



**TEWKESBURY COMMUNITY SAFETY
PARTNERSHIP
DOMESTIC HOMICIDE REVIEW
EXECUTIVE SUMMARY
Report into the death of Lisa
October 2023**

**Independent Chair and Author of Report: Shabana Kausar
Associate, Standing Together Against Domestic Abuse
April 2025**



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Lisa was an outgoing, friendly, and adventurous woman who had an effortless ability to connect and talk to just about anyone. Her curly hair and vibrant clothing reflected her lively spirit, which brought warmth and joy to those around her. Fiercely independent and unafraid to speak her mind, Lisa embraced life with curiosity and courage. She had a deep love for travel and found true happiness in discovering new cultures and experiences across the world.

At home, she found peace in the quiet moments—tending to her garden with her fluffy ginger cat, Treacle, by her side. Lisa appreciated the simple pleasures in life, like blooming flowers and watching the sun set over the ocean. However, despite her vibrant and joyful exterior, her lifelong struggle with her mental health became a daily battle. Her mental health, compounded by a toxic relationship, would sometimes overwhelm her, which sadly ended in tragedy.

She will be sorely missed as a mother, daughter, and friend. As a family we hope this report will shed some light into her struggles and complicated interactions with local authorities, emergency services and health care professionals. The areas of missed opportunity and misunderstandings, which can hopefully be learnt upon to provide better help to other people in similar situations in the future.

Pen portrait of Lisa by her son

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1. Preface

1.1 The Review Process

- 1.1.1 This review concerns the circumstances leading to the death of 57-year-old Lisa, who died by suicide in October 2023. At the time of her death, Lisa lived alone in her home in the borough of Tewkesbury. She was in an on/off relationship with David since 2010.
- 1.1.2 Lisa has been described by her family as someone who was fiercely independent and outgoing. She loved to travel and would often go on solo trips and many exciting adventures. Lisa was described as having the unique ability to talk to just about anyone and everyone and being very friendly. She loved tending her garden, swimming and spending time with her cat. Her son described her as having a real zest for life and that she brightened every room she entered.
- 1.1.3 On the day of her death, the fire service attended Lisa's home in response to a report of a fire in the back garden of Lisa's property. On arrival, Lisa was sadly found deceased in the summerhouse.
- 1.1.4 At the time of her death, Lisa was pursuing a stalking allegation against David through the courts. After an investigation, it was determined that Lisa had died by suicide with no third-party involvement.
- 1.1.5 The Review Panel expresses its sympathy to the family of Lisa for their loss and thanks them for their contributions and support for this process.

1.2 Contributors to the Review

- 1.2.1 This review has followed the 2016 statutory guidance for Domestic Homicide Reviews which was issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. A total of 13 agencies were contacted to check for involvement with the parties concerned with this DHR. Of these, 7 had only limited contact and submitted a Short Report. However, 5 had more extensive contact and were asked to submit Individual Management Reviews (IMRs). A combined chronology was also prepared. and a narrative chronology written by the Chair. The following agencies and their contributions to this review are:

Agency	Contribution
Gloucestershire Health and Care NHS Foundation Trust	IMR
Hertfordshire Partnership Foundation Trust	Short Report
Hertfordshire General Practitioner	Short Report

ICB for Primary Care	IMR
Gloucestershire Hospitals NHS Foundation Trust	IMR
South Western Ambulance Service NHS Trust	Short Report
Charlies Community Support	Short Report
Gloucestershire Domestic Abuse Support Service	Short Report
Gloucestershire Fire and Rescue Service	Short Report
Hertfordshire Constabulary	Short Report
Gloucestershire Constabulary	IMR
Tewkesbury Borough Council Housing	IMR

1.2.2 *Independence and Quality of IMRs:* The IMRs were written by authors independent of case management or delivery of the service concerned. All IMRs were written by authors independent of case management or delivery of the service concerned. All IMRs/Short Reports received were comprehensive and enabled the Review Panel to analyse the contact with Lisa and David, and to produce the learning for this review. Where necessary, further questions were sent to agencies and responses were received.

1.3 The Review Panel Members

Name	Job Title	Agency
Clare Hicks	Specialist Nurse for Safeguarding Adults	Gloucestershire Health & Care NHS Trust
Jeanette Walsh	Named Nurse for Safeguarding Children	Gloucestershire Acute Hospitals NHS Foundation Trust
Carol Smith	Deputy Head of Adult Social Care	Gloucestershire County Council
Donna Potts	Prevention Manager & Head of Safeguarding	Gloucestershire Fire & Rescue Service

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Farah Sunasee	GP	Surgery
Frankie Duddridge	Head of Services	Fear Free Domestic Abuse Charity
James Luxon	Detective Chief Inspector	Hertfordshire Police
Jo Sutherland	CEO	Charlies Cancer Support & Therapy Centre
Caroline Lucas-Mowat	Programme Manager (DA - Housing)	Gloucestershire strategic housing partnership
Jonathan Newman	Named Nurse for Safeguarding Adults	Gloucestershire Health & Care NHS Foundation Trust
Katie Lewis	Partnerships & Development Manager	Nelson Trust Women's Centre
Sam O'Malley	Designated Nurse Safeguarding Adults	Gloucestershire Integrated Care Board (ICB)
Lisa Ratcliff	Safeguarding Specialist	Southwestern Ambulance Service (SWAST)
Marcus McInerney	Detective Inspector	Gloucestershire Constabulary
Samantha Walsh	Specialist Safeguarding Practitioner for Adults and Children	Hertfordshire Partnership University NHS Trust (HPFT)
Sophie Jarrett	Domestic Abuse and Sexual Violence Strategic Coordinator	Gloucestershire Office for Police & Crime Commissioner (OPCC)
Tessa Davis	Service Manager	Gloucestershire Domestic Abuse Support Service (GDASS)

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- 1.3.1 *Independence and expertise*: Review Panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case.
- 1.3.2 The Review Panel met a total of three times, with the first meeting of the Review Panel in April 2024. There were subsequent meetings in August 2024 and December 2024.
- 1.3.3 The Chair of the Review wishes to thank everyone who contributed their time, patience and cooperation to this review.

1.4 Chair of the DHR and Author of the Overview Report

- 1.4.1 The Chair and author of this DHR is Shabana Kausar, an Associate of Standing Together. Shabana has received Domestic Homicide Review Chair's training from Standing Together. She has extensive experience in the domestic violence sector, having worked in both statutory and voluntary sector organisations. As a Violence against Women and Girls Strategic Lead, Shabana has commissioned and led reviews on behalf of three Local Authority areas in London. She is currently undertaking a PhD on Violence against Women at the University of London.
- 1.4.2 *Independence*: Shabana Kausar has no connection with the Safer Gloucestershire and the Tewksbury Community Safety Partnership or any of the agencies involved in this case.

1.5 Terms of Reference for the Review

- 1.5.1 At the first meeting, the Review Panel shared information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from May 2018 to the date of the death in October 2023. This timeframe was chosen because May 2018 marked a significant incident whereby Lisa came to the attention of services after having attempted to jump in front of a train near Cheltenham railway station. Agencies were asked to summarise any relevant contact they had had with Lisa and David outside of these dates.
- 1.5.2 *Key Lines of Inquiry*: The Review Panel considered both the "generic issues" as set out in 2016 Guidance and identified and considered the following case specific issues:
 - The communication, procedures and discussions, which took place within and between agencies.
 - The co-operation between different agencies involved with Lisa and David [and wider family].
 - The opportunity for agencies to identify and assess domestic abuse risk.
 - Agency responses to any identification of domestic abuse issues.
 - Organisations' access to specialist domestic abuse agencies.
 - The policies, procedures and training available to the agencies involved on domestic abuse issues.

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- How agencies responded to Lisa's mental health
- How agencies responded to Lisa and David's substance use
- How agencies responded to concerns around Lisa's suicidal ideation
- How agencies considered Lisa's experiences of isolation and economic abuse
- How agencies responded to/understood who did what to whom, as both Lisa and David were known as perpetrators of abuse.
- How agencies responded to David and understood the risk that he posed.
- The impact of COVID- 19 and agency responses.
- The impact of the on/off nature of the relationship, including post separation coercive control/stalking.
- Agencies understanding of wider social networks, specifically relationships with Lisa's sons.

2. Summary of Chronology

2.1 Summary of Information from Family

- 2.1.1 The Chair interviewed Ryan, Lisa's son, with his partner, in May 2024. They spoke about Lisa's experiences of services, the barriers she faced in accessing support and the missed opportunities. They also shared details of Lisa's personality and background.
- 2.1.2 They emphasised that Lisa was secretive about her relationship with David:
- 2.1.3 'She was secretive about her relationship, and I [Ryan] did not know that David was living with her until about a month before her death.'
- 2.1.4 Ryan shared that Lisa and David were due to get married in 2016, but Lisa called off the wedding two weeks before because she discovered David's drinking. Ryan told the Chair that Lisa went on their honeymoon to Mexico alone. Ryan explained that Lisa really enjoyed travelling and would often travel independently to many different countries. However, she could be secretive about this too.
- 2.1.5 'She did not always tell people she was going on holiday...she was "paranoid" that people would think it was strange that she went on holiday alone and did not want people to comment on this.'
- 2.1.6 Ryan felt that Lisa would also feel embarrassment about claiming benefits and did not want her parent to know. She was signed off by the doctor due to her mental health issues, but Lisa 'felt guilty about claiming benefits.'
- 2.1.7 Ryan felt that this secretive aspect of Lisa's personality had an impact on how she was viewed and supported by services:
- 2.1.8 'Mum was not always truthful with them [services], and this may have contributed to her slipping through the net...she was very good at convincing people that there was nothing wrong and that everything was okay...as she was friendly and intelligent.'
- 2.1.9 Ryan was concerned that Lisa would minimise her experiences, he felt that she was struggling with alcohol use, but Lisa did not agree with him and did not want to access support for this as she did not think she had an issue with alcohol.
- 2.1.10 'I encouraged her to attend a local alcohol support group in the church, which would also be a good place to meet people, but she did not want to go as she did not believe she had an issue with alcohol.'
- 2.1.11 Ryan explained that he often felt in the dark with what Lisa was experiencing because she would not share details. After Lisa's suicide attempt, Ryan shared that he reached out to his mother's neighbour to be able to be kept up to date on how Lisa was doing. He recalled that Lisa was not happy that he had exchanged numbers with the neighbour, as he Ryan was able to query what Lisa was telling him.
- 2.1.12 Ryan's partner shared with the Chair that this may have been because Lisa only wanted to focus on positive aspects of her life as she was protective over her relationship with Ryan and didn't want him her child to worry about her.

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- 2.1.13 Ryan stated that Lisa was becoming increasingly isolated. He reflected that he thought that she was lonely and bored since moving to Gloucestershire. He initially thought that Lisa had moved to be away from David but had since learnt that David was living with Lisa so was unsure of the reason for the move.
- 2.1.14 Ryan felt that Lisa was regularly concerned about money. Lisa had sold her car, which Ryan was confused by but reflected that it may have been due to money issues. However, he went on to say that he was not sure why Lisa was worried about money as 'she had some savings and did not have a mortgage.'
- 2.1.15 However, Lisa would sometimes borrow money from Ryan and from her father. Ryan also shared that 'David did not really have a job and mum supported him to complete a training course. David was dependent on mum financially. Particularly for housing, as without mum, David had to live with his own mother.'
- 2.1.16 When describing Lisa's relationship with David, Ryan reflected that Lisa felt guilty about the court proceedings. She was nervous about going to court for David's stalking and had complex feelings about it as 'she cared a lot for David and wanted him to be okay but also recognised that the stalking needed to stop.'
- 2.1.17 Ryan later found out that Lisa thought that David was lovely when he was not drinking and was good company, but that 'he was ruining her life.' Ryan read in the coroner's report that Lisa had shared that 'David has ruined my life and now I've ruined his.'
- 2.1.18 Ryan also explained that Lisa was worried that David would steal her cat, as this was something that he had done in the past. Ryan shared that Lisa had put up cameras after her car was vandalised and wire was placed over the garden gate to make the gaps smaller in case David tried to lure the cat and take him, as this had happened in the past.
- 2.1.19 When asked about what more services could have done to support Lisa, Ryan and his partner shared that, after Lisa's suicide attempts, many agencies were involved but the family were not notified of this. Ryan also stated that he felt that there were occasions where Lisa should have been sectioned, but did not understand why this did not happen. He emphasised the fact that Lisa would downplay her experiences and felt that agencies took this at face value.
- 2.1.20 Ryan also felt that services, such as the police, did not go far enough with their support. For example, he shared that he was surprised to learn that Lisa was allowed to go home after being stopped for drink driving, without any further action or support.
- 2.1.21 Ryan's partner also felt that there was no curiosity about Lisa's medication use and how this related to her alcohol use and suicidal ideation:
- 2.1.22 'Lisa had taken an overdose with her medication and then returned to her GP for more medication, and it was not questioned where the medication had gone.'
- 2.1.23 Both Ryan and his partner felt that agencies could have communicated better and shared information to build a better picture of what Lisa was experiencing. For example, when Lisa had attempted suicide in Birmingham, the British Transport Police took Lisa home without being aware of her history.

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- 2.1.24 They also felt that more could have been done to support Lisa after she had made accusations against David for stalking.
- 2.1.25 Ryan reflected on the occasion when he was called by Devon and Cornwall Police asking him to come and collect Lisa, 'but it appeared that their attitude leaned towards the problem being solved rather than considering onward support.'
- 2.1.26 Ryan knew that Lisa was receiving some support and would have a mental health support officer call her once a month to see if she was okay. However, this was not enough, and that Lisa would 'go into a panic and would not know who to call and she would either call the ambulance or the police when she was feeling low.'
- 2.1.27 When asked to describe his mother, Ryan and his partner shared that she was very quirky and friendly. They would try to see her often, but this was difficult when she moved to Gloucestershire, but they would always see each other at Christmas and birthdays. Ryan shared that their relationship was difficult at times, but that they had increased communication and would speak a lot in the last two-three years of Lisa's life.
- 2.1.28 Following the interview, Ryan wanted to share with the Chair the eulogy he had written for his mother's funeral, to better illustrate who she was as a person. Excerpts of this eulogy are included below:
- 2.1.29 'Mum was a fiercely independent and outgoing woman, her unique ability to talk to just about anyone and everyone, whether she knew them or not, led her on many exciting adventures.
- 2.1.30 Mum always had a love for gardening and flowers. Mum spent countless hours tending to and relaxing in her tranquil garden, which seemed to bring her true happiness and peace.
- 2.1.31 Mum had a real zest and love for life, she brightened every room she entered. Her charisma and sense of humour uplifted all our spirits.'

2.2 Summary of Information from Neighbour

- 2.2.1 The chair also interviewed Sophie, Lisa's neighbour, in August 2024. Sophie described her relationship with Lisa as close; they often went on short trips together and socialised regularly. However, Sophie felt that she was often kept in the dark with the full extent of what Lisa was experiencing and that she 'wasn't aware that things were as bad as they were.'
- 2.2.2 Sophie stated that she would often see David at Lisa's home and that their relationship was very on and off again. On one occasion, Sophie saw Lisa throwing David's belongings outside the window whilst telling him that she never wanted to see him again. However, Sophie would then see David back at the property not too long after. Sophie knew that Lisa was going to court because of David's stalking, but then would see him at the property, so she was unsure of the court case details.
- 2.2.3 Sophie mentioned that she was concerned about how much David drank and on occasions was worried about road safety when she saw him in his car. Sophie also felt

that Lisa would drink heavily, and that this was made worse by David who would influence her.

- 2.2.4 Sophie would often worry about Lisa. She recalled a time when David threatened to kidnap Lisa's cat. Lisa was going away, and she was very worried about this threat. She had told Sophie to call the police if David came to the house in her absence. For this reason, Sophie did not speak to David, and she had told Lisa that she did not want to speak about David nor want to know him. Therefore, Lisa's life with David was quite separate.
- 2.2.5 Sophie felt that Lisa would often tell little white lies about unnecessary issues: 'Lisa told Ryan that I had a home in Cyprus and that we went on holiday there together. This did not happen.' It was for this reason that Sophie was keen to get Ryan's number so that, between them, they could get a fuller picture of what Lisa was experiencing.
- 2.2.6 Sophie emphasised that she did not think Lisa was coping and that services needed to do more. Sophie often thought it would have been safer if Lisa was sectioned. Sophie shared that Lisa would worry about calling for help and having services turn up at her home. On one occasion, she apologised to Sophie for the ambulance turning up. When they did show up, Sophie very much felt in the dark and was not informed by services what was going on: 'this made it difficult to support Lisa.'
- 2.2.7 However, Sophie would support Lisa where she could. On one occasion, Sophie had to talk Lisa down from the roof. On another occasion, when Lisa decided to go on a trip, she left her keys with Sophie through her letter box. This would make Sophie worry about what was going on, but she felt she only knew half the picture.
- 2.2.8 When Sophie did speak to services, they would say everything was okay or that "she wasn't going to do anything." Sophie felt that services didn't fully appreciate that Lisa's actions were cries for help, which she felt went unanswered. Sophie also felt that services would look at each incident in isolation rather than a pattern of behaviour.
- 2.2.9 When asked to describe Lisa, Sophie shared that: "Lisa was very confident and intelligent. She could strike up a conversation with anyone and was very friendly. She was very supportive and was a good friend. She was particularly supportive after I lost my husband."
- 2.2.10 "She would often offer to take me on holiday, and we had some lovely trips together, including going on a steam train together."
- 2.2.11 "She was very fun and confident. If she wasn't happy with something she would say something. Lisa would love going on holiday. Whenever she broke up with David, she would say I need to get away."
- 2.2.12 "She also loved her garden and would regularly tend to it. But this changed in the last few months before her death where the garden became quite overgrown."
- 2.2.13 "Lisa also loved her cat. I thought the cat may have prevented Lisa's death, but sadly it didn't."
- 2.2.14 Sophie also shared that there were times that she would be annoyed at Lisa, especially when she did not hear from her and was left worried. Lisa would also have mood

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swings, and on one occasion, Lisa ignored her when in Tesco's. On reflection, Sophie felt this was because Lisa was not taking her medication. Sophie felt that Lisa's bi-polar was getting worse.

- 2.2.15 Sophie spoke about the sadness of learning about Lisa's death. She recalled going into Lisa's home after and seeing photographs strewn all over the kitchen floor of Lisa's children. Sophie shared that she had lost a close friend.

2.3 Summary of Information from alleged Perpetrator

- 2.3.1 David had died shortly after Lisa, therefore was not involved in this review.

2.4 Summary of Information Known to the Agencies and Professionals Involved

- 2.4.1 A range of agencies had contact with Lisa. Broadly this contact related to the following services:

- Police and fire services
- Health services
- Domestic abuse services and other specialist support
- Housing

2.4.2 Police and fire services

- 2.4.3 Lisa had extensive contact with Gloucestershire Constabulary, where she was known as both a victim of domestic abuse and an alleged abuser of David. She was also known to the police in relation to her mental health support needs and as a missing person. The police demonstrated good practice in undertaking welfare checks on Lisa and placing a police alert on her home address. However, there were instances where the police did not recognise domestic abuse, and the risk David posed to Lisa. For example, in May 2020, Lisa was arrested after being accused of throwing a bottle at David and causing a cut to his head. She disclosed years of abuse at the hands of David, but this was not reported as a crime and not investigated.

- 2.4.4 There was also a further missed opportunity to identify who had done what to whom in February 2023, when Lisa was arrested for hosing David with water after he turned up at her property. Lisa shared with police that David had shoved her into a wall and threatened to kill her. However, David was not arrested whilst Lisa was.

- 2.4.5 In September 2023, Lisa was stopped by police driving on the M5, after a neighbour requested a welfare check after Lisa had called them to say that she wanted to end her life. She was breathalysed and allowed to continue her journey after being under the legal limit. She was not offered any support or referred to any support services.

- 2.4.6 The police did later arrest David in September 2023 for stalking and Lisa was supportive of the investigation.

- 2.4.7 Gloucestershire Fire and Rescue Service were requested to attend Lisa's home in September 2023 to support with a welfare check, whereby Lisa was not found at the property. The Watch Manager in charge of that incident has explained that he did not consider raising an internal safeguarding report because he did not identify high fire-

risk factors. However, a safeguarding report could have been raised regarding Lisa's alcohol use and poor mental health. This was not done as they were informed that the ambulance service would do so, however, it is important to not rely on other responding services to make referrals.

2.4.8 The second involvement from Gloucestershire Fire and Rescue Service was in October 2023, in relation to the fire where Lisa was sadly found deceased.

2.4.9 Health services

2.4.10 Lisa was known to a number of health services. She had extensive contact with Gloucestershire Health and Care NHS Foundation Trust (GHCFT) in relation to her mental health support needs from May 2018 to July 2023. GHCFT provided Lisa with a range of support for her mental health needs, but there were missed opportunities to identify and respond to domestic abuse. On several instances, Lisa told her care coordinator that she was worried about David's drinking, and in June 2022 shared that his behaviour changed as a result of his alcohol consumption. Lisa shared that David did not like people coming to the home, and plans were made to change how visits were conducted with Lisa. Later in September 2022, Lisa also shared that she would feel relieved when he would go to visit his mother as it allowed her to relax. Despite these indicators, there was no professional curiosity about domestic abuse, and it was not routinely enquired about.

2.4.11 There were also missed opportunities by GHCFT to identify the risk associated with Lisa's mental health. During the timeframe of this review, Lisa had attempted suicide 5 times, with the final attempt sadly resulting in her death. Despite this, notes indicate that the care coordinators believed Lisa when she would say that the suicide attempts were "silly mistakes." Lisa presented well and would regularly be described by her care coordinator as "pleasant and polite." There were missed opportunities to see past this façade and fully understand Lisa's vulnerability.

2.4.12 Further, GHCFT made the decision to discharge Lisa back to her GP in July 2023 due to non-engagement. She was last seen by a mental health professional in May 2023 and agreed to be discharged from their services in July. This was the same time that there was increased police involvement with Lisa and David. There was a missed opportunity to understand the reasons for Lisa's non-engagement and her support needs.

2.4.13 Lisa had a close relationship with her GP. She would reach out to her GP for support and her GP was noted to send Lisa regular check in messages, which was good practice. The GP also advocated on Lisa's behalf, contacted mental health services to ensure that Lisa had the support she needed. However, there were missed opportunities in identifying and responding to domestic abuse. In March 2019, Lisa suffered a head injury which was assessed by her GP. On this occasion she was not directly asked about domestic abuse. In May 2022, Lisa took an overdose, which she attributed to having drunk too much alcohol and having poor mental health. Risk from others was not explored.

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- 2.4.14 A few days before her death, Lisa had contacted the GP to request assistance completing an insurance cancellation form for a flight that she had been unable to take due to gastrointestinal problems. She mentioned in this discussion that she had a police case against her ex-partner for stalking. Again, there was a missed opportunity to explore Lisa's experience and support needs. The GP determined Lisa's suicide risk level as low.
- 2.4.15 Lisa also presented at Gloucestershire Hospitals Foundation Trust (GHFT) in May 2018 and May 2022, after she had made attempts to end her life. On these occasions, Lisa had shared her concerns about David's drinking. However, she was not asked about domestic abuse and was referred to mental health colleagues.
- 2.4.16 South Western Ambulance Service Trust (SWAST) responded to a number of 999 calls and provided Lisa with appropriate support and care. SWAST also appropriately shared information with the emergency department and to Lisa's GP. However, there were missed opportunities to ask about domestic abuse on their interactions with Lisa. She was asked about her home life and stress factors, but a direct enquiry was not adopted.
- 2.4.17 In February 2023, SWAST attended the home after Lisa had hosed David with water, and he had sustained a head injury. She had disclosed to the police that David had shoved her and threatened to kill her. If domestic abuse had been established by SWAST, this would have resulted in a safeguarding referral to her GP. A safeguarding referral to the GP was made for David, but the Lisa's name was not added in the referral.

Domestic abuse services and other specialist support

- 2.4.18 Lisa was known to Gloucestershire Domestic Abuse Support Service (GDASS), in February 2023 as the alleged perpetrator against David, and in September 2023 as a victim. In February 2023, the police referred David to GDASS after he had threatened to kill Lisa and was then wounded, allegedly by Lisa. GDASS contacted David, who did not engage with their service, and he was closed to them in March 2023. The police referral for David indicated a domestic abuse history between both parties, including counter allegations from Lisa in the incident. However, there was no work undertaken to determine who had done what to whom, which is in line with GDASS's counter allegations policy, as they were unable to engage David to determine who did what to whom. GDASS were unable to make direct contact with Lisa as she was recorded as the alleged perpetrator in the police referral.
- 2.4.19 In September 2023, GDASS received a police referral for Lisa, outlining instances of threats and stalking. Lisa did not want to engage in support from GDASS as she shared that she needs were being met. A risk assessment was not undertaken for Lisa, and GDASS were not able to establish Lisa's substance and mental health support needs as Lisa did not want to engage.
- 2.4.20 In May 2023, Lisa was referred to Charlies Community Support by Birmingham Response Policing Team, after they had established that she was caring for her terminally ill partner. Lisa had expressed that she felt lonely caring for her partner. She was referred to a meeting group in Cheltenham and advised to contact a Cancer Nurse

Specialist for counselling. Lisa did not present at the Cheltenham group and there was no follow up with Lisa. No questions were asked about domestic abuse or risk as part of the conversation. No carers assessment was undertaken.

Tewksbury Borough Council

2.4.21 Lisa had regular contact with the council Tax Office and the Counter Fraud and Enforcement Unit (CFEU), in relation to her Single Person Tax Status. She has informed the CFEU of the difficulties in her relationship with David, they were also aware of the on/off nature of their relationship, with David moving in and out of Lisa's home four times over the course of the timeline of this review. Lisa had also informed the CFEU of her mental health support needs in November 2022. Council Tax and Revenues departments within Local Authorities have unique insight into people's domestic situations, yet none of these disclosures prompted any action, nor resulted in Lisa being flagged as a vulnerable concern. The Review Panel were made aware that, during this time, Tewkesbury Borough Council did not have a domestic abuse policy in place, nor offer their staff domestic abuse specialist training.

2.5 The following services had contact with David

- Police
- Health services
- Domestic abuse services

Police

- 2.5.1 David had a number of interactions with both Gloucestershire and Hertfordshire Constabulary. With Gloucestershire police he was identified as both a victim and perpetrator of domestic abuse. It was not until August 2023 that David was arrested for his abuse of Lisa. The police showed good practice in removing David from the property and pursuing a stalking allegation, but there were missed opportunities to identify David's abusive behaviours prior to this period.
- 2.5.2 Hertfordshire police had historic records of domestic abuse between David and Lisa in 2016, where David was noted as the alleged abuser. During the timeframe of this review, David came to the attention of police in June 2022 after concerns were raised by his sister regarding his mother's safety. The police undertook a DASH risk assessment, and the incident was recorded as non-crime domestic abuse. David had shared that he was living with his mother after an argument with his partner. There was a missed opportunity to recognise David's pattern of behaviour.
- 2.5.3 In September 2023, David's sister again called Hertfordshire police with welfare concerns about their mother. She shared that David was an alcoholic and she had wellbeing concerns for her mother. No offences were disclosed, and safeguarding advice was given. However, the month prior, in August 2023, Gloucester police had informed Hertfordshire that David had been arrested for stalking Lisa. Again, there was a missed opportunity to recognise David's pattern of abusive behaviour and the risk he posed to others.

Health services

- 2.5.4 David was registered at the same GP as Lisa. However, the surgery was not aware that they were partners. They also had different GPs. In February 2023, the GP received a SWAST safeguarding referral where David was identified as the victim of domestic abuse. However, there were no details of his partner. David's next face to face appointment was in April 2023, where he attended with Lisa, and so it was not appropriate to ask about the SWAST referral. No link between Lisa and David was established.
- 2.5.5 As discussed earlier, SWAST appropriately responded to a domestic abuse disturbance and send a safeguarding referral to the GP in line with their safeguarding processes. However, Lisa's details were omitted, impacted the ability to join the dots.
- 2.5.6 David also presented at GHFT in relation to his ill-health and in February 2023, after he sustained a head injury. A DASH risk assessment was undertaken, and an appropriate referral was made to GDASS domestic abuse service.

Domestic abuse services

- 2.5.7 David was referred to GDASS by the police in February 2023. Attempts were made to contact David, but these proved unsuccessful, and a voicemail message was left with David. As mentioned earlier, if GDASS were able to engage David, more could have been done to determine who had done what to whom, which is in line with GDASS's counter allegations policy.

3. Conclusions and Lessons to be Learnt

3.1 Conclusions

- 3.1.1 Lisa tragically died by suicide in October 2023 after experiencing abuse by her partner, David, and suffering from mental ill-health.
- 3.1.2 This tragic incident must not be allowed to overshadow Lisa's life. Conversations with Lisa's son and neighbour have shed a light on a bright and friendly character. Despite her experiences of abuse and mental ill-health, Lisa had been described as a sociable and confident person who had the best time when in her garden, when travelling, and when spending time with her cat. It is this memory of Lisa which ensures and will be missed.
- 3.1.3 The Review Panel extends its sympathy to all those affected by Lisa's death and thanks all those who have participated in the review.
- 3.1.4 There has been significant learning identified during the course of this review, which the Review Panel hopes will prompt individual agencies, as well as the appropriate partnerships, to further develop their response to domestic abuse. This learning is summarised below.

3.2 Key Themes and Learning Identified

- 3.2.1 The most substantive learning of this case has related to four key areas: 1) understanding what a victim 'looks like' and who does what to whom, 2) limited multi-agency working and absence of domestic abuse enquiry 3) Limited understanding of multiple disadvantage and, 4) limited understanding on what it means to be a carer.

Understanding what a victim 'looks like' and who does what to whom:

- 3.2.2 How Lisa presented to agencies had an impact on how she was or wasn't supported. Lisa was often described as compliant, engaging, and confident. She also almost always showed regret for any suicide attempt and would minimise how she was feeling. This resulted in agencies not fully recognising Lisa's vulnerability and support needs. The review has found that professional curiosity is needed to see beyond how someone presents in order to better understand their experience. Professionals must understand that victims present in a myriad of ways and must receive the support they need.
- 3.2.3 The review has also found that there was confusion in understanding who does what to whom, with both Lisa and David known to the police as domestic abuse perpetrators. It is important that professionals understand that domestic abuse is the misuse of power and control and that there needs to be an awareness of who does what to whom, in order to better identify the primary aggressor.

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- 3.2.4 Understanding how a victim presents and who does what to whom ensures that the right people are referred to support and held to account. Recommendations have been made to address these points.

Limited multi-agency working and absence of domestic abuse enquiry

- 3.2.5 A number of different agencies held information on Lisa, but this information was either not shared, not shared appropriately, or there was no follow up after an onward referral was made. This meant that agencies had a patchy picture of the situation and therefore a limited understanding of risk. If information was shared effectively through a broader partnership working approach, agencies could have put the pieces together to build a clearer picture of Lisa and her needs. We also saw that many agencies did not ask about domestic abuse as part of the support they offered.
- 3.2.6 Where good multi-agency practice was identified in this review, was reliant on individual initiative rather than being embedded in processes and procedures. Individual good practice is commendable but can result in inconsistencies and missed opportunities. It is important that Tewkesbury Community Safety Partnership take a wider collaborative and multi-agency approach to ensure their systems and processes are robust and fit for practice, ensuring they work in partnership with other agencies and appropriately share information.
- 3.2.7 We know that no one agency can single handily tackle domestic abuse and that a coordinated community response is needed to provide victims with the support they need. Recommendations have been made to address these points.

Limited understanding of multiple disadvantage

- 3.2.8 This review has also found that there was a limited professional awareness of the intersection of experiencing abuse, substance use, and mental health. As discussed earlier, experiencing abuse can have a significant impact on the mental wellbeing of victims and can result in them using substances as a coping mechanism for managing the trauma.
- 3.2.9 Instead, Lisa's needs were addressed in isolation by different services, and some needs not addressed at all. Dissecting these issues and not seeing how they were compounding each other, meant that Lisa was not fully supported in the way she needed. As we know that domestic abuse is the most common cause of mental health difficulties in women, and results in self-harm and suicide rates among survivors which

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are at least four times higher than the general female population,¹ it is important that agencies adopt a multi-agency approach which centres the needs of survivor.

- 3.2.10 Addressing multiple disadvantage must go further, and the response must include an understanding of domestic abuse and the relationship between mental health and substance use. Recommendations have been made to address these points.

Limited understanding on what it means to be a carer

- 3.2.11 The review has found that there are extensive links between domestic abuse and perpetrators in care giving roles. The power and control a perpetrator has is compounded by the care giving responsibilities that they are given. In addition, professionals often only see the 'caring' side of their behaviour. Similarly, this review found that due consideration was not given to the caring responsibilities that Lisa had in looking after David who was severely unwell.
- 3.2.12 Lisa was not offered a carers assessment, despite sharing concerns about looking after David and the change in David's behaviour as his health deteriorated. Similarly, David was not offered a carers assessment despite Lisa mentioning to her care coordinators that David was taking care of her.
- 3.2.13 Carers assessments can play an important part of identifying risk but also in identifying any specific support for either the carer or cared for person. Assessments include discussions on what the care looks like, how caring affects someone's life, including their physical, mental, and emotional needs. A carers assessment for either Lisa or David could have supported agencies to better understand risk, need, and any experience of domestic abuse.
- 3.2.14 There is a growing awareness of the relationship between domestic abuse and caring responsibilities. It is vital that agencies better understand this intersection to ensure that victims' needs are recognised, and appropriate support is offered where needed.

¹ Against Violence & abuse: Complicated Matters: A toolkit addressing domestic and sexual violence, substance use and mental ill-health: 2013. PP. 24

4. Recommendations

4.1 Recommendations from the review

Recommendation 1:

Gloucestershire Domestic Abuse Local Partnership Board to identify how they can better raise awareness and improve responses to people impacted by multiple disadvantage who have experienced domestic abuse.

Recommendation 2:

Gloucestershire Domestic Abuse Local Partnership Board to raise awareness of the links between suicide and domestic abuse.

Recommendation 3:

Gloucestershire Health and Care NHS Foundation Trust to review their processes in relation to their responsibility in identifying and supporting carers.

Recommendation 4:

Gloucestershire Domestic Abuse Local Partnership Board to identify how to raise awareness of domestic abuse perpetrated by carers.

Recommendation 5:

Gloucestershire Health and Care NHS Foundation Trust to raise awareness of multiple-disadvantage to ensure that staff are supported to respond to services users who experience multiple-disadvantage and present in a range of ways.

Recommendation 6:

The police to ensure officers are trained in understanding who does what to whom and link with a [Respect](#) accredited service for domestic abuse perpetrator training.

Recommendation 7:

Safer Gloucestershire to ensure that emergency services that attend an incident appropriately share information to ensure that safeguarding referrals are completed with relevant information included.

Recommendation 8:

NHS England to support local ICBs to review internal processes to ensure that systems are appropriately capturing home make up.

Recommendation 9:

Police to ensure that domestic abuse risk assessments processes include an assessment of a pattern or history of abuse, in order to avoid responding to incidents in isolation.

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Recommendation 10:

Police to ensure that they are appropriately sharing information with other forces on perpetrators who live across different areas.

Recommendation 11:

Tewkesbury Housing to better engage in multi-agency domestic abuse partnership working as part of the coordinated community response, and to secure Domestic Abuse Housing Alliance accreditation.

Recommendation 12:

Gloucestershire Health and Care NHS Foundation Trust to ensure staff are trained to identify and safely ask about domestic abuse, and, once disclosure is made, to appropriately refer onto support.

Recommendation 13:

Tewkesbury GP Surgeries to explore the implementation the IRIS best practice domestic abuse model and to link with the GDASS GP Development Workers.

Recommendation 14:

Mental Health Liaison Team to provide assurance to Safer Gloucestershire that they are routinely undertaking domestic abuse risk assessments.

Recommendation 15:

As per NICE guidance, SWAST to ensure that their staff are trained to confidently ask about domestic abuse in a way that makes it easier for people to disclose.

Recommendation 16:

Charlies Community Support to develop and embed a domestic abuse policy and implement appropriate training for staff.

Recommendation 17:

GDASS to review initial engagement process and ensure that referrals to mental health and substance use services are made when the service user does not want to engage with domestic abuse support.

Recommendation 18:

The Gloucestershire Domestic Abuse Local Partnership Board to review its commissioned service approach to those from minoritised backgrounds and explore commissioning options for the provision of by and for services (reflecting the findings from the Gloucestershire Domestic Abuse Needs Assessment 2024).

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Recommendation 19:

The Gloucestershire Domestic Abuse Local Partnership Board to ensure that their members have stand-alone domestic abuse policies in place which also include detail of the link with suicide and multiple disadvantage.

Recommendation 20:

Safer Gloucestershire to ensure that their members attend training which includes detail of multiple disadvantage.

Recommendation 21:

The Gloucestershire Domestic Abuse Local Partnership Board to raise awareness of domestic abuse and the risk that abusers pose to victims.

Recommendation 22:

Safer Gloucestershire to review the impact of lockdown on the work of their partnership practice.

Recommendation 23:

The Gloucestershire Domestic Abuse Local Partnership Board to undertake an awareness raising campaign on the role friends and family can play in supporting survivors of domestic abuse.