DOMESTIC HOMICIDE REVIEW OVERVIEW REPORT INTO THE DEATH OF DAVID IN MAY 2022

Parminder Sahota
Independent Author and Chair
Date Completed:

Acronyms

Care Program Approach	CPA
Care Coordinator	CC
Community Mental Health Team	CMHT
Domestic Homicide Review	DHR
Domestic Violence Protection Notice	DVPN
Domestic Violence Protection Order	DVPO
East London Foundation NHS Trust	ELFT
Multi-Agency Risk Assessment Conference	MARAC
Occupational Therapist	OT
Out Patient Appointment	OPA

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Preface

The Independent Chair and Review Panel send their deepest condolences to all those impacted by David's untimely passing and thank them for their involvement and support in this process.

The primary objective of a Domestic Homicide Review (DHR) is to permit the learning of lessons from the death of a person(s) in a relationship where domestic abuse was known to have occurred. Professionals must understand what transpired in each situation for these lessons to be thoroughly and effectively digested. What must be modified most to lessen the likelihood of such tragedies?

The chair thanks the panel and persons who submitted chronologies and materials for their time and cooperation.

"Dad was the life and soul of the party; he was a great guy."

1.1 Introduction

1.1.1 The report was written following the tragic death of David (pseudonym) in May 2022. Central Bedfordshire Community Safety Partnership received a referral from Bedfordshire Police. The case was discussed at a partnership meeting convened on 28 June 2022. The group determined that the domestic homicide review criteria had been satisfied.

1.1.2 Adopted in 2011, Section 9(3) of the Domestic Violence, Crime, and Victims Act of 2004 added Domestic Homicide Reviews (DHRs). A DHR refers to an investigation into the circumstances surrounding the death of a 16-year-old or older individual that has or appears to have been caused by violence, abuse, or neglect.

1.1.3 The DHR was conducted following the Home Office's Multi-Agency Statutory Guidance for Domestic Homicide Reviews (updated in December 2016). [1]

1.1.4 Section 2 of the statutory guidance highlights circumstances which indicate a DHR:

'*Where a victim took their own life (suicide), and the circumstances give rise to concern, for example, it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.'*

1.1.5 Before his passing in May 2022, David resided in Central Bedfordshire. This review examines the agency's responses and support for David.

1.1.6 In addition to considering agency involvement, the review will appraise the last years of David's life (April 2019– May 2022) to determine any relevant background or history of abuse before his death, whether community support was obtained and whether there were barriers to seeking community support. Taking a holistic approach, the review aims to find strategies for lowering the risk associated with such scenarios.

1.1.7 The review will concentrate on the agency's interactions with David between April 2019 and May 2022.

1.1.8 This review does not replace criminal or coroner's courts or resemble a disciplinary proceeding.

1.1.9 David was discovered hanged by the police.

1.1.10 The Coroner noted the medical Cause if death:
A Asphyxia
B Hanging

1.1.11 The contributing factors in the record of inquest were: mental health issues, history of suicide attempts, suicide ideation, history of domestic abuse between David and his

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

partner Sharon (pseudonym), the removal of his stated protective factor, his dog, the Domestic Violence Protection Order (DVPO)[2] in place but ineffective and the delayed emergency response on eth day he died.

1.2 Case Summary

1.2.1 In May 2022, David's neighbour called the police to report that Sharon was banging on David's front door, and David was distressed since Sharon had his dog.

1.2.2 The police records stated that David and Sharon had both been victims of domestic abuse in the past, and Sharon had a current DVPO prohibiting her from contacting David. Additionally, David was documented as having mental health problems. The police were waiting for an available unit to respond.

1.2.3 The police received a further call three hours later the same day from the neighbour, who was concerned David may have harmed himself as he was with him earlier, there were pills all over the kitchen, and he could not contact David.

1.2.4 The police arrived one hour later and found him hanged through the back window after receiving no response to their knocking.

1.2.5 The paramedics arrived twenty minutes later and certified the death.

1.3 Timescales

1.3.1 Following the 2016 Multi-Agency Statutory Guidance for the Conduct of DHRs, Central Bedfordshire Community Safety Partnership commissioned this review in response to a decision to proceed with a review on 28 June 2022.

1.3.2 The Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews specifies the requirements of the review chairs and authors in sections 36 through 39. In this review, the responsibilities of the chair and author were merged.

1.3.3 The independent chair/author for this DHR was commissioned on 18 August 2022. Central Bedfordshire Safety Community Partnership approved the finalised report on 15 August 2023.

1.3.3 The first panel meeting was held on 16 September 2022.

1.3.4 A second-panel meeting reviewed agency chronologies and determined that three agencies would request Individual Management Reviews and four would request Summary reports.

[2] https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010

1.3.5 The Home Office guidelines stipulate that reviews, including the overview report, should be concluded within six months of their initiation.

1.3.6 Delays were due to securing a chair for the review.

1.4 Confidentiality

1.4.1 Until the Home Office Quality Assurance Panel approves the release of the overview report, the results of each review are confidential. Only contributing officers/professionals and line managers have access to confidential information.

1.4.2 The review has been anonymised following the 2016 Home Office Domestic Statutory Guidance. As a result, only the independent chair and review panel have been identified. Pseudonyms have been applied to protect the names of the victim, his daughter, and the alleged perpetrator, and the date of death has also been removed.

1.4.3 The following terms have been anonymised throughout this report to preserve the victim's identity, family, and the alleged person causing harm.

1.4.4 The victim: David
1.4.5 Daughter: Gemma
1.4.6 Father: Thomas

1.4.6 The alleged person causing harm: Sharon. As Sharon suffered from poor mental health, the mental health representative agreed to review her circumstances and report on the suitability of establishing contact. The panel learned Sharon had moved and was no longer in contact with the agencies represented. We agreed to avoid contact to lessen the likelihood of harm to her mental health.

1.5 Equality and Diversity

1.5.1 During the review process, the review chair and panel reviewed all protected characteristics under the 2010 Equality Act.

1.5.2 David was of white British heritage and was 55 years old at his death.

1.5.3 The characteristics relevant to this review are disability and sex.

1.5.4 In 2008, David was involved in a road traffic collision that resulted in him undergoing surgery and nailing[3] his left femur (thigh bone). David had access to a mobility scooter, which he was hesitant to use; he had been granted a higher disability rate and was expecting a mobility car in February 2023. He had spoken of how this would benefit him and increase his independence.

[3]. A metal rod is inserted into the centre of the femur and then fixed at both ends with screws.

1.5.5 The fracture clinic reviewed him; he walked with one crutch, and there were no reports of pain or complications.

1.5.6 David reported suicidal thoughts to A&E in April 2019, his first encounter with mental health services.

1.5.7 David had contacted the police to report that he had attempted suicide by self-harm. As a result, he was admitted to the mental health unit twice during the review period.

1.5.8 David was diagnosed with recurrent depression[4].

1.5.9 According to a study conducted in the United Kingdom, 16% of men seeing their GP with symptoms of anxiety or depression had domestic abuse-related behaviours.[5]

1.5.10 Support agencies frequently fail to identify male abuse and neglect situations involving female abusers. Recent DHR research emphasises a lack of training and support in recognising and responding to male domestic violence: Mankind Charity claims that in 2021, just 58 out of 238 refuge slots for victims of domestic abuse supported male survivors. Another study conducted by Bristol University reveals that health professionals rarely enquire about the domestic ties of male victims.[6]

1.5.11 Bristol University[7] identified reasons why males in abusive relationships might not seek assistance. According to the findings, specialised training is necessary to address the unique needs of men and build more robust levels of trust.

1.5.12 Additional research[8] was conducted on the obstacles preventing males from seeking help in intimate partner relationships. Responses to first help-seeking, Health and Well-Being, and Credibility and Status were identified as the main themes. The research revealed that men were the predominant group to report instances of gender-based discrimination or gender-related ideas that acted as barriers to obtaining assistance. The obstacles that were recognised were organisational and professional repercussions of seeking materialised aid for a significant number of male victims. The lack of thorough professional scrutiny of the disclosures levied against them by their abusive partners was highlighted as one of the contributing factors.

1.5.13 Additionally, professional curiosity and training were highlighted in a separate study[9]. Domestic abuse affects both men and women, but the similarities and differences between their experiences remain little understood. Moreover, the perpetrator's gender and/or sex influence the victim's experience of intimate partner violence. Even though men may appear to encounter comparable "kinds" of abuse, the interpretation of these violent acts varies. Therefore, assessing intimate partner violence without considering its context (including perpetrator's gender, sex, intention, meaning, severity, patterns,

[4] Repeated episodes of depression
[5] https://pubmed.ncbi.nlm.nih.gov/25991450/
[6] https://www.centreforsocialjustice.org.uk/newsroom/why-are-men-often-overlooked-as-victims-of-domestic-abuse
[7] https://www.bristol.ac.uk/primaryhealthcare/news/2019/male-victims-of-domestic-abuse.html
[8] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9554285/
[9] https://journals.sagepub.com/doi/10.1177/15248380211043827

and patterns) sustains the issue of gender asymmetry, hinders the precise interpretation of findings, and prevents cross-study comparisons.

1.5.14 The first of its kind study, undertaken by the University of Warwick and Refuge[10], presents extensive and substantial evidence on the incidence of suicidal ideation among victims of domestic abuse. They emphasised risk factors such as depression, psychological distress, despair, hopelessness, difficulties with drugs or alcohol, childlessness, and cumulative experiences of abuse, particularly sexual abuse.

1.5.15 The preceding evidence demonstrates and underscores the necessity for health providers to enquire about domestic abuse against men and women.

1.5.5 David's vulnerability to abuse increased by gender and mental health.

1.6 Terms of Reference/Key Lines of Enquiry

1.6.1 Section 4.2 contains the complete Terms of Reference. This review intends to identify the lessons learned from David's tragic death, respond to those lessons, and ensure that individuals and families are supported effectively.

1.6.2 On 29 April 2021, the Domestic Abuse Bill obtained Royal Assent and was signed into law. The Act specifies the following legal definition of domestic violence:

Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if:

(a) A and B are each aged 16 or over and are personally connected to each other, and
(b) the behaviour is abusive.
Behaviour is "abusive" if it consists of any of the following—
(a) physical or sexual abuse;
(b) violent or threatening behaviour;
(c) controlling or coercive behaviour;
(d) economic abuse;
(e) psychological, emotional or other abuse; it does not matter whether the behaviour consists of a single incident or a course of conduct.
"Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to—
(a)acquire, use or maintain money or other property, or
(b)obtain goods or services.
(5) For the purposes of this Act A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child).

Two people are "personally connected" to each other if any of the following applies:

(a) they are, or have been, married to each other;
(b) they are, or have been, civil partners of each other;

[10] https://nspa.org.uk/wp-content/uploads/2021/04/New-Suicide-Report2c-Refuge-and-University-of-Warwick.pdf

(c) they have agreed to marry one another (whether or not the agreement has been terminated);
(d) they have entered into a civil partnership agreement (whether or not the agreement has been terminated);
(e) they are, or have been, in an intimate personal relationship with each other;
(f) they each have, or there has been a time when they each have had, a parental relationship concerning the same child;
(g) they are relatives.

1.7 Methodology

1.7.1 Home Office guidelines outline the procedure for performing a DHR.[11]

1.7.2 When David died, he resided in Central Bedfordshire; hence, the review panel consisted of agencies from Central Bedfordshire.

1.7.3 At the first meeting of the review panel, which took place on 16 September 2022, panellists shared their agency engagements for David. The panel determined the review period from April 2019 to May 2022. This timeline aligned with the scoping and agency interaction phases.

1.7.4 The review's approach was to request that agencies submit a chronology to determine which agency would be required to conduct an Independent Management Review (IMR) or summary report.

1.7.5 Independence and Quality of IMR and short report: They were written by professionals not involved in case management or service delivery. The reports allowed the panel to analyse its interactions with David and to compile the lessons learned for this review. The IMR and short reports indicated eighteen recommendations together. The reports and chronologies influenced the recommendations in this review.

1.7.7 The panel met four times in addition to a workshop with practitioners to inform and support the learning from the review.

1.8 Involvement of Family

1.8.1 The chair and the review panel acknowledged the vital role David's family could play in the review.

1.8.2 **The chair called Gemma (David's daughter)** on 6 December 2022. She was offered details for AAFDA.

1.8.3 Gemma stated that her father was "the life and soul of the party; he was a great guy." She described how her father's condition deteriorated after his motorcycle accident in

[11] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

2008; he suffered spinal damage and had metal rods in his legs. The relationship between Gemma's stepmother and father ended at this time.

1.8.4 Gemma received the coroner's report on her father on 5 December 2022; she was distressed because she was uninformed of his suicide attempts and his girlfriend's abuse.

1.8.5 Gemma stated that despite her father having mentioned a restraining order against the girlfriend, he kept this information to himself. He would not explain and report being a victim of domestic abuse to his family or friends as he was a "manly man."

1.8.6 Gemma was aware of her father's depressive condition. She saw the suicide attempts as pleas for assistance.

1.8.7 Gemma does not know why she or her siblings were not informed about David's suicide attempts and when he reported feeling endangered at home. However, she said she would have assured her father's safety that weekend.

1.8.8 We agreed to schedule a second call since Gemma had just received the report. In February and March of 2023, the chair contacted Gemma to request contact and an update on the review status. Unfortunately, the chair did not receive a response, and a letter was sent to Gemma to support engagement, no response was received.

1.8.9 **The chair contacted David's father, Thomas, on 23 March 2023, and a call was arranged for the following day.**

1.8.10 Thomas said that he had not been in contact with David in recent years. This was because David went missing and constantly changed his phone number. When Thomas was in touch with him, David frequently told him he did not understand. Thomas would ask David to help him understand, but the response was always the same: he did not understand.

1.8.11 Thomas believed that David had done a great job establishing his own business and was making a modest living. Unfortunately, he began using drugs in his late twenties, and from then on, his life began to suffer.

1.8.12 David's mobility deteriorated, and he was in chronic pain after his motorbike accident. However, Thomas believed David did not feel disabled and would not like using his mobility scooter.

1.8.13 Thomas commented that David's mother's death profoundly affected him, and his substance abuse harmed his mental health.

1.8.14 Thomas requested further communications with Gemma only and declined a copy of the report because he found it too painful.

1.8.15 Neither Gemma nor Thomas provided the chair with the contact information of any other friends or family members, and the panel also lacked such information.

Dinh Padicala	Associate Director for Adult Safeguarding & Domestic Abuse	East London Foundation Trust

1.9 Contributors to the Review

1.9.1 The following agencies and their contributions to this review:

Agency and Profile	Contribution- Chronology/IMR/Summary/Other
Bedfordshire Hospital *District General hospital*	Chronology and Short report
Bedfordshire Police	Chronology and IMR
East London NHS Foundation Trust (ELFT) *Provides a wide range of mental health, community health, primary care, well-being, and inpatient services to young people, working-age adults, and older adults in the City of London, Hackney, Newham, Tower Hamlets, Bedfordshire, and Luton.*	Chronology and IMR

1.10 The Review Panel Members

1.10.1 The independent panel members for this review were the following:

Name	Role	Organisation
Anna Bruce	Deputy Head of Service	Bedfordshire Probation Delivery Unit
Amy Thulbourne	Service Manager,	Central Bedfordshire Council
Craig Laws	Detective Chief Inspector	Bedfordshire Police
Claire Beet	Safeguarding Nurse Specialist	Bedfordshire Hospitals NHS Foundation Trust
Darryl Springer	Manager	East London Foundation Trust
Dinh Padicala	Associate Director for Adult Safeguarding & Domestic Abuse	East London Foundation Trust
Jayne Dingemans	Safeguarding Adult Lead	Bedfordshire Hospital NHS Foundation Trust
Jeanette Keyte	Head of Community Safety	Central Bedfordshire Council
Jenny Riddy	Detective Inspector Emerald Team	Bedfordshire Police
Jodie Tripcony	Safer Communities & Partnership Officer	Central Bedfordshire Council
Joy Leighton	Senior Operations Manager	Victim Support
Leire Agirre	Head of Quality Improvement and Adult Safeguarding	Central Bedfordshire Council
Lisa Scott	Safer Communities & Partnership Manager	Central Bedfordshire Council
Lucy Wilson	Adult Safeguarding Lead	Bedford Hospital
Marie Gresswell	Detective Chief Inspector	Bedfordshire Police
Martin Witchard	Review Officer	Major Crime Team, Police
Nadean Marsh	Designated Safeguarding Nurse	Bedfordshire Luton & Milton Keynes Integrated Care Board
Nina Page	Domestic Abuse Team Manager	Central Bedfordshire Council
Nina Wright	Deputy Director, Luton Mental Health & Well-Being Services	East London Foundation Trust
Rachael Clifford	Public Health Principal, Mental Health and Wellbeing	Public Health
Su Childerhouse	Assistant Director, Public Protection & Transport	Central Bedfordshire Council
Toni-Marie Doherty	Head of Safeguarding	Bedfordshire Hospitals NHS Foundation Trust

1.11 Chair and Author of the Overview Report

1.11.1 Parminder Sahota is an independent reviewer who has worked in Safeguarding and Domestic Abuse for eleven years and obtained DHR Chair training in 2021 from Advocacy After Fatal Abuse. She has worked in the NHS for over 20 years as a Mental Health Nurse with a particular focus on crisis work and working with persons diagnosed with a personality disorder. She is currently employed as the Director of Safeguarding, Prevent, and the Domestic Abuse Lead for an NHS Trust.

1.11.2 Before this review, Parminder Sahota had no contact with the family members, Sharon, or Central Bedfordshire Community Safety Partnership and is independent of participating agencies.

1.12 Parallel Reviews

1.12.1 East London Foundation NHS Trust completed a Serious Incident Review[12] in November 2022.

1.12.2 The inquest is set for 21 June 2023.

1.13 Dissemination

1.13.1 After the Home Office grants permission to publish, this report will be widely disseminated, including, but not limited to:

- Executive Board of the Central Bedfordshire Safety Community Partnership
- Members of the Central Bedfordshire Community Safety Partnership
- Agencies represented.
- Safeguarding Adults Board
- The report will also be published on the Central Bedfordshire Community Safety Partnership Website

BACKGROUND INFORMATION

2.1 The Facts

2.1.1 In May 2022, David's neighbour called the police to report that Sharon was banging on his front door; David was upset that Sharon had taken his dog.

2.1.2 David and Sharon had been victims and perpetrators of domestic abuse in the past, which the police were aware of. In addition, Sharon was now prohibited from contacting David by a Domestic Violence Protection Order (DVPO). Sharon's location was unclear when the police were called.

2.1.3 The police database revealed that David had a mental illness.

[12] https://www.england.nhs.uk/patient-safety/serious-incident-framework/

2.1.4 A few hours later, the neighbour called again to express concern for David, assuming he may have self-inflicted injuries because the kitchen was littered with prescription medications when he visited his home earlier.

2.1.4 When the police knocked on the door, there was no response. The officers went around the back of the property and saw David hanged in the kitchen. Police gained entry and attempted CPR without success. The attending paramedics certified the death.

2.2 Background Information about David

2.2.1 Due to the minimum involvement with family, the voice and background are brief and include agency-held information.

2.2.2 David was 55 at his death; he had three siblings and four children; his first child was born when he was 15.

2.2.3 According to David's father, David ran a business that went bankrupt; he misused alcohol and drugs, formed unhealthy relationships, and had been in trouble with the law.

2.2.4 David's family exerted significant effort to assist him in overcoming his substance abuse. Despite this, they finally ceased providing him with financial assistance and instead provided him with emotional support, encouragement, and other practical help, such as supplying meals, etc.

2.2.5 David would frequently disappear for months, re-emerge briefly, and then disappear again.

2.2.6 The family was surprised to learn that David had experienced domestic abuse and that no one was aware of this. David's daughter revealed that she had viewed the text messages between her father and his ex-girlfriend and was surprised by their content. The text messages were not shared with the chair. She informed her sister that she last saw their father on the Friday before he passed away.

2.2.7 The police called David's daughter to inform her that the restraining order had not been properly served due to a misunderstanding regarding the document. She stated that she had been told that test reports suggested her father's system had drugs at his death.

2.2.8 The police confirmed that the DVPO was not located and not served as a missed opportunity to arrest Sharon. Bedfordshire lacked a procedure for monitoring the progress of DVPOs; consequently, a learning review was conducted after David's death. The Luton Magistrates Court granted the DVPO, and the Police National Computer (PNC) will be updated accordingly. Sharon's absence from the courtroom resulted in the PNC's update to "not served." The responsibility for ensuring timely

service would revert to the officer present at court (not necessarily the applying officer) and Emerald following confirmation that the order has been granted. As the order had not been entered into any police system until it was served, a search on the system yielded no record.

2.2.9 No audit trails or records were maintained. Historically, the order was passed from duty sergeant to duty sergeant to action until it was served.

2.2.10 Historically, the service of the majority of orders obtained was contingent upon the defendant's presence at the court proceeding. Officer intervention was minimal in this regard, and there was no established policy or process for locating and serving such orders.

2.2.11 The policy concerning domestic violence protection orders and notices, including the steps involved in obtaining an order and any subsequent breaches, has been revised by the detective inspector. However, the policy seems to fail to acknowledge the perplexity that emerged in relation to Sharon. It is advisable to consider the inclusion of the following in the policy: who is accountable for the order and its service in the absence of the perpetrator at court, the location where the order is maintained, and the maintenance of an audit trace that includes updates on failed attempts to serve the DVPO. Officers on patrol may encounter the individual and be able to execute the directive.

2.2.12 To proactively monitor breaches of these orders, the Emerald team is collaborating with the Crime Reduction and National Monitoring unit to install recording devices and audible alarms in the residences of victims. During the order, the victim will receive round-the-clock support to deter the perpetrators. Perpetrators are duly notified of the presence of the equipment. This improves the victim's safety and may furnish evidence to support the pursuit of victimless prosecutions in cases where victims are hesitant to participate.

3.1 Key Events from April 2019 to May 2022

Date	Contact	Agency
09.04.19	David presented to A&E with suicide ideation; he was assessed by mental health and transferred to a mental health bed.	Bedfordshire Hospital
08.08.19	Following a four-week hospitalisation to an out-of-borough mental health ward, David attended A&E. On his return to Bedford, he was without support. He was referred to mental health. He indicated that he had no housing and was sleeping rough. A friend accompanied him to his parent's home with mental health to follow up on housing and the CMHT.	Bedfordshire Hospital
23.09.20	David did not attend his last eight appointments at the hospital for his cardiac device appointment.	Bedfordshire Hospital
19.02.21	David's mum's funeral	
20.02.21	A security guard called to express concern for David. David had told his cousin that he meant to kill himself by putting a	Police

	hosepipe through his car window. David had gone missing just a few days before his mother's funeral, and his car was parked outside his flat. When the police arrived, David said he was alright, and his phone was broken.	
30.06.21	David called the police, hearing voices telling him to harm himself and others. He had contacted a doctor, but they could not help, and he thought he would kill himself if he did not obtain treatment. Police arrived and took him to the mental health HUB.	Police
30.06.21	David accompanied two police officers to the HUB. Unfortunately, David had self-harmed on his stomach with the intent to end his life. Consequently, he was admitted to the mental health ward.	ELFT
30-06.21-28.07.21	Admission to mental health ward.	ELFT
20.07.21	Request for an occupational therapy assessment and support to locate suitable housing accommodation.	Adult Social Care
21.10.21	After calling the crisis line, David was admitted to a mental health ward. David intended to hang himself using a tie from his suit. However, he stated that he did not wish to do so since he did not want the manager of his temporary housing to locate him in this manner.	ELFT
21.10.21-09.11.21	Admission to a mental health ward: David was reported missing and discharged in his absence.	ELFT
06.11.21	David was reported missing from the mental health ward. The nurse said that he was suicidal after attempting to hang himself, which resulted in his admission. However, the nurse stated that whilst on the ward, he was deemed at low risk of suicide. As a result, his status as missing was removed.	Police
07.11.21	The ward alerted the police since David had not returned. They indicated that David was returning drugs to the unit for another patient. In addition, David feared this patient. When the police spoke to David, he indicated he wanted to leave the ward and was unafraid of anyone.	Police
14.12.21	David was happy to receive an offer for a one-bedroom home and to be moving into this residence.	ELFT
09.01.22	A member of David's residence staff called the police to report people fighting, including a female. However, the police only found David.	Police
14.01.22	A group of people had gathered outside David's flat; another individual was visiting his flat and was a reputed drug dealer and 'pimp' in the area.	Police
15.01.22	David was identified as a suspect in an assault on an adult male victim, in which he allegedly gripped his neck and headbutted him. The victim was unsupportive and refused to cooperate with the investigation.	Police
16.02.22	New patient registration	GP
24.02.22	Medication review	GP
28.02.22	Domestic Abuse Report David was reportedly the perpetrator, while Sharon was the victim. There was an argument between the two, and David slapped Sharon across the face.	Police

	Domestic Violence Protection Notices (DVPN)[13] issued	
28.02.22	Domestic Abuse Report David was the victim, and Sharon was the perpetrator. David awoke to find Sharon yelling at him while standing over him. Sharon picked up the television to throw it at him while intoxicated. David raised his right arm to defend himself. The television struck his hand, causing swelling and discomfort. She then threw a mobile phone at his ribcage. DVPN issued	Police
01.03.22	Domestic Abuse Report David was reported as the perpetrator, while Sharon was the victim. Sharon entered David's home via the window as she did not have a key. David assisted Sharon into the house, and they argued. She claimed he pulled her hair. Negative statement from Sharon not supporting police action.	Police
01.03.22	David's partner contacted 111, concerned that he was "so much", and enquired whether the medication had an effect. David informed 111 that he had awoken and eaten dinner, his symptoms had improved, and he agreed to end the call.	GP
04.04.22	Domestic Abuse Report David was named the victim, while Sharon was identified as the perpetrator. David had returned home, they argued, and Sharon allegedly struck David in the head with a phone. Negative statement from David not supporting police action.	Police
04.04.22	An argument occurred when Sharon attended the property to collect her belongings.	Police
12.04.22	Domestic Abuse Report David and Sharon engaged in a verbal altercation; Sharon was observed to be intoxicated and began shouting and swearing at David. David left the property.	Police
12.04.22	David reported that his knees were swollen and asked that his partner's number be called. Unfortunately, it was discovered that David's partner was not with him, and he was poorly.	ELFT
14.04.22	A neighbour who was walking his dog reported an incident to the police. The neighbour was approached by Sharon, who stated someone had reported her partner for benefit fraud, and David believed it was the neighbour and that he (David) was going to hang him. The neighbour stated that he attempted to communicate with David and knocked on his door, but he was absent. He added that the female was intoxicated and visibly high. Police approached the informant. Sharon was also seen, and she stated that she had come to the property to view the dog, and David had left the address to avoid an altercation. Sharon then left the address.	Police
16.04.22	Sharon reported concern for David as she hadn't seen him for 48 hours. However, the police determined David was safe. He indicated that he needed to get away from his partner as she had been drinking too much. He stated that he would be 'going back home later today'.	Police

[13] https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010

16.04.22	Partner called the police after not seeing David for 48 hours out of concern for his well-being.	ELFT
17.04.22	David's neighbour reported a hate crime against Sharon.	Police
17.04.22	The police contacted the emergency duty team to confirm the address after the family reported David missing. The police believe there was domestic abuse in the household but were uncertain about who.	Adult Social Care
18.04.22	Domestic Abuse Report David had been staying with a friend for a few days to get some respite from Sharon. On returning home, Sharon was there, and whilst in the living room, she slapped David on the face, causing no injury. Police attended and arrested Sharon for this and the public order offences against him. The investigation was filed, no further action was taken, and a DVPN was issued. The Domestic Abuse Risk Assessment (DARA)[14] risk assessment scored as 'high'. DVPN was to be issued.	Police
20.04.22	Domestic Abuse Report Sharon received a Domestic Violence Protection Order (DVPO) stipulating that she not contact David, enter his home, or come within 100 metres of his address.	Police
20.04.22	Domestic Abuse Report Sharon had assaulted David and is terrified of her and her associates.	ELFT
24.04.22	David visited A&E due to abdominal pain/collapse/chronic leg pain/chronic weight loss, and difficulty passing urine. History of alcohol issues, asthma, depression, and a motorcycle accident that resulted in bilateral femur pins and chronic pain. Sharon was noted as the next of kin.	Bedfordshire Hospital
25.04.22	Domestic Abuse Report David stated that he was a victim of domestic abuse from Sharon. Following a verbal argument, David attempted to leave, and Sharon struck him in the face and scratched his stomach. Both parties were arrested and blamed each other, and with no supporting evidence, the case was filed with no further action.	Police
25.04.22	Domestic Abuse Report According to the report, David was the perpetrator, and Sharon was the victim. David allegedly grabbed Sharon by the throat after a verbal disagreement, struck her multiple times, and punched her face, causing a cut to her lower lip and bruising.	Police
25.04.22	Domestic Abuse Report David claimed that his ex-partner (Sharon) was abusive, and he obtained a restraining order against her. He wished to move and could no longer afford the bed and breakfast where he was staying.	ELFT
27.04.22	Domestic Abuse Report	ELFT

[14] https://library.college.police.uk/docs/college-of-policing/Domestic-Abuse-Risk-Assessment-2022.pdf

	Police notification to ELFT: David and his ex-partner were intoxicated when arrested for alleged Actual Bodily Harm. It was revealed that David was both a victim and perpetrator of domestic abuse. The Care Coordinator (CC) for David was on leave, so the duty worker sought to reach him. The worker was supposed to discuss the situation with the team, but this never occurred.	
Ten days before David's death	Domestic Abuse Report David said his ex-partner subjected him to domestic abuse, and he requested relocation through the housing association. He felt uneasy in the area and constantly looked over his shoulder. He had been staying at his friend's house out of concern. He reported that the council refused to rehouse him. No further action was filed.	Police
Five days before David's death	David noted to be sofa surfing.	ELFT
Three days before David's death	Domestic Abuse Report David was reported as the perpetrator, and Sharon was the victim of a common assault; David had punched Sharon. However, no further action was filed.	Police
Two days before David's death	Domestic Abuse Report The CC visited David at his home; he admitted he was a victim of domestic abuse and was terrified to stay home. The CC communicated with housing to discuss alternative accommodation. David declined the offer and discussed staying with his daughter.	ELFT
Two days before David's death	Domestic Abuse Report David planned to spend time with his daughter. He described the violence from Sharon and her partner and requested a new residence. He stated that his dog was a protective factor for him.	ELFT
Date of death	David's neighbour called out of concern. David's dog had gone missing from a friend's car, and his partner was banging on his door.	ELFT
Date of Death	David's neighbour contacted the police to report a concern about David.	Police

4.1 Analysis of Agency Involvement

4.1.1 This section explores the agencies' involvement with David.

David had contact with the following Agencies:

1. Bedfordshire Hospital
2. Bedfordshire Police
3. East London Foundation NHS Trust

Bedfordshire Hospital

4.1.2 David attended the hospital three times during the review period, as shown in the chronology.

Physical Health

4.1.3 David had a reveal device (a small device placed in the chest to continuously monitor the heart rate and rhythm following admissions for dizziness & blackouts) inserted in 2018. Following this insertion, he was offered a follow-up the following year. However, he did not attend any of the eight appointments he was given.

4.1.4 Bedfordshire highlighted a need for more professional curiosity following his non-attendance. Although a letter was written to the GP, it was unclear whether David had been contacted.

Domestic Abuse

4.1.5 David did not report domestic abuse; he identified Sharon as his next of kin on his third visit.

4.1.6 Half of the male victims (49%) fail to inform anyone that they are victims of domestic abuse, and they are two and a half times less likely to tell anyone than female victims (19%).[15]

4.1.7 The term "victim" may not be suitable to express the sentiments and position of persons who have experienced domestic abuse because it implies a passive experience of both the assault and any "help" that may be provided. The term "survivor" is preferred because it emphasises an active and creative response to abuse instead of a "victim," which may indicate passive acceptance.[16] In addition, Gemma described her father as a "manly man," thus the label "victim" may not sit well with him.

4.1.8 Health practitioners rarely ask men about their experiences of domestic abuse.[17] This is due, in part, to the gendered nature of domestic abuse and a scarcity of research on male victims of domestic abuse and the available services for them.[18]

4.1.9 According to the NICE standard for Domestic Violence and Abuse, front-line agencies, including health, should enquire about domestic abuse.[19]

Alcohol

4.1.10 Their analysis revealed a reference to alcohol at his attendance on 24 April 2022, but no evidence indicated this was discussed in terms of offering support.

4.1.11 Men are more likely than women to drink alcohol, to drink at levels above the low-risk thresholds, and to be dependent on alcohol.[20]

4.1.12 Research shows a constant and robust link between alcohol usage and intimate partner violence. For example, according to one study, alcohol was involved in 30% of couples that reported intimate partner violence.[21]

[15] https://www.mankind.org.uk/statistics/statistics-on-male-victims-of-domestic-abuse/
[16] https://www.womensaid.org.uk/information-support/the-survivors-handbook/
[17] https://www.sciencedirect.com/science/article/abs/pii/S1359178914001049
[18] https://pearl.plymouth.ac.uk/handle/10026.1/9037
[19] https://www.nice.org.uk/guidance/qs116/chapter/quality-statement-1-asking-about-domestic-violence-and-abuse
[20] https://www.ias.org.uk/wp-content/uploads/2020/12/Men-and-alcohol.pdf
[21] https://www.drinkaware.co.uk/facts/health-effects-of-alcohol/alcohol-and-gender/alcohol-and-men#aggression

4.1.13 Alcohol and mental illness are inextricably intertwined. Excessive drinking might harm your health. On the other hand, some people may drink to alleviate the symptoms of mental illness.[22]

4.1.14 Many domestic abuse incidents occur after one or both parties have had alcohol, and alcohol is more typically implicated in more aggressive incidents. Living with domestic abuse can also be terrifying, unpleasant, and draining. This can lead to some people using alcohol to cope with domestic abuse's physical and mental health consequences.[23]

4.1.15 The domestic abuse occurrences reported in the chronology include Sharon being intoxicated when she assaulted David and both she and David being intoxicated during a police call.

4.1.16 As a result, an increased understanding of the effects of alcohol on physical health, mental health, and the likelihood of domestic abuse should have encouraged health practitioners to explore this further.

4.1.17 Regarding its "did not attend policy," the hospital issued one recommendation.

Bedfordshire Police

4.1.18 Approximately 38 years ago, David came to the attention of the police for the first time. The national police computer lists sixteen arrests for him. Arrests date back to 1984 and include Actual Bodily Harm, driving under the influence of alcohol or drugs, Criminal Damage, Public Order Violations, Grievous Bodily Harm, Handling, and Theft.

Mental Health

4.1.19 The incident on 20 February 2021 was the first time David was identified as vulnerable. The police did not take further action; the concern was due to David's intent to end his life and his announced plan. Although David stated that he was fine, the chair would anticipate communication with mental health professionals and verify that David was receiving support for his recent grief owing to the potential risk.

4.1.20 On 6 and 7 November 2021, the police were told that David was missing from the ward; the second report also indicated that David was bringing drugs to the ward for a patient and feared this patient. The police called David, who denied having any fears. However, the police accepted that they did not pursue the drug report, which may have led to criminal proceedings.

4.1.21 Sharon expressed concern to the police on 16 April 2022 since she had not heard from David for 48 hours. In their review, the police observed that a referral to mental health services should have been considered. Accordingly, a referral to mental health services was made on April 20, 2022.

Alcohol and Drugs

[22] htthttps://alcoholchange.org.uk/alcohol-facts/fact-sheets/alcohol-and-domestic-abuse ps://www.mentalhealth.org.uk/explore-mental-health/a-z-topics/alcohol-and-mental-health

[23]

4.1.22 The police attended an incident on 9 January 2022; the police record reported "no fights had occurred, people who can't handle their alcohol and got a bit shouty'.

4.1.23 The panel agreed that using this language to help people better appreciate the concerns and/or the potential risks was improper.

4.1.24 On 14 January 2022, the police were called to David's house; the police enquiry revealed that David's vulnerabilities and the context of the incident, which could constitute cuckooing, were not investigated. Furthermore, the police overlooked intelligence that David was allegedly bringing drugs to the mental health unit a few months prior.

4.1.25 In certain circumstances, drug dealers will take over a nearby property, usually that of a vulnerable individual, and use it as a base for their illicit business. This is referred to as cuckooing.[24]

4.1.26 Poverty or solitude, drug dependence, and adults living alone who require welfare benefits are the most frequent targets of cuckooing. Promises of money, companionship, and drugs are used to get access. According to Thomas, David had a history of substance abuse, and the mental health unit had reason to believe that David was transporting illicit substances to the ward. Moreover, David had experienced homelessness.

4.1.27 The chair suggests that information should have been forwarded to adult social care under the 2014 Care Act's safeguarding adult duty.

4.1.28 David was identified as vulnerable, and the police acknowledged this after receiving a call from David on 20 February 2021. The author agrees with the police review and their recommendation to address this.

Domestic Abuse

4.1.29 Between 28 February 2022 and May 2022, nine domestic abuse incidents involving David and Sharon occurred.

4.1.30 On 28 February 2022, the first domestic abuse incident was reported to the police (see the chronology for details). David declined safeguarding and indicated he has a supporting family. Sharon was the alleged perpetrator and was issued a DVPO on 2 March 2022.

4.1.31 Under some conditions, consent can be revoked[25]:

- Without consent, emergency or life-threatening situations may necessitate disclosing essential information with the appropriate emergency services.
- The law does not prohibit organisations from sharing sensitive, personal information. Sharing information may be justified if the information is confidential, but a safeguarding concern exists.

[24] https://www.nationalcrimeagency.gov.uk/what-we-do/crime-threats/drug-trafficking/county-lines
[25] https://www.scie.org.uk/safeguarding/adults/practice/sharing-information

- The law does not prohibit organisations from releasing sensitive, personal information when the public benefit served outweighs the public interest served by maintaining confidentiality, such as when a serious crime can be averted.
- Within the boundaries of the Data Protection Act 2018 and the General Data Protection Regulation, information can be exchanged legally.

4.1.32 It is also recommended that frontline staff and volunteers always disclose safeguarding issues according to their organisation's policy - usually to their line manager first, except in emergencies.

4.1.33 The police review revealed the following:

- Considering Sharon's history, a safeguarding concern should have been raised, and David should have been referred to mental health services.
- A Street Index Gazetter (SIG) marker should have been considered for David's address. This would enable the police to identify victims, repeat victims, and vulnerable people at risk of domestic violence or safeguarding. The marker was placed on March 4, 2022.
- The Domestic Violence Disclosure Scheme[26], often known as 'Clare's Law,' permits police to disclose information on people with a history of abusive or violent behaviour to safeguard a potential victim from danger. In addition, the right to know under the scheme empowers the police to disclose information to a potential victim on their initiative if they believe it will safeguard that person.
- Sharon's recent background, including her alcohol problems and domestics, may have been disclosed. Although she was always classified as the victim, alcohol played a vital role in the domestic and public order offences for which she was arrested. Domestics had also been a regular occurrence when she visited the homes of ex-partners. David had expressed concern about the escalation of violence.

4.1.34 The incident on 1 March 2022 should have led to Sharon's arrest, remand, and appearance before a magistrate for violation of the DVPN.

4.1.35 Section 26(1)(a) (Crime and Security Act 2010)[27] specifies that the individual must be detained in custody until the magistrate's court can hear the DVPO application.

4.1.36 Sharon violated the DVPO on April 4, 2022. David called the police to report that she was acting aggressively at his home. He had locked himself in the bathroom. When the police arrived, Sharon stated she was gathering her possessions. The police claimed that no crimes had been committed. However, there was a breach of the DVPO.

4.1.37 Breach of a DVPO—A constable may arrest an individual without a warrant if they have reasonable grounds to believe that the individual violates the DVPO. The individual must be remanded in custody and brought before a magistrates' court within twenty-four hours of arrest. The violation of the DVPO shall be considered a civil contempt of

[26] https://www.met.police.uk/advice/advice-and-information/daa/domestic-abuse/alpha2/request-information-under-clares-law/
[27] https://www.legislation.gov.uk/ukpga/2010/17/section/26/enacted

court under section 63 of the Magistrates' Court Act of 1980 (MCA). Section 57A of the MCA permits the transfer of civil proceedings to a different magistrates' court.[28]

4.1.38 DVPOs are civil orders that fill a "gap" in victim protection by allowing police and magistrates' courts to impose protective measures in the immediate aftermath of a domestic abuse incident where there is insufficient evidence to charge a perpetrator to provide victim protection via bail conditions.[29]

4.1.39 The fifth report of domestic abuse occurred on 12 April 2022, and the police noted they should have referred the case to the Multi-Agency Risk Assessment Conference (MARAC).[30]

4.1.40 A referral to MARAC was made on 18 April 2022.

4.1.41 The police report for the 25 April 2022 incident was unclear and did not depict the facts or mention past domestic abuse episodes.

4.1.42 The College of Policing[31] clarifies that counterclaims should be thoroughly investigated to prevent hasty judgments regarding which side in a relationship is the victim and which is the offender.

4.1.43 There was an incident involving the non-service of the DVPO; the Independent Office for police conduct is investigating this matter.

4.1.44 The police noted sixteen recommendations in their review.

East London Foundation NHS Trust

4.1.45 David's initial interaction with mental health services occurred in April 2019, when he was admitted to a mental health ward and followed up by the Community Mental Health Team (CMHT) and a CC in the community. However, the case was closed for a year, and a second referral was received in June 2021, resulting in hospitalisation.

4.1.46 David was diagnosed with Recurrent Depressive Disorder. David had been open to the Community Mental Health Team (CMHT) since July 2021 and remained open when he passed away. David had been prescribed Sertraline (an anti-depressant) and Zopiclone (a sleeping tablet), and the Care Program Approach (CPA)[32] had been utilised to address his care needs.

4.1.47 David had six admissions to an inpatient psychiatric hospital due to suicidal ideation and intent. His last two admissions:

[28] https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010#:~:text=1%20A%20breach%20of%20a,5000%20or%202%20months'%20imprisonment.
[29] https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010
[30] https://safelives.org.uk/sites/default/files/resources/MARAC%20FAQs%20General%20FINAL.pdf
[31] https://www.college.police.uk/app/major-investigation-and-public-protection/domestic-abuse/first-response
[32] https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/

1. **June 2021 – July 2021 (28 days)**: A relapse believed to have been precipitated by COVID lockdown and issues obtaining a repeat prescription for Sertraline. David presented with anxiety and depression-related suicidal ideation. For his physical pain, he had been purchasing Morphine, Tramadol, and Naproxen online. However, David discovered upon hospital discharge that he had been deregistered from the GP and could not obtain repeat medicine. In addition, David had difficulty engaging with the CMHT because of mobile phone issues. As a result, he relapsed and was readmitted to the hospital with the same symptoms.
2. **October 2021 – November 2021 (19 days):** David presented with suicidal ideation, which included pouring petrol over himself and setting alight to himself. While on the ward, David was referred to the local authority community occupational therapist (OT) regarding equipment to support safety in the home. David went on leave from the ward and declined to return. Once assured of his safety, the ward discharged him to follow-up contact by the CMHT within 72 hours, ongoing support by the CC and a medical review within four weeks.

4.1.48 David's limited interaction with his CC resulted from the CC having to take emergency leave. The CMHT policy mandates a minimum monthly interaction to enable effective review recovery and address any issues that may emerge. During absences, the policy requires that caseloads be passed to a designated colleague. The nature of the sudden leave and recruitment and retention challenges may have led to the need for more transfers.

4.1.49 ELFT observed that the medical review was conducted four months later than anticipated and suggested that difficulties with recruitment and retention were contributing factors.

4.1.50 However, the CMHT OT contacted David and assisted him in securing suitable housing and benefits. He was referred to the local authority community OT, and no risks were recognised till 21 April 2022.

4.1.51 The CPA further specifies that reviews should be conducted every six months. On 25 April 2022, a change in David's social care needs should have necessitated a review of his care; however, this did not occur.

4.1.52 David disclosed recent suicidal thoughts during the assessment but stated he wanted to live for the sake of his dog. He expressed a desire to recover, planned to spend the night with a friend, and agreed to communicate if his mental health deteriorated and contact the police if he felt at risk.

4.1.53 Due to the concerns, the CMHT agreed to contact David via telephone the following day; David texted the CMHT that he would be away until 29 April 2022.

<u>Domestic Abuse</u>

4.1.54 During the assessment on 25 April 2022, David revealed a traumatic history of domestic abuse. He also reported receiving threats from individuals due to the rumours his ex-partner had disseminated. Consequently, he feared returning home and stayed at a bed and breakfast. As a result, he exhibited emotional behaviour and complained of sleep disturbances.

4.1.55 Following the disclosure, a DASH risk assessment[33] should have been performed to identify the risks, and David should have been sent to the given or referred support services. The DASH Risk Checklist is an established method for assessing risk. DASH is a vital resource for victims. It is based on studies regarding the indicators of domestic abuse with a high risk.[34]

4.1.56 During the review period, ELFT was aware of two safeguarding concerns. However, the panel discovered that these concerns had not been formally brought to Adult Social Care, contrary to the belief that they had been. Because David was hospitalised and in a place of safety, the police indicated that they had not issued a formal safeguarding concern.

1. **21 April 2022**: A police notification stated that David's ex-partner beat him daily, threatened to send people to kill him, shattered many mobile phones, attended his home, refused to leave, and had his benefits deposited into her account. It further noted that David lacked familial support. The ELFT review revealed no evidence that a referral had been sent to the CC per the protocol. The notification also indicated that the referral had been made to adult social care, which ELFT could not confirm occurred.
2. **25 April 2022**: During the assessment, David expressed distress regarding his experience with domestic abuse. He explained that although he had only moved into his bungalow in February 2022, he no longer felt secure living there or walking outside. As a result, he had been sleeping at a bed and breakfast but could no longer afford it, so he intended to stay with a friend that night. David indicated that he would inform the police if he felt threatened and denied having thoughts of killing himself. He also stated that he would contact the CMHT or after-hours services if his situation altered.

4.1.57 ELFT discovered that the contact two days before David's death should have indicated a safeguarding adult concern to be raised. However, it did not. Moreover, this provided an additional opportunity to explore and do a DASH risk assessment.

4.1.58 ELFT identified actions to be performed considering their review's findings:

- The monitoring procedure has been revised, and outpatient appointments (OPA)/CPA are now monitored weekly via Reporting Services. This contributes to the weekly Performance Huddle with the Operational Lead and Team Manager.

[33] https://safelives.org.uk/sites/default/files/resources/Dash%20for%20IDVAs%20FINAL_0.pdf
[34] https://www.dashriskchecklist.co.uk/

- OPA/CPA is reviewed as part of core supervision for 4-6 weeks. Before supervision, three records are visually audited, and one form is formally audited using an auditing tool and recorded during supervision.
- A key performance indicator targets CPA every six months, and it is discussed at the weekly multidisciplinary meetings.
- As required, risks are updated after contacts via the risk checkbox in progress notes.
- The CPA review is scheduled on the CC electronic patient record calendar. The missed OPA resulted from human error and administrative personnel issues. The risk of recurrence is mitigated with the implementation of new procedures and the addition of administrative support from the bank while recruitment continues.

4.1.59 ELFT provided one recommendation about suicide awareness.

4.2 Overview

4.2.1 This report section analyses the key lines of Enquiry (KLEO) to confirm that they have been addressed and met.

4.2.2 **KLEO 1**: Were local domestic abuse and adult safeguarding procedures followed by agencies who had contact with David?

Analysis

4.2.3 Contrary to its procedures, which provide guidelines on when and how to refer victims/survivors of domestic abuse, ELFT did not raise a safeguarding adult concern, complete a DASH or refer David to domestic abuse services.

4.2.4 In their section above, the police response is noted.

4.2.5 **KLEO 2**: Were perpetrator disruption or victim safety planning options available to your agency/agencies during the review period? If so, why were they not considered or were there barriers to using them?

Analysis

4.2.6 Sharon was served with a DVPO by the police; however, they did not execute the mandatory obligations outlined in the DVPO when Sharon violated its terms. Please refer to the section about the police contact above.

4.2.7 **KLEO 3:** Were service responses to David affected by the COVID-19 pandemic?

Analysis

4.2.8 During this time, no services reported any impact on David's ability to receive a response.

4.2.9 **KLEO 4:** Was information shared promptly and to all appropriate partners during the period covered by this review?

Analysis

4.2.10 This review indicated that information was not provided; the police reported they did not share information regarding safeguarding owing to a lack of consent, and David's right to know under the Domestic Abuse Disclosure scheme was not communicated to him.

4.2.11 ELFT did not complete the DASH risk assessment or follow up on the safeguarding concerns.

4.2.12 Information sharing is a vital aspect of a frontline practitioner's job. A precise risk assessment is essential to adequately protect adults and children. It identifies the needs of the entire family and is crucial for safeguarding and promoting the welfare of adults.[35]

4.2.13 Domestic homicide reviews and safeguarding adult reviews have indeed demonstrated that health, police, and social services made poor decisions not to communicate information about domestic abuse with others since the patient had the capacity to refuse permission and no legal safeguarding duties applied.[36]

4.2.14 The UK Caldicott Guardian Council[37] developed a single-line ethical standard for sharing information.

"An individual's information may be shared if it is believed necessary to prevent or reduce the risk of serious harm to themselves or others."

4.2.15 **KLEO 5** Are there areas that agencies can identify where national or local improvements could be made to the existing legal and policy framework?

Analysis

4.2.16 The panel discussed the current improvements, which emphasise the suicide risk linked with domestic abuse and reinforce training by incorporating the homicide timeline and suicide timeline. In addition, there is cooperation with the male independent domestic abuse advocate and the local football team to increase domestic abuse awareness among males.

4.2.17 The panel discussed the DASH risk assessment and felt this did not help identify suicide risk.

4.2.18 However, it is essential to remember that risk assessments are snapshots in time and may not fully reflect the actual risk posed by the victim or survivor.

[35] https://safelives.org.uk/sites/default/files/resources/A%20Practitioner%27s%20Guide%20to%20GDPR%20-%20England%20%26%20Wales%20version.pdf
[36] https://bmjopen.bmj.com/content/12/6/e057022
[37] https://www.ukcgc.uk/domestic-violence

4.2.19 The University of Manchester[38] also indicated that risk assessment methods in isolation do not effectively forecast the future risk of self-harm or suicide. Ninety-five percent of research studies failed to predict future risk accurately.

4.2.20 **KLEO 6:** Information: What knowledge/information did your agency have that indicated that those involved might be victims of domestic abuse and criminal exploitation, and how did your agency respond to this information?

Analysis

4.2.21 David was a victim of domestic abuse, and the police and ELFT were aware that he was potentially being exploited to bring drugs to the hospital.

4.2.22 The Office for National Statistics estimates that 1.6 million women and 757,000 men reported abuse in 2020. Mankind Charity registered that in 2021, just 58 out of 238 refuge spaces supported male survivors. Statistics on the number of men facing domestic abuse may not always portray the whole reality. Male victims of domestic abuse are two and a half times less likely to tell anyone about the abuse they're experiencing, meaning it may never be recorded.[39]

4.2.23 The government publication[40] "Supporting Male Victims" acknowledges that negative perceptions are barriers to reporting and seeking assistance. However, it emphasises the need to ensure male victims/survivors have timely and appropriate access to support.

4.2.24 In March 2022, the Government issued a revised Male Victims Position[41] addressing male victims of domestic abuse and other crimes, including sexual abuse and forced marriage. The Statement included the following:

"Harmful stereotyping and popular myths and misconceptions around male victims can be additional barriers to reporting and seeking help. For example, stereotypes around masculinity can have a significant role in a male victim's experience of domestic abuse. As a result, male victims may be less likely to disclose that they are being abused or may not recognise they are victims of domestic abuse as they may believe the term 'domestic abuse is only applicable to women."

4.2.25 **KLEO 7:** Does your agency have any information that helps understand the possible 'triggers' in David's life that may have led to his suicide?

Analysis

4.2.26 David expressed fear of being at home and wanted assistance with moving. Domestic violence was cited as the cause of his fear.

[38] https://sites.manchester.ac.uk/mash-project/risk-assessment-tools/
[39] https://www.mankind.org.uk/statistics/
[40] https://www.gov.uk/government/publications/supporting-male-victims/supporting-male-victims-accessible#identification-and-reporting
[41] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1073565/Supporting_male_victims_2022.pdf

4.2.27 In 2021, he was admitted twice to the mental health unit for suicidal ideation. In addition, ELFT has produced a recommendation to increase suicide awareness.

4.2.28 On the morning that David took his own life, the police were notified that Sharon was banging on his door and that he was distressed. Unfortunately, due to other events, they did not attend this occurrence.

4.2.29 **KLEO 8:** Were practitioners alert to potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator?

Analysis

4.2.30 ELFT and police were aware of the domestic abuse David endured. As a result, the police issued a DVPN to Sharon. Refer to their sections for specifics.

4.2.31 Between February and May 2022, the police were called nine times for domestic abuse involving David and Sharon. During these occasions, each was reported as both victim and perpetrator. This could lead to the perception of abuse from both parties.

4.2.32 Elizabeth Bates[42] characterised it as:

'*Bidirectional or mutual abuse can be prevalent and unrelenting in big and small matters. It suggests that both partners can display aggressive behaviours during a conflict. However, this may not be the case with each conflict episode and may not be symmetrical.'*

4.2.33 **KLEO 9:** Have your agency policies and procedures been established for identifying domestic abuse and dealing with those concerns? Were these assessment tools, procedures and policies considered effective?

Analysis

4.2.34 Panel members acknowledged they have policies and procedures to assist staff in identifying abuse. In addition, Bedfordshire Hospital has a domestic abuse clinic where they can invite victims/survivors for additional support. The hospital also places posters in non-patient areas, such as staff facilities, to raise awareness of domestic abuse among staff.

4.2.35 **KLEO 10:** What were the key points or opportunities for assessment and decision-making in this case? Do reviews and decisions been reached in an informed and professional way and in keeping with organisational and multi-agency policies and procedures?

Analysis

4.2.36 The section on specific agencies examines this in depth. However, the policies and procedures needed to be adhered to.

[42] http://elizabethbates.co.uk/uncategorized/why-we-need-to-investigate-experiences-of-bidirectional-intimate-partner-abuse/

4.2.37 **KLEO 11:** Were joint assessments taking place to assess factors such as mental ill-health, alcohol misuse and domestic violence abuse?

Analysis

4.2.38 There were no shared assessments. ELFT acknowledged being aware of two safeguarding concerns, but they still needed to be addressed, and there was no combined decision-making or planning.

4.2.39 **KLEO 12:** Should the information known to your agency have led to a different response?

Analysis

4.2.40 The panel agreed that the review's findings may not have prompted a different response.

4.2.41 **KLEO 13:** How accessible were the services for David?

Analysis

4.2.42 David accessed services, but on the morning of his death, due to the level of demand and an assessment of all incidents based on Threat, Risk and Harm, the police did not attend his residence

4.2.43 **KLEO 14**: Was there any additional action that could have been taken, and would it have made a difference? (Missed opportunities?)

Analysis

4.2.44 Please refer to the agency sections.

4.2.45 **KLEO 15:** Capacity and resources: Were there issues about capacity or help in your agency that impacted the ability to provide services to the victim, the alleged perpetrator(s), or any other relevant others? If so, did these issues affect the agency's ability to work effectively with other agencies?

Analysis

4.2.46 The police were unable to visit David's residence. ELFT cited problems with recruitment and retention. This resulted in David receiving delayed follow-up.

4.2.47 **KLEO 16:** Are there lessons to be learned from the case relating to how your agency safeguards victims and promotes their welfare or the form that it identifies, assesses, and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, managing, supervising, and working in partnership with other agencies and resources?

Analysis

4.2.48 Please see section 6.1

4.2.49 **KLEO 17:** Identify good practices where responses may have exceeded the required standards.

Analysis

4.2.50 The CMHT OT addressed health and social care needs associated with housing, mobility issues, practical safety in the home, accessing community resources, and establishing a connection with the local authority Community OT services. Additionally, the OT coordinated with the hospital for physical health issues and follow-up appointments, and the daily duty worker was available to provide additional assistance.

4.2.51 The Team Manager and Operational Lead of the CMHT were committed and dedicated to a service afflicted by recruiting and retention issues, increased sickness, the requirement for urgent annual leave, and increased referrals and chronicity in a post-pandemic environment.

5.1 Conclusion

5.1.1 The purpose of the review is to determine the circumstances behind the death of David in May 2022 and 'articulate life through the eyes of the victims.'[43]

5.1.2 David was 55 years old when he took his own life. Previously, he attempted suicide, and as a result, he was admitted to a mental health unit.

5.1.3 The suicide timeline of Jane Monkton Smith[44] is utilised to facilitate learning and highlight the potential for agency engagement.

1. **The perpetrator has a history of abuse.**
   The police knew of Sharon's prior interactions with the law and incidences of domestic abuse. However, David was unaware of his right to know under the domestic violence disclosure scheme.
2. **The Relationship starts quickly or intensely.**
   The documents indicate that David began his relationship with Sharon a few months before his death, although the exact date is unknown.
3. **There is a relationship dominated by control.**
   David declared to the police and ELFT that he was so terrified of Sharon that he desired to relocate; he was not referred to domestic abuse services, and ELFT did not complete a DASH nor progress the safeguarding concerns.
4. **The victim starts to disclose as they become more distressed by abuse or violence**.
   David reported domestic abuse to the police, but his family was unaware of this. His disclosures to ELFT received no response.
5. **The victim seeks help from agencies like the Police, Mental Health Services, GPs, or Independent Domestic Violence Advocates.**
   Between February and May 2022, the police received nine reports of domestic abuse involving Sharon and David.

[43] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf
[44] https://twitter.com/JMoncktonSmith/status/1495129374886174728

David disclosed to his mental health team that he had a traumatic history of domestic abuse.

6. **The victim starts talking about ending their life as abuse and stalking are persistent and intense.**
   David was hospitalised after two suicide attempts. On the day of his death, he was reportedly distressed and afraid of Sharon.
7. **The victim says they feel completely trapped by the perpetrator and will never be free.**
   David stayed at a bed and breakfast because he feared returning home. On the day he died, Sharon allegedly banged on his front door, and he was distraught by this and the fact that she had his beloved dog.
8. **There is a suicide.**

6.1 Lessons to be Learnt

6.1.1 The review noted the following themes:

Agencies' response to Disclosures of Domestic Abuse

6.1.2 David disclosed domestic abuse to the police and ELFT.

6.1.3 The Department of Health and Social Care published guidance [45]in April 2022 to strengthen the response to Domestic Abuse. It states: 'Domestic abuse is a serious health and criminal issue. Practitioners are in a key position to identify and help interrupt domestic abuse.'

6.1.4 Furthermore, it states: 'Health professionals are responsible for addressing the health impacts on people directly or indirectly affected by domestic abuse. They also must ensure that other agencies are engaged to address the social, environmental, and broader impacts. People experiencing domestic abuse may choose to disclose it to health professionals, including GPs.'

Male Victims

6.1.5 David was a male domestic abuse victim. The police had issued Sharon a DVPN. However, the protocols were not followed.

6.1.6 David was a victim of domestic abuse, but despite ELFT's knowledge of this, no action was taken.

6.1.7 Respect[46] has developed a unique toolkit for working with male victims of domestic abuse to increase the response of agencies to this issue.

Bidirectional abuse

6.1.8 The relationship was reported to the police by David and Sharon, who were victims and perpetrators of domestic abuse.

[45] https://www.guidelines.co.uk/public-health/responding-to-domestic-abuse-guideline/456939.article
[46] http://hubble-live-assets.s3.amazonaws.com/respect/redactor2_assets/files/103/Respect-Toolkit-for-Work-with-Male-Victims-of-Domestic-Abuse-2019.pdf

Mental Health and Domestic Abuse

6.1.9 Although the reviewed documents indicated that David drank alcohol, it was unclear whether he was a dependent drinker.

6.1.10 Male victims of intimate partner abuse were examined in a study by Hines and Douglas, which[47] supported the hypothesis that intimate partner abuse is associated with higher levels of alcohol abuse. However, men who had experienced common couple abuse had the highest alcohol abuse and frequency of intoxication within the previous year compared to men who did not experience intimate partner abuse. In addition, men who experienced intimate abuse had higher levels of alcohol abuse within the past year but did not report a greater frequency of intoxication.

6.1.11 David also experienced depression.

6.1.12 In England, an estimated 589,000 people are dependent on alcohol. Approximately one-fourth of them are likely to receive medication for mental health, primarily for anxiety and depression, but also for sleep problems, psychosis, and bipolar disorder.[48] Public Health England[49] has established two fundamental principles regarding this issue: Working together and no wrong door.

Information Sharing

6.1.2 Save Lives and the police both highlighted information sharing.

6.1.3 The UK Caldicott Guardian Council has developed an information-sharing decision-making template.

7.0 Recommendations

7.1.1 Individual Agency Recommendations

7.1.2 Police

Recommendation one:

Probation ensures that partner agencies involved in an individual's risk management or sentence plan objectives are aware, and a mechanism for gathering information is agreed upon to enable monitoring of those objectives.

Recommendation two:

Where requirements are imposed at sentencing concerning the treatment of offenders and victims subject to domestic abuse, details will be recorded on Athena for future monitoring to encourage compliance.

Recommendation three:

Supervisors must ensure that all crimes that are identified are correctly recorded and an appropriate review and investigation plan set.

Recommendation four:

All must be reminded of the importance of accurately completing Athena entries.

[47] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3315600/

[48] https://ukhsa.blog.gov.uk/2020/11/17/alcohol-dependence-and-mental-health/

[49] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf

Recommendation five:

Officers must be reminded to submit intelligence, whether or not it is corroborated, and grade it accordingly.

Recommendation six:

Staff employed within the intelligence hub should be reminded to highlight intelligence concerning vulnerable persons to PPU so that partnership intervention can be considered.

Recommendation seven:

When DVPNs are issued referral to domestic abuse services should always be offered but are not automatically made.

Recommendation eight:

Full intelligence research should be conducted, including national police databases when considering how to progress an investigation.

Recommendation nine:

Where a need for a sig marker has been identified, or a DVPO has been issued, these should be placed immediately.

Recommendation ten:

A record of the domestic dispute under Sharon should be recorded on Athena.

Recommendation eleven:

Missing Persons Team to remind officers to be mindful of making appropriate referrals on conclusion of 'Return Interviews'

Recommendation twelve:

Reinforcement of DVPN/DVPO policies, particularly in standards across the workforce, to ensure consistency of practice, auditing and early intervention for vulnerable victims and perpetrators of domestic abuse.

Recommendation thirteen:

Supervisors, Gatekeepers and Managers to ensure all risk assessments and any referrals pertinent to any of the subjects have been,

- physically seen and endorsed accordingly.
- Review and revisit any significant developments or changes in the investigation for accuracy and recording.
- submitted to the relevant specialists and agencies for support.

Recommendation fourteen:

Consider revisiting the DVPO policy and updating it with details of ongoing responsibility of service, where the audit is held, and auditing failed attempts to serve the DVPO.

7.1.3 Bedfordshire Hospital

Recommendation One:

Bedfordshire Hospitals NHS Foundation Trust will review the process around escalation 'Did Not Attend' for adults.

7.1.4 East London Foundation Trust NHS

Recommendation one:

The team will attend the Trust Suicide Awareness and Prevention training. Team Manager to ensure that two staff attend per training session. It remains a rolling programme.

7.1.5 Multi-Agency Recommendations

Recommendation one: Agencies' response to Disclosures of Domestic Abuse

1.a The Central Bedfordshire Community Safety Partnership to receive assurance from partners concerning their inclusion of the NICE Quality Standard (QS116) in their service policies and procedures. Practitioners should be able to enquire about domestic abuse and respond to disclosures.

Recommendation two: Male Victims and Bidirectional abuse

2.a The Domestic Abuse Service and Workforce Development has facilitated public campaigns to identify and respond to domestic abuse. These should be ongoing and should continue to involve male survivors of domestic abuse.

2.b The Domestic Abuse Service and Workforce Development will review the Respect toolkit and incorporate its contents into its domestic abuse training and processes.

2.c The Domestic Abuse Service and Workforce Development to develop a partnership-based strategy for addressing bidirectional abuse.

2.d The Domestic Abuse Service and Workforce Development is tasked with developing resources to aid in the identification of bidirectional abuse and the availability of support for victims/survivors.

Recommendation Three: Mental Health and Domestic Abuse

3.a The local suicide prevention strategy should address the correlation between domestic violence and suicide, as well as alcohol and suicide.

3.b The partnership to improve awareness of the suicide timeframe.

Recommendation Four: Information Sharing

4. A Central Bedfordshire Community Safety Partnership will be established to receive assurance from partners concerning how they support staff to understand when consent can be overruled and to utilise the resources provided by the UK Caldicott Guardian.

The partnership will establish and monitor the action plan to meet the recommendations.

Appendix 1 - Action Plan

This action plan is a live document and subject to change as outcomes delivered.

	Recommendation	Scope of recommendation	Action to take	Lead Agency	Milestones	Target Date	Outcome
1	Probation ensures that partner agencies involved in an individual's risk management or sentence plan objectives are aware, and a mechanism for gathering information is agreed upon to enable monitoring of those objectives	Local	- Review process - Update and embed - Ongoing awareness raising/refresher - Monitoring/evaluation	National Probation Service	26.11.2025 – LS met with LJ Head of PDU and discussed action. LJ is happy that there has been significant process changes since this incident and that the response has improved. LJ will provide wording to update the action.	January 2026	**ONGOING**
2	Where requirements are imposed at sentencing concerning the treatment of offenders and victims subject to domestic abuse, details will be recorded on Athena for future monitoring to encourage compliance	Local	- Review process - Update and embed - Ongoing awareness raising/refresher - Monitoring/evaluation	Police	This has been scoped and Athena does not have the functionality to handle this tracking request.	August 2024	**CLOSED**
3	Supervisors must be reminded of their responsibility to investigate reported crimes, whether or	Local	- Reminder to all staff - Ongoing quality review process - Monitor in 121s	Police	Supervision of DA crime has been reviewed since this DHR and there are now further review	January 2024	**CLOSED**

	not a victim may be a suspect		- Refresher process - Audit/Evaluate		processes in place before a DA crime can be closed. This includes a DA checklist. DA is a priority for the whole force and had better governance structures and oversight in place.		
4	All must be reminded of the importance of accurately completing Athena entries	Local	- Reminder to all staff - Ongoing quality review process - Monitor in 121s - Refresher process - Audit/Evaluate	Police	The force has an investigation standards & vulnerability process manager who QAs DA investigations as part of his general work. He also delivers inputs to student officers and on various CPD/training days that teams hold.	January 2024	**CLOSED**
5	Officers must be reminded to submit intelligence whether or not it is corroborated and grade accordingly	Local	- Continue to flag importance of submitting intelligence - Supervisory review of submissions - Identify/act on low submitters - Ongoing review and evaluation	Police	The force has set up an Intelligence Board led by the DCS for the intelligence command. This has DCI and above attendance from every team across the force and there is a delivery plan to increase the intelligence submission across the force that is supported by local plans.	January 2024	**CLOSED**
6	Staff employed within the intelligence hub to be reminded of highlighting	Local	- Review current process - Update where needed	Police	The intelligence unit carry out daily scanning of intelligence submissions	January 2024	**CLOSED**

	intelligence concerning vulnerable persons to PPU so partnership intervention can be considered		- Promote and embed process - Ongoing review and evaluation		and logs of note/concern are shared with the PPU Hub.		
7	When DVPNs are issued, ensure automatic referrals are made to DA services		- Develop a referral process following the issue of a DVPN - Embed process - Ongoing evaluation	Police	A significant amount of work has gone into improving the number of DVPNs that are issued by not only the Emerald Team but by other teams too. This has an oversight process built in. Cases that meet the criteria for a DVPN are considered to be high risk and all high risk cases are referred to the appropriate partner agencies by the PPU Hub and are referred to victim support services too.	January 2024	**CLOSED**
8	When researching the domestic history of perpetrators or victims, consider using professional judgement in using legislative policies and processes. E.g. Domestic Violence Disclosure Scheme (DVDS) – Clare's Law	Local	- Review current knowledge of policies and processes - Identify knowledge gaps - Ongoing training/refresher training - Monitor/evaluate	Police	Increasing the use of the DVDS scheme has been a focus for the force for the past year. We have been consistent with the right-to-know applications but behind the expected volume for right-to-ask. The work over the last year has led to a significant increase in right-to-know disclosures	January 2024	**CLOSED**

					and as of Q2 2025 a new AI tool is being used to identify cases where a right-to-know could be applicable which is then reviewed by the PPU team to start the DVDS process off. This AI tool is identifying a huge proportion more than would otherwise have been readily identifiable.		
9	All staff must be reminded to research victims and suspects when considering appropriate action.	Local	- Review current process - Embed process - Supervisor review - Evaluation	Police	This is in place across investigation teams within the PPU and also the PPU Hub. This theme crosses over from other reviews and has been reiterated to Crime Teams too. It is also included in the DA training for FCR staff.	January 2024	**CLOSED**
10	When a need for a SIG marker has been identified, or a DVPO has been issued, these should be placed immediately	Local	- Review current SIG marker process - Update process if required - Embed process - Supervisor review - Ongoing evaluation	Police	Confirmed with the force control room that there is a dedicated email address for investigators to use to notify of the need for a SIG marker. This is monitored 24/7 by FCR staff and will be actioned as soon as seen.	January 2024	**CLOSED**

11	A record under Sharon of the domestic dispute should be recorded on Athena	Local	- Recorded to be added	Police	Record has been added	October 2024	**CLOSED**
12	Missing Persons Team to remind officers to be mindful of making appropriate referrals on conclusion of 'Return Interviews'	Local	- Referral process to be reviewed and update where necessary - Staff to be update - Ongoing supervision review - Evaluation	Police	This now in place. A referral is made that includes a summary of the return interview.	January 2024	**CLOSED**
13	Reinforcement of DVPN/DVPO policies, particularly in standards across the workforce, to ensure consistency of practice, auditing and early intervention for vulnerable victims and perpetrators of domestic abuse	Local	- Review of current process - Review of training - Embed training - Ongoing training/refresher training - Supervisor review - Evaluation	Police	Links to action 6 above, but in addition, an updated process was introduced in Q2 2023/24 to Emerald officers and CID. Patrol officers were directed to complete the updated training in CPD days. There were 50 DA champions trained across the force at that time and new champions were trained last week. These officer/staff are responsible for CPD re orders and interventions incl. any new	January 2024	**CLOSED**

					superintendents who are authorising DVPNs.		
14	Supervisors, Gatekeepers and Managers to ensure all risk assessments and any referrals pertinent to any of the subjects have been: • Physically seen and endorsed accordingly • Reviewed and revisited any significant developments or changes in the investigation for accuracy and recording • Submitted to the relevant specialists and agencies for support	Local	- Review current process - Update and embed new process - Regular monitoring and evaluation - Ongoing refresher training	Police	There is an initial risk assessment by attending Patrol officers that is checked by PPU Hub. THRIVE+ is revisited during the lifetime of the investigation. Monthly Supervisor reviews check on the quality of investigation and the referral status.	January 2024	**CLOSED**
15	Consider revisiting the DVPO policy and updating it with details of ongoing responsibility of service, where the audit is held, and audited failed attempts to locate	Local	- Review current process - Update where needed - Promote and embed process - Ongoing awareness raising/refresher training - Evaluation/monitoring	Police	A Power BI dashboard has been created to enable effective monitoring of DVPO conditions. The Emerald proactive team or Patrol officers are tasked daily to carry out checks and update the records. The process is overseen by the ACC at the daily force management meeting.	August 2024	**CLOSED**

16	Consider recording the incident as a domestic abuse on Athena	Local	- Consider whether to record - If agreed – record on Athena	Police	No additional DA record has been recorded.	December 2024	**CLOSED**
17	Bedfordshire Hospitals NHS Foundation Trust to review the process around escalation "did not attend" for Adults	Local	- Process to be reviewed - Process updated accordingly - Raise awareness and embed process - Review and evaluate	Bedfordshire Hospital NHS	LS chased TMD for update on action 26.11.2025	January 2026	**ONGOING**
18	The CSP to receive assurance from partners concerning their inclusion of the NICE Quality Standards (QS116) in their service policies and procedures. Practitioners should be able to enquire about domestic abuse and respond to disclosures	Local	- Partners to share their assurances that NICE standards are in their policies & procedures - Monitor responses - Chase responses and escalate where needed - Regular review and reassurance	All agencies	26.11.2025 – all partners have been contacted regarding their NICE Quality Standards.	January 2026	**ONGOING**
19	The Domestic Abuse Service and Workforce Development have facilitated public campaigns to identify and respond to domestic abuse. These should be ongoing and should continue to involve male survivors of domestic abuse	Local	- Create a programme of public campaigns - Deliver campaigns - Review impact	CBC	The Workforce Development training, Recognising the Signs and Assessing Risk in DA have both been updated with information about the male survivors. Toolkit has also been updated. All training is reviewed and evaluated on an annual basis.	August 2024	**CLOSED**

20	The Domestic Abuse Services and Workforce Development will review the Respect toolkit and incorporate its contents into its domestic abuse training and processes	Local	- Review current training provision against Respect toolkit - Identify any gaps - Update training provision where required	CBC	The Workforce Development training, Recognising the Signs and Assessing Risk in DA have both been updated with information about the counter allegations toolkit. The Counter Allegations Toolkit is recommended as best practice and guidance offered on how to complete if for every query involving counter allegations from frontline services. It is listed as MARAC action for the lead professional in MARAC discussions. All training is reviewed and evaluated on an annual basis.	August 2024	**CLOSED**
21	The Domestic Abuse Service and Work Force Development to develop a partnership-based strategy for addressing bidirectional abuse	Local	- Add bi-directional abuse to DA Strategy	CBC	Strategy Outcomes are currently being worked through into the Domestic Abuse Action Plan, bidirectional abuse will form part of the Action Plan and the Golden Threads around training and comms.	August 2024	**Ongoing**

22	The Domestic Abuse Service and Work Force Development is tasked with developing resources to aid in the identification of bidirectional abuse and the availability of support for victims/survivors	Local	- Review current training/provisions - Identify gaps - Resources to be created/implemented - Ongoing evaluation of resources	CBC	Completed. New resources and revised training will be evaluated and reviewed in 12 months. Themes from all DARDR will remain a priority and key point of evaluation for training moving forward.	August 2024	**CLOSED**
23	The Local Suicide Prevention Strategy should address the correlation between domestic violence and suicide, as well asl alcohol and suicide	Local	- Suicide prevention strategy to include domestic abuse - Strategy to be shared and agreed by the Local Partnership Board	Public Health	This has been discussed at the local Carers Board and several actions have been completed. The strategy is currently under review and will be present to the local DARDR Scrutiny Panel in May 2025.	August 2024	**CLOSED**
24	The Partnership to improve awareness of the suicide timeframe	Local	- Programme of awareness raising to be agreed and implemented - Training - Action to be added to Suicide Prevention Strategy - Evaluation - Identification of knowledge gaps	BDAP/Public Health	BLMK have published a Suicide Prevention Action Plan 2024-28. Timelines have been incorporated into Domestic Abuse Training – DA Responder Workshops - DA Level 3 GP Safeguarding Training	August 2024	**CLOSED**

					- Pan Bedfordshire DA training for professionals Training has been updated to incorporate signs/symptoms and suicidal ideation. CBCs DA Team sit on the Suicide Prevention Board and have contributed to the Suicide Prevention Plan to include domestic abuse, and have consulted with them to creating a learning package for Health Professionals on suicide and DA. There is a BDAP Domestic Abuse and Health Outcome Subgroup meeting regularly which is attended by mental health and suicide partners. A 7-minute briefing on DA & Suicide has been produced and shared with professionals across		

					the Local Partnership Board. Posters on DA and mental health and suicide have been created and shared with professionals such as GP surgeries and designated safeguarding leads.		
25	Central Bedfordshire Community Safety Partnership to achieve assurance from partners concerning how they support staff to understand when consent can be overruled and use the resource provided by the UK Caldicott Guardian	Local	- Partners to share their assurances how they support staff - Regular review and reassurance	CSP	CSP has contacted all partners to ask how they support staff.	January 2026	**ONGOING**

Appendix 2 – Home Office Letter

Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848
www.homeoffice.gov.uk

Lisa Scott
Safer Communities & Partnership Manager
Safer Communities & Partnership Team Community Safety,
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Central Bedfordshire Council Priory House, Monks Walk,
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SG17 5TQ

5th January 2026

Dear Lisa,

Thank you for resubmitting the Domestic Homicide Review (David) for Central Bedfordshire Community Safety Partnership to the Home Office Quality Assurance (QA) Panel. The report was reassessed in December 2025.

It has been noted that the quality of the action plan has been greatly improved. The QA Panel felt it was positive that condolences were provided by the chair and CSP to the victim's family and noted the initial positive engagement with their father and daughter in the beginning of the process. They were also pleased that a public health/mental health specialist was a member of the panel providing valuable insight into the victim's experience of mental health and the links to domestic abuse.

This DHR can be published but please note the following final feedback.

- Please check the formatting of the Review Panel Members table at the top of page 12.

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

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

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

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

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

Yours sincerely,

Home Office DHR Team