FINAL

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FOREST OF DEAN COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Into the death of Ms A[1]

In June 2021

Independent Chair and Author of Report: Paula Harding

Associate of Standing Together Against Domestic Abuse

[1] The victim's family were invited to provide a pseudonym for the victim, as is common practice, and chose the pseudonym 'Ms A' which was meaningful for them.

Family Statement

Ms A's mother shared her thoughts with the review.

"Nothing will bring my daughter back, but if lessons can be learnt from this review, it can stop this happening to another vulnerable person.

My daughter was always reluctant to let the different agencies communicate with each other so that would have been part of the problem. I understand that there could have been more joined up support and that would have made a difference to how everyone perceived the situation that my daughter was in.

If only she had let me know the situation that she was in I could have done something, but she just said that she was happy and had a great boyfriend. I am sad that this man could go on to ruin someone else's life."

1. Preface

1.1 The Review Process

1.1.1 This review concerns the circumstances leading to the death of Ms A, a 37-year-old woman and mother of an eleven-year-old child, who died at her home in the Forest of Dean in circumstances considered to be suicide. At the time of writing, an inquest has not yet been held but there are no criminal investigations implicating any other person in her death. As Ms A had experienced domestic abuse for several years before her death, her circumstances are considered within a domestic homicide review.

1.1.2 Ms A had experienced adverse childhood experiences, which left her vulnerable to domestic abuse which she experienced in her adult relationships. She had been known to mental health services since she was aged 24 and had a history of self-harm and suicide attempts. She was diagnosed with Schizoaffective Disorder and Emotionally Unstable Personality Disorder and was known to become overwhelmed when having to make decisions. Mental health services therefore arranged a deputyship of her finances to assist her to manage her money. At times Ms A's distress escalated into more serious episodes of mental illness and periods in hospital.

1.1.3 Ms A referred to her child as the most important factor in her life. Although there were times when her mental health impacted upon her ability to look after her child and she needed the help of social services, there were many years when Ms A and her child lived successfully together.

1.1.4 Ms A's last partner had a long history of violent offending and drug use whilst he was living in another police force area. His previous relationship lasted only 5 weeks during which time his domestic abuse escalated quickly to high risk and involved multiple assaults, jealousy, isolation from family, strangulation, borrowing large sums of money and threats to burn her house down if she contacted the police. At that time, he was known to MARAC, convicted of common assault and was subject to probation supervision when he met Ms A in January 2020.

1.1.5 The decision to undertake a domestic homicide review was made by the Chair of Forest of Dean Community Safety Partnership, and the Home Office was notified of the decision on 16th September 2021. An independent Chair and Review Panel were appointed, and the review was managed in accordance with the relevant statutory guidance.

1.1.6 The Overview Report was endorsed by the Forest of Dean Community Safety Partnership before being submitted to the Home Office for approval.

1.2 Contributors to the Review

1.2.1 This review has followed the 2016 statutory guidance for Domestic Homicide Reviews which was issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. A total of 18 agencies were contacted to check for involvement with the parties concerned with this review. Of these, 11 had relevant contact and were asked to submit reports based upon the extent of their involvement. A narrative chronology was also prepared.

1.2.2 The agencies and their contributions to this review are:

Agency	Contribution
Elysium Healthcare	Individual Management Review and Chronology
Forest of Dean District Council Housing Services	Short report and Chronology
Gloucestershire Constabulary	Individual Management Review and Chronology
Gloucestershire County Council Children's Social Care Services	Individual Management Review and Chronology
Gloucestershire Domestic Abuse Support Service	Short report and Chronology
Gloucestershire Health and Care NHS Foundation Trust	Individual Management Review and Chronology
Gloucestershire Hospitals NHS Foundation Trust	Individual Management Review and Chronology
Gloucestershire Integrated Care Board (formerly Clinical Commissioning Group)	Individual Management Review and Chronology
South-West Ambulance Service	Short report and Chronology
Hereford, Shropshire and Telford Probation Servic	Individual Management Review and Chronology
West Mercia Police	Individual Management Review and Chronology

1.2.3 *Independence and Quality of IMRs*: The IMRs were written by authors independent of case management or delivery of the service concerned. All IMRs received were comprehensive and enabled the panel to analyse the contact with Ms A and Ms A's partner, and to produce the learning for this review. Where necessary, further questions were sent to agencies and responses were received.

1.2.4 Change Grow Live (substance misuse services) was contacted but recorded no involvement with the Ms A and her partner.

1.3 The Review Panel Members

Panel Member	Job title, Organisation

Paula Harding	Independent Chair and Author
Andy Barge	Group Manager for Strategic Support, Forest of Dean District Council
Becky Dale	Deputy Head of Hereford, Shropshire & Telford Probation Service
Caroline Clissold	Housing Manager, Forest of Dean District Council
Heather Downer	Service Manager, Gloucestershire Domestic Abuse Support Service (GDASS)
James Holloway	Group Head of Safeguarding, Elysium Healthcare
Jeanette Welsh	Lead for Safeguarding Adults, Gloucestershire Hospitals NHS Foundation Trust
Jo Bridgeman	Specialist Nurse Safeguarding, NHS Gloucestershire Integrated Care Board (formerly Clinical Commissioning Group)
Kanchan Jadeja	Quality Assurance and Improvement Consultant, Gloucestershire County Council Children's Social Care Services (also representing Education Services)
Katy McIntosh	Named GP for Safeguarding Adults and Children, NHS Gloucestershire Integrated Care Board
Steven Cook	Detective Inspector, Statutory & Major Crime Review Team, West Mercia Police
Liz Emmerson	Head of Safeguarding, Gloucestershire Health and Care NHS Foundation Trust
Nicola McLean	Community Wellbeing Manager, Forest of Dean Community Safety Partnership
Nikki Smith	Assistant Head of Adult Social Care Operations, Gloucestershire County Council Adult Social Care Services
Sophie Jarrett	Domestic Abuse & Sexual Violence Strategic Coordinator, Safer Gloucestershire Partnership
Steve O'Neill	Senior Commissioning Manager, Drugs and Alcohol, Gloucestershire County Council
Susan Fereday	Detective Chief Inspector, Gloucestershire Constabulary

1.3.1 *Independence and expertise*: Review Panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case. Panel members included representation from Gloucestershire

Domestic Abuse Support Service (GDASS) who deliver domestic abuse services in the area. They provided expertise on gender, domestic abuse and the broader 'victim's perspective' to the panel. The panel further drew upon the expertise of the County's Domestic Abuse and Sexual Violence Strategic Co-ordinator and Substance Misuse Commissioner.

1.3.2 The Review Panel met a total of four times, and the Independent Chair met with the victims' family twice. Family members contributed to the terms of reference and considered the draft Overview Report. All comments by the family have been incorporated into the report.

1.3.3 The Chair of the review wishes to thank everyone who contributed their time, patience, and cooperation to this review.

1.4 Chair of the DHR and Author of the Overview Report

1.4.1 The Independent Chair of the review and author of the report is Paula Harding, an Associate of Standing Together. She has over thirty years' experience of working in domestic abuse with both senior local authority management and specialist domestic abuse sector experience. For more than ten of those years she was the local authority strategic and commissioning lead for domestic abuse and violence against women for a large metropolitan area and has been an Independent Chair and author of domestic homicide and safeguarding adult reviews since 2016. She completed an M.A. (Birmingham) in Equalities and Social Policy in 1997, focusing on domestic abuse and social welfare, and is a regular contributor to conferences, national consultations, and academic research. She completed the OCR certificated training funded by the Home Office for *Independent Chairs of Domestic Homicide Reviews* in 2013. She has also completed the on-line training provided by the Home Office, *Conducting a Homicide Review,*[2] received specialist training from Standing Together and has undertaken training on the Significant Incident Learning Process and Learning Disability Mortality Reviews.

1.4.2 *Independence:* Aside from having chaired one previous domestic homicide review for Gloucestershire, Paula Harding has no connection with the area or any of the agencies involved in this case.

[2] Available at https://www.gov.uk/guidance/conducting-a-domestic-homicide-review-online-learning

1.5 Terms of Reference for the Review

1.5.1 At the first meeting, the Review Panel shared information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from January 2020 to Ms A' death. This timeframe was chosen because this would cover the duration of the relationship which began in January 2020. Agencies were asked to summarise any relevant contact they had had with Ms A and her partner outside of these dates.

1.5.2 Terms of reference were drawn up and incorporated key lines of enquiry as featured below, in addition to the "generic" issues set out in the 2016 Guidance.

- To provide a brief pen picture of Ms A and her partner and summary of agency involvement prior to January 2020;
- To identify key episodes of agency involvement and analyse what needs, risk and threat did your agency identify for Ms A, her partner and her child and how the agency responded;
- If domestic abuse was not known, how might practitioners have identified the existence of domestic abuse from other issues presented to them;
- In what ways, if any, were agency's response influenced by issues of equality, diversity or vulnerability;
- How well equipped were staff in responding to the needs, threat or risk identified for the family. Were staff supported to respond to issues of domestic abuse, safeguarding and public protection through robust policies and procedures; strong management and supervision: training in domestic abuse; having sufficient resources of people and time;
- To analyse multi-agency working and the co-operation between different agencies to provide support and manage the threat and risks to the individuals;
- To identify any individual or multi-agency organisational systems that presented difficulties or challenges to the delivery of services to members of the family;
- To identify the impact of the Covid pandemic upon service responses;
- To identify areas of good practice in this case;
- To identify lessons to be learnt from this case about how practice could be improved. If these lessons have been subject to any previous reviews to provide details of actions required and progress against them;
- To identify recommendations for the organisation and how will the changes be achieved;

In addition, the following agencies are asked to respond specifically to the following points.

- Gloucestershire Health and Care NHSFT to also consider:
    - how compliance with medication was managed, and
    - the availability of clinical beds in the area; how decisions were made to accommodate Ms A out of area and any adversity mitigated in an out of area placement.

- Elysium Healthcare to analyse how risks to Ms A were understood and responded to and how they worked with other agencies to manage a safe discharge.
- Gloucestershire Hospitals NHSFT to analyse their response to Ms A's admissions during 2019.

1.5.3 The following agencies that have had less contact were asked to provide Information Reports:

- Gloucestershire Domestic Abuse Support Service to analyse their response to the referral by the police in January 2021 and outline the processes involved;
- Forest of Dean District Council Housing Services to provide an analysis of responses to Ms A since her application for housing in February 2017, to include: how risks and needs were identified; how worked with other agencies to mitigate risks; what housing options were available;
- West Mercia Police to provide an information report summarising Ms A's partner's offending history.

2. Summary of Chronology

2.1 **2020**

2.1.1 Ms A's partner moved in with Ms A and her child very quickly after their relationship began. This was shortly before the first lockdown for the Covid-19 pandemic in March 2020. Her partner let his probation officer know that he had a new relationship and he continued to be supervised by them for the following four months. During the lockdown, Ms A's child continued to attend school as a vulnerable child.

2.1.2 In June 2020, Ms A and her partner asked for the deputyship over her finances to be removed. Client Affairs declined, as they did not think that Ms A had capacity to manage her own finances and was spending a lot of money. However, the care co-ordinator assessed her under the Mental Capacity Act and assisted her to apply to the High Court for the deputyship to be removed.

2.1.3 In September 2020, Ms A's child advised their family support worker that her partner had assaulted the child. The child was made subject to a Child-in-Need Plan, rather than child protection, on the basis that Ms A had made progress in her mental health and home conditions. Later that month, Ms A was discharged from mental health services at her own request.

2.2 **2021**

2.2.1 In January 2021 Ms A told her social worker that her partner was abusive to her and had assaulted her child. She had had to take the child to the child's father for their

own safety. The social worker notified the police, and the perpetrator was arrested, then released with bail conditions to stay away from Ms A. However, when Ms A withdrew her statement, other evidence was not sought. Although previous allegations of domestic abuse in another force area were identified by the police, they did not know the detail and context and so Ms A was assessed as facing a medium risk of serious harm. The social worker put a further Child-in-Need Plan in place and Ms A spoke with Gloucestershire Domestic Abuse Support Service (GDASS), but they were unable to engage her thereafter.

2.2.2 Meanwhile, Ms A's partner was referred to mental health services three times by his GP requesting an assessment of attention deficit hyperactivity disorder (ADHD), noting his anger problems. When mental health services were able to reach and assess him, they notified his probation worker that he posed a high risk to Ms A.

2.2.3 Ms A's partner repeatedly breached his bail conditions and the police visited Ms A each time, but she declined them entry to her home, saying that everything was fine. The police did not seek evidence from third parties who had reported the breaches.

2.2.4 Thereafter, Ms A's mental health deteriorated, and she was admitted voluntarily to a private hospital in Exeter as there was no hospital spaces locally. She stayed in hospital for only nine days before she requested a discharge as she wanted to reunite with her partner.

2.2.5 Her local mental health services were asked to follow-up the discharge and on their way to visit her at home, the mental health Recovery Team bumped into her on the street. Ms A was too scared to be seen talking with them but was convinced to accompany them to the local mental health centre where she disclosed more about the domestic abuse and how frightened she felt about her partner. She discussed with the Team how she needed to plan her escape from her partner carefully. She said that she would contact GDASS when she was ready was advised that she could come into the office to use the phone when she needed to.

2.2.6 Although Ms A had displayed no indication that she was suicidal that morning, later that day she was found dead.

3. Key Findings

3.1 Indicators of Domestic Abuse

3.1.1 No agency knew the whole picture of domestic abuse that Ms A was experiencing. At times she disclosed a range of coercive control as well as physical assaults of her and her child. At other times she minimised or denied the abuse, which is not uncommon for victims who fear for their safety.

Learning Point: Minimisation and Denial

Practitioners need to develop trusting relationships so that a victim feels confident to be open and confident that she will be protected as soon as possible before the abuse escalates.

3.1.2 Shortly before Ms A died, she was planning to leave her partner and discussed her plans with practitioners. However, she was very fearful of her partner finding out about her plans.

Learning Point: Help Seeking and Separation

When a victim of domestic abuse tries to end the relationship or seeks help, their abuser knows that they are losing control and the risk to the victim increases.

3.1.3 Professionals were aware of indicators of economic abuse but largely attributed to a deterioration in Ms A's mental health.

Learning Point: Economic Abuse

Ms A's economic difficulties were largely attributed to her mental ill-health rather than considering that she may have been subject to economic abuse. At the same time as starting a new relationship: she was seeking to end the deputyship over her finances; was overspending; had stopped work; was arguing with her partner over finances and thought her bank account had been hacked.

The impact of economic abuse upon Ms A may have been significant, as it was an area of her life that she had experienced some loss of control in previous times. Economic abuse would have further enabled a domestic abuser to further gain control over her.

3.1.4 Ms A thought she could hear her partner talking in another room, but her partner always denied it and said that she was imagining it. Although Ms A had hallucinated in the past, it was also possible that her partner was gaslighting her and exploiting her vulnerability through periods of mental ill-health.

Learning Point: Gaslighting

For practitioners, being able to identify domestic abuse and gaslighting when there has been a history of complex mental health issues, is not always easy. Practitioners need to be equipped with an informed 'domestic abuse gaze' and professional curiosity to explore indicators of domestic abuse when they are present.

3.1.5 After her relationship began, Ms A became isolated from friends and family.

Learning Point: Isolation

Isolation from family and friends is a common feature of domestic abuse. It creates a framework for coercive control, depriving victims of independence, support and sources of help. Growing social isolation can also be an indicator of deteriorating mental health, but practitioners need to be professionally curious and explore the possibility of domestic abuse and coercive control. Social isolation could be an indicator of deteriorating mental health or domestic abuse or both.

3.2 Suicide, Mental Health and Domestic Abuse

3.2.1 Ms A had experienced domestic abuse in each of her long-term relationships and the characteristics of domestic abuse, in the sense of entrapment, hopelessness and despair, will undoubtedly have contributed to her mental ill-health and suicidal ideation which followed. However, Ms A usually reached out to family or mental health services for help when in crisis, citing her child as the main reason that she wanted to live.

3.2.2 Assessing the risk of suicide is not an exact science, particularly when domestic abuse is involved, but Gloucestershire are rolling out 'Suicide Timeline' training[3] to help practitioners understand the sequence of the escalation of domestic abuse and risk of suicide in their trauma informed responses.

Learning Point: Suicide and Domestic Abuse

Domestic abuse is thought to result in far more suicides than homicides. When domestic abuse is a factor, practitioners need to be alert not only to the risk that a domestic abuse perpetrator poses to their victim but also to the risk that a domestic abuse victim poses to themselves.

Mental health difficulties, substance misuse, self-harm, adverse childhood experiences, hopelessness and despair are known risk factors for suicide and known consequences of domestic abuse.

[3] https://eprints.glos.ac.uk/10579/

3.3 Health Responses to Domestic Abuse

3.3.1 Mental health services engaged well with Ms A for many years. Across health services, enquiries were often made about Ms A's relationship, but there were also missed opportunities to make direct enquiries about domestic abuse. For example, when Ms A may have been being gaslighted by her partner in March 2021, the GP assessed her behaviour as an acute stress reaction; mental health services did not ask about domestic abuse when Ms A asked for the deputyship over her finances to be removed; the Emergency Department did not record whether direct questioning was undertaken following her earlier overdose.

3.3.2 When Ms A was placed in a hospital out of their area one month before her death, there were shortcomings in the communications between the private hospital and mental health services, and mental health services were not informed about a significant incident affecting her risk of suicide. There were shortcomings in how her risk of suicide was assessed whilst in hospital and her risks of domestic abuse after discharge were not considered. Mental health services responded swiftly to her need for follow-up after discharge but did not undertake a DASH when her heightened risks of domestic abuse were known as they thought they needed her consent to do so.

3.3.3 Since this time, specialist services from GDASS have been co-located in hospitals, mental health teams and supporting the 73 GP Practices in the area.

3.4 Multi-Agency Management of Risk

3.4.1 There were missed opportunities by the police to gather evidence of domestic abuse, from third parties such as the social worker and neighbours who had reported her partner's repeated breach of bail conditions. There was also a missed opportunity to gather evidence on economic abuse.

3.4.2 There were missed opportunities by the Probation Service to take action to manage the risk of harm that Ms A's partner posed to her and the child. This would have included disclosing his history of domestic abuse to the police and children's social care and acting on information from them whilst he was under their supervision. This was important as the police and other agencies were not aware that his previous convictions for assault were related to domestic abuse or that he had been a high-risk perpetrator.

3.4.3 The information on previous convictions was held on the Police National Computer, whereas the information input by West Mercia Police regarding domestic abuse was held on the Police National Database (PND), which, the panel heard, only a limited number of officers had access to. Had the information been available, it would have shown domestic abuse behaviour that was similar to Ms A's partner's current abuse as well as her partner's capacity for rapidly escalating and high-risk domestic abuse. This would have led to more accurate multi-agency risk assessments for Ms A and her child; a Clare's Law disclosure about her partner's prior offending behaviour

could have been considered and probation services would have been notified of concerns of domestic abuse

3.4.4 Since this time, GDASS have Independent Domestic Violence Advisors (IDVAs) alongside police and social workers in the MASH to focus on seeking or maintaining engagement for domestic abuse victims who are considered 'hard to engage.'

Learning Point: Victim Engagement

Each agency brings specialist knowledge and expertise to the support of a domestic abuse victim, maximising the choices and action that is available to them.

Where an agency is finding it difficult to engage with a domestic abuse victim, but know that another agency is involved, they could consider co-working with the victim.

3.5 Child Protection

3.5.1 Ms A's child had experienced physical, emotional, and psychological abuse from Ms A's partner. The social worker engaged well with Ms A who was seen to be co-operative in protecting her child. However, there were occasions when concerns for the child should have escalated to a multi-agency strategy discussion; section 47 (child protection) enquiries and a more robust response to Ms A's partner's threat to the child.

Learning Point: Child Protection and Domestic Abuse

It has been common in child protection practice nationally to

- rely upon abused mothers to protect their children rather than the perpetrator to stop being abusive
- assume that separation and living elsewhere will automatically remove risk
- undertake only superficial assessment of abusers who remain largely invisible to the process and
- lack an understanding about the impact of coercive control on children and their mothers

Practitioners working in partnership to protect a child need to:

- understand the impact of coercive control upon the child and non-abusing parent and support the non-abusing parent to support the child
- take action to constrain or disrupt the abuser's behaviour

Domestic Abuse Statutory Guidance (2021) states:

"Addressing perpetrator behaviour is as important as safeguarding and supporting victims. Often, the courses of action considered are those aimed at the victims and non-abusive parents, placing additional burdens on them. Tackling perpetrator behaviour and placing the onus on them should be a key consideration for partnership work."

3.5.2 The social worker tried on three occasions to get support from CAMHS[4] for the child who was displaying emotionally erratic behaviour after cumulated adverse childhood experience and was unable to access any other services that had been suggested as alternatives.

Learning Point: Child Protection and Domestic Abuse

Ms A's child had experienced physical, emotional, and psychological abuse from her partner. The child did not appear to be able to regulate emotions but felt responsible for protecting their mother from abuse.

Although each child will respond in different ways, the Domestic Abuse Statutory Guidance recognises the significant impact of domestic abuse and coercive control on children and young people of all ages and alerts us to some of the impacts:

- "Feeling anxious or depressed;
- Low self-esteem and difficulties with forming healthy relationships;
- Hypervigilance in reading body language or changes in mood and atmosphere;
- Having difficulty sleeping, nightmares;
- Physical symptoms such as stomach aches or bed wetting;
- Delayed development or deterioration in speech, language and communication;
- Reduction in school attainment, truancy, risk of exclusion from school;
- Inconsistent regulation of emotions, including becoming distressed, upset or angry;
- Becoming aggressive or internalising their distress and becoming withdrawn;
- Managing their space within the home so they are not visible; and
- Using alcohol or drugs, or self-harming". (Home Office, 2021:53)
- Children will also often feel responsible for protecting their mothers from the abuse. (Katz, 2020).

Children and young people experiencing domestic abuse need a trauma-informed approach and benefit from specialist domestic abuse children's services to help them recover from their experiences (Home Office, 2021:54)

In Gloucestershire children and young people in schools:

- aged 5-18 years, can gain mental health support from the Young Minds Matter Service (aka Trailblazers) via the Mental Health Support teams
- aged 9-21 years, can gain counselling by self or professional referral to TiC
- aged 13-19 can gain support from the Gloucestershire Domestic Abuse Support Service young people's project, although this is not a mental health service

[4] Child and Adolescent Mental Health Services

4. Conclusion

4.1 This review has considered the circumstances leading to the tragic death by suicide of Ms A who, despite her experiences of domestic abuse through her adult life, and the impact of trauma upon her mental health, worked hard to provide a nurturing and caring environment for her eleven year old child.

4.2 There was evidence that over the years, there was much good practice from mental health and children's services to support Ms A and build trusting relationships with her. Whilst she did not disclose the full extent of the domestic abuse that she was experiencing from her partner, there were missed opportunities for agencies to identify the indicators of abuse. There were also missed opportunities to identify the threat that her partner posed to both her and her child as he had a history of high risk and convictions for violence against women, and further work is needed to ensure children too are protected from domestic abusers and both mother and child are supported to recover from domestic abuse and the impact of coercive control.

5. Recommendations

5.1 **Multi Agency Recommendations**

- **Recommendation 1**: The Forest of Dean Community Safety Partnership to recommend to Gloucestershire Children's Services that the final report of this review is attached to the child's social care records. This is so that, if the child wishes to read the report of the domestic homicide review when they are older, it will be available to them.
- **Recommendation 2**: Gloucestershire Domestic Abuse Local Partnership Board to receive assurance from Gloucestershire Police on their implementation of the Police, Crime, Sentencing and Courts Act 2022 and its impact upon domestic abuse offenders subject to bail over the 12 months following the Act coming into force.
- **Recommendation 3: Suicide and Domestic Abuse**

  Gloucestershire Domestic Abuse Local Partnership Board to raise professional's awareness of the need to identify mental ill-health, substance misuse and suicide as symptoms of domestic abuse and promote trauma-informed approaches to work with victims.
- **Recommendation 4: Mandatory Health Training on Domestic Abuse**

The Home Office is asked to consider consulting with the Department of Health and Social Care and the Royal Colleges over whether stand-alone domestic abuse training should be made mandatory for all front-line health professionals.

- **Recommendation 5: Police National Database**

  The Home Office to review access to the Police National Database for domestic abuse cases where there is information that a perpetrator of domestic abuse has had police contact in another force area.

- **Recommendation 6: Anger Management**

  Gloucestershire Domestic Abuse Local Partnership Board to seek assurance from its partner agencies that its position statement on anger management has been cascaded throughout their organisations and that anger management does not feature as a response to domestic abuse within its services.

- **Recommendation 7: Domestic Abuse and Child Safeguarding**

  Gloucestershire Domestic Abuse Local Partnership Board to recommend to the Safeguarding Children Board that a domestic abuse focussed review of multi-agency responses to child protection be undertaken to ensure that:

  - the impact of coercive control on both child and non-abusing parents is explored and understood;
  - domestic abuse perpetrators are not invisible to child assessments and that the threat they pose to families informs risk assessments and responses to protecting the child and their non-abusing parent;
  - robust safety planning is undertaken, alongside multi-agency protective interventions.

- **Recommendation 8: Taking Action against Perpetrators in the Context of Child Protection**

  Within its forthcoming Perpetrator Strategy, the Home Office is asked to include guidance to social workers and other professionals on providing evidence to support criminal and civil action against perpetrators of domestic abuse, particularly in the context of child protection.

- **Recommendation 9: Support to Children Experiencing Domestic Abuse**

  Gloucestershire Domestic Abuse Local Partnership Board to continue to work with health and local authority commissioners to review whether gaps remain and whether there is a need for specialist domestic abuse services for children and young people if not already available.

5.2 Individual Agency Recommendations

5.2.1 Primary Care

- To ensure professional curiosity and asking direct questions about domestic abuse when indicators of domestic abuse are present.

5.2.2 **Elysium Healthcare**

- For any newly admitted patient, the admitting nurse and doctor should make an entry on Carenotes at the point of admission, with some detail of mental state, and a risk assessment and management plan.
- In cases of suspected or disclosed domestic violence, the Safeguarding Lead should be consulted to inform further steps.
- The Acute Risk Matrix is a dynamic tool and should be updated whenever there is a significant event of concern, as it informs the Risk Management plan for the patient. Patients should have full multidisciplinary reviews, such as Ward Round meetings, at least once a week. Where possible, particularly if discharge is being considered, this should involve the Consultant Psychiatrist.
- The NHS Mental Health Service that will take over the care of the patient following discharge should be involved in the discharge planning process, as far as is practicable, particularly for non-detained patients who are not being managed under the Care Programme Approach. The Discharge Planning meeting should include discussion of the patient's presentation, identified risks and the level of support required post-discharge.

5.2.3 **Gloucester Health and Care NHS Foundation Trust**

- Ensure that GPs are informed when patients have stopped taking prescribed medication.
- Provide clear guidance on when operational teams should follow the Domestic Abuse Pathway.
- Promote the use of the DASH tool within GHC.
- Improve recording of household information and relationships on clinical systems.
- Provide clear guidance on when teams must follow the **CPA** discharge process of a patient on a section 117.
- Wider availability of Mental Capacity Act training, and increased clarity and a robustness when completing the recording forms on clinical systems.
- Review of GHC Mental Health Services Bed Management Policy.

5.2.4 **Gloucestershire Constabulary**

- To review the use of PND for domestic abuse cases where there is information that the perpetrator has had police contact in another force area.
- To provide assurance to the Community Safety Partnership that the changes that have been made to improve the standard of investigation and victim contact have resulted in positive outcomes for domestic abuse victims.

5.2.5 **Gloucestershire County Council Children's Social Care Services**

- Review of direct work and intervention using trauma informed methods when working with children who have lived with domestic abuse in their homes.
- Review of the support needs of Social Workers and their managers working with parents who present with suicidal ideation.
- Support Social Workers to be fully informed about the range of local support available for victims of Domestic Abuse, including the mental health IDVAs and the vulnerable women's project.
- Work with the Nelson Trust and Children's commissioning to review how accessible the vulnerable women's project is across the county. This is especially a challenge to access for women living in rural areas.
- Essentials 3.0 on Domestic Abuse to consider the learning from this IMR in relation to coercive control and impact on children.
- Explore the role of social workers in providing third party evidence for victims of domestic abuse.

5.2.6 **Hereford, Shropshire and Telford Probation Service**

- Review of transfer policy.
- Confirmation of staff training in Child Safeguarding and Domestic abuse.
- Discussion with staff regarding the importance of liaison with other agencies in all domestic abuse cases**.**
- New partners and their children are informed, protected and supported throughout a case and there is an appropriate response to all new information about the risk of harm.