Domestic Homicide Review
Executive Summary

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

Review Panel Chair and Report Author:
Parminder Sahota
PS Safeguarding LTD

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Preface

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

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

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

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

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

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

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

Section 1 – The Review Process

1.1 Introduction and Agencies Participating in the Review

1.1.1 This summary describes the Keeping Bristol Safe Partnership's (KBSP) steps to review the death of one of its residents. Lauren died by suicide at the age of twenty-two in March 2022.

1.1.2 The following pseudonyms have been used:

- Victim: Lauren
- Mother: Sophie
- Father: Luke
- Housemate: Daniel
- Ex-Partner: Adult A
- Alleged perpetrator: James

1.1.3 The process began with an initial meeting of the KBSP in March and June 2022, following the Multi-Agency Statutory Guidance for Domestic Homicide Reviews (2016[1]), they commissioned a domestic homicide review. Twenty-four agencies that potentially had contact with Lauren and James before the point of death were contacted and asked to confirm whether they had involvement with them. Eight agencies contacted confirmed contact with Lauren and were asked to secure their files.

1.1.4 The independent chair was commissioned in September 2022.

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

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

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

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

1.1.9 Subsequently, the conclusion of the review was delayed.

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

Section 2 – Contributors to the Review

2.1.1 The following agencies contributed to the review:

Agency and Profile	Contribution- Chronology/Individual Management Review (IMR)/Summary/Other
Avon and Somerset Constabulary (ASC)	Chronology and Summary Report
Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) Provides inpatient and community-based mental health services to 1.6 million people in the region.	Chronology and IMR
Bristol North Somerset and South Gloucestershire Integrated Care Board This includes councils, NHS hospitals, GP practices, and community and mental health services. They are working to enhance health and well-being, decrease inequities, and offer services to the one million Bristol, North Somerset, and South Gloucestershire residents.	N/A
GP	Chronology and IMR
Safe Link (Specialist Sexual Violence and Domestic Abuse Service) Provides domestic abuse support, mental health care for women, men and children and independent support for rape and sexual abuse victims.	Chronology and Summary Report
North Bristol NHS Trust A hospital and community healthcare facility for Bristol, South Gloucestershire, and North Somerset residents, it is also a regional centre for neurosciences, plastics, burns, orthopaedics, and renal.	Chronology and Summary Report
University Hospital Bristol and Weston NHS Trust includes Bristol Royal Infirmary (BRI) Provides services from the neonatal intensive care unit to care for the elderly and the residents of Bristol, Weston, and the southwest from birth to death.	Chronology and Summary Report
University of Bristol (UOB) Focused on addressing future global challenges through exceptional education, world-class research, and an entrepreneurial mindset.	Chronology and IMR
University Two Higher education institution Due to confidentiality and the institution's size, which could expose Lauren, the name is withheld.	Chronology and IMR

2.1.2 The chronologies and reports were authored by professionals independent of the case management or service delivery.

Section 3 – The Review Panel Members

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

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

3.1.2 The panel met five times.

Section 4 – Author of the Review

4.1.1 Parminder Sahota is an independent reviewer who has worked in Safeguarding and Domestic Abuse for eleven years and obtained DHR Chair training in 2021 from AAFDA. She has worked in the NHS for over twenty years as a Mental Health Nurse with a particular focus on crisis work and working with persons diagnosed with a personality disorder. She was employed as the Director of Safeguarding, Prevent (counterterrorism) and the Domestic Abuse Lead for an NHS Trust.

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

Section 5 – Terms of Reference for the Review

5.1.1 The statutory guidance sets out the purpose of domestic homicide reviews to:

- Establish the facts that led to the death in March 2022 and whether any lessons can be learned from the case about how local professionals and agencies worked together to safeguard Lauren.
- Establish what lessons will be learned from the death regarding how local professionals and organisations work individually and together to safeguard victims.
- Identify these lessons, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change.
- Apply these lessons to service responses, including changes to inform appropriate national and local policies and procedures.
- Prevent domestic violence and related deaths and improve service responses for all domestic violence and abuse victims by developing a coordinated multi-agency approach to identify and respond to domestic abuse at the earliest opportunity.
- Contribute to a better understanding of the nature of domestic abuse.
- Highlight good practice.
- Ensure that Lauren's voice is heard regarding her lived experiences and the impact of the domestic abuse on her mental health. Allowing her journey to be told and identifying the lessons that may be learnt.

5.1.2 Lauren moved alone from her hometown to Bristol in September 2017 to pursue her academic goals. In August/September 2021, she initiated an intimate relationship with James. Consequently, the scoping period encompasses an examination of the abusive relationship.

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

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

5.1.5 The panel agreed on sixteen terms of reference for this case.

5.1.6 The panel agreed on sixteen terms of reference:

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

that it identifies, assesses, and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management, and supervision, as well as working in partnership with other agencies and resources?

15. Are there areas where agencies can identify where national or local improvements could be made to the existing legal and policy framework?
16. The reports should consider any equality and diversity issues, including social status that is pertinent to the victim and alleged perpetrator, e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

Section 6 – Summary Chronology

6.1.1 Lauren received input from the following agencies during the period under review:

1. Avon and Somerset Constabulary
2. Avon and Wiltshire Mental Health Partnership
3. GP Practice
4. North Bristol NHS Trust
5. Safe Link
6. University Hospitals Bristol and Weston NHS Trust
7. University of Bristol
8. University Two

6.1.2 Lauren moved to Bristol at eighteen to study at university; she completed her first degree and commenced her master's at the second university in October 2021.

6.1.3 Lauren lived in shared accommodation with other students until she relocated to a new shared house in October 2021. She had one housemate, Daniel, who had lived with her since she began university. He described Lauren as lonely and with few friends.

6.1.4 Lauren had an elder sister and a younger brother; she spoke fondly of her family.

6.1.5 Lauren reconciled with her father four years before her death after her parents separated when she was ten. She identified him as supportive and felt safe around him.

6.1.6 In 2018, Lauren reported an allegation of rape, which concluded in September 2020, with no further action taken.

6.1.7 Since January 2019, Lauren received mental health services from AWP; she presented with emotional dysregulation, self-harm, suicidal ideation, and substance and alcohol abuse. In addition, she was diagnosed with borderline personality disorder (BPD[2]).

6.1.8 In August or September of 2021, Lauren began a relationship with James. Since this time, Daniel rarely observed her sober, and her self-harming behaviour escalated. James was also diagnosed with BPD, according to Lauren.

6.1.9 Evidence of Domestic Abuse

6.1.10 Daniel called the police in October 2021 to report the alleged rape of Lauren by James. The lack of further action was based on Lauren's decision not to pursue prosecution. However, ASC acknowledged that they had not conducted a thorough investigation, interviewed James, or obtained a statement from Daniel or other housemates.

6.1.11 Lauren reported James' controlling and coercive behaviour during a discussion with ASC. However, ASC did not pursue this complaint and acknowledged that they had not considered Lauren's decision not to pursue the allegation of rape within the context of coercion and control. In addition, Lauren's suicidal thoughts were not considered. This may have allowed ASC to consider Lauren at high risk of further domestic abuse, with potentially severe consequences based on professional judgement, and refer her to domestic abuse services without her consent.

Section 7 – Key issues arising from the review/lessons learned

7.1.1 Working with People Diagnosed with Personality Disorder

7.1.2 UOB and the GP emphasised this in their reviews, highlighting boundaries and Lauren's dependency on professionals.

7.2.3 The Knowledge and Understanding Framework (KUF[3]) is a national training programme designed to develop the skills, competence, and confidence of staff working across the health, criminal justice, and voluntary sectors. It enables staff to work more effectively with people with complex emotional needs, often associated with a diagnosis of *'personality disorder'*.

[2] https://www.nhs.uk/mental-health/conditions/borderline-personality-disorder/overview/
[3] https://www.kuftraining.org.uk/

7.1.4 **Information Sharing**

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

7.1.6 The UK Caldicott Guardian Council has developed an information-sharing decision-making template[4].

7.1.7 ASC could not refer Lauren to Next Link (Bristol's local domestic abuse service[5]) without her consent or a high-risk DASH assessment. However, ASC officers overlooked the potential influence of coercion and control on Lauren's decision not to pursue the allegation. Additionally, they neglected their safeguarding duty to inform Adult Social Care, given Lauren's care and support needs under the Care Act (2014[6]). This would have ensured that relevant agencies were aware of her as a victim of domestic abuse.

7.1.7 **Agencies' responses to disclosures of Domestic Abuse**

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

7.1.9 The Department of Health and Social Care published guidance[7] in April 2022 to strengthen the response to Domestic Abuse. It states: '*Domestic abuse is a serious health and criminal issue. Practitioners are in a key position to identify and help interrupt domestic abuse*.'

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

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

[4] https://www.ukcgc.uk/domestic-violence#:~:text=A%20template%20to%20support%20decision,not%20just%20those%20involving%20DVA.
[5] https://nextlinkhousing.co.uk/
[6] https://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/assessing-needs
[7] https://www.guidelines.co.uk/public-health/responding-to-domestic-abuse-guideline/456939.article

7.1.11 **Professional Curiosity**

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

7.1.13 ASC and AWP discussed the absence of professional curiosity in Lauren's interactions.

Section 8 – Conclusions

8.1.1 Lauren was twenty-two and studying for a master's at University Two. She commenced her studies in October 2021.

8.1.2 Lauren resided in Bristol and had a limited network of support. In August or September of 2021, she began a relationship with James. She characterised the relationship as intense, and James displayed coercive and controlling behaviour towards her. He encouraged her to self-harm and threatened to kill himself if she did not meet him or if she tried to end the relationship. Daniel reported an allegation of rape against Lauren by James to the police.

8.1.3 The alleged rape in 2018 concluded in 2020 with no further action due to evidential difficulties. Safe Link assisted Lauren during this time, and she was distressed to learn that the case had been closed.

8.1.4 As the claims against James were not pursued, only ASC knew Lauren was a victim of domestic abuse.

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

8.1.6 The suicide timeline of Jane Monkton Smith[8] was utilised to facilitate learning and highlight the potential for agency engagement.

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

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

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

Section 9 – Recommendations

9.1.1 Individual IMR Recommendations

Avon and Somerset Police

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

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

A recommendation open to ASC from North Somerset DHR 5:

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

Recommendation One

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

Recommendation Two

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

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

Avon and Wiltshire Mental Health Partnership

Recommendation One

9.1.6 Improve staff knowledge regarding identifying potential abusive behaviours and improve staff confidence in completing the domestic abuse risk assessment[9] to establish risk and context.

Recommendation Two

9.1.7 Awareness rising around considering domestic abuse outside of intimate partner relationships.

Recommendation Three

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

Integrated Care Board

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

Recommendation One

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

Recommendation Two

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

Recommendation Three

9.1.11 GPs are to be provided training to improve confidence and understanding of domestic abuse, the usefulness of DASH assessment forms, and the Multi-Agency Risk Assessment Conference[10] (MARAC) process.

SafeLink

Recommendation One

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

Recommendation Two

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

Recommendation Three

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

University Hospitals Bristol and Weston

Recommendation One

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

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

University of Bristol

Recommendation One

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

Recommendation Two

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

Recommendation Three

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

Recommendation Four

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

University Two

Recommendation One

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

Recommendation Two

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

Recommendation Three

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

10.1 Multi-Agency Recommendations

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

Health and Social Care

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

Post-16 Educational Settings

1.b The KBSP should work with the Safeguarding in Education Team to provide post-16 educational settings with literature and resources to assist young people in learning about mental health and where they can access help.

All Agencies

1.c All agencies and Post-16 Educational establishments to source and provide all frontline practitioners access to training such as level 1 Zero Suicide Alliance Level 2 Half-Day Suicide Prevention Course Training—No More Suicides[11].

1.d Staff to be provided with training opportunities and resources to identify risk factors, including coercion and control as an enabler for potential self-harm and suicide, to support individuals in accessing help and referring them to specialist services as appropriate.

10.1.2 Recommendation Two: Information Sharing

All Agencies

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

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

Health

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

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

3.b Avon & Wiltshire Mental Health Partnership NHS Trust, the GP, University Hospital Bristol and Weston NHS Trust are tasked with reviewing the existing measures that enable routine inquiry.[12]

10.1.4 Recommendation Four: Professional Curiosity

All Agencies

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

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

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

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

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