System	Safe Link	ISVA's will have access to the guidance provided, this will be supported through the Line management route and supervision processes	Complete	Completed. Guidance and resources provided to ISVAs for mental health support contacts for high-risk victims.
SA.11) Multi-agency meetings/reviews with MH services are to be considered for cases Safe Link supports and not solely rely on the client saying they have support in place.	Local	1. Guidance to be provided to ISVA's which details a recommendation to arrange a Professionals Meeting where it is thought that Multiple agencies are supporting the Victim, to ensure information about support available to the victim is shared proportionately and	Safe Link	ISVA's will have access to the guidance provided, this will be supported through the Line management route and supervision processes	Complete	Completed. Guidance provided to ISVA's on when to arrange a professionals meeting.

		duplication of work is avoided				
SA.12) Safe Link is now working closely with universities and holds a drop-in for clients to get support so we will ensure that any University students can access our services and we can work collaboratively with the well-being services within the University.	Local	1. Continued delivery of the Drop-In sessions	Safe Link	Ongoing delivery of Drop-In Sessions	Complete	Completed. Safe Links drop-ins are available at Universities.
SA.13) Staff to be able to access AWP mental health records on a need-to-know basis when the patient is under the care of University Hospitals Bristol and Weston.	Local	1.Confirm with KBSP the level of staff access to AWP mental health records across UHBW	University Hospitals Bristol and Weston	Staff in Emergency Departments in UHBW are able to contact AWP for information. Psychiatric Liaison team provide link between ED staff and AWP. Awaiting confirmation from Divisional wide General Manager of staff groups who have direct access to AWP	July 2024	Completed. The AWP Psychiatric Liaison team provide a link to UHBW staff and a patients mental health records.

				records and status of any work being completed with AWP regarding this.		
SA.14) The university will Consider the provision of training for Student Well-being/Residential Life around working with students diagnosed with personality disorders.	Local	1. Make a decision on ongoing training requirements for those services	University of Bristol	Joint service meeting on 20th April	Decision by May 2024. If we decide to go ahead with training, that would be by end of first term of academic year 24/25 (December 2024)	Completed: Jan 25: We will provide regular training for our Student Wellbeing and Residential Life services on working with students with diagnosis of personality disorder and practical strategies for holding boundaries, avoiding pitfalls.
SA.15) When interacting with external agencies in similar situations, where there is a lawful basis for information sharing, assumptions should not be made about individuals according to roles such as next of kin. Instead, individual	Local	1. Maintain current practice	University of Bristol	This is current practice	Completed	Completed. Next of kin/emergency contact records are confirmed by the individual alone.

identification of all relevant contacts should be provided, particularly for separated parents.						
SA.16) The university should consistently use the term 'emergency contact' instead of 'next of kin' to avoid conflation with legal definitions that do not apply in this context.	Local	1. Maintain consistent practice	University of Bristol	This is current practice	Completed	Completed. University to use emergency contacts in student records.
SA.17) All information relevant to students should be appropriately recorded on their case records, including after they left the university and after their death.	Local	1. Review of our Student death Processes is due to commence and should be completed by September 2024. This recommendation will be considered as part of that.	University of Bristol	Review of our Student death Processes	September 2024	Completed; April 2025. Review of Student death processes are now complete.
SA.18) Student Communications: To explore options for enhancing communication methods with students, e.g.	Local	1.SMS continues to be unavailable at the University, therefore another process was implemented to ensure all students who disengage from Student Wellbeing	University Two	New process for following up with students who have stopped engaging with SWS in place since start of 23/24	Completed by start of 23/24	Completed. • When individual Advisors have completed 2 attempts at contact, student is added to 'non-engagement' pathway on the central case management system

capacity to send SMS messages to students who have yet to respond to University Two emails.		Services, SWS are robustly followed up.				• A lead member of staff, supported by Admin completes a review of each student: o Where a 'risk' flag is raised, eg poor academic progress, 3 party concern student is escalated to 'ESP', enhanced support process – internal to SWS all students will be followed up by Mental Health Advisor and escalated to Managers for 'Trusted Contact' action o Where no 'risk flag' is indicated student will be called and a holistic review of their context will be carried out – if no satisfactory conclusion the student will be escalated to ESP as above for consideration of whether Trusted Contact Procedure should be followed.
SA.19) Guidance for workshop spaces: To develop guidance for participants in dealing effectively with sensitive topics (especially in workshop spaces on the Master's in Creative Writing programme).	Local	1.To check in with Academic team to determine if enhanced guidance is for this is required.	University Two	Review of guidance for workshop spaces.	May 2024	Completed. The Head of Student Wellbeing Services has discussed with the relevant academic coordinator, and we are satisfied that there is good and consistent practice across their courses in preparing students for sensitive and personal topics. The University has also recently launched an inclusive teaching framework, which includes guidance and

						resources on 'sensitive topics and brave spaces' which all staff are expected to follow: 'Inclusive Teaching'.
SA.20) Staff support: To ensure academic staff who taught the student receive personal and direct contact and support in the event of a student's death.	Local	1.The University to provide contact and support to staff.	University Two	Procedure reviewed.	Completed by start of 23/24	In the Event of a Student Death or Serious Injury Procedure was reviewed to ensure this provision is formally embedded. Procedure has not had to be run this academic year, but when it is a formal 'lessons learned' process is held to ensure any actions or amendments to Procedure are followed up.

Appendix 3: Home Office Feedback Letter

Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

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

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

17th December 2024

Dear the Keeping Bristol Safe Partnership,

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

The QA Panel felt that the pen portrait from family and friends, along with the quotes included from Lauren's tutors and housemate, gave a sense of who she was as a person. There was also helpful inclusion of the suicide timeline of Professor Jane Monkton Smith to facilitate learning and highlight the potential for agency engagement.

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

Areas for final development:

- Please ensure that the Terms of Reference are set out in full in section 1.6

of the Overview Report. The Terms of Reference should also be included in the Executive Summary.

- Please confirm whether review panel members were independent.

- Please indicate whether family members received a copy of the relevant Home Office leaflet.

- There is currently a different reason for the delay reported in the overview report and the executive summary. This should be clarified.
- Please remove the exact date of referral of the case and initial discussion by the CSP at paragraph 1.4.1 to increase anonymity (the month and year are sufficient).

- The scope covers the period of agency involvement, but should also cover the period of the abusive relationship and enhance the analysis of domestic abuse.

- The Equality and Diversity section does not identify the specific protected characteristics that relate to the alleged perpetrator, or any analysis relating to intersectionality of coercive control, domestic abuse and mental health issues. This should be added.

- A copy of the report should be sent to the local Police & Crime Commissioner, and they should be on the dissemination list within the report.

- Please replace the tabular chronology in section 2.2 with a combined narrative chronology, as required in the statutory guidance.

- Please correct the inconsistency in accounts regarding the 2018 rape. The chronology table states the decision not to go to trial was made in September 2020, whereas paragraphs 3.1.3 and 3.2.17 state that it was September 2021 and paragraph 6.1.6 of the Executive Summary states October 2020.

- Please clarify the source of the quote in paragraph 3.1.4.

- Paragraph 3.2.63 states that the policy regarding body worn video was due to be decided by June 2023. The report was finalised more than nine months later, so this paragraph should be updated to reflect the decision.

- The review may have benefited from an independent domestic abuse specialist, as well as input from drug and alcohol services on the panel. The CSP should consider this for any future reviews undertaken.

- The report should reflect on whether consideration was given to prosecuting the perpetrator in relation to the victim's suicide, given his

history of seeking suicide pacts and encouraging Lauren to kill herself.

- The overall analysis is not focused enough on the identification and response to domestic abuse. For example, paragraph 3.2.3 notes that there was positive information sharing between agencies and they ensured that Lauren received the necessary assistance. This is correct in relation to mental health, but not in relation to experiences of domestic abuse.

- The Panel felt more information could be included on the needs of victims who have had multiple experiences of violence against women and girls (rape, attempted sexual assault and coercive control). Further analysis of the impact of these experiences and how agencies might respond better in future would be helpful.
- Greater exploration of the police response to the allegation of rape and disclosure of coercive and controlling behaviour in October 2021 would be helpful. For example, why was the case not referred to Operation Bluestone? Why was a referral to an ISVA not considered? Why were the victim's housemate (who reported the rape) and the alleged perpetrator not interviewed?

- The report states that the perpetrator of the alleged rape in 2018 was a colleague and the datasheet refers to him as 'work colleague', whilst the chronology table suggests that 'acquaintance' would be more appropriate. Clarification is needed and if the perpetrator was a 'work colleague', did the panel contact the employer to explore their response?

- Lessons learned are documented well but are limited in relation to the experiences of domestic abuse and could be been extended to consider involvement of family and friends, the use of Clare's Law and the impact on victims of multiple experiences of violence against women and girls.

- The Overview Report and the Executive Summary would both benefit from a final proofread.

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