



Response to 'Charlotte' Domestic Homicide Review from the Keeping Bristol Safe Partnership

The Keeping Bristol Safe Partnership has today published a Domestic Homicide Review which was commissioned following the death of Charlotte (pseudonym) in March 2022.

Charlotte died by suicide in her home, and at the time of her death was being supported following the disclosure of domestic abuse committed by her former partner Darren who had taken his own life the previous year.

On behalf of the partnership, I would like to express my thoughts and sympathy to the families of Charlotte and Darren for their loss.

The Keeping Bristol Safe Partnership agreed to commission Mark Power, an independent author, to lead on this review. The review aimed to use the experiences of Charlotte to identify learning and to improve the way that agencies support people who are at risk of domestic abuse.

Domestic Homicide Reviews do not seek to apportion blame but consider what happened and what could have been done differently. They also recommend actions to improve responses to domestic abuse situations in the future.

A wide number of agencies from the safeguarding partnership took part in the review and five key learning themes were identified:

1. Understanding Charlotte and the response to reports of domestic abuse
2. Multi-Agency Risk Assessment Conference arrangements and referral criteria
3. Perpetrator management and prevention strategies
4. Multi-agency child protection procedures
5. Understanding the risk of suicide and the links to domestic abuse

By assessing Charlotte's experiences, the report author identified 10 multi-agency recommendations to improve future services. The Keeping Bristol Safe Partnership fully accepts the findings and we have been working with our members and agencies across the city to continue to embed the recommendations identified. An action plan has been developed and this is summarised below.

I would like to thank Mark Power for authoring this review and thank all those who took part and contributed.

If you are experiencing or have been impacted by domestic abuse, Next Link Plus service offers specialist support for women, men and children and young people from all communities. Call 0117 925 0680, text 07407 895620, email enquiries@nextlinkhousing.co.uk or online chat via the [Next Link website](#).

Also, you may want to contact the independent charity Advocacy After Fatal Domestic Abuse (AAFDA). AAFDA provide specialist and expert advocacy and specialist peer support to families and

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friends bereaved by domestic homicide, domestic abuse related suicides and unexplained deaths. You can [contact AAFDA online](#) or by calling 07768 386922.



Sally Rowe

**Independent Chair
Keeping Bristol Safe Partnership**

Summary of recommendations and planned actions or progress

Recommendation 1: Each organisation that uses the Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessment tool should review its policy and guidance to ensure that professionals take a holistic and person centred approach to the assessment of risk.

Reviews are in progress at most organisations, and have been completed by North Bristol NHS Trust, Next Link, NHS Talking Therapies, Bristol City Council – Childrens and Families Services and Avon and Somerset Police.

Recommendation 2: Each organisation should review its policy for the third party reporting of crimes to the police. Where necessary changes to policy should be made and any identified training needs addressed.

Keeping Bristol Safe Partnership has explored best practice guidance on third party reporting with partners and has added information to the domestic abuse training offer.

Recommendation 3: The Bristol Multi-Agency Risk Assessment Conference (MARAC) should review the current published arrangements and referral criteria, ensuring that the arrangements are clear and widely promoted within Bristol. Organisations should support the MARAC arrangements with organisational policy as to when referrals should be made and ensure the consistent application of policy.

Additional administrative support has been provided to MARAC to allow for more capacity to review and revise MARAC referral procedures. Any changes will be widely communicated across statutory and voluntary sectors.

Recommendation 4: The Avon and Somerset Constabulary should present its plans to manage serial perpetrators of domestic abuse to the Keeping Bristol Safe Partnership, outlining how this will be achieved and how it will measure ongoing performance.

This recommendation has been addressed in the Office of the Police and Crime Commissioner Plan 2021-2025. The DRIVE programme has now been rolled out - a flagship intervention working with those causing harm in their relationships to prevent abusive behaviour and protect victim-survivors.

Recommendation 5: MARAC Chairs should receive training in the management of serial perpetrators of domestic abuse, to provide the confidence to challenge and hold agencies to account.

The MARAC steering group has been re-established and is meeting quarterly. Staff from the DRIVE programme attend all MARAC meetings to consider each case.

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Recommendation 6: The KBSP Safeguarding Children's Partnership should seek assurances from Bristol Children's Services about the application of its multi-agency strategy discussion protocol and should consider how agency involvement is regularly monitored.

A report was taken to the Keeping Children Safe group in July 2024 and this agreed the quarterly reporting of attendance data going forward.

Recommendation 7: When cases involve domestic abuse, the domestic abuse services should be included within strategy discussions and consideration always given to being included in core groups, regardless as to the status of victim engagement. Perpetrator intervention services should be included in cases where they are working with the perpetrator.

Bristol City Council Public Health services and commissioned providers to review the capacity of the service to attend every strategy meeting where domestic abuse is a concern. Discussion is taking place to review how the commissioned providers can work more closely with Children's Social Care.

Recommendation 8: Bristol Children's services should consider the training requirement of its managers who chair child protection processes, in addition to the independent chairs of child protection conferences, to ensure that they have a broad understanding of domestic abuse and the importance of considering victim and perpetrator needs in relevant child safeguarding plans.

The Reducing Domestic Abuse Team offered training in all Area Offices and has met with all the Child Protection Chairs. They provided training, support and guidance to increase domestic abuse informed practice. Each area also has a Consultant Social Worker who has completed Safe and Together training and is able to provide ongoing support and development to colleagues.

Recommendation 9: The Keeping Bristol Safe Partnership should consider the development of a comprehensive multi-agency training package, to develop a consistent understanding of domestic abuse and suicide, enabling professionals to develop multi-agency support plans.

Resources have been added to the domestic violence training offer which covers the link between domestic abuse and suicide. Avon and Wiltshire Mental Health Partnership has delivered a webinar about their audit findings on suicide risks and domestic abuse. This is due to be recorded and uploaded onto the Keeping Bristol Safe Partnership website.

Recommendation 10: The Bristol, North Somerset and South Gloucestershire Integrated Care Board (ICB) should consider the learning from this review, as to how babies and young children should not be seen as protective factors in parental suicide, and liaise with the appropriate body to consider the development of national guidance.

Learning is continuing to be shared across the ICB area. Domestic abuse and suicide are a key theme in the ICB learning offer and the contact details for NextLink and MARAC have been promoted. A domestic abuse themed Q&A session has also taken place.

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