Domestic Homicide Review (DHR)

Overview Report into the death of ‘Daniel’

February 2022

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Overview Report Author

v.14

Date: May 2024

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Preface

This is a Domestic Homicide Review Report referring to the life and death of Daniel. This is the pseudonym chosen by the panel and will be used throughout this report.

I would like to begin by expressing my sincere sympathies, and that of the panel, to the family and friends of Daniel. This review has been undertaken in order that lessons can be identified to inform future responses to domestic abuse.

I would like to thank the panel and those that provided chronologies and individual management reviews for their time and co-operation.

1. Introduction

1.1 This report of a domestic homicide review (DHR) examines agency responses and support given to Daniel, a resident of Nottingham prior to his death in February 2022.

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

1.3 The review considers agencies contact and involvement with Daniel from January 2018, when there was a clear escalation in disclosures and more agencies becoming actively involved, to the date when Daniel died by suicide in February 2022.

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

1.5 Every effort has been made to conduct this review process with an open mindset and to avoid hindsight bias. Those leading the review have sought the views of family members and made every attempt to manage the process with compassion and sensitivity.

2. Timescales

2.1 Nottingham Crime and Drugs Partnership (now known as the Nottingham Community Safety Partnership) was notified of Daniel's death, by Nottinghamshire Police on the 24th March 2022. Following notification, the agencies involved were identified and provided an initial trawl of information known. On the 7th December 2022 the decision was made to undertake a Domestic Homicide Review.

2.2 The first panel meeting took place on the 10th January 2023 where the Terms of Reference for the review were formulated and agreed. An Agency Report author briefing was conducted on the 24th January 2023 and agencies were asked to submit their Agency Reports and chronologies by the 6th March 2023, this was later amended to the 27th February 2023 to allow disclosure of the Agency Reports to the Coroner[1].

[1] Agency Reports were made available to the Coroner 'for her eyes only' and were not included in any disclosure bundles.

2.3 A Professional Learning Event was held on the 27th March 2023 with a recall event on the 26th April 2023 to review the first draft of the Overview Report. The panel met again on the 24th May 2023 to review and sign off the final version of the Overview Report and agree recommendations.

2.4 The Overview Report and Action Plan was presented to the Nottingham Crime and Drugs Partnership Board on the 29th September 2023. The Overview Report and recommendations were agreed subject to some final amendments.

3. Confidentiality

3.1 Pseudonyms have been used for the victim and perpetrator in this case to protect the identities of those involved, and of their families. The pseudonyms were chosen and agreed by the panel as the family of the deceased did not wish to do so. Nevertheless, the family were informed of the pseudonyms used.

4. Terms of Reference

4.1 Statutory Guidance (Section 2.7) states the purpose of the DHR Review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- 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;
- Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- Contribute to a better understanding of the nature of domestic violence and abuse;
- Highlight good practice.

Specific terms of reference set for this review

- Identify examples of good practice, both single and multi-agency.

- Did professionals and agencies respond to disclosures of domestic abuse and coercive and controlling behaviour in accordance with agreed processes and procedures at the time of those disclosures?

- Was the agency's involvement in multi-agency/multi-disciplinary fora (including MARACs) effective?

- Analyse the quality of risk assessments undertaken in respects of both the victim and perpetrator. Were links between Mental Health (including risk of suicide) and Domestic Abuse (including historical domestic abuse) identified when risk was assessed?

- Is there evidence of whether any identified risk had been assessed as reaching the threshold for inter-agency information sharing?

- What evidence is there of communication and information sharing between agencies? How could information sharing, and communication have been improved during the scoping period both within and between agencies?

- Was consideration given to the victim's protected characteristics? What role if any, did these issues play for the victim in accessing services and support?

- To what extent did Covid-19 Lockdown and potential isolation impact on the victim accessing support, e.g., for domestic abuse or mental health services?

- To consider recommendations and actions from previous Domestic Homicide Reviews and assess if they are recurring/reappearing in this review.

5. Methodology

5.1 The method for conducting DHR's is prescribed by the Home Office Guidelines. These guidelines state: "Reviews should illuminate the past to make the future safer and it follows therefore that reviews should be professionally curious, find the trail of abuse and identify which agencies had contact with the victim, perpetrator or family and which agencies were in contact with each other. From this position, appropriate solutions can be recommended to help recognise abuse and either signpost victims to suitable support or design safer interventions".

5.2 Following the decision to undertake the review, all agencies were asked to check their records about any interaction with Daniel. Where it was established that there had been contact all agencies promptly secured all relevant documents, and those who could make an appropriate contribution were invited to become panel members. Agencies that were deemed to have relevant contact were then asked to provide an Agency

Report and a chronology detailing the specific nature of that contact. Where contact was minimal or outside of the scoping period agencies were invited to complete a summary report.

5.3 The aim of the Agency Report is to look openly and critically at individual and organisational practice to see whether the case indicates that changes could or should be made to agency policies and practice. Where changes were required then each Agency Report also identified how those changes would be implemented.

5.4 Each agency's Agency Report covered details of their interactions with Daniel, and whether they had followed internal procedures. Where appropriate the report writers made recommendations relevant to their own agencies and prepared action plans to address them. Participating agencies were advised to ensure their actions were taken to address lessons learnt as early as possible.

5.5 The findings from the Agency Reports were endorsed and quality assured by senior officers within the respective organisations who commissioned the report and who are responsible for ensuring that the recommendations within the Agency Reports are implemented.

5.6 On request from the independent chair, some authors provided additional information to clarify issues raised individually and collectively within the Agency Reports. Contact was made directly with those agencies outside of the formal panel meetings.

5.7 Those agencies who provided Agency Reports or summary reports are detailed within section 7 of this report.

6. Involvement of Family, Friends, Work Colleagues, Neighbours and Wider Community

6.1 Nottingham Crime and Drugs Partnership notified Daniel's parents of the DHR by letter on the 14th December 2022 and invited them to participate in the review. Contact details of the review Chair and Advocacy After Fatal Domestic Abuse (AAFDA) were also provided.

6.2 The review chair wrote to Daniel's parents following the conclusion of the Coroner's Inquest to invite them to contribute to, and participate in, the review. The review chair had email correspondence with Daniel's parents and was able to clarify some questions arising for them with regards to the review. Daniel's parents were provided with the Terms of Reference for the review and signposted to AAFDA for further support. Daniel's parents were notified on the 25th May 2023 that the review had concluded and were advised that there was still opportunity to contribute to the review if they so wished. At the time of writing, Daniel's parents have made no further contact with the chair.

6.3 However, the review was able to ascertain the following views of the family, which had been previously sought by the coroner. Daniel's parents had expressed great concerns regarding Daniel's relationship with Michael. They believed that Michael groomed Daniel and prevented him from becoming independent. They believed that Michael's controlling and coercive behaviour, and mental abuse of Daniel, impacted upon Daniel's mental health causing a deterioration, which essentially led to his death. The parents stated that they tried to maintain a relationship with their son, but due to Michael, their relationship distanced, and they were even prevented from seeing their son.

6.4 Michael was also notified of the DHR, and the Chair wrote to him inviting him to contribute to the review. The review chair spoke with Michael by phone who expressed a desire to participate, however, he did not take up the opportunity during the review process period. Michael was also notified when the review had concluded and advised that there was still opportunity to contribute to the review if he so wished. At the time of writing, Michael has made no further contact with the chair.

6.5 The review were aware through Agency Reports that Daniel had friends with whom he may have confided. Unfortunately, the review was unable to secure contact details for any of Daniel's friends for the purposes of contributing to this review.

7. Contributors to the Review

7.1 The agencies that have contributed to this review are as follows:

- Adult Social Care, Nottingham City Council – Agency Report
- Nottinghamshire Police – Agency Report
- NHS Nottingham and Nottinghamshire Integrated Care Board – Agency Report
- Nottinghamshire Healthcare NHS Foundation Trust – Agency Report
- East Midlands Ambulance Service – Agency Report
- Nottingham University Hospital – Agency Report
- Equation – Agency Report
- Department for Work and Pensions – Agency Report
- Tomorrow Project[2] – Agency Report
- Housing Aid, Nottingham City Council – Agency Report
- Nottingham Sexual Violence Support Service – Agency Report
- Human Flourishing Project[3] – Agency Report
- Nottingham College – Summary Report

[2] The Tomorrow Project are a community based suicide prevention, intervention and postvention service.

[3] The Human Flourishing Project (the HFP) provide free person-centred counselling with the aim of providing emotional and psychologically supportive therapy.

7.2 Agency Report and summary report authors were independent with no direct involvement in the case, or line management responsibility for any of those involved.

7.3 Further specialist advice was sought from Nottinghamshire Health Care Foundation Trust to provide an Autistic Spectrum Disorder perspective, from Equation to provide an LGBT perspective, and from Juno Women's Aid with regards domestic abuse. The review was unfortunately unable to secure specialist input with regards to age and ethnicity.

8. The Review Panel Members

8.1 The DHR panel members were as follows:

Name	Role	Agency
Julia Greig	Independent Chair and Author	Review Consulting
Paula Bishop Louise Graham	Domestic Violence & Abuse Policy Lead Sexual Violence and VAWG Lead	Nottingham Community Safety Partnership
Julie Stevens	Service Manager	Adult Social Care, Nottingham City Council
Joanna Elbourn	Detective Chief Inspector	Nottinghamshire Police
Nick Judge	Associated Designated Nurse	NHS Nottingham and Nottinghamshire Integrated Care Board
Amy Calvesbert	Named Nurse for Safeguarding	Nottinghamshire Healthcare NHS Foundation Trust
Liz Cudmore	Safeguarding Child and Young Person Lead	East Midlands Ambulance Service
Maggie Westbury	Adult Safeguarding Lead	Nottingham University Hospital
Marie Bower	Head of Service	Equation
Katy Pearson	Advanced Customer Support Senior Leader	Department for Work and Pensions
Katie Freeman	Clinical Operations Manager	Tomorrow Project
Fiona Ryan	Clinical Lead	Human Flourishing Project
Debbie Richards	Service Manager	Nottingham City Council – Housing Aid
Deborah Hooten	Operations Manager	Nottingham Sexual Violence Support Services
Julie Tomlinson	Lead Nurse - Safeguarding Adults	DHU Healthcare C.I.C (NHS 111)
Karen Turton	Domestic & Sexual Violence & Abuse Specialist	City Care

John Matravers	Head of Safeguarding, Quality and Assurance	Children's Integrated Services, Nottingham City Council
Jenny Mogensen	Autism Specialist for the review	Nottinghamshire Health Care Foundation Trust
Rebecca Butcher	Head of Student Services	Nottingham College
Geoff Howard	Independent Reviewer (observing)	Review Consulting

8.2 Independence and impartiality are fundamental principles of delivering DHRs. The impartiality of the independent chair and report author, and panel members is essential in delivering a process and report that is legitimate and credible. None of the panel members had direct involvement in the case, or had line management responsibility for any of those involved.

9. Author Of The Overview Report

9.1 Nottingham Crime and Drugs Partnership appointed Julia Greig to chair the review and to author the Overview Report. She works both independently and for a local authority as a registered social worker with extensive social work experience in the statutory sector working with adults. She has completed the Home Office approved course for Domestic Homicide Review Authors provided by AAFDA and is an accredited reviewer using the Serious Incident Learning Process. She maintains her CPD through Review Consulting and the AAFDA Network. She is currently undertaking Safeguarding Adult Reviews and Domestic Homicide Reviews in other local authority areas; this is her first review with Nottinghamshire. Julia Greig is independent of all agencies involved in this case and has never worked in Nottinghamshire or for any of its agencies.

10. Parallel Reviews

Nottinghamshire Healthcare NHS Foundation Trust (NHFT) Serious Incident Investigation

10.1 NHFT undertook a Serious Incident Investigation between June 2022 and February 2023 which focussed on the last four months involvement with Daniel. The Trust's report acknowledged shortcomings, including a lack of curiosity about Daniel's relationship and domestic situation. The report made the following recommendations:

1. Consideration of a clear care pathway to be identified for all patients by one team / individual where cases are perceived to be complex and initially do not meet individual team criteria.
2. Consideration of improved risk assessment and care planning for individuals like [Daniel] who continue to voice ideas of self-harm and distress, ensuring that the look at issues in the present and not solely linked to previous assessments.

3. Improved professional curiosity linked to safeguarding issues and the subtle cues that patients give within assessments.
4. All staff must be aware of alerts on RiO[4] and be mindful of those alerts within assessments, care, and treatment plans.

Criminal process

10.2 Following further interaction with Daniel's parents, the homeowner's family, Daniel's place of work, education establishments, adult social care, GP and previous police contact, police identified a strong suggestion of controlling and coercive behaviour from Michael towards Daniel.

10.3 Electronic devices were seized (laptop, mobile phone, USB's, iPad, and Mac). Despite Michael disclosing that one of the devices was his, the passwords were not known. The devices were sent away for analysis but to date they either cannot be accessed or have nothing of significance on them.

10.4 Michael was arrested. Police searched the property, spoke to members of the household, examined relevant financial matters and the Will that Daniel had made. The police were unable to gather sufficient evidence to bring a charge of coercive controlling behaviour.

Coronial process

10.5 An inquest into Daniel's death was opened in August 2022 and a hearing took place in March 2023. The coroner determined death as suicide as a result of pentobarbital[5] toxicity and stated:

10.6 '[Daniel] died at his home address [redacted] on the [redacted] February 2022. He had Autism Spectrum Disorder and had a long history of suicidal ideation. He took his own life, forming a clear intention to do so.'

10.7 The coroner identified significant issues of care at the Nottinghamshire Healthcare NHS Foundation Trust and confirmed that a Regulation 28[6] letter would be sent to the Chief Executive of the Nottinghamshire Healthcare NHS Foundation Trust, setting out the outstanding matters giving rise to concern, which included:

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[4] electronic patient records (EPR) system

[5] Pentobarbital is a medication used to manage and treat several medical conditions, including seizures, intracranial pressure control, insomnia, and as a pre-anaesthetic.

[6] After an inquest, the Coroner can write a 'Prevention of Future Death' or 'Regulation 28' report. This occurs where the Coroner has heard evidence that further avoidable deaths could happen if preventative action is not taken. The report is sent to the person/authority who have the power to make the suggested changes. They must respond to these within 56 days showing how they have made changes according to the Coroner's recommendations, or how they intend to.

- Delayed progress of the Autism Strategy work across the Trust
- Insufficient progress with Complex case management
- The Serious Incident Investigation process

11. Equality And Diversity

11.1 The nine protected characteristics in the Equality Act 2010 were assessed for relevance to the Review. Daniel was a 23 year old Asian British gay man, of Sri Lankan heritage, with a diagnosis of Autistic Spectrum Disorder (ASD). He also experienced depression and suicidal ideation. His religion could not be confirmed but it was noted that Daniel referred to 'Catholic guilt'.

11.2 Michael was a 64 year old White British gay man at the time of Daniel's death. Nothing is known about his potential vulnerabilities.

11.3 The Home Office analysis of Domestic Homicide Reviews (2020-21)[7] summarises information and recommendations from domestic homicide reviews for the 12 months from October 2020. Fifteen of the 113 victims in the DHRs reviewed died by suicide, four were male and the average age was 32.

11.4 Although the average age of victims overall was 43 years old, 21% of victims fell into the 18 to 29 year old age group. Twenty-three percent of victims were male, and 89% of perpetrators were male. In the relationships between victims and perpetrators, 67% of the victims were or had been a partner of the perpetrator. Fifty-eight percent of victims had vulnerabilities, with one third of the vulnerabilities was mental ill-health.

11.5 The impact of protected characteristics is explored in detail in the analysis.

12. Dissemination

12.1 In accordance with Home Office guidance all agencies and the family of Daniel are aware that the final Overview Report will be published. Agency Reports will not be made publicly available. Although key issues, if identified, will be shared with specific organisations the Overview Report will not be disseminated until clearance has been received from the Home Office Quality Assurance Group.

12.2 The content of the Overview Report has been suitably anonymised to protect the identity of the male who died and relevant family members. The Overview Report will be produced in a format that is suitable for publication with any suggested redactions before publication.

12.3 The final report was shared with the Nottingham Crime and Drugs Partnership Board in September 2023. Once the report is approved by the

[7] Annex_A_DHRs_Review_Report_2020-2021.pdf (publishing.service.gov.uk)

Home Office, it will be shared with the DHR panel, family, Office of the Police and Crime Commissioner, and Domestic Violence Commissioner, and will be published on the Nottingham Community Safety Partnership website.

13. Background Information (The Facts)

13.1 East Midlands Ambulance Service received a call from Michael at 19:35 hours on a day in February 2022, reporting that Daniel was not breathing. Michael said that he had found Daniel in bed and thought he was dead. Michael had taken Daniel down from the bunk bed and began CPR. It was disclosed that there appeared to be a piece of chocolate in Daniel's mouth which Michael removed. Michael continued to administer CPR until the ambulance arrived. A paramedic pronounced death at 20:02 hours.

13.2 At 20:28 hours Nottinghamshire Police were contacted by East Midlands Ambulance Service who reported the death of Daniel at his home address. It was reported that it was not suspicious, but the death was unexpected.

13.3 Police officers attended the scene. Persons present at the address were Michael, and the two other household members who owned the house. A statement was obtained from both Michael and the male homeowner.

13.4 Michael disclosed that he had returned to the house after his night shift. He saw Daniel who was making breakfast. Michael gave Daniel some sweets and chocolate, they had a cup of tea, and both went to bed at around 09:30 hours. Michael woke up at 19:30 hours and discovered Daniel laying face up in the bunk bed and not breathing. Michael then raised help.

13.5 Police reviewed CCTV at the premises, which included an internal CCTV camera covering the outside of the bedroom door. A brief summary of that CCTV footage is provided as follows:

07:36 - Michael returns to the property.
07:52 – Daniel walks up the stairs with a plate of toast and enters the bedroom.
08:47 – Daniel leaves the bathroom and enters the bedroom.
08:48 – Daniel leaves the bedroom holding towels and enters bathroom but quickly returns to bedroom.
09:00 – Daniel leaves the bedroom and enters the bathroom.
09:11 – Daniel leaves the bathroom, hugs Michael, and enters the bedroom.
12:16 – Daniel leaves the bedroom with a plate of toast, walks downstairs, picks up parcel which was delivered and returns to the bedroom.
12:17 – Daniel leaves the bedroom and goes to the bathroom.
13:30 – Daniel leaves the bathroom and returns to the bedroom. This was the last sighting of Daniel on the CCTV.

13.6 Attending officers completed a body check. There were no marks or injuries to suggest foul play. A piece of chocolate was located on the bedroom floor near to where Daniel was administered CPR, this was recovered and sent for analysis. A post-mortem completed the following day did not identify a cause of death. Histology, heart, and brain were sent for further analysis and traces of Pentobarbital were found.

14. Chronology

Background History

14.1 Daniel was described as being very bright academically and had attained 13 grade A GCSE's. He then went on to study A-Levels, including politics and history.

14.2 Daniel and Michael were in a relationship and lived together. Daniel was aged 17 years old, and Michael was 57 when they met on an internet dating website and commenced their relationship in 2015.

14.3 It was reported that Daniel was meeting men on this website for sex. Daniel was also not getting along with his parents due to coming out as gay and Michael reported to police at the time that Daniel's parents were not supportive of his sexuality and had allegedly booked Daniel on a one-way ticket to Sri Lanka. At the time, Daniel was seen by police, he said he was afraid of what was happening at home but did not want to get his family into trouble. Police referred Daniel to the Honour Based Abuse Team, although it appears that no further action was taken. Police also spoke with Daniel's parents who said they had not booked a ticket to Sri Lanka, clarifying that he could go there to stay with family if he wanted. Police assessed this as parents being concerned for their son, that it was not Honour Based abuse, and that Michael had greatly exaggerated the report.

14.4 Michael stated that he wanted to provide help and support to Daniel and over a two week period, after meeting Michael online, Daniel moved out of his family home and moved in with Michael in January 2016. Daniel's mother contacted police concerned about the relationship and Daniel's vulnerability. Daniel was seen by police who concluded there were no immediate risks or concerns.

14.5 The home address of Daniel and Michael was a three bedroom house owned by an elderly couple who also lived at the address. Michael had lived at the address for around 40 years. Michael was a friend of the homeowners' son, and it was reported he visited the address on one occasion and never left. Daniel and Michael shared a bedroom, sleeping in a bunk bed. The homeowners were unaware that Michael and Daniel were in a relationship.

14.6 Nottinghamshire High School reported that between 2014 and 2015 Daniel showed a deterioration in his mental health. Daniel's sixth form school reported that Daniel was struggling with mental health between September and November 2015 and was referred to a counsellor.

14.7 Nottingham College reported that between 2017 and 2018 that Daniel's attendance declined, his mental health deteriorated, including suicidal thoughts and depression, and safeguarding issues arose in relation to being in a controlling relationship with Michael. The first safeguarding concern was raised by the college with adult social care in January 2017. Daniel was referred for counselling and began to receive weekly one to one sessions with a Learner Achievement Coach from September 2017.

Combined Narrative Chronology

2018

14.8 In early 2018 Daniel disclosed that he was in a controlling relationship and requested supported accommodation from his GP. Daniel's college also noted he was becoming more withdrawn and disengaged.

14.9 In February 2018 Daniel reported to police that Michael had become controlling, would not let him go out with friends and tracked his phone. A DASH was completed with the outcome of standard risk. Two weeks later Daniel's mother contacted police concerned that Daniel was in a controlling relationship, that he was taking anti-depressants and that he would take his own life.

14.10 Daniel's father raised a safeguarding concern with Adult Social Care in March 2018 alleging coercive and controlling behaviour of Daniel by Michael, this included the use of guns to control and bully Daniel. Daniel's father raised concerns again on the 8th May, and his uncle on the 15th May. Daniel told his GP in June 2018 that Michael was giving him amitriptyline and Nytol with alcohol and telling Daniel not to take his prescribed Sertraline; his GP also passed these concerns to Adult Social Care. These further concerns were considered as part of an ongoing safeguarding enquiry by Adult Social Care who shared the allegation around use of guns with the Police.

14.11 The social worker contacted the police again in June 20218 regarding the firearms at the property. Police reported that Michael had lodged his gun with the male homeowner at the property. The social worker raised concerns that male homeowner had early onset dementia. The police conducted a review of the firearms license and removed the firearms license from the male homeowner.

14.12 Adult Social Care remained involved until the 31st October 2018 supporting Daniel in response to the concerns raised around coercive and controlling behaviour. Adult Social Care utilised the college as a safe place to meet

with Daniel and worked in partnership with the Equation Independent Domestic Violence Advocate (IDVA) to support Daniel to keep himself safe and consider his options, which included alternative accommodation. During their meetings with Daniel, he disclosed that Michael had been physically abusive, putting his hands round his throat, using trackers and CCTV, and shared that Michael had been to prison for attempted murder, a matter which police later confirmed with professionals was not true.

14.13 A DASH was completed as medium risk and was referred to MARAC on the basis of professional judgment. The MARAC took place on the 19th July 2018.

14.14 Daniel began to withdraw from the support offered by Adult Social Care and Equation in August 2018, he stated he wished to remain in the relationship and felt he was unable to cope living independently. The safeguarding plan stated that monitoring would take place via the GP surgery and suicide prevention worker. Feedback was given to Daniel's father and the GP with a request to report any new further concerns to Adult Social Care.

14.15 During 2018 Daniel was expressing suicidal ideation. Daniel contacted with the Crisis Resolution Home Treatment Team (NHFT) in April 2018, May 2018, August 2018 (when he disclosed a coercive relationship), twice in September 2018, October 2018. Each call was in response to concerns for his own mental health, with thoughts of self-harm and suicide. Daniel was signposted to his GP, on one occasion to A&E and on another occasion was conveyed to A&E.

14.16 Daniel saw his GP again in August 2018 and informed GP1 that he was accessing the a.s.h usenet group[8]. The GP referred to the Local Mental Health Team (NHFT) and an assessment by Community Psychiatric Nurse (CPN) was agreed.

14.17 On the 13th August the CPN telephoned Daniel. Daniel informed the CPN that he could not talk due to being with his partner Michael and would call them back if he needed to. There was no further contact.

14.18 On the 22nd October 2018 Daniel attended college with the female homeowner and Michael where he said that he had decided to take a year out from college. The college felt the decision was heavily influenced by Michael and shared the information with Adult Social Care.

14.19 Daniel saw his GP in October 2018, following which the GP contacted the crisis team regarding a psychiatric assessment. The duty Local Mental Health Team worker attempted to call Daniel but got no response.

[8] The a.s.h (alt.suicide.holiday) usenet group was originally created to discuss the relationship between suicide rates and holiday seasons. However, it later evolved into a discussion forum where suicidal people could openly share their struggles or research suicide methods. A.s.h is unmoderated and information on suicide methods are uncensored.

14.20 On the 24th October 2018 Daniel contacted police stating that Michael was controlling him, and he wanted to kill himself. Police attended and Daniel stated he was having a "let down" due to be wrongly medicated but had no issues and "couldn't wish for a better family".

14.21 The following day Daniel attended the Emergency Department with Michael stating he was suicidal. A DASH was completed, and Daniel disclosed domestic abuse including coercive control. The DASH assessment was medium risk but due to the significant concerns of coercion and control and Daniel's declining mental health, the risk was escalated to high based upon professional judgment and referred into MARAC. The referral was not received by MARAC.

14.22 Throughout 2018 Daniel engaged with the Tomorrow Project support sessions until November 2018. Michael said that 'listening support offers Daniel a chance to reinforce he should kill himself.'

14.23 Daniel contacted NHS 111 on three occasions, and the police on one occasion, in November stating that he felt suicidal, but declined further assessment.

14.24 Daniel continued to see his GP throughout November and December 2018. On the 7th November 2018 GP1 provided advice and support around suicidal ideation including a review of Daniel's medication.

14.25 Daniel's first contact with the Department for Work and Pensions (DWP) was in November 2018. Daniel disclosed his depression and suicidal intent, and that he was in a coercive relationship.

14.26 Daniel continued to raise his ongoing thoughts of suicide with the Local Mental Health Team in November and he was told to call back if he needed further support. Daniel had his assessment with a CPN in December 2018, accompanied by Michael. Daniel was advised that his regular CPN would call him upon their return to work.

2019

14.27 In January 2019 Daniel asked the CPN if he could apply for supported housing. He said he had stopped taking some of his prescribed medication and that the homeowners forced him to drink alcohol when he did not want to and was made to take the female homeowner's medication. Daniel was advised to seek support from Framework[9] for accommodation. A further CPN appointment was arranged however Daniel did not attend and was therefore discharged from the service.

[9] Framework provide support and housing to people who are homeless Our services - Framework Housing Association (frameworkha.org)

14.28 In March 2019 Insight[10] referred Daniel to the Local Mental Health Team due to him disclosing that he had been looking for ways to end his life.

14.29 Housing Aid[11] referred to Adult Social Care in March 2019 regarding the need for alternative accommodation following concerns of domestic abuse. Housing Aid completed a housing assessment with Daniel in May 2019. When the social worker contacted Daniel he said that he knew he was in a controlling relationship, but it was not that bad. Daniel attended a meeting with Housing Aid and Adult Social Care in June 2019. He was advised on his housing options but decided he did not want to move.

14.30 On the 12th August 2019 Daniel contacted East Midlands Ambulance Service reporting being suicidal, he had belts around his neck but did not think he could jump. He said his thoughts were triggered by an argument with his housemate. Following telephone support Daniel said he felt better and he was left in the care of his friends (Michael and the homeowners).

14.31 On the 21st August the Sexual Violence Support Services conducted an assessment for therapy and accepted Daniel on to the waiting list for long-term Person-Centred Therapy.

14.32 In September 2019 Daniel called police reporting suicidal threats by Michael. Police attended and saw Michael who said that Daniel had taken what he said too literally due to his Aspergers, that he was fine and there were no concerns for his welfare.

14.33 In October 2019 Daniel attended Maytree[12] for four days respite.

14.34 The Local Mental Health Team received a referral from the Trent Psychological Therapy Service[13] on the 19th November 2019 identifying self-harm risks, suicidal thoughts, and a private admission due to trying to hang himself. A CPN assessment was agreed. The CPN completed an assessment with Daniel, Michael was also present. No were risks identified and records reported that Daniel's presentation was in keeping with his Autistic Spectrum Disorder (ASD) diagnosis. The CPN planned to discuss Daniel's case at the multi-disciplinary meeting. Daniel and Michael were given contact details for the Crisis Resolution Home Treatment team for further support if required.

14.35 Daniel saw his GP throughout 2019. His medication was reviewed and talking therapies was discussed as an alternative to medication. Daniel requested a referral to a psychiatrist for diagnosis and better understanding of his condition which the GP agreed to.

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[10] NHS Talking Therapies

[11] Housing Aid delivers the statutory homeless function within the Nottingham City area.

[12] The Maytree Suicide Respite Centre offer a free 4-night/5-day stay for people experiencing suicidal thoughts. Maytree | We're open to suicidal feelings

[13] Trent Psychological Therapy Service is commissioned by the NHS to provide psychological therapies for anxiety, depression and other common mental health problems, in Derbyshire.

2020

14.36 In January 2020 Daniel contacted the Crisis Resolution Home Treatment team expressing increased suicidal thoughts and he contacted the police reporting a domestic disturbance involving him and Michael. Following police attendance, officers were satisfied to leave all parties at the address. Daniel later relayed to his GP that he had called the police because he thought Michael would kill him.

14.37 Following the CPN's assessment in December 2019, Daniel was referred to Nottingham City Autism service. The service reviewed the referral and agreed that a Cognitive Behaviour Therapy (CBT) therapist would offer a telephone consultation to Daniel. The CBT therapist attempted to call Daniel on the 25th March, but he did not answer.

14.38 Daniel's first session with the Sexual Violence Support Service took place online on the 1st June 2020, Michael was present in the background. The second session took place on the 8th June. The therapist explained that Michael's presence was not appropriate, and this would not work moving forwards. Daniel assured the therapist that he was safe and did not want to be anywhere else. Daniel had three further sessions in June 2020 and no concerns were identified.

14.39 Daniel's sixth Sexual Violence Support Service session took place on the 6th July 2020. The session had to end early as Michael joined the session and displayed worrying behaviours towards Daniel (arm around Daniel's neck/chest in a controlling manner and speaking on behalf of Daniel). The therapist shared their concerns with the GP and stated that they could no longer work with Daniel due to the risks. Daniel was moved to the 'covid pause list', with a view to seeing him face to face once restrictions were lifted.

14.40 Daniel contacted NHS111 on the 7th August regarding his mental health and reported an attempt to end his life. Ambulance crew attended and Daniel declined any care, reporting he was being supported by his partner.

14.41 There was a further report of a domestic incident made to the police by Daniel in August 2019. Upon police arrival Daniel was on his bed and there were no complaints from either Daniel or Michael.

14.42 In November DWP held a case conference with Remploy[14] who were supporting Daniel. Remploy were concerned about Daniel's suicidal ideation. Daniel was then seen in person, and it was agreed that a referral would be made to the Safeguarding Team and to the Crisis Resolution Home Treatment team.

[14] Remploy (now Maximus) provide employment support and opportunities to disabled people.

14.43 On the 24th November Crisis Resolution Home Treatment team noted that they have been trying to see Daniel alone due to concerns that he is being monitored closely by Michael and that when the service tried to video call, Michael could be seen in background. The Crisis Resolution Home Treatment team requested a GP summary from the GP.

14.44 On the 26th November Daniel was assessed by a CPN. Daniel was seen alone. Daniel was asked if his partner had ever hit him, Daniel did not reply directly but made a comment about Michael's 'Pandora's Box'. Daniel was not accepted into the service however, 'ongoing suicidal ideation and risk to self by misadventure' was recorded. Daniel was provided with the contact details for Equation and was advised to contact Adult Social Care, Turning Point for emotional support and to self-refer to the Crisis Resolution Home Treatment team if he was struggling.

14.45 On the 3rd December Daniel was referred to the Tomorrow Project. The Tomorrow Project completed their assessment session with Daniel via zoom; Michael was also present. Following a discussion with a safeguarding lead, it was agreed to bring Daniel in for a face to face session in January and for a safety plan to be completed prior to the Christmas break, however contact could not be made with Daniel. The GP was informed of concerns around suicidal ideation. The GP contacted Daniel and Daniel said he was not suicidal.

2021

14.46 The DWP referred Daniel to Futures Positive[15]. The Local Mental Health Team recorded that Daniel was offered employment support and during this appointment Daniel disclosed feeling suicidal. Daniel was advised to contact the Crisis Resolution Home Treatment team if his mental health declined, and information was shared with the CPN to request extra support for Daniel. The Local mental Health Team continued to provide employment support over the phone until February 2021, although the DWP reported that Futures Positive was withdrawn by 6th January 2021 as Daniel was no longer in receipt of secondary mental health services.

14.47 Daniel attempted to cancel his January appointment with the Tomorrow Project citing covid-19 as the reason. The Tomorrow Project called Daniel who confirmed that Michael had written the email. The support session went ahead. The Tomorrow Project raised a safeguarding concern with Adult Social Care citing concerns of control and coercion from Daniel's partner. The Tomorrow Project were asked to complete DASH. Daniel had his next session with the Tomorrow Project on the 27th January. Daniel was offered face-to-face support and whilst he accepted, Michael refused. Daniel continued his sessions with the Tomorrow Project through to May 2021.

[15] Futures Positive is an NHS team providing a holistic person-centred approach to provide Employment support for people who are receiving Secondary Mental Health services.

14.48 Adult Social Care contacted the GP to arrange a meeting with Daniel in a safe environment. The GP confirmed that a referral to the mental health team had been made and offered to meet at the GP practice. Adult Social Care also liaised with Equation who recommended a referral to MARAC based on professional judgement. A referral to MARAC was made on the 4th February 2021 by Equation.

14.49 On the 25th February 2021 Daniel was reviewed by the CPN and assessed as not requiring CPN support. No suicidal plans or psychosis were identified. Daniel was signposted back to the GP and to continue with employment support.

14.50 On the 11th March Daniel was discussed at MARAC. Information was shared and an action plan created to increase safety, reduce risk, and hold the perpetrator to account. Actions taken from the MARAC were for all services to confirm the identity of Daniel when making telephone contact with him as Michael was known to pose as him. It was recommended that Daniel was seen in person where possible. Equation would contact Daniel and arrange an appointment.

14.51 A meeting was arranged with Daniel to meet with Adult Social Care and Equation at the GP surgery on the 31st March. However, Daniel cancelled on the day as he felt it was not needed. Equation contacted the Tomorrow Project asking that they share housing options with Daniel should he wish to flee, if they had a safe opportunity to discuss this with him. The Tomorrow Project had Daniel aware of the emergency options available and provided reassurance that support could be provided.

14.52 Daniel commenced employment in May 2021, working 40 hours a week. He advised the Tomorrow Project that he could not attend further sessions due to work commitments.

14.53 In July 2021 Daniel told the GP that his appetite was reduced. He said he was trying to keep it together and not have a breakdown. He said he went to the shops with the female homeowner, and she had taken him to see his parents twice. Although he would prefer to go alone, he did not because of coronavirus.

14.54 In August 2021 Daniel reported to his GP that he tried to kill himself with one on Michael's braces, triggered by criticism from Michael, and said he had to cope with thoughts of not being good enough to live.

14.55 Daniel had a telephone consultation with GP1 on the 24th September. Daniel reported Michael continued to tell him he was no good. Daniel said he would only move out if the homeowners died, he felt he would have a

worse lifestyle if he moved out and that there were many barriers to doing this.

14.56 On the 28th September 2021 Adult Social Care received a safeguarding concern from Daniel's friend. Daniel had disclosed that Michael controlled him and he sometimes felt like ending it all. The social worker called Daniel who said he had recently left his job due to feeling stressed and suicidal. Daniel said that he last spoke to his GP approximately a year ago and that it was not very helpful. Daniel said he did not feel his relationship was controlling and coercive but that other people did. He said he was willing to speak to adult services further.

14.57 Daniel told his GP in September that he continued to think about suicide daily. Daniel said he would engage with the Human Flourishing project. GP1 said he would refer to the Local Mental Health team. The Local Mental Health team advised that Daniel was not suitable for their service and that referrals should be made to the Attention Deficit Hyperactivity Disorder (ADHD) service. The GP promptly made a re-referral to which the Local Mental Health Team agreed to put Daniel on the CPN waiting list for an assessment. The referral to the ADHD service was not accepted due to there not being enough information relating to ADHD symptoms in the referral.

14.58 Daniel had a further consultation by telephone with GP1 on the 11th October. The GP updated the social worker and reiterated the ongoing controlling and coercive relationship.

14.59 The social worker spoke to Daniel on the phone for over an hour. Daniel said he was not too concerned about Michael's controlling behaviour. Daniel felt Michael was supportive and that he would not cope living without support and may end his life by hanging if this was the case. Daniel stated he was waiting for mental health support and felt he had never had the type of support he needed. Daniel recognised that his relationship was more restrictive than others but said it was better than living on the streets and being homeless. Daniel felt he could not afford supported living. Daniel was provided safety advice and Daniel confirmed that he did not want to leave Michael.

14.60 Daniel emailed Human Flourishing on the 18th October to request counselling.

14.61 The Local Mental Health Team assessed Daniel on the 2nd November by phone. Daniel disclosed he was still made to take other people's prescribed medication and drink alcohol. The assessment identified thoughts of suicide but no plan to carry through with actions. Daniel stated that he rarely left house. Daniel was not accepted into the service. The Local Mental Health

Team documented that the most appropriate service to support Daniel was the Human Flourishing Project. Daniel was advised that the GP should refer to Step 4 Psychology. A letter was sent to the GP and Daniel to advise.

14.62 Adult Social Care made a welfare call to Daniel on the 17th December. Daniel advised that he was using a suicide forum, but had no plans to end his life.

14.63 Daniel had a telephone appointment with GP1 on the 20th December. Daniel said he was having severe thoughts yesterday, thoughts of hurting other people and killing them in the shower. It made him feel like a bad person and he just wanted to kill himself because he did not want to have thoughts about killing others. Daniel said he thought about killing Michael by blows to his head and could picture and hear those images.

14.64 Following liaison with Daniel's GP, the Crisi Resolution and Home Treatment team completed an assessment with Daniel on the 21st December 2021. The assessment identified that Daniel was experiencing a decline in his mood, with sleep and diet affected. Michael stated that this was a result of stressors related to Daniel's parents. Risks were identified as self-harm, thoughts to harm others and feelings of hopelessness.

2022

14.65 Daniel contacted NHS111 on the 9th January with regards his mental health. The Crisis Resolution Home Treatment team provided talking support, Daniel discussed his current relationship and described feeling that he needed more support with his mental health. Daniel reported that he was visualising how he would harm others, including his partner, but stated he would not act on these thoughts. The plan agreed was for Daniel to chase the referral to Human Flourishing.

14.66 Daniel had a telephone appointment with his GP on the 10th January. He said he was having some thoughts of rage. The GP agreed to refer for Step 4 Psychology.

14.67 Adult Social Care discussed Daniel's case internally on the 19th January. It was agreed that Daniel would be contacted, if he was still denying abuse/control and coercion Adult Social Care would liaise with legal services to explore the use of inherent jurisdiction[16]. Legal services subsequently advised that the threshold for inherent jurisdiction would not be met and was therefore not an option.

[16] Inherent jurisdiction is a legal term that refers to the inherent power of a court or a judicial body to make decisions in cases where no specific law or statute exists to address the issue at hand.

14.68 On the 24th January Daniel had his intake appointment with Human Flourishing. Daniel was considered suitable for the service.

14.69 On the 26th January the GP was notified that the referral for Step 4 Psychology had been rejected as Daniel's mental health was too unstable and would therefore not be able to engage.

14.70 The social worker attempted to contact Daniel on the 27th January, 3rd, 15th, 18th and 21st February, he did not answer the phone and messages were left.

14.71 Daniel had a telephone consultation with GP1. Daniel disclosed that he had made some online friends but had issues with the suicide forum. Daniel disclosed he had thoughts about getting barbiturates Nembutal[17] from Mexico.

14.72 On the 31st January the Local Mental Health Team agreed to consider re-referral due the Step-4 Psychology referral being declined. Review of the referral identified instability, impulsivity and Daniel being unsettled. The referral also mentioned 'relationship difficulties'. The Local Mental Health Team referred to Turning Point.

14.73 The GP wrote to the Local Mental Health Team in early February requesting further input for Daniel. The Local Mental Health Team planned to discuss Damiel at their team meeting.

14.74 Michael phoned Daniel's GP surgery, a few days later, not happy with mental health services. He said a GP letter had been sent on Friday regarding Step-4 Psychology. Michael was worried about Daniel and said he would give them until Wednesday to respond otherwise he would make an official complaint to NHFT as this was not good enough.

14.75 The GP's referral to the Local Mental Health Team was reviewed and rejected due to no changes in Daniel's presentation and a decision to continue with a referral to Turning Point.

14.76 Michael phone the Local Mental Health Team reporting that Daniel was threatening suicide. Michael stated that the GP had taken Daniel off all medication and that Daniel was acting impulsively and had bought a car for £14,000 but could not drive. Michael said he would make a formal complaint about the service and would expect an apology if a dead body was found.

[17] Nembutal – generic name: Pentobarbital

14.77 Daniel had his first session with Human Flourishing in February and this reportedly went well. Daniel also had two consultations with his GP in February with nothing of significance noted.

14.78 A week later Daniel cancelled his counselling session with Human Flourishing stating that he did not feel able to come on the bus, he requested future sessions by phone. Human Flourishing discussed this internally and decided that it was preferable to continue with in-person sessions due to an understanding that Daniel had limited space to have privacy at home. This was communicated to Daniel by email on the 1st March.

14.79 A few days later Michael phoned 999 and requested an ambulance as Daniel was not breathing. Crew attended and confirmed Daniel was deceased.

15. Overview

15.1. The overview summarises what information was known to the agencies and professionals involved about the victim and the perpetrator.

15.2. Daniel was known to at least thirteen agencies between 2018 and 2021. All agencies were aware that Daniel and Michael lived together but the nature of their relationship was not always immediately clear to the agencies, with Michael referred to as friend, parent, carer and housemate in agency reports. However, by early 2018 Daniel's GP, Adult Social Care, Police and the college were aware that the two were in a relationship and that Daniel was experiencing coercive and controlling behaviour in his relationship with Michael. This became evident to further agencies as time progressed, and by most agencies at the time of the first MARAC meeting in August 2018.

15.3. All agencies were aware of Daniel's mental health issues and Autistic Spectrum Disorder.

16. Analysis

16.1 The analysis will address the terms of reference and the key lines of enquiry within them. In doing so it will examine how and why events occurred, information that was shared, the decisions that were made, and the actions that were taken or not taken. It will consider whether different decisions or actions may have led to a different course of events. It will also highlight examples of good practice throughout the analysis.

Response to disclosures of domestic abuse

16.2 There were a number of disclosures of domestic abuse throughout the period subject to review. In 2018 Daniel made the first disclosure to his GP in January and to the police in February, whereby he explicitly cited controlling behaviour. Further concerns were raised by his mother, his father, his uncle, his GP and the Include service just in that year. Daniel further disclosed behaviour, which amounted to domestic abuse and coercive controlling behaviour, to Adult Social Care and Equation. Daniel continued to disclose behaviour which indicated coercion and control throughout the scoping period and a number of agencies raised concerns about the same.

16.3 In response to disclosures, DASH risk assessments were completed by police, Adult Social Care, Equation and Nottingham University Hospital. There were a number of instances where DASH risk assessments would have been appropriate to undertake but were not, and opportunities for other services to assess the risk of domestic abuse, and to refer to adult safeguarding services. However, some of the agencies did seek further advice from their safeguarding leads, including the DWP and GP.

16.4 NHFT recognised that routine enquiry was not completed at numerous contacts with Daniel. If routine enquiry had been conducted this may have provided Daniel with opportunities to access specialist domestic abuse services. DASH risk assessments should have been completed after each disclosure of domestic abuse made by Daniel in line with the NHFT Domestic Violence and Abuse policy, these were not undertaken based on the assumption that other agencies were taking responsibility for safeguarding and had already assessed the risk. The fact that Daniel repeated the disclosures on several occasions to different professionals with no positive outcome may have left him feeling despondent.

16.5 Good practice was demonstrated by Adult Social Care in their liaison with specialist services and application of professional judgement to affect referrals to MARAC. The service also initiated safeguarding enquiries in accordance with the Care Act 2014 and the enquiries took account of the further concerns raised and disclosures made during the process. Adult Social Care also identified the presence of firearms which might have been used to exert control, and alerted police on two occasions, who responded in accordance with their own policies and procedures.

16.6 Adult Social Care and Equation undertook safe enquiry with Daniel, utilising the college for joint meetings. Unfortunately, after Daniel withdrew from college in October 2018 it became difficult to undertake safe enquiry with Daniel and it was suspected that he disclosed appointments to Michael who then made Daniel cancel them. Safe enquiry was further compromised by the covid-19 lockdown whereby most consultation with Daniel was undertaken remotely.

16.7 Daniel was deemed to have mental capacity, and so Adult Social Care considered the impact of coercive control on his ability to make decisions and explored the use of the Inherent Jurisdiction of the High Court. The Inherent Jurisdiction of the High Court is an option of last resort but provides a safety net to those whose decision making ability is impaired because of undue influence or duress but are not considered to lack capacity under the Mental Capacity Act 2005. The High Court's primary function is to facilitate the time and space for someone to make a decision free from duress or undue influence. There are cases where the High Court have directed someone on where to live, albeit for temporary duration, and have passed orders to allow professionals to access the adult in their home. Adult Social Care sought legal advice on making an application to the High Court but were advised that there was not sufficient evidence upon which to make such an application.

16.8 The police were contacted by Daniel on six occasions between February 2018 and April 2020 following reported arguments with Michael. A DASH was only completed following the first report. Nottinghamshire police reflected that in 2020 there was a lack of understanding of coercive and controlling behaviour in the Criminal Prosecution Service, and that understanding is better today. A prosecution was not pursued due to Daniel's lack of engagement in supporting a prosecution, the lack of independent evidence, and therefore no prospect of a prosecution. In 2023 all officers wear body worn cameras which are used in response to all domestic abuse incidents, whereby evidence from body worn cameras can help support cases leading to evidence led prosecutions.

16.9 The learning event discussed how and what evidence of coercive controlling behaviour could be gathered. The police said that it would be overwhelming for agencies to report every piece of evidence as and when it arose and suggested that MARAC would be the forum for initiating a request for evidence.

16.10 Responses from police and out of hours mental health crisis services were further compromised through the identification of Michael as a friend, carer, and housemate. It is not known if Michael or Daniel confirmed this was the relationship or whether it had been assumed, particularly due to the age difference, nevertheless there was historical information available to confirm that they were in a relationship. Further exploration of the relationship may have triggered a response involving an assessment of domestic abuse risk and onward referrals.

16.11 In relation to the police response in January 2020, the two other adults in the home were, mistakenly, considered a protective factor. A DASH in January and April 2020 would have been beneficial to assess the level of risk and would have been expected. Police reflected that this occurred three years ago, and since 2020 practice has changed and positive action would be taken now. Following significant work in this area the volume of completed DASHs in the past 18 months has increased significantly.

Assessment of risk

16.12 Specifically in relation to the quality of risk assessments and whether links between mental health (including risk of suicide) and domestic abuse (including historical domestic abuse) were identified when risk was assessed, it is evident that in the main the links were not made.

16.13 There was recognition by some agencies that the domestic abuse Daniel was experiencing was having an adverse effect on his mental health and onward referrals were made to mental health services and information shared with Adult Social Care and the GP as a result. However, the mental health service response focussed on the presenting mental health issue, neglecting the context of domestic abuse. In October 2018, despite a direct disclosure by Daniel and the service being aware of the recent MARAC, mental health services determined that Daniel's presentation was 'in keeping with Aspergers syndrome' and that he was hypomanic due to medication.

16.14 Coercive control was not identified by NHFT as a contributory risk factor to Daniel's mental health, despite the known history. Their agency report identified a gap in learning in respect of professionals' understanding of the impact that continued and sustained coercive control can have on mental health. Following the NHFT internal serious incident review, the Local Mental Health Team invited Equation to attend their team leaders meeting in November 2022 to provide a presentation around coercive control.

16.15 Research undertaken by Refuge and the University of Warwick into the links between domestic abuse and suicide identified that domestic abuse has a long term adverse impact on psychological wellbeing[18]. The fact that Daniel was experiencing suicidal ideation should have been considered in conjunction with the domestic abuse and coercion and control and should have raised the risk for agencies. Mental health of both the victim and the perpetrator are included in the DASH risk assessment, however, this case indicates that there needs to be a greater understanding amongst professionals about the impact of domestic abuse upon mental health and the prevalence of domestic abuse related suicides.

16.16 Although occurring outside of the timeframe subject to review, it is important to reference the allegation of Honour Based Abuse which was made by Michael early in the relationship. Although Daniel subsequently moved to live with Michael, Honour Based Abuse may have been an ongoing risk for Daniel. It is also possible that Michael used this allegation as a means of isolating Daniel further from his family. Either way there was a missed opportunity for agencies to explore the risk of Honour Based Abuse for Daniel and to secure specialist support for him in this respect.

[18] WRAP-Domestic-abuse-and-suicide-Munro-2018.pdf (warwick.ac.uk)

The Suicide Timeline

16.17 The Suicide Timeline[19] provides an eight-stage timeline for domestic abuse related suicide. It is a practical tool, for use by professionals, developed through research and analysis of case studies to understand the interactions between perpetrators of coercive control and their victims, and how these interactions may be linked to escalating and de-escalating risk of serious harm or homicide.

16.18 The stages represent potential escalating risk. The further along the stages, the higher the risk of serious harm, with opportunities at every stage to cease the progression. Each stage provides indicators of perpetrator and victim characteristics. Although the stages are arranged sequentially they are not necessarily mutually exclusive, they can and do overlap, and may not occur in order with 'circling' through the stages occurring in some cases.

Stage	**Alleged perpetrator characteristics**	**Victim characteristics**
1. History	History of domestic abuse, coercive control, stalking, routine jealousy, violence, history of criminal behaviour	History of vulnerability. Previous domestic abuse, coercive control or sexual assault, away from home (student), previous local authority care
2. Early Relationship	Speed and intensity	Speed and intensity
3. Relationships	Dominated by controlling patterns, violence in many cases	Subject to violence, drugs and alcohol, sexual violence
4. Disclosure	Control escalating, violence may escalate, persistent harassment	Starts to tell other about the abuse
5. Help-Seeking	Alleged perpetrator may use victim's mental health against them, may make threats to family/friends, counter allegations	Mental health services, GP for mental health, A&E, child services, social services, police
6. Suicidal Ideation	Alleged perpetrator may encourage suicide, persistent contact, threats	Suicide attempts, self-harm, may so they 'can't go on', may be convinced they will be killed, may have lost custody of the children

[19] Building a temporal sequence for developing prevention strategies, risk assessment, and perpetrator interventions in domestic abuse related suicide, honour killing, and intimate partner homicide - Research Repository (glos.ac.uk)

7. Complete Entrapment	Stalking, threats, persistent contact, threats to others, violence	May say 'I will never be free' or similar,
8. Suicide	Common for alleged perpetrators to find body, in some cases abuse transferred to victim's family	Most common to be at home with ligature, other methods also noted

The 8 stage Suicide Timeline

16.19 Stage one draws on previous research which identified that perpetrators are both repeat and serial offenders and that those who employ coercive control are likely to do so in all their intimate relationships. Criminal behaviour does not just relate to a criminal record and previous convictions, but may also be identified through testimony from professionals, the victim, family or the perpetrator themselves. History may also be identified through behavioural characteristics.

16.20 In relation to the victim, the research identified vulnerabilities from past domestic abuse, sexual abuse, child neglect, bereavement, or eating disorder.

16.21 Little is known about the Michael's history and past relationships. The only recorded offences relate to an attempted burglary in 1983 and possession of firearms without a licence. It was also reported that he was actively looking for 'young troubled boys/men' on the internet in order to 'save' them. Daniel believed that Michael had been to prison for attempted murder. Daniel had also alleged past sexual abuse as a child from a family member.

16.22 Stage two represents the early relationship. It is marked by relationships that develop quickly with early cohabitation, or early declarations of love. Families report the strong influence exerted by the perpetrator at an early stage and often express concerns about the speed of which the relationship developed.

16.23 The early relationship was marked in this case by early cohabitation, within two months of meeting. Daniel's family expressed concerns about grooming, and contacted police concerned about the relationship and Daniel's vulnerability.

16.24 Stage three relates to the relationship. In all cases reviewed relationships were dominated by intimate partner abuse with just over half evidencing serious repeated violence. Control and violence started at an early stage within the relationship.

16.25 The first concern of coercive and controlling behaviour was raised in 2017 and was followed by numerous reports of emotional and physical abuse, and coercion and control throughout the period of Daniel and Michael's relationship. Daniel reported controlling behaviour which included: the use of CCTV cameras and phone trackers; having to take photos to prove his whereabouts; physical abuse such as slapping, grabbing his throat, and inflicting burns; administration of medication he was not prescribed and withholding prescribed medication; forced consumption of alcohol; isolation from friends, family and professionals; control of social media and email; threats of violence; financial abuse; psychological abuse and gaslighting. There was also evidence that Michael controlled the household and that he used the female homeowner to exert control over Daniel.

16.26 During stage four the victim identifies the behaviour of the perpetrator as abusive and may start to disclose, usually to friends and family first. Disclosure may be incremental and may come before explicit help-seeking. Disclosure in health settings is common as the environment may feel more confidential and supportive, although research suggests that victims are more likely to disclose to their GPs than in an A&E setting, with victims returning to surgeries 30 or 40 times before managing to disclose domestic abuse.

16.27 Perceived escalation of the seriousness of the abuse is a key factor in the victim deciding to disclose. Equally shame, perpetrator threats, fear over increased violence, and how disclosure will affect social interactions, were reasons for hesitating to reveal abuse. It was found that early disclosure appeared to be more common in cases of domestic abuse suicide, than homicide cases. It is important for professionals to recognise that a disclosure will not represent the beginning of the risk but will likely be an indication of escalation. Disclosure is distinct from help-seeking as it is more likely to be linked to exploration and validation for the victim.

16.28 The first recorded disclosure by Daniel was in January 2018 when Daniel disclosed to the GP surgery, and soon after to the police. Daniel continued to disclose throughout the timeline to various agencies. Although Daniel's family reported their concerns to police and Adult Social Care it is unknown whether this was following a disclosure by Daniel to his family. It appears unlikely that this was the case as the family did not mention this in their reports and it is known that by this stage Daniel was significantly isolated from his family.

16.29 Help-seeking can occur at stage five, usually after disclosure, and often in response to the victim's perception that the abuse has escalated, and things have become more serious. Active help-seeking can be seen as a threat to the control exerted by perpetrators, as a result there may be consequences, and the perpetrator may also increase their control in response. Perpetrators are seldom deterred as a result of help-seeking, even if the help sought includes police involvement and results in arrest,

prosecutions, civil orders and so on, with perpetrators continuing to exert control despite any sanctions.

16.30 Help is most commonly sought from mental health services and the police. When help is sought from mental health services the help sought is for mental health linked to the domestic abuse being experienced. However, services do not always make those links explicitly; prescription medication is a more common response than specific help with the abuse.

16.31 The victim's mental health help-seeking appears to dominate assessments of them and the victim's assessment of themselves leading to self-blame. The victim being perceived as 'mentally unstable' creates perceptions that they are culpable in the abuse. This can become worse, and attention further diverted when the victim self-harms, talks about suicide, or makes attempts to end their lives. In some cases, it was felt by victims that if they received mental health support they would become 'strong enough' to leave the abuser.

16.32 Daniel was likely starting to seek help in 2018 when he started to request supported accommodation. As time passed Daniel began to deny that Michael was controlling and Daniel's help seeking became focussed on his mental health and suicidal ideation. Daniel talked about ending his life and made two attempts to do so. There are numerous contacts throughout the chronology of Daniel making contact with mental health services and seeking help for his mental health. As has already been mentioned, Daniel's mental health was responded to in isolation from the domestic abuse he was experiencing, links were not explicitly made and the impact of the abuse upon is mental health not fully explored or appreciated. As time progressed and Daniel began to receive more support from agencies there was evidence of Michael's control increasing, including Daniel's withdrawal from college, various appointments cancelled and withdrawal from agency support.

16.33 Furthermore, there was significant evidence of technology facilitated abuse, including the use of phone trackers and CCTV, alleged instances of Michale pretending to be Daniel in email correspondence, and prohibiting a safe and confidential space for online meetings. Such abuse would have limited Daniel's ability to seek help and attend the necessary meetings to receive the support he needed.

16.34 Although suicidal ideation is placed at stage six, this is considered the latest, but most common stage that suicidal ideation was noted in the cases analysed, although in some cases, it appeared in earlier stages, sometimes as early as stage one. Self-harm, suicidal ideation and suicide attempts are sometimes seen as confirmation of mental instability, re-focusing attention on the victim's mental health rather than the abuse.

16.35 Suicidal ideation can occur in parallel with homicidal ideation in perpetrators of high-risk abuse, and all suicidality should be taken seriously.

There were also cases in the sample where the perpetrator had actively encouraged suicide of the victim.

16.36 Daniel was expressing suicidal ideation from as early as February 2018, and he regularly reported this throughout the following three years. It certainly appears that in this case Daniel's suicidal ideation and suicide attempts were confirmation of his mental instability, which re-focused attention on his mental health rather than the abuse he was experiencing, including by Michael.

16.37 At stage seven the victim feels and sometimes vocalises that they feel trapped in a situation from which there is no escape and feel that nothing will get better.

16.38 Interestingly, there is evidence of entrapment very early on in the relationship. In late 2018 despite taking steps to pursue alternative accommodation Daniel resolved that he could not live independently, regularly referring to Michael telling him he had the mind of a twelve year old, and wished to remain in a relationship with Michael. Daniel made statements which indicated feelings of feeling trapped, such as 'I would have a worse lifestyle if I moved out but there are so many barriers to do this', that he could not cope living without Michael, that living with Michael was better than living on the streets, and that he would only leave once the homeowners died. These statements became more prominent from September 2020 and continued into late 2021. Furthermore, there were many indicators of financial abuse, including Daniel leaving his job, the writing of a Will, and the purchase of a car, that would have further fuelled feelings of entrapment for Daniel and was clearly a barrier to him leaving the relationship.

16.39 Suicide occurs at stage eight. The most common method of suicide was ligature and in at least 16 cases the perpetrator was the last person to see the victim and, in many cases, discovered the victim's body. In some cases it seemed clear that the victim had taken their own life and intended to do so, in some cases there was evidence that the perpetrator had encouraged suicide, and some families expressed concerns that suicide had been staged. It is common for the suicide to be accepted based on the mental health history of the victim, especially if there was a history of suicidal ideation.

16.40 Daniel died by suicide as a result of pentobarbital toxicity. Michael was the last person to see Daniel and discovered his body.

16.41 Application of the suicide timeline shines a light on Daniel's experiences of the coercive controlling behaviour perpetrated and the escalation of risk which ultimately culminated in his suicide. Each stage of the Suicide Timeline can be directly applied to Daniel's case and demonstrates how information can be gathered as an aid to assess risk, identify escalations in risk, and consider prevention strategies and interventions. The timeline also

highlights the importance of greater professional curiosity to minimise the risk of misinterpretation of presentations of mental and physical ill health, which may in fact be attempts of disclosure and help-seeking.

Multi agency response

16.42 Daniel was referred to, and heard at, MARAC on two occasions. The first MARAC was held on the 2nd July 2018 following a medium risk DASH which had been escalated to high risk based upon professional judgement, at the time Daniel was 19 years of age. Multiple agencies raised concerns regarding control and coercion and Adult Social Care, Nottinghamshire Police, Equation, NHFT and Childrens Integrated Services shared information. All agencies were instructed to add a domestic abuse marker to their files in relation to Daniel and to note that Michael was not to chaperone Daniel to or during appointments. The police were asked to review the DASH, link in with the Equation IDVA and liaise with the Serious Collision Investigation Unit for further information. Equation was tasked with meeting Daniel to explore risks and Adult Social Care were to review Daniel's history. Other actions were agreed in relation to the homeowners such as sharing MARAC minutes with their GPs. MARAC were unable to report if all agencies completed actions within the agreed timescale and action outcomes were not updated.

16.43 There was no evidence that MARAC considered how ASD could impact Daniel's understanding of what was being explained to him, or his understanding of coercion and control. However, a referral to an appropriate service, Include, was made.

16.44 Although it was noted that Daniel had to undertake chores as he did not pay rent, there was no evidence of discussions around Daniel being exploited for domestic servitude, although this may have been considered as part of the control Michael used over Daniel.

16.45 However, the MARAC allowed agencies to link together to share information and updates. Risk to the homeowners from Michael was considered. Checks for more information and requests for safety measures to be put in place were made. Agencies were made aware that Michael often presented as Daniel's chaperone, and of the potential risks to Daniel from Michael being treated as a chaperone. Daniel's mental health as a result of the domestic abuse he was experiencing was considered and shared. There were plans to review this alongside other risks posed by Michael when the IDVA and social worker next met with Daniel and joint meetings were arranged to enable the IDVA and other agencies to engage with Daniel when he met with the social worker. It was agreed that all contact with Daniel would be through his social worker as a means of managing risks.

16.46 The second MARAC was held on the 11th March 2021. Again, the referral was made based upon professional judgement following discussion with other agencies. Information was provided by Adult Social Care, police, Equation, NHFT, and Housing Aid. All agencies were asked to flag domestic abuse on their systems. Police were asked to review the DASH, Equation were asked to link with Adult Social Care for planned support for Daniel, NHFT were asked to share MARAC minutes with the Local Mental Health Team, to log on their systems that Michael sends emails on behalf of Daniel, and to link with Equation to provide support to Daniel. All actions were reportedly completed.

16.47 All agencies were made aware of Daniel's ASD although there was little evidence of agencies acknowledging this as something they must consider when working with Daniel. Historic information was shared that raised concerns of Honour Based Violence from Daniel's family which does not appear to have been explored further following a referral to the police's Honour Based Abuse team, there was a concern that Michael was seen by some of the agencies as a protective factor for Daniel in this respect.

16.48 Not all the agencies who were supporting Daniel attended the MARACs as they were not part of the core membership. This included third sector providers such as the Tomorrow Project, and the DWP.

16.49 Although there was effective information sharing and planning at both MARACs, there was little discussion noted about what could be done to hold Michael to account. However, it is of note, that where there is no charge for any offences, and no agencies actively involved with the perpetrator, and as such it is more difficult to hold that person to account. This would have been further compounded by Covid 19 and lockdown restrictions.

16.50 The two MARACs were the only multi-agency meetings held in respect of Daniel. The convening of a MARAC relies on any future disclosures triggering the completion of a DASH and a referral to MARAC if the threshold is met. This was an area of learning identified in DHR Chapeau which made the recommendation that 'All MARAC agencies to be reminded that repeat referrals of any risk level within a 12-month period should be referred back to the MARAC. This point to be emphasised in on-going MARAC training.'[20] Repeat MARACs can assist in reviewing the risk, actions and safety plans, and securing evidence. It is then significant that despite ongoing disclosure by Daniel, and concerns raised by agencies, there were only two MARACs held, almost three years apart.

16.51 It was further noted that a referral was made to MARAC in October 2018 but not received by the MARAC, highlighting the need for agencies to follow up on any referrals made and to ensure there are systems in place to acknowledge with the referrer any referrals received.

[20] ncc_dhr-operation-chapeau-exec-summary-26-nov-2020.pdf (nottinghamcity.gov.uk)

16.52 Given the number of agencies involved and supporting Daniel, identification of a lead agency would have been beneficial. Agencies reflected that due to the complexity of the presenting risks it would have been of benefit for agencies to have a separate multi-agency meeting outside of the MARAC to allow for a more detailed discussion around the risks and to develop a multi-agency action plan. Adult Social Care considered themselves to be the lead agency in this case, in terms of safeguarding, who could have coordinated a multi-agency response. However, once safeguarding enquiries were concluded there was no requirement for ongoing social worker involvement, and therefore no lead agency. It is recognised that there is no capacity in the workforce to allocate social workers on a permanent long term basis and therefore other actively involved agencies would have needed to take on the lead role in terms of ongoing support for Daniel.

16.53 Previous DHRs in the Nottingham area have identified a lack of any co-ordinated multi-agency approach with a danger that, if a case does not meet the threshold for MARAC, professionals do not feel empowered to call a meeting to discuss a case. The learning event considered other multi-agency forums available that could have been utilised in this case, and identified the monthly complex persons panel which provides a wraparound multi-disciplinary team coordinated by Adult Social Care. However, agencies felt that MARAC was the most appropriate forum and noted the availability of the MARAC plus meeting for repeat cases which allows additional time for discussion of these complex cases. It is acknowledged that the MARAC forum for repeat cases would not have been triggered for Daniel as there were only two referrals in three years, thus highlighting once again the need for agencies to complete the DASH and referrals to MARAC.

Information sharing

16.54 There were many examples of inter-agency information sharing and communication. There was excellent information sharing and communication between Nottingham College, Adult Social Care, the Tomorrow Project, Housing Aid, and Equation who also shared information with, and made requests for information from, Nottinghamshire Police.

16.55 Information was shared between agencies about the risk of domestic abuse and suicidal ideation. This was achieved not only via the MARACs held but also through referrals made to other agencies, such as Housing Aid.

16.56 There was evidence of good dialogue and information sharing between the GP and Adult Social Care. The GP and social worker also communicated and shared information with multiple partner agencies to

ensure that Daniel was in receipt of supportive services. There was evidence that requests for information and onward referrals were acted upon swiftly.

16.57 The Human Flourishing Project were not aware that Daniel had and was experiencing domestic abuse and coercive control. This was not communicated to them by any other agency because Daniel self-referred to the service and the service was not aware of the other agencies that were involved. It is acknowledged that their involvement was brief and so may not have made a difference in this case, but having this knowledge may have led to them alerting other agencies to the presence of Michael during a meeting, issues of confidentiality and privacy, and non-attendance.

16.58 Throughout NHFT's involvement there were several contacts where risks identified reached the threshold for information sharing between agencies and onward referral to external agencies such as Adult Social Care, in line with NHFT policies and procedures. However, this did not occur as there was an assumption that other agencies were taking responsibility for safeguarding and were already in possession of the information.

Protected characteristics

16.59 Daniel was diagnosed with ASD[21] in 2017. Daniel reported on many occasions that Michael would tell him that he had the mind of a 11/12 year old. Daniel was offered the ASD post diagnostic group. This group is described as an empowering group but is provided as a one-off session; one session would not have been enough to counter the perception perpetrated by Michael.

16.60 With regards to Michael's attendance at appointments, the autism specialist commented that it is common for autistic people to bring others to appointments to manage communication, this would be seen as a reasonable adjustment which conflicts with the notion of safe enquiry in domestic abuse. However, autism assessment requires information from another person (in addition to direct assessment of the client). It is preferable to speak to a parent about the client, but partners are often also included in the absence of parents. Daniel did not give consent to speak to his parents. While Daniel may well have communicated very effectively in sessions, the purpose of the informant is not to communicate on the client's behalf, it is to provide information about their communication, social interactions and evidence of any restricted/repetitive behaviours. People with ASD are not always able to see themselves through other people's eyes, so this third party information is considered an important part of the assessment. During his assessment for ASD the Neurodevelopmental Specialist Service were able to gather a lot of information from Michael reflecting the need for people with autism to have a supporter to manage

[21] Asperger syndrome (autism.org.uk)

communication. However, whilst there are some assessments where it is appropriate to have a supporter, there are other appointments where safe enquiry does not support this approach and professionals need to consider with the person how best to support their communication, including independent advocacy.

16.61 The DWP identified Daniel as a vulnerable customer and a number of steps were taken to provide Daniel with appropriate additional support, such as the involvement of the Disability Employment Advisor, creating six-point plans[22], referral to the DWP Psychologist, Intensive Personalised Employment Support and Employment Individual Placement Scheme, as well as external sources of support, including contact with his GP.

16.62 The GP evidenced making reasonable adjustments in response to Daniel's mental health and ASD, these included facilitating consultations when Daniel was late, providing extended consultations to allow Daniel to express his thoughts and feelings, and making rooms available for Daniel to meet with social workers and the IDVA.

16.63 Daniel presented to mental health services on multiple occasions with suicidal ideation, yet the level of risk associated with this appeared to be minimised and attributed to his diagnosis of ASD and therefore not responded to appropriately. Daniel had a number of comorbidities, which is more common with people with ASD. He suffered with depressive symptoms, anxiety and intrusive and obsessional thoughts, low self-esteem and poor confidence. Daniel's presentation appeared to have been linked to features of his ASD and not attributed to poor mental health. Therefore, treatment identification appeared to be problematic, and he was moved around mental health services without adequate support or a clear treatment pathway.

16.64 Research has shown that people with ASD are at higher risk of suicide than the general population, with up to 35% having planned or attempted suicide. People with ASD are believed to be at greater risk for a number of reasons. Actively masking their ASD can negatively affect their mental health; some experience difficulty in identifying and describing their emotions; they can get stuck and continuously mull over particular thoughts or behaviours, and this persistent thinking can lead to feeling trapped in an unbearable situation. People with ASD also experience a lack of appropriate support and services for their mental health and suicidality compared to the general population.[23]

[22] Six-point plans are completed when a claimant declares an intention to take their own life or self-harm. The process is triggered by the declaration, at which point DWP staff consider whether there is an immediate need to contact the emergency services. DWP staff will also consider signposting to appropriate external organisations who may be able to assist.

[23] Autistic people and suicidality (autism.org.uk)

16.65 It is evident that agencies did not fully consider or understand the impact of ASD upon Daniel's mental health and his understanding of healthy relationships, and would have benefitted from seeking specialist advice. It was clear that there was no agency route/pathway provided by NHFT to specialist advice. Agencies were dependent upon the success (or not) of Daniel accessing mental health and ASD services via the GP.

16.66 One in six to seven men will experience domestic abuse during their lifetime, however, the percentage of gay men (6%) who suffered domestic abuse in 2019/20 is more than for heterosexual men (3.5%).[24] LGBT victims of domestic abuse are twice as likely to have self-harmed and attempt suicide,[25] with one in eight LGBT people having attempted to end their life in the year 2017.[26]

16.67 LGBT victims often find it difficult to seek help for fear of being outed or having to disclose their sexuality. This does not appear to have been a significant factor for Daniel as he reached out and disclosed domestic abuse and his sexuality to a number of agencies. However, just because he disclosed his sexuality it did not necessarily mean he disclosed everything or felt comfortable about sharing his experience of abuse within the relationship. If there was sexual abuse he may have felt uncomfortable talking about it. Furthermore, Daniel had a complex relationship with his family, related to his sexuality and his family's negative response to this. This may have compounded his reliance on Michael for emotional and financial support as he relied on him for his accommodation and sense of belonging. The lack of a multi-agency joint approach, including the fragmented mental health support, and the ongoing feelings of inadequacy reinforced by Michael, may have prevented him from feeling able to function independently.

16.68 Whilst Daniel was able to access support from Equation Men's Domestic Abuse Service, at the time the service did not have a LGBT+ worker. Therefore, it would have been beneficial to secure the services of GALOP as an LGBT+ specialist.[27] Whilst agencies utilised the DASH to assess the domestic abuse risk, the LGBT Special Considerations Checklist (Appendix One) was not utilised. This checklist highlights the specific risk indicators for LGBT victims and would have enabled a greater appreciation of the risks, timelier multi-agency support and MARAC actions that were directly targeted at Daniel's experiences as a gay man.

16.69 Specifically in relation to housing, it is reported that there are concerns about male hostels in the City and fears around homophobia. Daniel may have therefore been concerned once he was told about the accommodation options. Daniel would have benefited from the Safe

[24] Male Victims - Domestic and Partner Abuse Statistics (mankind.org.uk)
[25] Free to be safe web.pdf (safelives.org.uk)
[26] LGBT in Britain - Health (stonewall.org.uk)
[27] Galop - the LGBT+ anti-abuse charity

Accommodation support that is now in available. Whilst the Safe Accommodation statutory duty did not come into force until October 2021, Housing had a discretionary duty to rehouse the vulnerable; experience of domestic abuse supports a person being more vulnerable than the average homeless person.

16.70 Both the age difference and sexuality may have led to the failure of professionals to recognise that Daniel was Michael's partner because of assumptions about relationships. In addition, the age difference between Daniel and Michael would likely have created a power indifference, particularly in the context of Daniel's culture.

Mental capacity

16.71 Adult social care confirmed that for every safeguarding concern and enquiry a social worker will assess the person's capacity to engage with the process. In this case the social worker also assessed Daniel's capacity to understand his relationship, and to consider alternative accommodation. Despite there being a number of social workers assigned to work with Daniel over the years, each one was experienced and competent, and all concluded that Daniel had capacity to make decisions in relation to safeguarding, his relationship and accommodation.

16.72 What was recognised is that it is difficult to assess how controlling and coercive behaviour can impact upon capacity. Although the Mental Capacity Act 2005 does not explicitly mention what to do when a person's relationships and interpersonal influence might affect their capacity, research shows that relational issues frequently arise during capacity assessments and in the Court of Protection, although it appears to be an area in which the court are still finding their way[28].

16.73 It is recommended that professionals assessing capacity should be mindful of interpersonal influence, and if it is suspected all practical steps should be taken to support independent decision making. It is also proposed that relational factors could be considered in the test for mental capacity and there is case law[29] to support the proposition that the assessment of capacity can take into account the interaction between the pressure that the person is under, and the impairment in the functioning of their mind or brain which makes it more difficult for them to understand, retain, use or weigh relevant information. Any argument made on this basis should spell out how the impairment and the interpersonal influence interact to cause the functional inability.[30]

[28] The person seems to be under the influence of someone else - Capacity guide
[29] NCC v PB & TB | 39 Essex Chambers
[30] The person seems to be under the influence of someone else - Capacity guide

16.74 Furthermore, the autism specialist commented that to understand relationships one needs to understand the perspective of others, seeing the world through someone else's eyes, which can be very difficult for people on the autistic spectrum, and it is quite possible that Daniel lacked this ability.

16.75 An added complication was that it was difficult to engage Daniel in terms of meeting with him. People with ASD can have very concrete understanding which can make assessing their capacity complicated, particularly in the areas of assessing someone's ability to weigh-up and use information relevant to the decision, and therefore any determination would require lengthy assessments to assess capacity. The social workers had limited time and opportunity to explore Daniel's understanding thoroughly and on reflection felt that specialist involvement during adult social care interventions with Daniel may have resulted in better outcomes for him.

Impact of covid-19 lockdown

16.76 In March 2020 the UK Prime Minister introduced a nationwide lockdown. All non-essential contact and travel was prohibited, and many services moved to remote working. Restrictions began to ease in July 2020 and people were able to meet up in limited numbers outside. There was further easing of restrictions in August 2020.

16.77 There was a further national lockdown introduced for four weeks on the 2nd November 2020 and from the 21st December 2020 London and the Southeast entered its third lockdown, this was extended nationwide on the 6th January 2021. The 'stay at home' order was finally lifted on the 29th March 2021 with most legal limits on social contact being removed on 19th July 2021 . Therefore, throughout most of the period in scope for this review, the country was in lockdown.

16.78 In some cases, victims' access to ongoing support or help with mental or physical health conditions was reduced during the lockdown, anecdotally people chose not to access services so as not to burden overwhelmed services. Although this does not appear to be the case for Daniel who continued to initiate contact with services. The pandemic also affected waiting lists for some agencies meaning that Daniel had to wait longer for support to be provided to him.

16.79 Adult Social Care reflected on the perception of health and social care services being overwhelmed during the pandemic and wondered whether this prevented others from making safeguarding referrals, although the other agencies participating in this review did not think this occurred in this case.

16.80 Daniel was reportedly spending a significant amount of time in bed during the pandemic and Michael reported that he was encouraging him to get up, which was the reason given in relation to an argument that led to police involvement. Police reflected that incidents occurring during the covid pandemic period and associated lockdown could have been interpreted in the context of people suffering anxiety and isolation during the pandemic.

16.81 During the pandemic a number of agencies moved to remote working, meeting with their clients/patients online or via telephone. In a number of online sessions with Daniel, agencies noted that Michael was present, and some observed his coercive and controlling behaviour during these interactions. This also meant that confidentiality was compromised and led to a withdrawal of services, it also increased the opportunity for technology facilitated abuse. For mental health the default was telephone contact with patients, although a follow up meeting was undertaken face to face, Michael was also present.

16.82 All agencies recognised that remote contact meant they missed communication that would have been conveyed visually. The autism specialist commented that people with ASD found the pandemic and lockdown particularly difficult and said that face to face contact with people with ASD must be the default unless there is good reason for it to be remote.

16.83 The Tomorrow Project continued to see their clients face to face recognising that remote consultation was a barrier to their work. Face to face appointments were offered to Daniel, he initially accepted these then declined by email, believed to be Michael, citing covid as a reason not to travel. The Tomorrow Project confirmed that they would have been able to provide evidence of essential travel to support his attendance.

16.84 Commentary on the impact of the covid-19 pandemic upon people with ASD has highlighted that individuals with ASD may be more during the pandemic due to the communication, socialisation, and executive functioning differences, finding it more difficult to adapt to and absorb the substantial and rapidly changing public health information. As a result, many individuals with ASD may have become increasingly reliant on their families and caregivers. Individuals with ASD may have also had difficulty with some core components of resilience such as making future predictions, envisioning multiple outcomes to a given situation, adapting and being flexible to abrupt changes.[31]

16.85 The covid-19 lockdown undoubtably had an impact upon Daniel. It likely affected his mental wellbeing leading him to feel further trapped in his relationship. It compromised the opportunity to meet with Daniel in a confidential space and to undertake safe enquiry. It also gave Michael the

[31] COVID-19 Pandemic and Impact on Patients with Autism Spectrum Disorder - PMC (nih.gov)

means to exert further control, and there is evidence that he utilised the restrictions to prevent Daniel attending an in-person meetings and to facilitate technological abuse.

17. Conclusions

17.1 Daniel experienced sustained coercive and controlling behaviour for at least four years prior to his death, and in all likelihood the abuse was present from early in the relationship.

17.2 Daniel disclosed controlling behaviour perpetrated by Michael on numerous occasions between 2018 and the date of his death, and agencies identified the risk of domestic abuse and shared concerns. Daniel also experienced depression and suicidal ideation for which he sought help on many occasions. Unfortunately, Daniel did not always receive the mental health support he required and when support was given, links were not made between mental health and the domestic abuse he was experiencing.

17.3 This review has highlighted a number of interacting complexities arising from Daniel's protected characteristics (gender, sex, age, sexuality, disability) which agencies found challenging to work with and, at times, lacked the expertise to respond to.

17.4 Application of the Suicide Timeline has highlighted the increasing risk for Daniel and has highlighted how application in practice can assist with information gathering as an aid to risk assessment, identification of escalating risk, and consideration of prevention strategies and interventions.

17.5 It is acknowledged that the scoping period dates back to 2018 and in the last five years there have been significant developments in responses to domestic abuse as well as new legislation[32]. Agencies have demonstrated, through this review, changes in practice which have already been implemented.

18. Lessons Identified

18.1 This part of the report summarises what lessons are to be drawn from this case and how those lessons should be translated into recommendations for action.

Victims of domestic abuse with ASD

18.2 The review has highlighted the need for specialist training and advice for those working with victims of domestic abuse who have ASD, to assist

[32] Domestic Abuse Act 2021

professionals in understanding how people with ASD view and understand the relationships they are in and receive support appropriate to their needs.

Assessing capacity

18.3 This area of learning links to the above. The review has identified the challenges of assessing mental capacity for people with ASD and the impact of interpersonal influence upon decision making where there is evidence of domestic abuse. The risk of victim blaming is recognised, and that it may not be directly applicable in this case as professionals felt that Daniel understood his relationship and had mental capacity to make decisions relating to it. However, it remains important learning for the future for professionals working with victims of domestic abuse where an assessment of mental capacity is undertaken.

Suicidality and ASD

18.4 Previous DHRs have identified the need for training in self-harm and suicide and have also recommended all agencies represented on the DHR panel commit to the Suicide Prevention Stakeholder Network. However, people with ASD are at higher risk of suicidality than their non-autistic counterparts. Agency responses need to be mindful of this when responding to people expressing thoughts of self-harm, suicidal ideation and suicide attempts. This may include consideration of developing or adapting assessment for suicide risk for people with ASD.

The impact of domestic abuse on mental health

18.5 Research has shown that mental health is often considered and responded to in isolation from the experience and impact of domestic abuse, and this was demonstrated in this case. Professionals should be aware of the impact of domestic abuse upon a person's mental health and tailor support in response which addressed both and recognises that domestic abuse is often the precursor to a decline in mental health.

Working with LGBT

18.6 LGBT people who experience domestic abuse also experience additional challenges to disclosure and access to support which is tailored to their needs. The research shows there is a higher risk of suicidality for this group. There are also additional indicators of risk which should be considered when assessing domestic abuse risk. Professionals should be confident in supporting members of the LGBT community, with an awareness of the specialist tools and services available. Consideration should be given to availability of specialist LGBT advice or worker within their services to ensure they are accessible to members of the LGBT community.

Intersectionality

18.7 The review has demonstrated the importance of recognising and understanding the intersectionality of protected characteristics, specifically age, disability, sexuality, gender, and ethnicity in this case. The review has recognised the importance of reviewing and taking into account

protected characteristics and intersectionality at the outset of the process, ensuring that all relevant protected groups are represented on the panel.

Multi-agency approaches

18.8 Agencies and professionals need to be aware of the multi-agency forums available in their areas that are designed to support multi-agency working and management of risk in complex cases. Whilst MARACs are the appropriate forum for cases of high risk domestic abuse these are often time pressured meetings, and in some cases, alternative forums should be considered. Such forums will ensure that cases can be considered in more depth, and the ongoing sharing of information, assessment and management of risk. Multi-agency forums, including MARAC, should identify a lead professional lead professional to ensure coordination, that information is shared, risk assessed and managed, and actions completed, and to act as a single point of contact for the other agencies involved.

Routine enquiry and risk assessment

18.9 This review has highlighted the need for routine enquiry, professional curiosity and risk assessment following suspected domestic abuse and disclosures of domestic abuse. Professionals should be confident in asking questions and assessing risk, signposting to appropriate support services for domestic abuse and ensuring appropriate referrals to MARAC. Professional curiosity should also be applied, and assessments of risk utilised, to gather sufficient information about relationships between persons where abuse is alleged.

Evidence/research based practice

18.10 Evidence-based practice is about making better decisions that informs action that has the desired outcome. An evidence-based approach is based on a combination of using critical thinking and the best available evidence. It makes decisions less reliant on anecdotes, received wisdom and personal experience, although professional judgement remains important and should be applied in combination with the evidence and research available. In this case it includes data and research relating to ASD, domestic abuse and suicide.

Gathering evidence of Coercive and Controlling behaviour

18.11 The review has identified the difficulties in gathering evidence of coercive and controlling behaviour to affect a successful prosecution of the offence. Professionals require advice and guidance on 'what' and 'how' to gather such evidence, and consideration should be given to the need to gather and submit evidence at MARAC.

Technology facilitated abuse

18.12 There was evidence of technology facilitated abuse. Michael utilised CCTV and mobile phone trackers, he was present during confidential online meetings and posed as Daniel in emails, and made Daniel send photos of his location when he was away from the home. The use of technology as a means of control is likely to have had a significant impact on Daniel's ability

to access help. Agencies therefore need to increase their understanding of technology facilitated abuse and how to respond.

18.13 In response, Equation have commissioned training entitled 'Domestic Abuse and Technology'. The training is available to all agencies and addresses: the increasing ways digital technologies are being used by domestic abuse perpetrators; the use of spyware, creation of fake accounts, use of covert devices, and the Internet of Things; how children are increasingly being used and harmed in technology-facilitated domestic abuse; and policy and practice recommendations to support victim-survivors. In addition, Equation have developed a new resource for practitioners which includes a tech safety plan template. As this work has already been undertaken, a specific recommendation around technology facilitated abuse has not been made by this review.

19. Recommendations

- Nottingham Community Safety Partnership to ensure that an intersectionality review is undertaken at the outset of every Domestic Homicide Review, that the principle predominating protected characteristics are considered and the panel are provided with a view about those characteristics.

- Nottingham Community Safety Partnership's partner agencies to develop professionals' awareness of the impact upon decision making for people who have mental capacity and who are, or may be, experiencing coercion and control and interpersonal influence.

- Nottingham Community Safety Partnership to liaise with the Safeguarding Adults Board and Children Safeguarding Partnership Board to identify the multi-agency forums available in the area, their purpose, membership, access criteria and referral routes, and then raise awareness of these across partner agencies to ensure that approaches and responses are coordinated.

- Nottingham Community Safety Partnership and their partner agencies to ensure that current training includes the Suicide Timeline (to include the additional risk indicators based upon protected characteristics for example, ASD and LGBT).

- Nottingham Community Safety Partnership to share information with partner agencies about the support available to people with ASD in the Nottinghamshire area.

- Nottinghamshire Police to advise partners how to gather and document evidence when there is coercive controlling behaviour through forums such as MARAC.

- Equation and Juno Women's Aid to promote the availability of local and national specialist LGBT domestic abuse support services with partner agencies. Including completing the LGBT Special Considerations Checklist alongside the standard DASH RIC

- Nottingham College to review their provision in relation to healthy relationships, men's services and LGBT support.

The following recommendations were made by agencies in their agency reports:

Equation

- Policies and procedures, staff induction/training/management is in place to ensure Referral timeframes are met. However, management can monitor Helpline capacity/waiting lists to ensure Equation has resources to meet this requirement.

- Caseworkers to be reminded/supported to explore/exhaust all safe means of contact with service users – covered in induction/training, team meetings, probation reviews, file audits and case management meetings.

- Caseworkers to be reminded/encouraged to cover work on each other's cases when the caseworker is not available to ensure no unnecessary gaps in service delivery.

Human Flourishing Project

- For all members of the HFP be required to attend the suicide prevention and intervention course and Understanding and Responding to Domestic Abuse courses, commissioned by Nottingham City Council (or equivalent).

East Midland Ambulance Service (EMAS)

- Professional curiosity to remain included in all aspects of ongoing safeguarding training.

- Ensuring the names of individuals on scene are documented to be reiterated in training and future communications; especially when behaviours of adults on scene are aggressive and intimidating. Body Worn Cameras are now in use at EMAS to ensure the safety of crews and EMAS service users.

Nottinghamshire Healthcare NHS Foundation Trust (NHFT)

- The Local Mental Health Team (LMHT) and Crisis Resolution Home Treatment (CRHT) to have regular joint multi-disciplinary team discussion on complex cases and consideration to be taken to invite other agencies if relevant.

- LMHT to complete the recommendations from the NHFT internal serious incident review.

- LMHT and CRHT to complete internal DASH Training and understanding Routine Enquiry training.

- LMHT and CRHT to identify a clinician to join the safeguarding champions network to help embed safeguarding processes and procedures into their clinical areas.

- LMHT and CRHT team leaders and managers with supervisory responsibilities should access the safeguarding supervision offer that is available via the Trustwide Integrated Safeguarding Service.

Nottingham Sexual Violence Support Service (Notts SVS)

- In any situation where clients request online or telephone counselling, however they cannot access a confidential space for counselling, Notts SVS Services will ensure that face-face counselling is delivered in a venue and location that meets the client's needs e.g., GP, Community Venue, Notts SVS Services counselling rooms. Face-face counselling is currently available to all clients requiring this and the client's preference is noted at their assessment and revisited when they are allocated to a therapist.

- Notts SVS Services workers, when sending emails will consistently state the DPMS ID and Flag on all internal communications with a requirement for the worker receiving the email to acknowledge receipt of the email to the sender and to update the sender once an action has been completed.

- Notts SVS Services workers that send emails with client actions will monitor these emails for a response and follow up within 5 working days if a response has not been received.

- Notts SVS Services Managers will ensure that all workers are aware of the above requirements and will monitor for compliance.

Nottingham University Hospital (NUH)

- Escalate need for read only access to mental health system (RIO) for NUH patients seen by CAMHS, DPM and RRLP to support communication and information sharing to effectively safeguard.

- Work with the Trust communication team to share the new professional curiosity video with all staff.

The Tomorrow Project

- The service recommends having additional professionals involved in the MARAC process. There would be great benefit to ensuring all services involved in such cases have access to all the information, allowing for better and more meaningful collaborative working.

MARAC Steering Group

- The Tomorrow Project to be invited to join the MARAC meeting as a discretionary member.

- The MARAC Steering Group consider if there are other agencies that should be included in the MARAC membership.

Appendix A: Risk Assessment – LGBT Special Considerations Checklist

Client	
Associated Service	
Date Checklist Completed	
Carried Out By	

Equalities Monitoring	
Gender	
Gender same as assigned at birth	
Identify as intersex or non-binary	
Preferred pronoun	
Sexual Orientation	

DASH RIC Questions	**Answer**	**Comment(s)**
Is this your first relationship since identifying as an LGB and/or T person?		
Is there an age difference between you and your partner/ex-partner?		
Has the client threatened to out or has outed you to family, work, children, friends, education, services, religious or other communities regarding your gender identity / sexuality / HIV status?		
Has the abuser any history of hate crime / incidents, harassment, homophobic, biphobic, transphobic views or criminal charges related to the above?		
Has the abuser threatened to withdraw / disrupt contact with children, due to your sexuality / gender identity?		
Do you use non-prescription drugs / chems (G, Tina, Methadone etc) alcohol? Do you have concerns about consent when using drugs / chems/ alcohol? Does the abuser		

coerce you into using chems / alcohol?		
Do you feel that you are at risk of contracting HIV, HEP C or any other STI?		
Does the abuser try to prevent you from expressing your gender identity or refuse to relate to you in your chosen gender identity?		
Does the abuser try to prevent you from accessing essential medications, surgery, services or other medical treatments?		
As an LGBT* person do you fear or have you experienced 'honour based' violence or forced marriage as a result of your family / religion / culture / communities beliefs regarding sexuality / gender identity?		
Does the abuser identify as		
Lesbian		
Gay		
Bisexual		
Heterosexual		
Trans		
Intersex		
Non-binary		
Cisgender		
Is there more than one person involved in the abuse?		
Does the abuser blame the abuse on your sexuality or gender identity?		
Have you ever experienced or been threatened with: conversion therapies / corrective rape / exorcisms/ talisman / corrective behaviours?		

Has the abuser threatened you with being taken out of the country to a place where there is an increased risk due to your sexuality / gender identity? Is a report to the Home Office a concern?		
Has the abuser attempted to isolate you from support?		
As an LGB and or T person, are you reluctant to approach services? Or have you been refused access to services or inappropriately referred?		
Do you have concerns about safety online - by the abuser? i.e. FB / Twitter / Grindr / Gaydar / girls / trans friendly		
Do other characteristics also feature in the abuse you experience or make you more susceptible?		
Age		
Class / financial disadvantage		
Disability		
Ethnicity		
Gender		
Immigration Status		
Pregnancy / childcare		
Marriage / civil partnership		
Religion / belief		
RIC Scoring	0	

Additional Details	
Has this case been taken to MARAC?	
Were there gaps in service provision available?	
Further comments / information	

Appendix B: DHR Juniper Report Recommendation and IMR Agency Action Plan

<u>This action plan is a live document and subject to change as outcomes are delivered.</u>

DHR Juniper Report Recommendations:

	Recommendation	Rationale	Scope of Recommendation - Local or National	Action to take	Lead Agency	Target Date	Date of Completion	Evidence: • Key milestones achieved in enacting recommendation • Outcome Have there been key steps that have allowed the recommendation to be enacted? List the evidence for outcomes being achieved What does outcome look like? What is the overall change or improvement to be achieved by this recommendation?	RAG
1	Nottingham Community Safety Partnership to ensure that an intersectionality review is undertaken at the outset of every Domestic Homicide Review, that the principle predominating protected characteristics are considered and the panel are provided with a view about those characteristics.	Vulnerabilities were not always apparent or considered and linked to potential risks Representation on the panel with regards to some of the protected characteristics was not addressed at the outset of the review and were considered and bought in late in the process	Local	Add section into local DHR process & flowchart map add over to evidence Advise all future DHR Chairs/authors to acknowledge any protected characterises at the start of the DHR process Specialist agencies to be asked to attend panel meetings	Nottingham Community Safety Partnership	February 2024	February 2024	To Note: Panel expert representation in reference to intersectionality is crucial at the initial stages of DHR'S • Written into local DHR process & flowchart map • DHR Chair acknowledges any protected characterises at the 1st meeting with panel meeting (agenda item) • Specialist agencies are invited to be part of and attend DHR panel meetings	G
2	Nottingham Community Safety Partnership's partner agencies to develop professionals' awareness of the impact upon decision making for people who have mental capacity and who are, or may be, experiencing coercion and control and interpersonal influence.	Whilst the victim was considered to have mental capacity, the impact of domestic abuse, CCB and interpersonal influence upon free decision making do not appear to have been considered	Local	Agencies to Review and highlight internal processes and seek assurances that the topic has been incorporated into existing training	All panel agencies	December 2024		To Note: Whilst victims may have mental capacity consideration should also be considered regarding impact of domestic abuse and coercive control and how this may impact upon free decision making	R
3	Nottingham Community Safety Partnership to liaise with the Safeguarding Adults Board and Children Safeguarding Partnership Board to identify the multi-agency forums available in the area, their purpose, membership, access	There was an apparent lack of awareness of the multi-agency forums available and those that may have been appropriate were not utilised	Local	Collate/map a list including purpose, membership, access criteria and referral routes and disseminate to agencies.	Nottingham Community Safety Partnership	December 2024		A new multi-agency group has been created called the '*Nottingham City Collective Review Group*'. The group are identifying the multi-agency forums available in Nottingham, their purpose, membership, access criteria and referral routes to share with partner agencies. The group are also identifying the key themes and learning regarding: • Domestic Homicide Reviews	A

	criteria and referral routes, and then raise awareness of these across partner agencies to ensure that approaches and responses are coordinated.							• Safeguarding Adults Review • Drug Related Deaths • Child Safeguarding Practice Reviews • Suicide	
4.	Nottingham Community Safety Partnership and their partner agencies to ensure that current training includes the Suicide Timeline (to include the additional risk indicators based upon protected characteristics for example, ASD and LGBT).	Not all professionals were aware of the suicide timeline, application of which may have affected responses and outcomes.	Local	Provider agencies provide assurances that Suicide Timeline and protected characteristics have been included in their internal training packages If an agency does not deliver domestic abuse training, NCSP to sign post to specialised agencies who deliver training (Equation/ Harmless)	All panel agencies	September 2024		To Note: All agencies are aware of the risk of suicide in cases of dv in reference to the stated characteristics within their agencies. **Nottinghamshire Police:** Discussed at the Vulnerability Board and is being adopted by the recently created Prevention Hub. Officers who oversee the force focus on suicide will review the Suicide Timeline and consider how to absorb it across the force training. The force has regular suicide training for new starters and has regular inputs for staff through the career. There is also a dedicated team that monitor suicides and participate in Multi-Agency activities, namely real times suicide surveillance and the initiative around the suicide cluster response.	**R**
5.	Nottingham Community Safety Partnership to share information with partner agencies about the support available to people with ASD in the Nottinghamshire area.	The impact of ASD was not always fully understood by professionals working with the victim	Local	NCSP to work with NHCFT to collate support service information on ASD and share with partner agencies.	Nottinghamshire Healthcare Foundation Trust	September 2024		The Autism Strategy is owned by the Integrated Care System as a whole and it is therefore advised that this action is extended to include other health partners across Nottingham and Nottinghamshire, including the ICB. NHCFT have developed an implementation plan to help monitor progress against the Autism Strategy alongside other ASD related actions from improvement plans. NHCFT are working with the ICB to develop a shared understanding identifying the need and necessary adjustments required for autistic people to receive equal access to services. An initial proposal has been developed between the ICB and NHCFT for a reasonable adjustment team. This work is being developed by the autism transformation group and meetings with the learning disabilities and/or autism integrated care system, ICS partner involving mental health commissioners. NHCFT have the Neurodevelopmental Specialist Service (NeSS). Information about this service can be found below. Diagnostic referral routes are through the GP. It is worthy of note that there is a significant supply demand for this service. Through right to choose, patients GP can request alternative diagnostic support.	**A**

								https://www.nottsautisminformation.org.uk/ offers information to autistic people and professionals and links to local and national support avaliable. The ICS have supported staff to train as SPELL trainers - this is a two day course on understanding an autism informed framework. Infrastructure is required to support roll out of this training across secondary, primary Care/Third Sector colleagues. The ICS have a system wide steering group to roll out the Oliver McGowan mandated training across the health workforce, and social care partners are engaged in this work. Bespoke training has been offered and delivered to several services and NHCFT plan to pilot Anna Freud training in 2024 with Autistic Nottingham* to adult mental health services. Autistic Nottingham and ImROC** have helped NHCFT to develop experts by experience roles with a focus on ASD. 6 people have now been trained as peer support workers and NHCFT are hopeful to build such roles into workforce models in the future. The peer support workers are employed by Autistic Nottingham. Mental health services can use the Green Light Toolkit to benchmark their service to see how effective it is at supporting autistic people and people with learning difficulties www.ndti.org.uk/resources/green-light-toolkit NHCFT recognise that staff and patients with ASD require reasonable adjustments to support them to function to their optimum. NHCFT are working with Autistic Nottingham to develop a reasonable adjustments toolkit which will be promoted across the organisation upon completion. NHCFT have established a Trustwide Sensory Practice Forum, which includes multi professionals and autistic people. The group have developed a Trustwide Sensory Screening Checklist that will be used for all new admissions and referrals to identify reasonable adjustments to access our services. *Autistic Nottingham – Supporting Autistic Adults without Intellectual Disabilities (Previously Asperger's/HFA) ** ImROC is: an independent 'not for profit' consultancy, training and research company focusing on and specialising in Recovery and improving the	

								lives of people with long term conditions including mental health conditions	
6.	Nottinghamshire Police to advise partners how to gather and document evidence when there is coercive controlling behaviour through forums such as MARAC.	The gathering of evidence would have provided a fuller picture and may have enabled the police to take action	Local	The Police to provide guidance/briefing to agencies on what information is required of them to support a criminal investigation Police advice is provided at MARAC on a case-by-case basis	Nottinghamshire Police	September 2024		*To Note: Agencies understand what information is needed to support a criminal Police investigation concerning coercive control* MARAC leads have been sent SafeLives guidance on Controlling and Coercive Behaviour and asked to share amongst all MARAC chairs to raise awareness. This guidance contains information on evidencing Control and Coercive behaviours and safeguarding options. This guidance has been disseminated and will ensure that Coercive and Controlling behaviour is considered at all points.	**G**
7.	Equation and Juno Women's Aid to promote the availability of local and national specialist LGBT domestic abuse support services with partner agencies. Including completing the LGBT Special Considerations Checklist alongside the standard DASH RIC	The LGBT special considerations checklist was not used in this case and may have highlighted additional risk factors affecting the response provided. The victim had little support around experiencing same sex domestic abuse	Local	To improve and the knowledge and understanding of local specialist LGBTQ+ support services	Equation Juno	September 2024	July 2024	**Equation:** Equation have a LGBTQ+ webpage and it includes a referral form for LGBTQ+ experiencing DA A LGBTQ+ Consortium of Services was included in our Professionals Newsletter (July edition) A Directory of LGBTQ+ Services has been completed ready to be signed off for uploading to Equation's Professionals Library The LGBTQ+ Special Considerations Checklist is embedded within our procedures and case management system, alongside the DASH RIC **Juno:** New staff are aware of the support organisations that they can signpost to, this done throughout a comprehensive induction. All staff participate in regular team meetings within their services and 4 weekly case management where managers will ensure frontline staff are aware of and actively supporting survivors through Juno services and/or signposting where appropriate Details of local and national support agencies are updated regularly. For example, The Emily Davidson Centre has opened up a refuge offering specialist support for LGBTQIA. Staff were immediately notified of the emergency refuge accommodation available via our intranet and the information was shared with services across Nottingham's DA sector partnership. '*The Loving Me service was established in 2022 by Trans+ people who are also experienced in delivering*	**G**

								support services to victims of abuse, exploitation and/or violence. Founded by Amanda Elwen and lead by Moss Ferry, The Loving Me service is proud to announce the opening of the first 7 bed refuge'. The Loving Me team has 6 practitioners who will support the individuals living in the refuge. Training for staff on the LGBT DASH RIC is provided by Equation as the locally commissioned DA training provider. This is enhanced through specific units delivered in our organisational induction and internal training programmes delivered in-house When signposting survivors, staff are acutely aware of the their responsibilities in relation to intersectionality and will signpost survivors appropriately and in line with their needs, their wishes and consent e.g. to LGBT service, black and minoritised service, disability services. Juno regularly promotes Equations VAWG awareness raising messages and shares promotional and specific events (LGBT History Month, Notts Pride)	
8.	Nottingham College to review their provision in relation to healthy relationships, men's services and LGBT support.	Specific support in these areas may have been beneficial to the victim	Local	College staff are equipped with the knowledge and skills to recognise and respond to domestic abuse and signpost to specialised services	Nottingham College	December 2024		• 1:1 Wellbeing Mentor support around all key themes. They will sign post to relevant support networks • Robust safeguarding system that triages all referrals (agencies and Police) and then supports all students that are in crisis and need support. • Mandatory safeguarding training for all staff. • Further certificated training for all first response officers. • Student net has a wellbeing hub that signposts to links for all abuse and is updated monthly. • Working towards having White Ribbon ambassadors to support males. • Providing enrichment weeks on keeping safe, healthy relationships and the safety within the night-time economy. • Regular tutorials around support for students.	**A**

DHR Juniper IMR Agency Actions

	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence • Key milestones achieved in enacting recommendation • Outcome	RAG
East Midlands Ambulance Service (EMAS)							
1.1	Professional curiosity to remain included in all aspects of ongoing safeguarding training.	To ensure staff are reminded to use professional curiosity	Incorporate into safeguarding training	Ongoing through 2023/24	Ongoing	Communication briefings completed. Included within safeguarding face to face, online, and brochure package.	**Green**
1.2	Ensuring the names of individuals on scene are documented to be reiterated in training and future communications; especially when behaviours of adults on scene are aggressive and intimidating. Body Worn Cameras are now in use at EMAS to ensure the safety of crews and EMAS service users	Improve record keeping and identification of people posing a risk eg aggressive behaviour	Incorporate into safeguarding training	Ongoing through 2023/24	Ongoing	Included within safeguarding face to face, online, and brochure package.	**Green**
Equation – Domestic Abuse Service for Men							
2.1	Policies and procedures, staff induction/training/management is in place to ensure Referral timeframes are met. However, management can monitor Helpline capacity/waiting lists to ensure Equation has resources to meet this requirement.	Referral timeframes to be adhered to ensure timely response.			26/4/23	Checklists and measures are in place to address capacity and reaffirm timeframes and audits of cases	**Green**
2.2	Caseworkers to be reminded/supported to explore/exhaust all safe means of contact with service users – covered in induction/training, team meetings, probation reviews, file audits and case management meetings.	Where it is not safe to contact victim, explore and exhaust other safe means of contact and evidence this in case notes.	Set as a standard agenda item in Team Meetings, File Audits and Case Management Meetings	24/05/23	24/05/23	Staff explore different ways of contacting service users to include via other agencies involved.	**Green**
2.3	Caseworkers to be reminded/encouraged to cover work on each other's cases when the caseworker is not available to ensure no unnecessary gaps in service delivery.	Where a caseworker is not available to take a call on a case, other case workers are to pick this up and update caseworker.	Team to be informed of arrangement to ensure service cover	24/05/23	24/05/23	Everything documented on case management system and respond. Arrangement for cover and hand over of cases when someone is on leave. Team fully aware – email circulated, addressed in Team Meeting and now monitored by Service Manager.	**Green**

Human Flourishing Project							
3.1	The recommendation is that all members of the HFP be required to attend the suicide prevention and intervention course and Understanding and Responding to Domestic Abuse courses, commissioned by Nottingham City Council. This can only have a positive impact on the provision of the service the HFP offers and may result in small signs of abuse or active suicidality being picked up and responded to in a way that enables disclosure.	Improved awareness and identification of domestic abuse and suicidal ideation and therefore improve response.	Counsellors to attend training as specified	30/06/23	02/06/23	All counsellors on placement to attend the Suicide Intervention and prevention course run by Harmless (or an equivalent course they have already done), also to attend the Understanding and Responding to Domestic Violence and Abuse (URDVA) course run by Equation (or an equivalent course as courses are not currently available to book). Suicide prevention: 100% attended URDVA or equivalent: 100% have attended All new counsellors who will join organisation in July and September have had training workshops on these topics and others as part of their ready for practice programme. They are also required to attend the above courses within a reasonable timescale. This will be an ongoing requirement for all counsellors.	**Green**
MARAC Steering Group (MARAC Process recommendation)							
4.1	The Tomorrow Project to be invited to join the MARAC meeting as a discretionary member.	Information from Tomorrow Project was shared by another agency at the MARAC	Invite The Tomorrow Project to be part of MARAC, get access to ECINs and signed up to relevant policies	April 2023	January 2024	As below. MARAC membership will be considered as part of the implementation of the new model.	**Green**
4.2	The MARAC Steering Group consider if there are other agencies that should be included in the MARAC membership	Identify other key agencies that should be represented at the MARAC and reduce gaps in knowledge and identifying risks	MARAC Steering Group workshop took place to review the process and membership	April 2023	January 2024	The Nottingham MARAC was reviewed during the early part of 2024. The review has been agreed at strategic level and the new operating model and associated processes will be implemented from 1st August. Three task & finish groups have been established to progress the implementation and MARAC membership will be revised and confirmed as part of this process.	**Green**
Tomorrow Project							
5.1	The Tomorrow Project to be invited to join the MARAC meeting as a discretionary member.	Information from Tomorrow Project was shared by another agency at the MARAC	Invite The Tomorrow Project to be part of MARAC, get access to ECINs	25th April 2023	Q2 2023	The Tomorrow Project are invited to attend the MARAC as and when required	**Green**
Nottinghamshire HealthCare NHS Foundation Trust (NHCFT)							
6.1	LMHT and CRHT to have regular joint MDT discussion on complex cases and consideration to be taken to invite other agencies if relevant	Improve information sharing and better pathway	Assurance that MDT discussions take place between LMHT & CRHT	May 2023	17/05/2023	Meetings regarding patients do take place on a case-by-case basis and crisis are invited if involved.	**Green**

						The team resolve things as they arise also via Team leaders and service managers. There are various mechanisms to do this Team calls a bespoke professionals meeting to which internal and sometimes external colleagues are invited, including LMHTs and crisis as needed we have done this very recently There is also multi-agency complex case forum held with PD Hub, Ness & NED – again LMHTs and crisis would be involved if relevant • CPA review held annually by care team/LMHT and crisis could be invited that if involved • CTR meeting if LD/Autism patient where care team/LMHT and crisis could be invited that if involved – we have done this very recently • PD Hub complex PD consultation meetings – again care team/LMHT and crisis could be invited that if involved • Ward round and pre discharge /117 meetings -– again care team/LMHT and crisis could be invited that if involved	
6.2	LMHT to complete the recommendations from the NHFT internal serious incident review	Recommendations made are relevant	Obtain Divisional QIP	May 2023	12/05/2023		**Green**
6.3	LMHT and CRHT to complete internal DASH Training and understanding Routine Enquiry training	Improve recognising and responding to domestic abuse	Obtain Divisional QIP	May 2023	12/05/2023	As per embedded action plan in 6.2	**Green**
6.4	LMHT and CRHT to identify a clinician to join the safeguarding champions network to help embed safeguarding processes and procedures into their clinical areas	Improve understanding of responsibilities regarding DVA and Safeguarding	Identify Safeguarding Link Professional	May 2023	12/05/2023	Joanne Halstead has identified herself as a Safeguarding Link Professional confirmed that Safeguarding is a standing agenda item at the Q & R Meeting	**Green**
6.5	LMHT and CRHT team leaders and managers with supervisory responsibilities should access the safeguarding supervision offer that is available via the Trustwide Integrated Safeguarding Service	Improve recognising and responding to domestic abuse	Promotion of Safeguarding Supervision	May 2023	17/04/2023	Safeguarding Supervision is promoted via the LMHT Leadership Meeting and posters embedded within the agenda	**Green**
Nottinghamshire Sexual Violence Support Service							
7.1	**Options for a Confidential Space** In any situation where clients request online or telephone counselling, however	Ensure options to prevent others being present during sessions,	Ensure that a range of face-face options are available for all	April 2023	April 2023	Many options to meet face to face and where client preference is and to continue this if ever back in	**Green**

	they cannot access a confidential space for counselling, Notts SVS Services will ensure that face-face counselling is delivered in a venue and location that meets the client's needs e.g., GP, Community Venue, Notts SVS Services counselling rooms. Face-face counselling is currently available to all clients requiring this and the client's preference is noted at their assessment and revisited when they are allocated to a therapist.	especially where control and coercion is identified.	clients requesting this.			position of covid and consider how this can be done safely e.g. GP surgery, other place (Bubble**)**	
7.2	**Internal Communications** Notts SVS Services workers, when sending emails will consistently state the DPMS ID and Flag on all internal communications with a requirement for the worker receiving the email to acknowledge receipt of the email to the sender and to update the sender once an action has been completed. Notts SVS Services workers that send emails with client actions will monitor these emails for a response and follow up within 5 working days if a response has not been received. Notts SVS Services Managers will ensure that all workers are aware of the above requirements and will monitor for compliance.	Improve record keeping and responses	Communicate new process to all staff.	End April	26/4/23	System to manage and monitor actions and responses to acknowledge they have been completed. Case management for complex case meeting now in place for approx. 2 years – post contact from this review	**Green**
Nottingham University Hospital (NUH)							
8.1	Escalate need for read only access to mental health system (RIO) for NUH patients seen by CAMHS, DPM and RRLP to support communication and information sharing to effectively safeguard.	Support improved communication and improve patient experience and potentially improve patient outcomes.	Escalate need for read only access to mental health system	Q1 2023	2023	This has already been requested, one member of the team now has read only access and we have asked that this access is given to 2 other team members	**Green**
8.2	Work with the Trust communication team to share the new professional curiosity video with all staff	Improve and encourage use of professional curiosity.	To share professional curiosity resources, information, website links and guides with NUH colleagues	Q1 2023	2023	The professional curiosity video was played as part of last year's mandatory training so was seen by approximately 13,000 staff. The video was: • Shared at the adult safeguarding committee • Sent out to the divisional champions to share within their teams • Sent out in the SG newsletter	**Green**

						The adult safeguarding team presented a professional curiosity session on staff timeout days and all mandatory ‘Think Family’ training includes information around professional curiosity.	

Appendix C: Home Office Letter – May 2024

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Louise Graham
Sexual Violence Lead
& Nottingham Consent Coalition Co-ordinator
Nottingham Community Safety Partnership
Nottingham City Council
Byron House
Maid Marion Way
Nottingham
NG1 6HS

9th May 2024

Dear Louise,

Thank you for submitting the Domestic Homicide Review (DHR) report (Daniel) for Nottingham Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 21st December 2023. I apologise for the delay in responding to you.

The QA Panel felt this was a thorough report that gives a sense of who Daniel was and that articulates the complexities experienced and how he made compromises. It was positive to see a local domestic abuse representative and Autism specialist on the panel which adds depth and insight. There was good practice shown through the learning event which contributed to the analysis and allowed good practice to be shared. The report also provides a good analysis on the barriers faced due to Daniel's protected characteristics. Overall, this is a sensitively written report, and the reader gets the sense that the panel has tried hard to understand Daniel's experiences, including through the use of evidence.

The QA Panel and the Home Office is content that the DHR may be published.

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

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

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an

annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

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

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

Yours sincerely,

Home Office DHR Quality Assurance Panel