Bath and North East Somerset Responsible Authority Group

Domestic Homicide Review

Into the death of Teddy (pseudonym)

July 2016

OVERVIEW REPORT

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Section One - Tribute to Teddy from her father on behalf of her family

'In reading this report, please remember, Teddy (my daughter) was just like everyone else. She had her strengths and weaknesses. From an early age, through circumstances out of her control, she was often put in situations where she could not protect herself either physically or mentally from those who she should have been able to trust.

A sparklingly bright, funny, kind and vivacious young Mother; she had recently rediscovered her Christian beliefs, but died before her time because she was a compassionate person, who cared too much for those in her life, even the individuals who caused her harm.

Teddy was essentially a fun and gregarious person with an infectious laugh, who loved the company of likeminded people. She could extract enjoyment from most situations. Her driving force was to create a happy, loving environment in which to raise her child.

I hope those who find themselves in similar circumstances and are in despair, will seek and accept the Support when offered.'

The Domestic Homicide Review Chair and Panel wish to express their sincere sympathies to all who have been affected by the death of Teddy who is remembered as a loving and caring daughter and mother. We thank Teddy's father for writing the moving Tribute to his daughter and the other members of Teddy's family and friends who have contributed to the deliberations of the Review, for their time, patience and co-operation.

Section Two - Introduction

2.1. This report of a domestic homicide review examines agency responses and support given to Teddy (pseudonym), a resident of Bath prior to the point of her death in July 2016.

2.2. In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before Teddy's death, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

2.3. A summary of the circumstances that led to a review being undertaken in this case is:

2.3.1. Teddy lived, on her own, in social housing in Bath. Her child Star (pseudonym) lived, from Sunday to Friday, with Marlon (pseudonym) the child's father and stayed with Teddy on Saturdays only. Raman (pseudonym) claimed he had been in a relationship with Teddy between 2012 and 2014. Whilst he lived in the Bristol area he had stayed with her on the night she died. At the time of her death Teddy had been in a two year relationship with Adan (pseudonym).

2.3.2. In July 2016 Teddy was found in her home in Bath, hanging from the living room door, by Raman (pseudonym).

2.3.3. The Police notified the Chair of Bath and North East Somerset Responsible Authority's Group, which includes the area Community Safety Partnership about Teddy's death. They informed the Chair that although they believed Teddy had taken her own life, it could relate to domestic abuse as she had previously been the subject of a Multi-Agency Risk Assessment Conference (MARAC) and that during the six months prior to her death she had reported two incidents of domestic abuse by Raman.

2.4. The review considers all contact/involvement agencies had with Teddy, Star and Raman during the period from 1 January 2012 to the death of Teddy in July 2016, as well as all contacts prior to that period which could be relevant to domestic abuse, violence, substance abuse, self-harm or mental health issues. The 1st of January 2012 was chosen for the detailed scope of the review as it is known that Teddy first met Raman sometime during 2012.

2.5. The key purpose for undertaking DHRs is to enable lessons to be learned from homicides and suicides where a person's death is suspected to have been as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each case, and most importantly, what needs to change in order to reduce the risk of such a tragedy happening in the future.

Section Three - Timescales

3.1. This review began on 3rd August 2016 and was concluded on 4th April 2017. Reviews, including the overview report, should be completed, where possible, within six months of the commencement of the review. The delays in completing this review were due to the postponement of the Coroner's Inquest to 23rd November 2016 in order to consider information provided by Teddy's family and to give time for the Children and Family Court Advisory and Support Service (CAFCASS) to provide an IMR, authorised by the Family Court. The Home Office was notified and agreed to these delays.

Section Four - Confidentiality

4.1. The findings of this Review are restricted to only participating officers/professionals, their line managers and the family of the deceased until after this report has been approved for publication by the Home Office Quality Assurance Panel.

4.2 As recommended within the "Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews" (2016), to protect the identity of the deceased and her family pseudonyms have been used throughout this report. The pseudonyms for Teddy and Star were chosen by Teddy's father, the pseudonyms used for Star's father and Teddy's partner at the time of her death was agreed by them. As the Review and Police were not able to contact Raman after Teddy's death the pseudonym was chosen by the DHR Panel.

4.3. Teddy who was of dual heritage, was aged 30 at the time of her death, her child Star was aged XX years of age and Raman, who is an Iranian Kurd, was aged 34 at the time of Teddy's death.

4.4 The Review Panel has obtained the deceased's confidential information, after her father gave his written consent. The Review has been unable to make any contact with Raman, the deceased's ex-partner and has therefore not accessed his medical records.

Section Five - Terms of Reference

5.1. Agencies that have had contacts with the deceased Teddy (pseudonym), her child Star (pseudonym) or Raman (pseudonym) should identify any lessons to be learnt from those contacts and set out provisional actions to address them as early as possible for the safety of future victims of domestic abuse particularly those who are vulnerable through mental health issues and/or substance misuse.

5.2. This Domestic Homicide Review which is committed, within the spirit of the Equality Act 2010, to an ethos of fairness, equality, openness, and transparency, will be conducted in a thorough, accurate and meticulous manner.

5.3. The Domestic Homicide Review will consider:

5.3.1. Each agency's involvement with the following from 1st January 2012 to the death of Teddy in July 2016, as well as all contacts prior to that period which could be relevant to domestic abuse, violence, substance abuse issues, self-harm or other mental health issues.

a. Teddy 30 years of age at time of her death

b. Raman aged 34 at date of incident

c. Teddy's child, Star aged XX at the time of the incident.

5.3.2. Whether there was any previous history of abusive behaviour towards the deceased or her child, and whether this was known to any agencies.

5.3.3. Whether family or friends want to participate in the Review. If so, ascertain whether they were aware of any abusive behaviour towards Teddy or Star, prior to the homicide.

5.3.4. Whether, in relation to the family members, there were any barriers experienced in reporting abuse?

5.3.5. Could improvement in any of the following have led to a different outcome:

a) Communication and information sharing between services

b) Information sharing between services with regard to the safeguarding of adults or children

c) Communication within services

d) Communication and publicity to the general public and non-specialist services about the nature and prevalence of domestic abuse, and available local specialist services.

5.3.6. Whether the work undertaken by services in this case are consistent with each organisation's:

a) Professional standards

b) Domestic Abuse policy, procedures and protocols

5.3.7. The response of the relevant agencies to any referrals relating to Teddy, Star or Raman concerning domestic abuse, harassment, other significant harm, mental health, substance abuse issues, sexual exploitation or any Safeguarding issue. It will seek to understand what decisions were taken and what actions were carried out or not and establish the reasons. In particular, the following areas will be explored:

a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with Teddy, Star or Raman

b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made

d) The quality of any risk assessments undertaken by each agency in respect of Teddy, Star or Raman

5.3.8. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective individuals and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.

5.3.9. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner.

5.3.10. Whether, any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.

5.3.11. The review will consider any other information that is found to be relevant.

Section Six - Methodology

6.1. The method for conducting a DHR is prescribed by Home Office guidelines. Upon receiving written notification of Teddy's death from the Police a decision to undertake a Domestic Homicide Review was taken by the Chair of the Bath and North East Somerset Responsible Authority Group during consultation with partnership members on 3rd August 2016. The Group noted that although it was suspected that Teddy had taken her own life, there were police records to indicate that she had previously been the subject of a Sexual Violence Multi Agency Risk Assessment Conference (MARAC) and that she had made a complaint of domestic abuse by Raman a few weeks prior to her death. The Home Office was informed of this decision on 8th August 2016. (Bath and North East Somerset Responsible Authority Group carries out the responsibilities of the Community Safety Partnership in the local authority area).

6.2. Agencies in the Bath and Bristol areas were contacted to search for any contact they may have had with Teddy, Star or Raman. If there was any contact then a chronology detailing the specific nature of the contact was requested. Those agencies that had relevant contact were asked to provide an Individual Management Review. This allowed the individual agency to reflect on their contacts and identify areas which could be improved in the future and make recommendations.

6.3. The DHR Panel considered information and facts gathered from:

- The Individual Management Reviews (IMRs) and other reports of participating agencies
- Coroner's Inquest
- The Pathologist Report
- Interviews with members of the deceased's family and friends
- Teddy's diaries and notes for the relevant period
- Discussions during Review Panel meetings.

Section Seven - Involvement of Family, Friends and Neighbour.

7.1. Teddy's father and Adan, her partner at the time of her death (who did not live with her) were contacted at the commencement of the Review by telephone and letter. Her father who lives in a different part of the country, agreed to sign a consent form for the review to access her medical records. He also chose the pseudonym, "Teddy", for his daughter and "Star" for his grandchild. Her father wished to be kept informed about the progress of the Review on behalf of the rest of her family who live in different parts of the UK and abroad. Both Teddy's father and Adan were provided with the DHR Terms of Reference and were informed about the advocacy support the family could receive from Advocacy After Fatal Domestic Abuse (AAFDA), they were provided with a AADFA leaflet and a Home Office leaflet for families was sent to her father.

7.2. During the course of the Review regular contact was maintained with Teddy's father. There was also telephone and email contacts with other individual members of Teddy's family including Star's father who, like Teddy's father, provided significant information to the review. Information provided by the family is included within this report. The family confirmed that there were no barriers stopping them reporting incidents of domestic abuse. They were also aware that Teddy had contacted the police on occasions and she had been given details of local specialist domestic abuse support services.

7.3. The Review Panel had the opportunity to consider information in Teddy's 2015 and 2016 diaries and in her note book.

7.4. The Review Chair wrote to and left numerous telephone messages for Raman, who was with her the day she took her own life; however he made no response and the police were not able to locate him. The Review Panel therefore chose the pseudonym, Raman, for him. At the conclusion of the Review further attempts were made to contact him at his last known address but without success.

7.5. Teddy's father and Star's father and paternal Grandmother were informed of the findings of the Review. Teddy's father read the draft Overview Report and Executive Summary at length and in private. His comments are reflected within this final report together with a short tribute to his daughter that he has written on behalf of the family. Star's father asked that it be stressed in this report, that he had only broken the door to Teddy's home in 2007 because she would not allow him to see his child. He stressed that he had never assaulted her physically. (See para 15.7).

7.6. Teddy's father accompanied by three other members of the family attended the DHR Panel meeting of 4th April 2017. At that meeting Teddy's father said the thoroughness and care taken during the Review gave the family some comfort. From the Review's reports, they had learnt much they had not known about Josie's life. Nevertheless they asked that it be noted within this report that whilst they acknowledge that Teddy had a history of self-harming and thinking about suicide, they continue to question the conclusions of the Coroner's Inquest that the cause of Teddy's death was suicide by hanging.

Section Eight - Contributors to the Review

8.1. Whilst there is a statutory duty that bodies including, the police, local authority, probation trusts and health bodies must participate in a DHR; in this case forty-five organisations have contributed to the Review:

- Avon and Wiltshire Mental Health Partnership NHS Trust: This organisation had relevant contacts with Teddy and an IMR was completed. A senior member of this agency who is independent of any contact with Teddy is a DHR Panel member.

- Avon and Somerset Constabulary: This organisation had relevant contacts with Teddy and Raman and an IMR was completed. A senior member of this Constabulary who is independent of any contact or involvement with Teddy, Star or Raman is a DHR Panel member.

- Avon Fire and Rescue Service: This service notified the DHR that it had no relevant contacts to report.

- Bath and North East Somerset Clinical Commissioning Group: This organisation notified the DHR that it had no relevant contacts to report. A senior member of this CCG is a Panel member.

- Bath and North East Somerset Council: This organisation notified the DHR that it had no relevant contacts to report. A senior member of the Council is a Panel member.

- Bath and North East Somerset Council Children's Social Care: This organisation notified the DHR that it had no relevant contacts to report.

- Bath and North East Somerset Council Drug and Alcohol Action Team (DAAT): This organisation notified the DHR that it had no relevant contacts to report. The DAAT Manager is a DHR Panel member.

- Bath and North East Somerset Council Housing: This organisation notified the DHR that it had no relevant contacts to report.

- Bath and North East Somerset (B&NES) Council Preventative Services Commissioning Team: B&NES Council Commissioners had no contacts, but as a relevant service commissioner in Bath and North East Somerset has reviewed its current commissioning practice in the light of this DHR.

- Bath & North East Somerset Responsible Authority Group: This organisation which acts as the Bath and North East Somerset Community Safety Partnership notified the DHR that it had no relevant contacts to report.

- Bath and North East Somerset Safeguarding Adults: This organisation notified the DHR that it had no relevant contacts to report. The Safeguarding Adults Team Manager is a Panel member.

- Bath and North East Somerset Safeguarding Children: This organisation notified the DHR that it had no relevant contacts to report.

- Bath Citizens Advice Bureau: This organisation notified the DHR that it had no relevant contacts to report.

- Bath Mind Advocacy Service: This organisation notified the DHR that it had no relevant contacts to report. The organisation was invited to provide a Panel member but was unable to do so.

- Bristol Drug Project: This organisation notified the DHR that it had no relevant contacts to report.

- Bristol City Council Children's Social Care: This organisation had relevant contacts relating to Star and Teddy and an IMR was completed. A senior member of the Department who was independent of any contacts relating to Teddy or Star is a DHR Panel member.

- Bristol City Council Housing Solutions: This Department had minor contacts with Teddy and Raman and a report was provided.

- Bristol City Council Safer Bristol: Safer Bristol had no contacts, but as a relevant service commissioner in Bristol has informed the Review of its current commissioning practice.

- Bristol Clinical Commissioning Group: This organisation completed an IMR in relation to the GP primary care services received by Teddy and an IMR was completed. A senior member of the CCG who had no involvement with any contacts with Teddy, Star or Raman is a member of the DHR Panel.

- Bristol Early Help: This organisation notified the DHR that it had no records of any relevant contacts to report.

- Bristol, Gloucestershire, Somerset, Wiltshire Community Rehabilitation Company: This organisation notified the DHR that it had no records of any relevant contacts to report.

- Bristol Sexual Violence Multi Agency Risk Assessment Conference (SV MARAC): This MARAC had relevant contacts relating to Teddy and a Report was completed.

- Children and Family Court Advisory and Support Service (CAFCASS): This organisation had relevant contacts relating to Teddy and Star and an IMR was completed with the permission of the Family Court.

- Curo Housing: This organisation notified the DHR that it had no records of any relevant contacts to report.

- Dear Albert, (Substance Misuse Support Service): This organisation had relevant contacts with Teddy and an IMR was completed.

- Developing Health and Independence (DHI): This organisation notified the DHR that it had no records of any relevant contacts to report.

- Star's School, Bristol:[1] This school had relevant contacts with Teddy and Star and a report was completed.

- Great Western Hospital NHS Foundation Trust: This organisation notified the DHR that it had no records of any relevant contacts to report.

[1]The name of the school has been redacted.

- Home Office Immigration Enforcement: This organisation had relevant involvement with Raman and an IMR was completed. A senior official from the Home Office who had no involvement with the contacts relating to Raman is a DHR Panel member.

- Knightstone Housing: This organisation notified the DHR that it had no records of any relevant contacts to report.

- Probation Service: This Service notified the DHR that it had no records of any relevant contacts to report. A senior probation officer is a DHR Panel member.

- NHS England: This organisation notified the DHR that it had no records of any relevant contacts to report. NHS England and NHS England South West provided senior independent Panel members for the DHR.

- Next Link: This Charity, which supports domestic abuse and sexual violence victims, notified the DHR that it had no records of any relevant contacts to report, other that in connection with the SV MARAC. The Charity's Safeguarding Officer is a DHR Panel member.

- NILAARI: This organisation had relevant contacts with Teddy, a report was completed. Support Counsellor was interviewed by the DHR Chair and provided a short report detailing her contacts with Teddy.

- North Bristol NHS Trust: This Trust notified the DHR that it had no records of any relevant contacts to report.

- Rainbow Centre for Children: This organisation notified the DHR that it had no records of any relevant contacts to report within the scope of the review period.

- Reach Housing Options and Advice: This organisation notified the DHR that it had no records of any relevant contacts to report.

- Royal United Hospitals Bath NHS Foundation Trust: This Trust notified the DHR that it had no records of any relevant contacts to report.

- Sirona Care and Health: This organisation notified the DHR that it had no records of any relevant contacts to report. A senior manager is a DHR Panel member.

- Southside: This Family Support and Domestic Abuse Service notified the DHR that it had no records of any relevant contacts to report. A senior manager is a DHR Panel member.

- South Western Ambulance Service NHS Foundation Trust: This Service notified the DHR that it had no records of any relevant contacts prior to Teddy's death to report.

- Survive: This organisation notified the DHR that it had no records of any relevant contacts to report.

- United Communities Housing Association: This Housing Charity had relevant contacts with Teddy and a report was completed. A senior housing Officer who is independent of any direct contact with Teddy is a member of the DHR Panel.

- University Hospitals Bristol NHS Foundation: This Trust had relevant involvement with Teddy and a Report was completed.

• Victim Support: This Victim's Support Charity notified the DHR that it had no records of any relevant contacts to report.

8.2. Thirteen of those agencies have completed Individual Management Reviews (IMRs) or reports. None of the Independent Management Report (IMR) Authors or Report Writers have had any contact or involvement with Teddy, Star or Raman or in the management of staff who had dealt with them. Two further organisations, Bristol City Council and Bath and North East Somerset Council that had no direct contacts, have reviewed their service commissioning contracts in light of this Review.

8.3. The Authors are:

Julie Mills: Avon and Somerset Constabulary

Jo Collins: Avon and Wiltshire Mental Health Partnership NHS Trust

Michelle Vittozzi: Bath and North East Somerset Council Commissioning

Verity Felles: Bristol City Council Children's Social Care

Nicky Debbage: Bristol City Council Housing Services

Stuart Pattison: Bristol City Council - Safer Bristol

Samantha Boobier: Bristol Clinical Commissioning Group

Natalie Wyatt: Children and Family Court Advisory and Support Service (CAFCASS)

Jon Roberts: Dear Albert

Simon King: Star's School, Bristol

Kenny Chapman: Home Office, Immigration Enforcement

Linda Mellows: Sexual Violence Multi Agency Risk Assessment Conference

Jean Smith: NILAARI

Jayne Whittlestone: United Communities Housing Association

Philippa Lloyd: University Hospitals Bristol NHS Foundation

8.4. Teddy's family, partner and Star's father also provided information to the DHR.

8.5. The DHR has been given access to the Pathologist's Report and statements made for the Coroner's Inquest.

Section Nine - Review Panel

9.1. The DHR Panel consisted of senior officers, from the statutory and non-statutory agencies who are able to identify lessons learnt and to commit their organisations to setting and implementing action plans to address those lessons. None of the members of the panel have had any contact with Teddy, Star or Raman.

9.2. The Panel members are:

- Andrea Maine: Detective Inspector, Avon and Somerset Constabulary
- Daniel Badman: Interim Quality Director Avon and Wiltshire Mental Health Partnership NHS Trust
- Sarah Jeeves: Adult Safeguarding and Quality Assurance Nurse, Bath North East Somerset Clinical Commissioning Group
- Samantha Jones: Inclusive Communities Manager, Bath North East Somerset Council
- Sue Tabberer: Team Manager Safeguarding Adults Quality Assurance, Bath North East Somerset Council Adult Safeguarding
- Carol Stanaway: Commissioning Manager, Bath and North East Somerset Council (Drug & Alcohol Action Team)
- Paulette Nuttall: Designated Safeguarding Adults and MCA Lead Nurse, Bristol Clinical Commissioning Group
- Fiona Tudge: Service Manager Children and Families, Bristol City Council
- Linda Mellows: Safeguarding Officer, Missing Link Housing (Next Link)
- Helen Chrystal: Designated Nurse Safeguarding, NHS England
- Carole Crocker: Assistant Nurse Director Quality & Safety, NHS England South West
- Kevin Day: Senior Probation Officer, National Probation Service
- Geoff Watson: Professional Lead for Social Work, Sirona Care and Health
- Debbie Sheppard: Family Services Manager, Southside
- Femi Robinson: Senior Housing Officer, United Communities. Due to organisational changes, Jayne Whittlestone: Communities Manager took over from Femi Robinson as the panel member for United Communities.
- Kenny Chapman: Assistant Director, Immigration Enforcement
- David Warren: Domestic Homicide Review Chair
- Mark Hayward: Business Support Manager, Bath and North East Somerset Council, Review Administrator
- Panel Adviser re Bristol SV MARAC: Charlotte Leason: Domestic & Sexual Violence Coordinator, Multi-Agency Risk Assessment Conference (MARAC)

• Observer: Andrew Sutherland: Quality and Safety Manager: NHS England.

9.3. Expert advice regarding domestic abuse service delivery in Bath and North East Somerset (BANES) has been provided to the Panel by Southside, which provides the commissioned Independent Domestic Violence Adviser (IDVA) Service in BANES. Specialist independent advice relating to health issues has been provided by NHS England. Specialist advice regarding safeguarding adults and children has been provided by the BANES Safeguarding Board and specialist advice regarding substance abuse has been provided by Bath & North East Somerset DAAT.

9.4. The DHR Panel met formally five times. The schedule of their meetings is:

- 13th September 2016, The Guildhall, Bath
- 25th October 2016, The Guildhall, Bath
- 13th December 2016, Cadbury Room, Somerdale Pavillons, Keynsham
- 7th February 2017, The Guildhall, Bath
- 4th April 2017, The Guildhall, Bath

Section Ten - Chair of the Review and Author of the Overview Report

10.1. The Chair of the DHR Panel is a legally qualified and accredited Independent Domestic Homicide Review Chair. He has passed the Home Office approved Domestic Homicide Review Chairs' courses and possesses the qualifications and experience set out in paragraph 37 of the Home Office Multi-Agency Statutory Guidance (2016).

10.2. He has an extensive knowledge and experience in working in the field of domestic abuse and sexual violence at local, regional and national level. He has provided pro-bono legal work for a local Refuge and its residents; been responsible for the funding and monitoring the delivery of domestic abuse services across the South West Region of England between 2004 and 2010 and was a member of two Central Government committees, one responsible for the development and monitoring Violence Against Women and Children policies and services and the other for the funding of local domestic and sexual abuse services, during the same period.

10.3. The Chair has no connection with the Bath and North East Somerset Responsible Authorities Group and is independent of the agencies involved in the Review. He has previously served as a senior police officer in Avon and Somerset Constabulary until 1999. More recently he has been the Government Office South West Regional Criminal Justice Manger and in a voluntarily capacity he has been the Chair of a substance abuse charity. Since 2011 he has chaired numerous statutory reviews including serious case reviews, mental health reviews, drug related death reviews and domestic homicide reviews.

10.4. He has had no previous dealings with Teddy, Star or Raman.

Section Eleven - Parallel Reviews

11.1. Criminal Proceedings: Raman was initially arrested on suspicion of Teddy's murder but no further actions were taken as there was no evidence to support any legal proceedings.

11.2. Coroner's Inquest: In November 2016 the Avon Coroner held an Inquest into the circumstances of Teddy death and after considering information presented by Teddy's father and evidence provided by Avon and Somerset Constabulary and Avon and Wiltshire Mental Health Partnership he concluded that the cause of Teddy's death was suicide by ligature suspension. The Coroner has been extremely helpful to the DHR by providing copies of statements made for the purposes of the Inquest.

11.3. NHS England was satisfied that Teddy's death does not fit the criteria for a Mental Health Homicide Review; nevertheless NHS England agreed to be involved in this DHR.

Section Twelve - Equality and Diversity

12.1. The Panel and the agencies taking part in this Review have been committed within the spirit of the Equality Act 2010 to an ethos of fairness, equality, openness, and transparency. All nine protected characteristics in the Equality Act were considered and the Panel was satisfied that services provided were generally appropriate. Teddy's ethnicity, gender and mental health vulnerability were considered to be of particular relevance.

12.2. The Review Panel found no evidence to indicate that Teddy's dual heritage, (black and white British) influenced the manner in which agencies delivered services to her. However the Panel noted that Teddy's NILAARI Counsellor believed that Teddy deliberately chose bereavement counselling from a Black, Asian and Minority Ethnic (BAME) Charity (NILAARI) after her mother's suicide. Whilst the Counsellor believed this was because Teddy knew of the organisation through its substance abuse support work;,Teddy's father told the Review that, at the time ,Teddy had explained to him, that as she knew about NILAARI, she felt that she would receive more empathy and understanding from a BAME counsellor. NeverthelessTeddy's father does not believe Teddy's dual heritage would have inhibited her from seeking support from other services. He drew attention to her contacts with the national substance minus charity "Dear Albert".

12.3. The Panel when considering Teddy's vulnerability as a woman, noted that in January 2014 Teddy was referred to the Bristol Sexual Violence MARAC (21st January 2014) as her NILAARI counsellor was concerned that she was vulnerable to ongoing sexual exploitation by a man she had known from childhood. The MARAC which included representatives from Bristol Adult Safeguarding, Avon and Somerset Constabulary, the charities Next Link and NILAARI were informed that Teddy refused to give any information about this man. None of the Agencies had any information recorded that could identify him and there were no records found at that time to indicate that Teddy had ever come to attention in relation to sexual exploitation in any way.[2] In view of Teddy's refusal to provide any detailed information it was agreed that NILAARI would continue to support Teddy and encourage her to report the abuse to the police. That NILAARI would work with Next Link around Independent Sexual Violence Adviser (ISVA) support and Housing as appropriate, The Police created an intelligence report detailing the risks to Teddy and Star and would share it with Bristol Children's Social Care. It was agreed that if there was any further information it would be brought back to the SV MARC.

12.4. According to Teddy's family and friends, she continued to visit this unnamed man and take money from him for sexual favours until the time of her death. The DHR Panel is of the opinion that this man groomed Teddy from an early age and that Teddy was an 'adult at risk' within the meaning of the Care Act (2014)[3]. The Panel accepts

[2] The DHR has found that a hospital clinic had a record of Teddy informing them of two sexual assaults in Oman in 2000 when she was 14 years of age. The Trust was not part of the MARAC at that time.

[3]The Care Act definition of 'vulnerable adult' provided refers to the previous guidance set out in 'No Secrets' (2000). The new definition under the Care Act (Section 42) sets out the following.
The safeguarding duties apply to an adult who:

- *has needs for care and support (whether or not the local authority is meeting any of those needs)*
- *is experiencing, or at risk of, abuse or neglect*

that the NILAARI counsellor took the correct course of action in referring Teddy to the Bristol SV MARAC and that in the circumstances of that time, the actions taken whilst limited were appropriate.

12.5. Teddy's mental health was clearly relevant to how her GP, the mental health service and the police dealt with her. The Panel, with advice from the Bath North East Somerset Council Adult Safeguarding Manager, was satisfied that the agencies generally provided Teddy with appropriate support services and care but were hampered by her frequent non-attendance of appointments and her worries about the possibility of information being shared with Children's Services. The Panel considered questions of vulnerability in this context and after consulting with her family and friends, were satisfied that there was sufficient evidence to show that Teddy was "able to take care of herself and able to protect herself against significant harm or exploitation" (see the then "No Secrets" (2000) definition of a vulnerable adult[4]) and therefore agencies were correct in determining that she was not a vulnerable adult.

12.6. More generally, the Panel was of the view that Teddy may have been an 'adult at risk' by virtue of the fact that she may have had care and support needs in relation to her drug use and mental health and there were concerns of alleged abuse and sexual exploitation. The Panel considered however, that Teddy was assumed to have mental capacity to choose not to engage with services. There was also an assumption that she was able to protect herself. Whilst a referral was made to the SV MARAC, there was a missed opportunity to make a referral into Multi-Agency Safeguarding Adult Procedures as a means for agencies to come together to consider the wider issues and concerns of alleged abuse and non-engagement with services in a more formal way. There may well have been other opportunities where a safeguarding referral could have been made. The Panel was of the view that professionals should ensure that a safeguarding adult referral is made when concerns are identified, this is included within the Review's recommendations.

12.7. The DHR Panel is satisfied there are no equality issues of concern in the manner agencies that have been involved with Star, have carried out their responsibilities.

12.8. Although the Review has been unable to ask Raman about his experiences; the Home Office and Police IMR authors have reported their satisfaction that there are no apparent equality or diversity issues in the way the organisations have dealt with Raman.

- *as a result of those care and support needs is unable to protect themselves from either the risk of, or experience of abuse or neglect.*

[4] A person (over the age of 18) 'who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation' No Secrets (2000)

Section Thirteen - Dissemination

13.1.Each of the Panel members, the IMR authors, the Chair and members of the Bath and North East Somerset Responsible Authority Group have received copies of this report. A copy will be sent to the Avon and Somerset Police and Crime Commissioner.

13.2. Teddy's father and Star's father were contacted prior to the conclusion of the review and informed of the findings of the Review. Teddy's father read the Overview Report and he wrote a short tribute to his daughter which has been included within this report. The family later had the opportunity to read the final draft of the Overview Report and Executive Summary prior to the final meeting of the DHR.

Section Fourteen - Background information (The Facts)

14.1. Teddy lived on her own, in social housing in Bath. Her child, Star lived, from Monday to Friday, with Marlon (father) and stayed with Teddy from Friday evening until Monday morning.

14.2. Raman had been in a relationship with Teddy between 2012 and 2014. Whilst he lived in the Bristol area he told the Police he had stayed with Teddy on the night she died. Teddy's family and friends had reason to believe that Raman had regularly supplied Teddy with illegal substances. At the time of her death Teddy had been in a relationship for about two years with Adan (pseudonym) but they did not live together. Adan who lives in Cheltenham, had not been aware that she was still seeing her ex-partner Raman other than to occasionally obtain illegal substances from him.

14.3. When interviewed by the police after Teddy's death, Raman said that on the evening of the 15th July 2016 Teddy met him in Bristol and drove him to her home in Bath they took her dog for a walk. Raman later told the police that he had lost his mobile phone when they were out. They went back to Teddy's home where Raman claimed they watched TV and Netflix. On reading this Report, Teddy's father pointed out that from the Netflix account (which he provided to the DHR), it was clear Teddy had last used the account on 24th June 2016 and had never been able to receive television, (as there was no aerial) other than through her internet account which had stopped working at that time. During a visit to Teddy two weeks prior to her death, she had shown her father that she was no longer able to use Netflix because her internet no longer worked and asked him how to get an aerial fitted.

14.4. Raman later told police officers that he had taken the dog for a walk just before sunrise the following morning, hoping to find his mobile phone. (He was seen on the street, on CCTV at 4.54am.) He said he returned to Teddy's home at about 6.25am when he found Teddy hanging from an interior door. He took her down and ran out into the street to find help. Teddy's father on reading this report asked that it be added that he disputed Raman's recollections. Teddy's father had disputed this at the Coroner's Inquest and the police had provided a written reply stating that Raman had been seen on CCTV at 4:47 am walking down XX Road walking back at 5:03am some 2hrs and 15 minutes before the sole ambulance crew arrived at Teddy's address at 7:15 am. On examining Teddy the ambulance crew said that rigor mortis has set in. On arrival the Police communicated that there were discrepancies in the initial account provided by Raman.

14.5. At 7.13am on XX July 2016 the police received a call from a woman who had been stopped on her way to work at the Bath Royal United Hospital by Raman. He said his English was poor and asked her to assist him as his female friend had hung herself. She

went with him to a nearby house where she found Teddy laid on a couch, unresponsive. The woman telephoned 999 for an ambulance and the Ambulance controller talked her through CPR. She saw that a scarf was tied to a door handle.

14.6. On their arrival police officers found a notepad on the table in the living room with a message: “Shame on you, shame, shame, shame if tonight doesn’t.”

14.7. The officers were aware of a domestic incident between the couple on 1st June 2016 when Raman had slapped Teddy across the back of her head. Teddy had initially reported it to the police but had then withdrawn from the case.

14.8. Raman was arrested on suspicion of murder but after an investigation, a decision was taken by the Crown Prosecution Service that there was no evidence to support any criminal proceedings.

14.9. The post-mortem report confirmed the cause of Teddy’s death was as a result of “a ligature suspension - hanging”. There were no other significant injuries. “She appeared physically fit and well”, however there were traces of cocaine in her body which indicated recent usage of the drug. It was noted in the Pathologist’s report that Teddy had made a previous suicide attempt and that Teddy’s mother had committed suicide by hanging in 2013.

14.10. In November 2016 an Inquest was held and the Coroner, after considering evidence from Teddy’s family, found that the cause of Teddy’s death was suicide by ligature suspension.

Section Fifteen - Chronology

15.1. The events described in this section have been summarised from the detailed chronologies of agencies that had contact with Teddy, Star or Raman and from information provided by Teddy's family, friends and from her diaries and note book.

15.2. Teddy's father told the DHR that he and Teddy's mother split up when Teddy was a few months old. Although Teddy lived with her mother and her mother's new partner in Bristol her father kept in regular contact until Teddy was about seven years of age when her mother asked him to stop seeing her, claiming it upset Teddy too much. When Teddy was ten years of age her mother had another daughter. Not long after, Teddy's step-father died. Later her mother met and married an American citizen. They moved to the United States of America when Teddy was about thirteen years of age. Teddy's father informed the Review that Teddy had told him that her step-father was heavily involved in drug-dealing and was frequently violent to Teddy's mother in the presence of Teddy and her half-sister. Whilst in the USA, Teddy was raped by another man and that made Teddy's mother decide to leave her violent husband and returned to the UK.

15.3. Teddy's father told the Review that Teddy's Mother and the two girls, on their return to Bristol, moved in with an older man whom she had known previously. Teddy's half-sister later confided that this man introduced Teddy to cannabis and would often masturbate in front of them. Some years later, Teddy told her father that when she was fourteen years of age this man raped her. Adan informed the Review that Teddy had told him that she would often visit this man and that he would sexually abuse her then give her money. Teddy's NILAARI support worker was so concerned, after Teddy confided in her about this man, that she made a referral to the Bristol Sexual Violence MARAC in January 2013. Teddy, who did not know about this referral, never gave up this man's identity and her father only knew of him by a street name.

15.4. In 2001 Teddy whilst being seen at a Bristol hospital revealed that in December 2000 she had been sexually assaulted by a 38 year old man whilst on holiday with her aunt in Oman. She told the hospital neither her aunt nor her mother knew about the assault. It is not clear if the perpetrator was a local man in Oman or if it was the Bristol man referred to in the above paragraph.

15.5. When Teddy was sixteen years of age, she contacted her father and asked to go and live with him. Due to the disruptions in her education, Teddy did not do well in school, but after leaving school she immediately took up work, firstly in a fast food outlet which she enjoyed. She left when her mother set up a cleaning business and asked Teddy to work with her. During this period, Teddy met Marlon, an old school friend with whom she started a long term relationship. In May 2005 she gave birth to their child, Star.

15.6. Teddy's medical records contained a note on 3rd October 2006 that Teddy confided that she had experienced non-violent domestic abuse from her partner in the past but since they had separated, things had settled down and they were able to deal with issues much better. The partner's identity is not clear from the notes however Marlon has told the Review that at about this time they had a number of heated arguments.

15.7. On 16th November 2006 Teddy's Health Visitor recorded that Bristol Social Services had reported that Teddy's ex-partner had punched her during a row over childcare arrangements. The incident had not been reported to the police and no risk assessment was completed. The ex-partner was not living with Teddy at the time but went to her flat for access visits. Teddy said they had talked about problems and were trying to work things

out. The Health visitor's record noted Teddy's past history of domestic violence between her mother and step-father. The ex-partner is not named in the notes although the context again seems to indicate that it was Marlon. He has told the Review that whilst they argued he never hit her. He did however remember that on one occasion when Teddy would not open the door to him when he was wanting to visit Star, he smashed it open. The police were called but no further action was taken. He believed that incident was in April 2007. The police have a record that on 18th April 2007 neighbours called them as Teddy and Marlon were having a loud argument. They were given advice and leaflets regarding relationship counselling. The police acknowledged that this practice would not currently be acceptable domestic abuse cases.

15.8. In September 2007 Teddy went back to part time studies at the City of Bristol College two days a week.

15.9. On 18th January 2008 Teddy had a GP consultation for depression. She stated she was having difficulties coping as a single mum. She admitted self-harming prior to giving birth to her son, whilst taking antidepressants; however she said she had no currant thoughts of self-harming or suicide and no thought of harming her child. She was given medication and an appointment for the following week. She did not attend the appointment and when contacted by the Surgery, she explained she had forgotten as she felt much better and had only taken the medication for two days.

15.10. On 4th February 2008 Teddy took an overdose of paracetamol and was taken to hospital where her stomach was pumped. She said she had drunk too much whilst out with friends and then taken too many paracetamol tablets. She stayed with her Mother for two weeks after coming out of hospital and she said she had no thoughts of self-harm or suicide. Teddy's mother made a complaint about the level of the Health Visitor support Teddy was receiving. This was reviewed by a GP who ascertained that the health visitor had only been able to make telephone contact as Teddy was staying with her mother at that time and had therefore not kept any arranged appointment. The GP arranged for Teddy to receive an enhanced health visitor.

15.11. In April 2008 Teddy visited her GP feeling low and with thoughts of suicide. She had stopped taking antidepressants and was not willing to start them again. By June 2008 after receiving specialist support she reported that her moods had improved and she had started counselling with a single parent action network.

15.12. Raman who is an Iranian Kurd, entered the UK illegally in June 2005 and claimed asylum. In August 2005 his application was initially refused but this was withdrawn soon afterwards by the Home Office. He therefore had an outstanding application until a decision was made on 3rd August 2010 to grant him indefinite leave to remain in the UK.

15.13. From 2006 Raman has come to the attention of the police on a number of occasions for non-relevant offences, including an assault on a male, various driving related offences and failing to comply without reasonable cause to the requirements of a community order. In 2014 he was arrested for possession with intent to supply cannabis.

Section Sixteen - Overview

16.1. This overview summarises what information was known to the agencies, professionals involved about Teddy, Star and Raman. (including information directly from NILAARI Counsellor.) It also includes relevant information provided by Teddy's family and friends.

16.2. According to Teddy's father during 2012 she had started a two year relationship with Raman, who had allegedly been supplying her with illegal substances. Little is known of their relationship, as her family was at that time living in different parts of the country or abroad, however her family believes she separated from Raman some time in 2014 when she decided to stop using illegal drugs. During 2014 she commenced a relationship with Adan although he did not live with her.

16.3. On 13th September 2012 Teddy saw her GP after self-harming by cutting her left arm. She told the GP that she felt low as she had recently been made redundant and she was battling to stop using cannabis.

16.4. Teddy's father told the DHR that early in May 2013 Teddy's mother asked Teddy for a loan of money which she did not have to give; not long afterwards her mother took her own life by hanging. Teddy was deeply distressed and attended seven sessions of bereavement counselling with NILAARI (a Black and Asian led community based charity for people with mental health, offending behaviour, or problematic substance use issues).

16.5. On 20th September 2013 Teddy's ex-partner, (not named), took her to the Accident and Emergency Department at the Bristol Royal Infirmary after she disclosed suicidal thoughts. She was seen by the mental health liaison team and told them she was struggling with low mood, suicidal thoughts and disturbed sleep since her mother committed suicide by hanging four months earlier. Teddy was given an assessment during which she described thoughts of hanging herself with the cord of her dressing gown. She said, however, that concern for her child stopped her from acting on those thoughts. Teddy admitted that as a coping mechanism she was using drugs and alcohol regularly after her son was in bed (alcohol and cannabis) and weekend crack use when Star was in the care of Marlon.

16.6. Over the following weeks, Teddy told the mental health service's Bristol Intensive Team (BIT) that she felt she was benefiting from grief counselling provided by NILAARI and that they had developed a safety plan. She reported she was trying to break away from a psychologically abusive relationship (she did not say with whom) and felt a sense of relief as a result.

16.7. In September and October 2013 during contacts with BIT, Teddy disclosed sexual abuse when she was fourteen years of age by "a man in position of trust". She had told the team that the perpetrator was retired, but she declined to disclose any further detail or to give his identity. The BIT Liaison staff explained their duty to share the information with Bristol Social Services, subsequently Teddy stopped all contact with the team. After numerous attempts, contact was made with Teddy on 25th October 2013 when she reported improvements in her mental state. She was later discharged as she did not respond to further telephone calls or to a letter asking her to confirm that she wanted to continue in treatment.

16.8. On 28th November 2013, Teddy's Housing Officer contacted BIT expressing concern about Teddy, who was talking about taking her own life. This was followed by a referral

from Star's social worker who was also concerned that Teddy was feeling low and was having suicidal thoughts. Teddy was contacted and confirmed she was feeling low due to difficulties relating to custody issues but said she had no plans to carry out any suicidal thoughts.

16.9. In January 2014 Teddy was found to have tied a ligature around her neck. She told the mental health team that although she was in a "dark place" she was not suicidal, she had only done it to 'see what it felt like' as she was thinking about her mother (who had died by hanging). The mental health team, whilst aware of her historical self-harming by cutting and her suicidal thoughts of hanging, concluded that this incident was not a serious suicide attempt. It was recorded that Teddy described her child as the key protective factor preventing her from self-harming and she claimed she had an emergency/safety plan developed with a named worker at NILAARI.

16.10. On 21st January 2014 a referral was made by NILAARI to the Bristol Sexual Violence Multi Agency Risk Assessment Conference (SV MARAC). At the SV MARAC meeting concerns were heard about her complex relationships, her mental ill-health, her suicidal ideation and her emotional needs following her mother's suicide in 2013. It was discussed that she had been the victim of sexual exploitation from her mid-teens by the same perpetrator who was still involved in her life. As Teddy refused to give any information about the man, it was agreed that NILAARI would continue to work with her and encourage her to provide more details. It was also stated that Teddy was at the triage stage of being under the care of the mental health service.

16.11. On 12th February 2014 Teddy was assessed by the mental health service and discharged to her GP with a plan to contact BIT or NILAARI if distressed. Bristol Children's Social Care was informed.

16.12. Marlon, Star's father contacted Bristol Children's Social Care and later, on 30th October 2014 he commenced legal action to have custody of Star due to his worries about Star's safety as he felt Teddy was not able to cope with the child.

16.13. On 25th February 2014 Teddy reported to the police that her car tyre had been slashed. She said that this had happened three times in three months and she felt that she was being targeted and that she believed that it was someone that knew her. She worried that she was being watched and also feared for the safety of her son. The incident was investigated, during which CCTV footage from the area where the car was parked was viewed. No suspect was identified.

16.14. On 7th May 2014 Teddy assaulted a neighbour by punching him to the floor. The victim was vulnerable, due to health problems and being elderly. The punch caused a head injury and broke the victim's glasses. He then suffered a fit and was taken to hospital where he was treated for his injuries. Teddy was identified as the suspect and following an investigation, she voluntarily attended at a police station on 26th May 2014 and was given a formal caution. In reaching this decision, the supervising officer took into account that it was Teddy's first offence, the fact that she fully admitted her involvement and regretted her actions. It was considered whether the victim's vulnerability should be taken into account as an aggravating factor, however in mitigation, it was an impulsive action by Teddy and resulted in very minor injuries. There were two further incidents involving verbal disputes between Teddy and this neighbour over the next two months which resulted in police attendance but no further action. Teddy's father asked that it be added to the Report that Teddy had told him, she had previously been assaulted by the neighbour's girlfriend causing her severe bruising. (The Police have no report of this assault).

16.15. On 9th December 2014 the police received a third party report of an argument between Teddy and her ex-partner. Teddy was contacted but refused to give any details of the incident other than to confirm that she had had an argument with her unnamed ex-partner. She refused to provide details of him and did not want to speak with the Police any further. The incident was referred to Lighthouse, a specialist team tasked with supporting victims and witnesses (See Appendix A - Glossary of Terms). Background checks were carried out on the 11th December 2014 and an attempt was made to engage with Teddy to carry out a needs assessment. Teddy indicated that she was fine and did not want any additional support. A DASH risk assessment was undertaken and recorded as “Domestic Violence Standard”.. There was mention on the log that another argument had been overheard the previous day. There was no mention on the record regarding Teddy’s child Star.

16.16. On 2nd January 2015 the police received a complaint from a third party that Teddy and her sister were having a heated verbal argument. Officers attended and the sisters spoke openly and freely in the presence of each other and were visibly embarrassed at the police being called. They both described the same account of the argument, which had been resolved. As there were no signs of disturbance or injuries, and no identifiable victim, the matter was recorded as a Force Incident in accordance with the Avon and Somerset Constabulary Force Procedural Guidance.

16.17. On 27th January 2015 Teddy had a GP consultation as she was feeling depressed due to her pending house move and remembering her mother’s death.

16.18. On 16th March 2015 Teddy moved from her social housing accommodation in central Bristol to accommodation in Bath. She had told her father and sister that she was moving as she wanted to get away from people whom she felt were bad influences in her life and to enable her to more easily stop using illegal substances as she was worried about losing access to her child Star. It is noted in the United Communities Housing Association records that the reason given for the move request was that she wanted to move because of problems with her neighbour.

16.19. On 7th April 2015 an unknown offender threw a brick through a window of Teddy’s car while it was parked near her new address in Bath. Enquiries were made with Teddy who initially suspected that the damage might have been caused by her ex-partner, Raman, but had no evidence to support this. A needs assessment was conducted and Teddy was provided with details regarding Lighthouse. House to house enquiries were conducted, with a negative result. Teddy later stated that her ex-partner was not involved in the incident and was not stalking or harassing her, the case was filed with no further police action.

16.20. On 17th July 2015 a Court Order was made that Star should live with Marlon and have contact with his mother, Teddy each weekend from after school on Friday’s to school on Monday and half the school holidays. Teddy had argued that her mental health had improved and therefore Star should live with her.

16.21. On 3rd September 2015 Teddy saw her GP, informing him that she was feeling very low as she had lost custody of Star, except at weekends. As she was then living in Bath she was advised to register with a GP in Bath so that she could receive help from local services. However she asked to remain with her Doctor in Bristol whom she trusted until she felt stronger.

16.22. On 20th October 2015 Teddy's GP made an emergency referral to the mental health service requesting an assessment of her suicide risk. During a consultation Teddy had revealed that she had a suicide plan but would not disclose any details due to concerns that this might impact on child custody issues. She explained she no longer had main custody of her child, who was then aged ten and she said this was having a significant detrimental impact on her mental state. It was noted that Star had previously been identified as the key protective factor against suicide.

16.23. Teddy did not respond to telephone contacts from the mental health service and a police welfare visit was made. She confirmed she felt well and would contact the mental health service. However she did not do so and despite several telephone calls from BIT no contact was made until three days later. A triage assessment was carried out and a plan agreed that she would re-engage with psychological services. Teddy did not attend her appointments and on 4th November 2015 the police were again requested to carry out a welfare check. When seen Teddy told the police officer she would contact the mental health services to say she no longer wanted to engage with their service. Although a number of calls were made to her, she did not respond and on 18th December 2015 the referral to the mental health service was closed.

16.24. Teddy's GP notes disclosed that on 4th December 2015 she was seen by a consultant regarding lumps on her breast which were found to be non-cancerous. Whilst she felt depressed as she was concerned about the history of breast cancer in her family, she said she did not feel suicidal.

16.25. On 25th January 2016 Teddy called the police stating her ex-partner, Raman had assaulted her. He had visited her house and hit her following a verbal argument. Teddy requested that the police did not attend as she felt ashamed and embarrassed. The information was forwarded to the Police victim support service Lighthouse and Teddy was contacted by them, however she refused a visit from the police but agreed to attend a police station. Teddy told the officers that Raman had threatened to go and make problems with the father of her child, he had done that previously about three to four months earlier, but she refused to have any further police involvement (Marlon, Star's father has told the review that he had never had any contact from Raman.)

16.26. On 8th March 2016 Teddy called the police stating that her sister was following her around the house, being argumentative and aggressive. Officers attended and spoke with both sisters independently. Both described pushing each other but nothing more. Neither sister were prepared to engage with a risk assessment (DASH) and as no offences were disclosed, no further action was taken.

16.27. On 30th March 2016 Teddy called the police, reporting that her sister was at her house, "stomping around and shouting obscenities in her face". Teddy had asked her to leave but she had refused. Upon attending, officers separated the sisters and after speaking to both of them, it was determined that no offences were disclosed. A DASH risk assessment was conducted on the basis of what the officer perceived, as neither Teddy or her sister would engage with the assessment. Although the previous incidents were noted, no further police action taken other than advice being given to Teddy.

16.28. On 14th April 2016 there was a further 999 call from Teddy stating her sister was trying to hurt herself. On attendance, officers found that Teddy's sister was calm and there was no sign of injury. Both sisters said they had a verbal argument due to anger issues since the death of their mother. Teddy expressed surprise that the police attended rather than an ambulance. No offences were disclosed and no further police action was taken. A

referral was however made to the Police Safeguarding Unit (SCU) as due to the number of calls relating to the sisters it was believed there could be safeguarding or vulnerability concerns. On the following day, the SCU determined that based on the information provided, there was no reason to believe that Teddy was in crisis and therefore there was no role for SCU at that time.

16.29. On 1st June 2016 Teddy contacted the police reporting that she had been assaulted by her ex-partner, Raman. He had attended her house in the early hours of the morning, but later refused to leave which lead to an argument. He had accused her of being in a relationship with another man over the past two years. During the argument he had slapped her to the rear of the head but this had caused no visible injuries. Officers attended and Raman was arrested, however Teddy refused to pursue the complaint. A treat as urgent marker was placed on the address. Raman was released and a referral made to the Bristol Mental Health Team. Star, her child had not been present during the incident.

16.30. At the end of June 2016 Teddy's father became increasingly concerned that in spite of Teddy's good intentions and efforts she was not able to stop taking illegal substances. On her behalf he contacted the national substance abuse support organisation, Dear Albert as she did not want to seek help locally. A support worker promptly contacted Teddy by telephone and as she expressed a wish to go into a residential treatment centre he explained the different processes to enable her to do so. She said she would discuss them with her father. She made no further contact with the organisation.

16.31. On 15th July 2016 Teddy's father who lives over two hundred miles from Bath, telephoned Teddy to finalise a visit to see her and Star the following day. He said she was in a good mood and was looking forward to his visit. Later that day Teddy travelled to Bristol and met with Raman. Raman claimed Teddy drove him back to Bath and during the evening they walked her dog before returning to her home. Raman told the police, he had lost his mobile during the evening and rose early on the morning of the 16th July 2016 and took Teddy's dog with him when he went to look for his phone. On his return, he found Teddy hanging from a door with a ligature around her neck.

Section Seventeen - Analysis

17.1. Agencies completing IMRs were asked to provide chronological accounts of their contact with Teddy, Star or Raman prior to Teddy's death. Where there was no involvement or insignificant involvement, agencies advised accordingly. In line with the Terms of Reference, the Review focused on the contacts from 1st January 2013 to 16th July 2016, together with relevant information prior to that time. The recommendations to address lessons learnt are listed within the action plans in section 20 of this report.

17.2. The Review Panel has checked that the key agencies taking part in this Review have domestic abuse policies and is satisfied that they are fit for purpose.

17.3. Thirteen organisations have provided Individual Management Reports or reports detailing their relevant contacts. The Review Panel has considered each carefully from the view point of Teddy and Star to ascertain if interventions were appropriate and whether agencies acted in accordance with their set procedures and guidelines. Where they have not done so, the Panel has deliberated if all of the lessons have been identified and that they were being properly addressed. Good practice is acknowledged where appropriate. Two other organisations , BANES Council and Bristol City Council although they had no direct contacts, have, as a result of NILAARI destroying closed files, provided the DHR with details of their current commissioning processes.

17.4. Panel members, having read the IMRs and chronologies and questioned the IMR Authors, are satisfied that the authors have addressed those points within the Review's Terms of Reference which are relevant to their organisations. The following is a summary of the analyses of each report together with the Review Panel's opinion on the appropriateness of the agency's interventions.

17.5. **Avon and Somerset Constabulary (ASC)**

17.5.1. The IMR Author completed a detailed IMR and Chronology of contacts. (A summary of those contacts is included in section sixteen of this report.) From the evidence the author found from records and interviews she was satisfied that prior to Teddy's death, the police took appropriate positive action on each of the occasions they dealt with Raman.

17.5.2. The Avon and Somerset Constabulary has a force policy on domestic abuse which together with procedural guidance for staff and officers dealing with incidents of domestic abuse provides an effective framework to deal with offenders and protect vulnerable victims. The Guidance ensures that incidents and risk assessments are recorded on the police database (Niche) so that any future occurrences can be effectively assessed and acted upon. Overall, force policy in relation to the investigation of offences and practice guidance in relation to domestic abuse was followed, including risk assessments using the DASH tool.

17.5.3. The Author highlighted the benefits of the Niche (database) which was introduced in September 2015. The business processes in Niche differ from the former database (Guardian) in that certain actions are no longer automated and have to be pro-actively commissioned by the data in-putter. There is a need to ensure that officers and staff understand the need to create tasks (e.g. to refer to the Safeguarding Care Unit or Lighthouse) as such it is no longer automated by the system. So that Niche is used to best effect, users must be conversant with differences in business procedures around the tasking of referrals. Effective practice with regard to the need to undertake pro-active

tasking in Niche has been regularly highlighted to officers. Training has been provided requiring officers to complete a Public Protection Notice on Niche.

17.5.4. Nonetheless the Author pointed out that although the intelligence regarding the Sexual Violence MARAC discussion on 17th February 2014 was recorded against Teddy's profile on the Police Guardian and Niche data systems, this was not referred to in any of the subsequent dealings with Teddy. It was therefore not possible to establish if this intelligence was taken into consideration. As Teddy had been identified as vulnerable as a result of the MARAC, this should have been taken into account when dealing with her on subsequent occasions. The IMR Author considered that referrals/risk assessments might have been different if the intelligence had been considered. In particular, more persistent efforts might have been made to engage with Teddy and/or additional referrals could have been considered to support her.

17.5.5. It was also noted that there was no mention of Star when the police dealt with the domestic argument incident on the 10th December 2014. This may have been because Star was then living with Marlon (father), but if the officers had been aware of the child, they should have made a referral to Children's Social Care.

17.5.6. The Review Panel accepts that Avon and Somerset Constabulary has fit for purpose domestic abuse policies and procedures and is satisfied that the IMR author has identified key lessons to be learnt. The Panel highlight the victim support unit, Lighthouse (see Appendix A) as an example of good practice.

17. 6. **Avon and Wiltshire Mental Health Partnership NHS Trust**

17.6.1. The IMR author decided that in the absence of information about what happened, it was not possible for her investigation to draw clear conclusions about how Teddy's death came about. Instead she sought to review the care provided to establish whether there were lessons that could be learned or improvements that could be made to the service. In doing so she considered the following:

17.6.2. Was the care provided appropriate overall?

17.6.2.1. Teddy had three periods of care under Bristol Mental Health Services, between 2013 and 2015. On each occasion she was referred due to suicidal thoughts and low mood. There were known to be significant risk factors present, her mother's death by suicide and the loss of custody of her son. It is recorded that Teddy had difficulties engaging with services on each occasion.

17.6.2.2. On each occasion, Teddy reported being well supported by non-NHS providers of mental health care, including NILAARI and also with LIFT psychology, getting help with drug and alcohol use as well as bereavement counselling. Teddy was able to access this help when she wanted it and needed it. Mental Health Services assessed/triaged Teddy on request from other agencies and offered advice and further appointments. Mental Health Services were keen to try and engage with Teddy but it appeared that she did not want to engage meaningfully with them. Teddy did not progress to the Care Programme Approach (CPA) as she was either referred back to her GP or she had disengaged with services before this could be put into place.

17.6.2.3. There is evidence to suggest that Teddy was ambivalent about engagement with mental health services and this served as a barrier to her developing a relationship with

services. She expressed a lack of trust on more than one occasion and there was never an opportunity for her to meet consistently with a single practitioner and develop a rapport.

17.6.2.4. Teddy did engage with NILAARI and described a supportive experience with a named counsellor. There was a record of a potential plan to carry out a joint assessment but Teddy did not respond to the 'opt in' letter and therefore this assessment never took place.

17.6.2.5. The report author considered if services could have been more proactive in engaging with Teddy. However, it was evident that staff did not rely on opt-in letters to the service; they made numerous attempts at telephone contact, voicemails and texts. They also communicated with referrers to the service (GP's, The Social Worker). Following a DNA (Did not attend) on 4 November 2015 a detailed plan for follow up was recorded and pursued. Multiple calls were made and a welfare check by the Police requested. When the Police reported that she was found 'well' with no concerns about her welfare, and that Teddy said that she would make contact there was further contact attempted ending in a letter to her encouraging her to register with a local GP and to access support more local to her new address.

17.6.3. Were the risk assessment and subsequent management plans appropriate?

17.6.3.1. The report author referred to the 'Clinical Risk Assessment and Management: Guidance for Practitioners'. She found that the last risk assessment was completed 12th February 2014 when Teddy was assessed by Bristol recovery service. The assessment identified the following risks:

- Risk of harm to self without suicidal intent – overall risk rating Medium.

  Teddy had used a ligature in January 2014. She described doing so to 'see what it felt like' and was thinking about her mother (who died by hanging) when she did this. She described being in a 'dark place' but denied suicidal intent, and said she had not been looking after herself well at the time. Her historical suicidal thoughts of hanging herself with her dressing gown cord are also noted.

  She described a history of self-harm by cutting, and this was established to be superficial harm in nature.

  Teddy described her son as the key protective factor preventing self-harm. She had an emergency/safety plan developed with a named worker at NILAARI.

- Risk of harm from others, including emotional and psychological abuse including bullying, risk of physical harm, and risk of sexual exploitation – overall risk rating Medium

  No selection was made for Child Protection Plan indicator.

  No selection was made for domestic abuse

  Selection made for:
  - Risk of emotional/psychological abuse including bullying
  - Risk of physical harm
  - Risk of sexual exploitation

Past and current relationships with men who physically, psychologically and sexually abuse her were noted. There was no further detail recorded.

- Risk of harm to others, aggression and abuse to general public – overall rating Medium/Low

  Risk to others included angry outbursts to family and members of the local authority. No specific incidents noted.

- Risk of accidents, driving whilst under the influence of drugs and alcohol – overall risk rating Low.

  No further details recorded.

- The overall risk rating was Medium[6]

17.6.3.2. The IMR Author considered that selection should have been made for domestic abuse. Although it would not necessarily have added to the risk profile or increased it, it would have been a more complete representation.

17.6.3.3. Using the above definition of medium risk, it was felt that this description and rating of risk was appropriate. Teddy had described her mood as having improved more recently and was able to look after her eight year old child, who she described as a protective factor. She stated she had self-harmed (ligature and cutting) but recognised these are unhelpful behaviours. Teddy was accessing LIFT group-work and support from NILAARI and had a plan for contacting NILAARI or the Bristol Intensive Service (BIT) team if she experienced highly distressing thoughts and feelings.

17.6.3.4. No further risk assessment was carried out in period of October 2015 – Dec 2015 when the referral was closed. However, at this point in Teddy's pathway, staff carried out a triage telephone call only and not an assessment. Therefore, there was no opportunity to undertake and record a new risk assessment. The Triage process is not an assessment; it is the opportunity to gather information and aid prioritisation of referrals.

17.6.3.5. The staff member completing the triage call did however complete a brief 5Ps formulation[7] on 23rd October 2015. This clearly identifies changes in Teddy's situation (such as losing custody of her child) as recorded in the progress notes, that an assessor would have been able to use, should an assessment have ever been able to be completed.

17.6.3.6. There was no further contact from services to undertake an assessment to be able to update the risk assessment. Formulation on 23rd October 2015 also identifies that despite her child not living with her, Star was still a protective factor, and Teddy was

[6] Medium risk is described as *'A term used for a person who has the potential to engage in serious harm but, in the most probable future scenarios, there are sufficient protective factors to moderate that risk. The individual demonstrates that they want to engage with, and at time contribute to, planned risk management strategies and may respond to treatment. This person may become 'high risk' in the absence of protective factors identified in the risk assessment.'*

[7] The 5P Model in Formulation- protective factors. Predisposing, Precipitating, Presenting, Protective and Perpetuating factors.

describing reduced suicidal ideation and no plans. Therefore, the IMR author concluded that pertinent information was included in the notes to inform any assessment that was subsequently arranged.

17.6.4. Is there any record of safeguarding or AWP involvement with a sexual violence MARAC.

17.6.4.1. There were no safeguarding referrals completed by AWP staff regarding Teddy or her child. Teams were aware of involvement with Children and Young People's Services regarding her child, aged eight at the initial point of contact with mental health services, and there was evidence of some information being exchanged regarding risks associated with Teddy's mood and behaviour, and her use of drugs and alcohol.

17.6.4.2. There was no reference in the progress notes to any involvement or notification by other agencies regarding a sexual violence MARAC or MARAC of any kind.

17.6.4.3. The IMR author considered whether a referral to a MARAC should have been made and sought advice from the Trust's Associate Director for Statutory Delivery.

17.6.4.4. An Adult Safeguarding referral was made by BRI Liaison Services in 2013 about Teddy's disclosure of sexual abuse in her youth. However, in 2013 it was felt that advice should have been sought from the Trust's Safeguarding Team when current difficulties were mentions with past and current alleged abusive relationships. This was a missed opportunity. It was evident that Teddy struggled to protect herself from abuse and in circumstances such as this staff should seek to work with the individual to more clearly assess the risks and glean information for onward referral. Staff should have completed a CADDA-DASH (Co-ordinated action against domestic abuse) risk assessment. However, the advice from the Trust's Associate Director for Statutory Delivery was that it was felt that if this had been done it was unlikely to have met the threshold for a MARAC but without full information this cannot be said for certain.

17.6.5. Was the GP kept informed of decision making by AWP?

17.6.5.1. The IMR author highlighted that there were notes which indicated that there had been appropriate correspondence with the GP and others:

"20.09.13 BRI Liaison Summary of Assessment – Cc GP
23.09.13 Bristol Intensive Service Summary of Assessment – Cc GP
16.10.13 Primary Care Liaison Service Opt in Letter – Cc GP
07.10.13 Bristol Intensive Service Discharge Summary – Cc GP
31.01.14 Primary Care Liaison Service Appointment letter – Cc GP/ CYPS
13.02.14 Primary Care Liaison Service Summary of Assessment – Cc GP/CY
16.11.15 Bristol Recovery Central & East Service Opt in Letter – Cc GP"

17.6.6. Why was the service user not more proactively supported to change GP and could AWP ensured transfer of care to BANES AWP services?

17.6.6.1. When Teddy did not attend her planned appointment on 4th November 2015 her care was discussed in the Bristol Crisis Team multi-disciplinary meeting. It was recorded that it would be difficult to continue to provide Teddy with a service as she then lived in Bath. It was agreed that they would ask that Teddy re-register with a new GP in her locality.

17.6.6.2. At this point in time there were concerns for Teddy's safety and a request for a welfare check was made. It was agreed that once Teddy's safety was established they would discuss Teddy registering with a Bath GP and for her to have an assessment by Recovery Services in her area. It was also agreed to refer Teddy to Bath Crisis Services if she was presenting in Crisis. If Teddy remained ambivalent about an assessment from Recovery Services then she could be signposted to BaNES Talking Therapies.

17.6.6.3. The record shows that BaNES Intensive Services were contacted by Police as they were requesting information on the situation and presenting risks to Teddy. Therefore it is clear that BaNES services were aware of Teddy living in their area and the concerns for her safety.

17.6.6.4. On 6th November 2015 it was recorded that the Police reported that Teddy was safe and well and would contact mental health services. Therefore there was no reason to refer Teddy to Bath Crisis Services.

17.6.6.5. On 16 November 2015 the Bristol Recovery Service wrote to Teddy explaining that:

- They had offered an appointment which she had accepted for 4 November 2015 but did not attend.
- That they were unable to reach her and had concerns for her safety and had requested a police welfare check.
- The police had advised that she had been found safe and well and that she had told the officers that she would contact the team regarding the referral.
- The team were unable to reach her despite numerous voicemails.
- The team requested that Teddy call within 2 weeks from the date of this letter so they could discuss the referral.
- The team also recommended that Teddy register with a GP in Bath for her to be able to access mental health services locally.

17.6.6.6. The letter closed with the instruction that if no contact was forthcoming from Teddy then the referral would be closed. No further contact from Teddy was received therefore her referral was closed by Bristol Recovery Team. No further contact was made to Teddy by B&NES services.

17.6.7. The IMR author concluded that:

- Teddy was not under Care Programme Approach (CPA), she had been triaged only at this point and no formal assessment had taken place, therefore the usual procedures for transfer of care did not apply.
- B&NES Intensive Service contacted the Police to seek the outcome of the welfare check on 5th November 2016. They were informed that she was safe and well. They did not telephone Teddy or arrange to visit as no referral to them had been made.
- Telephone contact was attempted with Teddy by Bristol Services and messages were left for her that were not returned; therefore:
- Bristol services wrote to Teddy as described above and this was copied to the GP.

17.6.8. The Review Panel accepts that there is evidence that efforts were made to retain Teddy in services and that she was encouraged to change GP's to a local Practice in Bath

so that her mental health care could be transferred to the Bath service to facilitate easier face to face contact. The Panel is satisfied that the IMR Author was thorough and open in her review and has identified the key lessons to be learnt and has made appropriate recommendations to address them.

17.7. **Bristol City Council Children's Social Care**

17.7.1. Teddy's GP made a referral to Children's Services on 16th October 2013, (with Teddy's knowledge), raising concerns regarding Teddy's emotional health, in particular her feelings of depression and suicidal thoughts since her mother's suicide four months before. Teddy had told her GP that she sought support for herself and to protect her child. An initial assessment was undertaken within seven days as guidance stipulated.

17.7.2. The outcome of that assessment was for on-going social work support under Child in Need procedures. Teddy engaged in this process and there were identified protective factors, which included, Star and Teddy's close relationship together with fact that Star had regular contact with Marlon and paternal family.

17.7.3. Concerns increased in January 2014 around Teddy's emotional health and stability. However, the IMR author was satisfied that these were safely managed within Child in Need procedures; largely due to Teddy's willingness to engage with professionals and there being a safe support network, which included Star's father and paternal family. A support package was identified within Child in Need procedures.

17.7.4. By May 2014 Teddy began to disengage with the social workers, the mental health service and with NILAARI. The Family Intervention Support Service (FISS) Edge of Care Team ended their involvement as Teddy no longer engaged with them. Star's father wanted Star to be in his full time care and he was advised to seek legal advice. The social worker tried to have a meeting with Teddy and Star's father on 27th May 2014 but Teddy did not attend. Star's father told the social worker that he preferred to make arrangements with Teddy, rather than to pursue resolution through the court. Bristol Children's Social Care involvement then ceased.

17.7.5. In February 2015 Star's father contacted Bristol Children's Social Care to inform them that Star had been living with him Sunday to Friday since December 2014 and that Star stayed with Teddy on Saturdays. He explained he had been worried about Teddy's emotional health and her ability to cope with caring for Star and that this was now being considered by the Family Court. Consequently the Department's final involvement was that of providing information to CAFCASS.

17.7.6. The IMR Author concluded that there were no lessons to learn as all contacts relating to the wellbeing and safety of Star had been conducted in accordance with correct procedures and policy. At the time of the Department's involvement, Teddy had appeared stable and co-operated with the social worker. Star's father had indicated that her and Teddy had come to a voluntary arrangement regarding Star's custody.

17.7.7. The Review Panel is satisfied that Bristol City Council's Children's Social Care has considered each of the terms of reference of this Review and whilst not having a direct lesson to learn from contacts with Teddy and Star, have nevertheless identified a lesson to learn from discussions during the review and have made an appropriate recommendation to address it.

17.8. **Bristol City Council Housing**

17.8.1. The IMR Author confirmed that the only contact with Teddy was a rehousing application on "HomeChoiceBristol" on 13th February 2014 when she was living in a flat in the inner city area of Bristol. The application was cancelled on 8th April 2015 as Teddy did not renew her application.

17.8.2. Bristol City Council Housing did have a rehousing application on "HomeChoiceBristol" dated 17th February 2015 in respect of Raman. This application was cancelled on 13th April 2016 as Raman failed to renew his application. Housing had no record of Raman residing at the address he gave to the police. There were however numerous notes relating to noise, constant visitors, claims of prostitution and drug dealing at the address. The named tenant is currently in prison.

17.8.3. The IMR Author was of the opinion that there were no Equality issues in the way in which Housing decisions were made and that all of the contacts were in accordance with Council's policy and procedure. She confirmed that Bristol City Council has a fit for purpose domestic abuse policy.

17.8.4. The Review Panel is satisfied that there are no lessons to be learnt or recommendations to make by Bristol City Council Housing.

17.9. **Bristol Clinical Commissioning Group re Teddy's GP Practice**

17.9.1. The IMR Author made the following points from her review of Teddy's GP records:

- Teddy had a significant mental health history.
- Teddy was prescribed antidepressants on many occasions over the years and frequently she declined to take this medication as she claimed she experienced side effects from them. It was clear that Teddy had the capacity to make this decision. On one occasion Teddy chose not to take her antidepressant because she believed she could not drink alcohol with antidepressants and she wanted to drink in this period.
- Prior to Teddy's suicide, she had been anxious about a lump in her breast. She had a family history of breast cancer and this lump was likely to have caused her considerable anxiety. It was found not to be cancerous in 2015 but in May 2016 another lump was identified and was of continuing concern to her.
- There were long gaps between consultations where Teddy was seen for a period in relation to her depression and then the consultations appeared to stop and then commence again months later.
- There was a reference to domestic abuse in Teddy's GP records in 2006 which related to her ex-partner, Star's father. It was clear she was given appropriate advice, including about the effect of domestic abuse on children; the contact details of the domestic abuse support service, Next Link and it was emphasised she could contact the surgery Health Visitor with any problems in the future.
- There was no evidence in the records of any domestic abuse from Raman although there was a reference on 13th September 2012 that her then (unnamed) partner was unsupportive to her.
- There was evidence in the records that Teddy at times did not attend appointments which were made for her and there were reasonable attempts made by the GP to

telephone her or her mother following an appointment which she did not attend to check if she was OK.

- There was also evidence that Teddy was referred to appropriate agencies and given advice about counselling in terms of her mental health following the death of her mother.

- Teddy was identified as requiring an enhanced health visitors service in view of her difficulties as a single parent and the ongoing issues in relation to contact with her ex-partner due to child custody arrangements.

- It was identified in the records that Teddy was socially isolated in terms of having no parents nearby as her mother was deceased and her father lived in the north of England. She was identified as having limited support from friends.

- There were notes about Teddy self-harming (cutting herself) on a number of occasions

17.9.2. During a consultation on the 13th September 2012, there was a record that Teddy had mentioned that her partner was unsupportive. He was not named.

17.9.3. On the 23rd May 2013 there was a GP consultation following the suicide of Teddy's mother and it was documented that an appointment for bereavement counselling had been made. The next time Teddy was seen by her GP was on 3rd July 2013 when she identified that she was finding the bereavement very difficult. It was unclear if there was continued health visiting support at this stage or whether Star was too old for this service.

17.9.4. On the 3rd September 2015 Teddy had a consultation at the GP Practice and she identified that she was having a very difficult time as she had lost the custody of Star and was feeling very low. At that point the records stated that she was seeking help from the Mental Health Services.

17.9.5. The IMR Author highlighted that it was not usual practice for a GP to 'keep a patient on their GP case load' who had moved out of the area. She believed that this could demonstrate a commitment to Teddy's care as the GP was cognisant of her self-harming and suicidal thoughts at that time.

17.9.6. The Panel noted that after Teddy had moved from the Bristol GP Practice locality to Bath; her GP had encouraged her to move to a Bath GP practice but nonetheless continued to treat her because she was vulnerable and self-harming at that time. Whilst it is a patient's responsibility to change GP practice if he/she moves out of a Practice locality, a GP Practice can apply to NHS England to remove the patient from their list without the need for a warning if the reason for removal relates to a change of address. (Standard General Medical Services Contract 2015/2016 Clause 13.10.4). In this case the Panel acknowledged the good intentions of the GP in continuing to keep Teddy registered on the Practice list but was of the opinion that Teddy's decision not to move GP practice stopped her being able to access local secondary care services from which she may have more readily sustained face to face contacts. The IMR author has discussed this with the GP Practice and it has been identified as a lesson learnt and an appropriate recommendation has been made.

17.9.7. The DHR Panel observed that Teddy had a number of GP appointments in relation to urinary tract infections (UTIs). The IMR Author explained she had questioned the GP about this and he had responded that the infections were not such as to raise concerns of

abuse. Teddy had first experienced these specific health problems after she gave birth to Star and the GP had referred her to Gynaecology. The infections were treated and viewed as incidents related to the delivery of a baby. The IMR Author was not convinced that there was a missed opportunity, particularly as the Practice were never aware of any suggestion of sexual exploitation.

17.10. **Bristol Sexual Violence Multi Agency Risk Assessment Conference (SV MARAC)**

17.10.1. The Bristol Sexual Violence MARAC was a one year pilot programme to provide a multi-agency response to victims of serious or repeated sexual violence. On completion of the pilot year, it was not continued due to funding issues. The Chair, from the Charity, Next Link, has provided the DHR with a report relating to the referral of Teddy in January 2014.

17.10.2. The referral was made by NILAARI after Teddy had disclosed historic and continuing sexual abuse by a man she refused to identify, during a counselling session.

17.10.3. On 21st January 2014 Teddy's referral was discussed at the SV MARAC high risk sexual violence meeting. The MARAC members were told Teddy had suicidal ideation and had complex grief and emotional needs following her mother's suicide in 2013. Teddy had told NILAARI about her complex relationships with men. She has been the victim of sexual exploitation since her mid-teens by the same perpetrator who was still involved in her life. The meeting was told that Teddy used cannabis daily and class A drugs (cocaine and heroin) occasionally.

17.10.4. An action plan was formulated which included sharing information with Bristol Children's Social Care, Housing and Safe Link for ISVA support. It was agreed that a supporting letter should be sent to Bristol Home Choice to recommend that Teddy be allocated a new flat away from the inner city of Bristol. The action plan also required the police to record an intelligence report regarding the SV MARAC's concerns on their database (at the time this database was Guardian). Having recorded the actions from the MARAC meeting as intelligence, the police would be in a position to respond appropriately to safeguard Teddy and her son should there be any report of an incident causing concern.

17.10.5. It was identified that the police intelligence report was recorded four weeks after the MARAC meeting was held, leaving Teddy's vulnerability undetectable by other officers not directly involved in the MARAC process. This was a result of the MARAC actions were not given a timescale. A date should have been provided to complete the action from the MARAC meeting highlighting any urgency. Speedier recording would have better protected her and should have been undertaken, bearing in mind the vulnerability of the parties involved.

17.10.6. The Review Panel acknowledges that as the SV MARAC is no longer in existence, (due to lack of funding) there is no purpose in including a recommendation in relation to the need for clear timescales for agreed actions. DV MARACs in both Bath and North East Somerset and Bristol already adhere to a maximum seven day timescale for all urgent actions in accordance with national guidance

17.11. **Children and Family Court Advisory and Support Service** (CAFCASS)

17.11.1. On 15th January 2017, the Bristol Designated Family Judge gave authority for CAFCASS to provide the DHR with a report in connection with their contacts with the family.

17.11.2. The CAFCASS Report author noted Star's father, made an application for a Section 8 Child Arrangements Order on 28th January 2015. The same day the Family Court made an ex-parte Prohibited Steps Order, preventing Teddy from removing Star from the father's care pending the outcome of the 'First Hearing Dispute Resolution Appointment' (typically the first inter-parte hearing in Private Law proceedings). Marlon's application and the subsequent court order were later received by CAFCASS on 10th March 2015. The information received included that Star had been living with Marlon from December 2014, but that Teddy had changed her mind and planned to remove Star. Marlon stated he was concerned about any potential removal, as he alleged that Teddy had hit and shouted at Star. Marlon also alleged that Teddy was unstable as she had "mentioned suicide."

17.11.3. At a hearing on 16th March 2015 the Court directed safeguarding checks and a Section 7 report from CAFCASS. A case plan was completed which included alleged risk issues which details of Teddy's mental health, drug abuse and the sexual abuse she suffered as a child. It also noted that Marlon had come to police attention in 2006 and 2007 for domestic abuse towards Teddy sand had been given a caution on both occasions.

17.11.4. The completed Section 7 report which was filed with the Court on 1st May 2015 considered the previous domestic abuse by Marlon, but noted that there had been no incidents for over seven years. Nevertheless the Family Court Adviser (FCA) completed face to face interviews and observed Star with each of his parents. These observations were both very positive and "the warmth, affection and "banter" between Star and each of his parents" were noted. The FCA also made contact with Star's class-teacher who reported positive changes in Star's presentation since living with his father, as he appeared much happier. (Note: The School IMR author attributed the changes to be a result of the work of the school's Learning Mentor.) Teddy's family confirmed that it was as a result of a meeting between Teddy and Star's Head of Year, that the School Learning Mentor had worked with Star to help him improve his confidence and school performance.

17.11.5. The Report author was of the opinion that the Family Court Adviser made a sound, evidence-based recommendation for Star to remain living with father, and to spend time with mother three weekends out of four (this was already the status quo and was working well for the child). In view of Teddy's likely distress at these recommendations, it was agreed that Teddy should be invited to the office to discuss the recommendations face to face, so she did not receive this news on her own.

(NOTE: At the DHR Panel meeting on 4th April 2017, Teddy's father asked that it be added to the report that Teddy had phoned him, distraught that Marlon knew about parts of her medical history which he should not have known. Teddy believed that he had read this in the FCA's report, a copy of which she received two days before the Court hearing. It was the unofficial sharing of this information to her ex-partner that really upset Teddy. She felt that the CAFCASS representative belittled the confidentiality of the report and in turn this made Teddy defensive about sharing her personal information with Agencies in case they provided it to other people. The family are of the opinion that personal information such as medical history, should have been redacted prior to the Report being shared with her ex-partner.

The family nevertheless wished to acknowledge that Star has a Dad who loves him no less that his Mum did.

The CAFCASS IMR Author was asked for a response to Teddy's father's comments. She and the CAFCASS National Child Care Policy Manager have both reviewed the file and are satisfied that there is evidence to indicate that the FCA approached the case with an open mind and did not disclose personal medical data. They highlighted the Judge at the time "concluded that the FCA's report was just, balanced, factual, evidence based and child centred, and that the mother was given sufficient opportunities to put her views.)

17.11.6. After an unsuccessful Dispute Resolution Appointment on 12th May 2015, a contested final hearing was held on 17th July 2015. Teddy was legally represented and after considering Teddy's statement, a final order was made in line with the recommendations of the Family Court Advisor.

17.11.7. The Report author noted that an analysis of the facts, indicated that Teddy's mental health was identified as a risk issue at the outset and was carefully explored with enquiries being made with Teddy's GP, the mental health service and with NILAARI. Based on this independent information, the positive improvements to the Star's wellbeing during the time he was living with his father and Star's own expressed wishes and feelings, the Report author was satisfied that the FCA made defensible, child-centred recommendations for the child to remain living with father for the majority of time. Nevertheless the Report author commented that the Section 7 report could have been clearer about the FCA's rationale for considering the past domestic abuse not be a barrier to Star's safely remaining with his father. She did acknowledge that the FCA's closing summary clarified that, the possible effects of domestic abuse on the child had been considered. It would also have been helpful for the FCA to reinforce her risk assessment with reference to a risk assessment tool such as SafeLives-DASH or the Barnardo's DV Risk Identification Matrix.

17.11.8. The DHR Panel whilst accepting that in this case there is evidence that the domestic abuse Teddy suffered from Marlon was considered; it draws attention to a USA survey of 201 psychologists from 39 states who conducted custody evaluations indicated that domestic violence was not considered by most to be a major factor in making custody determinations.[8]

17.11.9. The DHR Panel noted that the lessons identified by the Report author have already been fed back to be addressed at the local area with the FCA and in an unrelated turn of events, use of evidence based assessment tools has been made mandatory in cases where domestic abuse is a feature. This was formalised in the recently launched CAFCASS Private Law Domestic Abuse Practice Pathway.

17.11.10. The DHR Chair drew the Report author's notice to the recommendation in "Learning From CAFCASS Individual Management Reviews (2013)" that (in Public Law cases) Children's Guardians should be alert to any indicators of (a parent's) suicidal ideation or behaviours, and to pass this information promptly to the local authority". The Chair asked if this could be a policy in private law cases. A response was given by the

[8] Ackerman, M. J., & Ackerman, M. C. (1996). Child custody evaluation practices: A 1996 survey of psychologists. *Family Law Quarterly, 30*, 565-586.

CAFCASS Policy Director who wrote the 2013 Review paper. He acknowledged that where a parent loses custody of a child and CAFCASS is aware that they already have a history of self-harming and/or attempting suicide, there could be a duty of care to inform the parent's GP or mental health service provider of the Court's decision. If the parent does not give consent to this information being shared, it would be necessary to seek a legislative change within the Family Procedural Rules to allow the sharing of such information.

17.11.11. The DHR Panel whilst making the national recommendation for the above legislative change is clear that in child protection cases, children should never be considered a protective factor for parents who feel suicidal as this belief significantly increases the risk to the child.[9]

17.12. **Dear Albert** (Substance Abuse Support Service)

17.12.1. Dear Albert is a non-statutory organisation which provides information and support to address any form of addictive behaviour or substance misuse.

17.12.2. The Organisation was first contacted by Teddy's father asking for help on her behalf as she was worried about going to a local substance misuse support service.

17.12.3. There were four pre-assessment telephone contacts with Teddy over a period of days. During the first of those calls Teddy admitted that she used cannabis and crack cocaine regularly. She made no mention of using any other drug but the Counsellor felt she was not telling him everything. She said she thought she could come off drugs but felt under pressure from her drug dealer. She stated she wanted to go into residential rehabilitation and two ways of accessing this were explained to her at some length. She was categoric that she would not go through local services, even though a referral by a local agency could result in residential rehabilitation being funded. Nevertheless she said she was going visit her father and would discuss the options with him. Unfortunately Teddy did not contact the Counsellor again.

17.12.4. During one of the telephone conversations Teddy confirmed she had thought of suicide but after questioning her, the Counsellor did not gain the impression that she was thinking about it at that time or that she was at any risk. The Organisation has a policy on what action to take in the case of any client threatening to take their own live, but the author recognised it needed to be reviewed.

17.12.5. The Report Author concluded that the information provided to Teddy was appropriate and helpful but nevertheless there were lessons to learn.

17.12.6. The Review Panel is satisfied with the lessons identified by the IMR Author and with the recommendations made.

17.13. **Star's School, Bristol**

17.13.1. The IMR Author confirmed that Star was a pupil at the school and that in October 2014 Teddy had a meeting with the child's teacher about concerns relating to Star's effort and attitude to work during lessons. Star did not appear happy at school and did not mix

[9]Brandon, M. et al. (2011) A study of recommendations arising from serious case reviews 2009-2010 (PDF). [London]: Department for Education.

well with other pupils. Teddy confirmed that Star's behaviour at home was also worrying but she said she did not feel able to deal with this. She explained she was receiving medical help as she was suffering from depression, caused by an acrimonious split from Star's father. The school was aware that there had been Children's Social Care involvement.

17.13.2. Star's teacher informed Teddy that the school had a Learning Mentor who could support children to re-engage with their education and learning and could arrange a meeting if she wanted. Teddy agreed to this taking place and subsequently the Learning Mentor organised a programme of weekly sessions with Star.

17.13.3. It was noted that Star had no siblings and spent little time with other children outside of school. Star spent a lot of time playing computer games alone when he was home. The Learning Mentor gradually built up trust between himself and Star and introduced Star to a new friends group. Star's confidence grew and there was an improvement in academic work. Teddy had regular progress reports from the mentor and after only six weeks, Star's school attendance improves from 84% to 90%.

17.13.4. The IMR Author was of the opinion that the school identified Star's problems quickly and took positive and effective action to help.

17.13.5. The Review Panel is satisfied that the school has no lessons to learn and acknowledges the Learning Mentor scheme as an example of good practice.

17.14. **Home Office, Immigration Enforcement**

17.14.1. The IMR Author confirmed that the Home Office had contact with Raman when he entered the Country illegally in June 2005 and claimed asylum. In August 2005 his application was initially refused but this was withdrawn soon afterwards by the Home Office. He therefore had an outstanding application until a decision was made on 3rd August 2010 to grant him indefinite leave to remain in the UK.

17.14.2. The IMR Author explained that all of the investigations carried out by the Home Office were in line with the policy at that time.

17.14.3. The Review Panel are satisfied that the Home Office has no lessons to learn from this case.

17.15. **NILAARI**

17.15.1. NILAARI, a Black and Asian led community based charity for adults and young people with mental health issues, (re)offending behaviour or problematic substance use is based in the heart of inner city Bristol. Initially the DHR received a response from NILAARI that there were no records to indicate any previous contact with Teddy, however after it became clear from other organisations IMRs that Teddy had been helped by Nilaari, further enquiries were made.

17.15.2. The Chief Executive of the Charity notified the DHR that in March/April 2015 the Charity had lost out in a commissioning process and a large portion of the client files had been destroyed pending closure, therefore there were no records of any involvement with Teddy. She acknowledged that from the information provided by other agencies and the SV MARAC that there had been contacts with Teddy. From the information gleaned from

those other organisations it was apparent that NILAARI provided Teddy with close support in relation to her housing, finances, mental health and drug problems. It was also evident that her NILAARI Counsellor had ascertained that Teddy had been sexually exploited and had therefore made a referral to the Bristol Sexual Violence MARAC.

17.15.3. The Mental Health Service records noted that Teddy described a supportive experience with a named NILAARI counsellor. There was also a record of a potential plan to carry out a joint assessment but Teddy did not respond and the assessment never took place.

17.15.4. The DHR was able to trace Teddy's NILAARI Counsellor, who is no longer employed by NILAARI. She provided a written report based on her memory of her work with Teddy, she confirmed that full records were kept at the time, in accordance with guidelines and practice within the service. She stated that Teddy had self-referred to NILAARI for bereavement counselling following the sudden and unexpected death of her mother. The Counsellor said Teddy seemed keen to access a Black, Asian, Minority Ethnic (BAME) led organisation. Teddy met with the Counsellor initially for six sessions with a review and then a further six sessions. Teddy reported issues around her housing, as well as some alcohol and cannabis use, which she believed helped her to cope with the tragedy of her mother's death.

17.15.5. A MARAC referral was made by the Counsellor after Teddy disclosed an ongoing relationship with an older male whom she said she had known "for several years". She reported that money was exchanged for sexual favours. Teddy refused to identify this person in any way. After the MARAC meeting, the Counsellor continued to ask Teddy about the man but she steadfastly refused to discuss or identify him. Teddy had a "couple of final booster sessions" with NILAARI and at the point where work ended the Counsellor remembered that she seemed to be quite positive and keen to do some voluntary work.

17.15.6. NILAARI's Chief Executive has acknowledged that all files should have been retained, in line with the requirements of the data protection act, and passed on to the commissioning organisations when they were in the process of closure. Now that NILAARI has reopened, an action plan has been introduced for client files and all associated papers to be held on a secure database in line with data protection.

17.15.7. The Review Panel accepts, from the evidence of other agencies and from the report from the counsellor, that a supportive and caring relationship was maintained with Teddy over a twelve month period. The Panel is also satisfied that the lesson learnt regarding record keeping is appropriate and will be properly addressed by the proposed action plan. Commissioner organisations in Bath and North East Somerset and in Bristol have agreed a recommendation to ensure that when a contract is not renewed with a service provider, the outgoing provider agency will be reminded of the need to pass ongoing files to the new provider and to forward closed files to the Commissioner for archiving.

17.16. United Communities Housing Association

17.16.1. The IMR Author found that from a review of all notes and contacts there was no evidence that Teddy ever raised issues with United Communities about abusive behaviour towards her or her son. The main issues for United Communities and Teddy related to her rent arrears and her claim for benefits.

17.16.2. United Communities was aware of her mental health problems and she had made reference to suicidal thoughts on at least two occasions. The first time this occurred United

Housing followed up with a report to the Mental Health Services. On the second occasion Teddy was advised to contact her GP. No third party reports of abuse or neglect were ever reported to United Communities.

17.16.3. United Communities has a fit for purpose domestic abuse policy and all of the staff interviewed, by the IMR Author, showed they were fully aware of the approach to take when a resident discloses domestic abuse and/or mental health. Teddy met with staff of United Communities on a number of occasions and at no point did she disclose any indications of domestic abuse.

17.16.4. The IMR Author highlighted that as residents may not always report domestic abuse, United Communities endeavoured to encourage reporting both by victims and third parties, by regularly producing domestic abuse awareness information in its newsletter and website which are available to all residents and to the general public. United Communities also has positive relationships with local specialist domestic abuse services in the areas in which it works.

17.16.5. The IMR Author assessed the training and awareness of staff around domestic abuse. There was a good general understanding of domestic abuse processes and/or services which is victim centred. The Association has however decided to review training in the light of this case.

17.16.6. The Author concluded that while sharing information internally could be improved, overall the work and support undertaken by United Communities was consistent with their professional standards and their domestic abuse policy, procedures and protocols.

17.16.7. The Review Panel is satisfied that United Communities had no reason to suspect that Teddy was or had suffered domestic abuse. They acknowledged that when Teddy informed the housing officer of her mental health problems a positive response was taken. The Panel accepts the lesson learnt and recommendations made are appropriate.

17.17. **University Hospitals Bristol NHS Foundation**

17.17.1. The Report author's chronology indicated that Teddy was first seen in 2001 when she was 14 years of age. She disclosed that she had been sexually assaulted, sexual intercourse on two occasions with a 38 year old man, whilst on holiday in Oman. She was advised to talk to her mother about the assault and arrangements were made for her to contact Barnardos the following day. **T**here was no evidence of a discussion regarding reporting the assault to the police. This was believed to have been because the assault took place in Oman. There was no documentation regarding referral to or discussion with Children's/Social Services. However the case was discussed at the MAGs (Multi Agency Group – attended by social workers, community paediatricians, police and lead by Sexual Health) meeting in May 2001. The outcome of that meeting was that there was concern regarding the lack of information about school and family and a plan was made for a health adviser to contact Teddy and Barnados to follow up. Teddy told the health adviser that she had attended the Brook clinic to talk over her issues and no longer felt it necessary to contact Barnados. She agreed to make a review appointment with a senior doctor at XXX and did re-attend, although no further social history was taken at that attendance.

17.17.2. The Report writer stated that if a young person made such a revelation now; a referral would have been made immediately to Children's Social Services, the action

undertaken to refer to the MAGS meeting would be the same, however it would be undertaken much quicker. A decision would be made regarding contact with Police in Oman, would depend on identifying how great a risk the perpetrator would appear to be but the main focus would be on supporting the child.

17.17.3. Teddy was seen at the hospital on a number of other occasions but only one had any significance this Review. In October 2014she attended the hospital after being pushed over by her partner. There was no record that she was asked about domestic abuse.

17.17.4. The hospital introduced a question about Domestic Violence in to their electronic records in November 2014 and had further Domestic Violence training associated with this introduction (as part of an IRIS pilot - Identification and Referral to Improve Safety). At this time, there was significant learning following the training and this resulted in additional referrals to the Safeguarding team and Next Link. The hospital department recognised the significant learning that has taken place and is confident that any similar disclosure to that made in October 2014 above, would be actively managed.

17.17.5. The Review Panel is satisfied that that practice has changed since the incidents in 2001 and 2014 and that the Hospital foundation now has a fit for purpose domestic abuse policy.

17.18. **Bath and North East Somerset Council Commissioners**

17.18.1. The Bath and North East Somerset Council Commissioning Support and Contracts Manager reported to the DHR the Council's policy on the retention of service user records and transferring of files upon contract termination.

17.16. 2. On termination of a contract (however such termination may arise) the Service(s) Provider is required to deliver up to the Council all working papers, computer disks and tapes or other material and copies provided or prepared by it (or any sub-provider of the Provider) pursuant either to the contract or to any previous obligation owed to the Council regarding the Service(s).

17.16.3. Specifically in relation to service user health records the following are clauses from standard contacts:

- The Provider shall create, maintain, store and retain Service User Health Records for all Service Users. The Provider shall retain such records for the periods of time identified in Law and securely destroy from thereafter. Subject to compliance with the Law, the Provider shall at the reasonable request of a Council promptly transfer or deliver a copy of the Service User Health Records held by the Provider for a Service User for which the Council is responsible to a third party provider or healthcare or social care services designated by the Council.

- The Provider shall:

  i. Use Service User Health Records solely for the execution of the Provider's obligations under this Agreement and;
  ii. Give each Service User full and accurate information regarding his/her treatment and shall evidence that in writing in the relevant Service User Health Record.

17.16.4. The DHR Panel are satisfied that these provisions properly ensure that a service provider would know what to do with client files in the event of their contract being terminated for whatever reason.

17.19. **Bristol City Council Safer Bristol Community Safety Partnership**

17.19.1. In view of NILAARI having destroyed all of their closed files after the service contract with Bristol City Council was not renewed; Bristol City Council have reviewed their service provider contracts.

17.19.2. In the past there was the expectation that service provider organisations would retain files in accordance with the requirements of Data Protection legislation. Current practice however is that where a service provider organisation's contract is not renewed by Bristol City Council and the organisation subsequently closes; Bristol City Council would expect documents relating to ongoing clients to be passed to the new contract holder with the client's permission. Bristol City Council would not expect either the new service provider or Bristol City Council to be provided with closed client notes due to client confidentiality and Data Protection issues. However since 2013 Safer Bristol has introduced, "Theseus" a database system on which all client treatment records are retained by the Council as the asset owner and designated data controller of that information. Bristol City Council is therefore satisfied that in the event of a service provider organisation closing for whatever reason, the Council retain sufficient information to be able to respond to any current or future request for information from a statutory review.

Section Eighteen - Key Issues

18.1. The Review Panel, having had the opportunity to analyse all of the information, obtained from the family and friends of Teddy and from agencies, about Teddy's life considered the following to be the key factors in this review:

18.2. **Teddy's unstable and traumatic early life.**

18.2.1. It is apparent from the information provided by family members that both Teddy's mother and father loved her, however they separated whilst she was still a baby and although her father continued to see her regularly for a few years, her mother stopped those visits and her father later moved to a different part of the country.

18.2.2. Following that short period of stability, Teddy's mother had, to the rest of the family's knowledge, at least two relationships in which she was the victim of serious domestic violence which often took place in Teddy's presence. When Teddy was ten years old, her half-sister was born and Teddy spent much of her non-school time looking after her. Her step-father died and her mother entered a relationship with an American man.

18.2.3. The family's move to the USA when Teddy was about thirteen years of age was particularly stressful, with her new step-father regularly beating her mother and subsequently being arrested and imprisoned due to his involvement in violence, firearms and drugs. Whilst her step-father was in prison, Teddy was raped by another man and her mother brought her daughters back to the UK without reporting the rape to the police. They moved in with a man Teddy's mother knew, and Teddy later claimed this man introduced her to cannabis and cocaine use and when she was fourteen years old, also raped her. Again this rape was not reported to the authorities.

18.2.4. Early in 2001 when she attended a hospital clinic she disclosed the some weeks earlier she had been sexually assaulted whilst on holiday in Oman. She was 14 years of age.

18.2.5. Those traumatic events contributed to Teddy being prone to depression and anxieties. In the opinion of her family, they also adversely affected her education, which ended without her having any qualifications.

18.2.6. It is regrettable that the sexual abuse Teddy suffered as a child was not reported at the time, not only would the perpetrators have been dealt with, but children's services in both the UK and USA would have able to assist Teddy in dealing with the traumas she suffered. Research in the USA highlights that girls who are sexually abused are more likely engage in self-harming behaviour, and be a victim of intimate partner violence later in life.[10] If practitioners are made aware of the abuse at an early stage and are able to work to prevent further childhood abuse it can significantly reduce suicidal behaviour in later life.[11]

18.3. **Teddy's mental health**

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[10] Factors Associated With Child Sexual Abuse - stacks.cdc.gov
2008; Kaufman & Widom, 1999; Trickett, Noll, & Putnam .Child Abuse & Neglect 2000 24 10 1257 1273 11075694 Trickett PK Noll

[11] Is impulsivity a link between childhood abuse and suicide? (2010)
M. Dolores Braquehais' ', Maria A. Oquendo, Enrique Baca-García, Leo Sher

18.3.1. The DHR Panel noted that most people who choose to end their own lives do so for complex reasons. In the UK research has shown many people (90%) who die by suicide have a mental illness, most commonly depression or an alcohol problem.[12] The NHS Choices website highlights that a number of things determine how vulnerable a person is to suicidal thinking and behaviour. These include:

- Life history – for example, having a traumatic experience during childhood, a history of
- Mental health issues
- Lifestyle – for example, drug or alcohol misuse.
- Relationships - loss of a loved one

There is also significant research evidence which shows a direct link between women's experiences of domestic violence and heightened rates of depression, trauma symptoms, and self-harm.[13]

18.3.2. The presence of these factors increased the likelihood that Teddy would self-harm and experience suicidal ideation. At different times and to different people and organisations, Teddy described the causes of her low moods as being because: she was finding it difficult to cope as a single mother with little money; that she had been in an abusive relationship; that she had suffered sexual abuse as a child; that she was distraught over her mother's suicide and that she was worried about losing custody of her child.

18.3.3. Teddy did not seek medical help until 2008 when she was finding it difficult to cope as a single mother after her separation from her partner Marlon, by which time her anxiety and depression had triggered self-harming and suicidal thoughts. She claimed the treatment she received helped and it was not until 2012 that she again saw her GP after self-harming. This was followed by three periods of care under the mental health service. On each occasion she was referred due to suicidal thoughts and low mood. She told several professionals that she would not carry out any of her suicidal thoughts because of the need to care for her child.

18.3.4. The DHR Panel considered at length what if any additional lessons could be learnt in terms of information sharing, awareness of risks and encouraging Teddy to access the most appropriate service.

18.3.5. It was noted that Teddy's mental health treatment was characterised by how well she responded to medication and her habit of stopping taking her prescription and ceasing contact with her GP and the mental health service as soon as she felt better.

18.3.6. At the time of her death, in spite of attempts to maintain contact with her, Teddy had exercised her freedom of choice to disengage with the mental health service. In her desire to appear mentally well to help her reclaim further custody rights to her son, she hid the full extent of her anxieties from agencies. It was therefore accepted that no agency

[12] Mortality statistics in England and Wales by sex and age range (ONS) Dec 2015

[13] Mental Health and Domestic Violence: 'I Call it Symptoms of Abuse'
Cathy Humphreys Ravi Thiara Br J Soc Work (2003) 33 (2): 209-226. **DOI:** https://doi.org/10.1093/bjsw/33.2.209 Published: 01 March 2003

had sufficient information to justify seeking to have her detained under the Mental Health Act to treat her against her will.

18.4. **Teddy's substance abuse / vulnerability**

18.4.1. Teddy's father told the DHR that whilst Teddy's step-father was a convicted drug dealer, her family believe she was introduced to illegal drug use as a teenager by the older man with whom her mother lived on their return from the USA.

18.4.2. Teddy, over a number of years regularly used cannabis and more recently crack cocaine and occasionally heroin, which she told her family and Adan, she was purchasing from Raman. After splitting up with Marlon, she made several attempts to stop using controlled drugs. According to her family her move from Bristol to Bath was an example of this; she wanted to make a fresh start, away from drugs, Raman and other undesirable friends.

18.4.3. In spite of her efforts and good intentions she found it difficult to abstain without help. In September 2013 she told the mental health team that as a coping mechanism she was using cannabis and alcohol after Star was in bed and crack cocaine when he was staying with his father.

18.4.4. Her family were aware of her desire and efforts to give up drugs and they informed the police that Raman was a drug supplier, in the hope that if he was arrested she would find it easier to abstain. Whilst the Police recorded the information it was insufficient for them to act upon. Her father also contacted the national drug charity, "Dear Albert", to seek help for her. She had telephone contact with a counsellor but she died before arrangements could be made for her to be considered for residential rehabilitation

18.4.5. Whilst it was known to the Mental Health Service, her GP and Bristol Children's Services that she used controlled drugs, she was careful to minimise the level of her usage, emphasising she was taking steps to abstain. The agencies therefore had no reason to suspect that her use of controlled drugs may have made her vulnerable within the meaning of the Care Act.

18.5. **Teddy's relationship with Raman**

18.5.1. The Domestic Homicide Review has not been able to make any contact with Raman in spite of numerous efforts directly and indirectly. The information relating to him is therefore limited to the facts obtained from the Police and from the Home Office Immigration Enforcement, and from the opinions of Teddy's father, sister and partner.

18.5.2. Teddy's father and Adan, her partner at the time of her death, told the Review that Teddy had first got to know Raman as a drug supplier early in 2012, but later had a relationship with him for about two year before she met Adan in 2014. Neither of them knew she was still seeing Raman. Her sister said Teddy renewed contact with Raman after she moved to Bath, primarily to buy drugs from him and that occasionally he would stay over. She said she tried to warn Teddy to stop seeing him and they would often argue about this.

18.5.3. In September 2013 when it is known that Teddy was in a relationship with Raman, she told the mental health service that she was trying to break away from a psychologically abusive relationship and that she felt a sense of relief as a result, she did not, however, name her partner.

18.5.4. Raman had come to the attention of the police on a number of occasions, primarily for vehicle related offences but also on one occasion for possession with intent to supply controlled drugs. There were incidents in January 2016 and June 2016 when Teddy contacted the police, reporting that Raman had assaulted her by slapping the back of her head. On the first occasion she said she did not want the police to attend but on the second occasion the police attended and arrested Raman. Teddy refused to give evidence against him and as there was no visible injury no further action was taken.

18.5.5. Teddy's father telephoned the police on one occasion, to inform them that he suspected that Raman was a drug dealer but he did not know sufficient information for the police to be able to take any action other than to record the information he provided.

18.5.6. When the police attended Teddy's death, a notepad was found on the living room table open on a page, on which were written the words "shame on you shame, shame, shame if tonight doesn't". It is not clear when this was written. Raman told the police that Teddy was low during the evening before her death, complaining about the lack of contact with her child.

18.6. **Teddy's relationship with an unnamed older man**

18.6.1. Teddy's father told the review about an older man, believed to be now in his sixties, who her mother, Teddy and her sister stayed with in Bristol when they returned from the USA. Teddy had told her father that this man had raped her when she was fourteen years of age.Teddy's sister, had later told him that this man introduced Teddy to cannabis and cocaine and that he would often masturbate in front of them when they were children.

18.6.2. After her mother committed suicide, Teddy, while receiving bereavement counselling from NILAARI, disclosed "a relationship with an older male known to her for several years". She reported that money was exchanged for sexual favours but she refused to identify this person. The Counsellor referred the information to the Bristol SV MARAC. Consideration was given to Teddy's vulnerability but it was concluded that she did not meet the threshold to be considered a vulnerable adult as it was clear she was able to make her own choices. Teddy's family and friends believe she continued to visit this man up to the time of her death.

18.7. **Custody of Star**

18.7.1. Teddy found it difficult to manage as a single mother after she split up with Marlon. Money was tight and emotionally she found it difficult to cope with a toddler, she became depressed and started to self-harm, before seeking medical help in September 2008. Although she admitted to having suicidal thoughts she stressed that the care of her child prevented her from acting on those thoughts.

18.7.2. In October 2013 Teddy's GP made a referral to Bristol Children's Services, (with Teddy's knowledge), raising concerns regarding Teddy's emotional health, in particular her feelings of depression and suicidal thoughts since her mother's suicide four months before. Teddy had told her GP that she sought support for herself and to protect her child. An assessment resulted in on-going social work support under 'Child in Need' procedures. Children's Services reported that Teddy engaged in this process and there were identified protective factors, which included Star and Teddy's close relationship together with the fact that Star had regular contact with Marlon and paternal family. Although concerns

increased in January 2014 around Teddy's emotional health and stability these were safely managed within child in need procedures with Teddy engaging positively.

18.7.3. Although Marlon initially tried to resolve child care issues informally with Teddy, in January 2015 he made an application to the Court for Star to live with him claiming that Teddy was threatening to commit suicide and a prohibited steps order was made preventing Teddy from removing Star from Marlon's care other than for agreed contact.

18.7.4. According to Teddy's father, the fear that the mental health service and other support services could share information about her with Children's Services or CAFCASS inhibited Teddy from seeking help from local drug support agencies and was the reason she disengaged with the mental health service. She was worried that if it was known she continued to use drugs and suffered from depression she would be prevented from having contact with Star.

18.7.5. A CAFCASS Family Court Adviser (FCA) in preparing her court report noted that Marlon had raised risk issues regarding Teddy's mental health, stating that Teddy "was alleged to have taken an intentional overdose in Sept 2013". Consequently the FCA sought information from Teddy's GP, the mental health service and from NILAARI about her mental health issues. Her GP "advised that although (Teddy) was not completely neglecting her mental health, she was not doing sufficient to manage it either".

18.7.6. In July 2015 a final Family Court order was made for Star to live with Marlon and to have contact with Teddy each weekend from after school Friday to school on Monday, and half the school holidays. One in four weekends were to be with Marlon and in that week Teddy was to have contact from Wednesday to Friday. Teddy who was represented, argued that her mental health was much improved therefore Star should live with her.

18.7.7. Whilst the FCA took care in ensuring that Teddy was given the custody recommendations tactfully and in a safe environment, without Teddy's consent, she was inhibited by Family Procedural Rules from warning Teddy's GP or mental health service provider of Teddy's vulnerability to suicidal thoughts after the formal loss of Star's custody.

18.7.8. Over the following twelve months Teddy ignored her family's pleadings to seek help, telling them of her aim to regain better custody rights to Star. After her death, Raman told the police that she had seemed depressed about not having custody of Star.

18.7.9. The Panel noted parallels in Teddy's life to findings of a research project based in Women's Aid outreach service[15] i.e. "witnessing and experiencing domestic abuse, responding positively to support from voluntary sector, not engaging fully with mental health services and custody problems re her child. The research showed a direct link between women's experiences of domestic violence and heightened rates of depression, trauma symptoms, and self-harm. "Their experiences of mental health services were often found to be negative… offering medication rather than counselling support…….the negative, consequent effects on child contact and child protection proceedings if the woman is labelled with mental health problems. Alternatively, women found services, often in the voluntary sector, helpful when they provided the following interventions: helping women name domestic violence; actively asking about the abuse; attending to safety planning; responding to women's specialist needs; and actively working with women

[15] Women's Aid Annual Survey 2015

to recover from abuse experiences. Support for her children was also seen as very helpful."

18.7.10. As highlighted earlier in this section, there were a number of critical stresses in Teddy's life, but it was evident from the notebook found after her death and from what she told her father and Raman, that it was the formal loss of Star's custody, which dominated her thoughts over the last twelve months of her life.

18.8. **Non-Transfer of Services**

18.8.1. Whilst Teddy moved from Bristol to Bath in March 2015 she did not transfer Star to a school in Bath nor did she register with a local GP practice.

18.8.2. Star remaining at school in Bristol was a practical solution as the child was in the last year of junior school and stayed with Marlon in Bristol during the week. Later this arrangement was confirmed by a court order. Teddy's father wished to add that: "Although Star stayed in junior school in Bristol, Teddy intended to enrol him in a school in Bath when it was time for him to move to a senior school.

18.8.3. Teddy not registering with a GP in Bath did however cause difficulties for the mental health service being able to facilitate face to face meetings with Teddy. She failed to attend meetings arranged in Bristol and the service had to rely on telephone contact with her. It was highlighted in the mental health service IMR that were Teddy to engage in ongoing support and input from Mental Health Services then this would be best provided in Bath to enable her to build rapport with mental health professionals and other relevant agencies.

Section Nineteen - Conclusions

19.1. The Review Panel assessed the Individual Management Reviews and other reports as being thorough, open and questioning from the viewpoints of Teddy and/or Star. It is satisfied:

- That those organisations which conducted all of their contacts with Teddy, Star or Raman in accordance with their established policies and practice have no lessons to learn.

- That the other organisations have used their participation in the Review to properly identify and address key lessons learnt from their contacts with Teddy, Star or Raman in line with the DHR's Terms of Reference.

19.2. The Panel highlights the support of the Bristol District Family Court Judge in permitting CAFCASS to contribute to this review.

19.3. Due to Raman leaving his last known address after Teddy's death and not responding to letters or voicemail messages, the DHR has had no opportunity to seek his view point on his contacts with agencies.

19.4. The Panel is satisfied that the implementation of the recommendations made during the Review will address needs identified from the lessons learnt and make life safer for victims of domestic abuse, particularly those with mental health or substance abuse problems. The Panel acknowledges the sentiments of Teddy's family that whilst it is essential that key domestic abuse, substance abuse and mental health services are locally available; individuals with needs must exercise their free choice to access and maintain contact with those services. The Panel, nevertheless, recommends that agencies remind staff to strive to retain vulnerable patients/clients in services.

19.5. The Panel considered that Teddy's death was predictable. She had a known history of self-harming and making suicide plans and she no longer had full custody of her child, whose care had been the reason, she gave, for never previously carrying out her suicidal thoughts. However the Panel noted that Teddy had hidden the full extent of her anxieties and mental health problems and at the time of her death she had stopped having contact with any of the agencies that might have been able to have foreseen from her moods that she was contemplating to self-harm or to take her own life. Teddy's father told the Review that although Teddy's distrust of agencies sharing information about her, made her disinclined to seek local help, she had been making positive efforts, on her own, to deal with her mental health and drug problems so that she could show that she was able to safely care for Star.

19.6. The Panel notes that Teddy had been the victim of domestic abuse during the six months prior to her death and research indicates that: "Violent behaviour in the last year of life is a significant predictor of suicide".[16] In Teddy's case, the Panel does not believe there were sufficient grounds, (other than with the benefit of hindsight), for agencies to have considered that the domestic abuse she was subjected to by Raman, increased her vulnerability to suicidal thoughts.

[16] Violence, Alcohol, and Completed Suicide: A Case-Control Study. (2001) Kenneth R. Conner, Psy.D., Christopher Cox, Ph.D., Paul R. Duberstein, Ph.D., Lili Tian, M.A., Paul A. Nisbet, Ph.D., and Yeates Conwell, M.D.

19.7. The question if Teddy's death could have been prevented was also considered. The Coroner's inquest found no evidence of any possible involvement in Teddy's death by Raman; nor was anything found to indicate that Raman could have sought help for Teddy sooner. Police enquiries did not reveal any evidence of violence or domestic abuse having taken place during the evening before Teddy died. The Pathologist found no evidence that Teddy had suffered any recent assault. There were no records or any calls to the emergency services during the night and the neighbour did not hear any noise from Teddy's address.

19.8. The Review Panel notes the current calls on the Government to develop a legal route for the successful prosecution of domestic violence perpetrators whose victims commit suicide; but the Panel is satisfied that in this case there is no evidence to indicate that Teddy committed suicide as a means of escaping abuse.

19.9. Teddy's father informed the DHR that he had spoken to her, on the telephone, the day before she died to make arrangements about visiting her and Star the following day and she seemed to be happy and looking forward to seeing him. The Panel has therefore concluded that there were no warning signs that Teddy was intending to attempt to take her own life on XX July 2016 and no single agency had sufficient information to have enabled them to take action which might have prevented Teddy's death at that time.

Section Twenty - Lessons Learnt

20.1. **Avon and Somerset Constabulary**

20.1.1. The police had a total of fifteen contacts with Teddy and received information concerning her vulnerability via a third party following the Sexual Violence MARAC meeting where she was referred as being at risk of serious sexual violence. Although recorded as "intelligence" in relation to Teddy on "Guardian" (the then ASC Crime and Incident recording system which was later replaced by "Niche",) this information was not entered onto the Police National Computer (PNC). PNC does contain a section headed 'Police Print of Intelligence Information' however research indicates that this is not routinely populated with intelligence regarding MARAC discussions/referrals. If this was the case, officers attending incidents could cause enquiry to be made for individuals known to be at the scene. This would ensure that officers have timely information when at the scene and could deal with victims identifying vulnerability early and the efficiency in making appropriate and timely referrals improved. Although the intelligence regarding the Sexual Violence MARAC discussion was recorded against Teddy's profile on "Guardian" and "Niche," this was not referred to in any of the subsequent dealings with her and therefore it is not possible to say that it was taken into consideration. This is likely to have been because it was not a Domestic Abuse MARAC. However, as Teddy was identified as vulnerable as a result of the MARAC, this presented an opportunity for such to be taken into account when dealing with her on subsequent occasions. It is possible that referrals/risk assessments might have been different if the intelligence had been considered. In particular, more persistent efforts might have been made to engage with Teddy and/or additional referrals could have been considered to support her.

20.1.2. When safeguarding checks are carried out in relation to any individual, it is important that both Niche and the Police National Computer (PNC) are researched. At the time of the contacts between Teddy and the police during the period of this review "Guardian" was flagged in relation to the Sexual Violence MARAC discussion. However it was routine for such flags to be set for a duration of twelve months, as any further involvement with the parties would have given rise to a repeat referral to MARAC where such occurred within twelve months. Current practice is to flag MARAC discussions and referrals on "Niche" a) indefinitely (Force Northern Safeguarding Unit (SCU)) b) for fifty years (Bristol SCU) and c) indefinitely (Southern SCU). Consideration should be given to standardising this with officers and staff required to ensure that this is notified for inclusion on PNC where appropriate and actioned from the MARAC meeting if proportionate to do so.

20.1.3. There was no record on police systems regarding any details of Star being taken into care or living with Marlon (father). Therefore there was no record or understanding by police that Teddy's mental health may have been adversely affected by Star's removal from her care which could have been taken into account when police were in contact with her. This information could have been shared with police by partner agencies especially if there were further concerns for Teddy's mental health. This would have enabled the police to make more informed decisions when dealing with Teddy in relation to her contacts with them. There was no record of a child at most of the incidents police attended, presumably as Star was not present. However if it was recorded that vulnerable parties had children and details were taken, this information could be shared with partners, allowing a bigger picture of risk and vulnerability for that child to be considered.

20.2**. Avon and Wiltshire Mental Health Partnership NHS Trust**

20.2.1. A DASH risk assessment should have been completed by staff in 2013.

20.2.2. Advice should have been sought from the Trust's Safeguarding Team when current difficulties were mentioned with past and current alleged abusive relationships

20.2.3. When requesting a welfare check clinicians should ensure that they inform the police of any dependents of the subjects of the welfare checks.

20.3. **Bristol City Council Children's Social Care**

20.3.1. Whilst Bristol City Council Children's Social Care has no direct lessons to learn, the Department has identified a lesson from the circumstances of Teddy's suicide. Where a social worker is aware that a parent, who is involved in child protection enquiries, has mental health problems, or a history of self-harming or suicide attempts; the social worker should consider encouraging the parent to inform his/her GP or mental health service provider that they may be at risk of added stress due to the child care proceedings.

20.4. **Bristol Clinical Commissioning Group re Teddy's GP Practice**

20.4.1. In September 2015 Teddy told her GP that she was living in Bath, which was outside of the GP Practice locality in Bristol. Her GP asked her to change to a GP practice near to where she was living as this would enable her to access other local NHS services; however she chose not to do so. Over there following months her GP continued to see her for different ailments during which time there were missed opportunities to encourage Teddy to move to a Bath GP Practice.

20.5. **Children and Family Court Advisory and Support Service (CAFCASS)**

20.5.1. The Family Court Adviser could have been clearer in the Section 7 report about the rationale for considering the past domestic abuse to not be a barrier to Star's safely remaining with his father. (The FCA's closing summary does clarify that she properly considered the effect of domestic abuse on a child).

20.5.2. It would also have been helpful for the FCA to reinforce her risk assessment with reference to a risk assessment tool such as SafeLives-DASH or the Barnardos DV Risk Identification Matrix.

20.5.3. There was good practice by the CAFCASS Family Court Adviser CAFCASS in seeking information from Teddy's GP, the Mental Health Service and NILAARI about her mental health and in taking Teddy's suicidal ideation into consideration in the manner she was informed about the Family Court decision on the custody arrangements for Star. However whilst CAFCASS Family Court Advisers are permitted to **seek** information from external agencies as part of their reporting duties, the Family Procedure Rules dictate that Family Court Advisers's can only **share** information from private family law proceedings if doing so is to a professional in furtherance of child protection (this is likely to be restricted to a local authority social worker or a police officer). There is a lesson to be learnt from Teddy's suicide, that when it is known that a parent has a history of self-harming or of suicide attempts, there is a duty of care to share information about custody decisions with the parent's GP.

20.6. **Dear Albert**

20.6.1. The lessons taken from this review is the need to review policy of not taking notes during preliminary soundings or until agreement on undertaking full assessment is agreed.

20.6.2. It is apparent there is a need to review the policy on when to call emergency or other services when suicide is mentioned. (Counsellors have now completed an independently provided Suicide Awareness training programme.)

20.6.3. There is a need for further training around suicidal ideation.

20.7. **United Communities Housing Association**

20.7.1. In this case, the Association had no reports or indications of domestic abuse. There are however areas that can be improved around sharing information, communication, training and insight.

20.7.2. Whilst United Communities has an open and easy to use database, the information on it is not in a standard format and not easy to identify the action listed.

20.7.3. It was unclear from the records at United Communities what information each team held on residents. Examples in this case were around Star living with Teddy and the income/work details for Teddy. Some of this information was known to the Tenancy Sustainment Officer but was not apparently shared with the housing/income team.

20.8. **University Hospitals Bristol NHS Foundation**

20.8.1. When Teddy reported sexual assaults in 2001 whilst support was provided Children's Social Services and the Police were not formally notified although representatives from both services were on a Multi-Agency Group when the assaults were discussed. Policy and practice has changed and the Children's Social Services and the Police would be formally notified.

20.8.2. Teddy should have been questioned about domestic abuse when she attended at a hospital department in October 2014 after reporting that she had fallen having been pushed by her partner. The foundation now has a fit for purpose domestic abuse policy and questions would routinely be asked about domestic abuse in such circumstances.

Section Twenty-One - Recommendations

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date
That the Family Court Procedure Rules are amended to enable CAFCASS Family Court Advisers to share information (with or without consent) with a parent's GP or mental health service where it is known the parent has mental health problems, self-harms or has suicidal ideation and may be more vulnerable due to child custody decision which has gone against them in a Private Law case	National	Chair of the Bath and North East Somerset Responsible authority Group to write to Dept. Justice with this recommendation; pointing out that in cases where there is no evidence of direct impact on a child, a FCA cannot share information with a GP when it is known that a parent has a history of mental ills less, self-harming or suicidal ideation that may be adversely effected by private law child custody decision.	Department of Justice, Family Court's Division	letter to be sent by 30th April 2017 The Dept Justice adds this permissible disclosure to the table of information set out in Practice Direction 12G of The Family Procedure Rules 2010	31/12/17

Ensure that the warning markers, attached to subjects on police systems to enable effective safeguarding measures to be taken, are fit for purpose	Local	Review the range of warning markers that are attached to subjects and, where necessary, introduce additional warning markers. Conduct checking and testing to establish compliance with their use	Avon and Somerset Constabulary		07/02/2017
The planned review of the ASC Domestic Abuse Procedural Guidance (scheduled for June 2017) is brought forward to ensure that effective guidance is provided in relation to the use of Niche in dealing with Domestic Abuse.	Local	Carry out a review of the ASC Domestic Abuse Procedural Guidance in accordance with APP	Avon and Somerset Constabulary		07/02/2017 Further revision completed 8/01/2018
Officers are reminded that when attending incidents where domestic abuse is suspected or reported, they should always explore whether the parties have children, whether present or not, and that this is to be recorded on Niche. Any children identified should be linked to the relevant party on Niche.	Local	Audit of DA referrals to ensure child safeguarding is actioned and recorded	Avon and Somerset Constabulary	(Outcome – better recording, linking and sharing of correct information informing better risk assessments and sharing of relevant information predicting future risks)	31/12/2016

That the Domestic Abuse training programme which commenced at the end of 2015/16 should as a matter of policy by embedded as a key training requirement for all personnel.	Local	Training programme to continue to be delivered and updated as necessary to reflect new legislation etc to ensure that all existing and new staff understand their responsibilities relating to DA in accordance with AWP Policy	Avon and Wiltshire Mental Health Partnership NHS Trust	Continuing Training programme	Training programme in operation Staff training will be ongoing
Review the Guidance for information sharing with police when Welfare Checks are requested to ensure that key information is shared.	Local	Information sharing police document will be amended to include specific guidance relating to Welfare checks	Avon and Wiltshire Mental Health Partnership NHS Trust		31/03/17
AWP to review it's Safeguarding Training to ensure it includes recognition of vulnerability through abusive relationships and sexual exploitation.	Local	amendments made	Avon and Wiltshire Mental Health Partnership NHS Trust		31/3/17
If a third party accompanies a patient to a referral, they will be asked to identify themselves and their details recorded.	local	Added to personnelGuidance	Avon and Wiltshire Mental Health Partnership NHS Trust		28/02/2018

That Bristol City Council Children's Social Care acknowledges that whilst a child's safety and welfare will always be of paramount important; where a parent involved in child protection enquiries is known to have a history of mental health problems, self-harming of suicidal ideation, current guidance should include practice about encouraging the parent to notify their GP or mental health service provider that they may be vulnerable to added stress because of the child protection enquiries/proceedings. It the parent refuses to seek such medical support, the social worker should discuss the risks with a supervisor on whether the information should be shared without consent. In accordance with Data Protection each case must be considered on its individual circumstances relating to the level of risk of serious harm to the parent. All social workers would be informed about this guidance	Local	This will be embedded into the procedures and current guidance when work within child protection. This will be provided to all social workers.	Bristol City Council Children's Social Care	– Additions made to the guidance by June 2017 To draw to attention of all social workers by July 2017 Include in future training.- ongoing.	

That Bristol CCG/NHS England remind GP Practices that if a patient who is accessing ongoing secondary health services, moves outside the Practice area it should be clearly explained to them that they should move practice to the locality where they live to enable them to access other local NHS services.	Local	Letter to GP practices to be drafted and circulated explaining the issue and setting out need to remind all patients if they are not already doing so.	Bristol CCG/ NHS England		31/3/2017
Review policy of not taking notes during preliminary soundings or until agreement on undertaking full assessment.	Organisation wide nationally	Policy to be rewritten to ensure that clear notes of initial contacts are consistently made	Dear Albert		31/03/20l7
Review policy on when to call emergency or other services when suicide is mentioned.	Organisation wide nationally	Policy to be rewritten to set out policy and good practice in sharing information and advising clients	Dear Albert		31/03/20l7
To include further staff training around suicidal ideation so that front line personnel fully understand the new policy and good practice.	Organisation wide nationally	New Training Programme to be developed and delivered to all key personnel.	Dear Albert		31/03/20l7
Nilaari is working towards becoming a paper free organisation. Plans for client files and all associated papers to be held on a secure database in line with data protection are underway.	local	Introduction of electronic filing system	NILAARI		31/03/2017
It is recommended that the United Communities database system is reviewed so that information is recorded in a more concise, clear manner and includes visits, phone calls, emails etc. This will make any further reviews easier to follow.	Local	Review how information is stored and create a format for this.	United Communities		31/03/2017

It is recommended that United Communities considers widening its database so that key information relating to tenants can be shared internally where relevant and indicate when it is shared. The review of information is part of a wider consideration that United Communities is considering around customer data and CRM.	Local	Review how information is shared internally and note the person / team it is shared with.	United Communities	United Communities will consider internal data sharing from the information retained and how this is shared with other officers	31/03/2017
It is recommended that a policy is written setting out support procedures for residents who are known to have suicidal ideation and that this together with the existing safeguarding policy is cascaded to all personnel as part of structured a training programme	Local	Develop policy and update all staff on Association's approach on suicide	United Communities		31/03/2017

United Communities has a Domestic Abuse policy and has in the past held training through BAVA for staff. It is recommended that refresher training on Domestic Abuse. . is carried out for all staff.	Local	This is to be led by the Head of Housing within the next 6 months. It is a challenge for staff to both identify the signs around abuse and ask residents if abuse is occurring. The association needs to consider how it can do this in a wider context and possibly offer training to contractors to identify the signs when carrying out repairs for the association in residents homes. Also to consider how the support teams ask residents questions about abuse in a sensitive and useful way if there are any signs of this.	United Communities. This is to be led by the Head of Housing within the next 6 months		31/03/2017

United Communities recommends that other agencies involved in domestic abuse cases engage with social housing providers whose input may be able to enhance the safety of domestic abuse victims living in social housing, especially if there is a risk to the tenancy.	Local Cross agencies	Partnership organisations to All to consider referring information to the social housing provider.	BANES RAG		31/03/2017

Appendix A: Glossary of Terms

Avon and Somerset Constabulary

Avon and Somerset Constabulary checked the following data bases in completing the Police Chronology:

- PNC (Police National Computer) – Contains information of convictions, remand history and court appearances of identified individuals.

- PND (Police National Database, previously Impact Nominal Index) – a national Police computer system which allows officers to establish, in seconds, whether any police force anywhere else in the country holds relevant information on someone they are investigating. Previously, this information would not have been visible outside the force holding the record and was implemented following the Soham enquiry.

- ASSIST – a "data warehouse" search tool used with Avon and Somerset Constabulary that trawls all other Avon and Somerset systems for information on individuals in relation to road traffic collisions, liquor licensing, firearms, calls for service from the public and details of crimes reported to the Police.

- WEBSTORM – The command and control system used by Avon and Somerset Constabulary to manage calls for service. Whenever a public contact requiring police action is received a 'log' is created at the first point of telephone contact with the Police and attendance is managed by control room staff based in Police Headquarters. If the call results in the police recording details of a criminal offence or a crime related incident the STORM log will be concluded with a Guardian reference number for the incident.

- Guardian – This is a crime and intelligence management system and was implemented in 2007. All criminal offences and crime related incidents will be recorded here, including all domestic abuse cases regardless of whether a crime or verbal argument is reported. The system enables information relating to domestic abuse, child abuse and missing persons to be linked to a nominal record. Information which is not reporting a specific incident will be recorded as "intelligence" – this would include information obtained from a third party, via Crime Stoppers or shared by another agency. Risk assessments use the national DASH questionnaire and are collated in one section, remain dynamic and linked to the individuals involved. These are available at all times to all staff and ensure a complete history can be viewed in one place.

- CMU – Prior to the implementation of Guardian in 2007 domestic abuse incidents were recorded on a paper based CMU system which was then managed using electronic tracking software.

- Lighthouse Integrated Victim Care Programme

In 2011, the Avon & Somerset Criminal Justice Board initiated a project to better understand the end to end journey of a victim of crime. It found that there was significant overlap and duplication in some areas, and gaps in others. A key recommendation was to

simplify the landscape for victims, seeking to re-align key victim services into one, more holistic, multi-agency model - drawing on learning from other successful integrated models such as IOM.

This project was an important pre-cursor to what is now known as the Integrated Victim Care programme, fostering a shared ambition amongst the criminal justice and community safety partners to develop a more coherent and 'joined-up' response to victim needs locally.

The programme led to the creation of the Lighthouse Victim and Witness Care teams. This new approach went live on October 1st 2014.

Drivers for change

There were a number of key drivers which led us to evaluate, analyse and redesign our approach to victim care, including:

✓ The new Victim's Code of Practice, which came into effect in December 2013. It details a minimum level of service to which all victims are eligible, and places an emphasis on the police conducting thorough needs assessments for victims and signposting to support - with services focused on victims of greatest need according to four clearly defined 'priority groups'.

✓ The EU Directive on the rights, support and protection of victims of crime, which has been formally adopted by the UK and must be implemented by all member states by 16th November 2015. Responsibility for providing services within the directive rests largely with PCCs, including providing all victims with access to free and confidential support services (regardless of whether or not a crime is reported) and advice on practical matters. It also requires that victims with specific identified needs will be provided with more specialist support, such as counselling.

✓ The devolvement of victim services commissioning responsibility to PCCs. Following the 'Getting it Right for Victims & Witnesses' consultation early 2012, radical recommendations were adopted to devolve MoJ victims funding to PCCs for local commissioning from April 2015 (plus additional funding being raised from reform of the victim surcharge arrangements and other sources). Avon and Somerset are one of just 7 'early adopter' areas who will be moving away from the existing national commissioning arrangements from October 2014.

Background to the Programme

The programme was initiated in May 2013 by Avon and Somerset Constabulary and the Police & Crime Commissioner's Office. It is led by a multi-agency programme board (established in October 2013) with wide representation from criminal justice and community safety partners.

The Board developed a shared vision and strategy for victim care, which was published in November 2013.

Objectives

A crucial objective of the programme was the implementation of new 'Integrated Victim Care' teams across Avon and Somerset, by October 2014. The teams bring together victim contact functions in the Police service, co-located with partners, to provide more coordinated, end-to- end care for victims. These teams sit alongside a parallel commissioned service to meet the more specialist victim needs, including support for victims who do not wish to report to the police. These Integrated Victim Care Teams are now called Lighthouse.

Other key objectives of the IVC programme were:

✓ Commissioning services to ensure that victims have access to appropriate support (including victims who choose not to report to the police) and align partner strategies and commissioning processes to improve accessibility, consistency and standards of support for victims in Avon and Somerset.

✓ Developing robust, common needs assessments, processes and referral mechanisms to ensure that victims have access to appropriate support.

✓ Refining monitoring and service improvement arrangements to enable more active listening to the voice of victims – including consultation and complaints mechanisms.

✓ Developing a more victim-focused approach to the delivery of restorative justice, embedding this practice across the criminal justice process and increasing opportunities for victims to take part in RJ.

What do the new Lighthouse Victim and Witness Care teams look like?

The teams consist of police staff and key partner organisations, co-located into multi-agency 'hubs'. The hubs pick up all serious crime cases (including hate crime, sexual and domestic abuse) and those that involve victims who are vulnerable, intimidated or

persistently targeted (as defined in the Victim's Code of Practice). They are co-located with the Police safeguarding units, and aligned closely with the other 'managing people and places' functions of the new constabulary operating model.

Lighthouse is a team of 82 Police Staff members, working out of 3 hubs, covering the entire Avon and Somerset Constabulary Force area. They work extended hours, covering weekends and evenings, in order to be available when victims need them most.

The new teams:

✓ guide a victim through their journey from first point of contact with the police, through the investigation and on to the end of the criminal justice process

✓ provide greater ownership of the whole journey of a victim, reducing handovers and providing a 'single point of contact' approach—simplifying the landscape for victims

✓ ensure victims receive adequate and tailored support – through co-located, integrated partnerships to ensure smooth handovers, effective information transfer and 'one-team'

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)

Teams involved

Bristol Crisis Service:

Operates a waking 24-hour service, 7 days a week, 365 days a year. Service users requiring "emergency" (within 4 hour) assessments will be transferred to the BCS as the single point of entry. In crisis the BCS endeavour to engage and support anyone needing immediate and intensive input.

Bristol Royal Infirmary Mental Health Liaison Team:

A service managed by University Hospitals Bristol NHS Foundation Trust, the team provides assessments in the ED of patients who are experiencing mental health problems coinciding with, or as a result of their physical health problems, including psychosocial assessments following an episode of self-harm.

Bristol Recovery Team (AWP):

Recovery services provide ongoing mental health assessment and intervention for individuals with severe and enduring mental health needs, through the provision of intensive multidisciplinary packages of care. All assessments, treatment, monitoring and review are undertaken within the framework set by the *Care Programme Approach (CPA) and Risk policy.*

Bath & North East Somerset Intensive Service (IS):

Provide an emergency assessment and home treatment service for people as an alternative to hospital admission, or to facilitate early discharge from hospital. The intensive service may receive referrals from a number of external or internal sources, and following a period of home treatment the service user would usually be referred on to the Recovery Team for on-going treatment and support

B&NES Recovery Service (Recovery Team):
A community mental health team that provides secondary mental health assessment, support, treatment and care coordination under the Care Programme Approach (CPA).

Primary Care Liaison Service

The Service provides a rapid, comprehensive and prioritised specialist mental health triage and face-to-face assessment service, and is open to referrals from all health and social care professionals. PCLS acts as a conduit to all other essential areas of Trust provision including targeted intervention services such as the Intensive Services.

LIFT psychology

Primary Care Psychology Services offer access to a range of therapeutic interventions across our localities to support people's differing emotional needs.

NILAARI

NILAARI is one of 18 diverse organisations from both the public and voluntary sectors who work in partnership to provide community services for Bristol. They work with Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) as one of the 'Any qualified providers' (AQP) to deliver 1:1 and group counselling therapies covering Bristol and South Gloucestershire.

Definitions of Terms used

CPA - The **Care Programme Approach** (CPA) is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs. The Care Programme Approach (CPA) describes how mental health and social services identify needs and help service users to get the help they want and need.

Care plan - The care plan is a means of communicating and organising changing

MARAC, or multi-agency risk assessment conference, is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists.

Abbreviations used in this report

AWP; Avon & Wiltshire Mental Health Partnership NHS Trust

BIT: Bristol Intensive Service

PCL: Primary Care Liaison Service

SW: Social Worker

MARAC: Multi Agency Risk Assessment Conference

CYPS: Children and Young People's Service

CPA: Care Programme Approach

LIFT: Least Intervention First Time (primary care psychology

Appendix B: Bibliography

A study of recommendations arising from serious case reviews 2009-2010 (PDF). [London]: Department for Education. Brandon, M. et al. (2011)

Borderline Personality Disorder: The Nice Guideline on Treatment and Management 2009.

CAADA Responding to Domestic Abuse: Guidance for General Practice.

CAFCASS Private Law Domestic Abuse Practice Pathway. (2016)

Care Act 2014

Child custody evaluation practices: A 1996 survey of psychologists. Family Law Quarterly, 30, 565-586.Ackerman, M. J., & Ackerman, M. C. (1996).

Code of Practice for Victims of Crime (October 2015)

Domestic Homicide Review Toolkit.

Domestic Violence, Crime and Victims Act 2004.

Equality Act 2010

Factors Associated With Child Sexual Abuse - stacks.cdc.gov
2008; Kaufman & Widom, 1999; Trickett, Noll, & Putnam .Child Abuse & Neglect 2000 24 10 1257 1273 11075694 Trickett PK Noll JG

Good Medical Practice 2013

Guidance to doctors & GPs on the release of medical records into a Domestic Homicide Review. Sheffield Safer & Sustainable Community Partnership.

Guidance on Safeguarding and investigating abuse of vulnerable adults NPIA (2012)

HM Government Information Sharing: Guidance for practitioners and managers.

Impulsivity a link between childhood abuse and suicide? (2010) M. Dolores Braquehais, , , Maria A. Oquendo, Enrique Baca-García, Leo Sher

Intimate Partner Violence as a risk factor for mental disorders: A Meta-Analysis. Jacqueline M. Golding

Learning from CAFCASS Individual Management Reviews (November 2013)

Mental Health and Domestic Violence: 'I Call it Symptoms of Abuse' Cathy Humphreys Ravi Thiara (2003).

Mental Health Homicide Review: NHS England
https://www.england.nhs.uk/south/publications/ind-invest-reports/south-central/avon-wiltshire/

Mental Health and Domestic Violence: 'I Call it Symptoms of Abuse' (2003).

Mortality statistics in England and Wales by sex and age range (ONS) Dec 2015

Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Home Office 2013)

NHS England Standard General Medical Services Contract 2015/6

Nice Guidance on “Domestic Violence and Abuse: How Health Services Social Care and the Organisations they work with can respond effectively”. (February 2014)

Safeguarding Vulnerable People in the NHS; Accountability and Assurance Framework (NHS England July 2015)

Serious Incident Framework (NHS England Patient Safety Domain March 2015)

Standards of Conduct, Performance and Ethics - Health and Care Professions Council 2016

Violence, Alcohol, and Completed Suicide: A Case-Control Study
Kenneth R. Conner, Psy.D., Christopher Cox, Ph.D., Paul R. Duberstein, Ph.D., Lili Tian, M.A., Paul A. Nisbet, Ph.D., and Yeates Conwell, M.D. (2001)

Women’s Aid, National Survey 2015

Working Together to Safeguard Children, Department for Education (2010)

Appendix C: Report from "Dear Albert" (detailing completed actions).

Response to Recommendation - Suicide Awareness

Recommendation No.1:

Review policy of not taking notes during preliminary soundings or until agreement on undertaking full assessment is agreed.

Action:

1) This practice has been reviewed and we have created a new template to capture notes and keep relevant initial contact details obtained from a first call prior to assessment.

2) This template is titled 'Dear Albert Initial Contact Form v1.1' (see below)

3) This will capture basic information and provide an appropriate record of initial l caller communication

4) The use of the Initial Contact Form will improve our overall monitoring, while also allowing us better able to retrieve caller information if required.

5) The Initial Contact Form is also designed to flag-up any potential mental health issues, and suicide ideation, with structured guidance on how to proceed and signpost as appropriate.

6) For callers looking for a specific piece of information, or who are requiring information on a particular mutual aid meeting, then it will not be necessary to complete the Initial Contact Form. The exception to this is when the caller gives some indication, or the Dear Albert worker detects, that there may be a certain mental health issue or the caller mentions suicide or self-harm.

7) In this case the Initial Contact Form is to be filled out. Only trained Dear Albert workers can fill out the Initial Contact Form and, when necessary, go to the structured response guidance section regarding identified suicide ideation.

8) The Initial Contact Form has a section designed to identify if suicidal ideation is apparent. This section is linked to clear guidance on how to proceed and escalate the appropriate response depending on risk level.

Name of Dear Albert worker

Date of call

Time of call

Name

Address or location

Confirmation of phone number

Reason for call

Drivers/dual diagnosis identified

Suicide ideation mentioned or detected (see over)

Alternative contact number

Additional comments

Recommendation No.2:

Review our policy on when to call emergency or other services when suicide is mentioned.

Action No.2:

1. This policy has now been reviewed. The existing policy;
   'Only staff trained to deal with suicidal ideation deal with calls' was viewed as safe, appropriate and fit for purpose.

2. However after consultation n and training our response is to improve safeguarding by way of clearly written guidance. This includes how to respond to suicidal ideation with a written and scaled procedure.

3. Procedure for Dear Albert to follow:

a. Risk of suicide deemed LOW
   - Some suicidal thoughts. No suicide plan. Says he or she won't attempt suicide. - Action: Offer to send/text support information.

b. Risk of suicide deemed MODERATE
   - Suicidal thoughts. Vague idea of how suicide might be carried out but no plan. Says he or she won't attempt suicide.

- Action: Offer to send/text support information. Clarify that caller is not alone and that they know what to do if thoughts persist. Explore existing support network. Offer to refer into support services.

c. Risk of suicide deemed HIGH
- Suicidal thoughts. Specific plan to commit suicide with some action taken place. Says he or she won't attempt suicide.
- Action: Clarify that caller is not alone and that they know what to do if thoughts persist or if further action is contemplated. Identify support that can be accessed immediately. Instigate immediate referral into support services. Inform caller that emergency services are to be called, but that we will call straight back or stay on the line.

d. Risk of suicide deemed SEVERE
- Suicidal thoughts. Specific plan that is likely to lead to death with clear action and intent. Says he or she will attempt suicide.
- Action: Call emergency services immediately. Inform caller that emergency services are to be called, but that we will stay on the line.

4. The policy has always been that if there is any doubt that suicide is a possibility then emergency services are called immediately.

Recommendation No.3:

To have ongoing staff training around suicidal ideation.

Action No. 3:

- Staff x2 completed RCC* Suicide (and self-harm) Awareness Training - 2/2/2017
- More training is to be booked for later in 2017 as part of CPD training structure

"RCC suicide (and self-harm) awareness training to public, private, and voluntary sector organisations as well as individuals across Leicester, Leicestershire, & Rutland.
Content: half day suicide awareness sessions covering the myths about suicide; attitudes towards suicide; known suicide risk factors; and guidance on how to help those suffering stress or having suicidal thoughts"
*RCC is the trading name of the Rural Community Council (Leicestershire & Rutland)
Registered charity (No: 1077645)
Company Limited by Guarantee (No: 3665974)
Suicide and self-harm awareness funded by Leicester city council and Leicestershire partnership NHS Trust.
Data Protection:

● All service user contact is conducted in line with our vulnerable adults and confidentiality policies.

● Until electronic versions are created, any hard copy completed forms are be kept in a fireproof locked cabinet
within the office to adhere with data protection and data storage law.

● All electronic versions of the completed forms are stored on a secure, password protected server. Helplines and support group information to made available to callers:

Organisation: Mind
Website: mind.org.uk
Call: 0300 123 3393
Email: info@mind.org.uk
Info: National mental health charity (England and Wales) Opening hours: Mon-Fri: 9am-6pm.

Organisation: PAPYRUS Website: HOPELineUK Call: 0800 068 41 41 Email: pat@papyrus-uk.org SMS: 07786 209697

Info: HOPELineUK is a specialist telephone service staffed by trained professionals who give non-judgemental support, practical advice and information to;

Children, teenagers and young people up to the age of 35 who are worried about how they are feeling. Anyone who is concerned about a young person

Opening hours: Mon-Fri: 10am-10pm, weekends: 2pm-10pm & bank holidays: 2pm-5pm

Organisation: Samaritans
Website: www.samaritans.org
Call: 08457 90 90 90
Email: at jo@samaritans.org.
Hours: 24 hours, 7 days a week
Info: operates a 24-hour service available every day of the year. If you prefer to write down how you're feeling, or if you're worried about being overheard on the phone, you can email Samaritans

Organisation: Childline
(0800 1111) Helpline for children and young people in the UK. Calls are free and the number won't show up on your phone bill.

Organisation: Depression Alliance
A charity for people with depression. It doesn't have a helpline, but offers a wide range of useful resources and links to other relevant information.

Organisation: Students Against Depression
http://studentsagainstdepression.org/
A website for students who are depressed, have a low mood or are having suicidal thoughts.

Useful resources for phone support volunteers:

https://www.helpguide.org/articles/suicide-prevention/suicide-prevention-helping-someone-who-is-suicidal.htm

Appendix D: Avon and Somerset Domestic Abuse Procedural Document 8/1/2018

How to use this guidance:

This procedure is reflective of the College of Policing Authorised Professional Practice (APP) on domestic abuse, and where possible is linked to the respective sections of that practice. It also includes links to Crown Prosecution Service Guidelines. A summary is included within each heading as to what the APP / CPS Guidelines cover, and any local considerations or enhancements to this procedure and detailed below. Due to issues with linking to individual pages within APP, some of the links return to the "header page" from which you can then link direct to the section you require.

CONTENTS:

1. Introduction

APP is reflective of ACPO (now NPCC), Home Office and HMIC guidance, and responds to developments in the field of domestic abuse. The headings in this report are reflective of the HMIC Inspection (2014) Everyone's business: Improving the police response to domestic abuse - HMICFRS

The APP paints the picture nationally. Within Avon & Somerset figures abstracted from Qlik Oct 2017 show that domestic abuse represents a greater proportion of overall crime locally (12%) than nationally (8% of all crime). It represents a third of all recorded assaults with injury.

Domestic abuse is not only high volume, but also high risk. Getting the Police response wrong can have severe consequences and result in a failure to protect victims from assault, mental harm or even death. It is too late to recognise Police failings in a serious Case Review following such a death.

Real and sustained improvement requires leadership at every level, top to bottom. Training with regards to domestic abuse must be seen as a priority, and attendance facilitated. The constabulary has adopted stringent performance management frameworks to measure individual and team performance against domestic abuse objectives (utilising Qlik).

Separate Force Procedural Guidance has been produced for:

Domestic Violence Disclosure Scheme (DVDS). The APP is referred to later within this document.

Domestic Violence Protection Notices & Orders (DVPN / DVPO). Similarly the APP is also referenced later.

2. Context & Definitions

The cross-government definition of domestic violence and abuse is:

… any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, **intimate**

partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:

- psychological
- physical
- sexual
- financial
- emotional

This definition, which is not a legal definition, includes honour-based abuse (HBA), female genital mutilation (FGM) and forced marriage. Detailed guidance relating specifically to FGM is set out in authorised professional practice (APP) on FGM.

Domestic abuse can give rise to a wide range of separate criminal offences, including the specific offence of controlling or coercive behaviour in an intimate or family relationship. Officers are required to take preventive and protective measures even where no criminal offence is apparent, particularly where there are signs of controlling or coercive behaviour. Seemingly low-level or minor events which may in fact amount to a pattern of behaviour or a course of conduct indicative of stalking or harassment may be misinterpreted as non-crime incidents but to do so has potentially serious consequences. If an incident fits the definition of domestic abuse, it must be recorded as a domestic abuse incident.

Officers and staff must deal with every incident of domestic abuse, including controlling or coercive behaviour, in a professional way. The police duty is to take reasonable steps to make the victim safer, regardless of how many times they have been called and regardless of how many times a victim may have not supported police actions. All incidents must be investigated fully and recorded properly. This ensures that any follow-up and future actions are based on the best available information and intelligence.

Officers must be able to recognise controlling or coercive behaviour as it can be a warning sign of a risk of future violence towards the victim. Although the conduct may appear low-level, any behaviour or pattern suggestive of controlling or coercive behaviour must be treated seriously and investigated to determine if an offence has been committed under section 76 of the Serious Crime Act 2015 (SCA). Controlling or coercive behaviour towards another can also include or be committed in conjunction with a range of other offences.

Description of controlling or coercive behavior

The Home Office describes controlling behaviour as:
… a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

The Home Office definition of coercive behaviour is:
… an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

Avon & Somerset Constabulary recognise that Controlling or coercive behaviour can take a range of forms. Officers and staff dealing with domestic abuse incidents MUST be alert to patterns of behaviour that could be controlling or coercive.

The principal characteristic of such behaviour is that it involves a pattern of continuing and repeated abuse. This abuse often appears routine and so-called low-level but, taken as a whole over time, it can cause the build-up of constant anxiety and fear. It can also create an environment in which increasingly harmful conduct is accepted as normal by the victim. It is sometimes compared to grooming a child. If the level of control is sufficiently high, the victim may actually believe that allegations made against the perpetrator are false.

Many individual acts of this type will not constitute an offence in isolation but can do so when taken together. Officers must be able to recognise if there is a pattern, as it is often when the victim challenges their abuser and the pattern of control is threatened that the situation can escalate into physical and sexual violence.

See also Checklist: Conducting the victim interview – controlling or coercive behaviour and Suspect interview, spotlight on controlling or coercive behaviour.

Home Office Statutory Guidance Framework

Victims and perpetrators of domestic abuse

Anyone can be a victim or perpetrator of domestic abuse regardless of:

- sex or gender identity
- cultural heritage or ethnicity
- sexual orientation
- religion or belief
- age
- disability
- social status or wealth
- occupation (including police officers and staff).

When attending an incident, officers should not make assumptions about the alleged offender or victim based solely on the above factors but instead judge every case on its own merits and particular facts.

Both the victim and perpetrator have to be at least 16 years old for domestic abuse to be flagged as such under the definition. If the victim is under 16, the matter is treated as child abuse. Sixteen- and seventeen-year-olds may also experience particular issues which are addressed separately. In all cases, whether child abuse, domestic abuse or both, police officers should be victim-focused, identify the best outcome, and apply safeguarding principles. The Crown Prosecution Service (CPS) Domestic Abuse Guidelines for Prosecutors state that prosecutors should apply the domestic abuse policy to all cases of current or former partner or family abuse irrespective of the age of the offender or the complainant. Where an offender is under the age of 18, the CPS legal guidance on Youth Offenders also applies.

The definition of domestic abuse includes a wide range of relationships within the family context. Collectively, these relationships can be categorised as either intimate or non-intimate (familial) relationships.

Intimate relationships can be between heterosexual and same-sex partners, as well as those involving a transgender partner or partners. Former partners are also included in the definition.

With regards to non-intimate or familial abuse, the term family member includes mother, father, daughter / son, brother / sister, grandparents, in-laws and step family.

Officers and staff are required to interpret this definition. Family members do not necessarily have to be related by blood. Officers should consider the way they live as a family unit. Although foster parents or family are not explicitly referenced in the definition, similar dynamics and considerations apply, particularly in long-term foster placements, and victims should be offered the same protection as any other domestic abuse victim.

A serial perpetrator is someone who has been reported to the police as having committed or threatened domestic abuse against two or more victims. This includes current or former intimate partners and family members. The definition of serial perpetrator has been adopted because it can be used as a tool to support better perpetrator management. Additionally, it should:

- be used for monitoring and recording purposes
- inform force strategic assessments and individual risk assessments
- support the domestic violence disclosure scheme.

See also CPS Domestic Abuse Guidelines for Prosecutors, previous domestic abuse incidents and serial perpetrators.

Offences associated with domestic abuse

See CPS Domestic Abuse Guidelines for Prosecutors, impact and dynamics of domestic abuse.

Why do victims continue abusive relationships?

It is common for victims to remain with or return to their abuser. This can be difficult for outsiders to understand. An outsider may easily reach the conclusion that an abusive relationship should end. For a victim, however, reaching a decision is a much more complex process and may be hard or impossible for that person, especially where children are involved.

The AVA project provides a useful two-page guide (Appendix A of the linked document) on how a victim might weigh up the pros and cons of leaving, which shows that reaching the decision is not as straightforward as it may seem to an outsider. Appendix B of the linked document includes a flow chart setting out the process by which victims are thought to seek help, emphasising how many failed attempts to seek help there may be before any outcome is reached.

Barriers to reporting abuse to the police

It is vitally important that all staff coming into contact with victims of domestic abuse understand the significant barriers to reporting abuse to the police or maintaining support during criminal proceedings. Victims may have complex survival strategies in place to minimise risk and keep the peace with the perpetrator. The victim may fear that police involvement will destabilise this peace and increase the risk of further abuse.

Victims may mistrust the police. They may have had previous negative experiences where officers were unsupportive or the criminal justice system did not resolve the issue positively for them. They may have suffered increased abuse following a previous unsuccessful engagement with the police. They may simply fear that the police will not believe them.

Seeking to understand the reasons behind the behaviour is not about judging a victim's actions, but about being able to tailor the police response to that individual. Understanding their actions is key to understanding what will make them safer.

Officers should think about the reasons why a victim may stay or withdraw support. They should be aware that, no matter how many times a victim may initiate and withdraw, the person may eventually choose to end the relationship if provided with the right support. It is crucial, therefore, to approach each incident without making assumptions and to apply the same level of effort to risk assessment, safety planning and investigation on each occasion. A police officer's primary duty to ensure public safety applies particularly to vulnerable persons, which includes domestic abuse victims. A victim who refuses to engage with the police may be prepared to work with other domestic abuse services – officers should always consider referring a victim to specialist domestic abuse services, even if they are not engaging with the police.

3. Risk & Vulnerability

Primary risk assessment

When investigating a domestic abuse incident, it is the responsibility of the attending officer or first responder to carry out a primary risk assessment at the first opportunity, usually at the scene. Officers and staff carrying out risk assessments should have a thorough knowledge of the possible risk factors for domestic abuse, including those in relation to certain groups of victims, and be skillful in applying these factors to individual cases, using professional judgement. Within Avon & Somerset constabulary officers should use the DASH risk assessment alongside the BRAG* assessment (*currently subject to a pilot study).

In all cases officers must take the wider context of the relationship and any history of abuse into account, in addition to the nature of the specific incident. Officers should follow the initial risk identification and safety planning processes even where no criminal offence appears to have been committed. The incident may form part of a pattern of controlling or coercive behaviour. Risk identification and assessment should be integral to any police investigative response to domestic abuse within the constabulary.

Officers attending domestic incidents must bear in mind any potential risk to other parties apart from the victim, most particularly children whether they are present or not. Children (and unborn) must be properly linked to both the incident and to the involved parties on niche, so that their relationship can be properly determined and any risk assessed.

Attending officers should also raise a tasking through niche to ensure that a referral is made to the Safeguarding and Lighthouse Unit.

Secondary risk assessment

Avon & Somerset Constabulary expects its' staff to maintain a continuing and dynamic process of assessing risk to ensure that consideration is given to changing circumstances. If the risk assessment changes it is vitally important that communication is had with others that might be actively involved in either investigating the case or supporting the victim

Consideration of issues affecting certain groups of victims

Avon & Somerset Constabulary believes that consideration needs to be given to the different needs or issues relating to individual characteristics of victims, be that by age, gender, sexual orientation, disability, cultural background, immigration status or profession. Further advice can be found by following this hyperlink.

Familial abuse

Police officers are accustomed to dealing with intimate partner abuse, which is what is traditionally thought of as domestic abuse. Familial (non-intimate partner) abuse poses some different challenges in terms of finding the appropriate response. It can be less easily recognisable as domestic abuse, yet it falls within the definition and should be treated as such. Types of familial abuse are illustrated by following this link.

4. Identification & reporting

All reports of domestic abuse should be recorded in accordance with the National Standard for Incident Recording (NSIR) and, where necessary, the National Crime Recording Standard (NCRS) (contained in the Home Office, Counting rules general rules, 2015). Accurate recording of domestic abuse incidents is essential to identify patterns of behaviour and coercive control, as well as to correctly fulfil requests under the domestic violence disclosure scheme (DVDS). Under-recording or downgrading incidents is dangerous because it can give a false intelligence picture.

It makes no difference whether reports of domestic abuse are made direct by involved parties, referred via agencies or reported by third-parties. Avon & Somerset Constabulary expects staff to properly record the incident and / or seek advice if they don't know what to do.

The links between an investigation into another offence and associated offences of domestic abuse might not always be apparent. There are significant associations between domestic abuse and child abuse for example. In households where domestic abuse is present, children may also be abused. Figures provided in Coordinated Action Against Domestic Abuse (CAADA, now SafeLives) In plain sight: the evidence from children exposed to domestic abuse suggest that direct harm to the child may occur in over half of cases where children are exposed to domestic abuse. Similarly, in households where there is child abuse, domestic abuse may be present.

Officers must be aware of such links. Honour-based violence, vulnerable adult abuse, stalking & harassment, homicide, suicide, missing person investigations are just some examples of the type of incident that could be linked to domestic abuse (for further info click here).

5. Call handler & front office staff response to reported domestic abuse incident

The constabulary believes that staff may need to spend longer on a domestic abuse call than other calls because of the need to deal with the call in context. Providing a high-quality response should take priority over any pressure to move on to other calls. It is important to establish as much information with regards to both the incident and history as it is safe to do so.

Perpetrators sometimes call 999 themselves to make a counter-allegation by:

- falsely alleging that they are the victim of an assault in order to pre-empt an assault allegation against them
- reporting an assault on themselves, which is actually an act of self-defence or resistance by the primary victim.

Further specific advice for such staff can be found here

6. First Response

First response officers have a dual role to play when attending domestic call-outs. They should:

- recognise signs of abuse and the need for safety planning to protect victims (or potential victims) and prevent offences from occurring in the longer-term
- identify criminal offences so that offenders can be brought to justice and dealt with robustly within the judicial system.

Response officers should:

- ensure immediate safety
- build rapport
- carry out an initial investigation
- identify risk
- initiate support and protection (initial safety planning)
- ensure a good handover takes place, where applicable.

The first responder remains responsible for investigation and safety planning unless and until the case is handed over to a specialist or other investigating officer.

Officers should apply a positive approach to resolving the call-out, which may range from arrest to other forms of action. See arrest and other positive approaches.

The first priority of the police is to make people safe. At domestic abuse incidents it is particularly important that officers take positive action to make the victim and any children safe. This may mean arresting a person suspected of an offence, where the power to arrest exists, or taking other positive steps to ensure safety, such as organising refuge accommodation or organising the fitting of a panic alarm.

Officers must be able to justify the decision **not** to arrest where the grounds exist and it would be a necessary and proportionate response. In some situations, other positive approaches may be more appropriate, e.g., when the behaviour does not amount to criminal conduct.

En-route to the scene officers should endeavor to obtain a full picture of the situation, the family and their previous history. They should obtain all relevant information from the call handler about the incident and parties involved to enable initial risk assessment prior to arrival at the scene.

Officers should also be prepared to gather evidence as soon as they arrive at the scene. Body-worn video (BWV) recordings can provide excellent evidence, particularly in criminal proceedings, as they:

- have significant dramatic impact
- record the scene exactly
- record the demeanour of the parties
- accurately record significant comments at the scene.

Attending officers need to be aware of their lawful powers of entry.

There is some good evidence to show that where officers responding to domestic abuse are equipped with body-worn cameras the proportion of sanctioned detections resulting in a criminal charge increases.

Where access to the property is denied, this does not necessarily mean that no entry is possible. It does, however, mean that any decision to enter in spite of objection by the victim or another person must be legally justifiable. Officers should accurately record both the power of entry invoked and the reasons why it is believed to apply.

Concern for welfare alone has been held to be insufficient to justify entry under section 17(e) of PACE. The purpose of 'saving life or limb' in that provision has been interpreted as meaning that there should be a 'fear that something has happened or may happen which would involve serious injury to a person' (Syed v DPP [2010] EWHC 81 (Admin)).

Officers must consider the need for first aid or other medical assistance as appropriate. Officers should accompany the victim in order to maintain the continuity and integrity of the evidence, and to coordinate any investigations undertaken Any injuries should be documented as fully as possible using BWV, photos, body map and written descriptions.

Children

A child is any person under the age of 18. The police have a duty to protect children from harm. In all investigations the principle that the welfare of the child is paramount should be observed. Officers should seek to establish whether any children ordinarily resident in the household or present are subject to child protection plans.

Officers investigating domestic abuse offences should identify whether a child was present when the incident occurred, or whether a child is ordinarily resident at the address where it occurred. When officers do not see children, they should ask if children are resident at the address and should look for signs of children, such as clothing and toys. They should check bedrooms. Where they are told children are on the premises, officers should ensure they see each child to check that they are safe and well.

Whether officers speak to the child depends on the nature of the incident and likelihood of injury. Even where it appears the child is already aware of the incident, first response officers should only ask sufficient questions to establish the safety of the child, crime scene location, suspect identity and location, and to ensure the preservation of evidence.

They should record all questions and answers for the preparation of any subsequent interview. It is important to allow the child to answer without interruption.

Officers do not need parental consent to speak with the child but, if it is refused, officers should record all requests for consent to interview and should consult and involve children's social care departments as appropriate.

Children exposed to domestic abuse are subject to harm and risk. Allowing this to happen may amount to an offence of child neglect, which means the child may be a direct victim as well as a witness. See child abuse investigations for further information.

If the child is a potential witness to the domestic abuse, either as an observer or as a victim in their own right, they should be interviewed in accordance with the guidelines set out in Ministry of Justice (2011) Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, and using special measures. Officers should consider involving a registered intermediary from the outset.

Officers MUST record the name, date of birth, sex of child, primary carer or care-arrangements for looked after children, school or nursery of the child. These details MUST be linked onto the niche record.

Officers should also record full details of the details of the child's circumstances, as witnessed by the officer, to include personal welfare, cleanliness, communication ability, injuries and demeanour, details of anything said by the child and full details of other children ordinarily present at the address.

Vulnerable adults

The broad definition of a vulnerable adult is a person:

Who is or may be in need of community care services by reason of mental or other disability, age or illness and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.

The offence of ill-treatment or wilful neglect of a person lacking capacity, under section 44 of the Mental Capacity Act 2005 (MCA), can be committed by anyone responsible for that adult's care and support. This includes familial carers or a family member holding a power of attorney for the vulnerable adult and can therefore be domestic abuse.

Officers must work in line with the MCA. This is particularly challenging where a person appears to have capacity but the decisions they are making place them at risk of abuse or neglect. Officers should seek advice from supervisors and use professional judgement to balance competing factors. If in doubt, officers should consider it unlikely that they will be criticised for taking steps to make a person safe against their will when the officers consider, with good reason, that the person cannot make a properly informed decision about their welfare.

Building rapport

Checklist: Actions on arrival at the scene provides information on how officers should ensure the safety of victims and children and preserve evidence. To achieve this, officers must establish a rapport and effective communication with the victim.

If an incident is handled effectively and sympathetically on the first occasion, the victim is more likely to have the confidence to call the police again if the situation recurs. Establishing a good rapport also means the victim is more likely to cooperate with the risk assessment and safety planning process, thereby improving the chances of preventing or reducing future incidents.

Many factors can prevent a victim from giving a full and frank account of what has happened. There may be hostility or distrust based on the victim's previous experiences with the police. It may be difficult to access the premises if the victim refuses entry. Victims may be misusing substances or experiencing mental ill health. They may be traumatised by years of abuse, feel terrified of their partner or have come to accept the abuse as normal. Officers must avoid being dismissive or judgmental towards the victim, especially if they are frequently called to the same address. It is important to understand the dynamics of domestic abuse and to empathise with victims who choose not to, or are unable to, end an abusive relationship. The role of the police is to protect, not judge.

Carrying out the initial investigation

It is common for victims not to support, or to appear not to support, the police, an investigation or criminal proceedings for a variety of reasons. Officers should not assume that investigating the incident in such circumstances will not result in a positive outcome, and should take steps to build a case for a potential evidence-led prosecution, i.e. a prosecution based on hearsay or circumstantial evidence, or featuring a hostile witness. The first responder should look for corroborating evidence immediately on arrival at the scene as this is the best opportunity to investigate.

Officers should ensure that they read and use the Joint NPCC and CPS Evidence Gathering Checklist for use by Police Forces and CPS in Cases of Domestic Abuse.

Avon & Somerset Constabulary have developed a Domestic Abuse Toolkit for use by all officers attending domestic related incidents.

Although DVPN / DVPOs are normally obtained at a later stage of criminal proceedings, officers need to be thinking about the potential for obtaining one from the outset. Where the perpetrator is arrested, officers should ask the victim if they would like such a notice / order and in what terms, and record the answer in the victim's statement.

If there is a need for an interpreter at the scene, an approved interpreter should be sourced if possible. Where none is available and there is a need to secure immediate safety, officers should consider using a telephone interpreting service, limiting its use to preliminary inquiries.

Officers should only use family members as interpreters as a last resort and only for the purpose of securing immediate safety. This applies particularly to children. Some family members may be vulnerable to abuse or intimidation by the perpetrator and asking them to interpret could put them at risk. No suspected perpetrator should ever be used and if HBA is suspected it is never appropriate to use a family member.

Officers should avoid jumping to conclusions about which of the parties in the relationship is the victim and which the perpetrator. This applies to all types of relationships, whether heterosexual, same sex, transgender or familial (non-intimate partner). They should probe

the situation and be aware that the primary aggressor is not necessarily the person who was first to use force or threatening behaviour in the current incident. They should examine whether:

Counter-allegations require police officers to evaluate each party's complaint separately and conduct immediate further investigation at the scene (or as soon as is practicable) to determine if there is a primary perpetrator.

If both parties claim to be the victim, officers should risk assess both. There may also be circumstances where the party being arrested requires a risk assessment, as in the case of a victim retaliating against an abuser. Officers should bear in mind the possibility that the relationship is a mutually abusive one.

It is the responsibility of first responders to initiate safety planning and set out options for the victim, even where this is subsequently followed up by a specialist officer. Urgent safeguarding actions can be put into place straight away – a matter of hours can make all the difference to that victim's safety.

Sometimes it is not possible to assure a victim's safety by taking measures to address the perpetrator's behaviour, for example, if the suspect is feared to be very violent and has left the scene. Moving a victim out of their home is a serious step and risks victimising the person again. In some cases, however, it may be unavoidable. In these circumstances, a refuge may be an option for some victims, but there are limited places and many restrictions on who can stay there.

Refuge operate a network of refuges and community-based support services across the country for women and children who need advocacy and support and a safe place to stay.

Women's Aid also support a network of specialist services. Specialist refuge and support services also exist for victims of domestic abuse who might experience additional barriers to reporting or escaping domestic abuse.

National Domestic Violence Helpline (Run by Refuge and Women's Aid)
0808 2000 247

There are organisations which can help victims with obtaining injunctions or other aspects of family law.

The National Centre for Domestic Violence (NCDV) provides assistance with applying for emergency injunctions and is usually able to do so within 24 hours of first being contacted. See civil orders for further information.

Rights of Women provides advice about the law to women and have a family law advice line staffed by volunteer legal professionals.

8. Arrest and other positive approaches

The first priority of the police is to make people safe. At domestic abuse incidents it is particularly important that officers take positive action to make the victim and any children safe. This may mean arresting a person suspected of an offence, where the power to arrest exists, or taking other positive steps to ensure safety, such as organising refuge accommodation or organising the fitting of a panic alarm.

Officers must be able to justify the decision **not** to arrest where the grounds exist and it would be a necessary and proportionate response. In some situations, other positive approaches may be more appropriate, for example, when the behaviour does not amount to criminal conduct.

The basic principles of safeguarding apply in relation to both adults and children. Officers must always consider risk in accordance with the national decision model (NDM). If the assessment identifies a risk of harm, it is never appropriate to do nothing. Arrest may not be possible because the grounds for arrest are not met or arrest would be a disproportionate response to the incident. Where there is domestic abuse and the victim is at risk of harm, however, the duty of positive action requires officers to consider and implement proportionate alternative measures to protect the victim and their children.

Where an offence has been committed in a domestic abuse case, arrest will normally be 'necessary' within the terms of the Police and Criminal Evidence Act 1984 (PACE) to protect a child or vulnerable person, prevent the suspect causing injury or criminal damage and/or allow for the prompt and effective investigation of the offence.
Proactive investigation is always required in cases of domestic abuse as the victims, children, neighbours and other witnesses may be reluctant to interfere with what they perceive as personal matters. They may also fear threats, emotional pressure and violent reprisals.

Code G of the PACE Codes of Practice states that, among other grounds, an officer may carry out an arrest to allow prompt and effective investigation of the offence or the person's conduct where there are grounds to believe that a person may intimidate, threaten or make contact with witnesses or destroy evidence.
The decision whether or not to arrest a suspect rests with the police officer, and officers should not ask victims whether they require an arrest to be made.

The decision to prosecute in domestic abuse cases must be made by the CPS, in accordance with the Director's Guidance on Charging, 5th Edition and the Aide-memoire on charging in domestic abuse cases. The CPS (2015) Domestic abuse charging advice sheet has been prepared for police officers and prosecutors to further clarify the existing requirements around police referral of domestic abuse cases to the CPS.

It can be difficult for officers attending a domestic abuse incident to establish what has happened. A primary perpetrator of abuse may claim to have been assaulted by the other party and have injuries apparently supporting their account. They may in fact have been caused in self-defence by the primary victim. A manipulative perpetrator may be trying to draw the police into colluding with their coercive control of the victim. Police officers must avoid playing into the primary perpetrator's hands and take account of all available evidence when making the decision to arrest.

Where counter-allegations are made at the scene, officers should evaluate each party's complaint separately to determine whether there was a primary perpetrator. See determining the primary perpetrator and dealing with counter-allegations.

While arrest must be considered in every case, there are occasions when there are insufficient grounds or when it would not be a necessary or proportionate response. In these circumstances officers should focus on protecting the victim and preventing further

incidents by considering other forms of positive action, e.g. removal to prevent a breach of the peace.

Domestic violence protection notices and domestic violence protection orders can provide short-term protection for a victim following a domestic incident involving a perpetrator over the age of 18. A DVPN issued by the police prohibits the perpetrator from molesting the victim, as a minimum. It gives the victim a respite from their abuser and an opportunity to engage with services without the perpetrator being on the scene. The DVPN is followed up with an application for a DVPO in the magistrates' court within 48 hours of service (not including Sundays, bank holidays, Christmas Day or Good Friday). The resulting DVPO, if granted, lasts for between 14 and 28 days.

In order for it to be an option, the officer should conclude that there are reasonable grounds to believe that:

- the suspect has used or threatened violence against the victim, and
- the DVPN is necessary to protect the victim from violence or threat of violence by the suspect.

It is appropriate to consider issuing a DVPN at incidents when an arrest has not been made and positive action is required, a charge is not possible, an investigation is continuing or results in a caution or no further action (NFA), or a suspect is bailed without conditions restricting their contact with the victim. See DVPN/DVPO for detailed information on the process.

Avon & Somerset Constabulary direct staff to consider the use of DVPN/DVPOs in instances where suspects are released under investigation, as a means by which victims of domestic abuse can be safeguarded.

If there are reasonable grounds to believe that the person has breached the DVPO, they should be arrested and brought before a magistrates' court within 24 hours of arrest. The time of arrest should be prominently flagged on the breach paperwork so that the 24 hours do not expire before the breach can be dealt with. Sundays, bank holidays, Christmas and Good Friday do not count towards the 24-hour period.

The arrest should be made at the first opportunity. It is important to be proactive, as any delay loses the victim's confidence and defeats the purpose of the order. It is also damaging in court because magistrates often query the existence of risk if the police appear relaxed about the urgency of the situation.

There is no power of entry for breach of a DVPO so officers must rely on section 17 of PACE or the power relating to a breach of the peace.

A number of different emergency injunctions can be obtained in the civil courts to protect victims for a period of time. The victim may apply for them even if the perpetrator is subject to bail conditions or a DVPO, as those offer only short-term protection.

Officers should make victims aware of these options. They cannot give detailed advice on the process but they should:

- emphasise the need to act promptly if the victim wishes to take this step, as the court is likely to give more weight to evidence of abuse if it is recent

- refer the victim as soon as possible if they wish to pursue this course of action.

A violent offender order (VOO) can be applied for under Part 7 of the Criminal Justice and Immigration Act 2008 (CJIA) where a person is believed to pose a risk of serious violent harm to the public or any particular member of the public. This is defined as a current risk of serious physical or psychological harm, caused by the offender committing any one or more of the offences specified in section 98(3) of the CJIA. VOO is a civil order and can only be applied for by a chief officer of police by complaint to a magistrates' court.

Cautions are rarely appropriate in domestic abuse cases. By nature, they involve the aggravating factor of breach of trust and abuse is not often reported on the first occasion. Controlling or coercive behaviour may also influence the victim's views on a caution. Charge is, therefore, always the preferred option where the case passes the evidential and public interest tests. Only in very limited cases can they be applied.

Restorative justice (RJ) is rarely appropriate in domestic abuse cases and not recommended in cases involving intimate partner abuse. Domestic abuse incidents are among the most hazardous of cases because of the risk to victims of re-victimisation or serious violence and the potential effects of controlling or coercive behaviour. Any officer considering the use of restorative justice in a domestic abuse case must take advice from supervisors and other agency experts.

Youth Offenders and Out of Court Disposals

When considering the use of an Out of Court Disposal for a youth – including those under 16 years of age – that has committed an offence which otherwise meets the criteria of domestic abuse, the following approach should be followed:

- If there is no previous intelligence of any domestic related incidents and when considering the full circumstances of the offence and previous offending history of the youth, the outcome is likely to be an Out of Court Disposal, the case should be referred to the Youth Panel via the Youth Justice Officer.

- If there is intelligence of previous domestic incidents, even if no formal previous offending history, as there is a pattern the case should be referred to the CPS to make the decision. Ensure that this intelligence is detailed in materials to CPS when requesting a charging decision.

- *Please note that offences that are not admitted or are indictable only must be referred to the CPS for a decision irrespective of previous offending history.*

Threats to Human Life and Zephyr's Protected Persons Service

Where there is an imminent risk of serious harm please contact the Force Duty Officer who will be able to provide further advice**. Consideration should also be given in relation to the Force Policy and Procedures for in Managing Threats to Human Life**

- Risk To Life or Threats of Serious Harm
- Protected Persons Referral Guidance

Zephyr's Protected Persons Service supports police forces in the South West to tackle the threat from Level 2 crime, as well as other areas of policing where there is a

substantial threat to the safety of an individual or other significant threat to an individual's life. The main responsibility of the team is to provide reasonable safeguards for the safety of anyone where there is a substantial threat to their safety. The unit provides forces with options for ensuring that essential witnesses are able to provide evidence. The team is able to protect people other than witnesses if there is believed to be a substantial risk of harm – it is no longer dependent on criminal proceedings. The team will deal with circumstances where the risk to a person's safety is so serious that relocation, a change of identity, or both are necessary. The unit is also a point of contact for advice and guidance and encourages early consultation on protection issues. The unit can offer advice and guidance to officers dealing with a fearful witness and if necessary can meet with them and explain the options available to safeguard their security and welfare.

Please contact Zephyr's Protected Persons Service for further advice on 01275
841773/5 - normal officer hours or 07785 432422 - 24/7 on call for urgent matters (police only)

9. Investigative development

When investigating incidents of domestic abuse, officers should not only be searching for evidence to support a criminal prosecution but also looking for signs that abuse may be occurring, even where the conduct may not amount to a crime. The incident being investigated may be the latest in a series and indicate an increase in frequency or seriousness that should be considered as part of any risk assessment. Detecting the abuse early means safety measures can be put in place to prevent escalation.

Officers should investigate domestic abuse proactively from the outset with a view to building an evidence-led case that does not rely on the support of the victim. Detection of domestic abuse is more likely to result if a victim supports police action and prosecution, but there are many reasons why a victim may not do so and it is important to extend the investigation beyond the victim. Further advice and guidance can be found below;

Prosecution based on hearsay evidence

Prosecution based on a hostile victim

Prosecution based on circumstantial evidence

In all domestic abuse cases, investigating officers (IOs) should explore the history of domestic abuse. Patterns of abuse are not always apparent because incidents attended in the past may have been recorded as verbal only or otherwise deemed trivial. Officers should obtain as much detailed information as possible to understand the context and identify signs of coercive, controlling or threatening behaviour. Officers should use such information to support the prosecution file and, where relevant, to show that the offence is part of a pattern of domestic abuse. Avon & Somerset Constabulary have developed a simple data analysis tool (Qlik) which can be used to quickly determine previous incidents involving any party, and can apply some scientific processing of data to help determine risk (alongside the DASH and BRAG risk assessments).

Further advice and extensive guidance is available via the above links, and also contained within the Domestic Abuse Toolkit form.

Advice with regards to the management of suspects within custody can be found at Post arrest management of suspect & casefile.

The Police and CPS have agreed charging standards for certain types of offence, including assaults. To enable the CPS to make a decision about a particular case, the police should provide them with as much information as possible. This also assists in the effective prosecution of the case, and can be used in the protection of the victim and any children if a charge is deemed appropriate.

Advice regarding file preparation can be found at checklist - file prep.

10. Pre-charge bail management

The powers relating to the use of pre-charge bail which are set out in PACE have been amended by the Policing and Crime Act 2017. Pre-charge bail is a unique policing tool and should be tailored to the specific circumstances for which it is being granted. Bail is an alternative to custody – it allows for officers and staff to continue the investigation without the suspect being detained. Conditional bail allows officers to attach conditions to bail which can protect complainants or witnesses, preserve evidence and mitigate the risk of further criminality.

Officers should proactively consider the use of DVPN/DVPOs in order to help mitigate risk towards any victim or associated party (such as children).

11. Victim safety & support

The Ministry of Justice (2015) Code of Practice for Victims of Crime (the Victims' Code) sets out in detail the entitlements of victims of crime and the corresponding duties of the various agencies, including the police and witness care units (WCUs), throughout the entire criminal justice process. For the purposes of the Code, victims of domestic violence are classed as 'victims of the most serious crime'. This means that they are entitled to an enhanced level of service.

Under the Victims' Code, the police must offer a domestic abuse victim the opportunity to make a victim personal statement (VPS), even if they have not given any other witness statement. They should also ask the victim if they want the VPS read out or played in court, and if they would like to read it out themselves, although it is for the court to decide how the VPS should be presented.

The VPS is especially important in domestic abuse cases because it is the victim's opportunity to convey the context in which the offending has occurred (including controlling or coercive behaviour) and the impact it has had on the victim, how the perpetrator has made them feel and any long-term health or other consequences. It is also appropriate to include reference to any observed impact of the offending on children too young to make their own statement, for example, changes in behaviour such as experiencing nightmares or comments made by the child which are heard by the victim.

If a VPS is made early on in the proceedings, it is useful to obtain a further VPS later in the case to provide an update on how the offending has affected the victim, as some consequences are not immediately apparent and others have long-term impact.

Officers should ask the victim for their views on obtaining a restraining order from the outset, preferably in their witness statement. Although they are usually imposed post-conviction as part of sentencing, restraining orders can also be imposed on acquittal or where the prosecution is discontinued. For the court to properly consider imposing an order, especially a non-conviction order, it needs to know the views of the victim.

Officers must take all reasonable steps to identify vulnerable or intimidated victims. Where such a victim is likely to be called as a witness in criminal proceedings and may be eligible for special measures, the police must explain the provisions included in special measures to the victim, and must record any views that the victim expresses about applying for them. For further information on special measures see APP on investigation, working with victims and witnesses and APP on prosecution and case management, special measures for vulnerable and intimidated witnesses.

When a victim indicates that they wish to withdraw their support for the prosecution process, a statement should be taken stating and describing any reasons for the withdrawal. The officer will explain to the victim that making a withdrawal statement does not necessarily mean they will not have to attend Court and give evidence if necessary. Withdrawal statements taken with care may still be used as evidence in current or future criminal proceedings or as evidence within the family court system. Any withdrawal of support for a prosecution should prompt a revised risk assessment process and safety planning.

The officer in the case should notify the CPS without delay if the victim indicates a wish to withdraw support for the prosecution. They should notify the CPS of their thoughts as to the veracity of the reasons given, how the case should be dealt with, how the victim might react if compelled to attend and how the decision would be likely to be impact on the safety of the victim or the safety of the children of the family.

The officer will be prepared to attend Court to give such evidence orally, in the case of an application being made under Section 116 of the Criminal Justice Act 2003.

Specialist Domestic Violence Courts (SDVCs)

Victims and witnesses should be further assured that the Avon and Somerset Local Criminal Justice Board has established **Specialist Domestic Violence Courts.** Cases of domestic abuse will normally be heard at one of these venues where specialist provisions have been made available.

Officers will ensure all paperwork, particularly charge sheets are stamped with domestic abuse in order to ensure cases are presented at Specialist Domestic Violence Courts, or heard by a magistrate trained in Domestic Abuse.

Referral to MARAC

Where a victim of domestic abuse is identified as being at high risk of harm, they should be referred to MARAC. The one-off meeting combines up-to-date risk information with an assessment of the victim's needs. The MARAC process establishes whether the offender poses a significant risk to any particular individual or to the general community and links the victim's needs to the provision of appropriate services for the victim, children and

perpetrator. Within Avon & Somerset Constabulary this process is managed by the Safeguarding & Lighthouse Coordination Unit

Domestic Violence disclosure scheme

The domestic violence disclosure scheme (DVDS), also known as Clare's Law, was introduced to increase protection for domestic abuse victims. It establishes recognised procedures for disclosing information to enable new or existing partners of previously violent individuals to make informed choices about how and whether they take forward that relationship. This process is managed by the Safeguarding Unit.

Perpetrator Management

Avon & Somerset Constabulary actively manage and monitor known serial perpetrators of domestic abuse within the Integrated Offender Management Unit. Neighbourhood staff are expected to assist in the longer term management of victims and offenders, and all staff should proactively consider opportunities to implement problem-solving solutions to reduce such risks in the long term.

The police have a role in helping to develop and support safety plans as part of their risk management processes. In general, the victim, with assistance from an IDVA or other independent advocacy service, should carry out the safety planning, with officers being able to contribute to the process by implementing safety measures as part of a risk management plan or action plan. It should be carried out in consultation with other agencies, for example, fire service, housing, and children's services.

12. Management considerations when dealing with Police victims & perpetrators of domestic abuse.

Police officers who commit domestic abuse-related offences should not be treated differently to any other suspect. They should be investigated and held accountable through the criminal justice system in the same way as any other person. There are, however, some issues which are specific to police suspects and their victims and need to be given particular consideration. APP clearly sets out procedural guidance in this regard.
The first recipient of an allegation of a domestic incident involving an Avon and Somerset employee will **immediately** refer the information to a supervising officer, normally of the rank of inspector or above (and certainly above where the suspect is themselves a higher ranking officer).

The supervising officer will pass the information as soon as practicable to **all** of the following:

- Head of Professional Standards Unit
- Head of Safeguarding & Lighthouse

Where necessary consideration should be given to contacting:

- Nominated ACPO officer
- Appropriate Portfolio Commanders for the relevant victim/offender.

The decision to inform these officers will be determined on a case by cases by the head of the Professional Standards Unit.

Victims of police domestic abuse offenders, including victims who are also police officers (whether or not the suspect is employed by the Constabulary) should expect and be given the same level of service as other victims of domestic abuse. They should be offered confidential support from both internal and external sources.

The details of all such allegations will be subject to normal force incident recording procedures and subject of a Niche record, however reports will be flagged and subject to restricted access to safeguard the information and prevent unnecessary access and disclosure

Media

In the event of a case attracting media interest advice should be sought from the force press office and a media strategy agreed. Media strategies must be inclusive of and clearly communicated to involved partner agencies.

The potential trauma to victims and their families must be considered at all times when responding to media interest. Unless court attendance is necessary any press releases should avoid identifying victims, children and their location.

Avon and Somerset Constabulary will use the media positively to raise awareness of domestic abuse, reinforce it is criminal and unacceptable, encourage reporting and improve public confidence.

E-learning

The following two e-learning packages have been developed and can be accessed through the NCALT application:

The **Basic Awareness** package is suitable for any member of staff within Avon and Somerset Constabulary and takes approximately 30 minutes to complete.

The **Responding to Domestic Abuse (DASH)** module is suitable and recommended for all frontline officers (PC – INSP) who will be responding to domestic abuse incidents, and those officers who will be involved in the risk identification, risk assessment and risk management processes. This module can be found in the NCALT index under "R".

Last Review Completed:	24/10/17 (C/Insp Nigel Colston)

Appendix E; Avon and Somerset Constabulary Domestic Abuse Toolkit

DOMESTIC ABUSE TOOLKIT

For first response at the scene

Name of Complainant:	
Date of completion:	Time of completion:
Completed in presence of victim: Y/N Rationale if "No":	

Location of completion:
Storm Ref:
Niche Ref:
Exhibit Number:
Reporting Officer:
Supervising Officer:
DASH Risk level: Standard / Medium / High
Safe to Contact: Y/N

INITIAL ACCOUNT

K / ^

..	
.	
.	
..	
/ W	Y/N

Signed as a true and accurate record
Name Signature

PARTY 1 DETAILS	
Victim / O ender / Involved Party / Mentioned	
Name	D.O.B
Address	
Male Female	Sexual Orientation
First Language	Interpreter Yes/No
Landline	Mobile
Email	
Occupation	
Doctor	
Relationship with other party	
Miscellaneous Information (Special measures, disability needs, contact restrictions, substance/alcohol abuse)	

Statement obtained Yes/No (If “no” explain rationale/reason)

PARTY 2 DETAILS	
Victim / O ender / Involved Party / Mentioned	
Name	D.O.B
Address	
Male Female	Sexual Orientation
First Language	Interpreter Yes/No
Landline	Mobile
Email	

Occupation
Doctor
Relationship with other party
Miscellaneous Information (Special measures, disability needs, contact restrictions, substance/alcohol abuse)
Statement obtained Yes/No (If “no” explain rationale/reason)

WITNESS 1 DETAILS	
Name	D.O.B
Address	
Male	Female
Landline	Mobile
Email	
Occupation	
Relationship with Victim/O ender	
Date of previous incident/s witnessed	
Statement obtained Yes/No (If “no” explain rationale/reason)	

WITNESS 2 DETAILS	
Name	D.O.B

Address	
Male	Female
Landline	Mobile
Email	
Occupation	
Relationship with Victim/O ender	
Date of previous incident/s witnessed	
Statement obtained Yes/No (If “no” explain rationale/reason)	

CHILD 1 DETAILS	
Name	D.O.B
Male	Female

Relationship with involved parties		
Contact: Landline / Mobile / Email		
School / Occupation		
Doctor		
Witness to incident Yes/No	Where during incident	Repeat Witness Yes/No Same involved parties Yes/No
Statement obtained / Video interview Yes/No (If "no" explain rationale / reason)		

CHILD 2 DETAILS	
Name	D.O.B
Male	Female
Relationship with involved parties	
Contact: Landline / Mobile / Email	
School / Occupation	
Doctor	

Witness to incident Yes/No	Where during incident	Repeat Witness Yes/No Same involved parties Yes/No
Statement obtained / Video interview Yes/No (If "no" explain rationale / reason)		

CHILD 3 DETAILS		
Name		D.O.B
Male	Female	
Relationship with involved parties		
Contact: Landline / Mobile / Email		
School / Occupation		
Doctor		
Witness to incident Yes/No	Where during incident	Repeat Witness Yes/No Same involved parties Yes/No

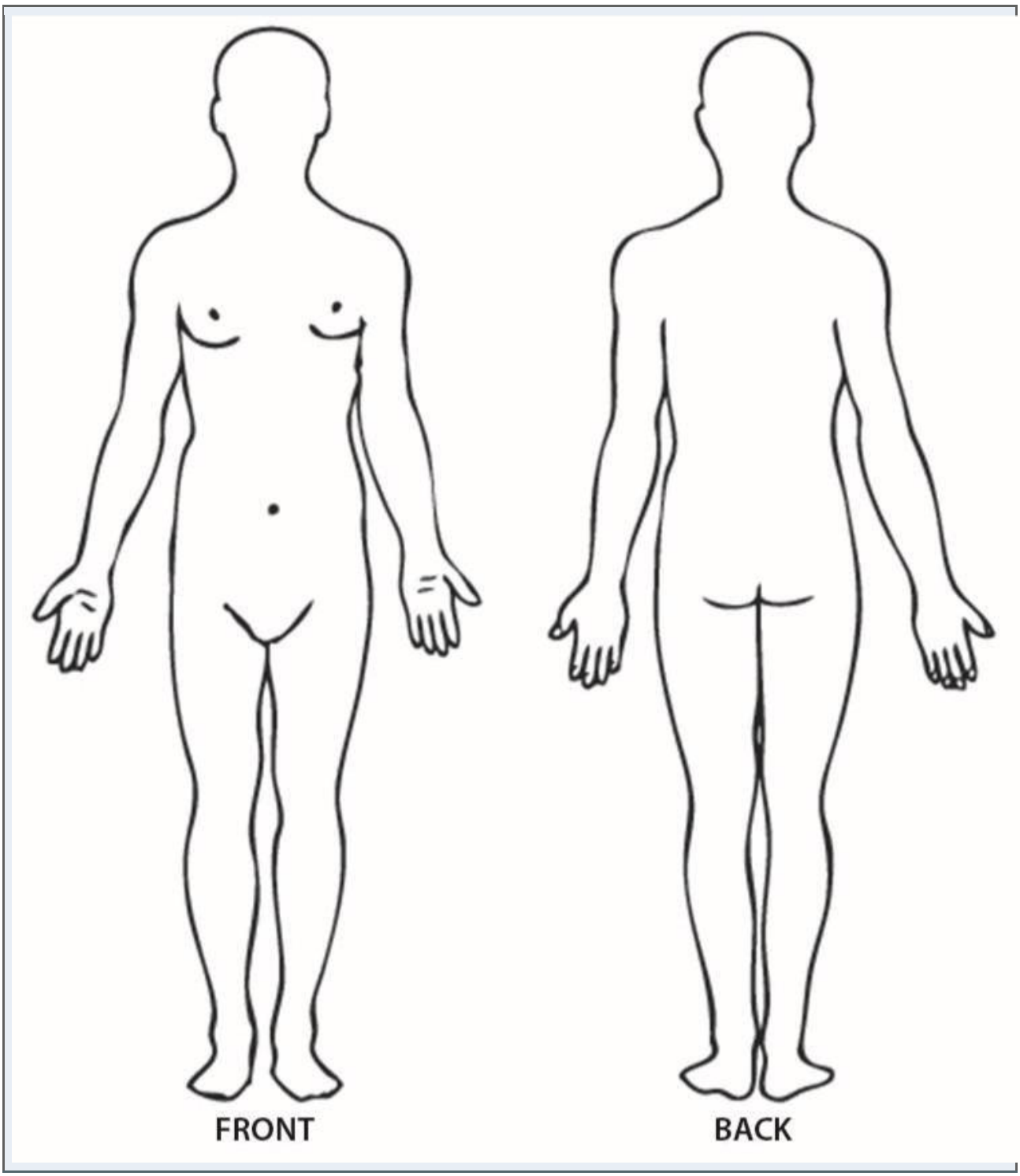
Statement obtained / Video interview Yes/No (If "no" explain rationale / reason)

CHILD 4 DETAILS		
Name		D.O.B
Male	Female	
Relationship with involved parties		
Contact: Landline / Mobile / Email		
School / Occupation		
Doctor		
Witness to incident Yes/No	Where during incident	Repeat Witness Yes/No Same involved parties Yes/No

Statement obtained / Video interview Yes/No (If “no” explain rationale / reason)

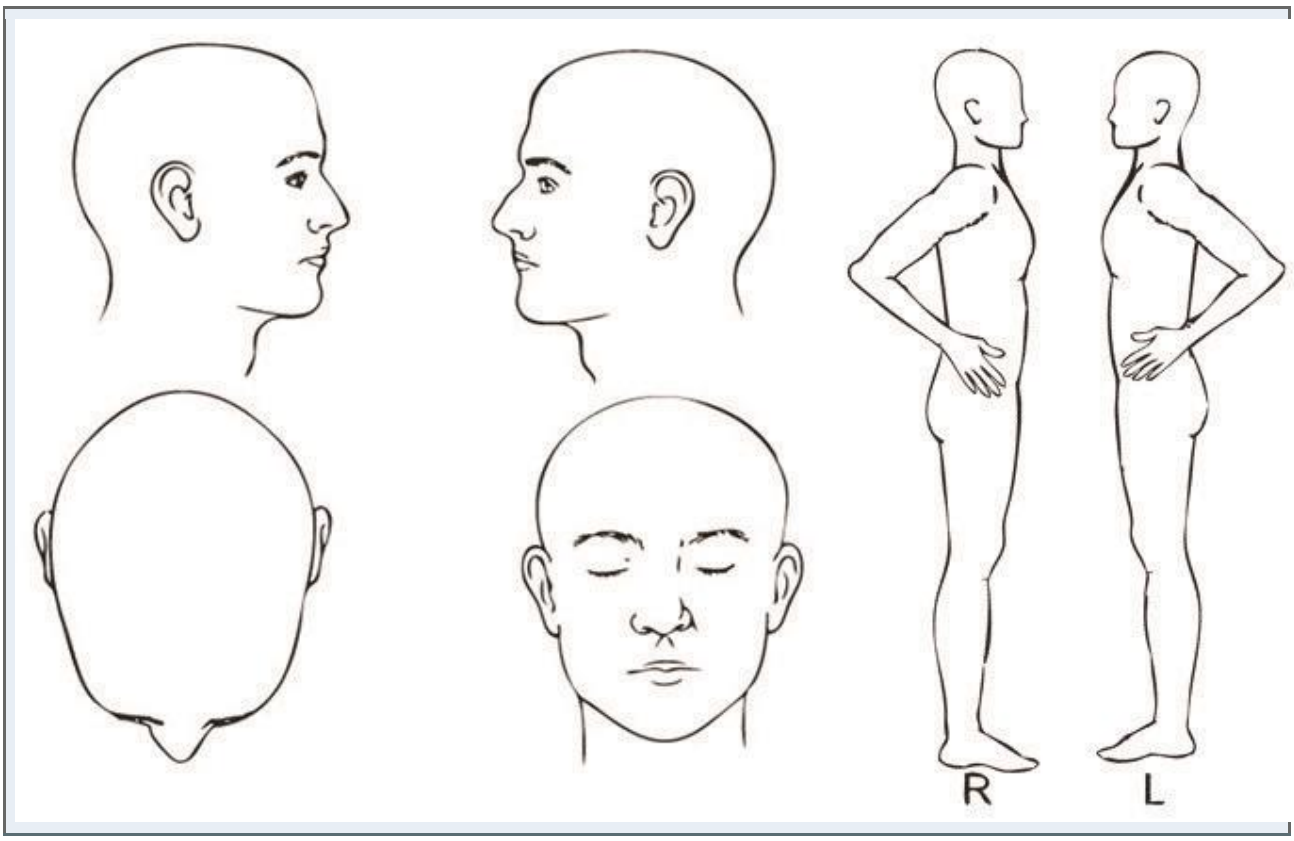
BODY MAP

NUMERICALLY MARK THE SIGHT OF AN INJURY ON THE BODY MAP RECORDING THE NATURE / DESCRIPTION OF INJURY. CONSIDER PHOTOGRAPHS.



BODY MAP

BODY MAP CONTINUED


R
L

DASH 2009 Risk Model

This **risk indicator checklist** will assist you to make a decision on the level of risk to serious harm present for this victim and how you will make them safe.

Ensure you are in **private and cannot be overheard or interrupted**.

Completion of DASH is a tool to assist the investigation and ensure appropriate support and safeguarding for the victim; not a tick box exercise.

The context and detail of what is happening is very important.

The questions highlighted in bold are high risk factors.

Record any responses to the questions in the space provided and expand in notes where necessary.

CURRENT SITUATION	
1. Has the current incident resulted in injury? (Please state what and whether this is the rst injury)	Yes ☐ No ☐

2. **Are you very frightened?** Comment _____ _____ _____ _____ _____ _____ _____ _____ _____	Yes ☐No ☐
3. **What are you afraid of? Is it further injury or violence?** (Please give an indication of what you think. Name of abuser(s) might do and to whom). Name: Kill Name: Further Injury & Violence Name: Other (please specify) Self Children Self Children Self Children Other (please specify) Other (please specify) Other (please specify) ☐☐☐ _____ _____ _____ ☐☐☐ _____ _____ ☐☐☐ _____ _____ _____	Yes ☐No ☐

4. **Do you feel isolated from family / friends i.e. does (** Name of abuser(s) **) try to stop you from seeing friends / family / Dr. or others?**	☐ Yes ☐ No
5. Are you feeling depressed or having suicidal thoughts?	Yes ☐ No ☐
6. **Have you separated or tried to separate from (** Name of abuser(s) **) within the past year?**	Yes ☐ No ☐
7. Is there con ict over child contact? (If Yes, please state what)	Yes ☐ No ☐

8. **Does (.....) constantly text, call, contact, follow, stalk or harass you?** (Please expand to identify what and whether you believe that this is done deliberately to intimidate you? Consider the context and behaviour of what is being done)	Yes ☐No ☐

CHILDREN / DEPENDENTS (If no children/dependants, please go to the next section)	
9. **Are you currently pregnant or have you recently had a baby (in the past 18 months)?**	☐ Yes ☐No
10. Are there any children, step children that aren't (.....) in the household or are there other dependants in the household (i.e. older relative)?	Yes ☐No ☐

11. Has (.....) ever hurt the children/ dependants?	Yes ☐No ☐
12. Has (.....) ever threatened to hurt or kill the children/dependants?	Yes ☐No ☐
DOMESTIC VIOLENCE HISTORY	
13. Is the abuse happening more often?	Yes ☐No ☐
14. Is the abuse getting worse?	☐ Yes ☐No
15. **Does (.....) try to control everything you do and/or are they excessively jealous? In terms of relationships, who see you, being "policed at home," telling you what to wear for example. Consider honour based violence and stalking and specify the behaviour)**	Yes ☐No ☐

16. **Has (.....) ever used weapons or objects to hurt you?**	Yes ☐No ☐
17. Has (.....) ever threatened to kill you or someone else and you believed them?	☐ Yes ☐No
18. **Has (.....) ever attempted to strangle/choke/ suffocate/drown you?**	Yes ☐No ☐

19. Does (.....) do or say things of a sexual nature that makes you feel bad or that physically hurt you or someone else? (Please specify who and what and consider the attendance of a specialist officer if disclosure sexual offences is made) _____ _____ _____ _____ _____	Yes ☐No ☐
20. Is there any other person that has threatened you or that you are afraid of? (If yes, consider extended family if honour based violence. Please specify who) _____ _____ _____ _____ _____ _____ _____	Yes ☐No ☐
21. Do you know if (.....) has hurt anyone else (children / siblings / elderly relative / stranger, for example)?. Consider HBV. Please specify who and what) Children Another family member Someone from a previous relationship (please specify) ☐Other (please specify) ☐☐☐ _____ _____ _____ _____ _____ _____ _____	Yes ☐No ☐
22. Has (.....) ever mistreated a family pet? _____ _____ _____ _____	Yes ☐No ☐

ABUSER(S)	
23. Are there any nancial issues? For example, are you dependent on (.....) for money/have they recently lost their job/other nancial issues?	☐ Yes ☐No
24. Has (.....) had problems in the past year with drugs (prescription or other), alcohol or mental health leading to problems in leading a normal life? (Please specify what) Drugs Alcohol Mental health ☐☐☐	☐ Yes ☐No
25. Has (.....) ever threatened or attempted suicide?	Yes ☐No ☐

26. Has (.....) ever breached bail/an injunction and/or any agreement for when they can see you and/or the children? (If yes, Please specify what) Bail conditions Non Molestation/Occupation Order Child Contact arrangements Forced Marriage Protection Order Other ☐☐☐☐☐ _____ _____ _____ _____	Yes ☐No ☐
27. Do you know if (.....) has ever been in trouble with the police or has a criminal history? (If yes, please specify) DV Sexual violence Other violence Other ☐☐☐☐ _____ _____ _____ _____	Yes ☐No ☐
Other relevant information (from victim or officer) which may alter risk levels. Describe: consider for example victim's vulnerability, disability, mental health, alcohol/substance misuse and or the abuser's occupation/interest – does this give the unique access to weapons i.e. ex-military, police, pest control. Also include any information on any other agencies working with either party and their contact details. _____ _____ _____ _____ _____ _____ _____ _____	

RISK TO VICTIM – officers must use professional judgement to assess the risk to the victim and any children. As a guide, the number of “yes” answers given by the victim during the assessment can indicate risk as follows:

1-7 – Standard Risk 8-13 – Medium Risk 14 and above – High Risk

If you decide to reduce or escalate the risk you must explain why below and within the Officers Observations section of the Public Protection Notification (PPN) in Niche. Remember to link all parties, to the Occurrences—particularly children.

Standard Medium or High

Standard Current evidence does not indicate likelihood of causing serious harm.

Medium There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse.

High There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious.

Risk of serious harm—”A risk which is life threatening and/or traumatic and from which recovery, whether physical or psychological can be expected to be difficult or impossible.

After using this risk assessment checklist I believe you are at risk of serious harm. I need to support you to prevent further risk.

I will (list the safety plan you have devised and agreed with the victim—see safety planning options over- leaf):

Voice of the Victim

Record the victim's views, concerns and any other information pertinent to the investigation from the perspective of the victim, parties present and children affected by the incident: _____

EARLY PREVENTION AND DISRUPTION OPTIONS

- **Remove the Risk..**

  By arresting the suspect and obtaining a remand in custody

- **Avoid the Risk..**

  Domestic Violence Protection Notice (DVPN/DVPO), Criminal Behaviour Order

(CBO), Appropriate bail conditions. Place of safety. Circulate suspects details if left the scene. Home security advice, Sanctuary Scheme.

- **Reduce the Risk..**

  DA specialist support, arrange follow up visit and means of communication; consider personal or home panic alarm. Alert friends, family and support networks. Treat all calls as URGENT marker (TACAU) and alerting neighbourhood officers

- **Accept the Risk..**

  Domestic Violence Disclosure Scheme (Clare's Law). Remember for many reasons, victims may not wish to engage with police, however, this does not negate your duty of care and requirement to SAFETY PLAN

- **Workflow all High Risk DA cases through to SCU for MARAC consideration**

- **Workflow all DA through to SCU if there are safeguarding concerns for children**

SPECIALIST SUPPORT

- 24hr national domestic violence helpline
  0808 2000 247

- Childline
  0800 1111

- Mens Advice Line
  0808 801 0327

- National Stalking Helpline
  0808 802 0300

- National LGBT Domestic Abuse charity - Broken Rainbow - **0300 999 5428**
  Visit Lighthouse Victim and Witness Care for a full list of local support services: www.lighthousevictimcare.org

LIGHTHOUSE
Victim and Witness Care

Workflow all DA offences through to Lighthouse irrespective of risk rating

EVIDENCE AND ACTIONS CHECKLIST

Have you collected **all available evidence**, including material other than the complainant's Statement?	YES	NO	COMMENTS
Body worn video recording	☐	☐	
Digital photography of victim/suspect/scene, etc.	☐	☐	
Forensic opportunities e.g. damage/blood spatter/DNA retrieval	☐	☐	
Digital evidence e.g. text messages, emails, voice mail, social media messaging	☐	☐	
Early evidence kit	☐	☐	
Consider CSI	☐	☐	
Consider SOIT	☐	☐	
Attending o cers notes/statements i.e including own observations and hearsay evidence	☐	☐	
999 recording/Command and control printouts	☐	☐	
Exhibits e.g. clothing, weapons, letters	☐	☐	
Statements of victim/witnesses (include hearsay, **Victim Personal Statement (VPS)**)	☐	☐	

Signi cant statements/admissions from suspect	☐	☐	
CCTV	☐	☐	
H2H enquiries	☐	☐	
Medical consent form signed (see sample form at rear)	☐	☐	
Special measures considerations	☐	☐	
Any existing civil/criminal orders/harassment warnings , etc.	☐	☐	
Signed consent for referral	☐	☐	
Childrens Social Care referral to specialist support service	☐	☐	
Previous history/risk assessments	☐	☐	
Summary of previous/current criminal history (PNC, PND, VISOR, local databases)	☐	☐	
Safety planning	☐	☐	

Investigating Officers - refer to FULL CPS/Police joint checklist.