Domestic Homicide Review
Executive Summary

Keeping Bristol Safe Partnership

Report Into the Death of Charlotte in March 2022

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CONTENTS

1. THE REVIEW PROCESS

1.1 Introduction

In May 2022, the Keeping Bristol Safe Partnership (KBSP) considered the case of Charlotte who had died of suicide in her own home. At the time of her death, she was being supported by a number of services, following the disclosure of domestic abuse committed by her previous partner Darren, who had taken his own life the previous year. At the time of their respective deaths, Charlotte and Darren were both aged 20 years and had been in a relationship since their teenage years. The safeguarding partnership determined that the circumstances of Charlotte's death met the criteria for a Domestic Homicide Review (DHR).

This DHR[1] was subsequently commissioned, which aimed to use the experiences of Charlotte to identify improvements in the way that agencies work together to support people who are at risk of domestic abuse. A wide number of agencies from the safeguarding partnership took part and five key learning themes were identified. These are discussed in this report as follows:

a) Understanding Charlotte and the response to reports of domestic abuse.
b) MARAC arrangements and referral criteria.
c) Perpetrator management and prevention strategies.
d) Multi-agency child protection procedures.
e) Understanding the risk of suicide and the links to domestic abuse.

This executive summary has been prepared to outline the key findings of the review and to provide context for the recommendations. Further information about the review process and the information considered in the review may be found in the main overview report. Throughout the report, pseudonyms have been used to protect the identity of persons involved which were chosen by the panel and agreed by Charlotte's mother.

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

1.2 Methodology

An independent chair and author[2], was appointed to work alongside a review panel of local professionals to undertake the DHR. The chair being independent of the KBSP, the agencies involved, and not having any prior involvement with any party to the DHR. A terms of reference[3] was provided by the KBSP and supported the DHR by identifying a number of key issues for it to examine.

Each agency provided a chronology of events and an individual management review (IMR), analysing practice events and considering how changes to practice may deliver future improvement. The review panel then met on four occasions for the further analysis of events and to identify the systemic reasons as to why better outcomes were not achieved. A detailed DHR overview report was then prepared in addition to a DHR action plan, outlining how the safeguarding partnership will deliver the identified improvements. The DHR reports and the action plan, have passed the KBSP quality assurance process.

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

[2] An overview of the independent chair, Mark Power, is attached at Appendix A

[3] Appendix B – Terms of reference

Charlotte's family were invited to take part in the DHR but did not respond to the correspondence sent by KBSP. In light of this, and after careful consideration, a decision was taken for the DHR not to approach any other party for their contribution, including the family of Darren.

1.3 The Review Panel and Contributors

A full list of the agencies contributing to the review is provided at Appendix C of this report, which also details the method of their contribution and the names of agency representatives. Each of the IMR authors and the panel members were fully independent of Charlotte's case, not having any prior involvement with her or Darren.

1.4 Parallel Reviews – Coronial Process

The Coroner for the area of Avon held an inquest into Charlotte's death and concluded that she had died of suicide. The coroner also held an inquest into Darren's death, concluding that he had taken his own life, but that his intention was not clear.

2. SUMMARY AND CHRONOLOGY

2.1. Background Information – An Overview of Charlotte and Darren

Charlotte

During her childhood, Charlotte lived with both parents before their relationship came to an end and her father moved out of the family home. Her parents' relationship was described as volatile, with her mother subjected to significant verbal abuse and controlling and coercive behaviour. Charlotte was exposed to parental domestic abuse within her home and family environment.

After the relationship came to an end, her father made a number of allegations to children's services about her mother's ability to look after the children. Children's services recorded a number of contacts that primarily related to family arguments, which after the family being visited by social workers were assessed as not meeting the criteria for the offer of services, outcomes that Charlotte's mother agreed with. Additional children's services support was provided to the family after Charlotte suffered from an illness that had required her to spend a sustained period of time in hospital.

Charlotte and Darren had known each other since childhood and had been in a relationship for many years. This was described as an 'on and off' relationship, with a pattern of breaking up and reconciliation. During the breaks, Darren would have relationships with other partners, whilst Charlotte continued to hope that the relationship would succeed in the longer term. During early 2020, Charlotte believed that she was pregnant, but subsequent tests showed this not to be the case. Later that year Charlotte did become pregnant, which she described as unexpected and unplanned. The long-term history of domestic abuse in their relationship first became known to support agencies during her pregnancy, when she reported being the victim of controlling and coercive behaviour, financial abuse, and threats of physical violence.

Charlotte and Darren's child was born in the summer of 2021, which intensified her desire for their relationship to work and for them to live happily as a family. During the following months she made efforts to progress the relationship, despite the continuance of domestic abuse that significantly impacted upon her mental wellbeing and led to her having feelings of suicide. Despite receiving support from the mental health services, these feelings remained constant.

Charlotte blamed herself for Darren taking his own life, which led to the further deterioration of her mental wellbeing and increasing thoughts of suicide. Despite being supported by mental health

services she took her own life in March 2022. Charlotte left a letter explaining the reasons for her death and describing her feelings at that time. She wrote that all she had wanted was to live as a family with Darren and their child, but that this was not possible now. She felt responsible for his death and was sorry for the hurt that she had caused him and his family, believing that the only way to prevent herself from causing further hurt was to take her own life.

Darren

Darren had been known to the police since childhood and was suspected to have been involved in a variety of criminal offences that included both acquisitive and violent crime. At the time of his death, he had been convicted on a number of occasions with further prosecutions pending. He had also been investigated for a large number of offences that had not resulted in any charges, due in some cases to the victims not supporting a prosecution, and in other cases due to other evidential difficulties.

Darren's family was also well known to the police and had an extensive criminal history that included the suspected commission of violent crimes. During his childhood Darren was exposed to and influenced by this offending, whilst also being exposed to domestic abuse in the home.

Darren was a serial perpetrator of domestic abuse and in addition to Charlotte he was known to have committed offences against a further two partners. In July 2020 he committed offences against a partner after their relationship had come to an end, having subjected her to domestic abuse over a sustained period. He was subsequently convicted of these offences. In March 2021, he started to commit a series of offences against a new partner after she had ended their relationship and this led to the commission of a serious assault for which he was arrested. At the time of his death the CPS were considering whether he would be prosecuted for the offences. Following his conviction for the July 2020 offences, he was sentenced to complete a domestic abuse perpetrator education programme (Building Better Relationships) but died before this commenced.

Following the birth of their child, Darren saw Charlotte and their child on a frequent basis. Throughout this time, he continued with the on and off relationship and despite being banned from attending Charlotte's supported accommodation was seen to repeatedly attend the premises. The continuation of this relationship provided him with the opportunity to commit further offences against Charlotte, which culminated in him seriously assaulting her in November 2021.

In December 2021, Darren took his own life, having told family members that he was estranged from Charlotte and that he could not live without her. During the evening of his death, and after having consumed alcohol, he had repeatedly telephoned Charlotte to say that he could not live without her and their child. Due to the volume of calls Charlotte stopped answering them. Shortly afterwards he was found deceased by members of his family.

2.2. Chronology of Key Events

1) During November 2020, following the confirmation of her pregnancy Charlotte had her first appointment with the community midwife team. During their meeting the midwife explored the nature of her relationship with Darren and asked about any history of domestic abuse. Charlotte stated that whilst there was no abuse in the relationship they did argue after he had been drinking alcohol.
2) During early February 2021, Charlotte and Darren had a number of verbal arguments after he had commenced a new relationship with another person, which escalated to Charlotte being assaulted by the new partner and a member of Darren's family. Darren was not involved in the assault. This was reported to the police and whilst two people were quickly arrested, Charlotte chose not to pursue a complaint and the investigation was subsequently closed with words of advice being

given to the arrested persons. Charlotte also reported this incident to her community midwife, who in addition to offering her support made a safeguarding referral to children's services about their unborn child's risk from domestic abuse.

3) On the 9th February 2021, the Family Nurse Partnership began their work with Charlotte with a family nurse appointed to support her through the pregnancy and her child's early years. The relationship with Darren was explored and the risks of domestic abuse recognised. A number of referrals were made to engage partnership agencies in the support of Charlotte, including referrals to the domestic abuse services (Next Link) and a child safeguarding referral to children's services. An assessment of the child safeguarding referral concluded that appropriate support for her was already in place and that as the relationship with Darren had come to an end, there was no significant risk to the unborn child that necessitated any further children's services action.

4) On the 12th February 2021, the probation service (Community Rehabilitation Company) updated a risk assessment that considered the likelihood of Darren's future offending. This identified the risk of domestic violence that he posed to current and previous partners, in addition to children involved in his future relationships. The risk management plan specified the need to consider a MARAC referral should future events meet the criteria and to consider a referral to Next Link in relation to new partners. A MARAC referral was not considered necessary at that time.

5) On the 18th February 2021, a Next Link support worker responded to the referral received from the family nurse and contacted Charlotte to explore how they could support her. During this meeting she disclosed that she had previously received threats of violence from Darren and his family, which had been reported to the police. A DASH[4] risk assessment was completed, which assessed the risk of harm as medium, and a safety plan was put into place. A support plan was agreed in response to Charlotte's self-defined needs, which included support for a housing move request, legal advice about Darren's conduct, and support to manage abusive relationships.

6) Next Link informed the police of Charlotte's disclosures and she was visited by a police officer. Charlotte disclosed a history of domestic abuse in their relationship that included threats of violence toward her and their unborn child, financial abuse, and a sustained conduct of controlling and coercive behaviour. She did not wish to make a complaint but wished the police to know her history in case of any escalation following the birth of their child. The officer completed a number of referrals to support agencies and a DASH risk assessment was completed that assessed her risk of harm as medium. A referral to help her seek a restraining order was offered, however declined by Charlotte as she feared that this would exacerbate her situation.

7) In March 2021, Charlotte moved into new housing, a specialist housing provision that supports women with their individual needs and helps them progress to future independent living. Charlotte was supported by a support worker for the period of her residence, who completed a needs and risk assessment with her. The risks of domestic abuse were fully explored and a safety plan was created that included a ban on Darren attending the housing, in addition to the submission of a safeguarding referral to children's services. Shortly after moving into her new accommodation, Charlotte informed Next Link that she did not require any further support and her case was subsequently closed.

8) On the 29th April 2021, children's services received and assessed the safeguarding referral from the housing provider, during which Charlotte outlined the history of her abusive relationship and the risks of violence from Darren's family. She explained that whilst their relationship had ended, she still wished him to be part of their child's life and that she felt he would be a good father. As

[4] Domestic abuse, stalking and 'honour'-based violence. Risk assessment grading – standard, medium, high.

the relationship had concluded and other services were providing support, it was decided that an offer of Early Help would be a proportionate response.

9) During May 2021, Charlotte informed her midwife that she had been receiving harassment from Darren, causing her to fear for her safety and the safety of her unborn child. She explained that she did not want Darren to be at the birth, or to have any parental responsibility for their child. A birth plan was developed to reflect this and to record Darren's risk of violence.

10) During the summer of 2021, Charlotte was admitted to the hospital maternity ward for the birth of her child. She did not inform Darren of her admission, however after hearing from friends that Charlotte had gone into labour, he attended the hospital. Despite the security staff having instructions to prevent him from entering the hospital, he was able to access the maternity ward where he started to shout aggressively whilst looking for Charlotte. Charlotte told her mother that she was fearful he would become violent in the ward, Charlotte told the midwife to allow him to be present for the delivery of their child. After the birth of their child, she continued to have contact with Darren and by the end of June they were having daily contact.

11) On the 2nd July 2021, Darren threatened his new partner with violence. She was pregnant and he had threated to harm the unborn child after she had tried to end the relationship. Whilst she reported this to the police, she did not wish to make a complaint and as such Darren was never spoken to by the police.

12) On the 5th July 2021, Charlotte reported to her family nurse that she had spent the night in a hotel with Darren, during which time they had a 'massive argument' and that he had caused damage whilst throwing things around the room. The nurse visited Charlotte, who was distressed and in a low mood, saying "she did not want to be here anymore". Whilst she did not accept the offer of a referral to Next Link, she accepted referrals to children's services and VitaMinds, an NHS service providing talking therapies for people suffering from low mood. The family nurse also made an appointment for Charlotte with her GP to consider further support. Whilst a number of referrals were made for Charlotte, the incident was not reported to the police by any of the agencies.

13) On the 8th July 2021, the domestic abuse committed by Darren against his new partner escalated and he was subsequently arrested for a serious assault upon one of her family members who had intervened to protect her. Following his arrest, a file was submitted to the CPS for a decision upon criminal charges, however Darren died before a charging decision was made.

14) On 8th July 2021, children's services received and responded to the safeguarding referrals that had been submitted following the hotel incident. Charlotte explained that she found it difficult to separate from Darren and would like support with this. A decision was taken to conduct a formal social care child and family assessment.

15) On the 13th July 2021, VitaMinds conducted an initial assessment with Charlotte in response to the referral received from the family nurse. Charlotte explained that her primary problem was her relationship with Darren, who was violent to her and others – including random strangers. She explained that she had been physically assaulted by him whilst pregnant and that she was fearful of his family. She explained that she had reported incidents to the police, however investigations would conclude without any outcomes. Charlotte explained that she had suicidal thoughts but did not have any intent to act upon them. It was recorded that her child was a protective factor, helping to prevent her from acting upon thoughts of suicide. After this initial appointment Charlotte did not respond to offers of further support and she was subsequently discharged from the service.

16) On the 26th July 2021, children's services convened a multi-agency strategy discussion following the completion of the child and family assessment. It was agreed by all parties that Charlotte's child was at risk of suffering significant harm due to a number of factors, including domestic violence in the relationship, Darren's history of domestic violence in a previous relationship, and

his misuse of controlled drugs. It was agreed that the case would proceed to an initial child protection conference. Whilst this was a reasonable outcome, the number of agencies attending the strategy meeting was limited and key agencies such as the family nurse partnership and mental health services were not invited.

17) On the 3rd August 2021, Charlotte's housing provider informed a number of partner agencies that Darren had been secretly visiting Charlotte in her home and that Charlotte was now unhappy with her housing provision and would like to move.

18) On the 26th August 2021, Charlotte's mother used the 999 service to contact the police and report that Charlotte was having a fight with Darren at her housing accommodation. The police attended and spoke with Charlotte who denied that an argument had occurred. The incident was closed with no further action. The housing provider was aware of this incident and as Charlotte and Darren's child had been present during it, a child safeguarding referral was submitted.

19) On the 1st September 2021, the initial child protection conference was held for their child. Both parents attended the meeting, in addition to the key professionals who were working with the family. The meeting was an open forum and Darren was permitted to hear all contributions, creating difficulties for some of the professionals who did not speak openly in his presence due to fears of compromising the safety of Charlotte and their child. The conference agreed that a child protection plan would be opened.

20) On the 7th September 2021, the first multi-agency child protection core group was held, a group convened to deliver the child protection plan. The family nurse informed the meeting that Charlotte had separated from Darren, who was now harassing her with multiple phone calls and messages. The police, who do not routinely attend core groups, were not informed of the potential domestic abuse offences.

21) On the 10th September 2021, the housing provider reported to the police that Charlotte appeared to have temporarily moved out of her accommodation and was at risk from Darren who had been visiting her home. The police spoke to her about this, however she stated that she had not had any recent contact with Darren and was not at risk. A DASH risk assessment was completed and graded as medium. She declined the offers of further support and the case was closed.

22) On the 15th September 2021, Charlotte contacted Bristol City Council Housing and Landlord Services to say that she did not feel safe in her current accommodation and would like to move. Housing services confirmed that they were already seeking to identify a new provision. Whilst enquiries were made Charlotte spent time living at her mother's home.

23) On the 21st September 2021, Charlotte's mother reported to the police that Darren had attended her home and caused criminal damage before running away. Darren was arrested, but denied being involved in the incident and was subsequently bailed to allow further police enquires. Whilst the police recorded and investigated the criminal damage, offences of domestic abuse harassment were not considered. The subsequent police investigation did not result in any criminal charges due to a lack of evidence. A safeguarding referral was made to children's services and further support provided to the family.

24) In October 2021, Darren appeared at court to be sentenced for the domestic violence offences that he had committed in July 2020 against a previous partner. He was sentenced to a community order supervised by the probation service and was required to complete the 'Building Better Relationships' domestic abuse education programme. He was scheduled to commence this programme in December 2021, but died prior to its commencement.

25) On the 20th November 2021, Charlotte's housing provider reported to the police that Darren had attended her accommodation whilst being banned from doing so and at this time Charlotte was once again living at her supported accommodation. The police control centre researched their

databases and did not find any legal restriction to prevent his attendance at the premises. The caller was advised of this and no further action taken.

26) On the 22nd November 2021, the family nurse met with Charlotte and saw that she had bruising to her face and body. She stated that this had been inflicted during a random attack whilst she had been out the previous Saturday evening and that she had not reported it to the police. The nurse shared this information with a children's services domestic violence support worker who had been working with Charlotte. The support worker contacted Charlotte, who disclosed that she had actually been subjected to a five-hour assault by Darren, who had repeatedly headbutted and punched her causing injuries to her face and body. During the incident Darren had also made threats to burn her mother's house down. The support worker reported the assault to the police. It was agreed that Charlotte's housing placement was no longer safe and efforts to identify a new housing provision intensified.

27) On the 25th November 2021, the police visited Charlotte who declined to discuss the assault. Whist the police recorded details of the crime, Darren was never arrested or spoken to about this assault. A DASH risk assessment was completed by the attending officer, which was initially graded medium but following a professional discussion with the domestic abuse support worker changed to high risk. The incident was reviewed by a Police Inspector, who identified that the assault was serious and that a MARAC referral should be made. Whilst referrals to a number of agencies were made, following a discussion with the Bristol MARAC coordinator the police were informed that this did not meet the criteria for a referral as Charlotte was engaging with a Next Link IDVA. At this time Charlotte was not actually working with Next Link, but a support worker from children's services.

28) On the 8th December 2021, the probation service reviewed the risk of Darren reoffending and reassessed the level of risk to Charlotte as high. No referrals to the MARAC were considered as had been suggested in previous probation service risk assessments.

29) On the 13th December 2021, a child protection core group reviewed the most recent assault upon Charlotte and the fact that she was still hopeful that her relationship with Darren could be successful. It was felt that the risk to their child was increasing and it was agreed to commence child protection legal proceedings.

30) On the 14th December 2021, Charlotte moved into her a new housing provision that was provided by Places for People. A customer support worker was appointed to assess Charlotte's risks and to support her identified needs. This included her economic wellbeing, staying safe and healthy, and improving her ability to enjoy life and achieve her ambitions.

31) On the 15th December 2021, Darren failed to appear at court for dishonesty offences not related to this DHR. This was the second time that he had failed to appear for these offences and the court issued a warrant for his arrest.

32) Shortly after his non-attendance at court, Darren took his own life. The evening before he had repeatedly contacted Charlotte by text message, saying that he could not live without her and their child. Charlotte was extremely distressed by his death and she was immediately supported by the agencies working with her. A multi-agency strategy discussion was held, during which the emotional risk to Charlotte was recognised in addition to the risk that Darren's family may blame her for his death.

33) On the 7th January 2022, Charlotte registered with a new GP practice following her housing move. There was early liaison between the family nurse and the GP practice, who informed them of the domestic abuse history and Darren's death.

34) On the 29th January 2022, a review child protection conference agreed that the risk to Charlotte's child from domestic abuse no longer existed and the child protection plan was closed. The

children's services case was subsequently closed and the support concluded. It was noted that Charlotte continued to receive support from partnership agencies, which included supporting her employment and educational aspirations.

35) On the 4th March 2022, Charlotte submitted an online self-referral to VitaMinds, outlining that she was having suicidal thoughts and that it was possible that she could act upon them. A duty worker responded to the referral that same day and spoke with Charlotte on the telephone. She explained that she was feeling guilty over Darren's death and whilst having no immediate intent to act upon her suicidal thoughts, she had written a suicide note to her child. It was recorded that her child was a protective factor in preventing her from acting upon her thoughts. A safety plan was put into place and number of referrals were made to seek the support of other organisations. A referral was also made to children's services, explaining that Charlotte was struggling to look after herself and her child. The referral was subsequently assessed by children's services, who determined that no further social care or early help service was required, as Charlotte had been proactive in seeking support from other services.

36) Later that day the VitaMinds duty worker discussed Charlotte's case with the Specialist Community Perinatal Mental Health Service (delivered by AWP) and it was agreed that a referral for specialist support should be made. The VitaMinds worker was advised to ask Charlotte to destroy her suicide letters, which Charlotte subsequently declined to do.

37) On the 7th March 2022, the Perinatal Mental Health Service reviewed the referral and later invited Charlotte to attend a video appointment on the 16th March.

38) On the 15th March 2022, the family nurse conducted a regular visit with Charlotte, during which she reviewed her mental wellbeing and discussed what further support Charlotte required from the service. Charlotte did not disclose any thoughts of self-harm and explained that she was engaging with the services provided by her GP and VitaMinds. She declined the support of a family support officer to assist with feelings of social isolation. The same day Charlotte and her child were seen at her GP practice and it was noted that whilst she was 'pondering' about Darren's death, she did not have any thoughts of self-harm and was being supported by VitaMinds and other services.

39) On the 16th March 2022, Charlotte attended her appointment with the perinatal service. Charlotte discussed that Darren's family blamed her for his death and had sent her threatening messages. She explained that she had struggled with self-care and that she was suffering from a low mood with suicidal thoughts but described her child as a protective factor preventing her from acting on these feelings. A further appointment was made for Charlotte to have a medical review with a doctor on the 24th March, to consider an extended assessment and a diagnosis. After the appointment had been made, Charlotte was contacted by telephone and appeared happy with the support that she was having.

40) A small number of days after this appointment, Charlotte's mother contacted the police to outline that Charlotte had made suicidal comments to a friend and had not been heard from since. This resulted in an immediate police response and Charlotte was found deceased in her home, having died from suicide. At the time of her death, Charlotte had left her child in the care of her mother.

3. CRITICAL ANALYSIS AND LEARNING

3.1 Finding 1: Understanding Charlotte and the Response to Reports of Domestic Abuse

Learning:

DASH risk assessments were not routinely completed and when done did not follow a trauma informed approach to the assessment of risk. Charlotte's strong desire for her relationship with

Darren to succeed was not understood and this prevented her from being offered the complex support that she needed. When incidents of abuse were identified, professionals did not always report these to the police.

What Happened In This Case

The domestic abuse in Charlotte and Darren's relationship first came to light in early 2021, as health services commenced support for her pregnancy. A history of domestic abuse was identified during the initial pregnancy risk assessments and following a Next Link referral Charlotte disclosed a recent incident of domestic violence which the IDVA reported to the police. Charlotte declined the long-term support of the Next Link IDVA and declined to support the police in taking any enforcement action with Darren. Both agencies completed a DASH risk assessment, with both assessing her as at medium risk from future harm.

At this time Charlotte and Darren were estranged but had been in a long-term relationship since childhood, with an established pattern of breaking up and then reconciling their relationship. One of the most important things to Charlotte was the success of their relationship and being together as a happy family unit. As a child Charlotte had been exposed to domestic abuse in her home and it is likely that this helped to normalise the existence of domestic abuse in relationships and contributed to her acceptance of it.

Darren had also been exposed to domestic abuse in his childhood and had already committed serious domestic violence offences against a previous partner and her family. Charlotte had wanted to involve Darren in their child's life, which combined with their history, made the continuance of their relationship and the likelihood of further domestic violence foreseeable. The initial DASH risk assessments based their risk grading on the presenting information within individual incidents and as such a medium risk grading was a reasonable outcome. However, if they had taken a greater trauma informed approach and considered the full history of the individuals involved, it is possible that professionals may have seen a greater risk of future violence. Darren had already been discussed at a MARAC for his previous offending and it would have been a reasonable decision to make a referral for Charlotte.

In July 2021, shortly after the birth of her child, Charlotte disclosed a further incident of domestic violence to her family nurse. Whilst a child protection referral was submitted to children's services, a DASH was not completed and the family nurse did not report the incident to the police. Charlotte declined the offer of a further Next Link referral.

The child protection referral led to a multi-agency child strategy discussion, where the agencies agreed that the child was at risk from domestic abuse in the parental relationship and that formal child protection procedures were necessary. Whilst this multi-agency meeting considered the risk to the child, it did not specifically consider the risk to Charlotte and how this may be mitigated. Whilst it is accepted that the child protection procedures are intended to protect the child and not the adult, it would have been appropriate and beneficial to consider a MARAC referral at this stage. This would have allowed a multi-agency forum to plan how to reduce the risk to Charlotte.

During the subsequent months further domestic abuse crimes came to light and these were discussed at the core group planning meetings. DASH risk assessments were not routinely completed and the offences were not reported to the police, preventing a complete picture of Darren's offending history from being recorded on the police databases, which would have prevented the police from making informed decisions about the risk Darren posed and how future incidents should be responded to.

During Charlotte's initial disclosure of domestic abuse, she reported that Darren had stolen money from her and the relevant agencies correctly identified this as financial abuse. Whilst she didn't report any future similar thefts, she made a number of requests for financial assistance as she was struggling to manage her finances. Whilst she was provided good support to access benefits, there did not appear to be any consideration given to the continued existence of financial abuse and this was not explored when further instances of domestic abuse were reported by Charlotte. This lack of curiosity prevented a full understanding of Charlotte's situation and may have prevented the identification of further crimes which may have been reported to the police.

As the child protection processes continued, the risk to Charlotte actually increased as she felt the need to disguise her continued relationship with Darren, allowing him into her supported accommodation and not being fully open about the relationship with the professionals supporting her. During October and November 2021 Charlotte continued to meet with Darren and towards the end of November she was the victim of a sustained and serious physical assault.

In December 2021, the multi-agency core group met to consider the child protection plan, at which time Charlotte continued to want Darren involved in their child's life and was hopeful that her relationship with Darren could be successful. The increasing risk to the child from domestic abuse was recognised and the child protection response increased proportionately, with an agreement to progress child protection legal proceedings. Whilst the increasing risk to the child was properly recognised and responded to, the increasing risks to Charlotte were once again not actioned. Multi-agency arrangements to protect Charlotte were clearly required and a MARAC referral would have been appropriate.

Had a MARAC been held at this stage it would have allowed Charlotte's housing provision to be more closely scrutinised and considered in accordance with her needs. Charlotte's mother had made representations to both housing and children's services, that if Charlotte was not accommodated near to her family and friends, she would become isolated, affecting her emotional wellbeing and driving her to spend more time with Darren in the absence of any other support. Instead, Charlotte was provided accommodation in a different area of the city and after Darren's death withdrew into herself, spending more and more time alone in her room. A MARAC would have helped to fully consider the risk of this housing provision and allowed more detailed planning to manage it.

<u>What's Needed To Deliver Future Improvement</u>

A Person-Centred Approach to DASH Risk Assessments

The DHR identified the inconsistent use of DASH risk assessments by a number of agencies and a lack of confidence amongst professionals in their use. DASH risk assessments were not routinely completed following disclosures of abuse and when they were completed, they tended to focus on the presenting issues of the specific incident, rather than taking a holistic look at Charlotte's relationship with Darren and a trauma informed approach to the assessment of risk. The assessments would have been more effective if they had considered childhood experiences, the history of their relationship, any known information about Darren's offending, and the fact that Charlotte was a vulnerable young mother in an unstable and violent relationship. Whilst professionals were determined to support Charlotte, any safeguarding activity was unlikely to be successful until the underlying causes of the domestic abuse and Charlotte's determination for the relationship to succeed were understood and supported through a multi-agency approach.

In order to make future improvements it is recommended that all agencies refresh organisational policy in the use of DASH risk assessments and where necessary provide training to ensure a consistent quality of assessments that take a person centred and trauma informed approach to the assessment of risk. The current KBSP DASH risk assessment form contains relevant questioning in relation to

financial abuse and this subject should be included in any training programme to support professionals in the use of assessments. Excellent resources are available online, such as the advice and guidance provided on the website of the Serving Economic Abuse charity[5], an organisation dedicated to raising awareness of economic abuse and transforming responses to it.

Third Party Reporting to the Police

Whilst the family nurse received a number of domestic abuse disclosures and reported these to children's services, these were not reported to the police which may have been done through established third-party reporting procedures. A full record of domestic violent crimes was therefore not recorded on the police databases, which would have prevented the police from making informed decisions about the risk Darren posed and how future incidents should be responded to.

The issue of perpetrator management is explored later in this report, however in order for such an approach to be successful it relies on being fully informed and having a complete record of crimes. The DHR identified that whilst each of agencies supported the third-party reporting of domestic abuse crimes to the police, this was not consistently done. It is therefore recommended that alongside a review of DASH risk assessments, agencies consider their policies in relation to the third-party reporting of crimes and its consistent application.

Recommendation 1:	*Each organisation that uses the 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. Where necessary changes to policy should be made and any identified training needs addressed.*

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.*

3.2. Finding 2: MARAC Arrangements and Referral Criteria

Learning:

The Bristol MARAC referral criteria is preventing the highest risk domestic abuse cases from receiving the benefits of multi-agency planning. There is a need to review the criteria, whilst ensuring that it is consistently applied by professionals.

What Happened In This Case

A multi-agency risk assessment conference (MARAC) is a forum for agencies and other specialists to share information about the highest risk domestic abuse cases and to develop multi-agency plans to reduce risk. This may involve the provision of support to victims, the coordination of enforcement activity with perpetrators of violence, and in some cases supporting perpetrators to change their behaviour and prevent further offending. Due to the complexities of Charlotte's case, a MARAC was needed to provide the comprehensive support that she required.

Darren had been exposed to domestic abuse in his childhood and at a relatively young age had a history of domestic abuse offending. Whilst he was due to commence the Building Better Relationships education programme in December 2021, a MARAC meeting could have provided earlier

[5] https://survivingeconomicabuse.org/about-us/

opportunities for intervention. This may have helped to reduce the likelihood of further offending, whilst supporting his emotional wellbeing and reducing his own risk of self-harm.

The Safe Lives domestic abuse charity provides a framework for effective MARAC arrangements, including a recommended referral criteria. This criteria provides guidance for the identification of higher risk cases through the DASH risk assessment score, the use of professional judgement, and the identification of escalating incidents where three incidents are recorded within a twelve-month period. The Bristol MARAC has a published referral criteria that reflects these principles, which if followed should have resulted in a number of MARAC referrals being submitted.

In 2020, the Bristol MARAC referral criteria was reviewed to manage the high volume of cases, leading to the adoption of a new principle where a referral was not required if the person was already being supported by an IDVA from Next Link or the Victim Support service. The rationale being that the IDVA could use their expertise to identify when a MARAC referral was necessary. This procedure is not recorded in the published arrangements and led to confusion in Charlotte's case.

The DHR examined the reasons why a MARAC referral was not completed and identified the following:

a) Professionals from a wide number of agencies simply did not consider a MARAC referral, despite the criteria being met on a number of occasions. Whilst multi-agency child protection procedures were followed, domestic abuse multi-agency procedures for Charlotte were not. This omission may have been as a result of overly focusing on child protection procedures, or simply a lack of awareness of the MARAC arrangements.

b) In November 2021, the police considered making a referral, but after consultation with the MARAC coordinator believed that it did not meet the criteria as it had been recorded that a Next Link IDVA was already working with Charlotte. This was not the case as on two occasions Charlotte had declined the support of Next Link. Her children's services domestic abuse support worker had been mistaken for an IDVA by a number of agencies and as a result the MARAC referral was not made.

<u>What's Needed To Deliver Future Improvement</u>

It is recommended that the Bristol MARAC reviews its published referral criteria, whilst additionally reviewing the unpublished principle of a referral not being required if an IDVA is involved. Not only is the current situation likely to cause future confusion, it also excludes higher risk victims who are engaging with an IDVA from receiving the benefits of a MARAC and is contradictory to the principle of higher risk cases being supported by multi-agency planning.

A change to the referral MARAC criteria will increase the number of referrals, which will likely place an unsustainable demand upon current resources. It is therefore essential that any change to policy should be supported with an appropriate increase in MARAC resources.

Any new policy and procedure should be promoted widely within Bristol, to ensure that professionals have a good understanding of the MARAC arrangements and the referral criteria. All agencies within the Keeping Bristol Safe Partnership should develop clear policies to outline when a referral should be made and should ensure the consistent application of policy.

Recommendation 3:	The Bristol MARAC should review the current published arrangements and referral criteria, ensuring that the arrangements are clear and widely promoted within Bristol. Any change to the referral criteria should be supported with an appropriate increase in MARAC resources. Organisations should support the MARAC arrangements with organisational policy as to

	when referrals should be made and ensure the consistent application of policy.

3.3. Finding 3: Perpetrator Management and Prevention Strategies

Learning:

A greater use of perpetrator management and prevention strategies may have reduced the likelihood of Darren's future offending.

What Happened In This Case

Darren was a serial perpetrator of domestic violence, having committed offences against two partners in addition to Charlotte. He had a pattern of starting with 'lower level' offences, which escalated to the commission of serious assaults. When positive action was taken that was likely to lead to a prosecution, he desisted from committing further offences against that specific victim. The incidents of domestic abuse against Charlotte followed his established pattern. At first there was a lower level of abuse and when not prosecuted for these offences, the incidents became more serious culminating in the November 2021 serious assault.

During the period in which his offending escalated, Darren was attending Charlotte's supported accommodation despite being banned by the housing providers. The housing agencies reported this to the police, however they were unable to take any enforcement action as the ban on his attendance was only a condition of Charlotte's residence and was not legally enforceable.

Had Darren not died after seriously assaulting Charlotte in November 2021, it is likely that he would have continued to commit further offences until positive and robust action was taken against him. He was not however arrested for the assault or spoken to about it. Whilst the police considered an evidence-based prosecution, which does not require victim cooperation, they felt that they had insufficient evidence to achieve this. There were however reasonable grounds to suspect that he had committed an offence and an arrest would have been both lawful and proportionate, whilst providing the opportunity to gain Charlotte's confidence to provide an evidential account of the assault.

During her contribution to the DHR, Charlotte's mother explained that both she and Charlotte lost confidence in the police to keep them safe. They had reported a number of incidents, however none of these led to a prosecution and worsened Darren's conduct towards them. As a result, they stopped reporting crimes and incidents as a way of avoiding further confrontation. During the peak of his offending, Darren had made threats to burn the family home down and Charlotte's family lived in constant fear, believing him capable of carrying out these threats. The threats were not reported to the police as the family felt that this would make him more likely to harm them.

As a serial perpetrator it would have been proportionate to ensure that Darren was arrested for every incident where reasonable grounds existed to suspect that he had committed an offence, with a premium standard of investigation conducted by a suitably accredited investigator. Rather than focusing on individual incidents, it would have been beneficial to investigate the pattern of his offending to secure greater evidence and increase the likelihood of a prosecution. Where relevant this could have been supported by bad character evidence, using evidence from his previous convictions. Where evidence could not have been secured prior to his release from custody, civil orders may have been considered, such as a Domestic Violence Prevention Notice (DVPN). The police may have been supported with such enforcement action by the housing providers, who may have obtained legal orders preventing Darren from attending the premises and which could have provided police powers of enforcement. Had a greater level of perpetrator management been pursued, then this may also have led to the consideration of using the Domestic Violence Disclosure Scheme to alert any new

partner to the risk of domestic abuse[6]. Had a MARAC referral been made for Charlotte, then this would have provided the opportunity to achieve this level of agency coordination. Following his death, any identified offences committed by his family may also have been proactively responded to through a coordinated multi-agency response.

In addition to an enforcement strategy, a perpetrator education and prevention programme may have been a key strand of any multi-agency plan to reduce Darren's offending. Whilst he was due to commence the Building Better Relationships programme in December 2021, it would have been beneficial to support him with an earlier opportunity to engage with a prevention programme. Whilst such a service was not commissioned at the time of this case, new arrangements have since been introduced. This includes a fully commissioned intervention programme for high-risk perpetrators delivered by the DRIVE Project, in addition to a trial of the Resend Project, a service for lesser risk perpetrators. Not only would such services have helped Darren, but it would also have demonstrated to Charlotte an intent to support him and provided a further opportunity to gain her confidence.

What's Needed To Deliver Future Improvement

The commissioning of the DRIVE Project in Bristol is a positive development, which addresses the learning identified in this DHR and prevents the need for a specific recommendation in respect of intervention programmes.

The Avon and Somerset Constabulary should review how it manages serial perpetrators of domestic violence, to ensure that positive action is taken against offenders and that offences are investigated to a high standard by a suitably trained investigator. The constabulary's Domestic Abuse Delivery Plan provides a commitment to achieving this, outlining how it will focus upon positive action, victimless prosecutions, and working with partners to tackle the highest risk offenders and serial perpetrators. Whilst this is a positive delivery plan, the KBSP would benefit from knowing how this will be achieved and how ongoing performance will be measured.

In addition to supporting victims of abuse, the Bristol MARAC should maintain a strong perpetrator focus to deter future offending, particularly when an individual is identified as a serial perpetrator of domestic violence. Multi-agency plans should include both prevention and enforcement strategies. It is recognised that many MARAC chairs may not have a detailed knowledge of perpetrator disruption tactics, which would provide the confidence to challenge agencies in their enforcement activity. There would be value in providing them with such training.

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

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.*

[6] https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/domestic-violence-disclosure-scheme-factsheet#:~:text=The Domestic Violence Disclosure Scheme, previous abusive or violent offending.

3.4. Finding 4: Multi-Agency Child Protection Procedures

Learning:

The lack of agency involvement in the child protection meetings prevented Charlotte's needs from being fully considered, increasing her vulnerability and preventing the development of comprehensive multi-agency plans. The initial child protection conference did not make use of two-part conference arrangements, which created difficulties for the professionals and potentially affected the quality of information presented.

The multi-agency child protection procedures were an important aspect in the way that Charlotte's disclosures of domestic abuse were responded to and as such they were examined during the review, which identified three distinct areas of learning. Each is dealt with in this section of the report under the following headings:

a) Strategy discussions – agency involvement.
b) Core groups – multi-agency planning.
c) Initial child protection conference arrangements.

a) Strategy Discussions – Agency Involvement

What Happened In This Case

In July 2021, a multi-agency strategy discussion was convened by children's services in response to the child protection referrals, its purpose being to share information and determine if the threshold for child protection had been reached, and if so to plan a response. To ensure that all relevant information is considered during strategy discussions, and to develop multi-agency safeguarding plans, it is standard practice to invite all agencies that are working with the family to these meetings. This follows the national child protection guidance 'Working Together 2018' and the KBSP multi-agency protocol. When domestic abuse is a factor in the safeguarding concerns, then it is good practice to also invite the domestic abuse services, even when they are not already working with the victim. The July strategy meeting did not follow this guidance and only a limited number of agencies were invited. Key health agencies such as the family nurse partnership were not included, nor the probation service which at this time was working closely with Darren. The Next Link domestic abuse service was also not invited. The most likely reason for these omissions was that a decision had already been made about the child protection threshold and that a small meeting of the three key safeguarding partners was held to officially ratify this decision.

This approach however had a detrimental impact upon the child protection proceedings and the support offered to Charlotte. The absence of the family nurse meant that they were unaware of information held by other agencies and this impacted upon their ability to effectively assess risk. The absence of the probation service prevented its staff from understanding the full extent of Darren's domestic abuse offending and prevented a contribution to a multi-agency safeguarding plan. The absence of Next Link meant that the risk to Charlotte was not fully considered, had it been then a MARAC referral would have been a reasonable outcome.

What's Needed To Deliver Future Improvement

A wide range of agencies should be included within strategy discussions and the DHR has been reassured by children's services of an ongoing commitment to ensure this happens. It would however be useful for the KBSP safeguarding children's partnership to consider the learning from this DHR and to seek assurances about the application of its multi-agency strategy discussion protocol.

Domestic abuse services have a critical role in any case that involves domestic abuse and should be included within all relevant strategy discussions, regardless as to whether they are working with the

victim. This will ensure that the needs of the victim are considered, in addition to other multi-agency safeguarding arrangements such as the MARAC.

b) Core Groups – Multi-Agency Planning

What Happened In This Case

The multi-agency core group was implemented to deliver the child protection plan and whilst it included a number of agencies, it did not include the probation service who were still working with Darren, nor the Next Link domestic abuse service, who whilst not working with Charlotte may have provided expertise in the management of domestic abuse cases. The reasons for this are not clear, but likely due to an oversight, or due to a lack of knowledge of domestic abuse cases. The omission of these key agencies was not identified during case management and supervision. Whilst the purpose of child protection procedures is to protect the child and not necessarily the adult, helping to protect Charlotte from further domestic abuse, and helping Darren to change his behaviour, should have been key aspects of the child protection plan for which Next Link and the probation service may have provided key contributions.

During the core group meetings further domestic abuse crimes were identified and discussed, however these were not reported to the police. Whilst it is normal for the police to not be a member of core groups, it is essential for them to be informed of any newly identified crimes and to be consulted as to how reports are responded to. In these circumstances it would have been appropriate to have convened a further strategy discussion, to ensure that the crimes were recorded and to agree the multi-agency response. Such an approach would comply with the Working Together 2018 guidance and reflect good practice. It is not clear as to why this was not done.

What's Needed To Deliver Future Improvement

Domestic abuse services should be included within core groups for all domestic abuse related cases, regardless of their involvement with the victim. Where the probation service, or other perpetrator intervention services, are involved in the case then they should also be included within core groups.

When crimes that have not previously been reported to the police are disclosed in core group meetings, then a strategy discussion should be convened to ensure that the police are able to record the details and are part of a multi-agency response.

Children's services should consider the training requirement for its managers who chair core groups and strategy discussions, to ensure there is a broad understanding of domestic abuse including how supporting victims and the perpetrators of abuse should form part of multi-agency child safeguarding plans.

c) Initial Child Protection Conference Arrangements.

What Happened In This Case

The initial child protection conference (ICPC) held in September 2021, followed the format of an open meeting attended by Charlotte and Darren, in addition to the professionals who were supporting them and their child. This open forum created difficulties for some of the professionals, who were required to discuss Darren's domestic abuse offending in front of him. This created barriers to speaking openly, due to the concerns of compromising the safety of Charlotte and their child.

In order to prevent such difficulties, there are established procedures for a two-part conference which are used in domestic abuse related cases, this provides an initial confidential meeting and is followed by the open forum which the perpetrator may attend. It is not clear as to why this didn't happen in

this case, but it is likely that the ICPC chair was not fully aware of the case circumstances and that the children's services manager had not considered the need for a two-part meeting.

What's Needed To Deliver Future Improvement

The learning from this DHR should be shared with children's services managers and the independent chairs of child protection conferences, to ensure that two-part conferences are considered and used when relevant. Prior to an ICPC or a review conference, the children's services lead should consult with the other agencies to identity any concerns and any need for a two-part conference.

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.*

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.*

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.*

3.5. Finding 5: Understanding the Risk of Suicide and the Links To Domestic Abuse

Learning:

There is a need to increase a professional awareness of the links between domestic abuse and suicide, which is a national issue and not unique to the KBSP. Connected to this, are the risks of considering babies and young children to be a protective factor in parental suicide.

What Happened In This Case

Charlotte first disclosed thoughts of suicide in July 2021 and during a subsequent appointment with the VitaMinds mental health service, explained that these feelings resulted from the domestic abuse committed by Darren and from his general violent conduct. Charlotte denied having any intent to act on these thoughts and it was recorded that her newly born baby was a protective factor from any suicide intention. Whilst offered further appointments she did not respond to the correspondence and was discharged from the service. Despite having a knowledge of Charlotte, the mental health services were not invited to the July 2021 strategy discussion meeting and were not involved in the subsequent child protection plan, which did not specifically consider any specialist support for Charlotte's mental wellbeing.

Following Darren's suicide, the risk to Charlotte's mental wellbeing was quickly identified and whilst she was provided with emotional support by the professionals already working with her, there was no consideration of specialist support. The child protection plan was subsequently closed and the support from children's services concluded. As Charlotte's mental health deteriorated, further safeguarding

referrals were submitted to children's services and whilst the offer of early help services would have been reasonable, there was no further support offered to Charlotte and her child.

The further involvement of mental health services did not take place until March 2022, when Charlotte referred herself to VitaMinds and later received support from the specialist perinatal mental health services. During these appointments she explained that she felt responsible for Darren's death and had feelings of guilt. She explained that she was having thoughts of suicide that she may act upon and had written letters to her child explaining the reasons for her suicide. Despite this she said that she did not have an immediate intent to take her own life and her child was described as a protective factor reducing the risk of suicide. Charlotte took her own life shortly after her appointment with the perinatal service and before she could receive further specialist support.

During the DHR, the review panel examined how the agencies responded to Charlotte's deteriorating wellbeing and identified two key issues. Firstly, the link between domestic abuse and her risk of suicide was not understood by the professionals working with her and secondly, there was a commonly held view that Charlotte's child was a protective factor in helping to prevent her from taking her own life.

The failure to understand the links between domestic abuse and suicide was a key learning theme of this DHR and had there been a greater understanding of this, then the risk to Charlotte may have been better understood and she may have received greater support. The involvement of mental health services within the child protection plan would have helped to support Charlotte at an early stage, whilst also reducing the risk of her child suffering harm as a result of poor parental mental health. Following Darren's death, specialist bereavement counselling may have been provided to help reduce Charlotte's feelings of guilt, whilst helping her to understand that this guilt stemmed from a sustained period of domestic abuse. The provision of coordinated early help services may have provided her with much needed support, whilst an earlier intervention of specialist mental health services may have provided her with improved outcomes.

Many domestic abuse support organisations have sought to raise awareness of the links between suicide and domestic abuse, outlining the need for a greater national awareness to protect victims. Further research has examined the risk of suicide in young mothers and also how poor parental mental health has the potential to cause babies and young children significant harm and whilst this DHR does not suggest that Charlotte's child did suffer in this way, it is an important piece of learning for future cases. A number of research project papers have been published that are relevant to both the risks of suicide and how a baby or young child may impact upon this risk. Examples relevant to this DHR include:

- In 2023, the Agenda Alliance charity published a research paper[7] highlighting the links between domestic abuse and suicide. It identified that women who experience domestic abuse are three times more likely to have made a suicide attempt than those who have not experienced abuse and that these links have been critically under-examined. As a result of the findings, the agenda alliance recommended that all public authorities should ensure that staff were trained to understand the links between abuse and suicide and knew how to support those at risk.
- A research project[8] published by the University of Gloucestershire and Professor Jane Monckton Smith, outlined the clear links between domestic abuse and suicide. It has a detailed explanation of the stages from the disclosure of abuse to suicide and produces narrative tools for the development of risk management strategies and interventions. Not only does this project provide

[7] https://www.agendaalliance.org/documents/138/Underexamined_and_Underreported_Briefing.pdf

[8] https://eprints.glos.ac.uk/10579/16/10579_Monckton-Smith_(2022)_Home_Office_Report.pdf

an excellent training opportunity for professionals, but it also supports them with methods to assess and manage risk.

- In July 2022, the Advocacy After Fatal Domestic Abuse charity (AAFDA) in partnership with the University of Warwick, completed an analysis of domestic homicide reviews in cases of domestic abuse suicide[9]. This aimed to contribute to learning about domestic abuse suicide, in addition to learning about the relevant DHR process. One of the relevant learning themes to this case, being the "lack of professional curiosity to ask questions about domestic abuse, about suicidality, or about the connection between the two".
- The MBRRACE-UK organisation reports annually upon maternity related deaths in the UK and in November 2022 published a report[10] that examined the lessons from the deaths of mothers during their pregnancy and up to one year following birth. Whilst this did not examine the issue of domestic abuse, it did examine the prevalence of suicide in young mothers, which is relevant to Charlotte's case. The research identified that mental health related deaths (suicide or substance abuse) accounted for almost 40% of deaths in the first year after a child's birth and it identified a rising trend of suicide in young mothers.
- The NSPCC has published guidance[11] to support children whose parents suffer from poor mental health and specifically highlights the risks to babies and children in their first year of life. This demonstrates how poor parental mental health can affect how parents' bond with and care for their child. This is particularly relevant to this DHR and helps to evidence why babies and young children should not be seen as protective factors in parental suicide. The guidance also outlines how this may cause significant harm to a child, impacting upon intellectual, emotional, social, and psychological development.

The DHR review panel fully accepted that from a child protection perspective, a young child should not be seen as a protective factor in parental suicide as this created risk to the child. The panel further considered how useful this was in reducing the risk to the adult from suicide, with some health professionals expressing a concern that this should not be relied upon as whilst some parents may see their children as a reason to continue living, this can very quickly change to a point where they believe the child to be better off without them. Other health professionals however disagreed with this view and felt that this could be a useful strategy in managing the risks of patients.

Whilst there may not be agreement in the medical community as to whether a young child can be effective in reducing risk to the adult, the child protection risks are clear and well evidenced. All public agencies have a legal duty to promote the wellbeing of children and continuing to see children as protective factors in parental suicide is entirely contrary to the principles of current legislation (Children's Act) and best practice guidance. As such the learning from this review needs to be considered at a national level to consider whether guidance is required for all health professionals and for other professionals working with children.

<u>What's Needed To Deliver Future Improvement</u>

To deliver future improvement significant work is required within all agencies to develop an understanding of suicide and domestic abuse, both to understand risk and to improve the multi-agency response. The key areas for development evidenced during this DHR being:

[9] https://aafda.org.uk/learning-legacies

[10] https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2022/MBRRACE-UK_Maternal_CORE_Report_2022_v10.pdf

[11] https://learning.nspcc.org.uk/children-and-families-at-risk/parental-mental-health-problems

- The need to develop a consistent understanding of the links between domestic abuse and suicide, whilst providing professionals with the tools to support vulnerable people.
- Multi-agency child protection processes should ensure that parents at risk from domestic abuse receive effective multi-agency support, either as part of the child protection arrangements or by a referral to other multi-agency arrangements such as the MARAC.
- The need to develop an understanding as to how poor parental wellbeing may cause harm to babies and young children, and how they should not be seen as protective factors in parental suicide.

In order to address this learning, it is recommended that a comprehensive multi-agency training package is designed and delivered in Bristol, to develop a consistent understanding of the links between domestic abuse and suicide and enabling professionals to develop effective multi-agency support plans. Whilst considering how this may be achieved, the research project conducted by Professor Jane Monckton Smith would be an excellent starting point, which would not only develop an understanding of this issue but provide the opportunity to consider how its narrative tools for managing risk may be used in Bristol.

The learning from this DHR as to why young children should not be seen as a protective factor in parental suicide is a national issue and one that would benefit from national guidance. It is therefore recommended that the Integrated Care Board considers this learning and identifies the correct body to consider the development of future guidance. This may sit with NHS England or may be an issue that the national Child Safeguarding Practice Review Panel may wish to consider.

Many of the agencies participating in the DHR have already recognised the need for this development and have already put single agency action plans into place and these are summarised at Appendix B.

Recommendation 9:	*The KBSP 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. This should also consider how the learning identified in this DHR may contribute to the Bristol Suicide Prevention Strategy 2022-2025.*

Recommendation 10:	*The Bristol, North Somerset and South Gloucestershire Integrated Care Board, should consider the learning from this DHR, 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.*

4. SUMMARY OF RECOMMENDATIONS

4.1. Summary of Recommendations

Recommendation 1:	Each organisation that uses the 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. Where necessary changes to policy should be made and any identified training needs addressed.

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.
Recommendation 3:	The Bristol MARAC should review the current published arrangements and referral criteria, ensuring that the arrangements are clear and widely promoted within Bristol. Any change to the referral criteria should be supported with an appropriate increase in MARAC resources. Organisations should support the MARAC arrangements with organisational policy as to when referrals should be made and ensure the consistent application of policy.
Recommendation 4:	The Avon and Somerset Constabulary should present its plans to manage serial perpetrators of domestic abuse to the KBSP, outlining how this will be achieved and how it will measure ongoing performance.
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.
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.
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.
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.
Recommendation 9:	The KBSP 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.
Recommendation 10:	The Bristol, North Somerset and South Gloucestershire Integrated Care Board, should consider the learning from this DHR, 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.

4.2. DHR Response Plan

The KBSP partnership has developed a response plan to this DHR. It has been published alongside this report on the KBSP website.

APPENDIX A – THE INDEPENDENT CHAIR AND AUTHOR

The independent chair and author of this report, Mark Power, is independent of the KBSP and all of the agencies involved in the review. Mark previously worked in the police service, serving with both Wiltshire Police and the Gloucestershire Constabulary. In addition to being an accredited Senior Investigating Officer for homicide investigations, he specialised in protecting vulnerable people and led police safeguarding teams for both children and adults. Through this work he developed extensive experience of multi-agency public protection and chaired a number of strategic partnership forums. Relevant experience in the context of this DHR includes working at a strategic level for the partnership response to child protection, domestic abuse, and the management of perpetrators.

Mark is now an independent reviewer conducting a variety of safeguarding reviews and provides independent scrutiny to safeguarding partnerships. 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 undertakes regular continuous professional development.

APPENDIX B – DHR TERMS OF REFERENCE

DOMESTIC HOMICIDE REVIEW
TERMS OF REFERENCE

1. Introduction

These terms of reference have been produced to guide a Domestic Homicide Review commissioned by the Keeping Bristol Safe Partnership (KBSP). The review follows the death of Charlotte, who died in March 2022.

The decision to undertake this review was made in August 2022, 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 Charlotte'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

- Charlotte XXXX (Deceased)

3.2 Other Relevant Parties

- Darren XXXX (Deceased)
- XXXX (Charlotte and Darren's child)

3.3 Date Parameters

The review will examine all relevant information during the period of Charlotte's relationship with Darren; and within any of Darren's other relationships where domestic abuse was known or suspected to exist.

Information will be deemed relevant as follows:

- 1st August 2019, to the date of Charlotte's death in March 2022. A detailed chronology of agency information concerning their contact with Charlotte and Darren. This should include how agencies considered Charlotte's history during the assessment of referrals.
- Relevant information concerning Darren's history as a perpetrator of domestic abuse. Including his relationship with a previous partner, which led to his arrest in July 2020 for domestic abuse offences and a subsequent breach of a restraining order.
- Any relevant information that falls outside of these parameters may be summarised in an introductory paragraph.

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 recording and responding to reports of domestic abuse, including how agencies considered making third party reports to the police and examining any barriers that Charlotte, or her family, may have had to reporting incidents.
2. The role of schools in identifying domestic abuse and supporting young people, including how referrals to other agencies and the MARAC are considered.
3. The effectiveness of MARAC referrals and, where relevant, multi-agency action planning.
4. Arrangements for the management of 'serial perpetrators of domestic abuse'. Including both enforcement and multi-agency prevention initiatives.
5. Information sharing within child protection procedures and the effectiveness of early help services and multi-agency planning. This will include multi-agency information sharing processes following the child protection referrals and how different health teams became aware of information relating to a history of domestic abuse relating to both parties. This should also examine how both parties experience of domestic abuse in their childhood may have been considered when responding to the safeguarding referrals for their child.
6. The role of fathers with newborn babies and how Darren was seen and acknowledged by services.
7. How babies may be seen as a protective factor in managing the suicidal thoughts of parents.

8. The effectiveness of the multi-agency support provided to Charlotte following the suicide of Darren. Including health services and children's social care / early help.
9. How was Charlotte's experience of domestic abuse considered by the agencies whilst they were supporting her mental wellbeing. Including how domestic abuse is seen as a risk factor for suicide and how the agencies work together to understand and reduce this risk.

4. Methodology

Voice of Charlotte

Charlotte's family will have an integral role in the review, to ensure that events in Charlotte's life are accurately reflected and the effects upon her fully considered. The reviewer will seek to identify close friends of Charlotte who may be able to provide relevant information as to what was happening in her life.

Review Panel

A multi-agency review panel will be formed to deliver the review. This will involve key agencies from the Keeping Bristol Safe 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. Any 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 and 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. This will include an action plan endorsed by the KBSP, outlining how any improvements to safeguarding practice will be implemented.

The report will be signed off by the KBSP SAR/DHR Sub-group and Domestic Abuse and Sexual Violence Delivery Group before submission to the Home Office DHR Quality Assurance Panel.

5. Timescales

The KBSP agreed to conduct the DHR on 14th August 2022, the chair was appointed on 11th October 2022 and the first panel meeting held on 15th November 2022.

The Home Office guidance outlines that where possible a Domestic Homicide Review should be completed within a six-month period from the date a decision is taken to conduct it. In practice, it is widely accepted that this timescale is difficult to achieve for the participating agencies and it is further recognised that many families will often wish for a longer time frame affording them time to consider the information from the review. There will be an intention to complete it within six months of commencing, however this will be used as guide and where necessary the timeframe may be extended.

APPENDIX C – REVIEW PANEL AND CONTRIBUTORS

A list of the agencies contributing to the review is provided below. This outlines the agencies that provided a written submission and those providing a member of the review panel. Each member of the review panel and each IMR author, were entirely independent of Charlotte and Darren's case.

Agency	**Job Title / Role**	**IMR**
Avon and Somerset Police	Detective Chief Inspector	Yes
Avon and Wiltshire Mental Health Partnership	Domestic Abuse Lead	Yes
Bristol MARAC	MARAC Coordinator	Not Required
BNSSG Integrated Care Board – Representing the GP Practices	Designated Nurse/ Professional – Safeguarding Adults	Yes – Two GP Practices
Bristol City Council – Children and Families Services	Families in Focus Area Manager	Yes
Bristol City Council - Education	Safeguarding in Education Team Manager	Not Required
Bristol City Council - Housing and Landlord Services	Housing Safeguarding Reviews and Improvement Officer	Yes
Bristol City Council Public Health	Head of Service – Public Health, BCC	Not Required
Elim Housing Association – Bristol and Gloucestershire	Director of Housing Services	Yes
National Probation Service	Senior Probation Officer	Yes
Next Link	Senior Services Manager	Yes
North Bristol NHS Trust	Named Midwife for Safeguarding	Yes
Places for People - Bristol Parents Alliance	Services Manager	Yes
Sirona Care & Health CIC	Named Lead for Safeguarding Children (Bristol)	Yes
NHS Talking Therapies – Previously known as VitaMinds	Clinical Lead	Yes