



TEWKESBURY COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Overview Report into the death of Lisa

October 2023

Independent Chair and Author of Report: Shabana Kausar

Associate, Standing Together Against Domestic Abuse

April 2025



1. Preface	4
1.1 The Incident.....	4
1.2 Introduction.....	4
1.3 Timescales	5
1.4 Confidentiality	6
1.5 Equality and Diversity	6
1.6 Terms of Reference	8
1.7 Methodology.....	9
1.8 Contributors to the Review.....	10
1.9 The Review Panel Members.....	11
1.10 Involvement of the Victim’s Family, Friends, Work Colleagues, Neighbours and Wider Community	13
1.11 Involvement of the Perpetrator and their Family, Friends, Work Colleagues, Neighbours and Wider Community	14
1.12 Parallel Reviews	14
1.13 Chair of the Review and Author of Overview Report.....	14
1.14 Dissemination.....	15
1.15 Previous Case Review Learning Locally.....	15
2. Background Information (The Facts)	17
2.1 The death	17
2.2 Background information on victim and alleged perpetrator.....	17
3. Chronology	19
3.1 Overview	19
3.2 Summary of Significant Events Prior to the Time Period Under Review	19
3.3 Time Period Under Review	20
4. Overview	28
4.1 Summary of Information from Family	28
4.2 Summary of Information from Neighbour	30
4.4 Summary of Information Known to the Agencies and Professionals Involved.....	32
5. Analysis.....	37
5.1 Domestic Abuse.....	37
5.2 Analysis of Agency Involvement / Responding to the Terms of Reference	41
6. Conclusions and Lessons to be Learnt	54
6.1 Conclusions.....	54
6.2 Key Themes and Learning Identified.....	54
7. Recommendations.....	57
7.1 Single Agency Recommendations (Identified by Individual Agencies).....	57
7.2 Multi Agency Recommendations (Developed by the Review Panel)	59

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

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

1. Preface

1.1 The Incident

- 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 her 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 Introduction

- 1.2.1 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004 and should be conducted in accordance with the December 2016 Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (hereafter 'the statutory guidance').
- 1.2.2 The *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews* (2016) states that: "Where the victim took their own life (suicide) and the circumstances give rise for concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken. Reviews are not about who is culpable" (Para 18). The CSP decided that the circumstances of Lisa's death warranted the commissioning of a DHR.
- 1.2.3 This Domestic Homicide Review (hereafter 'the review') examines agency responses and support given to Lisa,¹ a resident of the borough of Tewkesbury, prior to the point of her death by suicide at her in October 2023.

¹ Not their real name.

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

- 1.2.4 The review will consider agencies contact/involvement with Lisa's and David's² from May 2018 to October 2023.
- 1.2.5 In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse before the death, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.
- 1.2.6 The key purpose for undertaking DHRs is to explore the lessons learned from a death by suicide where it is known or believed that they previously experienced domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.
- 1.2.7 This review process does not take the place of the criminal or coroners' courts, nor does it take the form of a disciplinary process.

1.3 Timescales

- 1.3.1 This review was commissioned by Safer Gloucestershire in conjunction with Tewksbury Community Safety Partnership. Having received notification from the police on 6 October 2023, a decision was made to conduct a review. Subsequently, the Home Office were notified of the decision in writing on 7th November 2023.
- 1.3.2 Standing Together Against Domestic Abuse (hereafter 'Standing Together') were commissioned to provide an Independent Chair (hereafter 'the Chair') for this review in December 2023. The completed report was handed to the Safer Gloucestershire in conjunction with Tewksbury Community Safety Partnership on 16th May 2025. In June 2025, it was signed off by the Safer Gloucestershire partnership, before being submitted to the Home Office Quality Assurance Panel on 17th June 2025. In December 2025, the completed report was considered by the Home Office Quality Assurance Panel. In January 2026, Safer Gloucestershire received a letter from the Home Office Quality Assurance Panel approving the report for publication. The letter will be published alongside the completed report.
- 1.3.3 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. Longer was needed to ensure engagement with family and coordination of meetings so all agencies could attend.

² Not their real name.

1.4 Confidentiality

- 1.4.1 The findings of this review are confidential until the Overview Report has been approved for publication by the Home Office Quality Assurance Panel. In the interim information has been available only to participating officers/professionals and their line managers.
- 1.4.2 This review has been anonymised in accordance with the 2016 statutory guidance.
- 1.4.3 The following pseudonyms have been used in this review to protect the identities of the victim, other parties, those of their family members, and the perpetrator:

Name	Relationship to Victim
Lisa	Victim
David	Alleged perpetrator
Ryan	Victim's son

- 1.4.4 These pseudonyms were chosen by the panel after the family stated that they had no preference on names, as long as they were far removed from the original names.

1.5 Equality and Diversity

- 1.5.1 The Chair and the Review Panel have considered the protected characteristics under the Equality Act 2010 of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation during the review process.
- 1.5.2 Throughout the review, the Review Panel identified that the following protected characteristics required specific consideration:
- 1.5.3 Sex: The impact of Lisa's sex has been an enduring feature of domestic abuse related deaths. This characteristic is therefore relevant for this case, as the deceased was female, and the alleged perpetrator of abuse is male. In considering the links between domestic abuse of suicide in women, it is estimated that more women take their own life as a result of domestic abuse than those that are killed by their intimate partner. Studies have shown that almost 30 women attempt suicide every day, as a result of

experiencing domestic abuse. It is also estimated that every week three women take their own lives.³

Age: Lisa was 57 years old at the time of her death. Research shows that older victims experience abuse for twice as long before seeking help.⁴ Older clients are also hugely underrepresented amongst domestic abuse services and are less likely to leave in the year before accessing help and are more likely to be living with the perpetrator after getting support. The SafeLives research refers to victims who are 60 years or older. However, this characteristic was still relevant for this review.

- 1.5.4 The following have also been identified as pertinent to the lived experiences of Lisa and David:
- 1.5.5 *Substance use and mental health:* Lisa had a long history of mental health and substance use support needs. The panel felt it was important to recognise the link between experiencing trauma and using substances as a coping mechanism⁵ but also to recognise any impact Lisa's substance use or mental health needs may have had on her access and engagement with services, as well as responses of services. David had a long history of alcohol use and was diagnosed with a liver-related illness. The panel were clear that substance use does not cause abusive behaviour but can compound existing abusive behaviours. The panel, did therefore, consider how David's substance use may have compounded already abusive behaviours.
- 1.5.6 *Caring responsibilities:* Although Lisa was not formally recognised as David's carer, nor David as Lisa's, the panel felt it was important to acknowledge the caring responsibilities they both undertook for each other. There is extensive research which highlights the relationship between caring responsibilities and domestic abuse. Carers as victims of domestic abuse are at risk of controlling behaviours from the person they care for, and carers as perpetrators of domestic abuse can give somebody complete control over another person's day-to-day activities and resources.⁶ The impact of this was explored by the panel and features later in the report.
- 1.5.7 The Review Panel took an intersectional and ecological analysis approach to better understand the lived experiences of both Lisa and David. This means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand an individual's journey and experience with local services and within their community. As stated by Kimberlé Crenshaw, "If you don't have a lens that's been trained to look at how various forms of discrimination come together, you're unlikely to develop a set of policies that will be as inclusive as they need to be."

³ SafeLives, How widespread is domestic abuse and what is the impact? <https://safelives.org.uk/policy-evidence/about-domestic-abuse/how-widespread-domestic-abuse-and-what-impact> (accessed 16 February 2021)

⁴ <https://safelives.org.uk/spotlight-1-older-people-and-domestic-abuse>.

⁵ Herman, J Trauma and Recovery: The aftermath of Violence from domestic abuse to political terror Basic Books, 1992

⁶ Amanda Warburton-Wynn, "Carers and domestic abuse – the elephant in the room?" The journal of adult protection, 2023, 25:1, pp. 14-19.

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

- 1.5.8 An ecological analysis considers someone's identity and lived experiences at an individual, relational, community, and societal level. It is about how individuals relate to those around them and to their broader environment.⁷
- 1.5.9 An intersectional analysis considers the complex ways in which differing aspect of someone's identity and lived experience can combine or intersect in the context of structural discrimination to create heightened and persistent forms of inequality, marginalisation, disadvantage and powerlessness.⁸
- 1.5.10 Taking an ecological and intersectional approach can help identify the factors that create, sustain or exacerbate someone's risks and needs. An ecological and intersectional approach can also identify the barriers someone may have faced in recognising or reporting domestic abuse, their options for safety and protection available, and considers any conscious or unconscious bias or privileging by agencies and or society.

1.6 Terms of Reference

- 1.6.1 The Terms of Reference are included at **Appendix 1**. This review aimed to identify the learning from this case, and for action to be taken in response to that learning with a view to preventing homicide and ensuring that individuals and families are better supported.
- 1.6.2 The Review Panel was comprised of agencies from Gloucestershire, as Lisa was living in that area at the time of her death. Agencies were contacted as soon as possible after the review was established to inform them of the review, invite their participation and request them to secure their records.
- 1.6.3 Additionally, it was established that the perpetrator/victim had contact with agencies in other parts of the region/country and therefore agencies in those areas were contacted for information and involved remotely in the review.
- 1.6.4 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

⁷ Further information on this approach can be found online, such as in EAW (2011) *A Different World is Possible: A call for long-term and targeted action to prevent violence against women and girls*, https://www.endviolenceagainstwomen.org.uk/wp-content/uploads/a_different_world_is_possible_report_email_version.pdf:

⁸ Intersectionality is a term rooted in Black feminism and Critical Race Theory and coined by Kimberlé Williams Crenshaw in the 1989 landmark essay "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics," and furthered this in 1992 with "Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color.", these, amongst her other work can be accessed online for further information regarding this approach to analysis.

railway station. Agencies were asked to summarise any relevant contact they had had with Lisa and David outside of these dates.

1.6.5 *Key Lines of Inquiry:* The Review Panel considered both the generic issues as set out in the 2016 statutory 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.
- 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 on 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.

1.7 Methodology

1.7.1 The Review applies the statutory definition⁹ of domestic abusive behaviour as consisting of a single incident or course of conduct between two people who are personally connected, each aged 16 or over, and involving any of the following:

⁹ The Domestic Abuse Act 2021 received Royal Assent on 29 April 2021: <https://www.legislation.gov.uk/ukpga/2021/17/part/1/enacted>

physical or sexual abuse

violent or threatening behaviour

controlling or coercive behaviour

economic abuse

psychological, emotional or other abuse

- 1.7.2 Economic abuse is defined as “any behaviour that has a substantial adverse effect on a person’s ability to acquire, use, or maintain money or other property or obtain goods or services” (s.3: Domestic Abuse Act 2021).
- 1.7.3 Controlling behaviour is: “a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.”
- 1.7.4 Coercive behaviour is: “an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.”
- 1.7.5 This definition includes “so-called ‘honour’ based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.”
- 1.7.6 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 narrative chronology was also prepared.
- 1.7.7 *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.
- 1.7.8 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.
- 1.7.9 *Documents Reviewed:* In addition to the above information, the Review Panel and/or Chair reviewed a number of other documents during the review. Where appropriate, these are referenced in the report.

1.8 Contributors to the Review

- 1.8.1 The following agencies were contacted, but recorded no involvement with Lisa or David:
- Local authority Children Social Care Services
 - Sexual Assault Referral Centre

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

- Local Authority Education Services
- Probation

1.8.2 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

1.9 The Review Panel Members

1.9.1 The Review Panel members were:

Name	Job Title	Agency
Clare Hicks	Specialist Nurse for Safeguarding Adults	Gloucestershire Health & Care NHS Trust

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

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
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	South Western 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)

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

- 1.9.2 *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.
- 1.9.3 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.
- 1.9.4 The Chair wishes to thank everyone who contributed their time, patience and cooperation to this review.

1.10 Involvement of the Victim’s Family, Friends, Work Colleagues, Neighbours and Wider Community

1.10.1 The Review Panel sought to involve the family, friends, work colleagues, neighbours and the wider community.

1.10.2 Victim’s Family

Name ¹⁰	Relationship To Victim	Means of Involvement
Ryan	Son	In person interview
Referred to as son’s partner	Son’s partner	In person interview

1.10.3 Once the decision to conduct the DHR had been confirmed, the Safer Gloucestershire Partnership notified Lisa’s son of this decision on 19th December 2023: a letter was sent via the officer in charge of the investigation, along with the Home Office leaflet, information on Advocacy After Fatal Domestic Abuse (AAFDA)¹¹ and the Victim Support Homicide Service (VSHS).¹² In January, the Chair also wrote to Ryan, Lisa’s son, including additional information on the DHR process. These were emailed directly to Ryan.

1.10.4 The Chair highlighted that any participation in the review was voluntary and that they could contribute in the way they found best. Ryan agreed to taking part and an in-person meeting was arranged to go through the draft Terms of Reference and key lines of enquiry in May 2024. The meeting provided a valuable insight into who Lisa was and has helped bring her voice to this report.

¹⁰ Not their real name

¹¹ AAFDA provide emotional, practical and specialist peer support to those left behind after domestic homicide. For or more information, go to: <https://aafda.org.uk>.

¹² The Victim Support Homicide Service supports bereaved families to navigate and know what to expect from the criminal justice system and providing someone independent to talk to. For more information, go to: <https://www.victimsupport.org.uk/more-us/why-choose-us/specialist-services/homicide-service>.

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

1.10.5 The draft Overview Report was shared with the family in December 2024. Feedback was shared and some clarification was provided. These were incorporated into the report.

1.10.6 Victim's Friends, Work Colleagues, Neighbours and Wider Community

Name ¹³	Relationship to Victim	Means of Involvement
Sophie	Neighbour	Telephone interview

1.10.7 At Ryan's request, the Chair also contacted Sophie, Lisa's neighbour. The Chair arranged a telephone conversation with Sophie in August 2024. Sophie provided helpful insights into Lisa's needs, her relationship with David, and her experiences of services. This has been captured in section 4.

1.11 Involvement of the Perpetrator and their Family, Friends, Work Colleagues, Neighbours and Wider Community

1.11.1 Perpetrator

1.11.2 The chair was informed that the alleged perpetrator, David, died in October 2023, so was not involved in this review.

1.12 Parallel Reviews

1.12.1 *Criminal trial:* The case did not go to trial. Evidence Led Prosecution was considered in light of Lisa's death, but the decision to take no further action against David was made before he died on the basis of insufficient evidence.

1.12.2 The officer in charge (OIC) was invited to provide details on the circumstances surrounding the death. The OIC was invited to the first meeting of the Review Panel to provide details on the circumstances surrounding the death.

1.12.3 *The Coroner's Inquest:* The death of Lisa was referred to the HM Coroner, and an inquest was opened on 16th October 2023 and adjourned awaiting the conclusion of the DHR.

1.13 Chair of the Review and Author of Overview Report

1.13.1 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

¹³ Not their real name

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.

- 1.13.2 Standing Together is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response (CCR).¹⁴ The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides. Standing Together has been involved in the Domestic Homicide Review process from its inception, chairing over 90 reviews across England and Wales from 2013 until present day.
- 1.13.3 *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.

1.14 Dissemination

- 1.14.1 Once finalised by the Review Panel, the Executive Summary and Overview Report will be presented to Safer Gloucestershire for approval and thereafter will be sent to the Home Office for quality assurance.
- 1.14.2 Once agreed by the Home Office, the Executive Summary and Overview Report will be shared with Safer Gloucestershire, Gloucestershire Domestic Abuse Local Partnership Board, the Coroner, Gloucestershire Safeguarding Adults Board, Gloucestershire Safeguarding Children's Partnership, and the Domestic Abuse Commissioners Office, and also published. There will be a range of dissemination events to share learning.
- 1.14.3 The Executive Summary and Overview Report will also be shared with the Commissioner of the MPS and the Police and Crime Commissioner for Tewkesbury.
- 1.14.4 The Executive Summary and Overview Report will also be shared with Lisa's family.
- 1.14.5 The recommendations will be owned by the Safer Gloucestershire Coordinator in conjunction with the Domestic Abuse and Sexual Violence Strategic Coordinator

1.15 Previous Case Review Learning Locally

¹⁴ For more information, go to: <https://www.standingtogether.org.uk/ccr-network>.

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

1.15.1 This is the 27th DHR commissioned locally.¹⁵

1.15.2 The Review Panel considered the learning and recommendations from other reviews in the analysis and the development of recommendations for this DHR. These have identified the following learning and/or recommendations as relevant to this DHR:

- Creating safe environments for disclosure and help seeking
- Domestic abuse results in more suicides than homicides. Practitioners need to be alerted to risk from perpetrator and risk victim is to themselves.
- Understanding barriers to engagement with services
- Responding to survivors with multiple disadvantage
- Awareness of domestic abuse and identifying perpetrators
- The ability for all front-line professionals to confidently speak to survivors of domestic abuse about their situation despite any denial or minimisation and to understand where these barriers come from and to address domestic abuse beyond basic inquiry.
- Services to be actively aware of association of mental ill health and substance misuse with DA and provide services tailored to their needs and welfare.

1.15.3 These issues are discussed in the analysis.

¹⁵ To access published DHRs, go to: [https://www.gloucester.gov.uk/community-living/community-safety-crime/domestic-homicide-reviews-dhrs/#:~:text=A%20Domestic%20Homicide%20Review%20\(DHR,in%20an%20intimate%20personal%20relationship](https://www.gloucester.gov.uk/community-living/community-safety-crime/domestic-homicide-reviews-dhrs/#:~:text=A%20Domestic%20Homicide%20Review%20(DHR,in%20an%20intimate%20personal%20relationship)

2. Background Information (The Facts)

The Principal People Referred to in this Report						
Referred to in report as	Relationship to the victim	Age at time of V death	Ethnic Origin	Faith	Nationality & Immigration Status	Disability
Lisa	Victim	57	White	Unknown	British	Yes
David	Ex-partner	60	White	Unknown	British	Yes
Ryan	Son	26	White	Unknown	British	None
Sophie	Neighbour and friend	60s	White	Unknown	British	None

2.1 The death

- 2.1.1 In early October, neighbours contacted Gloucestershire Fire and Rescue Service to report a fire in the back garden of Lisa's property. On arrival, Lisa was sadly found deceased in the summerhouse. Gloucestershire Fire and Rescue Service contacted the police, who quickly established a crime scene. The crime scene was kept in place until fire investigation and scenes of crime were able to conclude a forensic examination.
- 2.1.2 Subsequently, an investigation was undertaken which found that Lisa had died by suicide. The investigation had found that Lisa was identified on CCTV purchasing petrol from a local service station alone, driving away alone, and was reported by neighbours as arriving home alone. Taking this into consideration, along with Lisa's history of self-harm and suicide attempts, the incident was deemed a non-suspicious suicide with no third-party involvement.
- 2.1.3 *Post-Mortem:* A post-mortem was held on Lisa's body a few days after her death, where a pathologist recorded the cause of death was the result of burning and the inhalation of fire fumes.

2.2 Background information on victim and alleged perpetrator

- 2.2.1 *Background Information Relating to Victim:* At the time of her death, Lisa was 57-years old and a White British national. She had been diagnosed with Bi-Polar Disorder in 2009 and previously worked as a Civil Servant, however, she left this role due to health and wellbeing issues. Lisa lived in Hemel Hampstead before moving to Tewkesbury 7 years before her death. She lived by herself in a house which she owned.
- 2.2.2 Lisa was in a relationship with David since 2010. She was noted to have told professionals that she experienced abuse from David for years, although the exact period is unknown.

At the time of her death, she had reported David for Stalking and Harassment and was exploring criminal justice remedies.

- 2.2.3 *Background Information Relating to Perpetrator:* David was 60-years old and a White British National. He lived in between Lisa's home in Tewkesbury, his mother's home in Hemel Hempstead, and was noted on occasion as rough sleeping in his car. In 2022, he was diagnosed with Liver Cirrhosis due to excessive alcohol consumption and died at the end of October 2023 due to this illness, a few weeks after Lisa was found deceased. He had no previous convictions.
- 2.2.4 *Synopsis of Relationship with the Perpetrator:* Lisa and David had an on-off relationship where both were known to services for domestic abuse related offences. They were separated at the time of Lisa's death.
- 2.2.5 *Members of the Family and the Household:* Lisa lived alone and had two adult sons from a previous marriage, which ended in divorce in 2005. She was estranged from her eldest son, who lived in the United States, but had contact with her younger son who lives in London with his partner.

3. Chronology

3.1 Overview

- 3.1.1 The following chronology describes the contact that Lisa and David had with agencies. The time period under review is from May 2018, which marks a significant incident affecting Lisa, through to the date of her death in October 2023. However, there are some significant events prior to the time period under review which have been summarised in 3.2.

3.2 Summary of Significant Events Prior to the Time Period Under Review

- 3.2.1 In February 2009, Lisa came to the attention of services after an attempted overdose. She was seen at A&E and reported the cause of the overdose to be stress related but later told her GP, that this was the result of an argument with her partner. There is nothing in the notes to indicate that domestic abuse was explored by the GP, and she was referred to mental health services.
- 3.2.2 In August 2009, Lisa was found to have walked off a platform at a train station in Hertfordshire after drinking to excess. She told health services that this was promoted by an argument with her boss at work who was concerned about her taking too much time off work. She was assessed by a Consultant Psychiatrist and diagnosed with Bi-Polar disorder.
- 3.2.3 In April 2011, Lisa was reported as a missing person by her partner, David. It was reported that she was under stress as her job as a Civil Servant was under review. After 12 hours, Lisa returned to the home address is Hemel Hempstead and was visited by police. She had previously expressed concern that the police would section her but engaged and accepted a referral to the Crisis Team at a local Mental Health Centre. It was noted on records that Lisa had attempted suicide in March 2011 and had been detained twice under Section 136 of the Mental Health Act.
- 3.2.4 In March 2012, Lisa visited her GP for a mental health review and was noted to be drinking 18 units of alcohol a week and was advised to reduce her intake.
- 3.2.5 In 2016, Lisa called the police reporting a verbal domestic abuse incident with David after she had found out that David was an alcoholic. In light of this information, she shared that she had called off her wedding to David, which was due to take place in two days' time. Lisa also shared that David had previously threatened to burn the house down. A Domestic Abuse, Stalking and Honour Based Violence (DASH) Risk Identification Checklist (RIC) was undertaken and assessed as standard risk. Both parties were under the influence of alcohol and Lisa was noted to not wanting to pursue with police action. No referral to domestic abuse or substance use services were made.
- 3.2.6 Lisa and David moved to Tewkesbury in Winter 2016.

3.3 Time Period Under Review

2018

- 3.3.1 In May 2018, the British Transport Police were called after a member of the public stopped Lisa from attempting to jump in front of a train near Cheltenham Railway Station. She had been on the phone at the time with a Mental Health Crisis Team and was reported to have shared that she had “lost touch” with her boys. She also stated that she had taken an overdose with her depression medication and alcohol. The Crisis Team called the ambulance and police services.
- 3.3.2 Lisa was taken to Gloucester Emergency Department. An assessment was undertaken, and Lisa was assessed as at High Risk on the hospital matrix and not medically fit for discharge. She was noted to have told hospital staff that she “felt stupid” and “regretted her actions.” Lisa had explained that she did not want to end her life but “more to numb the pain.” She denied any further suicidal thought and explained that the alcohol had impaired her judgement.
- 3.3.3 Lisa remained in hospital for 3 days before being discharged home and to her GP. She was also referred to the Drug and Alcohol Recovery Team (DART) and provided Crisis Mental Health support numbers.
- 3.3.4 In a telephone conversation with her GP, a few days later, Lisa reported feeling better and that on the night of the incident, she had drunk a bottle of wine which had led to “dark thoughts.” She shared that she had been drinking more recently but had now completely stopped. She requested more medication, which she told the GP that her partner would administer. No questions were asked about domestic abuse, and no Carers Assessment was undertaken for David.
- 3.3.5 Lisa continued to have face-to-face appointments with her GP. She was offered a Psychiatric Medication Review but rejected this due to a previous negative experience of being sectioned.

2019

- 3.3.6 In March 2019, Lisa was admitted to Southmead Emergency Department after it was documented that she had a head injury, which she reported was after she had fallen onto a step. She is seen by her GP a few days later for a follow-up due to associated headaches and difficulties concentrating at work. Lisa was provided an information leaflet and given advice if she was worried.
- 3.3.7 The next day, David called an ambulance as Lisa was found unresponsive in bed. She was attended to and discharged the same day. The GP followed up again the following day, where Lisa confirmed she was fine and back at work.

- 3.3.8 Neither during her stays in hospital, nor at her visits with the GP, was Lisa asked about domestic abuse.

2020

- 3.3.9 In May 2020, Lisa informed the Council that her partner had moved out and so she wanted to apply for Single Person discount on her Council Tax Bill.
- 3.3.10 The following day, police were called to her home address after David had refused to leave her property, whereupon Lisa was reported to have thrown a bottle at David's head, causing a small cut. Both parties were separated, and Lisa informed the police that she had experienced years of abuse from David. It was noted that both Lisa and David were intoxicated.
- 3.3.11 A risk assessment was undertaken for David, which was assessed as standard risk. David agreed to sleep in his vehicle outside of Lisa's home, before leaving in the morning. He collected his items and returned the keys to Lisa so that he could not return into the property. David refused hospital treatment and there was no further action. Lisa's allegation of years of abuse were not recorded as a crime and not investigated.
- 3.3.12 In August, Lisa informed the Council that her partner had moved back into her home and she wanted the Single Person discount on her Council Tax Bill to be removed.
- 3.3.13 In December, an unknown female suspect was reported to have screamed at Lisa. The incident was investigated, the suspect was not identified, and the case resulted in no further action.

2021

- 3.3.14 In February 2021, Lisa had an appointment with her GP and a 'not fit for work' statement was issued for a 2-month period due to stress and anxiety.
- 3.3.15 A few days later, Lisa informed the Council that her partner had moved out and so she wanted to apply for Single Person discount on her Council Tax Bill.
- 3.3.16 In May, Lisa is admitted to the Emergency Department for chest pains. These chest pains continued throughout May. There was no explanation for the onset of the pain. At the hospital, Lisa shared that the chest pain was stopping her from doing anything, it was affecting her mental health, that she had been drinking more, and that she didn't want to go down a "slippery slope." An appointment was made with her GP.
- 3.3.17 In July, Lisa started a new job in a warehouse. In August, she damaged her lower back after lifting a heavy item. She was prescribed analgesia and given a 'not fit for work' statement. She was issued another 'not fit for work' statement in September.

- 3.3.18 In September, David visited his GP due to persistent numb feet. Blood tests were undertaken, and he was referred to Gastroenterology. In September, David requested a 'not fit for work' statement from his GP. The statement was extended in October to December 2021.
- 3.3.19 Lisa's mental health continued to deteriorate, and her GP referred her to Mental Health Intermediate Care Team (MHICT) at Gloucestershire Health and Care in October.
- 3.3.20 Later in October, an unknown male suspect exposed himself to Lisa. The matter was investigated but resulted in no further action as the suspect was not identified.
- 3.3.21 In November, Lisa was supported by MHICT. An assessment was undertaken, which found that Lisa was depressed and low of mood. She mentioned her mother's challenges with Dementia and made regular reference to her relationship with her sons, stating that if she ended her life, her money could have gone to her sons. She did go on to say that she did not want to act on these thoughts. Lisa told the assessor that she did not want to be visited at home, as she did not want David to know what was happening as he "has his own problems right now." No further questions appear to be asked of Lisa related to this request. She was continued to be supported by MHICT and also referred to recovery for medication review and management, care coordination, development and relapse prevention planning.
- 3.3.22 In December, Lisa met with her Care Coordinator who undertook a telephone discussion with her. Lisa explained that she continued to feel low, and some days just stayed in bed. She mentioned that she had not felt low for a number of years but reflected that could be related to the time of year with the dark evenings.
- 3.3.23 At the end of December, Lisa was discharged from MHICT. Her GP also extended her 'not fit for work' statement for a further 2 months.

2022

- 3.3.24 David continued to be seen by the Hepatology team.
- 3.3.25 In February, Lisa told her Care Coordinator that her long-term partner, David, supported her. She went on to state that "I feel that I am a shell of myself." The Care Coordinator described Lisa as presenting as pleasant and polite.
- 3.3.26 In March, Lisa had a telephone call with a Consultant Psychiatrist at the Recovery Clinic, where she stated she felt "lost" to her normal self and had gone downhill.
- 3.3.27 In April, David saw his GP for a clinical examination. He explained he was struggling with his symptoms and was drinking more alcohol as a result. Consideration of home circumstances were not documented.
- 3.3.28 In May, Lisa called 999 because David was having difficulties breathing. The paramedic noted that David was annoyed at Lisa for calling 999 on his behalf. It was noted that the

paramedic was called away to a category one emergency so left prematurely. No follow up noted on this observation.

- 3.3.29 In May, Lisa missed telephone calls from the Recovery Team. A few days later, a friend of Lisa's contacted the police to inform them that Lisa has messaged her saying that she would kill herself. The police arrived at her home where there was no response to their knocks on the door. Officers entered the property and found Lisa slumped over a sofa in the garden house conscious and breathing. Lisa explained that she had taken an overdose of her prescribed medication. She was transported by crew to Gloucester Emergency Department with a pre-alert due to her reducing level of consciousness on route.
- 3.3.30 A mental health assessment was undertaken at hospital, which was assessed as amber. A recent split from alcoholic partner was noted by ambulance crew. It was also noted that Lisa had text her son during that afternoon stating suicidal intent. She later told the hospital that she felt like a terrible mother, having "walked out" on her sons some years ago. She stated that her older son no longer talks to her. She went on to state that her relationship with David was fine, despite the paramedic comments. Lisa was discharged back to her GP and the Mental Health Liaison Team (MHLT).
- 3.3.31 A few days later, Lisa met with her Care Coordinator for an assessment where she was assessed as at medium risk. She informed the Care Coordinator that alcohol had exacerbated her worries and that she had impulsively taken the overdose. She stated she now felt "silly" for having done this and was regretful of her actions. She went on to state that she lived with David, who she had been with for 12 years, and reported that they had a close relationship. She spoke fondly of her 12-year-old cat and said that she took pride in her garden. The Care Coordinator noted that Lisa appeared kempt, maintained eye contact, and that her speech was fluent and well-formed.
- 3.3.32 Lisa continued to be seen at face-to-face appointments with her Care Coordinator throughout May. At one session, she explained that she increased her alcohol consumption when David went to visit his mother. At this session, David was noted to join the meeting and expressed his concerns in leaving Lisa to visit his mother, as he was not able to support Lisa. The Care Coordinator recommended that Lisa arranged to meet her own mother when David went to see his.
- 3.3.33 Lisa told the Care Coordinator that she felt better. She was on her own as David was visiting his mother and she went on to tell the Care Coordinator that she was happy to have a bit of time to herself. She stated that she knew she drank too much but that David had an issue with alcohol which he minimised. Lisa told the Care Coordinator that David was a secret drinker and had been for years. She knew when he had been drinking as his behaviour would change but he would refuse to get help. This was not further explored by the Care Coordinator and no questions about domestic abuse were asked. Her next appointment was booked for July.

- 3.3.34 In late June, the police are notified of a verbal dispute between David and his mother. No offenses were disclosed, and safeguarding advice was given, it was noted as a non-crime domestic abuse incident with no follow up.
- 3.3.35 David continued to be seen by health professionals in relation to his diagnosis of liver cirrhosis. In July he was told that his lifespan was 2-3 months.
- 3.3.36 In mid-July, Lisa missed telephone calls from her Care Coordinator. At the end of July, she told her Care Coordinator at their telephone session that she was sorry for missing the earlier calls, stating that the heat had exhausted her and that she had rested in the house and forgotten the calls. Lisa shared her ongoing concerns with her mother's health. She was noted as presenting as pleasant and polite.
- 3.3.37 In early-August, the Care Coordinator recommended that Lisa was referred to a substance use support service, as Lisa continued to explain her use of alcohol. Lisa declined the referral and was advised to self-refer. In late-August, Lisa explained that she was feeling improved by the weather and always felt better in the summer.
- 3.3.38 In September, Lisa explained to her Care Coordinator that she continued to take walks, and her long-term goal was to go swimming. She continued to share her concerns with David's drinking and told the Care Coordinator that when David goes to see his mother, she 'can feel relieved just for some time for herself so that she can just relax and do what she wants to do.' No further questions were raised in response to this.
- 3.3.39 In October, Lisa told her Care Coordinator that she was not doing brilliantly as she had started a new job but had to stop after 3 days as she became overwhelmed. She reflected that she was not ready to return to work.
- 3.3.40 David was noted to tell the Gastroenterologist that he was feeling better and was now back at work and largely abstinent from alcohol.
- 3.3.41 In November, Counter Fraud Enforcement Unit wrote to Lisa to say a data match indicated she may not be entitled to Single Person Discount as David was registered on Electoral Register to vote at her address. Lisa wrote back to inform them that David stayed at weekends but would move in permanently before Christmas. She disclosed she was under the care of Mental Health services.

2023

- 3.3.42 In early January, Lisa telephoned the Council Tax office to advise that David had vacated the property. The next day, David contacted his GP with several large bruises on legs and arms and with no history of hurting himself. The GP explained that his low platelet count, associated with a liver condition, could cause bleeding and bruising.
- 3.3.43 In mid-February, Lisa informed her Care Coordinator that she had been on holiday by herself but had to cut the 10-day holiday to 7-days as it was "becoming too much." She also shared that her relationship with David was "off," but the reasons for this were not explored by her Care Coordinator.

- 3.3.44 A week later, Lisa called the police to say that she was being stalked by David and that he was making his way to her property drunk. A neighbour then called police to say that Lisa was throwing cans at David. David was found outside the property in a flower bed with multiple head wounds. He was intoxicated and taken to the emergency department. When questioned, Lisa alleged that David had shoved her into a wall and threatened to kill her. She then hosed him down with cold water and threw beer cans at his head and smashed a glass bottle over his head. Lisa was arrested. A risk assessment was undertaken for David but not for Lisa. The incident resulted in no further action as no parties supported prosecution. SWAST's information to David's GP did not contain details of the alleged perpetrator.
- 3.3.45 The risk assessment undertaken by the Police for David resulted in a medium risk assessment and he was referred to Gloucestershire Domestic Abuse Support Service (GDASS), who attempted to engage with him, but he did not respond. His case with GDASS was closed in March 2023.
- 3.3.46 In March, Lisa missed a number of phone calls from her Care Coordinator. In April, David visited his GP with Lisa where he reported fatigue, weight loss, and reduced appetite. He reported that he was not drinking. Just over a week later, Lisa called the ambulance as David had had a cardiac arrest. He refused hospital admission and told his GP the next day this was due to "pig-headedness." He was transferred to the emergency department as the GP was concerned with his health. Over the next few days, David was seen by Alcohol Liaison, where he stated that he did not want to engage with services.
- 3.3.47 In early May, Lisa was picked up by British Transport Police for jumping onto a train track in Birmingham under the influence of alcohol. She was transported back to Cheltenham into the care of the Recovery Team and her Care Coordinator. Lisa was also referred by Birmingham Response Policing Team to Charlies Community Support, which provides free holistic therapies and support to anyone affected by Cancer. Charlies Community Support referred Lisa onto onward support, which she did not access.
- 3.3.48 In a telephone conversation with her Care Coordinator, Lisa apologised for not replying to phone calls and asked to change her face-to-face meetings to phone calls. Her reason for this was that David had end stage liver disease and was out of hospital and that he did not like visitors when he was at home. Lisa also stated that she had no thoughts to harm herself or others and that it was 'a very silly thing to do.' The reason David did not want anyone visiting the home was not explored. The Care Coordinator noted Lisa presented as "pleasant and polite, voice was normal tone rate and pace conversation was open and free."
- 3.3.49 The following week, the Care Coordinator met with Lisa face-to-face in a coffee shop. Lisa stated she felt better for coming to meet the Care Coordinator at that location and agreed that future appointments could be a mix of telephone and coffee shop meetings. Lisa informed the Care Coordinator that she had a job interview for an administrator role at a pharmacy.

- 3.3.50 A few days later, Lisa informed the Council Tax office that David had returned to live in her property.
- 3.3.51 On 19th May, Lisa fell on a train station platform whilst intoxicated. She was in an emotional state, stating that she felt low and depressed, that her partner was very poorly and that she was struggling. She stated that she was not actively suicidal. British Transport Police sent a letter to Lisa's GP and made a referral to carers support.
- 3.3.52 At the end of May, Lisa met with her Care Coordinator, where she stated that she was settling into her new job and knew that she was not to drink alcohol without having food at the same time. She agreed to continue to engage with her Care Coordinator.
- 3.3.53 Over June, Lisa's GP sent a number of supportive text messages to her. Lisa also missed a number of phone calls from her Care Coordinator over June. Contact was made in July, whereby Lisa apologised and stated that she had been looking after her unwell mother in Hertfordshire. The Care Coordinator advised that if Lisa was not able to inform the Care Coordinator of appointment times, then she would be discharged in her absence, and would be re-referred back to the Recovery team for assessment. At the end of July, Lisa is discharged back to her GP due to non-engagement with her Care Coordinator.
- 3.3.54 In early August, an unknown suspect damaged Lisa's car windows with what appeared to be a BB gun. This was not an isolated offence against Lisa, so it was not believed to be specifically targeted against Lisa. It resulted in no further action due to insufficient evidence.
- 3.3.55 On 8th August, Lisa telephoned the Council Tax office to advice that David had vacated the property.
- 3.3.56 A day later, Lisa's son contacted the police to raise concerns for her welfare as she had called him to tell him that her 'life wasn't worth living' and then her phone was off. Lisa was found by police in her car. She was breathalysed and then arrested for drink driving. At the station she blew under the legal limit and no further action taken was taken. Lisa was taken home by officers, where she was seen to put the remaining alcohol down the sink. A referral was made to the Crisis Team.
- 3.3.57 On 12th August, David was admitted to the emergency department intoxicated and with a head injury. David's sister called the ward and informed them that she had concerns that David was homeless after separating from his wife and that he planned to live with his mother in Hertfordshire on release, which she was also concerned about.
- 3.3.58 On a number of occasions, David was arrested by the police for stalking Lisa. On 20th August, he visited Lisa's home intoxicated and waited outside. On 1st September, he was arrested for Breach of the Peace and Assault. On 2nd September, he was caught peering through Lisa's window, and on 3rd September, he was arrested for attending Lisa's home again. A risk assessment was undertaken and assessed as medium risk. Lisa was referred to GDASS domestic abuse service. GDASS explained their service offer to Lisa, but Lisa explained that she felt safe and that her needs were being met by the police. The police

incidents resulted in no further action due to Lisa and David's death. It was not believed there was sufficient evidence to consider an evidence-led prosecution.

- 3.3.59 On 5th September, Lisa came to the attention of Devon and Cornwall Police. She was reported to be under the influence of alcohol at a bar. She was assessed and identified as not needing to be detained under Section 136. She was signposted to mental health and substance use services and the incident resulted in no further action.
- 3.3.60 In mid-September, Lisa was telephoned by a GP Practice Nurse who undertook an annual review. Lisa shared that she was struggling due to the end of a long-term relationship with her ex-partner who was very ill. She stated that she felt guilty that he was living with his mother and became tearful on the call. She went on to share that she felt lonely but had no thoughts of suicide. Domestic abuse was discussed, but Lisa shared that she had separated from David, and that he was living abroad.
- 3.3.61 In late-September, police attended David's mothers' home after his sister called the police with concerns for her mother's welfare. She shared that David had moved in and was drinking heavily. Their mother had taken a fall and was left on the floor for 9 hours as David was unable to lift her.
- 3.3.62 Lisa called her GP to say that she had diarrhoea and vomiting and had missed a flight. Her insurance wanted confirmation that she had been in contact with GP. Lisa was advised to put her request to the GP in writing.
- 3.3.63 A few days later, Lisa called 999 stating that she wanted to stab herself. When ambulance crew arrived they were unable to gain entry, so the fire brigade was called, who used bolt cutters to gain entry. Despite searching the house, garden and summer house, Lisa was not found. The property had evidence of alcohol bottles and packets of medication on scene, vomit on the sofa, and vomit-stained clothes upstairs. Lisa was noted as a missing person and the police were called. An alert was set up for Lisa's car and police remained at her home.
- 3.3.64 Lisa was located shortly after driving on the M5. She was stopped by police and breathalysed. She was under the legal limit and so was allowed to continue her journey, as no immediate concerns were identified by the officers at the scene.
- 3.3.65 In early October, neighbours contacted Gloucestershire Fire and Rescue Service to report a fire in the back garden of Lisa's property. On arrival, Lisa was sadly found deceased in the summerhouse
- 3.3.66 Three-weeks later, David died from his illness.

4. Overview

4.1 Summary of Information from Family

4.1.1 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.

4.1.2 They emphasised that Lisa was secretive about her relationship with David:

'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.'

4.1.3 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.

'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.'

4.1.4 Ryan discussed that he 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.'

4.1.5 Ryan felt that this secretive aspect of Lisa's personality had an impact on how she was viewed and supported by services:

'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.'

4.1.6 Ryan was concerned that his mother 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.

'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.'

4.1.7 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 was able to query what Lisa was telling him.

- 4.1.8 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 to worry about her.
- 4.1.9 Ryan spoke about his concern 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.
- 4.1.10 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.'
- 4.1.11 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.'
- 4.1.12 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.'
- 4.1.13 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.'
- 4.1.14 Ryan also explained that Lisa was worried that David would steal her cat, as this is 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.
- 4.1.15 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 he 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.
- 4.1.16 He 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.
- 4.1.17 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.

'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.'

- 4.1.18 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.
- 4.1.19 They also felt that more could have been done to support Lisa after she had made accusations against David for stalking.
- 4.1.20 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.'
- 4.1.21 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.'
- 4.1.22 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.
- 4.1.23 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:
- 4.1.24 '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
- 4.1.25 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.
- 4.1.26 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.'

4.2 Summary of Information from Neighbour

- 4.2.1 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.'

- 4.2.2 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.
- 4.2.3 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.
- 4.2.4 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.
- 4.2.5 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.
- 4.2.6 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.'*
- 4.2.7 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.
- 4.2.8 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 were help, which she felt went unanswered. Sophie also felt that service would look at each incident in isolation rather than a pattern of behaviour.
- 4.2.9 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.
- She would often offer to take me on holiday, and we had some lovely trips together, including going on a steam train together.

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."

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 had become quite overgrown.

Lisa also loved her cat. I thought the cat may have prevented Lisa's death, but sadly it didn't.'

- 4.2.10 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 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.
- 4.2.11 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.

4.3 Summary of Information from alleged Perpetrator

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

4.4 Summary of Information Known to the Agencies and Professionals Involved

- 4.4.1 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

Police and fire services

- 4.4.2 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.

- 4.4.3 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.
- 4.4.4 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.
- 4.4.5 The police did later arrest David in September 2023 for stalking and Lisa was supportive of the investigation.
- 4.4.6 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.
- 4.4.7 The second involvement from Gloucestershire Fire and Rescue Service was in October 2023, in relation to the fire where Lisa was sadly found deceased.

Health services

- 4.4.8 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, she 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.
- 4.4.9 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.

- 4.4.10 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.
- 4.4.11 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.
- 4.4.12 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.
- 4.4.13 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.
- 4.4.14 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.
- 4.4.15 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

- 4.4.16 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's 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.

- 4.4.17 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.
- 4.4.18 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

- 4.4.19 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.
- 4.4.20 The following services had contact with David:
- Police
 - Health services
 - Domestic abuse services

Police

- 4.4.21 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.

- 4.4.22 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 Sophie 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.
- 4.4.23 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 offenses 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

- 4.4.24 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.
- 4.4.25 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.
- 4.4.26 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

- 4.4.27 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.

5. Analysis

5.1 Domestic Abuse

- 5.1.1 Taking into account the government definition above, information gathered by the police as part of the suicide investigation, information provided by agencies, and by Lisa's family and friends, it is clear that David exerted abusive behaviour towards Lisa.
- 5.1.2 Tragically, it will never be possible to know the full extent of Lisa's experiences. However, as a minimum it appears Lisa experienced the following:
- 5.1.3 *Physical abuse:* Lisa had disclosed to police in February 2023 that David had shoved her into a wall.
- 5.1.4 *Coercion, threats and intimidation:* Lisa had extensive experience of coercive and controlling behaviour perpetrated by David. In February 2023, she had disclosed that David had made threats to kill her. She also known to police services for being subjected to stalking and harassment from David, particularly over August and September 2023. We also know that Lisa and had discussed with her care coordinator, on a number of occasions, concerns she had about David's behaviour change after he had been drinking. Lisa had also reported to her neighbour threats David had made to harm her pet.
- 5.1.5 *Emotional abuse and isolation:* Lisa's experience of isolation was compounded by her mental health support needs and by lockdowns associated with COVID-19. We also see her being isolated by David, who did not want her care coordinator meeting her in her home.
- 5.1.6 *Economic abuse:* Although no direct evidence was shared with the panel on economic abuse, David struggled with employment and housing. This may have increased his financial dependence on Lisa. Indeed, this was seen in David regularly moving in and out of her property and being homeless when he was not able to stay with Lisa or his mother. Furthermore, from the chair's interview with Lisa's son, Ryan, there were concerns that David was financially dependent on Lisa.

Mental health and substance use

- 5.1.7 The relationship between trauma, substance use, and mental health is well documented and has a significant impact on a victim being able to access support. Research shows that there is a direct relationship between being a victim of domestic abuse and experiencing mental distress; with depression, anxiety and PTSD being most identified, followed by self-harm and suicidal behaviour.¹⁶ Further, research highlights that domestic abuse victims often use substances as a means to cope with the trauma that they are

¹⁶ Golding, Jacqueline M. "Intimate partner violence as a risk factor for mental disorders: A meta-analysis." *Journal of family violence* 14 (1999): 99-132.

experiencing.¹⁷ For example, victims may use alcohol to detach from painful experiences when their ability to spontaneously dissociate has been eroded or use substances to moderate symptoms of PTSD.¹⁸ Lisa was known to services for her alcohol use, and the emphasis was often placed on abstinence without exploration of the reason why Lisa was consuming alcohol and how it may have been a coping mechanism. This can be seen in a text message from her GP:

5.1.8 'I am just touching base with you to check all is still okay? I had tried calling you but no reply. I hope you are steering clear of the alcohol...'

5.1.9 Although the tone of the message was supportive, it is important to recognise the emphasis on abstinence. Research highlights that it is important for practitioners to consider an integrated approach which recognises that the ways in which dealing with one issue can escalate risk in other areas of the survivor's life. For example, where alcohol or drugs are used as self-medication or a way to cope with trauma responses, the risk of suicide and self-harm can increase in the short-term when people begin to address the substance use.¹⁹ Sadly, we see this in Lisa's experience of substance use. A core principle of supporting people through their recovery, therefore, must be safety.

5.1.10 The Panel welcomed news that Gloucestershire have been successful in joining the Making Every Adult Matter Network, which will support them to align with national best practice and support them to explore how to better respond to multiple disadvantage.

5.1.11 We also know from research that both substance use, and serious mental illness influence the likelihood of being in unsafe environments and increase vulnerability to violence victimisation.²⁰ Perpetrators are well documented to use a victim's mental ill-health or substance use as a means of abusing them. Research²¹ has found that:

- Perpetrators may blame their infliction of abuse on the victim's substance use or mental ill-health.
- They may use a victim's mental ill-health as an excuse to isolate the victim, saying she is unable to cope going out by herself, or discouraging her from participating in social activities.

¹⁷ Humphreys, Cathy, Ravi K. Thiara, and L. Regan. "Domestic violence and substance use: overlapping issues in separate services." Final Report, University of Warwick and London Metropolitan University (2005).

¹⁸ Herman, Judith Lewis. "Complex PTSD: A syndrome in survivors of prolonged and repeated trauma." *Journal of traumatic stress* 5.3 (1992): 377-391.

¹⁹ *Against Violence & Abuse: Complicated Matters: A toolkit addressing domestic and sexual violence, substance use and mental ill-health*: 2013. PP. 83

²⁰ Howard, Louise M., et al. "Domestic violence and severe psychiatric disorders: prevalence and interventions." *Psychological medicine* 40.6 (2010): 881-893.

²¹ O'Brien, Kate, and Michael Daffern. "The impact of pre-treatment responsivity and treatment participation on violent recidivism in a violent offender sample." *Psychology, Crime & Law* 22.8 (2016): 777-797 and Fox, Bryanna, and David P. Farrington. "What have we learned from offender profiling? A systematic review and meta-analysis of 40 years of research." *Psychological Bulletin* 144.12 (2018): 1247.

- They may excuse their own behaviour because of the victim's mental health or substance use problems by accusing the victim of causing the abuse by their own erratic behaviour.

5.1.12 Despite this, no focused work was undertaken by Lisa's care coordinator to understand the role of David and the risk he may have posed to Lisa.

Learning Point: It is important to raise awareness of the relationship between substance use, trauma, and domestic abuse, and to address the barriers facing victims in accessing support. In adopting an approach which focuses on the way that victims use substances as a coping mechanism, the way that perpetrators use a victim's substance use and/or mental ill-health to control their victims, and the barriers substance use creates in the accessibility of support, it is possible to challenge any victim blaming and hold perpetrators to account.

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.

Caring responsibilities:

5.1.13 Although neither were formally assessed as carers, both David and Lisa were noted as providing care and support of each other when they came to the attention of services at points of crisis and need. The relationship between domestic abuse and caring responsibilities is often overlooked by statutory organisations but are identified in an increasing number of domestic homicide reviews.²² Research has found that carers as victims of domestic abuse are at risk of controlling behaviours from the person they care for, such as being restricted on having time away, being required to report their movements and becoming socially isolated. Carers as perpetrators of domestic abuse can give somebody complete control over another person's day-to-day activities and resources.²³

5.1.14 David's health vulnerability was recognised by Lisa, who was often noted to feel guilty in contacting the police or pursuing the stalking allegations. She was also noted to feel guilty in removing him from her property and assumed the role of caregiver for David. She regularly referenced the stress of taking care of David to agencies. Similarly, agencies were aware of David's role in caring for Lisa, especially after Lisa had made suicide attempts. Despite this, there was no professional curiosity on the caring responsibilities

²² Amanda Warburton-Wynn, "Carers and domestic abuse – the elephant in the room?" The journal of adult protection, 2023, 25:1, pp. 14-19.

²³ Ibid.

they had for each other and how this may have compounded experiences of power and control.

5.1.15

Learning Point: Caring responsibilities are varied, and it is important that professionals recognise the impact of supporting someone with mental ill-health., The issue of carers as perpetrators of domestic abuse is being overlooked by statutory organisations because they often do not fit the traditional patterns of abusive relationships, and the complexities of the caring role can make typical safety options unsuitable.²⁴

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.

The ways in which Lisa presented to agencies:

- 5.1.16 A key feature of this review is the ways in which Lisa presented herself and how she was viewed by services. Lisa was regularly referred to as “pleasant,” “polite,” “warm,” “open,” and “welcoming.” She would engage with services and was often seen to be contrite after her suicide attempts. As a result of this, there are many occasions where agencies took her comments at face value and not fully explore her vulnerability and the associated risk.
- 5.1.17 Sadly, there are many prevalent societal myths and stereotypes about who a domestic abuse victim is, how they present, and what support they need. Statutory services do not always operate outside of these societal attitudes, which can have an impact on the support that survivors need. The Crown Prosecution Service recently revised their legal guidance to directly challenge damaging myths and stereotypes, stating that:
- 5.1.18 ‘The notion there is a typical victim of domestic abuse is wrong, damaging and can prevent sufferers coming forward. Many people seem to have a fixed idea about what a domestic abuse victim looks like and what their circumstances are. They are wrong.’²⁵
- 5.1.19 Seeing beyond how Lisa presented and instead focusing on her support needs was, therefore, vital.
- 5.1.20 Significantly, Lisa’s presented to the police differently and led to her being considered by the police as a perpetrator against David in February 2023. In instances where a couple are seen “to be as bad as each other,” research by Hester shows that a more nuanced

²⁴ Ibid.

²⁵ <https://www.cps.gov.uk/cps/news/there-no-typical-victim-domestic-abuse-cps-says-it-revises-its-legal-guidance-challenge> (accessed Nov 2024)

understanding is needed of who does what to whom.²⁶ Hester’s analysis in 2009 of 96 police cases of domestic abuse perpetration found that where alcohol is involved, it is more likely to arrest both parties as the circumstances appear “chaotic.” However, the research also found that violence by men was more likely to involve fear and control of victims and be a repeat pattern. In contrast, women were more likely to use violence in self-defence and had lower records of repeat incidents, indicating that they were not instigating a pattern of coercive control.

- 5.1.21 Additionally, Johnson’s typology differentiates between different forms of conflict and control and highlights that “mutual violence” is often assumed rather than an understanding of “violent resistance,” whereby an individual is violent, but not controlling, and is responding to the power and controlling behaviour of the abuser.²⁷ The panel considered how understanding who does what to whom can support agencies to understand how to identify and appropriately respond to risk and need. It also ensures that abusers are held to account.

Learning Point: Domestic abuse victims come from all walks of life and present in a myriad of ways. It is important that agencies do not hold a stereotypical view of what a victim looks and behaves like. Understanding that domestic abuse is the result of the misuse of power and control ensures that professionals recognise who does what to whom and that the right response is adopted.

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.

5.2 Analysis of Agency Involvement / Responding to the Terms of Reference

- 5.2.1 The following section responds to the lines of enquiry as set out in the Terms of Reference in section 1.6.
- 5.2.2 Analyse the communication, procedures and discussions, which took place within and between agencies. The co-operation between different agencies involved with Lisa and David.

²⁶ Hester, M. (2013). Who does what to whom? Gender and domestic violence perpetrators in English police records. *European Journal of Criminology*, 10(5), 623-637.

²⁷ Johnson MP (2006) Conflict and control: Gender symmetry and asymmetry in domestic violence. *Violence Against Women* 12(11): 1003–1018.

- 5.2.3 There were a significant number of services who were supporting Lisa and who held key information regarding her experiences, but this review has highlighted that this information was not often shared on to other agencies to better coordinate support for Lisa. Limitations in multi-agency information sharing meant that there were missed opportunities to see Lisa's holistic experience and provide wrap-around support for her.

Between health services

- 5.2.4 In February 2023, SWAST appropriately sent David's GP a safeguarding referral which detailed his experience of domestic abuse. However, this referral omitted details of the alleged perpetrator, Lisa. This meant that the GP surgery was unable to connect the dots and see the issue of domestic abuse between Lisa and David. This was a missed opportunity. Assurance needs to be provided that safeguarding referrals are completed with relevant information included.
- 5.2.5 It is important to note that the GP surgery's internal processes also did not pick up on the intimate relationship between Lisa and David. Understanding the home make-up of patients helps to build a picture of risk and need. Although the Review Panel understood that David and Lisa did not register at the GP practice at the same time, it is important that a robust internal system is in place which outlines household make-up. This could have supported the GP surgery to understand Lisa's relationship with David without them having to specifically state themselves.
- 5.2.6 It is also unclear whether the various health agencies regularly shared information with each other. Aside from SWAST and the GP, Lisa was also accessing support from GHFT and GHCFT. All these agencies held pieces of information about Lisa, her mental health needs, her substance use, her experience of abuse, as well as changes in her circumstances. There are examples of health agencies referring Lisa to other health agencies under the assumption that the other would be picking up on need identified. For example, Lisa came to the attention of GHFT in May 2018 after she had attempted suicide. The hospital was aware of David's issues with alcohol, yet this was not explored. Instead, Lisa's physical health care was met, and she was referred on to the Recovery Team.
- 5.2.7 It is vital, of course, that health partners support patients with their presenting need, however a holistic approach is needed to ensure that wrap-around support can be provided with those who face multiple disadvantage.

Between Gloucester and Hertfordshire police

- 5.2.8 As David would stay with his mother in Hertfordshire after being removed from Lisa's home, there was contact between Gloucester and Hertfordshire police. There were examples of good practice in terms of information sharing, for example, when Gloucester police arrested David and information regarding the incident was passed to Hertfordshire police for their information. Hertfordshire correctly logged the crime on their own system 'Athena' for any future research and reference.

- 5.2.9 However, the information that Hertfordshire police held on incidents related to David and his mother were not shared with Gloucester police. It is important to remind police staff that any report of a possible domestic nature is to be investigated to establish the safety of either party. Where the location is outside the force area, this information must be passed to the home force. This information could have supported Gloucester police to build a fuller picture of the risk David posed to women.

Between police and statutory services

- 5.2.10 In September 2023, Lisa had spoken to her GP about her stalking case. However, the GP did not receive any information related to this case from Gloucester police. It also appears that Lisa's care coordinator at GHCFT was not sighted on this information. This is significant, because Lisa was discharged from GHCFT back to her GP in July 2023, due to non-engagement. This time period coincided with Lisa's engagement with police and her pursuing a court case for stalking. Being sighted of this information could have support both Lisa's care coordinator and GP to better understand and respond to her needs.
- 5.2.11 Gloucester police were also called to Lisa's home on a number of occasions where counter allegations of domestic abuse were made. However, it appears that visits were often viewed in isolation. As mentioned earlier, there was also some confusion as to ascertaining who was the primary perpetrator and who did what to whom. Building up an understanding of a pattern of incidents and connecting the instances could have supported Gloucester police to better respond to Lisa's needs.

Between housing and other services

- 5.2.12 Tewkesbury Borough Council Housing held information on Lisa and David's relationship, in particular the on/off nature of it. Lisa had also shared that she had difficulties in her relationship and also with her mental health. Despite this, no onward referral was made nor signposting of Lisa to other services. This was a missed opportunity.
- 5.2.13 The Review Panel welcomed news that a countywide domestic abuse housing champions network is being established, which will support Tewkesbury Borough Council to better respond to domestic abuse. In addition, plans are underway to undertake the Domestic Abuse Housing Alliance accreditation, which is recognised as national best practice.

Learning Point: Ensuring internal and external referrals processes are robust are vital to creating a coordinated community response to domestic abuse. We know that no one agency can single handily tackle domestic abuse and therefore a joined-up approach is needed to effectively share information and provide victims with the support they need.

Recommendation 7: Safer Gloucestershire to ensure that emergency service crews 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.

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.

- 5.2.14 Analyse the opportunity for agencies to identify and assess domestic abuse risk and agency responses to any identification of domestic abuse issues.

Health services

- 5.2.15 As discussed elsewhere in this report, there were a number of missed opportunities to identify and appropriately ask about domestic abuse by a number of health agencies. Some services did not broach the subject despite clear indicators/disclosure made by Lisa. This included a number of conversations Lisa had with her care coordinator at GHCFT. There was no professional curiosity, direct enquiry, or domestic abuse risk assessment undertaken. GHCFT do have a standalone domestic abuse policy, which is best practice. There is an opportunity to review this and ensure that it includes guidance on safe routine domestic abuse enquiry as part of standard assessment processes.
- 5.2.16 As discussed earlier, the GP was not sent information about Lisa's disclosure to the police, however, there were missed opportunities to explore with Lisa some of the reasons for her drinking and feelings of suicidal ideation. This is especially true as it appeared that Lisa had a strong relationship with her GP and would see them often. The GP did receive a referral from SWAST informing them that David was experiencing abuse from his partner. At the next face-to-face GP appointment in April 2023, good practice was followed to not ask about domestic abuse as he was accompanied by Lisa. However, there was a missed opportunity to attempt to see David on his own and safely ask about domestic abuse.
- 5.2.17 The Review Panel considered the value of GP surgeries signing up to the Identification and Referral to Improve Safety (IRIS) programme. IRIS is a specialist domestic abuse training, support and referral programme for GPs that has been positively evaluated in a randomised controlled trial.²⁸ It is a partnership between health and the specialist domestic abuse sector and provides in-house domestic training for general practice teams

²⁸ Feder, Gene et al, 'Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomised controlled trial.' The Lancet, Volume 378, Issue 9805, 1788 - 1795

and a named advocate to whom patients can be referred for support. The IRIS programme can support GPs to better identify and respond to domestic abuse and is a programme which Lisa's GP would benefit from in supporting victims.

- 5.2.18 Lisa also visited GHFT hospital, first in 2018 after she was admitted after attempting to jump off a railway bridge. There was a missed opportunity by the mental health liaison team to ask Lisa about domestic abuse prior to her discharge four days later. The Review Panel welcomed the update that registered healthcare professionals at GHFT are required to complete a two-hour Domestic Abuse Stalking and Harassment Risk Assessment training. This can support staff to identify and appropriately respond to and can ensure that someone does not fall through the gaps. It is important that this training is reviewed and number of referrals to MARAC are monitored. It is also important that this training appropriately ensure service-users are sign-posted to specialist support.
- 5.2.19 As discussed earlier, SWAST responded to a number of 999 calls and provided Lisa with appropriate support and care. However, there were missed opportunities to ask about domestic abuse on their interactions with Lisa. The National Institute for Health and Care Excellence Domestic violence and abuse: multi-agency working guidance states in Recommendation 15 that Level 2 staff should be trained to ask about domestic violence and abuse in a way that makes it easier for people to disclose it. Level 2 staff includes ambulance staff.²⁹

Police

- 5.2.20 The police were one of the few agencies which Lisa did directly report to. In February 2023 she disclosed that she had suffered years of abuse from David in May 2020. She also disclosed that David had shoved her and made threats to kill in February 2023. Despite both disclosures, there was no follow up. The Review Panel recognised this as a clear missed opportunity to engage with Lisa and respond to her clear disclosure. There was also a missed opportunity to adopt what the Crown Prosecution Service calls an “offender-centric approach.”³⁰ This involves police studying the actions of the suspect before, during and after the alleged offence to glean a fuller picture of risk.

Domestic abuse services and other specialist support

- 5.2.21 Charlies Community Support have brief contact with Lisa where she expressed her worry in taking care of David. As discussed earlier, there is a strong link between domestic abuse and caring responsibilities. The Review Panel also noted that Charlie's Community Support do not have a domestic abuse policy or offer their staff domestic abuse training.

²⁹ <https://www.nice.org.uk/guidance/ph50/chapter/Recommendations> (accessed November 2024)

³⁰ <https://www.cps.gov.uk/cps/news/there-no-typical-victim-domestic-abuse-cps-says-it-revises-its-legal-guidance-challenge> (accessed November 2024)

There is an opportunity to review their response and better incorporate an understanding and response to domestic abuse.

- 5.2.22 As discussed earlier, GDASS were unable to engage with David after he was referred to their service in February 2023. The Review Panel welcomed news that GDASS have a counter allegations policy in place to ensure that they can establish who does what to whom.
- 5.2.23 GDASS also reached out to Lisa in September 2023 after a police referral to their service. Although Lisa declined the use of their service, there were missed opportunities to refer Lisa to alcohol and mental health support services.

Housing

- 5.2.24 Lisa had regular contact with the Council Tax Office and the Counter Fraud and Enforcement Unit, and she had informed them of the difficulties in her relationship with David, and of the on/off nature of their relationship. She had informed them that David had moved out and back in over May 2020, February 2021, January 2023, and August 2023. There were missed opportunities to ask about her home situation and the difficulties with David. As discussed earlier, Housing has a unique insight into the home lives of services users can be best placed to identify and respond to domestic abuse.
- 5.2.25 The Review Panel considered the benefit of Tewkesbury Housing undergoing Domestic Abuse Housing Alliance (DAHA) accreditation. DAHA provides an accreditation framework which includes 8 priority areas that considers an organisation's operations in relation to domestic abuse. It offers a range of benefits that support and guide organisations to deliver safe and effective responses to domestic abuse, by building in processes that help guide staff to adequately address the needs of survivors and hold abusers to account.³¹

Learning Point: People need encouragement to disclose domestic abuse, and disclosures need to be followed by action.³² In fact, research shows that, certainly in the case of domestic abuse, asking and taking no action can be more detrimental than not asking at all.³³ It is vital that professionals are trained to appropriately trained to ask and respond to domestic abuse.

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.

³¹ <https://www.dahalliance.org.uk/> (accessed November 2024)

³² Against Violence & abuse: Complicated Matters: A toolkit addressing domestic and sexual violence, substance use and mental ill-health: 2013. PP. 50.

³³ Parnitzke Smith, C. & Freyd, J.J. (2013). Dangerous Safe Havens: Institutional Betrayal Exacerbates Sexual Trauma. Journal of Traumatic Stress, 26, 119-124

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 service user does not want to engage with domestic abuse support.

Analyse organisations' access to specialist domestic abuse agencies.

5.2.26 This review has found that Lisa was known to a number of statutory services, but her access to specialist and third sector services was very limited. She was known to but not open to GDASS. Knowing that Lisa was experiencing multiple disadvantage of mental ill-health, substance use, and domestic abuse, having access to a specialist service that would be able to holistically support her would have been beneficial.

5.2.27 Women's Aid have undertaken work to demonstrate the value of specialist, non-statutory domestic abuse support. They highlight that that specialist services are valuable because they are continually improving the overall response to domestic abuse in a way that both empowers survivors to lead meaningful lives, as well as keeping the community safe. In particular, they a) recognise diversity of survivors and their experiences, b) engage survivors in the community, and c) identify gaps and fill them.³⁴

5.2.28 Further, the National Independent Domestic Abuse Commissioner undertook research³⁵ which found:

- Specialist services are effective in enabling victims and survivors to feel safer and more in control of their lives following abuse.
- Victims and survivors need a range of types of support to help them find safety and to cope and recover from abuse.

³⁴ <https://www.womensaid.org.uk/insight-into-the-value-specialist-domestic-abuse-services-provide/> (accessed November 2024)

³⁵ chrome-extension://efaidnbmninnibpcjpcglclefindmkaj/https://domesticabusecommissioner.uk/wp-content/uploads/2023/02/DAC_Mapping-Abuse-Survivors_Summary-Report_Feb-2023_Digital.pdf (accessed November 2024)

- Most victims and survivors from minoritised communities want to receive support delivered ‘by and for’ their own community.
- This is because specialist ‘by and for’ organisations are far more effective in supporting minoritised victims and survivors than other types of services.

5.2.29 The last two points are particularly important in relation to equality and diversity. We know that Lisa was an older victim of domestic abuse and therefore was minoritised by her experience and faced additional barriers to access support. This is because:

- services typically being set up with younger clients in mind
- older people being less likely to call 999
- particular cultural or generational attitudes that often exist towards marriage and family life.³⁶

5.2.30 We know that Lisa did not want to engage with substance use services and did not take up the offer of GDASS. Indeed, she did not recognise that she was heavily consuming alcohol, denying it on some occasions or choosing to focus on David’s use on other occasions. More work needs to be done by statutory services to refer into specialist services, to commission specialist services, and to raise awareness of specialist services. This ensures that survivors of domestic abuse understand the range of support available, especially minority groups of women who may not readily identify the support that they can access outside of statutory services.

Learning Point: Specialist services play an imperative role in supporting victims of domestic abuse, specialist those who are from minoritised backgrounds and face additional barriers in accessing support. Statutory services must engage with the voluntary sector as part of a coordinated community response to domestic abuse.

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).

Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.

5.2.31 Agencies involved in this review have a range of policies, procedures, and training in place, in relation to domestic abuse and these were described in each agency’s IMR/short report.

³⁶ <https://safelives.org.uk/resources-library/guidance-for-multi-agency-forums-older-people/> (accessed November 2024)

5.2.32 A summary of the agencies with domestic abuse policies and their training is outlined in the table below:

Agency	Domestic Abuse policy and review date at time of this report	Domestic Abuse Training
Gloucestershire Health and Care NHS Foundation Trust	Yes, standalone policy in place. Last reviewed in November 2023	Level 1 Safeguarding training for all staff. Level 2 training for professional/clinical staff receive training in recognising and responding to domestic abuse. Level 3 multi-agency safeguarding children and training incorporates domestic abuse, which is mandatory for staff depending upon role. Additional non-mandatory domestic abuse training is available.
Hertfordshire Partnership Foundation Trust	Yes, standalone policy in place. Last reviewed in October 2022	As part of Level 3 Adult and Child Safeguarding training, webinars on domestic abuse are offered to staff, including on Routine Enquiry, Coercion and Control, Stalking, Suicide and DA, Risk assessment and Safety Planning. Domestic abuse is integrated within the Safeguarding Level 3 training so is not mandatory, although this is being reviewed.
Integrated Care Board (The GP)	No. Safeguarding Adults Policy only	The practice has received a training session from GDASS within the last 3 years. Domestic Abuse training is not mandatory training.
Gloucestershire Hospitals NHS Foundation Trust	Yes, standalone policy in place. Last reviewed in October 2023	Mandatory Safeguarding Adults Training in place. Registered healthcare professionals are required to complete 2 hours of DASH training. Emergency Department staff have additional training in non-fatal strangulation. Non-registered healthcare staff have a 1-hour domestic abuse awareness session.
South Western Ambulance Service NHS Trust	Yes, standalone policy in place. Next review due July 2025	Mandatory Safeguarding Adults Level 2 in place. Level 3 is available for clinical staff. Face-to-face mandatory training available yearly and Domestic Abuse is a specific topic being covered this year. Additional ad hoc training available. Training review in place for 2025.
Charlies Community Support	Yes, standalone policy in place. Next review due November 2025.	New volunteers attend a mandatory half-day session on recognising the signs of domestic abuse using the toolkits from GDASS.
Gloucestershire Domestic Abuse Support Service	Yes, standalone policy in place. Last reviewed in March 2024. In addition, the Vulnerable Customers	Mandatory Safeguarding Adults Level 2, Mandatory Supporting Vulnerable Customers training, and Mandatory Domestic Abuse, HBA and Stalking Training All GDASS IDVA's are qualified or working towards the SafeLives IDVA Foundation Training Paladin ISAC qualified SPOC in service

	Policy includes reference to suicide	All GDASS Senior Leaders have the SafeLives Service Manager Qualification. Mandatory CPD DA training
Gloucestershire Fire and Rescue Service	Yes, as part of the Domestic Abuse Guidance for Employees and Managers Gloucestershire County Council Policy in place since April 2020.	Prevention Team and staff with specific safeguarding responsibilities are required to undertake domestic abuse awareness training. White Ribbon training is now a compulsory e-learning course for all staff in the organisation and is essential to become considered for promotion.
Hertfordshire Constabulary	Standalone policy in place. Last reviewed October 2024.	Specialist Domestic Abuse Unit has dedicated training staff. Mandatory training is delivered via a variety of platforms to all officers and PSCO, content depends on level and role within the organisation. There is a Force Vulnerability handbook which contains advice and guidance relating to domestic abuse issues, and specific sections and a portal on the force intranet sight containing information and guidance relating to domestic abuse and vulnerability issues.
Gloucestershire Constabulary	Yes, standalone policy in place. Last reviewed in January 2024	Domestic Abuse Matter rolled out across the force since October 2023. Domestic Abuse Routine Enquiry training also rolled out from October 2024. Mandatory stalking awareness delivered to Detective and Senior Investigating Officers. Stalking training is also provided by the stalking clinic team and Independent Stalking Advocacy Service. Localised training offered on an ad-hoc basis.
Tewkesbury Borough Council Housing	No. Safeguarding Adults Policy only. Development of domestic abuse policy underway,	GDASS provide training for all staff in management and frontline positions at Tewkesbury Borough Council. Stalking training has also been delivered to housing officers countywide.

5.2.33 Having a clear and robust standalone domestic abuse policy in place which is regularly reviewed can provide an organisation with the support and guidance to best respond to domestic abuse. It is also important that this policy is accompanied by regular and stand-alone domestic abuse training, which is mandatory for any appropriate professional to attend.

Learning Point: Domestic abuse policies must be kept up to date and utilised by staff. Staff also need to be regularly trained on all forms of domestic abuse, and specialist areas including domestic abuse and multiple disadvantage, and domestic abuse and mental health.

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.

How agencies responded to Lisa and David's substance use and how agencies responded to concerns around Lisa's suicidal ideation

5.2.34 This is addressed elsewhere in the analysis.

How agencies considered Lisa's experiences of abuse and the risk that David posed

5.2.35 Lisa was known to many services but most of the support she received was predominantly in relation to her mental health needs and any presenting issue, i.e. housing focused on her single person tax status only. The only service that knew of her experience of abuse was the Police. As discussed earlier, there were many missed opportunities to identify and respond to domestic abuse. However, this speaks to a wider issue of services seeing Lisa's issues in isolation and not joining the dots or understanding the root cause of her other presenting issues, i.e., what was impacting her mental ill-health and substance use? More needed to be done by agencies to consider Lisa's experience of abuse and the impact this had on her and her engagement with services.

5.2.36 The Review Panel also found that there were missed opportunities to understand the risk that David posed to Lisa. This is demonstrated by the police arresting Lisa in February 2023 for assaulting David, but not arresting David after Lisa had disclosed his violence. There is a recognition that more needs to be done to hold perpetrators to account as part of robust domestic abuse response, which includes an understanding of the risk that they pose.

5.2.37 The Review Panel considered that David was severely ill during the timeframe of this review and had died a few weeks after Lisa due to an alcohol related illness. There was reflection on whether this impacted how he was or was not perceived as a risk to Lisa by services. However, as discussed earlier regarding care responsibilities, vulnerable men can still be abusers. The stalking allegation was appropriately supported by the police, but all agencies needed to better understand Lisa's relationship with David and the risk he posed.

Learning Point: Domestic abuse can sometimes be overshadowed by other presenting issues, which can mean that it is not picked up by agencies, and the root cause of other associated issues is not explored. It is important that domestic abuse is centred in statutory support and awareness is raised on the risk that abusers pose to victims.

Recommendation 21: The Gloucestershire Domestic Abuse Local Partnership Board to raise awareness of domestic abuse and the risk that abusers pose to victims.

How agencies responded to/understood who did what to whom, as both Lisa and David were known as perpetrators of abuse.

5.2.38 This is addressed elsewhere in the analysis.

Impact of COVID-19 and agency responses.

5.2.39 Agencies involved in this DHR were asked to consider the impact of COVID-19 and lockdown on service delivery. Between May 2018 to October 2023, the timeframe of this review, there were national lockdowns between January 2021 to July 2021, and local lockdowns from September 2020 to November 2020 where staff were adapting to new ways of working within an untested period of time.

5.2.40 Further research on the impact of COVID-19 is still very much needed, but initial studies have found that existing mental health difficulties were exacerbated for many people, that there was inadequate access to mental health services, and that new remote ways to access mental health care, including digital solutions, presented substantial barriers to access.³⁷

5.2.41 The Review Panel considered the impact this had on Lisa and the barriers it may have placed in being able to access support. Findings have also highlighted the changing patterns of domestic abuse during the Covid-19 lockdown. Abuse by current partners as well as family members increased on average by 8.1% and 17.1% respectively over the lockdown period.³⁸ Although an important caveat is that this increase was also due to an increase in third party reporting,³⁹ it is still noted that locking down with a perpetrator increased risk by limiting opportunities for support.

5.2.42 The Review Panel considered this period of heightened risk and how this should have resulted in an increase of awareness of domestic abuse and use of DASH risk assessments.

Learning Point: The COVID pandemic forced a change in how frontline services were delivered.

As we return to life beyond the pandemic, it is necessary to review the impact of the lockdown on current service delivery.

³⁷ Gillard, S., Dare, C., Hardy, J. et al. Experiences of living with mental health problems during the COVID-19 pandemic in the UK: a coproduced, participatory qualitative interview study. *Soc Psychiatry Epidemiology* 56, 1447–1457 (2021)

³⁸ Ivandic, Ria, Kirchmaier, Thomas and Linton, Ben (2020) Changing patterns of domestic abuse during Covid-19 lockdown. CEP Discussion Papers (1729). London School of Economics and Political Science. Centre for Economic Performance, London, UK.

³⁹ Ibid.

Recommendation 22: Safer Gloucestershire to review the impact of lockdown on the work of their partnership practice.

Agencies understanding of Lisa's wider social networks

- 5.2.43 Much of agency involvement was directly with Lisa or through David. Although it is understood that consent is required for wider engagement, more could have done to explore Lisa's network of support.
- 5.2.44 Lisa regularly spoke about her sons. Ryan had contacted services when he was concerned about her welfare. However, when the chair spoke with him, Ryan mentioned that he very much felt out of the loop and did not know the extent of issues Lisa was experiencing. This was also articulated by Sophie, Lisa's neighbour, who told the chair that she was Lisa's confidant, but often felt shut out by services. Sophie picked up vital clues on Lisa's welfare, sharing with the chair that Lisa had cut all her hair off a few months before her death. She had also stopped tending her garden, which Sophie highlighted was a source of pride for Lisa and showed that her mental health was deteriorating.
- 5.2.45 We know that the social network within which abuse occurs can have a powerful role, either in identifying abuse and supporting the victim, or in (often unwittingly) sustaining or enabling abuse. And, for their own sake, friends or family of victims deserve more policy consideration, given the toll support can take.⁴⁰ Indeed, friends and family are more likely to be aware of abuse than anyone else, they can have positive impact through their emotional support, and informal networks can bridge the gap to specialists.

Learning Point: It is important that more awareness is raised on the role that friends and family play in ending domestic abuse as part of the coordinated community response. Often the first point of contact for victims, they can be the bridge between victims and support.

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.

⁴⁰ www.citizensadvice.org.uk/Global/CitizensAdvice/Crime%20and%20Justice%20Publications/Linkinthechain.pdf (accessed November 2024)

6. Conclusions and Lessons to be Learnt

6.1 Conclusions

- 6.1.1 Lisa tragically died by suicide in October 2023 after experiencing abuse by her partner, David, and suffering from mental ill-health.
- 6.1.2 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.
- 6.1.3 The Review Panel extends its sympathy to all those affected by Lisa's death and thanks all those who have participated in the review.
- 6.1.4 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.

6.2 Key Themes and Learning Identified

- 6.2.1 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:

- 6.2.2 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
- 6.2.3 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.

- 6.2.4 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

- 6.2.5 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.
- 6.2.6 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.
- 6.2.7 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

- 6.2.8 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.
- 6.2.9 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 are at least four times higher than the general female population,⁴¹ it is important that agencies adopt a multi-agency approach which centres the needs of survivor.

⁴¹ Against Violence & abuse: Complicated Matters: A toolkit addressing domestic and sexual violence, substance use and mental ill-health: 2013. PP. 24

- 6.2.10 Addressing multiple disadvantages 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

- 6.2.11 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.
- 6.2.12 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 this to her care coordinators that David was taking care of her.
- 6.2.13 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.
- 6.2.14 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.

7. Recommendations

7.1 Single Agency Recommendations (Identified by Individual Agencies)

- 7.1.1 The following single agency recommendations were made by the agencies in their IMRs.
- 7.1.2 These recommendations are also presented by agency in the single agency recommendation action plan template in **Appendix 3**. These recommendations should be acted on through the development of an action plan, with each agency reporting on progress to the Tewkesbury Community Safety Partnership.
- 7.1.3 Gloucester Health and Care Foundation Trust
- 7.1.4 Domestic abuse specific training Trust wide (identification; process; support). The recent GDASS appointment of a MHIDVA will widen opportunities to deliver training on recognising and responding to domestic abuse and completing a DASH form and this will be targeted to specific teams across the Trust.
- 7.1.5 Staff support and training opportunities would be further enhanced by having a dedicated Domestic Abuse Lead within the Trust.
- 7.1.6 Promote the use of the DASH tool within GHCF.
- 7.1.7 Consideration of the impact of domestic abuse in relation to assessment and management of risk of suicide.
- 7.1.8 Integrated Care Board
- 7.1.9 Update Primary Care Safeguarding Policy
- 7.1.10 Domestic Abuse training update
- 7.1.11 When patients register at a GP practice, to register them with the same GP as the rest of their household
- 7.1.12 Gloucestershire Hospitals NHS Foundation Trust
- 7.1.13 None provided.
- 7.1.14 South Western Ambulance Service Trust
- 7.1.15 None provided.
- 7.1.16 Charlies Community Support
- 7.1.17 Non provided.
- 7.1.18 Gloucestershire Domestic Abuse Support Service
- 7.1.19 GDASS to work in partnership with other agencies to explore information held on domestic abuse history.
- 7.1.20 To promote their service to ensure it is offered by multi-agency partners.

- 7.1.21 Gloucestershire Fire and Rescue Service
- 7.1.22 Agencies working with people who are experiencing poor mental health, substance use issues, or domestic abuse, to invite the GFRS Community Safety Team to give a short presentation to their staff on the fire risk associated with these factors, to improve referrals into GFRS for home fire safety visits.
- 7.1.23 That GFRS improve the professional curiosity of supervisory managers, to increase the opportunity for safeguarding.
- 7.1.24 Hertfordshire Constabulary
- 7.1.25 Remind staff any report of a possible domestic nature to be investigated to establish the safety of either party. Where the location is outside the force area, to be passed to the home force.
- 7.1.26 Gloucestershire Constabulary
- 7.1.27 Arrest all domestic abuse suspects unless exceptional circumstances apply and authorised by a Det. Inspector with a detailed THRIVE+ rationale.
- 7.1.28 Consider Evidence Led Prosecution in all domestic abuse investigations.
- 7.1.29 Consider the use of Domestic Violence Protection Notice in all domestic abuse investigations with violence or threats of violence.
- 7.1.30 Ensure MATAAC are considered in instances where an offender has been alleged to have committed domestic abuse twice in a 12-month period against one victim or at least one instance of domestic abuse involving a minimum of two different victims in a 12-month period.
- 7.1.31 Ensure domestic abuse training is mandatory across the organisation and ensure that there is refresher training for staff across the organisation.
- 7.1.32 Tewkesbury Borough Council: Housing
- 7.1.33 Development of a domestic abuse policy for Tewkesbury Borough Council, that clearly sets out the local authority's intentions in recognising and responding to domestic abuse and outlines the response that customers can expect to receive. It is also recommended that the local authority ensure there is a domestic abuse policy in place for staff.
- 7.1.34 Development of a related procedure for Revenues, and other relevant teams within the council – Housing, Customer Service, Community Safety/Anti-Social Behaviour which explains in practical terms how the policy will be applied in practice.
- 7.1.35 Development of mandatory training for revenues staff, in coordination with GDASS.
- 7.1.36 Encourage Revenues staff (and Tewkesbury Borough Council staff more generally) to access the GDASS Rural Domestic Abuse Champions Training.

7.1.37 Gloucestershire Housing Partnership Programme Manager will support the Housing Officer who is part of the countywide Domestic Abuse Housing Champions Network to think about how they can raise awareness of domestic abuse across the Local Authority.

7.1.38

7.2 Multi Agency Recommendations (Developed by the Review Panel)

7.2.1 The Review Panel has made the following recommendations during this review in response to learning identified. These are described in section 5 as part of the analysis.

7.2.2 These recommendations are also presented in the multi-agency recommendation action plan template in **Appendix 3**. The Tewkesbury Community Safety Partnership is responsible for overseeing the development and monitoring of an action plan.

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.

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 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).

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.

Appendix 1: Glossary

A&E	Accident and Emergency
AAFDA	Advocacy After Fatal Domestic Abuse
AFV	Adult Family Violence
BAMER	Black, Asian, Minority Ethnic and Refugee
CAMHS	Child and Adolescent Mental Health Service
CCG	Clinical Commissioning Group
CCR	Coordinated Community Response
CPS	Crown Prosecution Service
CPV	Child to Parent Violence
CRIS	Crime Recording and Information System
CSP	Community Safety Partnership
CSU	Community Safety Unit
DAHA	Domestic Abuse Housing Alliance
DASH RIC	Domestic Abuse, Stalking and Honour Based Abuse Risk Indicator Checklist
DHR	Domestic Homicide Review
DI	Detective Inspector
FSW	Family Support Worker
FLO	Family Liaison Officer
GP	General Practitioner / Practice
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review
IO	Investigating Officer
LAS	London Ambulance Service
LGBT	Lesbian, Gay, Bisexual and Trans
MARAC	Multi Agency Risk Assessment Conference
MASCE	Multi-Agency Child Sexual Exploitation Panel

MASH	Multi Agency Safeguarding Hub
MERLIN PAC	(MPS) report completed by police officer when they encounter a child in circumstances that cause a concern
MOPAC	Mayor's Office for Policing and Crime
MPS	Metropolitan Police Service
OIC	Officer in the Case
RASSO	Rape and Serious Sexual Offences
SCP	Safeguarding Children Partnership
SCRG	(MPS) Specialist Crime Review Group
SIO	Senior Investigating Officer
SLT	Senior Leadership Team
SOIT	Sexual Offence Investigation Technique
SPOC	Single Point of Contact
TAC	Team Around the Child
VAWG	Violence against Women and Girls
VRI	Visually Recorded Interview
VSHS	Victim Support Homicide Service

Appendix 2: Terms of Reference

This Domestic Homicide Review ('the review') is being completed to consider agency involvement with Lisa n and David following the death by suicide of Lisa in October 2023. This review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004 but will be described as a 'Domestic Abuse-Related Death Review'.

Purpose of the Review

1. To review the involvement of each individual agency, statutory and non-statutory, with Lisa and David during the relevant period of time May 2018 – October 2023. To summarise agency involvement prior to May 2018.
2. To establish what lessons are to be learned regarding the way in which local professionals and organisations work individually and together to safeguard victims.
3. To identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
4. To apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
5. To prevent domestic violence and abuse and domestic abuse-related deaths and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.
6. To contribute to a better understanding of the nature of domestic violence and abuse.
7. To highlight good practice.

Role of the Review Panel, Independent Chair and the CSP

8. *The Independent Chair of the Review will:*
 - a) Chair the review panel.
 - b) Co-ordinate the review process.
 - c) Quality assure the approach and challenge agencies where necessary.
 - d) Produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.
9. *The Review Panel:*
 - a) Agree robust terms of reference.
 - b) Ensure appropriate representation of your agency at the review panel: panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a review panel meeting.
 - c) Prepare Individual Management Reviews (IMRs) and chronologies through delegation to an appropriate person in the agency.

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

- d) Discuss key findings from the IMRs and invite the author of the IMR (if different) to the IMR meeting.
- e) Agree and promptly act on recommendations in the IMR Action Plan.
- f) Ensure that the information contributed by your organisation is fully and fairly represented in the Overview Report.
- g) Ensure that the Overview Report is of a sufficiently high standard for it to be submitted to the Home Office, for example:
 - o The purpose of the review has been met as set out in the Terms of Reference (ToR).
 - o The report provides an accurate description of the circumstances surrounding the case
 - o The analysis builds on the work of the IMRs, and the findings can be substantiated.
- h) To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.
- i) On completion present the full report to the Tewkesbury Borough Community Safety Partnership (CSP), in conjunction with Safer Gloucestershire
- j) Implement your agency's actions from the Overview Report Action Plan.

Tewkesbury Borough Community Safety Partnership (CSP), in conjunction with Safer Gloucestershire:

- a) Translate recommendations from Overview Report into a SMART Action Plan.
- b) Submit the Executive Summary, Overview Report and Action Plan to the Home Office Quality Assurance Panel.
- c) Forward Home Office feedback to the family, Review Panel and Standing Together Against Domestic Abuse ('Standing Together').
- d) Agree publication date and method of the Executive Summary and Overview Report.
- e) Notify the family, Review Panel and Standing Together of publication.

Definitions: Domestic Violence and Coercive Control

10. The Overview Report will refer to the terms domestic abuse and coercive control. The Review applies the statutory definition⁴² of domestic abusive behaviour as consisting of a single incident or course of conduct between two people who are personally connected, each aged 16 or over, and involving any of the following:

- 7.2.3 (a) physical or sexual abuse
- 7.2.4 (b) violent or threatening behaviour
- 7.2.5 (c) controlling or coercive behaviour
- 7.2.6 (d) economic abuse
- 7.2.7 (e) psychological, emotional or other abuse

⁴² The Domestic Abuse Act 2021 received Royal Assent on 29 April 2021: <https://www.legislation.gov.uk/ukpga/2021/17/part/1/enacted>

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

11. Economic abuse is defined as “any behaviour that has a substantial adverse effect on a person’s ability to acquire, use, or maintain money or other property or obtain goods or services” (s.3: Domestic Abuse Act 2021).
12. Controlling behaviour is: “a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.”
13. Coercive behaviour is: “an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.”
14. This definition includes “so-called ‘honour’ based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.”

Equality and Diversity

15. The review panel will consider all protected characteristics (as defined by the Equality Act 2010) of Lisa and David (age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation) and will also identify any additional vulnerabilities to consider (e.g., armed forces, carer status and looked after child).
16. The review panel identified the following protected characteristics of Lisa and David as requiring specific consideration for this case: Gender and Age.
17. The following issues have also been identified as particularly pertinent to this death: substance use and mental health.

Consideration has been given by the Review Panel as to whether either the victim or the [alleged] perpetrator was an ‘Adult at Risk’ Definition in Section 42 the Care Act 2014: “An adult who may be vulnerable to abuse or maltreatment is deemed to be someone aged 18 or over, who is in an area and has needs for care and support (whether or not the authority is meeting any of those needs); Is experiencing, or is at risk of, abuse or neglect; and As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.”

Abuse is defined widely and includes domestic and financial abuse. These duties apply regardless of whether the adult lacks mental capacity.

If it is the case that any party is an adult at risk, the review panel may require the assistance or advice of additional agencies, such as adult social care, and/or specialists such as a Learning Disability Psychiatrist, an independent advocate or someone with a good understanding of the Mental Capacity Act 2005.

The Care Act 2014 states; “Safeguarding means protecting an adult’s right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult’s wellbeing is promoted including, where appropriate, having regard to their views, wishes,

feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.”

The Review Panel determined that neither CF nor SC were considered to be an adult at risk.

18. *Expertise*: The review panel will include representation from Fear Free, to provide expert understanding into stalking and harassment.
19. If Lisa and David have not come into contact with agencies that they might have been expected to do so, then consideration will be given by the Review Panel on how lessons arising from the review can improve the engagement with those communities.
20. The CSP will make the link with any relevant interested parties outside the main statutory agencies.
21. The review panel agrees it is important to have an intersectional framework to review Lisa and David 's life experiences. This means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand one's journey and one's experience with local services/agencies and within their community.

Parallel Reviews

22. If there are other investigations or inquests into the death, the panel will agree to either:
 - a. Run the review in parallel to the other investigations, or
 - b. Conduct a coordinated or jointly commissioned review - where a separate investigation will result in duplication of activities.
 - c. The panel will do the following to ensure the review process dovetails with any other relevant review:
 - d. It will be the responsibility of the independent chair to ensure contact is made with the chair of any parallel process.

Membership

23. It is critical to the effectiveness of the meeting and the review that the correct management representatives attend the panel meetings. Panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.
24. The following agencies are to be on the Review Panel:
 - a. Gloucestershire Health and Care NHS Foundation Trust
 - b. Gloucestershire Hospitals NHS Foundation Trust
 - c. Integrated Care Board (ICB) to represent GP practice
 - d. Gloucestershire Constabulary
 - e. South Western Ambulance Service (SWAST)
 - f. Substance Misuse Services

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

- g. Local Authority Housing
 - h. Gloucestershire Domestic Abuse Support Service (GDASS)
 - i. Fear Free
 - j. Fire Services
 - k. Crown Prosecution Service
 - l. Charlies
 - m. Hertfordshire constabulary
 - n. Hertfordshire health services
25. Lisa and David lived in another local authority area: Hertfordshire. The Review Panel considered this and will consider inviting relevant agencies as per the timeframe of the review.

Role of Standing Together and the Panel

26. Standing Together have been commissioned by the Tewkesbury Borough Community Safety Partnership (CSP), in conjunction with Safer Gloucestershire to independently chair this review. Standing Together have in turn appointed their DHR Associate Shabana Kausar to chair the review. The review team consists of three Coordinators and a review Manager. The review Coordinator will coordinate and have oversight of the review. The manager will quality assure the review process and Overview Report. The contact details for the Standing Together review team will be provided to the panel and you can contact them for advice and support during this review.

Collating evidence

27. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted and secure all relevant records.
28. Chronologies and Short Reports/Individual Management Review (IMRs) will be completed by the following organisations known to have had contact with Lisa and David during the relevant time period: May 2018 – October 2023

Agencies to complete IMR and Chronology

- Gloucestershire health and care NHS foundation trust
- Gloucestershire Hospitals NHS Foundation Trust
- GP practice (to be represented by the ICB).
- Gloucestershire Constabulary
- GDASS
- Local Authority Housing

Agencies to complete Short Report and Chronology

- South Western Ambulance Service (SWAST)

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

29. Further agencies may be asked to completed chronologies and Short Reports/IMRs if their involvement with Lisa and David becomes apparent through the information received as part of the review.
30. Each Short Report / IMR will:
- Set out the facts of their involvement with Lisa and David.
 - Critically analyse the service they provided in line with the specific terms of reference.
 - Identify any recommendations for practice or policy in relation to their agency;
 - Consider issues of agency activity in other areas and review the impact in this specific case.
31. Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought Lisa and David in contact with their agency. These agencies are:
- a) Substance use services
 - b) Fear Free
 - c) Adult Social Care
 - d) Nelson Trust

Key Lines of Inquiry

32. In order to critically analyse the incident and the agencies' responses to Lisa and David this review should specifically consider the following points:
- a) Analyse the communication, procedures and discussions, which took place within and between agencies.
 - b) Analyse the co-operation between different agencies involved with Lisa and David [and wider family].
 - c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.
 - d) Analyse agency responses to any identification of domestic abuse issues.
 - e) Analyse organisations' access to specialist domestic abuse agencies.
 - f) Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.
 - g) Analyse how agencies responded to CF mental health.
 - h) How agencies responded to CF's and SC's substance use. .
 - i) How agencies responded to concerns around CF's suicidal ideation.
 - j) How agencies considered CF experiences of isolation and economic abuse.
 - k) How agencies responded to/understood who did what to whom, as both CF and SC were known as perpetrators of abuse.
 - l) How did agencies respond to SC and understand the risk that he posed.
 - m) Impact of COVID- 19 and agency responses.
 - n) The on/off nature of the relationship – post separation coercive control/stalking.
 - o) Agencies understanding of wider social networks, specifically relationships with CF's sons.

As a result of this analysis, agencies should identify good practice and lessons to be learned. The Review Panel expects that agencies will take action on any learning identified immediately following the internal quality assurance of their IMR.

Development of an action plan

33. Individual agencies to take responsibility for establishing clear action plans for the implementation of any recommendations in their IMRs. The Overview Report will make clear that agencies should report to the Safer Vale Partnership on their action plans within six months of the Review being completed.
34. The Tewkesbury Borough Community Safety Partnership (CSP), in conjunction with Safer Gloucestershire to establish a multi-agency action plan for the implementation of recommendations arising out of the Overview Report, for submission to the Home Office along with the Overview Report and Executive Summary.

Liaison with the victim's family and [alleged] perpetrator and other informal networks

35. The review will sensitively attempt to involve the family of Lisa the review, once it is appropriate to do so in the context of on-going criminal proceedings. The independent chair will lead on family engagement
36. David is deceased and therefore the alleged perpetrator will not participate in the review.
37. Family liaison will be coordinated in such a way as to aim to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.
38. The Review Panel discussed involvement of other informal networks of Lisa and David. The panel agreed to review networks and reach out as relevant to the review.

Media handling

39. Any enquiries from the media and family should be forwarded to the Tewkesbury Borough Community Safety Partnership (CSP), in conjunction with Safer Gloucestershire who will liaise with the independent chair. Panel members are asked not to comment if requested. The Tewkesbury Borough Community Safety Partnership (CSP), in conjunction with Safer Gloucestershire will make no comment apart from stating that a review is underway and will report in due course.
40. The Tewkesbury Borough Community Safety Partnership (CSP), in conjunction with Safer Gloucestershire is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

41. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.
42. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this review and for the secure retention and disposal of that information in a confidential manner.
43. It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Documents will be password protected.

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

44. If an agency representative does not have a secure email address, then their non-secure address can be used but all confidential information must be sent in a password protected attachment. The password used must be sent in a separate email. Please use the password provided to you by the Standing Together team. They should be reminded that they should remove the password and only share appropriate information to appropriate frontline staff in line with the review Confidentiality Statement and the specific Terms of Reference.
45. If you are sending password protected document to a non-secure email address, it must be a recognisable work email address for the professional receiving information. Information from review should not be sent to a Gmail / Hotmail or other personal email account unless in rare cases when it has been verified as the work address for an individual or charity.
46. No confidential content should be in the body of an email to a non-secure email account. That includes names, DOBs and address of any subjects discussed at review.

Disclosure

47. Disclosure of facts or sensitive information will be managed and appropriately so that problems do not arise. The review process will seek to complete its work in a timely fashion in order to safeguard others.
48. The sharing of information by agencies in relation to their contact with the victim and/or the alleged perpetrator is guided by the following:
 - a) The Data Protection Act 2018 governs the protection of personal data of living persons and places obligations on public authorities to follow 'data protection principles': The 2016 Home Office Multi-Agency Guidance for the Conduct of reviews (Guidance) outlines data protection issues in relation to reviews (Par 98). It recognises they tend to emerge in relation to access to records, for example medical records. It states 'data protection obligations would not normally apply to deceased individuals and so obtaining access to data on deceased victims of domestic abuse for the purposes of a review should not normally pose difficulty – this applies to all records relating to the deceased, including those held by solicitors and counsellors.
 - b) The Guidance and the Explanatory Notes to the Domestic Violence, Crime and Victims Act 2004 paragraph 7 of Section 2, states that the purpose of a review is to safeguard victims (see Section 2, paragraph 7(a)) and to prevent domestic violence and homicide (see Section 2, paragraph 7 (d)). Therefore, the legal power to share with the Review is created by Section 7(2) of Part 2 of Schedule 2 of the Data Protection Act 2018.
 - c) Data Protection Act and Living Persons: The Guidance notes that in the case of a living person, for example the [alleged] perpetrator, the obligations do apply. However, it further advises in Par 99 that the Department of Health encourages clinicians and health professionals to cooperate with domestic homicide reviews and disclose all relevant information about the victim and where appropriate, the individual who caused their death unless exceptional circumstances apply. Where record holders consider there are reasons why full disclosure of information about a person of interest to a review is not appropriate (e.g. due to confidentiality obligations or other human rights considerations), the following steps should be taken:
 - o The review team should be informed about the existence of information relevant to an inquiry in all cases; and

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

- The reason for concern about disclosure should be discussed with the review team and attempts made to reach agreement on the confidential handling of records or
 - partial redaction of record content.
- d) Human Rights Act: information shared for the purpose of preventing crime (domestic abuse and domestic homicide), improving public safety and protecting the rights or freedoms of others (domestic abuse victims).
- e) Common Law Duty of Confidentiality outlines that where information is held in confidence, the consent of the individual should normally be sought prior to any information being disclosed, with the exception of the following relevant situations – where they can be demonstrated:
- i) It is needed to prevent serious crime
 - ii) there is a public interest (e.g. prevention of crime, protection of vulnerable persons)
49. If there is a police criminal investigation, the police are bound by law to ensure that there is fair disclosure of material that may be relevant to an investigation, and which does not form part of the prosecution case. Any material gathered in this review process could be subject to disclosure to the defence, if it is considered to undermine the prosecution case or assisting the case for the accused.
50. The independent chair will discuss the issues of disclosure in this case with the police Disclosure Officer.
51. The independent chair, police and CPS will be minded to consider the confidentiality of material at all times and to balance that with the interests of justice.

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

Appendix 3: 'Lisa' DARDR ACTION PLAN							
Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome	RAG Rating
National Recommendations							
NHS England to support local ICBs to review internal processes to ensure that systems are appropriately capturing home make up.	National						
Multi-Agency Partnership Recommendations							
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.	Local	Chair of SG to write to key partners to highlight the recommendation and seek reassurance	Safer Gloucestershire	As per 'action to take'	Complete prior to publication	Chair of Safer Gloucestershire has written to all partners of Safer Gloucestershire and the County's emergency services collaboration board to ensure that relevant and timely safeguarding referrals are made	
Safer Gloucestershire to ensure that their members attend training which includes detail of multiple disadvantage.	Local	To ensure the ongoing work across the county into multiple disadvantage is reviewed by SG and included within its	Safer Gloucestershire	As per 'action to take'	Ongoing	GCC are currently undertaking work under the 'Making Every Adult matter' theme	

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

		workplan.				which seeks to address multiple disadvantage. Many SG members are already part of this workstream, but when it is more progressed, it will feature in the workplan for Safer Gloucestershire.	
Safer Gloucestershire to review the impact of lockdown on the work of their partnership practice.	Local	Chair of SG to write to key partners to seek reassurance that learning from lockdown has been considered and changes embedded into practice	Safer Gloucestershire	As per 'action to take'	TBD by Safer Gloucestershire	Multiple partnership reviews were already completed following C19 to learn lessons for the future. The Chair of SG has written to the Local Resilience Forum to ask how these recommendations were implemented in Exercise PEGASUS, the national Tier 1 pandemic exercise last year to ensure cross-over of learning.	

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

						More broadly, the OPCC has completed work to ensure the view of victims of crime will be considered in future emergencies.	
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.	Local	<ul style="list-style-type: none"> -Build awareness raising into DA LPB comms sub group forward plan -Roll out awareness campaign -Ensure DA strategy for 2025-2028 includes considerations around multiple disadvantage 	DA LPB comms sub-group and DA LPB strategic group	As per 'action to take'	December 2025 and ongoing	<p>New county DA strategy includes work streams around multiple disadvantage. This will be long term ongoing work.</p> <p>Update 28/01/26: The county has begun the MEAM process looking at multiple disadvantage across the county. This work will feed in to the DA LPB.</p>	
Gloucestershire Domestic Abuse Local Partnership Board to raise awareness of the links between suicide and domestic abuse.	Local	-Establish a working group alongside the suicide prevention partnership to review local approach and action to be taken to support suicide prevention in DA	County DASV Strategic Coordinator	As per 'action to take'	December 2025 and ongoing	DA and suicide prevention working group established and developing a bespoke action plan in conjunction with	

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

		cases -Link into DA LPB comms sub-group and build awareness raising into rolling plan				the county suicide prevention partnership.	
Gloucestershire Domestic Abuse Local Partnership Board to identify how to raise awareness of domestic abuse perpetrated by carers.	Local	-Build awareness raising into DA LPB comms sub group forward plan -Roll out awareness campaign	DA LPB comms sub-group	As per 'action to take'	TBC with comms subgroup	DA comms sub group established and group will build this in to future plans	
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).	Local	-Ensure this recommendation is considered within the recommissioning of the DA services locally	Gloucestershire County Council Public Health Commissioner for DA		April 2025 and ongoing	GDASS new contract includes the provision of support for minoritised groups and where possible engaging with 'by and for' services (currently a challenge due to limited/no provision locally that is specific to DA. Other services will be recommissioned with the same approach.	
The Gloucestershire Domestic Abuse Local Partnership Board to ensure that their members have stand-alone domestic	Local	-Issue policy guidance -Request DA LPB members report back	DA LPB Strategic Group	As per 'action to take'	June 2025 and ongoing	Policy guidance issued across the partnership.	

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

abuse policies in place which also include detail of the link with suicide and multiple disadvantage		on policy progress -DA and suicide working group to consider how best to incorporate this into policy guidance.				Mapping with majority of LPB members already taken place in 2023/24. To be followed up with specific reference to suicide and multiple disadvantage. DA and suicide working group has been established.	
The Gloucestershire Domestic Abuse Local Partnership Board to raise awareness of domestic abuse and the risk that abusers pose to victims.	Local	-Build awareness raising into DA LPB comms sub group forward plan -Roll out awareness campaign	DA LPB comms sub-group	As per 'action to take'	TBC with comms subgroup	DA comms sub group has run a number of awareness campaigns throughout 2025 that focus on various themes on DA risk and victim awareness. This work will continue as BAU.	
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.	Local	-Build awareness raising into DA LPB comms sub group forward plan -Roll out awareness campaign	DA LPB comms sub-group	As per 'action to take'	November 2024	16 days of action campaign for 2024 focused on awareness raising for family and friends.	

Gloucestershire Health and Care NHS Foundation Trust

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

<p>Gloucestershire Health and Care NHS Foundation Trust to review their processes in relation to their responsibility in identifying and supporting carers.</p>	<p>Local</p>	<p>Carer Support policy already in place and recently reviewed. Trust wide Comms will have been sent to highlight this. Produce a Safeguarding Focus on carer support.</p>	<p>GHC</p>		<p>September 2025</p>	<p>Carers Support Policy was last reviewed in April 2025.</p> <p>GHC have an Ambassador for Carer Practice and a dedicated page on the GHC Staff Intranet with information for staff on how they can support carers.</p>	
<p>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.</p>	<p>Local</p>	<p>Diversity and Inclusion Policy was due for Review in December 2024. Produce a Safeguarding Focus on supporting service users with multiple disadvantages.</p>	<p>GHC</p>		<p>September 2025</p>	<p>Update Feb 25: No update yet re Policy, I have contacted our EDI Lead and her line manager (Head of Organisational Development and Leadership) for an update.</p> <p>On a positive note, Trust teams from the Complex Emotional Needs service and the CHPSS (Complex</p>	

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

						Homelessness Partnership Support Services) team have engaged with the MEAM (Making Every Adult Matter) coordinator at the Local Authority to assist in working with people experiencing multiple disadvantage. The Safeguarding team will be having a presentation from the MEAM coordinator (GCC) with a view to producing the Safeguarding Focus as per the action.	
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.	Local	GHC Domestic abuse training plan - In conjunction with GDASS DA training has been reviewed and slides updated ready for wider delivery across GHC. A training plan for	GHC		Ongoing	Six sessions have already been delivered at Charlton Lane Hospital with a focus on DA and older people. Four more sessions are due to be delivered in	

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

		<p>2025 is in place and will focus on bespoke training for priority areas.</p> <p>Following a recent DHR recommendation a shared GDASS offer with Crisis Team Managers & First Point Contact Manager is now in place. A lunchtime teaching program for community hospitals + urgent care – bespoke DA session has also been planned for May 2025.</p> <p>The training includes:</p> <ul style="list-style-type: none"> • Understand the definition of domestic abuse and coercive control • Understand domestic abuse perpetrator behaviours • Be able to recognise domestic abuse risk factors • Explore how domestic abuse 				<p>June and July 2025.</p> <p>Update Feb 25: bespoke GDASS training has been completed – Gem may be able to fill you in more.</p> <p>GDASS bitesize learning is due to launch this month – this is a learning lunch delivered via teams 12-1pm by GDASS. The topics for the next 6 months are: Coercive controlling behaviour; Familial Abuse; The impact of domestic abuse on children; Stalking; Domestic abuse and older people; Domestic abuse and the workplace</p> <p>We have</p>	
--	--	--	--	--	--	---	--

		<p>specifically impacts people with mental health needs</p> <ul style="list-style-type: none"> • Understand how to complete the DASH risk assessment with victims/survivors of domestic abuse. • Understand high-risk indicators of domestic abuse. • Know how to refer to MARAC and understand the MARAC process <p>Provision of domestic abuse focussed training will be kept under review. A meeting is in place to consider Talking Therapies and specific training needs of this service as a future priority. Dates are also being offered to all staff including Admin, Receptionists, Clinical, Non-Clinical based at Wotton Lawn Hospital.</p>				<p>approached the safeguarding champions for the trust to become DA champions to work with GDASS, and we're seeking details of how much interest there has been.</p> <p>In regards to training Kirsty and I attended a meeting on Friday and we have decided to concentrate on implementing DA level 2 training and this will be essential to role for all staff that have to complete safeguarding level 3 training – adult and children practitioners. This will be for 2613 practitioners, the sessions are half a day so will need to do 3 sessions a month for compliance.</p>	
--	--	--	--	--	--	---	--

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

						Training has been completed with Charlton Lane staff, as well being offered to CRISIS service, GRIP team and Talking Therapies (seeking further details of progress towards this).	
Mental Health Liaison Team to provide assurance to Safer Gloucestershire that they are routinely undertaking domestic abuse risk assessments.	Local	<p>Screening questions are asked by the MHLT whenever there is evidence of concern, expression of risk or vulnerability. Routine internal note audits monitor and report against standards; including DA.</p> <p>Staff have 2 potential escalation routes and are advised to use one, or both depending on the situation.</p> <p>MHLT work closely</p>	GHC		Ongoing		

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

		<p>with the DA Lead in GHFT safeguarding team, and the safeguarding Adults Departmental Lead.</p> <p>All evidence of risk, including but not exclusive to DA, is dual recorded on both RiO and Sunrise systems ensuring transparency in real time.</p> <p>MHLT staff are also aware of how to make direct contact with GHC safeguarding team and how to complete and submit DASH.</p> <p>Typically either GHC or GHFT staff will mutually agree which professional will lead on the submission and, given that patients are exclusively under GHFT treatment, they tend to take lead. However, both parties can make independent submissions if required.</p>					
--	--	---	--	--	--	--	--

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

<p>Staff support and training opportunities would be further enhanced by having a dedicated Domestic Abuse Lead within the Trust.</p>	<p>Local</p>	<p>Continue discussions with GHC management and the ICB regarding funding for this post.</p>	<p>GHC</p>		<p>Ongoing discussion</p>	<p>Update Feb 25: This remains an ongoing discussion although currently paused. Due to ICB changes no definitive answer will be available in the short – medium term but GHC remains firmly behind the recommendation.</p>	
<p>Promote the use of the DASH tool within GHCFT.</p>	<p>Local</p>	<p>See staff training section above.</p>	<p>GHC</p>		<p>Ongoing</p>	<p>Update Feb 25: The GDASS training referenced above promotes DASH, and Safeguarding Practitioners in GHC team promote the use of DASH – the biggest opportunity for doing this is via our advice line, of which DA is the single most common topic for calls.</p>	

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

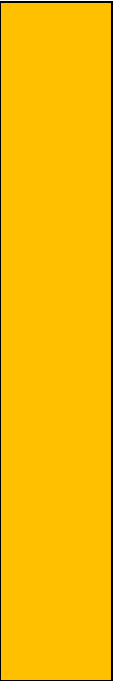
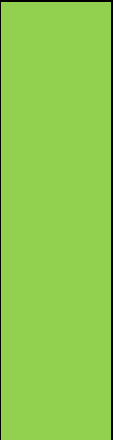
<p>Consideration of the impact of domestic abuse in relation to assessment and management of risk of suicide.</p>	<p>Local</p>	<p>GHC to develop staff awareness on the impact of domestic abuse in relation to assessment and management of risk of suicide. This will be done through safeguarding supervision, production of a Safeguarding Focus.</p>	<p>GHC</p>		<p>By the end of 2025</p>	<p>Update Feb 25: Trust rolled out a new Safety Assessment in Mental Health process which marks a shift from risk assessment to safety assessment, promoting a more therapeutic, person-centred approach that focuses on care, collaboration, and clinical understanding rather than prediction and scoring. Within that are new safety assessment templates on the Trust intranet which reference self harm / suicide as well as the DA risk to others – we have pointed out the suicide risk within the context of DA to the relevant new policy owner and will seek</p>	
---	--------------	--	------------	--	---------------------------	--	--

						some clarity about how the new process might address this.	
Gloucestershire Constabulary							
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.	Local	-Roll out of DARE training across the force -Plans for ongoing CPD from DARE -Develop links with local respect accredited service PRG to ensure opportunities for ongoing training are considered	Learning and Development	As per 'action to take'	April 2025 (and ongoing)	DARE training rolled out and L&D will pick up the ongoing delivery following the Hampton Trust delivery. PRG are currently reaching into the force to develop pathways for the service (this will be ongoing)	
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.	Local	-Roll out of DA Matters -Review of secondary risk assessment process and options for bringing in a specific tool -Roll out of DARA	Constabulary DA Steering Group (DCI lead for DARA subgroup)	As per 'action to take'	March 2026	Update April 2024:DA Matters roll out complete. DARA subgroup established and review of secondary risk assessment process underway. Roll out of DARA will take place once NICHE has been	

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

						rolled out across the force. Action is on track	
Police to ensure that they are appropriately sharing information with other forces on perpetrators who live across different areas.	Local	-Appropriate use of PND -High risk offenders with current orders are shared appropriately via FIB)	Superintendent DA lead for constabulary	As per 'action to take'	BAU	BAU	
Arrest all domestic abuse suspects unless exceptional circumstances apply and authorised by a Det. Inspector with a detailed THRIVE+ rationale.	Local	-Clear directive to be given re: positive action for DA and inspector authorisation -Revise force DA -DA matters training	Superintendent DA lead for constabulary	As per 'action to take'	June 2025	Update April 2024: Clear directive given across the force. DA Matters roll out complete. DA guidance under review and to be led by DCI for VAWG. Scrutiny panel established. Action on track Follow up action in 2026 required: to review full DA policy once NICHE in embedded.	

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

<p>Consider Evidence Led Prosecution in all domestic abuse investigations.</p>	<p>Local</p>	<p>-Clear directive on ELP provided -DA Matters Training -ELP guidance and training -DA CPS in house trial to incorporate EIA for ELP.</p>	<p>Superintendent DA lead for constabulary</p>	<p>As per 'action to take'</p>	<p>August 2025</p>	<p>Clear directive already provided, training rolled out and ELP guidance rolled out. CPS trial currently being agreed. Update Jan 26: CPS are embedded in force but not fully utilised. Discussions ongoing to mandate/improve engagement. Charging rates being monitored.</p>	
<p>Consider the use of Domestic Violence Protection Notice in all domestic abuse investigations with violence or threats of violence.</p>	<p>Local</p>	<p>-Training provided to all RIT staff and RIT Dis on the use of DVPN/Os at initial stage of investigation -Training provided to all Supt rank regarding the authorisation and intrusive supervision. -bi-weekly performance data provided to RIT SLT and investigations SLT</p>	<p>Superintendent DA lead for constabulary</p>	<p>As per 'action to take'</p>	<p>January 2025</p>	<p>Complete and ongoing</p>	

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

		re: usage of DVPN/Os - DVPNs reviewed in DMM process					
Ensure MATAC are considered in instances where an offender has been alleged to have committed domestic abuse twice in a 12-month period against one victim or at least one instance of domestic abuse involving a minimum of two different victims in a 12-month period.	Local	-MATAC is currently working through the use RFGS algorithm which incorporates repeat offending.	Superintendent DA lead for constabulary	As per 'action to take'	March 2024	MATAC is in place and ongoing	
Ensure domestic abuse training is mandatory across the organisation and ensure that there is refresher training for staff across the organisation.	Local	-Roll out of DA Matters with mandatory attendance issued -Ongoing CPD for DA rolled out -Roll out of DA Matters champions training -Roll out of 'voice of the child' training as part of DA CPD	Learning and Development	As per 'action to take'	November 2024 (and ongoing)	DA Matters roll out complete with mandatory order issued. CPD roll out ongoing with introduction of DARE and OP Sherlock training. DA Matters champions training roll out is ongoing with plans for champions CPD in place. 'Voice of child' training currently being procured.	

Gloucestershire Integrated Care Board

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

Tewkesbury GP Surgeries to explore the implementation the IRIS best practice domestic abuse model and to link with the GDASS GP Development Workers.	Local	IRIS will not be implemented in Gloucestershire and will not be considered as an extension to the current offer for GPs in Tewkesbury or Gloucestershire. This is due to the funding and implementation of a large scale project, whilst there is current adequate alternative service provision.	GICB Safeguarding team		May 2025		
		Gain clearer understanding of the support and provision of GDASS GP development workers across The Primary Care Network (PCN), and assurance that GP Practices have adequate links with these workers.	GICB Safeguarding team		December 2025	The GPs have been linked up with the GP development worker, at GDASS who presented at our SG Adults Forum in May 2025. Ongoing discussion at GP practice safeguarding visits and	

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

						GDASS' work with voluntary primary care domestic abuse champions across the county.	
Tewkesbury Borough Council							
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.	Local	Attendance at Domestic Abuse Local Partnership Board. Development of Housing Champions Network. Work with Housing Partnership Team to consider strategic approach to DAHA accreditation to enable consistency across 6 districts in the county.	TBC housing and Housing Partnership Team (HPT)	As per 'Action to Take'	Ongoing	TBC Housing Manager attends DA LPB Operational Group. Funding secured by HPT to support DAHA accreditation and strategic approach to DAHA accreditation being considered in light of local government reorganisation. Update 09.02.26: Countywide DAHA Project Lead recruitment to commence during Spring 2026 to support	

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

						accreditation work across TBC and two other district councils. This work will support the embedding of DA activity within TBC's emerging housing strategy.	
Development of a domestic abuse policy for Tewkesbury Borough Council, that clearly sets out the local authority's intentions in recognising and responding to domestic abuse and outlines the response that customers can expect to receive. It is also recommended that the local authority ensure there is a domestic abuse policy in place for staff.	Local	HPT to review and revise Homelessness DA Policy for county. Policy work will be supported by DAHA accreditation.	TBC with support from HPT	As per 'Action to Take'	Ongoing discussion	Work underway to build on the wider work being completed at TBC around training and council motion, and countywide work relating to homelessness. It will link to countywide DA policy guidance. It will also be supported under further discussions around DAHA accreditation	
Development of a related procedure for Revenues, and other relevant teams within the council – Housing, Customer Service, Community Safety/Anti-Social Behaviour which explains in practical terms how the policy	Local	As above, to ensure linked to policy work	TBC with support from HPT	As per 'Action to Take'	Ongoing discussion	As above.	

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

will be applied in practice.							
Development of mandatory training for revenues staff, in coordination with GDASS.	Local	Work with GDASS to establish access to recognising and responding as a mandated training offer for revenues staff, with plans for timely refresher training.	TBC/GDASS	As per 'Actions to Take'	Ongoing	GDASS have delivered training sessions to TBC staff, ongoing work of CSP to develop approach across district council teams.	
Encourage Revenues staff (and Tewkesbury Borough Council staff more generally) to access the GDASS Rural Domestic Abuse Champions Training.	Local	Council-wide motion to support the rural champions approach. Financial investment in Rural Champions from TBC. Regular engagement opportunities with rural champions training.	TBC/GDASS	As per 'Actions to Take'	Ongoing	In December 24, Council motion unanimously adopted which included: Training for all staff in mgr/ frontline positions at TBC and training opportunities for all Borough Cllrs given the opportunity to book training. The Leader of the Council writes to all Parishes/Towns Councils encouraging staff and Cllrs to book	

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

						training. Work with GDASS on the Rural Domestic Abuse Champions campaign and Cut it Out Campaign.	
Gloucestershire Housing Partnership Programme Manager will support the Housing Officer who is part of the countywide Domestic Abuse Housing Champions Network to think about how they can raise awareness of domestic abuse across the Local Authority.	Local	Champions training to be delivered, reflective practice offered. Bi-monthly peer support sessions and monthly best practice and resources.	HPT	AS per 'Actions to Take'	Ongoing	Champion trained and supported. Opportunity to roll out further within housing at TBC.	
South West Ambulance Service							
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.	Regional due to the size of SWASFT	The new safeguarding referral forms already have the question "do you feel safe" added. Training for last year (2024/25) included Domestic Abuse awareness, this continues into the new training developed for 2025/26.	SWASFT	Action already being taken by adding the question to the referral form. Training is ongoing throughout the year due to the size of our organisation. Safeguarding Supervision is ongoing.	Ongoing	Completed and ongoing.	

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

		<p>Due to the status of the current provider of Electronic Patient Record Systems (EPCR's), we are unable to amend and add this to the current EPCR system. SWASFT would look at introducing this question to the EPCR at next iteration.</p> <p>SWASFT have launched Safeguarding Supervision which enables staff to have supervision with a safeguarding specialist and reflect on aspects of safeguarding and practice.</p>					
Charlies Community Support							
Charlies Community Support to develop and embed a domestic abuse policy and implement appropriate training for staff.	Local	Implement a domestic abuse policy, train staff and volunteers. Run group sessions for new volunteers on recognising the signs of domestic abuse using the tool kits from GDASS	Charlie's CEO & Safeguarding Lead	As per 'action to take'	Current staff & volunteers completed Nov 24, ongoing for new recruits	Nov 2024 all staff & volunteers trained, domestic abuse policy reviewed and approved by GDAS, due for a review in November 2025.	

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

Gloucestershire Domestic Abuse Support Service (GDASS)						
GDASS to review initial engagement process and ensure that referrals to mental health and substance use services are made when service user does not want to engage with domestic abuse support.	Local	Review Support Planning Procedure and Case File Management (CFM) System	GDASS Management Team	Procedure and system reviewed and confirm that onward referrals to additional support services in included on intake, review and on closure to service.	March 2025	Procedure is reviewed yearly and shared as continuing CPD, CFM on a monthly basis where this is also reviewed.
GDASS to work in partnership with other agencies to explore information held on domestic abuse history.	Local	-GDASS to continue engagement across the multi-agency partnership -Information sharing / joint working agreements in place with partners - Co-location of staff within MASH, Police, Health etc	GDASS Management Team	As per 'action to take'	March 2025	Information sharing agreements in place with partner agencies, co-location remains and GDASS engagement (MARAC / MATAAC/ MASH) is embedded and on-going
To promote their service to ensure it is offered by multi-agency partners.	Local	-GDASS Professionals newsletter to be promoted across the partnership -GDASS comms strategy to ensure awareness raising of the service offer -Engagement at community events to promote the service	GDASS Management Team	As per 'action to take'	March 2025	-GDASS professional newsletter regularly promoted, service engaging at community events and through it's comms e.g. 16 Days of Action

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

Gloucestershire Fire and Rescue Service							
Agencies working with people who are experiencing poor mental health, substance use issues, or domestic abuse, to invite the GFRS Community Safety Team to give a short presentation to their staff on the fire risk associated with these factors, to improve referrals into GFRS for home fire safety visits.	Local – County Wide	<ul style="list-style-type: none"> - GFRS to carry out gap analysis of agencies who have not made any referrals for home fire safety visits so may be unaware of fire risk factors. - Offer agencies the professional's fire risk factors awareness presentation – in order of risk priority. - Evaluate awareness and monitor inward referral rates, and number of presentations taken up. 	GFRS Prevention Team	<p>Gap analysis by end of May 2025</p> <p>Make offer to Execs of agencies working with people at high or very-high risk of fatal fire June 2025</p> <p>Evaluate presentation and amend as needed.</p> <p>Monitor change to list of agencies making referrals</p> <p>Monitor against Fire Investigation report data for any further gaps.</p>	April 2025 to end October as focused project then BAU	<p>Gap analysis completed 10 April 2025.</p> <p>Contact details collated 16 April 2025</p> <p>Presentation offer letter for Execs of all agencies drafted for issue on 8 May 2025</p>	
That GFRS improve the professional curiosity of supervisory managers, to increase the opportunity for safeguarding.	Local	<p>Arrange more frequent "tea talks" for Safeguarding with anonymised case studies.</p> <p>Create refreshed Safeguarding training</p>	GFRS Prevention Team	<p>Talks to be arranged quarterly to catch different shift patterns</p> <p>Refreshed training has been delivered since March 2025</p>	March 2025 ongoing	<p>Training has been improved and delivered during March 2025 and will continue to June 2025.</p>	

OFFICIAL GPMS- not to be published or circulated until permission granted by the Home Office

		<p>session for supervisory managers</p> <p>Simplify the internal reporting process and include in training.</p> <p>Improve recording process for responding to concerns for welfare – within operational parameters.</p> <p>Review improvements in quality assurance reports</p>		<p>Reporting concerns paperwork simplified in March 2025</p> <p>Process of recording information when responding to “concerns for welfare” has been improved, to capture names so that repeated calls can be monitored and agencies contacted</p> <p>Improvements being monitored in quality assurance process - BAU</p>		<p>Complete</p> <p>Complete and being monitored in practice.</p> <p>Ongoing</p>	
--	--	--	--	--	--	---	--