Domestic Homicide Review Overview Report

Keeping Bristol Safe Partnership

Report Into the Death of Charlotte in March 2022

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Version:	Version 4. Final Version for Publication
Date of Completion:	28th August 2024
Date First Submitted to Home Office QA Panel:	7th February 2024

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1. INTRODUCTION

1.1. Circumstances Leading to the Review

In March 2022, Charlotte was found deceased having died by suicide in her home. At the time of her death, she was known to a number of services and was being supported 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. Following Charlotte's death, the Avon and Wiltshire Mental Health Partnership referred the case for the consideration of a Domestic Homicide Review (DHR).

In May 2022, the Keeping Bristol Safe Partnership (KBSP) considered the referral and having decided that it met the criteria commissioned this DHR. The review aimed to use the experiences of Charlotte to identify learning and to improve the way that agencies support people who are at risk of domestic abuse. 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.

The KBSP would like to express sympathy to the families of Charlotte and Darren for their loss.

1.2. Domestic Homicide Reviews – Purpose and Timescales

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

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

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

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

Normally a DHR should be completed within six months of being commissioned, a time period provided by the Home Office, or within a time frame agreed by the community safety partnership. A specific time frame was not defined for this DHR by the partnership, but there was an intention that it should be conducted as expeditiously as possible. The DHR commenced in October 2022, with the overview report being completed and approved for initial submission to the Quality Assurance Panel in November 2023.

1.3. Terms of Reference

A terms of reference[2] was agreed with the Keeping Bristol Safe Partnership, examining the support provided to Charlotte and how agencies responded to the disclosures of domestic abuse. This set out key lines of enquiry for the DHR to consider and parameters to assist in the identification of relevant information.

Key Lines of Enquiry

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 may have prevented Charlotte, or her family, from 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 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 was considered by the agencies whilst 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.

Information Gathering Parameters for Agency Chronologies and Individual Management Reviews

- A summary of information held by the agencies during the period of Charlotte and Darren's relationship and a detailed chronology of events commencing in August 2019, when Charlotte became known to the agencies.
- A detailed chronology of any relevant information about Darren's history as a perpetrator of domestic abuse within other relationships.
- A summary of any other information considered relevant, but which falls outside of the above parameters.

[2] Attached at Appendix A

1.4. Methodology

An independent chair was appointed to work alongside a panel of local professionals to undertake the review.

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

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

An overview report was then prepared, which was agreed by the review panel and passed the KBSP quality assurance process. This was then submitted to the Home Office Quality Assurance (QA) Panel, for its review prior to publication.

1.5. Involvement of Family and Friends

Charlotte's family were invited to take part in the DHR at its outset but did not initially respond to the correspondence sent by KBSP. As such there was not an opportunity for them to meet the review panel or attend any meetings. 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. The reasons for this have been communicated to the QA panel. Whilst this may have reduced the ability to present Charlotte's voice in the DHR report, it did not prevent key learning from being identified.

At the conclusion of the DHR process, Charlotte's family were again contacted and were provided an opportunity to read the overview report. They did respond to this contact, subsequently meeting with the DHR chair and providing some additional contextual information after having read the report. The decision not to approach any other party, including the family of Darren, was reviewed and for the same initial reasons a decision was made not to approach anyone else.

1.6. Agency Contribution and The Review Panel

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.

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

1.7. 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.

1.8. Parallel Reviews

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.

1.9. Equality and Diversity

The review panel was mindful of the need to consider the cultural backgrounds of both Charlotte and Darren, to identify any characteristics that contributed to the domestic abuse experienced by Charlotte and how this may have played any part in how services responded to the needs of both parties.

The Equality Act 2010 brings together the nine protected characteristics of: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex,

and sexual orientation. These were each considered in relation to Charlotte and three characteristics were identified as having a potential relevance to this review, these being sex, age, and pregnancy.

a) Sex - Whilst both males and females may experience incidents of domestic abuse, national statistics show that females experience higher rates of abuse, including repeated victimisation. Charlotte was therefore at a greater risk of domestic abuse due to her sex, as was her mother who herself experienced domestic abuse during Charlotte's childhood. Relevant research and statistics may be found published on the website of the 'Women's Aid' charity[3].

b) Age – The crime survey for England and Wales (March 2023) showed that a significantly higher proportion of people aged 16 to 19 years were victims of domestic abuse (8%) compared to those people in the elder age groups of 45 to 54 years (4.2%) and those aged 60 years and older (3.2%). Further research conducted by the Safe Live domestic abuse charity, indicates that 25% of young women aged between 13 and 18 years will experience domestic abuse within their relationships[4], reflecting Charlotte's experience.

c) Pregnancy and Maternity – Research published on the 'Safe Lives' charity's website, indicates that 30% of domestic abuse commences during pregnancy, and that 40-60% of women will experience abuse during their pregnancy[5]. Whilst Charlotte's abuse commenced prior to her pregnancy it continued during it and through maternity.

The panel ensured that the review always considered these issues in their analysis of the involvement of agencies and the potential impact upon decision making. It further considered the issue of honour-based violence, in relation to the abuse that Charlotte suffered from Darren's family. The panel did not identify any cultural issues that may have caused this abuse, however remained mindful of the issue throughout the DHR. The 'Karma Nirvana' honour-based violence charity has published guidance on its website (https://karmanirvana.org.uk/get-help/what-is-honour-based-abuse/).

1.10. Confidentiality and Dissemination

This report is written with the intention of publication and as such does not contain information which may identify those involved. In accordance with Home Office guidance pseudonyms have been used to protect the names of all others involved, the names Charlotte and Darren having been chosen by the review panel and agreed by Charlotte's mother. At the time of their respective deaths, Charlotte and Darren were both twenty years of age. Both were of a white British ethnicity.

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

Following the Home Office quality assurance process, this report will be published and may be widely disseminated. This will include dissemination to all agencies taking part in the DHR, the wider KBSP membership, and publication on the KBSP website. A copy will be offered to Charlotte's Family.

[3]https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/domestic-abuse-is-a-gendered-crime/

[4]https://safelives.org.uk/about-domestic-abuse/what-is-domestic-abuse/facts-and-figures/prevalence-and-impact/

[5] https://safelives.org.uk/research-policy/health/idvas-in-maternity-units/

2. CASE SUMMARY & CHRONOLOGY OF KEY EVENTS

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.

2.3. 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[6] 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 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.

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

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. OVERVIEW – THE ROLE OF INDIVIDUAL AGENCIES AND ORGANISATIONS

This section of the report summarises the written submissions provided by the individual agencies, outlining the key interactions with Charlotte and Darren, and highlighting the multi-agency learning themes that are explored further in this report. The agencies are listed in alphabetical order.

3.1. Avon and Somerset Constabulary

The police had extensive contact with Darren over a number of years, dating back to 2013. He had a suspected involvement in a variety of different crime types, including acquisitive crime, violent crime, and more latterly domestic violence offences. At the time of his death, he had a record of six convictions and had four impending prosecutions. He had been investigated for a number of further offences that had not resulted in any prosecution due to evidential difficulties.

Darren's first recorded domestic abuse offending was in July 2020, when at the age of nineteen he forced his way into a previous partners home, assaulting her and committing criminal damage. During the police investigation his victim described a history of domestic abuse in the relationship and provided evidence to support a prosecution. He was charged with the offences, after which no further offences were committed against his victim. A MARAC referral was made by the police and the Bristol MARAC heard the case.

During March and July of 2021, Darren committed further domestic abuse crimes against a different partner, with a series of incidents reported to the police. During the first three incidents his victim and

the witnesses to the crimes refused to provide the attending police officers with any information as to what had happened and as a result Darren was not arrested or spoken to by the police. The fourth incident resulted in a serious assault to a family member of Darren's ex-partner. Those involved supported the police investigation and Darren was arrested for the offences. The police evidential threshold was met and a file was submitted to the crown prosecution service (CPS) to decide upon a criminal prosecution. After this positive action Darren did not commit any further offences against his victim. Darren died before the CPS provided their advice upon criminal charges.

Darren's first recorded crime of domestic abuse against Charlotte was in February 2021, a third-party report made by Next Link outlining threats of violence that had been made against her and their unborn child. Charlotte was spoken to by the police and reported being the victim of controlling and coercive behaviour, threats of physical violence, and financial abuse where Darren would steal cash from her. At this time their relationship had come to an end and she did not wish to make a criminal complaint. As a result, Darren was not arrested or spoken to about these offences. A DASH risk assessment was completed and a number of referrals were made to partnership agencies to safeguard Charlotte and the unborn child.

Between August and November 2021, the police recorded a further three incidents of domestic abuse. The first was a report from Charlotte's mother that Darren was fighting with Charlotte at a different address, however upon attending the police were told by Charlotte that her mother had made a mistake and no incident had occurred. The second incident related to Darren causing criminal damage to a car owned by Charlotte's mother, for which Darren was arrested but not charged due to evidential difficulties. The third crime related to the serious assault committed upon Charlotte in November 2021, a third-party report from the children's services domestic abuse support worker. Charlotte refused to provide details of this assault and the support worker reporting the incident did not wish to provide a statement of evidence. As a result, Darren was not arrested or interviewed about the assault. Safeguarding referrals were made to other agencies and a decision made that this should be referred to the Bristol MARAC. Whilst a referral was considered, it was not done as following enquiries with the MARAC coordinator the police believed that it did not meet the referral criteria. The reasons for this are examined further in this DHR, alongside the MARAC referral arrangements.

In summary, Darren was a serial perpetrator of domestic violence who would commit repeated offences until positive action was taken and which was likely to result in a prosecution. When this did not occur, his offending escalated until serious offences of violence were committed. How the risk of Darren's offending may have been reduced, and how serial perpetrators of abuse are managed, is explored further in this report.

Whilst researching the constabulary's crime recording system, it became evident that the number of recorded crimes did not reflect the volume of crimes that had been committed against Charlotte and which were known to other agencies. Such a lack of information has the potential to affect the efficacy of risk assessments and to affect the quality of decisions about the necessity for positive action following reported incidents. The reason why this happened in Charlotte's case is explored further in this report.

Identified Learning

- *The third-party reporting of crimes to the police by partnership agencies and the recording of crimes.*
- *Proactive enforcement of serial perpetrators of domestic abuse.*
- *Effectiveness of the MARAC referral process.*

3.2. Avon and Wiltshire Mental Health Trust (AWP)

The AWP provided specialist perinatal mental health services to Charlotte and became involved in her case on two occasions. The first referral was received from Charlotte's GP in July 2021 and resulted in advice being provided to the practice, whilst the second referral was received from VitaMinds in March 2022 and resulted in services being directly provided to Charlotte.

The first referral was received from Charlotte's GP after she had presented as a new mother who was struggling with her baby crying and was suffering from a consistent low mood. The referral outlined that she had a difficult relationship with her child's father, who was physically and mentally abusive, and was having thoughts of 'not being here anymore'. The GP outlined that she had no plans of suicide and that her child was a protective factor in preventing her from acting on her thoughts. The GP summarised the treatment plan that had been put into place that included a referral to VitaMinds, and asked what other perinatal mental health support would be suitable. The GP was provided with information on relevant support organisations and was offered advice in relation to the involvement of the Next Link domestic abuse service and to consider a referral to children's services.

The second referral was received in March 2022, a few months after Darren had died from suicide. The referral explained that Charlotte was having suicidal thoughts and had written a suicide note to her child. Charlotte was provided with an appointment with a nurse, who was directed by her manager to further explore the suicidal thoughts and the note that Charlotte had written. During the appointment Charlotte's abusive relationship with Darren was discussed and it was identified that his family had sent her abusive messages blaming her for his death. The history of domestic abuse was not explored in any detail, or why she had feelings of guilt over his death, and there was no advice provided about reporting the abusive messages to the police. Charlotte's suicidal thoughts were explored and it was recorded that Charlotte's child was a protective factor in preventing her from acting upon her thoughts. At no time during the appointment did the nurse suspect that Charlotte was at immediate risk of self-harm. As an outcome of this appointment, Charlotte was provided with a further appointment with a consultant for an extended assessment, but died before this took place.

During her appointment, the potential link between domestic abuse and her risk of suicide was never understood. This has been identified as key learning by the AWP, which has commenced work to develop a wider professional understanding of this issue. The risk of seeing young children as a protective factor in parental suicide was also identified as key learning by the AWP and further work has been commissioned to address this. These learning themes are also applicable to other agencies and are explored in more detail within this report.

Identified Learning

- *The need for a greater exploration of domestic abuse and the consistent completion of DASH risk assessments, alongside improved partnership working with domestic abuse services.*
- *Understanding the links between domestic abuse and suicide.*
- *How infants are seen as protective factors in parental suicide.*

3.3. Bristol City Council Children's Services

Children's services had their first contact with Charlotte during her pregnancy in February 2021, following the receipt of safeguarding referrals outlining the risks to her unborn child from domestic abuse. As Charlotte was no longer in a relationship with Darren, and was receiving support from other professionals, it was assessed that it did not meet the threshold for social care involvement. The family nurse was advised to submit a further referral if the relationship recommenced. In April 2021, a further safeguarding referral was received from Elim Housing after Charlotte had moved into her new accommodation. As this repeated the information reviewed in the February, no further action was taken.

In early July 2021, after their baby had been born, Charlotte was subjected to a lengthy and serious assault by Darren and received a number of injuries. The family nurse submitted a safeguarding referral that was quickly responded to by children's services. A social worker was appointed to commence an assessment and it was identified that Charlotte had been unable to permanently end her relationship with Darren and that this created a risk to their child. A multi-agency strategy discussion was subsequently held on the 26th July 2021, to share information and to agree if the threshold for further child protection enquiries had been met. Whilst the strategy meeting should have included each of the relevant agencies working with Charlotte and Darren, the only agencies invited were the police and a representative from the health service. This denied the opportunity for key professionals to be involved in the information sharing and planning process. For example, the family nurse, housing support worker, mental health services, and the probation service were not invited to the meeting. Whilst this meeting made sensible decisions in relation to Charlotte's child, it did not consider the need for specialist support in relation to her mental wellbeing.

The strategy meeting concluded that the child protection threshold had been met and following an initial child protection conference, Charlotte and Darren's child was placed on a child protection plan to manage the risk from domestic violence. Regular multi-agency planning meetings (core groups) were convened to manage the child protection plan, however a number of key agencies were omitted from this group.

During the period that the child protection plan was in existence, Charlotte continued to have contact with Darren and suffered further domestic abuse. This led to an escalation in the child protection response and in December 2021 it was agreed that child protection legal proceedings were necessary to protect the child. Darren died before these proceedings commenced and at a subsequent review child protection conference, a decision was taken to close the child protection plan as the risk from domestic abuse had concluded. At this time, it was known that Charlotte was being blamed by Darren's family for his death and was receiving harassment from the family. The children's services case was closed on the 9th February 2022.

During March 2022, the increasing concerns for Charlotte's mental wellbeing led to a further referral being made to children's services. This was assessed as not meeting the threshold for any further social care action, and the offer of early help services was not deemed necessary as Charlotte was receiving support from other partnership agencies.

As part of the services provided to Charlotte and her child, children's services assigned her a domestic abuse support worker. Whilst this may have supported Charlotte, it created confusion within other agencies. This support worker role was confused with the IDVA service supplied by Next Link and as described earlier in this report this confusion affected the submission of MARAC referrals.

The child protection processes had an important role in Charlotte's case and have been closely examined in this DHR. This has enabled key learning themes to be identified, which are explored further in this report.

Identified Learning

- *The need to include relevant agencies within child protection multi-agency meetings, including strategy discussions and core groups.*
- *The need to consider specialist support for parents where domestic abuse is a key issue in the child's case.*
- *Understanding the links between domestic abuse and the risk of suicide.*
- *The value of providing a lead early help coordination role in complex cases.*

3.4. General Practitioners

Within the date parameters of the DHR, Charlotte was supported by two GP practices. The first practice with whom she was registered at the time of her child's birth and the second practice with whom she registered in January 2022, following her move to a new housing location.

Charlotte visited her first GP practice regularly, with the frequency of appointments increasing after becoming pregnant. The first domestic abuse concerns arose in February 2021 and the first concerns about her mental wellbeing were recorded in July 2021, following a report from the family nurse. This was immediately responded to and led to the submission of the referrals to VitaMinds and the AWP Perinatal Mental Health Service. Whilst it was identified that Charlotte was having thoughts of suicide, her child was recorded as a protective factor helping to prevent her from self-harm. Disclosures of domestic abuse were explored in detail and ongoing support was provided to Charlotte, that included good information sharing with the family nurse. Charlotte was provided with information about organisations that could support her mental wellbeing, including the Bluebell support service and Mothers for Mothers – a group who share their experiences to help improve the wellbeing of others. The practice continued to support Charlotte until she moved to her new GP practice.

Upon registration with the second GP practice, good information sharing occurred with the family nurse who provided Charlotte's history of domestic abuse and how Darren's death had impacted upon her mental health. Charlotte was offered an initial appointment for these concerns to be explored. Further concerns for Charlotte's mental wellbeing emerged in March 2022, when it was noted that she was suffering from a depressed mood and suicide ideation following the death of Darren. The notes record that her child was a protective factor in preventing her from acting on her suicidal thoughts and that she was receiving support from specialist mental health services.

As identified earlier in this report, the premise of a child being seen as a protective factor in parental suicide is a DHR learning theme that is explored fully in this report.

Identified Learning

- *Understanding the links between domestic abuse and suicide.*
- *How infants are seen as protective factors in parental suicide.*

3.5. Housing Services

(Bristol City Council Housing and Landlord Services/ Elim Housing / Places for People)

BCC Housing and Landlord Services received three requests to support Charlotte with housing and worked with the housing providers to facilitate a suitable provision. This included Charlotte's move into the supported accommodation provided by Elim Housing in March 2021 and her subsequent move into supported accommodation provided by Places for People in December 2021. BCC housing services responded quickly to these requests and engaged fully with partnership agencies, including Next Link, to ensure that Charlotte's needs were understood and a suitable provision found. During their work with Charlotte, staff showed a very good understanding of domestic abuse and the need to respond sensitively to housing requests. The housing representatives on the review panel felt that the commissioning of the final placement with Places for People could have been conducted more efficiently and have addressed this as local learning. Nonetheless housing was provided in a relatively short space of time and as this did not impact upon Charlotte's suicide then it is not dealt with any further in this DHR.

Elim Housing provided Charlotte with supported accommodation that specialised in providing services to young mothers in the early years of their child's life. Charlotte was assigned a support worker who

completed an initial risk assessment and worked with Charlotte in the development of a support plan. The risk of domestic abuse from Darren was immediately identified and he was banned from attending the premises, a condition that Charlotte agreed to. Despite this Darren continued to attend the accommodation and committed domestic violence offences on the premises. When this occurred, safeguarding procedures were followed and a total of four referrals were made to children's services. Incidents of Darren attending the premises were reported to the police, however the ban on his attendance had no legal basis that allowed the police to enforce it. This housing provision eventually broke down in November 2021, as it was no longer safe for Charlotte to remain there following the serious assault committed by Darren.

The risk to Charlotte was regularly assessed by her support worker and areas of good practice included information sharing in response to the domestic violence and the consistent submission of child safeguarding referrals. Areas of learning included the lack of DASH risk assessment completion and missed opportunities to make MARAC referrals. These areas of learning were common for a number of agencies and are explored further in this report. A further area of learning for housing providers was how civil orders may be used to prevent preparators of domestic abuse attending a housing provision and this is also explored later in this report.

Places for People provided Charlotte with accommodation that specialised in supporting young families. A support worker was appointed to support Charlotte with her identified needs and provided a high level of support, including help with employment and educational aspirations. At the time of her death, Charlotte was still being supported and appeared to be coping well. Areas of good practice included excellent information sharing with other services.

Charlotte's move to the Places for People housing provision, involved a move from one area of Bristol to another, which did cause Charlotte's mother considerable concern. She had identified that her daughter needed to be close to family and friends for emotional support and was concerned about her becoming isolated in an area where this support did not exist. As a result, she spoke with both housing services and children's services to try and identify a provision in a more suitable area but was told that an alternative provision did not exist. During her meeting with the DHR chair, Charlotte's mother explained that after Charlotte's move, she became more isolated and would spend the majority of her time alone in her room. She believes that this affected her emotional wellbeing and contributed to her suicide. The key learning as to how Charlotte was understood by agencies and how they were able to meet her emotional needs is explored later in this report. As outlined earlier in this section of the report, the identification of housing placements has been addressed by the housing providers as local learning and does not specifically need a DHR recommendation.

Identified Learning (Combined for All Providers)

- *The need to complete DASH risk assessments with a greater exploration of domestic abuse, including the consideration of referrals to domestic abuse services and the Bristol MARAC.*
- *Understanding the links between domestic abuse and suicide.*

3.6. Next Link

Next Link provides the domestic abuse service in Bristol, which includes the provision of independent domestic violence advisors (IDVA) to work with people at risk of domestic abuse. Next Link worked with Charlotte for a short time between February 2021 and April 2021, following a referral made by the family nurse. The support came to an end in early April 2021, when Charlotte explained that she did not need any further support, as she was already being supported by her housing support worker and the family nurse.

During the short time that Next Link worked with Charlotte, she disclosed that she had been the victim of assaults and threats from Darren. She was provided with emotional support in relation to this but declined the offer of further support. Whilst non-molestation and civil orders were discussed with Charlotte, she did not wish to purse any legal remedy.

In December 2021, Next Link received a referral from children's services for Charlotte to be considered for the Freedom Programme, a national domestic violence programme for victims of domestic abuse that is provided in Bristol by Next Link. Charlotte declined this support as she was being supported by a domestic abuse worker from children's services. Following this contact they had no further involvement in Charlotte's case.

3.7. North Bristol NHS Trust (NBT)

The North Bristol NHS Trust provided community midwifery services to Charlotte from November 2020 until the summer of 2021. During the first appointment in November 2020, a risk assessment was completed that included an exploration of Charlotte's home circumstances. She explained that she was in an 'on and off' relationship with Darren and whilst they argued when he was drunk there was no domestic violence in the relationship.

The first disclosures of domestic abuse arose in February 2021, after Darren had made threats to harm her and her family. This was explored by the midwife, who identified that Charlotte was the victim of emotional, financial, and physical abuse that included strangulation. Charlotte said that she had reported this to the police and recognising the risk of further domestic violence, the midwife submitted a safeguarding referral to children's services. The midwifery service was subsequently informed that children's services had not opened a case, as Charlotte was receiving support from other services.

During the following months, Charlotte had a number of midwifery appointments, however the records do not show any evidence that domestic abuse was screened for during these appointments and there is no comment as to who, if anyone, attended the appointments with her. During May 2021, further disclosures of domestic abuse were received as Charlotte reported that she was being harassed by Darren and that he had assaulted one of her family members. The risk of domestic abuse was recorded on her records and information was shared with the family nurse. Following the birth of Charlotte and Darren's child, Charlotte was discharged from the midwifery service.

Whilst analysing the service provided to Charlotte, the community midwifery service identified that there could have been a greater exploration of the domestic abuse and a greater liaison with partnership agencies, including early help services and the Next Link domestic abuse service. To deliver future improvements a new named midwife has been appointed to provide supervision and advice in complex cases, and to promote the involvement of early hep services. In addition, a new domestic abuse steering group has been developed to improve partnership working with the Next Link service and to provide a better response to domestic abuse.

Identified Learning

- *Exploring domestic abuse.*
- *Partnership working with early help and domestic abuse services.*

3.8. Probation Service

The probation service first commenced work with Darren in early 2020, after he had been sentenced to a community order following a conviction for theft. At this time the probation service consisted of two organisations, the National Probation Service and a privatised service called Community

Rehabilitation Companies (CRC). It was the CRC that provided the initial service to Darren, although in 2021 the two organisations once again became a single national service.

During the period of Darren's community order, he was arrested and charged with an assault upon his previous partner in the July of 2020, that led to a MARAC meeting and which the probation service attended. Despite initial domestic abuse preventative work being completed by the CRC, Darren went on to commit further domestic abuse offences and he was identified as posing a risk to any new partner. His risk management plan included the need to consider a new MARAC referral should his risk of domestic abuse offending increase.

In July 2021, Darren was convicted of the assault upon his ex-partner and in the September was sentenced to a community order, supervised by the national probation service, which included a requirement to complete the 'Building Better Relationships' education programme for perpetrators of domestic violence. Whilst Darren attended his first probation appointment in early October, his subsequent attendance was not consistent and a detailed assessment was not completed with him until the 11th November 2021. His risk assessment was later updated to identify that he posed a high risk to any current or new partner and any child in the relationship, however a MARAC referral was not considered necessary. Darren was provided with a date to start the Building Back Better programme in December 2021, that would have involved Charlotte being provided with a domestic abuse safety officer. Darren died before commencing his programme.

Whilst the probation service was known to be supervising Darren, they were not invited to the child protection strategy discussions, the child protection conferences, or the core groups. As a result, they were not fully aware of the multi-agency information that existed about Darren's risk to Charlotte or their child and whilst they should have been a key part of the multi-agency planning, they were not included.

Identified Learning

- *The need to include agencies working with the perpetrators of abuse within child protection meetings, for information sharing and multi-agency planning.*
- *The need to consider MARAC referrals, where a number of agencies are involved in a high-risk case of domestic abuse.*

3.9. Sirona Care & Health – Family Nurse Partnership

The Sirona Care and Health organisation provides the family nurse partnership in Bristol, a public health programme that supports first time mothers under the age of twenty-one during their pregnancy and their child's early life. It provided services to Charlotte from February 2021 up until the point of her death. The DHR panel recognised the excellent service delivered by the family nurse, who provided extensive support to Charlotte and comprehensively engaged with partnership agencies to ensure that she received the necessary support.

During their initial meeting, the family nurse identified and explored the issues of domestic abuse, assessing the risk that Darren posed to Charlotte and their child. A number of referrals to other agencies were made in relation to this risk, including children's services, Next Link, and other agencies that support young vulnerable parents. A wide number of agencies were engaged to support Charlotte in her other needs, including housing services, midwifery, GP, and the mental health services provided by VitaMinds. Throughout the period of supporting Charlotte, this multi-agency engagement continued and was seen as excellent practice by the DHR panel.

The family nurse met with Charlotte regularly and received a number of disclosures about domestic violence. This reflected the trust that Charlotte had in their professional relationship and each of the

disclosures was responded to, with repeated referrals and information sharing with partnership agencies. It was not however until July 2021 that a DASH risk assessment was completed by the family nurse, which followed a direction provided in a supervision session. Whilst it was best practice guidance to complete DASH assessments following disclosures of abuse, at that time they were not commonly completed by the health professionals. As the number and severity of violent incidents increased, it would have been appropriate to consider a MARAC referral, however this was not considered, most likely as it was believed that an IDVA from Next Link was already supporting Charlotte. In November 2021, records show that the family nurse spoke with an IDVA following an incident disclosed by Charlotte, however this was not a Next Link IDVA, but the domestic abuse support worker from children's services.

Following the assault upon Charlotte in July 2021, a strategy discussion meeting was convened by children's services, however the family nurse partnership was not invited despite the close working relationship that had been developed by the family nurse. This lack of information sharing prevented the family nurse from knowing the full extent of Darren's violent offending history, which would have impacted the ability to properly assess the risk he posed to Charlotte and their child. They were not informed of the information known to the police, or the information held by the probation service. Whilst this did not create any specific issues in this case, it created a risk that should be avoided in the future. The family nurse was involved in the subsequent child protection conference and the child protection plan core groups.

Following Darren's death in December 2021, the family nurse identified the potential for repercussions from his family and the risk to Charlotte's mental wellbeing. Emotional support was provided and a mental health assessment was conducted and regularly reviewed. On the 15th March 2021, the family nurse had the last meeting with Charlotte prior to her death. She confirmed that she had met with her GP and was ready to engage with the VitaMinds support. Charlotte was described as having positive interactions with her child and did not disclose any thoughts of self-harm.

Whilst analysing the service provided to Charlotte, the family nurse partnership identified the inconsistent use of DASH risk assessments as a learning theme. As a result, a training programme has been delivered in relation to domestic abuse and the completion of DASH assessments.

Identified Learning

- *The completion of DASH risk assessments.*
- *The consideration of MARAC referrals.*
- *Information sharing within child protection strategy discussions.*

3.10. VitaMinds

The VitaMinds organisation works in partnership with the NHS to provide talking therapies for people suffering from low moods, a service that accepts referrals from other professionals and self-referrals from those in need. In total the service received three referrals in relation to Charlotte.

The first contact was in May 2021, following a self-referral made by Charlotte that did not include any detail. She was sent an invitation to book an assessment but did not respond and was discharged from the service.

The second referral was received from the family nurse in July 2021, which outlined that Charlotte was suffering from a low mood with suicidal thoughts, but with no intent to act upon them. During the subsequent appointment Charlotte explained that her primary concern was her relationship with Darren, which including a history of serious domestic violence. She explained that whilst she had

reported incidents to the police this had not resulted in any positive outcomes and the violence had continued. Whilst issues of domestic abuse were explored during the appointment, a DASH risk assessment was not completed and despite the violence continuing a MARAC referral was not considered. Whilst discussing the thoughts of suicide, Charlotte explained that she did not have any intention to act upon them and that her child was a protective factor preventing her from any self-harm. After this initial appointment, Charlotte did not respond to offers of further support and she was later discharged from the service. At the point of discharge, she was sent a letter signposting her to the Next Link domestic abuse services and information was shared with the Families in Focus Early Help Service and her GP.

The third contact with Charlotte followed a self-referral in March 2022, outlining that she was having suicidal thoughts and that it was possible that she could act upon them. Whilst it was identified that Charlotte had written a suicide letter to her child, it was again recorded that her child was a protective factor that would prevent her from acting upon her thoughts. Issues of domestic abuse were explored during the appointment; however, a DASH risk assessment was not completed which would have allowed the issues to have been explored in greater depth. Charlotte was provided with information about the Bluebell support service and a referral was submitted to children's services. A referral was also submitted to the AWP specialist perinatal mental health service. A further appointment was made with Charlotte for the 21st March 2022, however she died prior to the appointment.

Whilst analysing the latter contact with Charlotte, the DHR panel representative identified that the suicide risk assessment lacked depth and when Charlotte declined to destroy her suicide note this should have resulted in a further and more in-depth assessment of risk. A theme throughout this DHR has been professionals not understanding the links between domestic abuse and suicide, particularly how Darren's death affected Charlotte. This multi-agency learning theme is explored later in this report.

Identified Learning

- *The need to complete DASH risk assessments with a greater exploration of domestic abuse, including the consideration of referrals to domestic abuse services and the Bristol MARAC.*
- *Understanding the links between domestic abuse and suicide.*
- *How infants are seen as protective factors in parental suicide.*

4. CRITICAL ANALYSIS AND LEARNING

This section of the report outlines the five key learning themes that were identified by the DHR. In addition, the review panel identified a number of single agency improvements actions for their individual organisations and these are summarised within Appendix B.

4.1 Review of the Terms of Reference

The terms of reference provided the DHR with key lines of enquiry, each of which was fully explored during the review. Five key learning themes were identified, set out below and detailed within the following sections of this report.

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.

There were two key questions within the terms of reference that did not identify any key learning and these are outlined as follows.

The role of schools in identifying domestic abuse and supporting young people, including how referrals to other agencies and the MARAC are considered.

During the review period, and during the time that domestic abuse was reported to have occurred in their relationship, neither Charlotte nor Darren attended an educational setting that may have received reports of abuse. School records have been examined and these did not reveal any reports of abuse made prior to the review period. Despite this, the DHR did consider how information about domestic abuse is shared with schools in Bristol and it was reassured that formal information sharing arrangements are in place, providing the structures for an effective safeguarding response and participation within multi-agency arrangements.

The role of fathers with newborn babies and how Darren was seen and acknowledged by services.

Previous child safeguarding cases, across the country, emphasise how 'hidden' father figures, those unknown to and not engaged by services, pose a risk to children and the issue was considered within this review's terms of reference. The DHR identified good practice in how the family nurse partnership and the midwifery service proactively engaged with Darren to understand the male figures within the child's life and to manage the risk that he may have posed. Both services shared information appropriately and were involved in the child protection arrangements.

4.2 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.

What's Needed To Deliver Future Improvement

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[7], 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.

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

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.*

4.3. 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 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.

What's Needed To Deliver Future Improvement

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.

4.4. 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[8]. 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. Key triggers for Darren's violence were the use of alcohol and controlled drugs, which provided an intervention opportunity. 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.

[8] 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.

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.*

4.5. 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.*

4.6. 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[9] 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[10] 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 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[11]. 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[12] 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[13] 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

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

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

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

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

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

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.

What's Needed To Deliver Future Improvement

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:

- 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.*

5. CONCLUSION AND SUMMARY OF RECOMMENDATIONS

5.1. Concluding Comments

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

In addition to the multi-agency recommendations, many of the participating agencies have developed their own action plans in relation to single agency (SA) improvements which can be found in Appendix B. In addition to addressing the multi-agency recommendations, the safeguarding partnership should hold individual agencies to account for delivering these single agency recommendations.

5.2. 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.

5.3. 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 – 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 B – LIVE DHR ACTION PLAN

Recommendation	Scope of recommendation Local/ Regional/ National	Action to take *What specific actions will be taken to fulfil this recommendation? Ensure the actions are SMART: Specific, Measurable, Achievable, Realistic, and Timely*	Lead Agency	Key milestones achieved in enacting recommendation *What are the key milestones within the plan for completing these actions which can be measured for progress reporting?*	Target Date *When will these actions be completed?*	Date of completion and Outcome *To be completed upon completion of actions.*
<u>Recommendation 1</u> 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.	Local	1.1. Ongoing DASH compliance monitoring. 1.2. A&S Police are looking to implement the DARA (in line with national implementation). DASH will remain in use as a specialist assessment until this time, but policy will be updated once DARA is introduced. a) Policy and training needs will be reviewed at the	1.1. Avon and Somerset Police 1.2. Avon and Somerset Police	DARA implementation in place supported by new guidance, policy and training.	Sept 2024 (subject to national guidance)	**Outcome: Organisational DASH risk assessment policies are reviewed to ensure holistic approaches are taken to assess risk.** 1.1. In progress. DASH continues to be the risk assessment tool used by the police for domestic abuse. DARA implementation is delayed due to the need to develop a compatible IT solution. The transition from DASH to DARA is being mapped out alongside ongoing domestic abuse assurance work under the Programme 2 change project.

		time DARA is implemented.				1.2. In progress. As above.
		1.3. AWP will review internal domestic abuse procedure to ensure that it is clear regarding staff expectation around assessment of risk and establishing context to the reports of abuse.	1.3. Avon and Wiltshire Mental Health Partnership	Review and approval of procedure by Safeguarding Management Group and Internal Governance if alterations are required.	December 2024	1.3. Not started.
		1.4. Sections pertaining to the completion of DASH assessments in the NBT "Domestic Abuse Act" 2022 policy to be reviewed and any changes signed off at the NBT safeguarding committee.	1.4. North Bristol NHS Trust	Policy reviewed with comments. Amendments to current policy will be signed off at committee. Next Link hospital IDSVA policies to be requested.	December 2023	1.4. Complete. The policy has been reviewed and is sufficient in encouraging staff to ask the appropriate questions and to signpost appropriate.
		1.5. Sections pertaining to the completion of DASH assessments	1.5. North Bristol NHS Trust		August 2024	1.5. Complete. The guideline was reviewed and re-ratified on 6/8/24.

		in the local guidance "Recognising and responding to domestic abuse in the Women's and Children's division" to be reviewed and ratified at the divisional guideline committee. 1.6. We will review our policies that refer to the use of a DASH RIC as part of our annual review process. 1.7. DASH RIC training is delivered as part of the induction process for Next Link Staff. 1.8. Annual DASH RIC training is delivered to all staff.	1.6. Next Link 1.7. Next Link 1.8. Next Link	Policy reviewed. Annual Training delivered.	December 2024 Ongoing. Completed annually.	1.6. Complete. Next Link continue to review the use of DASH's Risk Assessments annually in line with best practice for the sector. All team members are trained to complete a DASH RIC with a holistic and person-centred approach. 1.7. Complete. Training on DASH continues to be delivered as part of the induction process for all Next Link staff.

		1.9. Review safeguarding policy. 1.10. Send reminder to team about relevant policy. 1.11. Review safeguarding mandatory training and include section to walk through DASH and its application. 1.12. Review of relevant internal policies related to domestic abuse including the inclusion of the DASH Risk assessment	1.9. NHS Talking Therapies/ VHG 1.10. NHS Talking Therapies/ VHG 1.11. NHS Talking Therapies/ VHG 1.12. Bristol City Council – Children's and Families Services	Safeguarding policy has been reviewed and DASH & MARAC is explained. Comms to team Safeguarding Level 3 Training package to be reviewed and amended to explicitly discuss DASH and its application. Children's Procedure's Manual is reviewed by the Reducing Domestic Abuse team and relevant updates made to ensure up to date DASH guidance is included	September 2023 September 2023 May 2024 March 2024	1.8. Complete. As above. 1.9. Complete. 1.10. Complete. A reminder was sent to the whole service on 25/09/2023. In addition, internal mandatory risk training, attended every 18 months by all clinicians, was refined to ensure a clearer emphasis on the routine use of DASH. 1.11. Complete. Safeguarding mandatory training has been reviewed. Updates to Level 2 Safeguarding Adults is due to go live imminently to include the required amendments. 1.12. Complete. Bristol have reviewed our approach to assessment and embedded Systemic Social Work practice with a comprehensive training

						schedule. Systemic practice supports the development of skills in holistic assessment of risk and needs and is the practice model Bristol is committed to across all our services.
<u>Recommendation 2</u> 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.	Local	2.1. KBSP to explore with partners and the police appropriate guidance on third party reporting (sharing best practice examples and policies). 2.2. Necessary changes to policy and training to be included within the KBSP Domestic Abuse and Safeguarding Training package.	Keeping Bristol Safe Partnership	Guidance on 3rd party reporting shared. Policy and training updated	December 2024	**Outcome: Organisational advice on third party reporting is reviewed with up-to-date guidance shared.** 2.1. Complete. Best practice guidance was explored with partners on third party reporting. 2.2. Complete. KBSP Training officer has added information on third party reporting to the domestic abuse training offer, e.g. procedures on how to report on behalf on someone else.
<u>Recommendation 3</u> The Bristol MARAC should review the current published arrangements and referral criteria, ensuring that the arrangements are clear	Local	3.1. Membership of MARAC steering group to be re-reviewed and TOR to be refreshed. 3.2. MARAC Steering Group to review	MARAC Steering Group	3.1. MARAC steering group re-established.	December 2024	**Outcome: MARAC arrangements and referral criteria are clear to all agencies and effectively manage risk.**

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.		current arrangements and referral criteria. 3.3. MARAC Steering Group to ensure changes to guidance are widely communicated across both statutory and voluntary sectors. 3.4. MARAC Steering Group to ensure that organisations supporting the MARAC have updated their own organisational policies and are applying the policy consistently.		3.2 Revised and updated MARAC referral policy. 3.3. New guidance will be widely circulated and communicated to all agencies. 3.4. All agencies will have updated their organisational policies with the new MARAC referral guidance.		3.1. In progress. Steering group has been re-established and is meeting quarterly with a revised membership. The TOR is currently in development. 3.2. In progress. Additional administrative support has been provided to the MARAC to give the coordinator capacity to review and revise MARAC referral procedures in consultation with referring agencies. Discussion was had on 28/05 at Bristol MARAC steering group and it was agreed that a Task & Finish Group will be put into place to review the current arrangements. 3.3. Not started. When any changes are made, this will be communicated out via our normal distribution list of agencies who contribute to MARAC and will be updated on the KBSP website. 3.4. Not started. As above.

<u>Recommendation 4</u> 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.	Local	4.1. Avon and Somerset Police to submit detail of PCC plan to manage serial perpetrators, including multiple perpetrators of domestic abuse to the KBSP. 4.2. Avon and Somerset Police to share the evaluation of the DRIVE project with the KBSP.	Avon and Somerset Police	Locate performance report. Share PCC plan to manage serial perpetrators with the KBSP. Establish link with DRIVE project manager and obtain updates of implementation/ evaluation. Present evaluation of the DRIVE project to the KBSP Multi-agency Domestic abuse and Sexual Violence Delivery Group.	October 2023 October 2024	**Outcome: Serial perpetrators are effectively managed.** 4.1. Complete. This recommendation has been addressed in the OPCC plan for 2021-2025. This document can be found here: AS-Police-Crime-Plan-2021-2025-HR-Spreads.pdf (avonandsomerset-pcc.gov.uk), the relevant sections of which are p21 which discusses one of the Force's priorities ('male violence against women and girls, specifically domestic abuse, sexual offences, and stalking & harassment'), and p33 which discusses the strategy to reduce reoffending. The link to the OPCC homepage can be found here: Official website of the OPCC for Avon and Somerset (avonandsomerset-pcc.gov.uk). It is worth noting that the Police and Crime Commissioner has recently changed (now Clare Moody),

						and the above plan may be subject to change. 4.2. In progress. The DRIVE programme has now been rolled out to cover Bristol, North Somerset and South Glos. There was recent funding provided by the PCC, and all involved local councils to cover this cost. The local councils have commissioned a review of the scheme with an eye to future funding. This review is being headed by a Professor at the University of Nottingham.
<u>Recommendation 5</u> 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.	Local	5.1. Membership of MARAC steering group to be re-reviewed and TOR to be refreshed. 5.2. DRIVE representation to be present at all MARAC meetings to identify serial perpetrators who could be taken for consideration to a Domestic Abuse Perpetrator Panel.	MARAC Steering Group	Presentation to the Multi-agency Domestic Abuse and Sexual Violence Delivery Group on what's covered in the MARAC training programme and data on the number of chairs trained.	December 2024	**Outcome:** **MARAC Chairs understand measures for the management of serial perpetrators and work closely with police and DRIVE colleagues to ensure they are implemented.** 5.1. In progress. Steering group has been re-established and is meeting quarterly with a revised membership. The TOR is currently in development.

		5.3. MARAC Steering Group to provide assurance to the KBSP that all MARAC Chairs are trained in the management of serial perpetrators.				5.2. Complete. DRIVE staff now attend all MARAC meetings. 5.3. In progress. DRIVE attend every MARAC meeting and consider each case. An update is then given to the MARAC regarding their decision and rationale for each case.
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.	Local	6.1: Bristol City Council to provide data on attendance at multi-agency strategy meetings from statutory partners at the KBSP Children's Group	BCC Children and Families/KBSP	Data will be presented annually to the Children's Group and benchmarked against previous years. Low rates of attendance are addressed and reviewed if issues identified.	March 2024	**Outcome:** **There is a record of attendance from all relevant partners at multi-agency strategy meetings.** 6.1. Complete. A report was taken to the Children's group in July 2024 and this agreed the quarterly reporting of attendance data going forward.
Recommendation 7 When cases involve domestic abuse, the domestic abuse services should be included within strategy discussions and consideration always given to being included in core groups, regardless as to	Local	7.1: Bristol City Council Public Health Services and Next Link/Reprovide/DRIVE to review the capacity of the service to attend every strategy meeting where domestic abuse is a	Public Health/Children Social Care/Next Link	Bristol City Council Public Health Services and Next Link/Reprovide/DRIVE to review the capacity of the service to attend every strategy meeting where domestic abuse is a concern and	December 2024	**Outcome:** **Statutory decision making is informed by expertise from domestic abuse and perpetrator intervention services.** 7.1. In progress. This is still under review with providers.

the status of victim engagement. Perpetrator intervention services should be included in cases where they are working with the perpetrator.		concern and determine feasibility of this within the commissioning arrangements. 7.2: Where possible, services to work together to implement this and if not agree how domestic abuse informed practice could inform statutory agencies decision making. 7.3: Strategy protocol to be updated and rolled out		determine feasibility of this within the commissioning arrangement. If sufficient capacity, Information Sharing Agreements to be put in place between key organisations.		7.2. In progress. Discussion have begun to take place about how the commissioned providers can work more closely with Children's Social Care. 7.3. In progress. This is still under review with providers.
<u>Recommendation 8</u> 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	Local	8.1: Reducing Domestic Abuse team to offer training to all Child Protection Conference Chairs and Consultant Social Workers in Domestic Abuse Informed Practice within Child Protection	Reducing DA Team – Bristol City Council	Training to be designed. Training to be rolled out in every team.	February 2024 April 2024	**Outcome: Chairs of Child Protection conferences have been trained to understand the importance of considering the needs of the victim and perpetrators of domestic abuse within child safeguarding plans.** 8.1. Complete. The Reducing Domestic Abuse Team offered training in all Area Offices and met with all the

of considering victim and perpetrator needs in relevant child safeguarding plans.						Child Protection Chairs across the course of the project (which came to an end at the start of May 2024). They provided training, support and guidance to increase Domestic Abuse informed practice in every area. In addition, each area has a trained Consultant Social Worker who has completed the 5-day training in Safe and Together to provide ongoing support and development to colleagues
<u>Recommendation 9</u> 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.	Local	9.1: KBSP Training and Development Officer to update Multi-agency Domestic Abuse and Safeguarding training to include learning from this DHR, specifically highlighting the link between domestic abuse and suicide. 9.2: AWP to deliver a webinar to present to the KBSP on their audit findings on suicide risks and	KBSP – Training and Development Officer AWP	Update multi-agency KBSP Domestic abuse and Safeguarding Training. Webinar presented to KBSP. Webinar uploaded to KBSP Website.	June 2024 November 2024	**Outcome: KBSP Workforce to have access to training packages on domestic abuse and suicide.** 9.1. Complete. The KBSP training officer has added resources to the domestic violence training offer. The training offer covers the link between domestic abuse and suicide. 9.2. Not started. Partnership to discuss with AWP suicide prevention lead

		domestic abuse and upload to the KBSP website				on whether this training is still available.
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.	National	10.1: ICB to share the learning from this DHR across the BNSSG footprint to raise awareness of the risks to any individuals regardless of background or family dynamics presenting with domestic abuse and suicidal ideation. 10.2: NSPCC link will be shared across Primary Care network. 10.3: KBSP to write a letter to the DA Commissioner, CSPR National Panel and the NHS Safeguarding Adults National Network highlighting the key learning for health partners from	Bristol, North Somerset and South Gloucestershire Integrated Care Board KBSP	Learning to be shared across BNSSG footprint. Learning to be raised nationally for consideration.	June 2024	**Outcome: Awareness has been raised locally and nationally about the risks of seeing babies and young children as protective factors in potential parental suicide.** 10.1. Complete. Domestic abuse and suicide are already a key learning theme in the ICB training offer delivered to Primary Care. NextLink and MARAC contact details are shared with Primary Care in the ICB Newsletter. There is a domestic abuse themed Question & Answer session booked for Primary Care on 4th September. The link to this publication will be shared across the network in the newsletter once published. 10.2. Complete. May 2024: The ICB newsletter included

		this review to influence the Department of Health.				the NSPCC links that is shared across the network. 10.3. In progress. The KBSP are writing to the BNSSG Integrated Care Board to highlight key learning for health from this review.
SA. 1 To explore and develop staff understanding of Domestic abuse and the links to suicide, which will include the development of a training package.	Local	1.1: AWP Domestic Abuse Lead and the Trust's suicide prevention lead to look at identifying patterns in suicides where domestic abuse is identified as having been present prior to the death. 1.2: AWP Domestic Abuse Lead to work with the Trust's suicide prevention lead to develop a training package to deliver Trust wide to raise awareness of suicide risk and domestic abuse. 1.3: AWP Domestic Abuse Lead and	Avon and Wiltshire Mental Health Partnership	Development of a risk profile for domestic abuse and suicide to support understanding of the subject. Audit of suicides where domestic abuse features to identify themes and trends. Package available to sharing with agencies and internally with staff to raise awareness of the risk factors.	September 2023 May 2023	**Outcome: Domestic abuse and suicide training offer accessible to all AWP staff.** SA.1.1. Complete. Contact has been made by domestic abuse lead with national research leads on the topic area to discuss their findings. An audit has been completed of all cases of suicide in the past 2 years within the organisation. Those where domestic abuse was a factor have been reviewed in detail and themes have been pulled to develop understanding of risk factors and the accumulation of these, which may indicate red flags for suicide. SA.1.2. Complete. A roll out of a 1-hour training package to share the learning of the

		Suicide Prevention Lead to offer provision of bitesize domestic abuse and suicide training to partner agencies				domestic abuse and suicide audit in combination with national research into the topics has been offered Trust wide and has trained over 180 members of staff. SA.1.3. Complete. The development of the domestic abuse and suicide audit and findings were presented at Avon and Somerset Domestic Abuse Partnership meeting on 25th July 2023. An offer was extended to deliver this to partner agencies. Since this, a session has been provided to DRIVE on 12/09/2023.
SA.2 To explore and develop staff understanding of why children should not be seen as a protective factor in risk of parental suicide. Including the development of a training package.	Local	2.1: AWP to raise the issue of relying on children as a protective factor for suicide within the domestic abuse and suicide training.	Avon and Wiltshire Mental Health Partnership	Presence of a section regarding children as protective factors for suicide in the bite size learning.	Sept 2023	**Outcome: AWP staff trained on the risks of children being considered as a protective factor for the potential of parental suicide.** SA.2.1. Complete. This has been raised specifically within the domestic abuse and suicide training which was rolled out to the organisation.

SA.3: Regular safeguarding supervision is now provided to community and specialist midwife teams, which aims to help practitioners recognise and respond appropriately to risk in complex cases (this was not in place at the time of Charlotte's maternity care). Support is provided to ward staff by specialist midwives who, alongside the named midwife for safeguarding, promote principles of professional curiosity, respectful uncertainty and information sharing with all agencies involved in a family's care, when there are additional factors that may be associated with safeguarding risk.	Local	3.1: NBT specialist midwives to provide support to ward staff to promote principles of professional curiosity, respectful uncertainty and information sharing with all agencies involved in a family's care, when there are additional factors that may be associated with safeguarding risk.	North Bristol NHS Trust	Appointment of Named Midwife post.	March 2021	**Outcome: Named Midwife appointed to provide support to ward staff when there are concerns around safeguarding.** SA.3.1. Complete. Named Midwife post was appointed to in March 2021.
SA.4: Dialogue with Next Link and commissioners has led to the funding of a maternity specialist IDSVA who has been recruited to work closely with the	Local	4.1. Funding sourced for specialist Maternity IDSVA's	North Bristol NHS Trust	New Maternity IDSVA's appointed and co-located	September 2023	**Outcome: Maternity IDVA's co-located within Bristol's hospitals to support the maternity units' staff when working with women experiencing domestic abuse**

maternity unit in meeting the needs of women experiencing domestic abuse during their period of maternity care, providing advice and training to staff as well as working directly with pregnant women.						**during pregnancy/maternity care.** SA.4.1. Complete. Appointment of 2 x Maternity IDSVA's who are co-located in the main Maternity units of St Michaels Hospital and Southmead Hospital, providing direct onsite support for those accessing maternity units, short term support from women pre and post birth and a referral pathway into longer term support options as needed.
SA.5: New procedures for high-risk cases will recommend that a multi-agency meeting is considered when the person moves into a new placement.	Local	5.1. Staff already make referrals to MARAC for high-risk cases. The MARAC Coordinator determines what the approach will be going forward e.g. professionals meeting, MARAC meeting etc. 5.2: Existing procedures require Managerial review of all high-risk cases and	Housing Providers: 5.1 Places for People 5.2: Elim Housing	5.1. already in place 5.2. Already in place (Risk Management Procedure)		**Outcome: Procedures reviewed to ensure all high-risk cases are discussed at a multi-agency meeting.** SA.5.1 & 5.2. Complete.

		direct Manager and Officer to consider multi agency meeting as integral part of risk management plan.				
SA.6: To improve the effectiveness and timeliness of providing housing placements, a greater use of the existing family forum will be made to coordinate services provided by the various housing providers.	Local	6.1: Formally agree this ability within Family Forum 6.2: Develop protocol for how this will work 6.3: Review and evaluate at key points from initiation	All Housing Providers: Places for People, Elim Housing	These could be added to the performance data which family providers submit to BCC Commissioners. This would need to be agreed by BCC	1 April 2024	**Outcome: Housing placements to be timely and coordinated.** SA.6.1. 6.2. & 6.3. Complete. This action was closed as all avenues have been explored. The Partnership are satisfied that this will be taken forward if there is such a need again.
SA.7: Training will be provided to all staff to improve the understanding of domestic abuse and in the use of the DASH risk assessment.	Local	7.1: Training to be provided to all staff to improve the understanding of domestic abuse and in the use of the DASH risk assessment.	Sirona Care & Health	Development of a new Domestic Abuse policy.	October 2023	**Outcome: All staff at Sirona Care and Health trained on DASH risk assessments.** SA.7.1. Complete. 24/09/23 Sirona's new domestic abuse policy which was ratified on the 07/03/23 clearly directs Sirona staff to utilise a DASH risk assessment on disclosure or suspected domestic abuse if safe to do so with the Victim. As a responsible employer, Sirona care & health CIC has

						defined duties for managers, supervisors and staff members should they suspect or be the recipient of a domestic abuse/violence disclosure. The document is intended to provide staff with key guidance regarding the recognition and appropriate response to domestic abuse and outline Sirona's responsibilities towards service users and staff. Sirona safeguarding policies are reviewed annually and regular quality assurance audit programmes are in place and are monitored as part of the annual safeguarding workplan via SCARF (Sirona's Safeguarding children and adults at risk forum). Sirona Safeguarding Competency: Recognising and responding to domestic abuse is part of all Specialist Community Public Health Nurses safeguarding induction and preceptorship programme. Sirona care and health utilise a Think Family approach in safeguarding supervision and

						safeguarding training for staff and Domestic abuse is a key priority for exploration in both.
SA.8: Next Link to appoint a specialist young person IDVA and commission new services for people aged 16-25yrs at risk of domestic abuse.	Local	8.1: Next Link to appoint a specialist young person IDVA and commission new services for people aged 16-25yrs at risk of domestic abuse.	Next Link	Appointment of young person IDVA.	October 2022	**Outcome: Specialist young person IDVA appointed.** SA.8.1. Complete. Next Link has developed its services offered to young people at risk of domestic abuse to improve the efficacy of the support provided. This has included the appointment of a specialist young person IDVA, the commissioning of new services for people aged 16-25yrs, and partnership working with the Woman Kind organisation to provide counselling for young people.
SA.9: Procedures will be introduced to ensure that multi-agency meetings take place whilst supporting high risk maternity cases.	Local	9.1. Funding sourced for specialist Maternity IDSVA's	Next Link	New Maternity IDSVA's appointed and co-located	September 2023	**Outcome: Maternity IDSVA appointed, and specialist services developed to support pregnant women who disclose, or at risk of, domestic abuse.**

						SA.9.1. Complete. Next Link has developed its services offered to pregnant women who disclose or at risk of domestic abuse to improve the support provided. This has included the appointment of 2 x Maternity IDSVA's who are co-located in the main Maternity units of St Michaels Hospital and Southmead Hospital, providing direct onsite support for those accessing maternity units, short term support from women pre and post birth and a referral pathway into longer term support options as needed.

Appendix C – Home Office Feedback Letter

Home Office
Interpersonal
Abuse Unit
London
SW1P 4DF
Tel: 020 7035 4848 2 Marsham Street
www.homeoffice.gov.uk

Statutory Review Officer
Keeping Bristol Safe Partnership
KBSP Business Unit (City Hall)
Bristol City Council, PO Box 3399
Bristol
BS1 9NE

23 August 2024

Dear KBSP,

Thank you for submitting the Domestic Homicide Review (DHR) report (Charlotte) for the Keeping Bristol Safe Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 17th July 2024. I apologise for the delay in responding to you.

The QA Panel felt that the report was clear, well-structured and sensitively written. They also noted that there was good analysis which highlighted missed opportunities. The review feels open and despite the limited engagement of family and wider testimonial networks, we get a good sense of the victim and the challenges that she was trying to navigate. The report clearly demonstrates the impact of domestic abuse on suicidality and the links between the two.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

- It is mentioned on page 9 that Charlotte disclosed financial abuse. It would be helpful to explore what this was and the impact it had on her further.

- The equality and diversity section is currently very brief and underdeveloped. Protected characteristics of sex, pregnancy and age were not considered; these are all relevant here and should be further explored.

- It is currently unclear why 'honour'-based abuse was considered – was this in relation to the threats Charlotte experienced from Darren's family after his death?

- It would be helpful to include Charlotte's and Darren's ages and how long they had been in a relationship/known each other.

- The exact date of death of the perpetrator and the sex of their child is disclosed within the report. These should be removed.

- It is not clear from the information provided if Charlotte's family had any involvement in the selection of pseudonyms, which should be clarified.

- The report does not currently recognise that the disclosure of non-fatal strangulation in February 2021 represented an escalation of risk. This should be analysed further.

- In the Terms of Reference there was a question regarding the role of fathers – the report states that there was no learning in respect of this question. It would be helpful to set out how this was considered.

- At page 33, when considering research on suicide and domestic abuse, the work of Sarah Dangar and colleagues would be beneficial to include.

- Many of the recommendations lack robust language, for example 'seek assurances' (recommendation 6), 'should consider' (recommendations 8, 9 and 10) – the panel might re-consider the language here to develop robust recommendations.

- Some of the actions within the action plan are not SMART. For example, outcomes are missing where actions have been completed. The action plan requires improvement prior to publication.

- There was no reference to the Domestic Violence Disclosure Scheme (Clare's Law) in relation to Darren's partners. The Panel noted it would be useful to consider adding further information to this.

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

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

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

Please also send a digital copy to the Domestic Abuse Commissioner at

DHR@domesticabusecommissioner.independent.gov.uk

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

Yours sincerely,

Home Office DHR Quality Assurance Panel

Appendix D – Lead Reviewer and Author response.

MARK POWER SAFEGUARDING LTD

To: Statutory Review Officer
Keeping Bristol Safe Partnership
KBSP Business Unit (City Hall)
Bristol City Council, PO Box 3399
Bristol
BS1 9NE

From: Mark Power

Reference: Domestic Homicide Review – Charlotte

Dear KBSP,

Many thanks for forwarding the Home Office QA Panel's response to the DHR reports. I am grateful for the panel's assistance and have updated the reports to reflect their comments. Please find a summary of the changes made, and where a comment has not resulted in any change the reason for it. Any changes to wording of the reports I have made in red. Please feel free to return this to the normal font for publication. I have also updated the table of contents to reflect any changes to page numbers.

1. Financial Abuse – A request to clarify the context and its effect.

This was a good observation made by the panel. Clarification as to the extent of this abuse has been added on page 15 and the issue is further explored within Finding 1 at Section 4.2 of the overview report at pages 25 and 26. The executive summary has also been changed accordingly at pages 12 and 13. It would be worthwhile considering this small change within the action plan.

2. Equality and Diversity Section – Greater detail and clarification of honour based violence.

The section within the overview report has been re-written to reflect the QA panel's observations. At Section 1.9 on page 7.

3. Charlotte and Darren - Confirmation of ages and length of relationship.

This was already contained within the overview report, however I have now added this within the first paragraph on page 3, to ensure that this is more obvious. Also included within the executive summary at page 3.

4. Date of Darren's Death and the Sex of Child – Should be removed from the report.

Darren's date of death appeared in the main body of the report, whilst the sex of the child was within the terms of reference. Both were errors and have now been removed from the overview report and the executive summary.

5. Use of Pseudonyms – Charlotte's family's knowledge and agreement.

This has been clarified on page 7 (Section 1.10) of the overview report and also included within the executive summary at page 3.

6. Disclosure of Strangulation – No recognition that this represented an escalation of risk.

The detail of strangulation was provided by Charlotte during her first disclosure of abuse. Whilst I agree with the QA panel about the risk that this indicated, the risk actually grew considerably with the further disclosures of violence. The escalation of risk was fully considered during the DHR and within this context I do not consider that any change to the report would add additional value. Therefore, no change.

7. Role of Fathers Included Within the Terms of Reference.

An explanation was included within the report, to say the issue of hidden fathers had been considered and had resulted in the identification of best practice and that this was not therefore a theme for further development. I have added a small comment on page 24 to clarify further.

8. Research Upon Suicide and Domestic Abuse – Request to include Sarah Dangar's work.

This has now been included within Finding 5 at Section 4.6 – page 34. This has also been added to the executive summary at page 21.

9. Recommendations - An opinion that they lack robust language.

Having reviewed the recommendations, I am content that the wording of these clearly outline the further action required and does this in a way that provides agencies flexibility as to how they best achieve it. The key issue is how the action plan addresses the recommendations, and as such I have left the wording of these unchanged.

10. Domestic Violence Disclosure Scheme – Not currently mentioned within the report

A reference has now been included within the overview report at page 29; and within the executive summary at page 16.

There was no reference to the Domestic Violence Disclosure Scheme

Should you require any further detail or clarification, then please let me know.
Yours sincerely,

Mark Power