DOMESTIC HOMICIDE REVIEW
EXECUTIVE SUMMARY

Report into the death of Steve, who died in April 2021

Independent Chair and Author: Mark Wolski

Date of Completion: March 2024

Table of Contents

1. THE REVIEW PROCESS

1.1 This summary outlines the process undertaken by Keeping Bristol Safe Partnership (CSP), Domestic Homicide Review panel in reviewing the circumstances of Steve, a resident in Bristol who took his own life in April 2021.

1.2 The following pseudonyms have been in used in this review to protect their identities.

Table 1

Pseudonym	Relationship	Age at the time of the incident	Ethnicity
Steve	Deceased	24	White British
David	Father	58	White British

1.3 The coronial process concluded on the 23rd July 2021. The conclusion of the coroner as to the cause of death was 'suicide'. The medical cause of death was recorded as 'hanging'.

1.4 The Keeping Bristol Safe Partnership reviewed the circumstances against the criteria set out in the Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews and the chair of the CSP determined that a DHR should be undertaken. The Home Office was notified on 13th October 2021.

1.5 Agencies that potentially had contact with Steve and David prior to the point of death were contacted and asked to confirm whether they were involved with them.

2. CONTRIBUTORS TO THE REVIEW

2.1 Agencies were asked to check for their involvement with any of the parties concerned and secure their records. The approach adopted was to seek Individual Management Reviews (IMRs) for all the organisations and agencies that had contact with Steve and David.

2.2 The following agencies who had contact and their contributions are shown below.

Table 2

Agency	Trace of	Input
University Hospitals Bristol and Weston NHS Foundation Trust	Steve, David	Chronology and IMR
Avon and Somerset Police	Steve, David	Chronology and IMR
North Bristol NHS Trust	Steve,	Chronology
Bristol City Council Housing and Landlord Services	Steve, David	Chronology and IMR
Bristol City Council Children's Social Care	Steve, David,	Chronology and IMR
Local nursery	Samantha, Drew	Chronology and IMR
GP Practice	Steve, David	Chronology and IMR
Probation Service	Steve, David	Chronology and IMR

2.3 IMRs and factual reports were completed by authors who were independent of any prior involvement with Steve and David.

2.4 The authors and panel members assisted the panel further, with several one-to-one meetings and answering follow up questions as necessary.

3. THE REVIEW PANEL MEMBERS

3.1 The review panel members included the following agency representatives.

Table 3

Agency	Job Title
Avon and Somerset Police	Head of Major and Statutory Crime Review Team, Detective Chief Inspector
Avon and Wiltshire Mental Health Partnership	Head of Safeguarding
BNSSG ICB on behalf of GP	Interim Designated Professional/Nurse for Safeguarding Adults
Bristol City Council Childrens and Families Services	Head of Safeguarding and Area Services
Bristol City Council Housing and Landlord Services	Housing Safeguarding Reviews & Improvement Officer
Bristol City Council Public Health	Senior Public Health Specialist
Drug and Alcohol Services	Specialist Social Work Lead - ROADS Advice and Liaison Service
ManKind Initiative	Charity Manager
Probation Service	Senior Probation Officer
Bristol City Council Safeguarding in Education team	School Safeguarding Advisor
University Hospitals Bristol and Weston NHS Trust	Head of Safeguarding

3.2 The review panel met on five occasions.

3.3 Agency representatives were of appropriate level of expertise and were independent of the case.

4. AUTHOR OF THE OVERVIEW REPORT

4.1 The Chair of the Review was Mark Wolski. Mark has completed his Home Office approved Training, has attended subsequent Training by Advocacy After Fatal Domestic Abuse. (See Appendix A for full statement of independence)

4.2 Mark has no connection with Bristol, or any agencies involved in this case.

5. TERMS OF REFERENCE FOR THE REVIEW

5.1 The primary aim of the DHR was defined as examining how effectively Bristol's statutory agencies and Non-Government Organisations worked together in their dealings with Steve and David.

5.2 The purpose of the review is specific in relation to patterns of Domestic Abuse and/or Coercive Control, and will:

- Conduct effective analysis and draw sound conclusions from the information related to the case, according to best practice.

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their dependent children.
- Identify clearly what lessons are both within and between those agencies. Identifying timescales within which they will be acted upon and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Contribute to the Prevention of Homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- Highlight any fast-track lessons that can be learned ahead of the report publication to ensure better service provision or prevent loss of life.

5.3 Case specific key lines of enquiry included the following.

A. Analyse the **communication and co-operation** which took place within and between agencies regarding **Steve**.
B. Analyse the opportunity for agencies to identify and **assess the risk of domestic abuse** or **self-harm**, including what would have enabled or hindered disclosure.
C. Analyse agency **responses to any identification of domestic abuse or self-harm** issues. (*Including referrals, treatment, safety, and crisis planning*)
D. Analyse organizations' **access to specialist domestic abuse agencies**.
E. Analyse the **policies, procedures, and training** available to the agencies involved in domestic abuse issues.
F. Analyse any evidence of **seeking help**, as well as considering what might have **helped or hindered access to help and support**.
G. The extent to which **Covid-19** effected agency involvement with Steve.
H. The extent to which **substance misuse** and **financial pressures** impacted/effected Steve's circumstances.
I. The extent to which **'child access'** affected the circumstances of Steve.
J. Consider (a)Steve's **housing situation** had been considered by agencies and (b) whether they considered any obligations to signpost or refer him in respect of his housing situation.
K. The extent to which '**familial abuse'** was recognised as domestic abuse.
L. Analyse whether **Steve's gender** as a male victim had played a part in him being able to access services, and whether he was also seen as a perpetrator.
M. Linked to L. above**, Equalities**: The Review Panel will consider all protected characteristics.

5.4 The timeframe for this DHR was agreed as from ***April 2017*** until Steve's death in ***April 2021***. This was agreed proportionate, covering a period before the birth of his child who was aged three at the time of Steve's death.

6. SUMMARY CHRONOLOGY

6.1 Regrettably, the background history of Steve has not benefitted from the accounts of family or friends who felt unable to take part in the review process. Reliance has been placed on information made available from agency records, except for the landlord of the premises where Steve took his own life.

GP

6.2 Steve was well known to the practice as a child diagnosed with ADHD, referrals to CAMHs and working with his father and grandmother on parenting boundaries. Aged 17, Steve had an appendectomy and thereafter reported unexplained abdominal pains, to which the records show him having attended A & E to obtain morphine as opposed to attending primary care. It was noted in August 2015 he had attended a hospital emergency department 47 times for IV morphine. Further investigations were undertaken, and no causal factors identified. An emergency department support plan was put in place for Steve's attendances where he continued to attend reporting undiagnosed pain and requested intravenous morphine.

6.3 During the relevant period he was seen on four occasions and had one telephone consultation. The GP received information from other agencies including a MARAC enquiry made by the police, two alerts from the emergency department, one regarding an overdose following an altercation with his partner (2018), and one where he had attempted to take his own life (2020).

UHBWFT - Hospital

6.4 Steve had fifteen contacts with the Trust during the relevant period and there was an alert on his file regarding him being a regular attender seeking opiate medication. Three of his contacts during the relevant period related to abdominal pain (31/12/2018, 08/08/2019, 21/03/2021), associated with drug seeking behaviour. Six attendances related to head injuries, of which one related to an injury after drinking (23/12/2018), one to an assault by a stranger (13/01/2019), three related to assaults by his father (04/08/2018, 12/01/2020, 31/08/2020), and one related to a work injury. Two attendances related to self-harm, an overdose (05/08/2018) and an attempted hanging (05/12/2020). Further contact in April 2021 related to a course of treatment regarding an unrelated matter.

Police

6.5 The police attended seventeen incidents involving Steve during the relevant period. Some of the incidents that were recorded included counter allegations between Steve and David, though there was an occasion when police were called to the address twice on the same day. Most of the incidents were of a domestic nature between Steve and David, though there was one incident in July 2018 where Steve was assaulted in a pub and had part of his ear bitten off and another assault against Steve in the street by an unknown person in January 2019.

6.6 There was also one allegation of domestic assault in August 2018 perpetrated by Steve against his partner Samantha that resulted in Steve being arrested and charged. Because of this and the subsequent judicial restraint, Steve's access to his child was restricted.

6.7 On one occasion February 2020 David was arrested, charged, and convicted for an assault against Steve, resulting in David being supervised by probation for a period. Notwithstanding the conviction, Steve remained living in the same house as David.

6.8 The contacts with police were frequently typified by alcohol consumption, and on several occasions, mention was made of Steve's substance misuse as a further aggravating factor.

Bristol City Council Children's Social Care

6.9 An isolated notification was submitted 2009 when Steve was aged 13 highlighting on going arguments between David and Steve. At this time no additional concerns were noted by partner agencies or additional notifications submitted thereafter. The safeguarding threshold at this time was not met and no intervention was taken forward.

6.10 Bristol City Council Children's Social Care first became involved after the allegation of assault made against Steve by his partner in August 2018. An assessment was completed, and statutory involvement was not required. There was one further contact following an allegation that Steve had bitten his child's finger. Following assessment, no further action was taken, and it was noted there was no evidence of the child's finger having been bitten.

6.11 Steve did contact social care when he sought information about seeing his child, and he was advised to seek legal advice.

Bristol City Council Housing & Landlord Services (Housing)

6.12 Steve was living in private rented accommodation at the time of his death. However, he was recorded as an occupant at his father's address which is owned and managed by BCC H&LS until the date of his death in April 2021.

6.13 The housing records note that Steve was not always living at the address, and that David asked Steve to leave the address in April 2020 and Steve had presented as homeless in June 2020.

6.14 There are over 45 entries on the chronology provided by BCC H&LS. Many relate to routine maintenance, though there are a significant number relating to rent arrears that suggest a degree of financial pressure within the household, along with reported anti-social behaviour associated with Steve.

Probation Service

6.15 David was supervised by Probation Service following his conviction in June 2020 for an offence against Steve of Assault occasioning actually bodily harm for which he received a 12 month community order with a "Rehabilitation Activity Requirement" to comply with any instructions of the responsible officer (probation officer) to attend appointments with the responsible officer or someone else nominated by them, or to participate in any activity as required by the responsible officer up to a maximum of 10 days.

Steve's Landlord (John)

6.16 John explained that when Steve had arrived, he had lacked confidence, asking permission to make use of the facilities such as kitchen and bathroom. In hindsight this struck him as unusual, but he had responded saying to him words to the effect, "this is your home mate, help yourself, you can do what you want".

6.17 John said (in his own words) he thought Steve had been 'controlled' through actions such as Steve having had to ask to use the toilet or even to eat. He further explained Steve was frequently intoxicated and left his room in quite a state, littered with beer and wine bottles. He also knew that Steve had a difficult relationship with his former partner and having restricted access to his child was a worry for him. Steve had also spoken about financial worries, owing money to drug dealers and HMRC.

7. CONCLUSIONS AND KEY ISSUES ARISING FROM THE REVIEW

7.1 There are several factors that contribute to an understanding of Steve's vulnerability. It is clear from the account of his landlord, that Steve was unhappy, in some despair, having been heard to be crying on the evening he died by suicide. Whilst the panel could not identify a 'trigger event', it is arguable his death was not 'out of the blue' given some of the factors below.

7.2 Steve was an only child and a young man who had a disjointed upbringing, living between his mother at times and father/grandmother. He had been treated for ADHD as a child and may have had undiagnosed learning difficulties and there were reports of concerns regarding his behaviour. There was limited agency involvement prior to the relevant period, but when aged 13, a report regarding running away resulted in brief social care contact, and it was noted there were arguments between Steve and his father. Cross referencing with comments by Steve to housing about how his father treated him as a child, it is likely that childhood experiences affected his vulnerability and wellbeing as an adult.

7.3 There is no background of reported abuse before the relevant period and Steve's arrest for domestic abuse against his partner and mother of his only child is significant. Thereafter, there was a history of domestic abuse between father and son, that shows David as the primary aggressor. The abuse took several forms, predominantly physical, but also alluding to controlling behaviour and financial abuse.

7.4 There were several cross allegations of assault, many where alcohol was an aggravating factor, and frequently arising from minor arguments such as eating one another's food or not keeping the house tidy. Whilst neither party substantiated allegations, it is clear David was the primary aggressor and that his conviction for an assault on Steve was based on his admission as opposed to Steve supporting a prosecution. Notwithstanding this conviction, Steve remained in the same house as David, and his accommodation needs are noted as important in this review. After all Steve had said he had 'no-where else to go'.

7.5 There is evidence of controlling behaviour from father to son through conversations with professionals such as a conversation with housing (June 2020) where Steve said that he had to ask permission to use the bathroom or make food. This was corroborated in a similar account provided by his friend with whom he lodged. It was also reported by police when Steve had been asked by police why he remained at the address, and he had replied that he was 'scared to be on his own'. This indicates Steve's isolation and the link between his need for accommodation and control exercised over him.

Vulnerabilities & Worries (Steve's perspective)

7.6 The intersection of multiple vulnerabilities and worries is apparent over the relevant period. Each incident of self-harm, an overdose (August 2018) and attempted suicide by strangulation (December 2020) followed significant incidents. The panel were unable to identify a trigger event proximate to Steve's death.

Victim of Assault

7.7 Steve had been a victim of assault, where he incurred a significant injury to an ear. This featured in discussions following incidents of self-harm and following a comprehensive assessment of his mental wellbeing by his GP a year later.

Substance Misuse

7.8 Steve had formed a substance use (Opioid) dependency with prolific contacts with Emergency Departments prior to the relevant period (RP), flags having been placed on his medical record

and sporadic presentations during the RP seeking medication. It is likely from Steve's own accounts of being in trouble with cocaine dealers, as well as of others, that he was using illegal drugs. Steve was not signposted to substance misuse support services.

Child Access

7.9 The imposition of a restraining order on Steve that afforded protection for his former partner also restricted access to his child that Steve found difficult. Worries about child access formed a barrier to Steve seeking help from the police, as he was worried how his former partner, and social services would view police involvement.

7.10 At the time of his death, Steve was lodging in a house with others, one of whom was in a relationship with the mother of his child. This is recognised as a 'stressor' for Steve, owing to the separation from his former partner, and because this new boyfriend could see Steve's child more freely than he could.

Covid and Mental Health

7.11 Covid lockdown that commenced on 16th March 2020[1] had an impact at the time of isolating Steve and David, preventing them from working, getting out of the house and adding tension within the household. Steve's experience reflects academic research of people reporting psychological distress and symptoms of depression related to Covid.

Accommodation

7.12 A secondary effect was that it forced them to remain together, with no other easy option for Steve to live elsewhere. When he did present to housing, he was not treated as having priority need as a victim of domestic abuse and was put on a rough sleeping list.

Financial pressure and financial abuse

7.13 Money was a worry for Steve. Neither he nor his father were able to work during Covid. David had to be advised about claiming Universal Credit, and Steve spoke about the reliance of David on him and mentioned financial abuse to the police.

7.14 Steve was also worried about other debts, with reports of correspondence from HMRC that had concerned him, and the frequent references to being in trouble with cocaine dealers.

8. LESSONS LEARNED

8.1 The review identified several learning points that build upon agency IMRs. These have then been considered against a background of agency and policy developments that mitigate the need for several recommendations that may have otherwise arisen.

Vulnerability

8.2 The intersection of multiple vulnerabilities and worries as summarised above is apparent in this review.

Suicide Prevention

8.3 The research conducted during the review demonstrated links between domestic abuse and suicide, adverse childhood experience and suicide, and demographic groups such as labourers. Steve fell into these categories. The review identified an opportunity to strengthen

[1] Source: timeline-coronavirus-lockdown-december-2021 (instituteforgovernment.org.uk) (Accessed June 2023)

the local suicide prevention strategy by seeing suicide prevention through the lens of domestic abuse in accordance with recent research.

8.4 The review also highlighted a dichotomy in respect of BMJ advice on 'safety planning' and of suicidal ideation and its practical application that will be taken forward by Public Health.

Multi-agency working - Communication and Co-operation and MARAC

8.5 The absence of a multi-agency appreciation of the situation is apparent from this review. Information was shared between agencies in a linear fashion of agency to agency, but no overall picture of the relationship was available or sought. Escalating risk was not identified and the absence of a partnership policy on repeat domestic abuse incidents in accordance with previous HMIFCRS findings, proved to be a barrier to a multi-agency (MARAC) conversation that would have brought agencies together to secure a holistic overview of the circumstances. Linked to not recognising repeats as a barrier, is the current pathway for MARAC referrals going through IDVAs to refer, that creates another barrier and possible delay to multi-agency discussion.

Recognition, response, and professional curiosity

8.6 The review identified the need to promote professional curiosity across all agencies to help recognise and respond to domestic abuse. Intrinsic to this, remains the need to maintain comprehensive training and awareness, - in healthcare improvements to recognition and response to domestic abuse can be made through routine enquiry and reference to NICE guidelines health indicators of domestic abuse (QS116) that includes suicidal tendencies or self-harming , - through the improved use of coding to record suicidal ideation/self-harm in medical practice, - in the police through effective use of DASH/ BRAG tools and recognising the need to deal with cross allegations appropriately, - in children's services by developing the approach on the whole family.

8.7 Whilst recognising the subsequent cultural change programme undertaken by police, the review identified missed investigative opportunities and the opportunity to enhance the status of domestic abuse investigations by more timely supervision of crimes (within one day) that applies to all crime (seven and twenty-eight days). After all evidence gathering for domestic abuse is particularly time sensitive.

Unconscious bias

8.8 The potential for unconscious bias was apparent across multiple agencies. The police recognise the risk of domestic abuse being seen as a women's issue, not recognising familial abuse as domestic abuse. The fact that Steve himself did not recognise the circumstances as being domestic abuse may have impeded him securing the help he needed, suggesting a need for a wider piece of work to raise awareness. This potential for unconscious bias was similarly reflected by the UHBWFT and by housing.

Call handling.

8.9 The review identified assurance opportunities in respect of police handling of calls to specific localities and to ensure that policies regarding decisions to take no further action are adhered to.

Risk Management

8.10 The review shone a light on unusual circumstances of a victim living with the perpetrator under probation supervision, and owing to the gravity of offence, Steve as the victim did not qualify for a victim liaison officer. It found that there had been deficiencies in the quality of risk

management and planning, but that revised frameworks/policy and the National Probation Service now managing all offenders has resulted in improved supervision.

8.11 There was an acknowledgement by Probation Service that risk guidance is not specifically designed to predict all behaviours associated with domestic abuse. The IMR author acknowledges that the emphasis is on intimate partner violence, not interfamilial abuse indicating a gap in service guidance on DA.

9 GOOD PRACTICE

9.1 GP

- Communication between MARAC and GP that alerts the practice to high-risk cases.

9.2 Avon and Somerset Police

- The significant cultural change programme, aligned with a performance and quality assurance framework.
- DA Procedural Guidance

9.3 UHBWFT

- The Mainstreaming of HEADSS (Home, Education/Employment, Activities, Drugs, Sex and relationships, Self-harm and depression, Safety) initiative into hospital practice is seen as good practice that will assist in identifying vulnerable people such as Steve.
- Hospital IDVAs

9.4 Bristol City Council Children's Social Care

- The embedding of domestic abuse practitioners and use of 'signs of safety' model within the service is recognised as good practice.

9.5 Bristol City Council Housing and Landlord Services

- A housing IDVA embedded into service.
- Seeking DAHA accreditation will transform practice.

9.6 Education services

- Operation Encompass to alert schools of domestic incidents
- Alert Board and password system for supporting safe pick up and drop off with parents/carers.

10. RECOMMENDATIONS

10.1 Local Recommendations (Individual Agency)

10.1.1 GP Practice

- To ensure DVA risk is documented and coded in GP records.

10.1.2 Police

- LSU to increase supervisory oversight through audits and dip sampling.
- LSU to review the feasibility of implementing a process to identify multiple domestic abuse incidents between the same two parties regardless of their victim/suspect status.

10.1.3 UHBWFT

- To complete a focused piece of work to promote the Think Family agenda across all ED's.
- Think Family approach to raise awareness of non- intimate partner abuse.
- Medway alerts and Personal Support Plans to include prompt for staff to signpost to other services.

10.1.4 Education services

- Development of knowledge within the Education Workforce around the Domestic Abuse Act 2021 and the application of the Statutory guidance 2022.
- Development of training and support for the workforce around tackling parental conflict.
- Secure resource for the Police Safeguarding Notification Scheme from the statutory Local Safeguarding Partnership.

10.1.5 Childrens Social Care

- Increase use of family functioning and life story exploration in social work assessments with fathers who are causing harm through domestic abuse.

10.1.6 Partnership

- Commissioning of a male only domestic abuse service.
- Commissioning of male only Refuge accommodation

10.2 Overview Report Recommendations

The following recommendations have been agreed by the panel.

R1	Bristol City Council (Public Health) is to ensure that the link between all victims of domestic abuse and suicide is strengthened and plans to reduce suicide are embedded into partnership work on domestic abuse.	Public Health
R2	The ICB is to improve the ability of GPs to identify signs of domestic abuse and respond with appropriate professional interest that provides opportunities for survivors to disclose abuse.	ICB
R3	The GP practice seeks assurance that it has a system in place that demonstrates the recording of “suicidal ideation or thoughts of self-harm” using the codes as per the system of software in place for patient records.	ICB
R4	Public health to explore the evidence-base for the routine use of ‘safety planning’ tools for those who express suicidal ideation and/or have attempted to take their own lives within the suicide prevention strategy.	Public Health
R5	A&S Police are to ensure that call handling policies and protocols ensure that all outstanding calls to a location are dealt with by the first attending police unit.	Police
R6	A&S Police should conduct assurance work around Domestic Abuse NFA authorisations to check for adherence to current policy. The audit should inform the next steps to be taken to address the findings.	Police
R7	The Bristol City MARAC steering group set a threshold for repeat domestic incidents that results in automatic referral to MARAC, reassures itself that there are no unnecessary delays in referral of cases to MARAC and makes necessary policy adjustments.	Keeping Bristol Safe Partnership
R8	Keeping Bristol Safe Partnership is to coordinate a broad communication campaign targeting professionals and communities to raise awareness of domestic abuse and male victims, and to ensure male survivors know where to go for support.	Keeping Bristol Safe Partnership
R9	Seek to improve the identification of domestic abuse victims by, - emending policy to incorporate self-harm/suicidal ideation as an indicator of abuse, - by adapting the self-harm template to incorporate enquiry about domestic abuse and deliver training on unconscious bias.	UHBWFT
R10	Victim Support is to ensure that all actions mentioning VS are followed up.	Victim Support
R11	The learning from this review is shared across the partnership to raise awareness of domestic abuse including interfamilial abuse, links to suicide and all the learning opportunities raised.	Keeping Bristol Safe Partnership

APPENDIX G – ONE PAGE SUMMARY

1. Domestic Homicide Review

The Keeping Bristol Safe Partnership commissioned this DHR following Steve taking his own life in April 2021.

2. Case Summary

Steve was aged 24 at the time of his death. In April 2021, police were called by the ambulance service to Steve's rented accommodation where he had been found hanging in his room by two housemates and Steve's mother.

The police conducted a comprehensive investigation and, as there was no third-party involvement, the matter was passed to the coroner and the inquest concluded death by suicide.

The review was commissioned based on the recorded events of domestic abuse by his father during the relevant period prior to Steve's death.

3. The Facts – an overview

Steve was staying in lodgings with a couple at the time of his death, having lived in the family home with his father until a few months previously.

Steve had a disjointed upbringing, living with his father and grandmother for a period, during which he had been diagnosed with ADHD, possible low self-esteem and potential communication and learning needs. Aged 15, Steve moved back in with his mother following disruptive behaviour and two school moves.

Aged 17, following medical procedures and undiagnosed abdominal pains Steve developed a dependency on medication.

As a young adult, Steve moved back in with his father and took up work as a scaffolder. He had a partner with whom he had a child but had restricted access following one reported incident of domestic abuse (*August 2018*).

During the relevant period, police attended seventeen incidents involving Steve (including the incident above). Most incidents were of a domestic nature between Steve and his father. On one occasion his father was arrested, charged, and convicted for an assault against Steve. His father was then supervised by the Community Rehabilitation Company prior to the re-integration into the Probation Service. Steve remained resident with his father in the same accommodation (Father's house) and when he sought housing he was not identified as having priority need (victim of DA).

The practical effect of Covid at the time was also to isolate Steve and his father from others and require them to remain in the same household.

Other linked incidents also included attempts by Steve to take his own life (*Overdose August 2018, and attempted hanging December 2020*).

The review highlighted elements of controlling behaviour by Steve's father (*reportedly having to seek permission to use the kitchen and bathroom*) and potential financial abuse (*in respect of rent paid to father*) in addition to physical abuse.

Steve's drug habit also extended to illegal drugs, reportedly being in debt to drug dealers, and that with reported letters from HMRC proximate to his death added to Steve's worries.

4. Learning Points

Vulnerabilities: The intersection of multiple vulnerabilities *(substance misuse, mental health)* and worries *(child access, covid)* is apparent from this review.

Suicide Prevention: The review identified opportunities to strengthen the local strategic approach to suicide prevention by seeing it through the lens of domestic abuse and to consider the merits / practicalities of suicide safety planning.

Recognition & response (R&R): There remains a need for improved R&R of DA via professional curiosity, training, routine enquiry and recognising suicide/self-harming links to DA.

Unconscious bias: The risk of unconscious bias was apparent, not recognising familial abuse as DA, and thinking a young fit scaffolder could be at risk of such abuse.

4. Learning Points (Continued)

Partnership working: Steve's circumstances did not benefit from a multi-agency perspective of the relationship between father and son where escalating risk was not identified, with the case being heard only once at MARAC despite multiple domestic abuse related contacts.

Call Handling: Opportunities to seek assurance around police call handling to the same location and decisions to take no further action being in accordance with policy.

Risk Management: An opportunity to strengthen the development of probation risk management regarding domestic abuse in the planned redesign of risk tools in the redesign of systems.

5. Good Practice

GP: Communication between MARAC and GP

Police: Significant cultural change programme together with performance and quality assurance regime plus DA procedural guidance.

Hospital: Mainstreaming of HEADSS (Home, Education/ Employment, Activities, Drugs, Sex and relationships, Self-harm and depression, Safety) initiative for patients plus IDVA provision.

Children's Services: embedding of domestic abuse practitioners and use of 'signs of safety' model within the service.

Housing: Seeking DAHA accreditation plus a housing IDVA embedded into service.

Education services: Operation Encompass and use of an 'Alert Board' for supporting safe pick up and drop off for parents/carers.

6. Recommendations

R1: Bristol City Council (Public Health) is to ensure that the link between all victims of domestic abuse and suicide is strengthened and plans to reduce suicide are embedded into partnership work on domestic abuse.

R2: The ICB is to improve the ability of GPs to identify signs of domestic abuse and respond with appropriate professional interest that provides opportunities for survivors to disclose abuse.

R3: The GP practice seeks assurance that it has a system in place that demonstrates the recording of "suicidal ideation or thoughts of self-harm" using the codes as per the system of software in place for patient records.

R4: Public health to explore the evidence-base for the routine use of 'safety planning' tools for those who express suicidal ideation and/or have attempted to take their own lives within the suicide prevention strategy.

R5: A&S Police are to ensure that call handling policies and protocols ensure that all outstanding calls to a location are dealt with by the first attending police unit.

R6: A&S Police should conduct assurance work around Domestic Abuse NFA authorisations to check for adherence to current policy. The audit should inform the next steps to be taken to address findings.

R7: The Bristol MARAC steering group set a threshold for repeat domestic incidents that results in automatic referral to MARAC, reassures itself that there are no unnecessary delays in referral of cases to MARAC and makes necessary policy adjustments.

R8: KBSP to coordinate a broad communication campaign targeting professionals and communities to raise awareness of domestic abuse and male victims, and to ensure male survivors know where to go for support.

R9: UBHWT: Seek to improve the identification of domestic abuse victims by, - emending policy to incorporate self-harm/suicidal ideation as an indicator of abuse, - by adapting the self-harm template to incorporate enquiry about domestic abuse and deliver training on unconscious bias.

R10: Victim support is to ensure that all MARAC actions mentioning VS are followed up.

R11: The learning from this review is shared across the partnership to raise awareness of domestic abuse including interfamilial abuse, links to suicide and all the learning opportunities raised.