Domestic Homicide Review
Overview Report

Keeping Bristol Safe Partnership

Report Into the Death of Nevaeh in April 2019

Commissioned By:	Keeping Bristol Safe Partnership
Lead Reviewer and Author:	Mark Power (Mark Power Safeguarding- http://linkedin.com/in/markpower373)
Version	Final
Date of Completion:	14th September 2023

Contents

1. INTRODUCTION

1.1. Circumstances Leading to the Review

During April 2019, Nevaeh was found deceased having died by suicide in her home. At the time of her death Nevaeh was known to a number of services and was being supported following the disclosure of domestic abuse committed by her previous partner Colin from whom she had recently separated. The abuse had been reported to Avon and Somerset Constabulary, which on the 31st July 2019 submitted a referral for the consideration of a Domestic Homicide Review (DHR).

The Keeping Bristol Safe Partnership (KBSP) considered the referral and made a decision that whilst the DHR criteria had been met, the review should not commence until the conclusion of the coroner's inquest. This was to ascertain if a verdict of death by suicide was reached, to ensure that Home Office guidance for undertaking a DHR had been met. This was challenged by Nevaeh's family, with the support of the Advocacy After Fatal Domestic Abuse charity (AAFDA). In September 2020, the KBSP reconsidered its initial decision and commissioned this DHR. The KBSP accepted that it was not appropriate to delay a DHR for this purpose and have amended their processes to ensure that such delay does not happen in the future.

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

a) Multi-agency planning and information sharing
b) Housing providers and domestic abuse procedures
c) The police response to Nevaeh's reports of domestic abuse

The KBSP would like to express sympathy to Nevaeh's family for their loss and also to thank them for the way they have actively participated in the review. Recognition is also provided for the role of AAFDA in supporting Nevaeh's family during the review process.

1.2. Domestic Homicide Reviews – Purpose and Timescales

Domestic Homicide Reviews (DHR)[1] were established under Section 9(3) of the Domestic Violence, Crime and Victims Act (2004). The purpose being to:

- Establish what lessons are to be learned from the domestic homicide, regarding the way in which local professionals and organisations work individually and together to safeguard victims.

[1] https://www.gov.uk/government/publications/statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

- Identify clearly what those lessons are, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
- Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children, by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.
- Contribute to a better understanding of the nature of domestic violence and abuse, and highlight good practice.

The purpose of a review is to identify learning and they are not about proportioning blame. As such a DHR should not form part of any disciplinary process for the professionals involved in the case. Similarly, they are not inquiries into how a person died or who was responsible, this is a matter for the coroner and where relevant, the criminal courts.

Normally a DHR should be completed within six months of being commissioned, a time period provided by the Home Office, or within a time frame agreed by the community safety partnership. Due to the impact of the COVID pandemic, which impacted upon the capacity of all agencies, a specific time frame was not defined by the partnership, but an agreement made that it should be conducted as expeditiously as possible. Additionally, Nevaeh's family asked for a longer time period, to support their engagement in the process and to consider the findings. The DHR commenced in January 2021, with the overview report being completed and ready for submission to the Quality Assurance Panel in May 2022.

1.3. Terms of Reference and Methodology

An independent chair was appointed to work alongside a panel of local professionals to undertake the review. Terms of reference (see appendix A) were agreed with the Keeping Bristol Safe Partnership, that examined the support provided to Nevaeh and how agencies had responded to any disclosures of domestic abuse in her relationship with Colin. This also sought to examine if Nevaeh had reported any abuse during her new relationship with Angela. The key questions that the DHR was required to consider are outlined as follows:

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

Key date parameters were set. This required agencies to summarise any relevant information held since the start of Nevaeh and Colin's relationship in 2008 and a detailed analysis of information from November 2018, just prior to the first disclosures of domestic abuse.

Chronologies and Individual Management Reviews (IMRs) were provided by each agency, analysing events and considering how changes to practice may deliver future improvement. The authors of the reports were independent, not having any previous involvement with Nevaeh's case, and were able to bring an independent objectivity to the review process.

Practitioners and senior representatives from each agency formed a review panel that met on five occasions, the membership being independent of Nevaeh's case. The panel conducted a detailed analysis of events, to identify the systemic reasons as to why better outcomes were not achieved for Nevaeh and to identify potential improvements for consideration by the KBSP. Nevaeh's family and friends were an important part of the review process.

During the review, Nevaeh's family detailed a previous relationship in which she had suffered from domestic abuse. The DHR considered this as it was important to understand how previous relationships may have impacted upon her relationship with the agencies in this case.

1.4. Involvement of Family, Friends, and Previous Employer

Nevaeh's family were actively involved in the DHR process and provided valuable contributions throughout the review. The DHR sought to identify close friends of Nevaeh who may be able to provide a contribution and her family identified two close friends who were able to provide information about her relationship with Colin and what was happening in her life. One of these friends was also a work colleague and was able to provide additional context about a key time in Nevaeh's working life.

Nevaeh's previous employer engaged with the review, to provide details of key events that had taken place in the workplace and to discuss any potential organisational learning.

Nevaeh's ex-partner, Colin, willingly engaged with the review. He was able to provide information about his relationship with Nevaeh and answered any questions that he was asked. Whilst the DHR would have wished to obtain a contribution from Nevaeh's new partner Angela, this was not possible.

The KBSP would like to thank all those who contributed and were involved in the review process.

<u>Contributors</u>

Nevaeh's Family	A number of personal interviews throughout the DHR, supported by their AAFDA representative. The provision of

	supporting documents and details of the coronial inquest.
Colin	Personal interview with the Independent Reviewer.
Nevaeh's Friends	The independent reviewer met with two close friends of Nevaeh, one of whom was also a work colleague.
Nevaeh's Employer	The independent reviewer met with Nevaeh's manager to discuss: Nevaeh, relevant work events, and company policies including staff welfare and support arrangements. Additional HR documents were provided to support the information provided.

1.5. Agency Contribution and The Review Panel

A list of the agencies contributing to the review is provided in this section of the report. This outlines the agencies that provided a written submission and those providing a member for the review panel.

Agency	**Representative**	**Job Title / Role**	**IMR**
North Bristol NHS Trust	Claire Foster	Named Nurse for Safeguarding	Not required
University Hospitals Bristol and Weston NHS Foundation Trust (Including Unity Sexual Health)	Carol Sawkins	Senior Nurse Safeguarding	Yes
Bristol City Council Housing and Landlord Services	Krystal Presland	Policy & Practice Officer	Yes
	Martin Owen	Project Manager	
Avon and Somerset Constabulary	Andrew Sparks and Lee Jones	Both D/ Inspector - Major Crime Review Team	Yes
Next Link Bristol	Jayne Whittlestone	Senior Services Manager	Yes
Avon and Wiltshire Mental Health Partnership NHS Trust	Danielle Rowan	Domestic Abuse Lead	Yes
Bristol City Council Adult Social Care	Claudine Mignott	Service Manager	Yes
Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group	Paulette Nuttall	Head of Adult Safeguarding	Yes
Public Health, Bristol City Council	Sue Moss	Senior Public Health Specialist	

	Lizzie Henden	Senior Public Health Specialist	Not required
WomanKind Bristol	Kyra Bond	Chief Executive Officer	Not required

1.6. Independent Chair and Author

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

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

1.7. Parallel Reviews

The coroner for the area of Avon concluded Nevaeh's inquest in November 2022 and provided her cause of death as suicide. During the coronial process, Nevaeh's family made representations that the agencies had failed to support Nevaeh's needs and asked the coroner to consider issuing a Regulation 28 (Coroners and Justice Act 2009) notice[2] to prevent future deaths. After considering the facts the coroner declined to issue a notice and the did not identify any failings in the response to Nevaeh, or any identified learning for the agencies involved.

During the coronial process, the coroner declined a request for information held by the inquest to be made available to this DHR, ruling that it was not an interested party in the inquest. As such no material 'owned' by the inquest has been considered in this review. It is noted however, that the information provided to the coroner is likely to have also been legitimately provided to this review, by those agencies involved in the review process and by Nevaeh's family.

Whilst Nevaeh reported domestic abuse offences to the police, she died before her evidence had been formally obtained. Whilst the incidents have been recorded as crimes, the police have determined that it would not be possible to progress an investigation

[2] https://www.legislation.gov.uk/uksi/2013/1629/part/7/made

without Nevaeh's evidence. As such the police have not spoken to Colin about the offences and there is currently no intention to do so. Colin has provided a contribution to the DHR and has denied that any type of domestic abuse existed in their relationship.

1.8. Equality and Diversity

Soon after entering into her relationship with Angela, Nevaeh reported to a number of agencies that she had been the victim of abuse from Colin. The DHR examined whether the response to her was affected in any way by this new relationship and whether there was any potential learning from an equality and diversity perspective. Additionally, the DHR considered the potential for any equality and diversity learning in relation to Angela and her additional vulnerabilities. Having considered these issues, the DHR was reassured that the services provided to Nevaeh were not affected by any equality and diversity issues and that there were no barriers to accessing services due to her new relationship.

1.9. Confidentiality and Dissemination

This report has been written with the intention of publication and as such does not contain information which may identify those involved. In accordance with Home Office guidance, pseudonyms have been used to protect the names of all others involved, the name Nevaeh having been chosen by her family and the name Colin assigned to her ex-partner. Nevaeh was White British. At the time of her death Nevaeh was 30 years old and Colin was 32 years.

The report aims to be as succinct and practical as possible, whilst also providing context for the review findings. To achieve this an integrated chronology of key events has been prepared, which includes the relevant interactions between Nevaeh and the agencies involved. Further information, including the detailed analysis of events and the evidence underpinning this report is held in additional documents retained by the KBSP.

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

2. CASE SUMMARY & CHRONOLOGY OF KEY EVENTS

2.1. Background Information – An Overview of Nevaeh

Nevaeh commenced her long term relationship with Colin in 2008, having ended a previous relationship in which she had been the victim of serious domestic abuse. During that relationship she had reported a number of incidents of abuse to the police and after ending

the relationship had obtained a court non-molestation order[3]. Despite this, the perpetrator continued a course of harassment, breaching the court order and causing her a considerable amount of fear. Nevaeh's family believe that this will have directly affected her confidence in how the agencies could protect her from the abuse she subsequently received from Colin.

During the early stages of her relationship with Colin she made two reports to the police of verbal abuse committed by him in 2008. These incidents were recorded, however there was insufficient evidence to proceed with any prosecution. In 2009, Nevaeh reported a further two incidents of domestic abuse which had required police attendance. The first incident followed an argument where Colin had left her premises and had attempted to remove property which Nevaeh reported as belonging to her. This was recorded by the police as a civil dispute about the ownership of property and it was determined that a crime had not occurred. The second incident involved an argument with Colin and upon their attendance the police found Nevaeh with scratches on her wrist. She explained that she had inflicted the injury during the argument herself and the police determined that no crimes had been committed. Between 2009 and 2018 there were no further disclosures of domestic abuse recorded by the police or by any other agency involved in the review.

Having lived together for a number of years, Nevaeh and Colin moved into a new home in 2014. This was provided by Bristol City Council Housing and Landlord Services and was rented under a joint tenancy agreement. The tenancy agreement provided them both with legal rights of residence and entry to the property[4], whilst also making them both liable for rent payments.

Nevaeh worked full time in the social care sector and was described by her employer as conscientious, reliable, and very professional. She had an excellent employment record and was sociable with her colleagues. Nevaeh's friends describe her as being apparently happy in her relationship with Colin and they were not aware of any domestic abuse.

Nevaeh and Colin had been keen to have children and over a number of years had received private IVF treatments. These had not been successful and in early November 2018 they had their last review meeting with the treatment provider. Shortly after this meeting, on the 4th December 2018, their relationship broke down and Colin permanently moved out of the home. At this time Nevaeh reported to the police that she was being subjected to harassment by Colin, who was returning to the flat uninvited and was sending her unwanted text messages. After her relationship with Colin had come to an end, Nevaeh subsequently started a relationship with her new partner, Angela.

In February 2019, Nevaeh reported to the police that the harassment from Colin was continuing and that she had been the victim of long term domestic abuse during their relationship. The full detail of this disclosure was never established as Nevaeh died before her witness interview was arranged.

[3] https://www.gov.uk/injunction-domestic-violence/eligibility-non-molestation

[4] Housing Act 1988.

Nevaeh's family have described how Colin was verbally abusive to Nevaeh throughout their relationship and that on one occasion they had witnessed him physically assaulting her. They believe that this domestic abuse was a factor in the relationship breaking down and that the subsequent pattern of harassment committed by Colin was a key factor in Nevaeh's death. The family have considered the unsuccessful IVF treatment and feel strongly that this was not a factor in Nevaeh's decision to take her own life, as she had appeared relieved that the relationship with Colin had come to an end.

2.2. Chronology of Key Events

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

25th November, Nevaeh had a further meeting with her manager and explained that she was starting to feel much better.

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

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

8) Later that day, Nevaeh contacted Avon and Somerset Constabulary reporting harassment by Colin and was visited by a police officer. Nevaeh explained that she had separated from Colin and that having initially moved out of their flat, he had returned and removed property belonging to them both. She explained that she did not want Colin prosecuted, but wanted him to be prevented from going to the flat. She was asked about any violence in the relationship, to which she stated that she had not been the victim of violence and was not afraid of him. The incident was determined to be a civil matter and recorded as a non-crime incident. A DASH risk assessment was completed[5] to assess Nevaeh's risk from domestic abuse, a process which determines a person's risk as either standard, medium, or high. Nevaeh was assessed as a standard risk. The following day, the police contacted Nevaeh by telephone to check on her welfare and during this call she did not raise any further concerns. The incident was subsequently reviewed by staff within the constabulary's 'Lighthouse' victim care unit, who concluded that there was no role for them as a crime had not been committed.

9) On the 5th December 2018, Nevaeh contacted housing services to report that her relationship with Colin had come to an end and that he had moved out of their flat. She wanted to discuss tenancy options and how she could change to a sole tenant. She was provided advice about the legal status of joint tenancy agreements and advised to seek independent legal advice for any change of names on the tenancy agreement[6]. Nevaeh was not asked if domestic abuse was a factor in the tenancy change and it was not raised by Nevaeh.

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

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

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

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

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

13) On the 5th February 2019, Nevaeh had a further appointment with the GP practice mental health nurse and she explained that she was having flash backs about Angela attempting to take her own life. Post traumatic distress disorder (PTSD) was identified and comprehensive support was provided. This included a review of Nevaeh's medication, the consideration of providing therapy for PTSD, discussing options for further mental health support services, and providing a back dated statutory sickness form to help with Nevaeh's financial situation. During this consultation, Nevaeh disclosed that she was frightened of being alone in her flat as Colin still had access. She disclosed that she had been the victim of domestic abuse in the relationship, which had included being the victim of sexual assault. In response to this, the nurse signposted Nevaeh to other support agencies[7]. Nevaeh also outlined that she had been inflicting harm upon herself by making small cuts to her stomach, but when asked denied that she had any suicidal thoughts.

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

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

[7] Sexual Assault Services / Mental Health Employment Team

to arrange a video interview (ABE)[8] to capture her evidence, which due to her vulnerability would be more appropriate than a written statement. The ABE interview was arranged for the 3rd March, but was subsequently cancelled as the officer tasked to conduct it did not feel sufficiently trained.

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

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

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

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

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

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

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

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

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

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

24) On the 5th March 2019, an IRIS support worker[9] from Next Link spoke with Nevaeh in response to the referral submitted by the GP surgery and a face to face meeting took place on the 11th March. During this meeting Nevaeh disclosed that she had been the victim of domestic abuse over a ten-year period, which had included physical assaults. Nevaeh discussed her mental health and her need of financial support to pay her rent. A DASH risk assessment was completed, which assessed her as being at medium risk of harm. During the risk assessment Nevaeh disclosed that she felt pressurised into having sexual intercourse with Colin, but did not believe this to be rape. The support worker recognised that sexual abuse may have existed in the relationship and referrals to sexual offence support services and to the police were discussed, but were declined by Nevaeh. A support plan was put into place supporting Nevaeh with her financial circumstances, her housing situation, and provided options and advice in relation to counselling services. Regular contact with Nevaeh was maintained by telephone calls, text messages, and physical meetings. This included seven contacts during the following three weeks.

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

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

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

28) On the 27th March 2019, the Next Link IRIS worker submitted a referral to Bristol City Council Housing and Landlord Services by email, requesting that additional support was provided to find Nevaeh a new housing tenancy. This was submitted to the 'Home Choice Bristol' team, which is responsible for new housing requests and was not copied

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

to the housing officer who had been supporting Nevaeh. The email was received and forwarded to a manager for their consideration. Due to an administrative issue this referral was not opened by the manager or acted upon. The lack of response to the referral was not escalated by the IRIS worker.

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

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

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

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

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

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

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

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

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

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

2.3. Overview – The Role of Individual Agencies and Organisations

Nevaeh's Employer

Nevaeh's manager described how the company values the welfare of its employees and has proactive measures in place to support them. This includes an annual appraisal process and formal supervision sessions every six months. In addition, there was a monthly supervisors meeting where the welfare of staff was discussed and which as a supervisor Nevaeh attended. In addition to the formal processes, Nevaeh had regular contact with her manager which included informal discussions. Nevaeh's last formal supervision session was in August 2018.

Following the incident with Angela, company procedures were followed to ensure that Nevaeh was offered support, including an offer to take time off work. Nevaeh's family have highlighted that she would not have wanted to do this for financial reasons, as she was on a zero hours contract and would not have been paid for any time away from work. Whilst confirming that this would have been unpaid leave, her employer outlined how they provide flexible working and that Nevaeh would have had the opportunity to make up these hours at a later date. In addition to providing Nevaeh support in this specific incident, her employer also reviewed and improved the support they provided to all staff who work with vulnerable people.

Nevaeh's manager highlighted that Nevaeh and Angela's relationship grew in a very short space of time and without any warning. As soon as they became aware that their relationship had potentially exceeded professional boundaries, they addressed it with Nevaeh which led to her unexpected resignation. There was a period of three weeks between Angela moving into her accommodation and Nevaeh resigning.

The support provided to Nevaeh by her employer has been of careful consideration in this DHR. The review recognises that supportive practices for the welfare of staff do exist and as such there are no specific recommendations in relation to this.

GP Surgery

Following Angela's attempted suicide, Nevaeh approached her GP surgery for support. They responded quickly, providing an appointment with her GP and a follow up appointment with the practice mental health nurse that same day. Regular review appointments were provided for Nevaeh and the arrangements for accessing out of hours services also

explained. The risk to Nevaeh from self-harm was fully assessed and regularly reviewed at follow up appointments with the mental health nurse. Nevaeh had explained that she had suicidal thoughts, but that she had no intention of acting upon them. Nevaeh was supported in accessing further mental health services and she stated that she was pleased with her treatment and support plan.

Nevaeh's disclosures of domestic abuse and her housing situation were identified as key issues and addressed proactively by the mental health nurse. A referral was made to the domestic abuse service IRIS, a support service working from GP surgeries to support victims of domestic abuse. In Bristol, the Next Link organisation are commissioned to provide this service, working with victims who are assessed as being at a low or medium risk of harm. A referral was also made to Adult Social Care as Nevaeh was identified as being vulnerable. Nevaeh was additionally signposted to other support services.

During the last consultation with Nevaeh on the 19th March 2019, the mental health nurse recorded that Nevaeh seemed to be improving. Her mood and sleep patterns were better and she had been engaging well with other services.

Adult Social Care

Having received the referral from the GP surgery, Adult Social Care completed an assessment process which was thorough. This included liaison with the mental health nurse to understand the background and also contacting Nevaeh directly. During the assessment Nevaeh confirmed that she had reported the domestic abuse to the police and was now considering how she wished to proceed. Her housing situation was identified as the key issue for which she required support and the social care worker contacted the housing services directly to discuss it. They confirmed that they would provide Nevaeh enhanced support by opening a domestic abuse case. As a result, Adult Social Care concluded that Nevaeh did not require any further support from them. This was a reasonable conclusion in the context that Nevaeh would now receive housing support, had reported the domestic abuse to the police, and was receiving support for her mental health.

Bristol City Council Housing and Landlord Services

Housing services first became aware of Nevaeh's domestic abuse disclosures following the contact from social care. They immediately contacted Nevaeh to discuss it with her and provided enhanced support. This included opening a domestic abuse case and providing Nevaeh with a named point of contact who maintained contact with her. Nevaeh explained to the housing officer that she had a mental health nurse supporting her and that she had also been referred to the Next Link domestic abuse support service. Whilst support was provided to Nevaeh, there was no direct liaison between the housing officer and the IRIS worker to consider how they could work together to support Nevaeh's needs. Policy and procedure in relation to domestic abuse housing cases was followed, however those policies were unable to quickly resolve Nevaeh's housing situation. This issue is further explored later in this report and forms part of the DHR recommendations.

Next Link

Next Link was commissioned to provide the IRIS domestic abuse support service and following the GP referral an IRIS worker was allocated to Nevaeh. The IRIS worker received disclosures that Nevaeh had experienced domestic abuse over a ten-year period, which included physical assaults. A detailed DASH risk assessment was completed, which included asking if Nevaeh had been the victim of sexual abuse. Nevaeh disclosed that she felt pressurised into having sexual intercourse with Colin, this was explored by the IRIS support worker and referrals to other services, including the police, were discussed and declined. The DASH assessed that Nevaeh was at medium risk of harm, which was below the threshold for consideration of the MARAC[10] process, a multi-agency forum to coordinate the support provided to people who are at high risk of harm.

The IRIS worker maintained regular meetings with Nevaeh and focussed support on her housing and financial situation, which were identified as the key issues that Nevaeh would like to resolve. An email was sent to housing services asking for her housing issue to be prioritised, however this email was not actioned whilst Nevaeh was still alive. During the review, professionals from Next Link and housing services explained that contact between them was mainly done by email, rather than personal contact. A formal forum for the sharing of information does not exist, which staff from Next Link would welcome. They described that there were a number of routes into housing services and that they had difficulty in identifying the best point of contact.

In addition to the referral from the GP practice, Next Link also received a referral from the police. The delay in the police progression of the criminal investigation was identified by the IRIS worker, but not addressed directly with the police. How the domestic abuse services are able to coordinate multi-agency activity was considered in the DHR and forms part of the review recommendations.

<u>Bristol Wellbeing Therapies – Mental Health Services</u>

At the time of Nevaeh's death, Bristol Wellbeing was commissioned to provide a self-referral service to support people with their mental health and wellbeing. This was a triage service, which provided initial support and then where necessary referred a person for additional further support, including secondary mental health services.

During her consultation, Nevaeh explained that she was suffering from anxiety relating to a number of issues and the underlying reasons for these feelings were explored. Nevaeh explained that she was frequently harming herself by making small cuts to herself and that whilst she had suicidal thoughts, she had no intention of acting upon them. A risk assessment was conducted, which did not identify that Nevaeh was at risk of suicide.

During the consultation Nevaeh disclosed that she had been the victim of domestic abuse in a recent relationship. Whilst this person was not named, it was believed to be Colin from the time period discussed. This abuse included emotionally abusive and controlling behaviour. Nevaeh explained that the relationship had recently ended and outlined her

[10] Multi Agency Risk Assessment Conference - https://bristolsafeguarding.org/policies-and-guidance/domestic-abuse-and-families/

housing and financial difficulties. She also disclosed that she had been the victim of domestic abuse in a relationship prior to Colin. When asked about current domestic abuse, Nevaeh said that she did not currently feel at risk of harm from anyone.

The fact that Nevaeh had undergone several unsuccessful IVF treatments was also identified during the consultation and Nevaeh was signposted to other support services who would be able to provide specialist support.

The health professional meeting with Nevaeh consulted the mental health nurse from the GP surgery and there was evidence of good liaison between health professionals. The risk to Nevaeh from self-harm was further explored and confirmation was received that Nevaeh was receiving appropriate wellbeing support from domestic abuse services. As a result of the consultation Nevaeh was provided a place on a therapy course designed to help her in managing a low mood. She was also signposted to other services.

Unity Sexual Health

In April 2019, Nevaeh had an appointment at the Unity Sexual Health Clinic, where she disclosed that she had been the victim of a rape by her regular partner at the end of November 2018. Nevaeh confirmed that she had reported this to the police and that she was also receiving support from Next Link. The name of the perpetrator for the rape was not taken, in accordance with the established confidentiality policy.

As Nevaeh had stated that the rape had been reported to the police and that she was receiving support from domestic abuse services, it was not deemed necessary to make any referrals to other agencies. This complied with organisational policy. It was explained during the DHR that it would not be normal practice for professionals to take any action to verify the account provided by a patient, or inform other agencies of the disclosure. Referrals would only normally be considered if other safeguarding issues existed, for instance if there were care and support needs under the Care Act 2014 or where child safeguarding concerns existed.

Avon and Somerset Constabulary

In December 2018, Nevaeh made the first of two complaints of harassment from Colin. From the information provided by Nevaeh it was determined to have been a non-crime incident and from the information presented to the DHR this appears to have been a reasonable decision. A DASH risk assessment was completed in accordance with policy, during which Nevaeh stated that she did not feel herself to be at risk from Colin. The following day the police made a follow up call to Nevaeh to check on her welfare before closing the incident, this was good practice.

During Nevaeh's appointment with the police in February 2019, she reported criminal harassment by Colin and during her DASH risk assessment disclosed that she had been the victim of abuse over a longer period. The officer identified that she was distressed and was

fearful of Colin returning to the flat. It was decided that her evidence would be best captured in an ABE interview, which in the circumstances was a reasonable decision and followed guidance provided by the College of Policing. There was good evidence of the officer considering and supporting Nevaeh's wellbeing, with a referral to the Lighthouse Unit and signposting to additional support services.

Due to the fact that Nevaeh's ABE interview was never conducted, her disclosure of abuse was not captured and the full extent of potential criminal offences not identified. The police were not aware of the domestic abuse disclosures made to other agencies, including the physical assaults and the sexual offences. Had police staff appreciated the full extent of the offences disclosed by Nevaeh, it is likely that the risk to her would have been assessed as higher and would have resulted in a different police response.

The processes used in response to Nevaeh's report of harassment are fully explored later in this report and form part of the DHR recommendations.

2.4. Information From Family

Nevaeh's family were actively involved in the review process and has provided a valuable contribution. This included information about Nevaeh's relationships and other factors that may have contributed to the circumstances of her death. The key issues may be summarised as follows.

<u>Relationship with Colin</u>

- Throughout their relationship, Colin was considered by the family as being controlling and coercive which had a negative impact on Nevaeh's wellbeing. This was witnessed by the family, who did not like the way in which he treated Nevaeh.
- Nevaeh had never disclosed any physical assaults, however one incident of violence was witnessed by the family which involved Nevaeh being punched in the stomach whilst she was pregnant. Later in the pregnancy Nevaeh had a miscarriage, although it is not known whether this was related to the assault witnessed by her family.
- After their relationship had broken down, Colin had continually returned to the flat unannounced. He had removed property from the flat, which in addition to joint property had included personal items belonging to Nevaeh such as jewellery she'd owned before their relationship. He had also removed funds from the joint bank account, leaving Nevaeh in financial difficulty. Nevaeh's family believe that this was part of a conduct of harassment and domestic abuse, including financial abuse, which had a very negative impact upon her mental health and wellbeing.
- They outline that what Nevaeh wanted the most, was for the harassment to stop and to have Colin removed from the tenancy agreement. She was frightened to stay in the flat due to him retaining access and this was preventing her from moving on from the relationship.

<u>New Relationship with Angela</u>

- Nevaeh's family were concerned about her new relationship. They were aware that Angela had considerable emotional needs and were concerned that this put additional

pressure upon Nevaeh who felt that she needed to support these needs. Whilst they never saw any indication of domestic abuse in the relationship, they felt that Nevaeh was controlled by this need to look after Angela.

Key Issues Contributing to Nevaeh's Death

At the commencement of the DHR, Nevaeh's family believed that had the support provided by agencies been more effective, then improved outcomes for Nevaeh may have been achieved, specifically:

- the police response to Nevaeh's complaint of domestic abuse
- the support provided by Nevaeh's employer after the traumatic incident experienced at work
- that the risk created to Nevaeh by her mental wellbeing was not risk assessed effectively by any agency and therefore the risk not understood
- there were missed opportunities to coordinate the work of different agencies, potentially through the use of the MARAC (Multi Agency Risk Assessment Conference)

2.5. Information From Friends

Close friends of Nevaeh also provided key information to the DHR, concerning Nevaeh's relationships and other factors that may have contributed to the circumstances of her death. The key issues may be summarised as follows.

Relationship with Colin

- For the majority of their relationship, both Nevaeh and Colin appeared to be happy. There was no indication of domestic abuse and Nevaeh did not make any disclosures to suggest that this may be a factor in the relationship. They were aware of the unsuccessful IVF treatments and the pressures that this had caused at the end of the relationship. Nevaeh had told them that Colin blamed her for them not having a child and would make cruel comments about this which were very hurtful. This included saying that if she was unable to have a child, he would find someone else who was able to.
- After the relationship came to an end, Nevaeh disclosed that she was distressed that Colin was still entering the flat despite having moved out. She told them that he had taken things from the flat and that she was frightened to stay there in case he returned.

New Relationship with Angela

- Since beginning the relationship with Angela, Nevaeh had become more distant and did not see her friends as much. Nevaeh had told them that Angela did not like to be left alone and she was worried that Angela would harm herself if Nevaeh spent time away from her. They believe that for this reason Nevaeh was frightened to leave Angela alone and as such she was controlled by this new relationship.
- Nevaeh had told them about two arguments that she had with Angela, which had both occurred when Nevaeh had gone out without her. On one occasion, Angela had pulled her hair and on a second occasion she had slapped her.

Key Issues Contributing to Nevaeh's Death

- Colin returning to the flat and removing property was a critical issue affecting Nevaeh's wellbeing. Because of this she was fearful of staying in the flat and this was a key cause of anxiety.
- The second critical issue was the housing situation and the fact that Nevaeh was unable to resolve the issue of the joint tenancy. In addition to providing Colin legal access to the flat, it also caused Nevaeh difficulty in addressing her independent financial situation.

2.6. Information From Colin

Colin was willing to take part in the DHR to answer any questions and to provide his perspective about the domestic abuse disclosed by Nevaeh. A summary of the key information that he provided is outlined below. It is important to recognise that these are his views and ones not agreed with by Nevaeh's family.

Relationship With Nevaeh

Colin outlined how they had a very good relationship and that there had never been any domestic abuse between them. He denies that there was any verbal abuse, or that he assaulted her in any way.

They had been happy, however both became depressed towards the end of the IVF treatment. Following the review meeting in November 2018, both agreed that they were suffering emotionally and should seek support from their GP. Colin does not know if Nevaeh did this, however from information provided to the review it would appear that she did not. Nevaeh began to spend more time at work and became distanced from him. A short time later they agreed to give each other some space and Colin moved out of the flat temporarily. He hoped that they would get over their difficulties and that their relationship would continue.

Colin outlines how on the 4th December 2018, he received a message from Nevaeh telling him that the relationship was over and that he had two hours to remove his possessions from their flat. He did this at short notice and took his possessions in a hurry. He later reviewed what he had taken and identified that he did have some of Nevaeh's possessions, which he returned to her. He was unaware that Nevaeh had reported him to the police for returning to the flat and removing the property.

Disclosures of Harassment Made by Nevaeh

Colin stated that he was never aware that Nevaeh thought that he was harassing her, either through text messages or by him going to the flat. He did not know of any reports to the police. He explained that after their relationship came to an end, Nevaeh continued to contact him and asked for help in looking after their pets. This had included asking him to buy them food and to go around to the flat to let them outside, which he did. He explains that he still has the text messages from Nevaeh asking him to do this.

Colin also denies any suggestion of financial abuse, by taking money which belonged to them both. He explains that they had some joint savings for a holiday and after using some to pay part of the IVF bills, he returned the majority of the remaining funds to Nevaeh. He explained that at the time of him leaving the flat they were two months in housing rent credit, which he was happy to support Nevaeh with. He also supported Nevaeh by allowing her to have full use of his car, which he continued to pay the bills for.

Housing Services and Tenancy

Colin wanted to support Nevaeh in remaining in the flat and contacted housing services to remove his name from the tenancy. He signed the assignment form, however Nevaeh refused to sign it, meaning that the tenancy could not be changed. He believes that Nevaeh would not sign the form as she was struggling financially and didn't want to be solely responsible for the rent payments. After Nevaeh died, he was responsible for paying the rent debt, as it had not been paid after the relationship came to an end.

Key Issues Contributing to Nevaeh's Death

Colin believes that the cause of Nevaeh's death was from her mental health breaking down, as a result of the unsuccessful IVF treatment. He believes that had they had a child, they would still be together and happy.

Whilst not a cause of Nevaeh's death, he believes that Nevaeh's relationship with Angela created additional anxiety and made her mental health worse. He knew that Nevaeh worried about Angela and felt responsible for supporting her emotional health and care needs.

2.7. Angela

It was not possible to engage Angela within the DHR process. Whilst Nevaeh's family and friends have expressed concerns about their relationship, none of the agencies involved in this DHR had any information about the existence of any domestic abuse. Despite this, the issue of how agencies may have provided greater support to Nevaeh in her relationship with Angela is explored in this review.

2.8. Nevaeh's Voice

The contributions from Nevaeh's family and friends, in addition to the information supplied by the agencies involved, has enabled the DHR to capture Nevaeh's voice. In addition to this, at the time of her death Nevaeh left a number of notes which expressed her feelings at that time. Themes from those notes included:

- Feelings of very low esteem. Nevaeh describes how in the days before her death she had been criticised by others about a variety of issues. She outlines how she had tried hard to do the right thing, but that this did not seem to make a difference.
- Asking why men think it is acceptable to touch women without consent.
- Asking why Colin would not leave her alone.

- Expressing her feelings for Angela. Saying that she was the best thing to have happened in Nevaeh's life and that she had enjoyed spending time with her. Nevaeh went on to say that she was sorry that she had messed everything up and that she had "no choice now but to finally commit suicide". Whilst not given as a reason for Nevaeh's suicide, she appears to suggest that her relationship with Angela had come to an end. The status of their relationship at the time of Nevaeh's death could not be established during this DHR.

Whilst Nevaeh was being supported by a number of agencies, the review identified a sense that Nevaeh felt overwhelmed in working with them and that this made it difficult for her to fully engage with the services offered to her. In particular there were three key issues which if Nevaeh had been able to resolve, may have provided her better outcomes.

a) Addressing her housing and financial situation. To have a sole tenancy, allowing her to fully move on from her relationship with Colin.

b) For the harassment by Colin to be stopped, enabling her to feel safe.

c) To help improve her mental health and emotional wellbeing, whilst maintaining her personal relationships.

3. CRITICAL ANALYSIS AND LEARNING

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

i) Multi-agency planning and information sharing

ii) Housing providers and domestic abuse procedures

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

Finding 1: Multi-Agency Planning and Information Sharing

Learning:

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

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

At one time Nevaeh was supported by at least seven key agencies, all receiving different parts of her story about domestic abuse and the state of her mental health. Whilst there

was evidence of good communication between some professionals, this did not extend to the full sharing of information. As such, a complete picture of Nevaeh was never developed and she was never really understood. This made it impossible to fully assess the risk to Nevaeh, especially the risk that she may go on to harm herself. Had a formal process to share information existed then a holistic picture of Nevaeh may have been developed and a joint risk assessment completed. This would have been more effective than individual agencies assessing risk based solely on the information known to them.

In not developing this holistic picture of Nevaeh, the opportunity to provide additional support in her relationship with Angela was also missed. Angela was herself vulnerable with a number of care needs and Nevaeh clearly felt responsible for supporting her. Nevaeh's friends describe how she was fearful of leaving Angela alone in case she harmed herself and this meant that she spent less time with her friends. This in effect removed a key pillar of support from Nevaeh, which she had always previously enjoyed. Had this issue been identified, then Nevaeh could have been provided additional support in caring for Angela and managing her feelings about the relationship. The fact that Nevaeh had been unable to resolve her housing situation added pressure to this relationship, as she became more dependent on Angela for a safe place to spend the night.

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

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

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

If the provision of services to people in Nevaeh's situation is to be improved, then a change of approach to multi-agency working is needed. Any future change should involve working in partnership to deliver a person's self-defined needs, regardless of their risk level. In order to achieve this, it is recommended that Next Link develops a responsibility to coordinate the

services being provided to victims of domestic abuse who have complex needs and are being supported by a number of agencies. This should involve the use of professional meetings, attended by those directly involved in a case, which should aim to share information and develop joint planning. For any such change in practice to be successful, all agencies within the Keeping Bristol Safe Partnership will need to support the new multi-agency working arrangements regardless of the identified risk level.

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

Finding 2: Housing Providers and Domestic Abuse Procedures

Learning:

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

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

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

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

The second issue related to the request made by Nevaeh and Colin, to change their joint tenancy agreement to a sole tenancy in Nevaeh's name. Both Nevaeh and Colin wanted the

same outcome and had contacted housing services a number of times in an attempt to achieve this. This was not successful and caused additional anxiety for both parties.

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

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

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

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

In considering how future improvements may be achieved, the Domestic Abuse Housing Alliance partnership (DAHA)[11] is an excellent resource. Its 'Whole Housing Approach' provides extensive guidance in relation to the early identification and intervention for domestic abuse, aiming to keep victims safely in their home. It includes a perpetrator management toolkit[12], providing guidance for a change to joint tenancy and how the housing provider may commence legal action to remove a preparator of abuse from the premises. The principles of this guidance may have made a difference to Nevaeh, particularly in removing the onus from the victim to progress any necessary legal action.

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

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

Other guidance in the toolkit considers multi-agency working, such as supporting the police with information to obtain Domestic Violence Prevention Notices and Protection Orders[13].

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

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

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

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

Finding 3: Police Response to the Reports of Domestic Abuse

Learning:

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

The lack of police officers and staff trained to conduct Achieving Best Evidence (ABE)[14] witness interviews reduces the ability of the police to address domestic abuse and keep victims safe.

At the time of Nevaeh's report to the police in February 2019, Avon and Somerset Constabulary were using a system of scheduled appointments[15] to manage the demand of

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

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

[15] The Avon and Somerset Constabulary Response Appointments Scheme

calls requiring the presence of a police officer. This was not designed for serious or complex crime, or where the immediate attendance of a police officer was necessary. Guidance was provided to call centre staff as to the type of incidents which may be included in the appointments scheme. This included domestic abuse offences if the incidents were reviewed and authorised by an Inspector. Each appointment was for a maximum of 90 minutes and following a crime being recorded it would be allocated to a different officer if a further investigation was necessary.

Nevaeh contacted the police contact centre on the 9th February 2019 and reported that she was receiving harassment from Colin in the form of text messages. The report was risk assessed and determined that it should be managed by the response appointments scheme. An appointment was provided for her to meet a police officer a week later and the process of dealing with Nevaeh's report complied with the policy and procedures at that time.

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

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

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

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

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

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

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

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

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

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

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

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

4. WIDER CONTEXT – RISK OF SUICIDE FOLLOWING DOMESTIC ABUSE

Nevaeh died by taking her own life and this DHR considered whether in this specific case, there was any potential learning from the way in which the professionals understood the risk of suicide following domestic abuse. As detailed in this report, the key issue in Nevaeh's case was how agencies failed to share information and work together to understand her risk, rather than the lack of an overarching understanding about how domestic abuse increases the risks of suicide. For that reason, it was not an identifiable learning theme for this DHR and does not form part of its recommendations.

The way in which domestic abuse can increase the risk of suicide is an issue that is understood by the KBSP and one that is carefully being explored during a further DHR which is currently in progress. That DHR explores this as a key issue and will make recommendations to improve the way that professionals understand the risk of suicide following domestic abuse and to improve the way that agencies respond. That DHR will also make recommendations about the Bristol MARAC process.

5. CONCLUSION AND SUMMARY OF RECOMMENDATIONS

5.1. Concluding Comments

Nevaeh's experience has enabled the DHR to identify three key areas of learning, each of which provides the opportunity to improve future services. These have been fully considered by the KBSP, who have developed a response plan outlining how the DHR recommendations will be acted upon.

In addition to addressing the multi-agency recommendations, the safeguarding partnership should hold individual agencies to account for delivering the single agency recommendations.

5.2. Summary of Recommendations

Recommendation 1:	Next Link staff, providing services within the IRIS scheme or any other Next Link service, should consider a need to coordinate the provision of services to victims with complex needs and those who are being supported by a number of agencies. This coordination should consider the use of professional meetings to share information and develop joint planning, which should be supported by all agencies regardless of the level of identified risk.
Recommendation 2:	It is recommended that Bristol Housing and Landlord Services review their policies for supporting victims of domestic abuse. In

	particular this should include a policy for the proactive identification of domestic abuse and the development of a perpetrator toolkit.
Recommendation 3:	It is recommended that the current proposals to integrate housing and domestic abuse support services are commissioned and implemented.
Recommendation 4:	It is recommended that Avon and Somerset Constabulary audit the Incident Assessment Unit to ensure that it is providing a victim focussed response to reports of domestic abuse.
Recommendation 5:	It is recommended that Avon and Somerset Constabulary develop plans to address the lack of staff trained to conduct ABE interviews with vulnerable witnesses.

5.3. DHR Response Plan

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

Appendix A – DHR Terms of Reference

DOMESTIC HOMICIDE REVIEW
TERMS OF REFERENCE

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

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

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

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

3. Scope of Review
3.1 Persons Subject of the Review
- Nevaeh (Deceased)

3.2 Other Relevant Parties
- Colin (Nevaeh's ex-partner)
- Angela (Nevaeh's partner prior to her death)

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

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

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

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

4. Methodology

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

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

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

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

5. Timescales

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

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

Appendix B – DHR Live Action Plan

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

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

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

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

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

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

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

Appendix C – Home Office Feedback Letter

Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

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

Rebecca Dible
Project Support Officer
KBSP Business Unit (City Hall),
Bristol City Council,
PO Box 3399,
Bristol
BS1 9NE
14 September 2023

Dear Rebecca,

Thank you for resubmitting the report (Nevaeh) for Bristol Community Safety Partnership to the Home Office Quality Assurance (QA) Panel. The report was reassessed in August 2023.

The QA Panel were very positive about a number of aspects of the report, including:

- The levels of engagement with family and friends, and the employer, including the inclusion of DA policy within the action plan.
- The inclusion of public health specialists on the panel alongside domestic abuse specialists.
- Recognition of the number of agencies working with Neveah, the impact of this, and the recognition of bravery in contacting the police.
- The use of boxes to highlight learning points.
- Clear recommendations in the action plan.

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

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

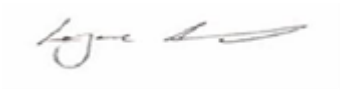
Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

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

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

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

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



Lynne Abrams
Chair of the Home Office DHR Quality Assurance Panel