MK Together | Safeguarding Partnership

Statutory Review - Overview Report

On behalf of Safer MK Community Safety Partnership

REPORT INTO THE DEATH OF CHRISTOPHER
January 2019

Report produced and Review chaired by Peter Stride
Foundry Risk Management Consultancy

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The following tribute has been prepared by the family of Christopher:

This world was never meant for one as beautiful as 'Christopher', forever 38, he was kind, loving and sensitive, a son, grandson, brother, nephew, and a dad who loved his children with all his heart, and he was loved so much by his family and his many friends, he touched the hearts of most people he met.

Christopher travelled when he was younger, he went to Australia and snowboarding in Austria, he loved going to the pictures and to concerts or just a gig in London and he always got chatting to someone.

Christopher craved his own home with someone to love and share all the goodness that he had, but that was not to happen and sadly Christopher lost his way and left this world, he didn't have his happy ever after, he left us all, our lives distraught and changed forever. WHY?

FOREWORD

Safer MK would like to express condolences to all those affected by the sad loss of Christopher. We sincerely hope the learning and recommendations gained from our enquiries and deliberations will help agencies to prevent similar incidents from happening again in the future. The Independent Chair of the Statutory Review Panel would like to thank all agencies who contributed to the process in an open and transparent manner. This review has demonstrated that more needs to be done to raise awareness and change attitudes towards domestic abuse and that it is crucial to offer appropriate and timely help and advice to victims, their families, and friends, and professionals. The panel is confident that the learning points and recommendations will provide a platform to help national, regional, and local agencies to implement measures designed to prevent what happened to Christopher from happening to others.

Following this death there is emerging evidence of positive change at a local level, and we all must do our utmost to take immediate action both to protect victims and to deal effectively with the perpetrators of domestic abuse. The chair would urge everyone to take note and act on the findings of this review. Together we must take the threat and harm posed by domestic abuse seriously at a leadership, frontline, and community level to help bring these types of tragedies to an end.

1 PREFACE

1.1 INTRODUCTION

1.1.1 This report is being prepared under the heading of a Statutory Review. It followed a structure and framework aimed at ensuring that all relevant and appropriate facts and information were obtained and analysed.

1.1.2 This report process (hereafter 'the review') examines agency responses and support given to Christopher, a resident of Milton Keynes prior to the point of his death in January 2019.

1.1.3 The review considered contact/involvement of agencies with Christopher and his partner Isabelle (partner at the time of his death) and Harriet (mother of Christopher's children) from January 2011 to January 2019 (up to and including the date of Christopher's death). In addition to agency involvement the review also examined the past to identify any relevant background or trail of abuse before Christopher'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.

1.1.4 Christopher was discovered hanged on a tow path, by an off-duty Police Community Support Officer (PCSO) from the Northamptonshire Constabulary. A call was put through to Thames Valley Police and officers attended the site. It was confirmed that Christopher was dead at the scene.

1.1.5 The key purpose for undertaking Statutory Reviews is to enable lessons to be learned from deaths where relationships had a history of domestic abuse. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened prior to each death, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

1.1.6 This review process does not take the place of the criminal or coronial processes, nor does it take the form of a disciplinary process.

1.1.7 The review panel expresses its sympathy to the family, and friends of Christopher for their loss and thanks them for their contributions and support for this process.

1.2 TIMESCALES

1.2.1 The decision to commission this review was taken, by Safer MK on 31 January 2019 and the Home Office was notified of the decision in writing on 4 February 2019. The review was subsequently completed in line with the Home Office guidance of 2016.

1.2.2 Foundry Risk Management Consultancy was commissioned to provide an Independent Chair (hereafter 'the chair') for this Statutory Review on 22 March 2019 and following an initial scoping exercise the first panel meeting took place on 5 June 2019 and the completed report was handed to the CSP in January 2022. It was submitted by the CSP to the Home Office Quality Assurance Panel in May 2022.

1.2.3 Home Office guidance states that a review should be completed within six months of the initial decision to establish one. The timeframe for this review was extended due to:

- The panel raised concerns as to the appropriateness of carrying out a 'Statutory Review' under the circumstances presented in this case. This has led to consultation at local and national level and the inevitable delays in the receiving and providing feedback and guidance.

- The inquest into Christopher's death was not concluded until December 2019, causing issues over disclosure and the restrictions under General Data Protection Regulations, Human Rights Act 2000, and the Data Protection Act 2018.

- The impact of the Covid-19 pandemic caused all Safeguarding Reviews to be suspended for several months by Safer MK. There have been further challenges presented by staff working remotely and with additional roles and responsibilities relating to issues of sickness, staff isolation etc.

1.3 CONFIDENTIALITY

1.3.1 The findings of this report are confidential until the Overview Report and Executive Summary have been approved for publication by the Home Office Quality Assurance Panel. Information is available only to participating professionals and their line managers.

1.3.2 This review has been suitably anonymised in accordance with the statutory guidance. The specific date of death has been removed, as has the sex of the children involved (to further protect their anonymity, they are referred to as Ch1, Ch2 & Ch3).

1.3.3 The following pseudonyms have been in used in this review for the deceased and other parties, to protect their identities and those of their family members:

Referred to in report as	Relationship to Christopher	Ethnic Origin	Faith	Immigration Status	Disability Y/N
Christopher	Deceased (aged 38 when he died)	White British	Christian	British Citizen	N
Harriet	Ex-Partner	White British	Unknown	British Citizen	N
Isabelle	Partner	White British	Unknown	British Citizen	N
Henry	Deceased's Father	White British	Unknown	British Citizen	N
Louisa	Partner's Mother	White British	Unknown	British Citizen	N
Child 1 (Ch1)	Deceased's Child	White British	Christian	British Citizen	N
Child 2 (Ch2)	Deceased's Child	White British	Christian	British Citizen	N
Child 3 (Ch3)	Partner's Child	White British	Christian	British Citizen	N

1.3.4 These pseudonyms were selected by the chair but were agreed with Christopher's father, Henry.

1.3.5 As per the statutory guidance, the chair and the Review Panel are named, including their respective roles and the agencies which they represent.

1.4 TERMS OF REFERENCE

1.4.1 The full Terms of Reference are included at Appendix 2, but in summary, the scope period was agreed as 1 January 2011 to after Christopher's death in January 2019. Agencies were asked to set out the facts, provide analysis of their involvement, and identify recommendations. Family and friends were fully consulted throughout the review as the review sought to identify any barriers to reporting domestic abuse and accessing services. This review's aim was to identify the learning from this death and encourage action to be taken in response to that learning, with a view to preventing similar deaths in the future and ensuring that individuals and families are better supported.

1.4.2 The Review Panel comprised of agencies from Milton Keynes, as the deceased was living in that area at the time of his death. Agencies were contacted as soon as possible, after the review was commissioned, to inform them of the process, their need to participate, and to secure relevant records.

1.4.3 As information was provided during the review, it was established that Christopher may have had contact with agencies (i.e. counselling services) privately accessed through his work. Despite efforts from the chair, including consultation with Christopher's family, employer and neighbours, details of this contact have not been identified.

1.4.4 Key Lines of Inquiry:

The Review Panel considered the following case specific issues:

- Set out the facts of agency involvement with Christopher, Harriet, Isabelle, Ch1, Ch2 and Ch3
- Critically analyse the service they provided in line with the specific terms of reference
- Identify any recommendations for practice or policy in relation to each agency
- Consider issues of agency activity in other areas and review the impact in this specific case

1.4.5 At the first meeting, the Review Panel shared brief information obtained from a 'summary of engagement' exercise about agency contact with the individuals involved. At this stage it was clear that there had been contact with statutory services and that no previous disclosures of domestic abuse had been identified or reported by Christopher, however several reports had been made by both of his partners, during this review period. As a result, the Review Panel agreed that the period for the review would be from January 2011 until the date of Christopher's death. This period was chosen as it covered Christopher's relationship with both Harriet and Isabelle, allowing for these details to be considered. Where appropriate, information that falls outside of this period has

been included to provide context. The Terms of Reference were discussed and agreed with the family prior to final sign off.

1.4.6 There had been significant concern raised by the panel with regards to the framework employed in reviewing this incident, and the inference of using the usual statutory review terminology. When reviews have been commissioned following an incident in which one party has died by suicide, use of this terminology could have a long-term impact on those close to the deceased. There has been further unease throughout this review about how certain information (i.e. medical records) can be obtained and used, when surviving parties decide not to participate. Such records, relating to Harriet and Isabelle, have not been requested and this has impacted upon the details recorded in this report. Therefore, the panel will be proposing a recommendation that the Home Office reviews the processes by which incidents like these are reviewed.

1.4.7 **Learning Point 1:** The panel feels that the Home Office needs to consider the way in which incidents similar to this are reviewed and a more bespoke process introduced. **Recommendation 1:** The Home Office to review current methodology and consider introducing a stand-alone 'Death by Suicide following Domestic Abuse' review process.

1.5 METHODOLOGY

1.5.1 Following the discovery of Christopher's body in January 2019, Thames Valley Police made a referral to Safer MK. On 31 January 2019 contact was made with the Home Office confirming the intention to carry out a Statutory Review. This referral was agreed on 4 February 2019.

1.5.2 The chair was commissioned for this Statutory Review on 22 March 2019 and following an initial scoping exercise chronologies were provided by six agencies on 30 May 2019. The initial panel meeting took place on 5 June 2019 and Individual Management Reviews (IMRs) were submitted by 30 June 2019. Further panel meetings took place in October 2019, January 2020, and March 2021. Due to the impact of the Covid-19 pandemic, Safer MK suspended the review process in March 2020, and restarted it in December 2020. Further challenges relating to Covid-19 and challenges from various review panel members meant that the completed report was not passed to Safer MK until January 2022.

1.5.3 Throughout the report the term 'domestic abuse' is used interchangeably with 'domestic violence' and the report uses the cross-government definition of domestic violence and abuse as issued in March 2013 and included here to assist the reader to understand that domestic violence is not only physical violence but a wide range of abusive and controlling behaviours. The new definition states that domestic violence and abuse is:

- Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence, or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or

sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.

- Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

- Coercive behaviour: is an act or a pattern of acts of assault, threats, humiliation (either in public or private) and intimidation or other abuse that is used to harm, punish, or frighten their victim. Abuse may take place through person to person contact or through other methods, including but not limited to, telephone calls, texts, emails, social networking sites or use of GPS tracking devices.

1.5.4 This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

1.5.5 On notification of the death, a scoping exercise was carried out in which agencies were asked to check for their involvement with Christopher and Isabelle. No information was known about children at this stage. Agencies were also asked to secure appropriate records. A total of nine agencies were contacted to check for involvement. Details of the contributions made by each of the nine agencies are recorded in Section 1.7.

1.5.6 Documents Reviewed:

In addition to the five IMRs and chronologies, documents reviewed during the review process have included:

- A published account of the coroner's summing up.
- Previous similar reports in Milton Keynes.
- The local training strategy; a demographic profile of the borough.
- Home Office Case Analysis.
- The Milton Keynes Domestic Abuse Needs Assessment 2018 - 2021.
- The Bedfordshire, Luton, Milton Keynes (BLMK) Joint Suicide Prevention Strategy.

1.5.7 The chair also reviewed statements taken by Thames Valley Police, where available and deemed to be appropriate, with regards to incidents that they attended.

Interviews Undertaken

1.5.8 The chair of the review undertook an interview with Henry and the close family of Christopher and has reached out to several of his near neighbours and a previous employer, using the details provided by the police investigation. Consequently, 'Mark' and 'Sean' came forward and were also interviewed; a summary of that conversation is recorded below in Section 1.6.

The use of the term DOM5 risk assessment

1.5.9 The terms DOM5[1] risk assessment is referred to at various points throughout this report. It is a version of the DASH[2] checklist and known to some of the panel agencies, however not all. Therefore, to provide clarity for readers outside the Thames Valley area and others not familiar with the DOM5 process the remainder of this report will adopt the anacronym DASH, in place of DOM5. A detailed explanation of the DOM5 process is provided in footnote 9 of this report.

1.6 INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND WIDER COMMUNITY

1.6.1 Safer MK notified Christopher's family, Harriet, and Isabelle in writing of their decision to undertake a review. Isabelle was kept informed through the Thames Valley Police Constabulary Family Liaison Officer.

1.6.2 The review panel believed that it was vital to take steps to involve Harriet, Isabelle, and Christopher's family throughout this process.

1.6.3 Harriet and Isabelle chose not to take part in the review. Extensive efforts were made to engage with both, including letters of introduction, offers of face-to-face meetings and the use of emails and phone calls. Despite this both have decided not to take part in this process.

1.6.4 There were no barriers in relation to communication with Christopher's family and they have been active participants. The chair has met with the family of the deceased including his parents and both brothers. The deceased's father (Henry) was nominated as the family representative for the chair and author. During the period of this review the chair has carried out several interviews with family members and a summary of those conversations is detailed below.

1.6.5 Henry has been regularly contacted by the chair to keep the family informed as to the progress of the review. He had several opportunities to contribute to the development of the report and provide feedback, as well as meeting with the chair and communications through telephone and email.

1.6.6 The Review Panel agreed that it was not appropriate to interview Ch1, Ch2 or Ch3.

[1] Dom 5 – a risk assessment form detailing all persons present and children in the household.
[2] DASH - Domestic Abuse, Stalking and 'Honour'-based violence.

1.6.7 The family were signposted to agencies providing specialist and expert advocacy and at the conclusion of the process reviewed the draft report. Due to restrictions of Covid-19, the draft report was presented via a video conference process, which took place over three meetings during December 2021. Henry and his wife were present during each meeting, and they were provided with periods of privacy to read over the details and were encouraged to provide feedback and indicate areas for amendment. The final version of this report reflects this feedback.

1.6.8 All of those making contributions have been able to do so via the contact method of their choice.

INTERVIEW WITH THE DECEASED'S PARENTS AND BROTHERS

1.6.9 Christopher was a seaman with the Merchant Navy between the ages of 16-19 and returned home upon leaving in 1999. He got a job working for an insurance company in Milton Keynes. He remained there for a few years, before moving to work for a larger insurance company. Things did not go well for Christopher, in his new job, and eventually he returned to his former employer (Sean) where he was employed up until the time of his death.

1.6.10 In terms of relationship history, after a failed relationship in his early 20s, it took Christopher some time to trust women and he did not have any significant partners, until he met Harriet at the age of 27. The couple had two children (Ch1 and Ch2) and they separated in the spring of 2014. This relationship was reported to have been difficult and there were several incidents, outlined in the police IMR, where police were called to the family home. On some occasions Christopher was described as the victim and on other occasions as the perpetrator. Christopher was described by his family as being a loving father to his children.

1.6.11 In the two years after the breakup of the relationship with Harriet, there were several concerns raised over Ch1 and Ch2, where Children's Social Care were contacted by both sets of grandparents worried about the welfare of the children and Harriet's ability to look after them effectively.

1.6.12 In the two months following the separation from Harriet, Christopher met Isabelle and the two began cohabiting along with Isabelle's mother and daughter (Ch3) Again, this relationship appears to have been violent and abusive, with several visits from the police to the family home, also outlined in their IMR. Once more, on some occasions Christopher was alleged to have been the victim and on others Isabelle is described as the aggrieved party.

INTERVIEW WITH NEIGHBOURS

1.6.13 The chair asked the police to provide them with details of neighbours and friends who were interviewed during the enquires that were completed during their investigation. Various names and addresses were provided, and the chair wrote to each of them. As a result, one local resident (Mark) made contact and was interviewed. A summary of this interview is recorded below.

1.6.14 The chair has spoken to Mark who lived close by the deceased and Isabelle's family home. The report will refer to him as Mark although this is not his real name. Mark was a neighbour for several years and had several contacts and interactions with them. He knew Christopher quite well and described feeling immensely sad when he heard of his death, he describes Christopher as being a physically small and very gentle man who got on with everyone.

1.6.15 Mark formed the opinion that for much of the time Christopher and Isabelle did not get along and he would regularly see and hear them arguing. Mark formed the view that Isabelle was the dominant partner in their relationship and that Christopher normally appeared to be very subservient.

1.6.16 Mark described often hearing shouting and banging from Christopher's home and reported once hearing Christopher saying, 'stop hitting me'.

1.6.17 Mark wishes to pass on his condolences to all those affected.

INTERVIEW WITH PREVIOUS EMPLOYER

1.6.18 The chair has spoken to Sean, who was Christopher's line manager at work at the time of his death. Sean confirmed that he had also been his manager between 2001 and 2011. Sean confirmed that Christopher had been an excellent employee and someone upon whom he could rely. In fact, in 2017, when Sean was looking for new staff, he approached Christopher inviting him to apply for a role. Over time Sean and Christopher had become friends and occasionally they would meet socially, normally playing 5-a-side football.

1.6.19 Sean was asked, by the chair whether Christopher ever discussed having problems at home, or whether there were ever any issues around his performance which may have been linked to family difficulties. Sean told the chair that during his initial period of employment Christopher had been in a relationship with Harriet but by 2016 Christopher was living with Isabelle. Christopher's personality and behaviour was similar during each relationship. Sean confirmed that there were sometimes issues of a domestic nature and occasionally minor difficulties with timekeeping. Occasionally Christopher would be late for work, however whenever this happened, he would make up the time later. Sean also commented that there were times when Christopher spent long periods on the phone either outside of the office or in the toilets and it was apparent that these calls were not work-related. Sean said that Christopher would frequently call him and ask for the day off, usually at the last minute.

1.6.20 The chair asked whether Sean had ever seen any physical evidence of injuries on Christopher and Sean confirmed he had seen scratches and bruises and when asked about these Christopher had said that these had been because of clumsiness or accidents in the house such as walking into a door or a rake, for example.

1.6.21 Eventually Sean became concerned about Christopher's domestic circumstances and the two would regularly chat. Sean would suggest to Christopher that things weren't going well, and they needed to be sorted out. He offered practical help including the use of a room to stay if things ever became too much. This offer was never taken up by Christopher.

1.6.22 Sean also told the chair that he knew the house where Christopher lived was owned by his girlfriend and her mother, however Christopher made regular contributions towards the food and bills. Sean knew that Christopher and Isabelle had bought a car together, but this appeared to be their only joint financial commitment.

1.6.23 On the day before his death Christopher had spoken to Sean asking for another day off, which Sean granted. Sean knew that this was due to family problems and asked Christopher whether he was going to visit his parents, he confirmed that he was. At the time Sean believed this to be nothing unusual and as he liked Christopher was happy to give him some flexibility. This was the last time that Sean spoke to Christopher.

1.6.24 Sean described Christopher as a true gentleman, short in stature but big in heart. He was extremely polite and often quite timid. In terms of relationships, Sean thinks that Christopher was desperate to make them work and feels this made him both passive and submissive. He described Christopher’s relationships as toxic and has expressed his sorrow and upset at the passing of his colleague and friend.

1.6.25 Sean was asked by the chair, about specific details regarding domestic abuse matters that Christopher may have revealed, but Sean confirmed that Christopher had never done so.

1.7 CONTRIBUTORS TO THE REVIEW

1.7.1 The following agencies were contacted but had not had any contact with Christopher, Harriet or Isabelle.

- Central and North West London NHS Foundation Trust (CNWL)[3]
- The National Probation Service and Community Rehabilitation Company
- Milton Keynes Adult Social Care
- Milton Keynes Housing

[3] CNWL was never provided with the details of Harriet and therefore no searches were ever carried out to identify if contact or engagement ever took place. As Harriet has never engaged with this review or provided any permission to access her medical records, this was not pursued by the review process. CNWL did receive a referral for Isabelle, however for similar reasons as Harriet no research or disclosure was made by CNWL.

1.7.2 Other agencies reported contact with various members of the family and details of these contacts are recorded within the Combined Chronology. Each of these agencies prepared a chronology report and IMR i.e.

Agency Name	Known to Agency	Chronology	IMR
Thames Valley Police	Yes	Yes	Yes
GP Surgery	Yes	Yes	Yes
MK-ACT	Yes	Yes	Yes
Milton Keynes University Hospital Trust	Yes	Yes	Yes
Children's Social Care	Yes	Yes	Yes

1.7.3 Quality and Independence of the IMR authors

The IMRs were prepared by authors who were independent of any service delivery or case management of any of the parties involved in this process. The IMRs were comprehensive and allowed the panel to analyse the contact with Christopher, either of his former partners or their immediate family (where relevant). The detail ensured that the panel was able to identify learning and recommendations for this review and, where necessary, follow-up questions were sent to agencies and responses received, prior to, or at, subsequent panel meetings.

1.8 THE REVIEW PANEL MEMBERS

1.8.1 The Review Panel comprised of the following agency representatives:

Peter Stride, Panel Chair, Foundry Risk Management Consultancy Ltd

Andrew Thompson, Detective Inspector, Thames Valley Police

Sue Burke, Chief Executive Officer, MK-Act Domestic Abuse Charity

Nadean Marsh, Head of Nursing Quality and Safeguarding, Milton Keynes University Hospital NHS Foundation Trust

Lisa Johnson, Lead Nurse Safeguarding Adults, Milton Keynes University Hospital NHS Foundation Trust

Susie Payne, Quality and Performance Manager, Milton Keynes Council Adult Services

Amanda Derbyshire, Designated Nurse for Adult Safeguarding, Milton Keynes Clinical Commissioning Group

Lesley Mellor, Partnerships Officer, MK Together Partnership

Jo Smart, Programme Manager, MK Together Partnership

Julia Roberts, Safeguarding Manager, Milton Keynes Council Children's Social Care

1.8.2 The Review Panel met a total of six times, with the first meeting on 5 June 2019. There were subsequent meetings on 1 October 2019, 29 January 2020, 25 August 2020, 12 November 2021 and March 2021. Draft reports were reviewed at the latter meetings with the Review Panel subsequently receiving updates from the Chair.

1.8.3 The chair of the review wishes to thank everyone who contributed their time, patience, and cooperation in this process.

1.9 CHAIR OF THE REVIEW AND AUTHOR OF THE OVERVIEW REPORT

1.9.1 Peter Stride was appointed by Safer MK as Independent Author of this review panel. Peter is a retired Metropolitan Police Officer and has over 30 years of detective experience in the field of Domestic Abuse, Public Protection and Safeguarding in London. His experience includes specialist and generic investigative roles at New Scotland Yard and the boroughs of Westminster, Brent, and Harrow.

1.9.2 As Detective Chief Inspector he has been the vice chair of two Local Adult and Children's Safeguarding Boards and was responsible for the creation and implementation of various MASH[4] and MACE[5] panels as well as chairing MAPPA[6] and MARAC[7] meetings.

1.9.3 Since retirement Peter has established his own consultancy business, coaching and training in a range of risk management environments focusing upon child and adult safeguarding within the public sector.

1.9.4 Peter has completed Home Office approved Training and has attended subsequent Training by Advocacy After Fatal Domestic Abuse.

1.9.5 Peter is an experienced review chair and has completed a wide variety of reviews including those concerning domestic homicide and the safeguarding of both adults and children.

1.9.6 The chair has no connection with Safer MK and have never been an employee within any of the partnership agencies represented in this review.

1.10 PARALLEL REVIEW

[4] Multi Agency Safeguarding Hubs
[5] Multi Agency Child Exploitation
[6] Multi Agency Public Protection Arrangements
[7] Multi Agency Risk Assessment Conference

1.10.1 Inquest

On 16 December 2019 the Coroner concluded that Christopher had died by suicide, with the medical cause of death being recorded as 'suspension from a ligature around the neck'.

1.10.2 Police Investigation

Detectives from the Thames Valley Police investigated the circumstances surrounding the finding of Christopher's body and confirmed that there was nothing to indicate foul play or third-party involvement in his death. Consequently, the matter was formally classified as an 'unexplained death' and closed.

1.11 EQUALITY AND DIVERSITY

1.11.1 The Review Panel considered all the nine protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation during the review process.

1.11.2 At the first meeting of the Review Panel, it identified that the protected characteristic of sex required specific consideration. Analysis of previous similar reviews reveals gendered victimisation across both intimate partner and familial homicides with females representing most victims and males representing the majority of perpetrators.

1.11.3 This review has been commissioned following the death by suicide of a male and the ONS figures for 2019 confirm that 72% of deaths by suicide are carried out by men[8]. Yet despite efforts to source details of the causes of these deaths the chair has had to rely upon limited research and small amounts of witness testimony to be able to understand why men make the ultimate decision when involved in relationships containing issues of domestic abuse.

1.12 DISSEMINATION

1.12.1 Once finalised and agreed by this review panel, the Executive Summary and Overview Report was presented to Safer MK for approval. Upon agreement, both documents were sent to the Home Office Quality Assurance panel for assessment and sign off.

1.12.2 The recommendations and action plan will be owned by Safer MK, who will be responsible for disseminating learning through professional networks locally, as well as receiving reports on the progress of the action plan.

[8]8 In 2019 there were 5691 reported deaths by suicide. 4303 were carried out by men. 16.9% per 100,00 is the highest annual number since 2000.
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2019registrations

1.12.3 The Executive Summary and Overview Report will be shared with the Police and Crime Commissioner for Thames Valley.

1.12.4 The report will be published once complete, in line with statutory guidance.

1.13 PREVIOUS LEARNING FROM SIMILAR REVIEWS

1.13.1 Three previous reviews have been undertaken by Safer MK. The chair has reviewed the recommendations and can find none which impact on this review or the circumstances which lead to it.

1.13.2 It is commendable that Milton Keynes Council maintains a register of such reviews, including their status, key issues, and recommendations. The chair reviewed this register following the fourth panel meeting, to identify any relevant recommendations.

2 BACKGROUND INFORMATION (THE FACTS)

2.1 THE DEATH OF CHRISTOPHER

2.1.1 Towards the end of January 2019, in the morning, an off-duty Police Community Support Officer (PCSO) was walking their dog along a tow path and found Christopher suspended from a tree. He was pronounced dead at the scene and, following a subsequent investigation, detectives from the police found no suspicious circumstances around the death and the matter was passed to the coroner.

2.1.2 Later that morning Isabelle was advised of Christopher's death by the police, as were his parents.

2.1.3 The following day, Thames Valley Police (TVP) spoke with Isabelle again and were advised by her that Christopher had left the house following an argument on the evening before his death, taking a small bag of clothes with him. She advised officers that Christopher lived with her, and they were due to get married.

2.1.4 At the time of his death Christopher lived in the Milton Keynes area with Isabelle and their children and this had been the case since the spring of 2014.

2.1.5 A post-mortem was undertaken and concluded that the medical cause of Christopher's death was suspension from a ligature around the neck.

2.1.6 The coroner undertook an inquest into the death of Christopher on 16 December 2019 and the formal conclusion recorded by HM Coroner was 'Suicide'.

3 COMBINED CHRONOLOGY

3.1 The assessment period agreed by the panel was from 1 January 2011 until the date of Christopher's death. The following entries detail the contact between

Christopher, Harriet, Isabelle, Ch1, Ch2 and Ch3 with statutory and non-statutory agencies.

3.2 Several incidents were recorded, during the IMR process, which fall outside the review period and one of them is worthy of recording here as it assists in understanding the nature of the relationship between Christopher and Harriet. On 28 November 2009 after a period of separation, they had dinner to reconcile their differences, but this descended into an argument. Christopher called his brother to collect him, and it was the brother who called the police. Officers completed a DASH risk assessment, questions regarding Christopher's concerns over the separation and financial issues had been answered in the affirmative. No offences were recorded as having been committed, the incident was risk assessed as being standard and therefore no further action was taken. Christopher and Harriet rejected support from the Domestic Violence Unit. However, Ch1 was recorded as being present and the police IMR says that Children's Social Care would have been notified in line with policy at that time, although there is nothing in the IMR to suggest that did happen. These details are not noted in the Children's Social Care IMR.

3.3 2011

3.3.1 Thames Valley Police – On **16 January 2011** with Christopher the aggrieved and Harriet the suspect. The report was made by one of Christopher's brothers stating that Christopher had been assaulted by Harriet. Christopher had returned home late from a football match and woke Harriet who struck Christopher in the face. When officers attended, they first considered cautioning Harriet who they thought to be drunk at the time, but the officers decided that the injuries had been caused accidentally, and no sanction was necessary. The IMR states that the DASH risk assessment[9] states that the incident resulted in a bloody nose and that Harriet had recently given birth to Ch2. It also includes a note that Christopher stated, on the DASH, that he felt that the abuse was getting worse and that he believed that this was due to Harriet's post-natal depression but that he did not want police involvement. Officers conducted a full investigation including interviews with Christopher's brother and neighbours, the 999-tape recording of the original call to police was also considered before the decision was taken not to take any further action. Details of the guidance given to police officers when attending reporting of domestic abuse are detailed in Appendix 3. The Crown Prosecution Service provide further advice and a checklist for those investigating such allegations, see Appendix 4.

3.3.2 Children's Social Care - On **17 January 2011** a referral was received from Thames Valley Police, following an allegation of *'assault by injury'* (this is the police crime category recorded). It was alleged by Christopher's brother, that Harriet had been taking drugs and assaulted Christopher. Upon following up this matter Christopher confirmed that the assault had occurred however no injuries were

[9] A Risk Assessment Proforma used during investigations into Domestic Abuse https://www.rtr-champs.org.uk/cms/sites/default/files/resources/risk/DOM5%202019.pdf

sustained. It is believed that Ch1 and Ch2 were at home during this incident. No further action was taken by Children's Social Care with regards to this.

3.3.3 Thames Valley Police – On **23 June 2011** an alleged assault occurred where Harriet was the aggrieved and Christopher was the suspect. Christopher and Harriet had been on an evening out in London but had become separated and returned home separately. Harriet was the first home followed a short time after by Christopher. Harriet alleged that Christopher had pulled her out of bed and kicked her before placing his arm across her neck and then bending her fingers back. In his interview with the police Christopher denied this and stated that Harriet had grabbed him by the genitals and was crushing them, and he bent her fingers back to remove her hand. No further action was taken against Christopher as there was insufficient evidence to proceed. A DASH risk assessment was completed stating that Harriet was frightened due to the attempt to strangle or choke her and that she had recently had a baby. There is no record of Christopher having been arrested as a result this incident and an interview had been carried out with Christopher voluntarily attending the police station, which appears to demonstrate a willingness to assist the investigation.

3.3.4 Children's Social Care - On **23 June 2011** A referral regarding the above matter was received and following an assessment using the CAF[10] a decision was reached that there were no apparent risks or threats to the children. The Referral and Assessment Team wrote to Harriet, offering support services and reminding her of the impact that domestic abuse can have on children. The referral was then closed.

3.3.5 Thames Valley Police – On **16 October 2011** a third party called police after having spoken to Harriet on the phone. The caller could hear Christopher shouting in the background and was unsure whether there had been any violence towards Harriet. The caller could hear that the children were also upset. Christopher had allegedly locked them out of the house after turning up to collect the children and had looked at Harriet's phone causing him to lose his temper. He then left the property; officers attended the address where no offences were disclosed. In completing the DASH Harriet declared that she had ended their relationship due to increasing violence and referred to the incident in June (3.3.3), but also stated that she thought Christopher was depressed, had threatened to die by suicide, and told her that he had thought of a variety of ways of doing it. Christopher had also told her that he had previously slit his wrists, as a teenager. Due to the presence of the children an automatic referral was made to Children's Social Care. The DASH assessment was completed with Harriet, and she answered yes to 16 of the questions. The perceived risk, to Harriet was considered standard. This is discussed later, during the analysis of individual agency performance.

3.3.6 Children's Social Care - Following a referral by the police after the above incident Children Social Care reviewed the circumstances and assessed that there were no

[10] Common Assessment Framework - greatermanchesterscb.procedureonline.com

risks or threats to the children and therefore no further action was taken, and the matter was closed.

3.3.7 Medical Centre – Christopher was seen on several occasions following marital breakdown with Harriet, between **17 October 2011** and **28 May 2012**. There are no details submitted as to the exact nature of the discussions or issues raised by Christopher on these visits.

3.4 2012

3.4.1 Thames Valley Police – On **23 September 2012** Harriet called the police and reported that her partner had been extremely violent and had been throwing her around. She remained on the phone line until officers visited the home address. She reported that Christopher was somewhere in the house and she was scared to leave the bathroom. Harriet told the officers that she was dizzy, that her head was hurting and that she was bleeding from her hip. Harriet told officers that the injuries had been caused by Christopher pulling her out of bed.

3.4.2 At approximately the same time police received a call from Christopher stating that he had been attacked. He stated that Harriet was making everything up and that she was drunk and had made allegations before and that he was simply looking after their two-year-old child who had been awoken by an argument that had occurred between the two of them after their evening with friends.

3.4.3 Harriet was taken via ambulance to Milton Keynes University Hospital for treatment and Christopher was arrested for assault. A relative of Christopher was contacted with regards to caring for the children. This relative challenged the arrest, telling officers that they did not know about the history of the relationship between Christopher and Harriet. The duty inspector was informed about this incident but there were no details available to the IMR author as to whether any further comment was made by the inspector.

3.4.4 The information available shows that the couple had had friends for dinner and cocktails and that Harriet had become very drunk, falling over a couple of times during the evening. The friends both corroborated Christopher's version of the evening and that he had seemed sober throughout dinner, and that there appeared to be no animosity between Christopher and Harriet. However, Christopher states that he felt the need to question Harriet about becoming so drunk during the evening at which point she grabbed Christopher by the throat and then locked herself in the bathroom. Christopher told officers that Harriet had fallen off her chair which she found amusing at the time but could be the cause of the injuries she sustained. He also stated that Harriet had earlier told him that he repulsed her but he believed that she would not hurt him intentionally.

3.4.5 Officers took a statement from Harriet in which she described the incident and confirmed that she been drinking cocktails. Harriet said that she was merry but not drunk. After the friends had left, she went to bed and was falling asleep when Christopher entered the room shouting and dragged her from the bed by her arm. Harriet stated that she caught her lower back on the chest of drawers

causing a cut, she did not recall what happen next, but her memory was of being in the bathroom calling the police on the house phone. She said Christopher had tried to open the bathroom door, he was hitting the door and shouting for her to let him in. She could hear Christopher speaking to somebody on the phone. The next she knew the police were at the door. Harriet stated that she was taken to hospital. Hospital staff had confirmed she had soft tissue damage to her arm, broken ribs, a bump on the back of her head with pain down her neck. Harriet stated she had no recollection of how the hip and the head injuries were caused.

3.4.6 Investigating officers took statements from the two guests who were at the dinner party, they agreed with the account provided by Christopher and described Harriet as being very drunk. They described at one point Harriet attempted to stand up but lost her balance falling forward off the chair and landing on another chair, Christopher was described as having drunk one cocktail and two bottles of beer and appeared sober.

3.4.7 Officers made the decision that there was insufficient evidence to charge Christopher and he was released. A DASH form was completed with Harriet but not Christopher. The DASH form was submitted by the reporting officer and then assessed, by the police supervisor, as being of a Medium Risk but later downgraded to Standard by the dedicated police team who investigate domestic abuse reports.

3.5 2014

3.5.1 Thames Valley Police – The last reported incident involving Christopher and Harriet took place on **26 February 2014**. Christopher was returning the children to Harriet, but she was not at home to receive them, he started texting her as she arrived home. The police were called after Harriet alleged that Christopher had pushed past her knocking her to the floor. Christopher was voluntarily interviewed by police later in the day after making a counter allegation. He stated that he returned the children to Harriet's address when she pushed them back to him telling Christopher to take the children to school at which point, he put his foot in the door to prevent Harriet from closing it. Both children were crying, so Christopher took Ch1 to school and attempted to leave Ch2 with Harriet, but she refused to open the door. Christopher then took Ch2 to their maternal grandmother. Following the police interview the decision was taken that there was insufficient evidence to prosecute Christopher and the case was closed.

3.5.2 Children's Social Care - On **28 February 2014** following a referral by the police, the service reviewed this and previous incidents and concluded that there was no significant risk to either adults or children and the case was closed.

3.5.3 MK ACT - In **February 2014** as the result of a referral to MK ACT Christopher was named as a perpetrator against an unnamed victim. MK ACT confirm that a safety plan for the victim was put in place after the referral was assessed as being of a Medium Risk. The incidents had previously been reported to the police resulting

in a Non-Molestation Order being issued against Christopher[11] which lasted for 26 days.

3.5.4 Children's Social Care – On **12 March 2014** a referral was received by the Mental Health Practitioner (from MKUHFT) who had been working with Harriet since the incident reported to police on **26 February 2014**. The practitioner was concerned about the emotional well-being of Ch1 and Ch2 as they had been exposed to incidents of domestic abuse, and the poor mental health of their mother. The case was transferred to the Children and Family Practice – Early Help service[12] on **13 March 2014** and closed on **22 July 2014.** The involvement with the Early Help service involved engagement with the school and nursery attended by both children. There is also clear reference to the involvement of school nursing and the health visitor. Furthermore, there was a visit arranged on 22 July with the local Children's Centre to discuss summer activities that the children could participate in, to support mum over the summer holidays.

3.5.5 Milton Keynes University Hospital Foundation Trust (MKUHFT) – On **3 June 2014** Christopher self-referred to the Emergency Department (ED) via private transport. He presented with a glass laceration wound to his right thumb. The reported injury occurred when washing up a glass at home, the wound was cleaned and dressed. There were no reported concerns raised regarding how the injury occurred. Christopher was discharged home with GP follow up.

3.5.6 Milton Keynes University Hospital Foundation Trust (MKUHFT) – On **24 July 2014** Christopher self-referred to ED by private transport. He attended with a left eye injury. The reported injury was sustained from practising kick boxing. Christopher reported that he needed go and collect the children and could not wait to be seen. Prior to leaving Christopher was advised to return as he'd expressed that the symptom of a pain in the eye was present. The ED telephoned Christopher three hours later, however there was no answer, and the matter was discharged.

3.5.7 On **17 October 2014**, Harriet reported an incident where Ch2 had been struck with a plastic bottle by Isabelle. Harriet reported that there was a prominent bruise on Ch2's eye and upon being questioned by Harriet as to how they got the bruise, Ch2 replied that Isabelle had hit them on the head. Harriet also reported that the children had informed her of other incidents whilst they had been staying with Christopher, but this was the first time where one of the children had been hurt. When officers arrived at Harriet's address and spoke with Ch1, it emerged that Christopher and Isabelle were having an argument when Isabelle threw an empty plastic bottle at Christopher which bounced off him hitting Ch2 on the rebound. The officers passed the case on to the Child Abuse Investigation Unit, who spoke with both Christopher and Isabelle, and they denied there being any verbal or physical altercations while the children had been

[11] The details of the non-Molestation included Christopher 1) being forbidden to use or threaten violenceagainst the applicant 'Harriet' and must not instruct, encourage or in any way suggest that any other person should do so. 2) Intimidate, harass, or pester the applicant 'Harriet' and must not instruct, encourage or in any way suggestthat any other person should do so. 3) Come within 100 metres of the applicant's 'Harriet' address 4) Send any threatening or abusive letters or text messages or other threatening communication.

[12] https://www.milton-keynes.gov.uk/children-young-people-families/early-help/children-and-families-practices-one-family-one-plan

present. Whilst Children's Social Care spoke with Ch1, it is recorded that Ch1 was too shy to speak with them and that there would be no further action taken.

3.6 2015

3.6.1 Children's Social Care – On **22 September 2015** an anonymous call was received raising concern about Ch1 and Ch2. The caller was concerned that the children appeared to be unkempt and smelled of urine and faeces. The caller was also worried about Harriet's abuse of alcohol, potential use of controlled drugs and incidents of domestic abuse involving previous partners. They were upset that Ch1 appeared to be 'withdrawn' recently and that Harriet seemed to be struggling to cope with Ch2's behaviour and the caller believed that the child was suffering with ADHD. Harriet was approached and informed CSC that she needed support as she was indeed struggling with Ch2's behaviour. She disputed the allegations of alcohol abuse and confirmed that she did have mental ill-health problems. The case was referred to Children and Families Practice (CFP) on **23 September 2015** and engagement between the CFP and Harriet lasted between 29 September 2015 and 13 November 2015. During this time there is evidence of close working with the school and the nursery. Schools were fully involved as part of the team around Ch1 and were part of the ongoing assessment and the decision to close the referral was based on the fact that Harriet had engaged well with the services offered.

3.6.2 Children and Families Practice – On **13 November 2015** the matter was closed as 'Concerns had been addressed' (as per 3.6.1 above).

3.6.3 Children's Social Care – On **7 December 2015** Christopher's father made a referral raising concerns over Harriet's mental health and misuse of alcohol. He reported that Ch1 and Ch2 had been living with Christopher since **6 November 2015** and that Harriet had been calling Christopher in the night asking to have the children back and she was self-harming. Christopher's father was concerned that Harriet would take the children out of school and that Christopher was taking legal advice regarding a residency order and he was advised to liaise with the schools, which he agreed to do.

3.7 2016

3.7.1 Children's Social Care – On **11 February 2016** Harriet's stepfather contacted the department reporting that Ch1 and Ch2 were now living with Harriet. He raised concerns over the children's well-being and confirmed that Christopher's family were now seeing the children one weekend a fortnight. He described Harriet's house as being in a very bad state, that in the morning the children were often up alone, partly dressed, fighting with each other and unfed. He expressed sadness and requested some discussion about what could be done as he felt that their care was being neglected. Harriet's stepfather stated that Harriet was under the care of the Community Psychiatric Nurse (CPN) and the Complex Needs Service (CNS). CSC wrote to Harriet and enclosed information on the CFP and available support agencies. A letter was also sent to Christopher's stepfather

advising him to seek legal advice regarding contact and residency. No further action was taken by CSC regarding this matter.

3.7.2 Children's Social Care – On **16 February 2016** Harriet's stepfather sent an email reporting that Harriet had been in contact with Christopher four days earlier telling him that she was feeling suicidal and had taken an overdose. Harriet had spoken to Christopher and told him that she had been drinking heavily. It appears that on both occasions the children had been either with Christopher or his parents. The matter was reviewed, and a letter was sent to Harriet's stepfather advising him regarding Residency Orders. As there was no reported risk to any of the children the matter was closed.

3.7.3 Thames Valley Police – On **28 February 2016** Christopher's father contacted the police stating that Christopher had been assaulted by Isabelle causing a black eye. He was concerned that although Christopher was living in the family home if he discovered that Henry (Christopher's father) had called the police he would leave and return to Isabelle. Officers arranged to meet Christopher at his workplace where he informed them that the injury was accidental and refused to engage in the DASH process. Officers handed Christopher a FAQ leaflet with safety advice.

3.7.4 Medical Centre – On **22 July 2016** Christopher registered with the GP surgery. He attended for a GP review, as he was a new patient, and the surgery had no records for him. Christopher reported a history of depression, anxiety, and counselling. He felt his anxiety levels were increasing, due to the responsibility of looking after his children, dealing with his ex-girlfriend, money, and work.

3.7.5 Medical Centre – On **15 September 2016** Christopher attended for a GP review. He reported longstanding depression since he was a teenager but said he had strong family support. He was seeing a counsellor, which had been arranged by work, but it was not helping. Christopher reported a relationship split with access to children being denied due to Child Support Agency (CSA) issues. He was also finding work stressful and was struggling to focus. The GP notes recorded that his children were a protective factor, and that Christopher was provided with details for 'Talk for Change'.[13] The doctor's notes also record 'no thoughts of deliberate self-harm.

3.7.6 Medical Centre – On **16 September 2016** Christopher spoke to the GP stating that he couldn't return to work. The GP issued a sick note and requested a review in one week.

3.7.7 Medical Centre – On **23 September 2016** Christopher attended for GP review. He had received three calls from work trying to arrange a meeting, but he felt stressed and not able to attend. The GP provided a sick note for work stating that repeated contact from work was worsening the situation.

3.7.8 Medical Centre – On **30 September 2016** Christopher attended a GP review. He said he felt brighter, was getting things done and was ready to return to work

[13] https://mktalkingtherapies.nhs.uk/

although he was anxious. The GP prescribed Citalopram[14] provided a sick note suggesting a reduced workload and arranged for a further review to be completed in 3-4 weeks' time.

3.7.9 Medical Centre – On **4 October 2016** Christopher attended a GP review. He reported feeling brighter and had tried to get back to work but HR was not supportive, and he had been given a full caseload. He reported poor concentration levels and feelings of stress in the workplace. He confirmed that he was still seeing the counsellor. Christopher reported family worries including access to children. The GP noted that there were no issues or concerns over self-harming.

3.7.10 Medical Centre – On **10 October 2016** Christopher attended a GP review. He had intended to return to work but had a tearful breakdown due to pressure from his boss and the workload he had been given. The GP provided Christopher with a sick note for one week and noted that he had shown no thoughts of self-harming. He confirmed that Christopher was seeing his counsellor and that the family was worried, particularly about his access to Ch1 and Ch2.

3.7.11 Medical Centre – On **17 October 2016** Christopher attended a GP review. He reported feeling a little better but was anxious about going to work, only contacting work through emails to and from HR. He was keen to leave his job and was looking for alternative careers. His family and friends had been supportive regarding his mood. Christopher added that he'd had his children at the weekend and felt relieved that they needed him. The GP affirmed his diagnosis of depression and provided a sick note for two weeks, with a further plan to review the situation then.

3.7.12 Medical Centre – On **28 October 2016** Christopher attended a GP review. Initially he felt worse on starting his medication but after taking it for a month was feeling a little better. He reported feeling tearful and anxious and had planned a meeting with work who had identified the cause for his work-related stress and were aiming to try to resolve the issues. Christopher didn't feel ready for a phased return to work as he wanted to wait for the outcome of his meeting with them. Christopher had identified other careers and was preparing to apply for new jobs; however, he was daunted by the prospect of job interviews but felt they would help his mental health. He was attending counselling. His diagnosis and medication remained the same.

3.7.13 Medical Centre – On **8 November 2016** Christopher attended a GP review, he had had a meeting with work where it was agreed he was not fit. Christopher

[14] Citalopram is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI). Often used to treat depression and also sometimes for panic attacks. Citalopram helps many people recover from depression and has fewer unwanted side effects than older antidepressants.

reported starting a grievance procedure. He continued seeing a counsellor and felt that the medication was helping.

3.7.14 Medical Centre – On **21 November 2016** Christopher attended a GP review, his ongoing grievance, at work, hadn't changed, but he continued to have support from his counsellor and family. He was in discussion with work but did not feel fit enough to return. Christopher was issued with a sick note for two weeks and additional medication, he was also advised to call 999 if he felt he was in a crisis.

3.7.15 Medical Centre – On **7 December 2016** Christopher attended a GP review, reporting no real change. He was still going through the grievance procedure at work and didn't feel he could resume while that was going on. He reported continued issues with anxiety but was still seeing his counsellor. He was given a sick note for work with a plan to review matters four weeks later.

3.8 2017

3.8.1 Medical Centre – On **5 January 2017** Christopher attended the surgery for a GP review, his grievance at work continued. He reported having a difficult time over Christmas and his family was concerned about his mood. He had been offered the chance to apply for a new job within the same company which was good as he was finding applying to new companies daunting. He would be working for a restructured team and the manager who he had the grievance against was not likely to be working there. The GP continued Christopher's medication and noted that there were 'no thoughts of self-harm or suicide' but there were concerns about his mood.

3.8.2 Medical Centre – On **6 February 2017** Christopher attended an emergency appointment for his ongoing issues of depression for which he was receiving private counselling. He also reported having an ongoing grievance against his supervisor at work. He'd had a meeting with the Occupational Health team and wanted to agree with them a plan to go back on phased return. The GP warned that long term sickness could impact upon his mental health but noted no ideation of self-harm. A further appointment was made for **20 February 2017**.

3.8.3 Medical Centre – On **20 February 2017** Christopher attended a GP appointment regarding his depression. He reported that things had worsened and that his work had not been in contact. Four days previously his girlfriend had left, she had been a strong supporting influence. He had not seen a counsellor recently as he had not been able to afford the bus/taxi fare. Christopher was given a sick note for two-weeks and he completed a PHQ9 Depression Test questionnaire[15] where he confirmed that he did not have any "thoughts that you would be better off dead, or of hurting yourself in some way". A further review was arranged for **10 March 2017**.

3.8.4 Children's Social Care – On **24 February 2017** Isabelle contacted CSC and spoke to a MASH social worker. She acknowledged that she was not feeling good the

[15] https://patient.info/doctor/patient-health-questionnaire-phq-9

week before but denied feeling suicidal. She said that she felt low but had not liked the practitioner she had seen at the hospital and had not wanted to talk any further. She explained that she had suffered from depression following the death of her father five years previously. Isabelle said that her mum was living with her, and this provided her with some support, which was good for Ch3's welfare. She said that she had spoken to Ch3's school and the child was settled and doing well. Isabelle denied being in an abusive relationship. She said that she worked part time and had friends she could talk to, nor did she want any support and would approach her GP or IAPT[16] or MK Act if necessary. A decision was made to close the case, contact was made with Ch3's school as there were identified safeguarding concerns, due to the disclosure made by Isabelle. A letter was sent to Isabelle with information about MK ACT.

3.8.5 Medical Centre – On **10 March 2017** Christopher attended a GP appointment for a review of his depression. He told the GP that he did not feel that he could work, and his employer was supportive of the idea of a phased return and change of role. He was prescribed medication to assist with his condition and invited to attend a review on **29 March 2017.**

3.8.6 Milton Keynes University Hospital Trust - On **12 March 2017** Christopher attended the Emergency Department after a road traffic collision caused an injury to his right wrist. He discharged himself, against advice from the health professionals present, who were concerned about his loss of consciousness following the accident. Christopher was advised to return to the Emergency Department if he felt unwell.

3.8.7 Medical Centre – On **29 March 2017** Christopher attended a GP appointment – he'd had a meeting with work the previous day. He was feeling worse but had been looking at a phased return to work, but they felt it wasn't suitable. He had resumed counselling. Christopher did not feel that his current medication was helping and asked about alternatives, the GP's diagnosis was that of 'Mixed Anxiety and Depressive Disorder (MADD)[17]'. His medication was changed, and he was given a three-week sick note for work. There was no further contact with Christopher regarding these episodes.

3.8.8 Milton Keynes University Hospital Trust – On the **02 August 2017** Christopher returned to the Emergency Department with a neck injury sustained whilst attempting to raise his child on to his shoulders. Christopher was assessed and discharged with some analgesia[18] and an advice sheet on neck injuries.

3.8.9 Medical Centre – Christopher visited the medical centre for problems with a strained neck on **4 August 2017**. He was prescribed pain relief and advised to consider a referral to the physiotherapist.

3.8.10 Thames Valley Police – On **10 December 2017** a call was made to 999 by Isabelle, requesting police assistance to remove Christopher from her property. She

[16] Improving Access to Psychological Therapy.
[17] https://www.sciencedirect.com/science/article/abs/pii/S0165178100001311
[18] https://en.m.wikipedia.org/wiki/Analgesic

reported that he was being intimidating, violent and refusing to leave. Isabelle confirmed that Ch3 was at the address, and it was noted by the call handler that Christopher could be heard in the background and that he appeared to be calm. When officers arrived at Isabelle's home, Christopher was preparing to stay with his parents and Isabelle confirmed that it had been a verbal argument, with officers noting that Isabelle was intoxicated. The officers then confirmed that Christopher had left the premises and advised Isabelle to keep the doors locked to prevent him from returning. The officers who initially attended the incident were Armed Response specialists who, once the risk had been mitigated, left the scene for local officers to deal with the appropriate paperwork. The IMR also confirms that Ch3 was spoken to at the time, but that Children's Social Care was not informed as per agreement between CSC and MASH[19].

3.8.11 Isabelle was subsequently called, and an arrangement was made to visit her at home. She declined the visit stating that she was putting her young child to bed and requested a call on the following morning. Officers attempted to contact her by phone, twice, on the morning of **11 December** but she didn't reply. When they attended her address, their notes describe Isabelle as being hostile and annoyed that they had arrived without an appointment and Isabelle did not engage with them. There is no record of any follow up with Christopher.

3.9 2018

3.9.1 Medical Centre – On **11 January 2018** Christopher made an appointment to discuss fertility matters and was referred to CARE (Northampton Fertility Clinic).

3.9.2 Medical Centre – On **28 March 2018** Christopher had an appointment with the clinic which he did not attend.

3.9.3 Medical Centre – On **10 May 2018** Christopher made an emergency appointment regarding back pain, which he later called to cancel.

4 OVERVIEW

The overview summarises what information was known to the agencies and professionals involved with the deceased, Harriet, Isabelle, and Christopher's family. Any other relevant facts or information about the deceased and other parties is also recorded.

4.1 THAMES VALLEY POLICE

4.1.1 Christopher was known to the police and involved in several incidents where he was viewed as being either the perpetrator or the victim of domestic abuse. At

[19] The matter was assessed and triaged by Thames Valley Police. The risk was considered to be standard and as the family were already known to the CSC, but with no current 'open' case, the police did not share details of this incident. In matters involving more aggravating factors (e.g. alcohol, drugs, violence etc) risk levels are raised beyond standard (Medium or High) and immediate disclosure is made.

no point was Christopher or either of his partners ever charged with a crime relating to the incidents recorded in this review.

4.1.2 Through the police IMR we understand that Harriet may have had some depressive tendencies which Christopher believed to be post-natal. We also know from the police records that Christopher believed that Harriet drank heavily and was potentially taking drugs.

4.2 THE MEDICAL CENTRE

4.2.1 The Practice saw Christopher regularly over two separate periods during the time frame of the Review. The first of these periods was following a marital breakdown, between 17 October 2011 and 28 May 2012 (the IMR author has assumed that this is the relationship between Christopher and Harriet). There are no details submitted as to the exact nature of the discussions or issues raised by Christopher on these visits. The second was between 22 July 2016 and 29 March 2017 for an episode of depression.

4.2.2 Details of Harriet and Isabelle's medical histories are not known to this review as neither have granted permission for the disclosure of their records. The chair has made multiple requests for both to engage with the review. However, these offers have never been acknowledged or accepted and the review respects this stance and empathises with the emotional difficulties faced by both people.

4.3 MK ACT

4.3.1 The IMR from MK ACT Domestic Abuse Intervention Service informed the review that in March of 2014 a referral to MK ACT named Christopher as an alleged perpetrator.

4.3.2 They state that a safety plan for the victim was put in place after the risk was assessed as being Medium. The incidents were reported to the police and following the interaction with MK-ACT a Non-Molestation Order was granted against Christopher.

4.3.3 As this review has been unable to get the permission, from either ex-partner, to reveal the details of their involvement with MK ACT no more information has been disclosed by this agency.

4.4 CHILDREN'S SOCIAL CARE

4.4.1 Children's Social Care had an involvement with the family unit comprising Christopher, Harriet and their two children (Ch1 & Ch2) before the review period, which was primarily due to several incidents of domestic abuse reported to Thames Valley Police which were shared with the Multi-Agency Safeguarding Hub. Christopher was presented as being the victim as well as the perpetrator during these episodes.

4.4.2 The early help service, known as the Children's and Families Practice, was involved with the family on two occasions. Firstly, between 1 April 2014 and 22 July 2014 and then between 29 September 2015 and 13 November 2015. On both occasions after an assessment, it was felt that appropriate interventions had been put in place to support the family and address any concerns.

4.4.3 Children's Social Care also noted that Ch1 and Ch2 had resided with Christopher for a period of seven weeks between 5 November and 26 December 2015, but do not state why. The Review assumes that this was as a result of the second Children and Families Practice intervention which was at the start of this period.

4.4.4 The information provided by Children's Social Care also states that after the breakdown of the relationship between Christopher and Harriet, Harriet then formed another relationship where domestic violence occurred, and that at this point (between 11 and 16 February 2016) both paternal and maternal grandfathers, as well as some anonymous referrers contacted Children's Social Care with concerns over Harriet.

4.4.5 The only contact that Children's Social Care had with Isabelle came through a referral to MASH on 20 February 2017 where Mental Health Services at Milton Keynes Hospital had assessed Isabelle on 17 February 2017 for presenting with low mood and suicidal ideation. Isabelle was reported as stating that she was in an abusive relationship and that she was partly to blame for the problems in the relationship. Children's Social Care visited Isabelle, concerned over the impact of this on Ch3. At this point Isabelle denied that the relationship was abusive and stated that Christopher was not living with her and Ch3 at that moment in time. The case was closed because of this assessment on 24 February 2017.

4.5 MILTON KEYNES UNIVERSITY HOSPITAL TRUST

4.5.1 There were four other visits to the MKUHFT. On 3 June 2014 Christopher attended with a glass laceration to his right thumb which occurred when washing up a glass. The wound was cleaned and dressed, and Christopher was discharged with a GP follow up. On 24 July 2014 Christopher attended with a left eye injury sustained during kick boxing practise. He left before he could be assessed as he needed to collect his children. He was advised to return to the Emergency Department and the unit called Christopher back three hours after his initial presentation but there was no answer, and he was discharged.

4.5.2 On 12 March 2017 Christopher attended the Emergency Department after a road traffic collision caused an injury to his right wrist. He self-discharged, against advice from the health professionals present who were concerned about his loss of consciousness following the accident. Christopher was advised to return to the Emergency Department if he felt unwell. 2 August 2017 saw him return to the Emergency Department with a neck injury sustained whilst attempting to raise his child on to his shoulders. Christopher was assessed and discharged with some analgesia and an advice sheet on neck injuries.

5 ANALYSIS

5.1 The Terms of Reference identifies key lines of enquiry which include:

- Set out the facts of agency involvement with Christopher, Harriet, Isabelle, Ch1, Ch2 and Ch3
- Critically analyse the service they were provided, in line with the specific terms of reference
- Identify any recommendations for practice or policy in relation to their agency
- Consider issues of agency activity in other areas and review the impact in this specific case

The facts leading to this death have been documented in the combined chronology and overview sections of this report. This section will seek to identify areas of good practice and, lessons that are to be learned and make recommendations to reflect those opportunities.

5.2 HINDSIGHT BIAS

5.2.1 The report author has attempted to view this case, and its circumstances as it would have been seen by the individuals at the time. It would be foolhardy not to recognise that a review of this type will undoubtedly lend itself to the application of hindsight bias. Hindsight always highlights what might have been done differently and this potential bias or 'counsel of perfection' must be guarded against. There is a further danger of 'outcome biases' and evaluating the quality of a decision when the outcome of that decision is already known. However every effort has been made to avoid such an approach.

5.3 DOMESTIC ABUSE/VIOLENCE

5.3.1 Christopher died by suicide. The reasons for this act cannot be explained with any certainty.

5.3.2 Care should be given to avoid stereotypical assumptions regarding domestic abuse. Irrespective of gender, domestic abuse occurs amongst people of all ethnicities, sexualities, ages, disabilities, religions or beliefs, immigration status, or socio-economic backgrounds. Domestic abuse can occur between family members as well as between intimate partners.

5.3.3 Considering the government definition of domestic violence and abuse, which describes a pattern of incidents of controlling, coercive or threatening behaviour, the review panel was able to determine that there was a broader history to this single act. This conclusion is based on the information provided by the police investigation and agencies involved, and it is important to note that we do not know with any certainty, the level of domestic violence within either relationship. Interviews with friends and family record their concerns not only about the

relationship between Christopher and his two partners but also the impact that this had upon their children. During both of Christopher's relationships there were several engagements with the agencies involved in this review both individually, for medical and health reasons, and as a couple, predominantly involving reports to the police. It is important to note that despite these contacts and allegations of domestic abuse these may not have been the only times when such abuse was occurring. It may simply be they were not reported, and that any perpetrator and root cause of the incidents is unknown.

5.3.4 Regardless of whether there was a wider pattern of domestic violence, there were tensions and emotional conflicts in Christopher's relationship with both Isabelle and Harriet. Indeed, prior to Christopher dying by suicide, it had been over 12 months since there had been any reported family problems or difficulties, and it seems that Christopher and Isabelle were actively seeking to have more children. This is evidenced by Christopher's visits to the family medical centre and referrals to various fertility clinics for several months in the Summer of 2018. There is nothing to suggest that these efforts to increase their family was ever the source of any dispute, abuse, or domestic violence.

5.3.5 Tragically it is not possible to build a picture of Christopher's perspective on his relationship with either Harriet or Isabelle. Christopher was having emotional problems at work and had spent many weeks and months absent, due to issues of anxiety and depression. It appears that there were concerns over Harriet's mental health and issues with alcohol abuse, family members from both sides reported the impact of these upon her ability to take care of her children. This relationship ultimately broke down and at the time of his death Christopher was in a new relationship with Isabelle. There were reported issues between the two, including calls to the police, and attendances at the Milton Keynes University Hospital Trust. Harriet had reported being in an abusive relationship and there had previously been an action plan prepared by MK ACT on her behalf. It is believed that this plan referred to Christopher as the perpetrator and involved supporting an application for a Non-Molestation Order to keep the two parties separated and prevent future offences or issues of harassment between them.

5.3.6 Christopher may have perceived that his world was caving in on him as he had many visits to the medical centre discussing feelings of depression and difficulties at work. He appears to have spent an extended period sick, away from his workplace. The records produced and analysed by the panel suggest the relationship between Christopher and Harriet was often a tempestuous one, with several calls to the police, not just by Harriet, but also family members including parents of both parties. Having said that there is nothing in these reports or from the information provided by friends and family to suggest any clues that Christopher would ultimately end his life. This is discussed in Section 5.4 below 'Male Victims of Domestic Abuse'.

5.3.7 If Christopher did have any wider concerns about his relationship with either partner or had experienced any domestic abuse or violence at the hands of either of his partners he appeared to keep them to himself. The panel has considered whether there were any barriers to prohibit or discourage the reporting of any

incident, issues, or concerns of domestic abuse by any of the parties involved. As can be seen, throughout the chronology, reports were made by many of the parties involved including not just Harriet and Isabelle but also family members, and involved agencies, for example the police and mental health practitioners. The one absentee from this list is that of the deceased himself and this raises the question about how aware, or confident, he was in the pathways that were available to men who feel they are victims of domestic abuse.

5.3.8 The review has sought to identify whether there was evidence of matters spiralling out of control or deteriorating in ways which could, or should, have been apparent to any agencies who were involved with the family. It is apparent that this was not the case, but this raises further questions about how aware the deceased or family and friends were with regards to the support services that were available to him and how professionally curious practitioners were when they had the opportunity to speak to Christopher and discuss subjects such as his mental and emotional well-being. These issues are discussed in Sections 5.5 Routine Domestic Abuse Questioning within Health Care, and 5.8 DOM5 Questionnaire and Professional Judgement.

5.3.9 The review has also considered whether Christopher's emotional health and well-being was a contributory factor in him making the decision to take his own life. As mentioned previously he had many visits to the GP surgery and discussed feelings of anxiety and depression with reference to matters at work. In September 2016 Christopher was prescribed anti-depressants, which he continued to take until his death, in March 2017 he was diagnosed with mixed anxiety and depressive disorder (MADD). It should also be noted that during these visits to the surgery the patient's records reflect that on four occasions the issue of self-harming was discussed, and Christopher told his doctor that he had no such thoughts. This position is supported when in February 2017 Christopher completed a Form PHQ9 on which he stated the same.

5.3.10 Throughout the review period Christopher had three periods of employment. The first and third were for the same employer and these appeared to have been reasonably calm, with regards to his day-to-day work. There were however concerns raised during the interview with his employer (Sean - Interview with previous employer) who comments that Christopher was regularly distracted with problems at home and they would often talk about things during their journeys to and from work. Sean formed the opinion that Christopher was desperate to keep his relationship intact and went to great lengths to dismiss or minimise any issues that were raised.

5.3.11 Analysis of the second period of employment seems to suggest that Christopher was much less happy. He spent long periods away from work due to issues with stress and depression. It is apparent that during Christopher's second period of employment he was receiving counselling provided by his employer and this is referred to several times during his conversations with his GP. There were several efforts made to carry out an Occupational Health Assessment (OHA) and Christopher was regularly encouraged to resume work in a controlled and staged environment. What is also clear is that despite what appeared to be reasonable

efforts being made by the employer Christopher was not able to face a return to work. It was during this period that he was first prescribed antidepressants.

5.3.12 In addition to whether there was an increasing amount of domestic abuse or related tension within his relationships, the review has discussed whether they should consider Christopher's death from different viewpoints.

5.3.13 One explanation for Christopher's act may be to focus upon his mental health (particularly his diagnosed condition of depression) and whether this would account for him taking his own life. Christopher had registered at the GP surgery in September 2016, and it was during this initial consultation that he reported to the doctor about having longstanding issues with depression, going back to his teenage years.

5.3.14 It was mentioned several times in this review, that depression was diagnosed by Christopher's GP on more than one occasion, and this is something that remained a regular theme from the point of registration until the final contact in March 2017. In February 2017 Christopher's condition appeared to have been re-diagnosed as being 'Mixed Anxiety and Depressive Disorder'[20]. This final diagnosis meant a change to Christopher's medication however, the details of this change are not known, and no referrals were made to IAPT services or secondary mental health services in Milton Keynes.

5.3.15 It was in February of 2017 that Christopher requested an emergency appointment with his doctor to discuss his depression and two weeks later at the follow up appointment reported that his depression was worsening.

5.4 MALE VICTIMS OF DOMESTIC ABUSE

5.4.1 This review does not wish to imply that the reason for his death is due to Christopher being the victim of domestic abuse. Sadly, it has not been possible to explore this with him and it is not appropriate to make any assumption from his engagements with agencies or reports from family members.

5.4.2 What is clear, as mentioned above, is that Christopher never initiated any reports or concerns himself and that the only referral pathway that he was given was to the NHS psychological therapies service 'Talk for Change'[21] regarding issues of depression. This service is managed by the Central and North West London NHS Foundation Trust and their records show that no contact from Christopher was ever received. Following the allegations made by Henry, in paragraph 3.7.3, Christopher was provided with various leaflets regarding support for matters including domestic abuse, by police officers.

5.4.3 The Office of National Statistics (ONS) report[22] that for the year ending 31 March 2019, 786,000 men were reportedly the victim of domestic abuse compared to

[20] According to ICD-10 criteria, mixed anxiety, and depressive disorder (MADD) is characterized by co-occurring, subsyndromal symptoms of anxiety and depression, severe enough to justify a psychiatric diagnosis

[21] https://www.nhs.uk/Services/clinics/Services/Service/DefaultView.aspx?id=342004

[22] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2019

1,600,000 women in the same year. In 75% of domestic abuse related crime recorded by the police (for the period) the victims were women. Therefore, the assumption has been drawn that 1 in 4 victims were men.

5.4.4 During this review period there are five incidents, reported by various parties, where Christopher was identified or reported, as the victim of domestic abuse, to Thames Valley Police. Several of these occasions would appear to offer an opportunity to consider the role or availability of services towards male victims. The review has identified that MK ACT is the sole commissioned provider of services for victims of domestic abuse. The service is a gender-neutral agency, and their services include a men's advice line. There are a wide variety of additional services and several examples of those are listed below

https://mensadviceline.org.uk/

https://www.mankind.org.uk/

https://www.itv.com/thismorning/articles/domestic-violence-men-helplines

https://www.refuge.org.uk/get-help-now/help-for-men/

5.4.5 **Learning Point 2:** The review feels that there is an opportunity to enhance the support provided in this area and that men should be offered greater encouragement to come forward when they feel they are the victims of domestic abuse and/or coercive control. **Recommendation 2:** Safer MK to become more proactive in encouraging male victims of domestic abuse to come forward and support service and advice lines should be advertised more widely.

5.4.6 That said, the issue of male death by suicide, with a background of domestic abuse history, is something which is very much in the public eye and this review feels it is appropriate to consider how this can be highlighted and brought to the attention of not just the public but specifically to potential male victims.

5.4.7 Despite several reports that Christopher was the victim of domestic abuse there appears to have been no referral ever made to any organisations or support network for male victims. It must be pointed out that he never reported or requested the need for any such referral, but it would seem to be good practice that once a report has been made either by a victim, or third party then the offer of such support would be beneficial.

5.4.8 **Learning Point 3:** When a report is made of domestic abuse by, or on behalf of a male victim, then a relevant referral should be offered. **Recommendation 3:** Safer MK should review current policies and processes and ensure that there is a referral pathway available to all 'reported' or 'recorded' male victims of domestic abuse.

5.4.9 <u>Good Practice</u>

The review has also probed the subject of suicide prevention and would like to praise the work being done by Safer MK in this area. The work being done by the Health and Wellbeing Hub includes:

- Suicide Prevention Action Planning Groups (SPAPG)
- Reduce the Risk of Death by Suicide in Key High-Risk Groups –
- People in the care of mental health services
- People in Contact with Primary Care
- People with a history of self-harm
- People in contact with the Criminal Justice System
- Specific occupational groups
- Tailor approaches to improve mental health in specific groups
- People who misuse drugs and alcohol
- Reduce access to means of death by suicide
- Provide better information and support for those bereaved or affected by a death by suicide
- Engage with and support the media in delivering sensitive approaches to suicidal behaviour
- Support Research, Data Collection and Monitoring
- Suicide Prevention and Mental Health Training, Awareness and Messages

5.4.10 Consideration has been given with regards to Christopher as a perpetrator of domestic abuse, who was in an abusive relationship and the value of the use of an intervention programme.

5.4.11 Despite being recorded as the aggressor on several police reports Christopher was never prosecuted for any of the reported crimes and during interviews with police officers, including those where he attended voluntarily, he provided accounts whereby he told the officers that his behaviour was as a result of aggression offered by either Harriet or Isabelle. Officers were unable to reach a threshold for prosecution as there was never evidence to support the allegations that were made.

5.4.12 There are no reports, known to this review, to suggest that Christopher was ever offered the opportunity to access a perpetrator programme and referrals into such a process require consent by the subject. This consent must include a recognition and acceptance of the subject's abusive behaviour and that they are ready to engage in a programme of change.

5.4.13 Given these two statements it seems unlikely that even if Christopher had been given the opportunity to engage in a perpetrator programme he would have participated. Of course, this is an assumption, and the review will never know for sure.

5.4.14 The accounts recorded during this review, including IMRs and interviews with family members and Christopher's employer have caused this review to conclude

that Christopher was not in denial about being a perpetrator of abuse but that he was a victim.

5.5 ROUTINE DOMESTIC ABUSE QUESTIONING WITHIN HEALTH CARE

5.5.1 The NHS produced a briefing document relating to Domestic Abuse[23]. Its content provides advice and guidance for those engaging with victims and those vulnerable to such incidents. The rest of this subsection (5.5.1 – 5.5.9) provides a summary of the document's content and a Learning Point and Recommendation are produced at its conclusion.

5.5.2 *"Healthcare professionals are privileged and able to play a unique and important role in the lives of their patients. They are entrusted with the opportunity and responsibility to explore any number of patient concerns that may adversely affect their health. It is the role of healthcare providers to routinely ask questions that may be considered highly personal and sensitive, for example … alcohol abuse.*

5.5.3 *Health care practitioners may feel awkward or embarrassed, but they broach the subjects just the same with their patients because their goal is to provide information and the support that can help them improve and enhance lives.*

5.5.4 *The impact of domestic abuse on individual's health and well-being is substantial including depression anxiety and despair.*

5.5.5 *Physical injuries are also common including bruises and abrasions. Whether in general practice, health visiting, nursing, psychiatric and mental health care or general medicine and surgery or emergency and accidental care, healthcare professionals have daily contact with patients whose health is damaged by domestic abuse and often faced risks of further or more extreme injury.*

5.5.6 *Asking about domestic abuse helps improve patient health and safety, many victims of domestic abuse interact with healthcare providers when seeking routine or emergency care. The healthcare setting is a critical and unique opportunity early identification and even prevention of domestic abuse.*

5.5.7 *Healthcare providers remain reluctant to enquire and assess for domestic abuse for reasons including discomfort, or lack of information on how best to support a patient disclosing abuse. This NHS briefing however acknowledges that domestic abuse, whilst undeniably a sensitive topic, allows frontline practitioners to ask patients about abusive relationships and is no more difficult than asking patients about sex, drugs or bowel habits.*

5.5.8 *The identification of a victim who may be of high risk of domestic abuse allows professionals to make a referral to the Multi-Agency Risk Assessment Conference (MARAC) and the NHS to identify its own coordinator and provides contact details.*

[23] DometicAbuseGuidance.pdf (publishing.service.gov.uk).

5.5.9 *Questions could be asked in a caring manner and with a stated reason for example "Domestic abuse is quite common and therefore I routinely ask all my patients about it". Patients are not offended or frequently say that they are glad somebody is asking them about it. Both patient and service provider testify that enquiring not only confirms that domestic abuse is an important healthcare issue for patients but also sends out a prevention message that domestic abuse is not acceptable. When providers enquire about the subject, they help patients to understand the connection between abuse, health problems and risky behaviour. In addition, they also provide the victim with relief from the isolation that they are more likely to be experiencing.*

5.5.10 *Health care professionals help patients improve their options for health and safety by assessing for abuse, validating the patient's experience, performing a brief safety assessment, documenting the abuse in the patients' medical record in the making of referrals to domestic abuse experts including IDVAs and MARAC coordinators as mentioned before".*

5.5.11 This briefing for healthcare professionals provides various options for taking action *ie*

- Commit to begin routine assessments for domestic abuse within their health setting
- Place victim safety cards in bathrooms and examination rooms and place domestic abuse posters within waiting areas
- It was also suggested that healthcare providers wear lanyards or badges that highlight their support against domestic abuse
- Introduce resource tables and distribute patient education material, including phone numbers of local shelters, hotlines and community resources
- The creation of a domestic abuse protocol or review to ensure all practical and appropriate measures and resources are dedicated to the subject
- Ensure the training is organised and up-to-date with regards to domestic abuse assessment and intervention
- Work with domestic abuse programmes in the community to let patients and the community know that the clinic, health care facility or health association cares about addressing domestic abuse
- Document assessment of domestic abuse in Vision or Emis and use an abbreviation such as DVA in any record of consultation.

This extensive commentary of NHS guidance regarding domestic abuse and professional curiosity links well with several incidents involved in this review and there are incidences in which Christopher attended the MKUHFT emergency department with injuries, including glass laceration and injuries to his neck and the records reflected a variety of visits to both hospital and medical centres in which he discussed feelings of depression, suicidal ideation and other issues of anxiety. Therefore, this review recommends that consideration is given to the implementation of the options provided by the NHS briefing in identifying and

supporting victims of domestic abuse through increased professional curiosity and routine questioning.

5.5.12 **Learning Point 4:** The options highlighted in this NHS document give clear guidance about the pathway to promote the subject of domestic abuse and support victims **Recommendation 4:** Healthcare agencies represented in the review should introduce the options contained in 'Domestic Violence a briefing for healthcare', particularly those in Paragraph 5.5.11.

5.6 IMPACT OF DOMESTIC ABUSE ON CHILDREN

5.6.1 One thing that was highlighted from the combined chronology and IMRs provided by individual agencies was a consistent theme of the presence of three children and their proximity to incidents of domestic abuse. The reports and concerns regarding the children include those from different grandparents and their anxieties over the impact that domestic abuse is having on their upbringing as well as physical and emotional well-being.

Research and Context

The details described here involve generic research and are not intended to specifically reflect the lives of Ch1, Ch2 or Ch3.

In general children are impacted by domestic abuse in many ways. They may hear one parent threatening or demeaning another or see a parent who is angry or afraid. They may see one parent physically hurt the other, causing injury or destroying property. Children may live with the fear that something like this may happen again and that they may even become the target of the abuse. Most children who live with domestic abuse can recover and heal from their experiences; one of the most important factors that helps children do well after experiencing domestic abuse is a strong relationship with a caring non-violent parent.

Research in 2017 by SafeLives[24] revealed that two in five children who live in families where there is domestic abuse have been living with that abuse since the day they were born. Some children's exposure to abuse starts at an early age and persists into later childhood. Of all the children in the research dataset, who had been living with domestic abuse for their whole lives, over a third lived with it for more than five years. This research also revealed that over half of the children concerned found it difficult to sleep and one third felt the abuse was their own fault. The research discovered that children exhibit high rates of behavioural problems within their peers and engage in risk-taking behaviour, making themselves vulnerable to other forms of abuse, exploitation, and harm.

[24] https://SafeLives.org.uk/insights-national-briefing-children

Attachment

Attachment refers to the pattern of the relationships children have with parents or carers early in their lives. It is the emotional bond that forms between a parent and child from birth and has a huge impact on a child's development. The way a parent or carer responds to their child will impact on the child's attachment style. This attachment style becomes a template for how future relationships are built with others, and a template for how someone feels about themselves and other people. If someone has experienced a relationship with a parent or carer which has been positive, they will develop a positive template for other relationships as well as positive feelings about themselves and others. But sometimes how children are cared for is not so positive, for various reasons, and this can make it harder for people to make and maintain positive relationships in the future, manage their feelings and behaviour, or feel good about themselves or others. When early attachments have been negative and lead on to difficulties with relationships and mental wellbeing, this can sometimes be described as attachment difficulties.

Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) are "highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence. They can be a single event, or prolonged threats to, and breaches of, the young person's safety, security, trust, or bodily integrity." (Young Minds, 2018).

Examples of Adverse Childhood experiences

- Exposure to domestic violence
- Subject to Physical abuse
- Subject to Sexual Abuse
- Subject to Emotional Abuse
- Living with someone who abused drugs
- Living with someone who abused alcohol
- Living with someone who has gone to prison
- Living with someone with serious mental illness
- Losing a parent through divorce, death, or abandonment

Impact of ACEs

Just like attachment, experiencing ACEs can have an impact on an individual's future physical and mental health, and often ACEs can be barriers to healthy attachment relationships forming for children. Some of the effects of ACEs on physical and mental health are:

- An increase in the risk of certain health problems in adulthood, such as cancer and heart disease, as well as increasing the risk of mental health difficulties, violence and becoming a victim of violence.

- An increase in the risk of mental health problems, such as anxiety, depression, and post-traumatic stress. One in three diagnosed mental health conditions in adulthood directly relate to ACEs.
- The longer an individual experiences an ACE and the more ACEs someone experiences, the bigger the impact it can have on their development and their health.

Some of the other things exposure to ACEs can impact, are:

- The ability to recognise and manage different emotions.
- The capacity to make and keep healthy friendships and other relationships.
- The ability to manage behaviour in school settings.
- Difficulties coping with emotions safely without causing harm to self or others.

Parents and carers have a responsibility to keep children and young people safe from harm and sometimes need support themselves to protect families from ACEs. Seeking to learn about and adopt healthy caring styles can make a big difference. *(Ref: Manchester University NHS Foundation Trust)*

5.6.2 Within the review period, the first record goes back to January 2011 involving incidents of reported violence between Harriet and Christopher where the children were present. There are two further incidents in 2011 as well as others in 2014 and 2015 where there have been arguments involving both sets of parents and concerns raised over the upbringing and neglect of the children. There was further anxiety raised with regards to Harriet's perceived alcohol or drug dependencies and possible mental health problems.

5.6.3 In terms of engagement, particularly in the early stages of this review period, the outcome of the referrals made to CSC were that the children were deemed not at risk, or of low risk. Follow up contact with Harriet included letters being written to her providing advice and requesting a call or email. It appears that Harriet did not respond to these requests, and it isn't clear, from the reports provided to this review, why she appears to have chosen to not engage.

5.6.4 The process of analysing risk, particularly early on in this review period create some interest. This review noted the example provided in October 2011 highlights this concern. Police were called to an incident and consequently Harriet provided 16 'yes' answers to her DASH risk assessment. This, at least in theory, should have led to a MARAC referral by the police. The agency analysis of this score has revealed that the majority of positive (Yes) related to a previous incident, four months earlier, and since then the couple had separated. Thames Valley Police considered the SafeLives guidance and quite reasonably take a view that there is a need to apply context to issues present when completing a DASH risk assessment and

whether a MARAC referral is required. This approach can mean that cases scoring less than the prescribed 14 'ticks' may still be referred to MARAC.

5.6.5 The attending officer categorised the risk as standard, which at the time triggered the 10% dip sampling policy. That is to say that 1 in 10 domestic abuse reports with a standard risk rating would be subject to a further risk assessment by specialist officers. Cases were selected by dip sampling and this case was not chosen. This appears to be unsatisfactory and potentially exposing the vulnerable to unnecessary risk, however an inspection by Her Majesty's Inspectorate of Constabulary in 2014[25] *Thames Valley Police's approach to tackling domestic abuse* recorded that "There are good and robust re-assessment and quality assurance systems in place to ensure appropriate action has been taken to safeguard those victims who are assessed as facing the greatest risk of harm (high-risk and medium risk). These victims have their initial assessments of risk reviewed by the specialist domestic abuse officers. Those who are identified as standard risk are still reviewed by the officer's supervisor, and small samples of these are routinely checked by the risk assessors in the referral centres to provide assurance of quality. This is good practice.

5.6.6 The Force has also put in place a process whereby a Service Improvement Department identifies cases which may be suitable for MATAC using risk assessment tools. This assessment process is referred to as the Recency Frequency Gravity Serial (RFGS) analytical process[26]

5.6.7 The daily tasking and briefing processes keep local officers informed of high-risk domestic abuse victims and perpetrators, including those offenders facing arrest, once found by officers.

5.6.8 For this review there is no further comment with regards practices that took place prior to this inspection.

5.6.9 The subsequent assessment of risk in relation to the children, by CSC, concluded that the risk to them was low. Looking objectively, it seems that one or the other of these assessments must have been inaccurate. However, one must consider the use of professional judgement and why, despite the outcome of the DASH risk assessment with Harriet, and separate assessment by CSC, the risk presented by Christopher does not appear to raise enough concern to generate immediate

[25] https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/2014/03/thames-valley-approach-to-tackling-domestic-abuse.pdf

[26] In order to identify potential perpetrators for MATAC, a tool (accessed via the Service Improvement Portal (SIPO)) identifies the top perpetrators on each LPA whose offending has been recent, frequent and of the most gravity. The matrix shows how many victims the perpetrator has offended against in the last 12 months. This enables us to take account of the serial nature of the perpetrators abuse and prioritise accordingly. The NPCC defines a serial perpetrator as 'someone who is reported (to the police) to have committed or threatened domestic abuse against two or more victims who are or were intimate partners or family members of the perpetrator in the last rolling 3 year period'. Perpetrator offending data taken from Niche is processed by an analytical tool which provides us with an 'RFGS score'; those deemed the most harmful offenders receive a higher score, the maximum score being 100. The key is to identify offenders who have not been highlighted through other threat, harm or risk processes, for example those perpetrators who continue to offend against their partner, ex-partner or family member, but the level of risk they pose to any one victim does not escalate. However, the level of harm the individual causes is substantial. A key component of MATAC is the RFGS model but a perpetrator being brought to MATAC doesn't rely entirely upon the RFGS model. Professional judgement is considered and referrals from colleagues or partners should be welcomed

referrals or further activity. The nature of the professional judgement used during this incident is not known to this review, despite the best efforts of the relevant agencies to discover the details. What is clear is that both agencies came to the same conclusion. However, had the SafeLives DASH guidance been followed then a MARAC referral would have been generated, Christopher and his family would have been brought to the attention of a multi-agency forum and, potentially, a wider support network introduced.

5.6.10 The MASH process has been in place for many years however at this stage of the review period it had not been created and so therefore it is not reasonable to consider recommendations or identify points of learning, in relation to these incidents, against subsequently introduced processes (i.e. the Multi-Agency Safeguarding Hub).

5.6.11 The details provided on the combined chronology record that some incidents included 'extreme violence'. Involvement with CSC was minimal, if any and referrals that were made and considered by CSC appear to have been risk assessed as being of low-level and often, as in the case with February 2014, a conclusion was reached that there were no concerns over the apparent risks presented to either parents or children.

5.6.12 **Learning Point 5:** Considering the volume and severity of the previously reported incidents this assessment of the level of risk is surprising and the review is seeking reassurances that current risk assessment processes within CSC are dynamic and robust and are based upon information whose provenance and accuracy are considered and assessed. **Recommendation 5:** CSC to ensure that current policies and procedures include suitable frameworks for the assessment of risk to all vulnerable children and that initial assessments are subject to regular, detailed review and management**.**

5.6.13 In March 2014 referrals were received by CSC from the mental health practitioner who was working with Harriet as she was concerned over the well-being of Harriet's children. Referrals were made to Children's Services and the matter was subsequently closed in July 2014. During this period the CSC records show that there was involvement with the school and nursery where the children attended, and with the health visitor. Arrangements were made with the Children's Centre to discuss summer activities the children could participate in to support Harriet over the summer holidays.

5.6.14 The second engagement with the CFP occurred three months later when Harriet's father reported concerns over the well-being and neglect of his grandchildren, and he commented that Ch1 had been withdrawn recently and he was concerned that Harriet may have issues with alcohol and drugs. Engagement between the CFP and the family lasted until November 2015 when the case was closed, and the conclusion recorded as 'Matters addressed'. As before there was involvement from the school and nursery to support the family. CSC closed the case as they were satisfied that Harriet had engaged appropriately with the services offered.

5.6.15 The chair has reviewed available opportunities for contact and support which can be provided to children and young people living in families with previous and ongoing domestic abuse. *ie*:

- www.youngminds.org.uk
- www.spec.org.uk

This review was confident that CSC already has a number of these referrals available and it seems fair and appropriate to highlight these opportunities.

Operation Encompass

5.6.16 At least one of the children within the family had been of school age during the review period. Operation Encompass encourages a line of communication and support between the police and educational settings. The aim is to offer immediate support for a child experiencing domestic abuse.

5.6.17 Information is shared by the police with a schools-trained Designated Safeguarding Lead (DSL) prior to the start of the next school day after officers have attended a domestic abuse incident that requires appropriate support to be given, dependent upon the needs and wishes of the child.

5.6.18 Operation Encompass appears to be an ideal opportunity for children in a similar position to those within this review to receive support throughout each day whilst at school. The rapid provision of support within the school environment means that children are better safeguarded against the short medium long-term effects of domestic abuse. This process has been in place, via the local MASH, for the last three years and therefore no recommendation is created here.

5.7 INFORMATION SHARING

5.7.1 This subject has been raised previously and it remains something which the review feels is crucial in the successful identification and reduction of domestic abuse and keeping people safe. Practitioners who encounter domestic abuse victims, perpetrators and their families, often need to assess whether and how to share personal information, regarding their clients, with other professionals. Lawful and reasonable information sharing can be vital to help victims, keep their children safe, carry out risk assessments, provide support and advocacy services and help bring perpetrators to justice.

5.7.2 The chair has researched national and local strategy to understand good practice and national expectations. The key benefits for the sharing of information include the following

- Increasing early identification of domestic abuse
- Facilitating a timely and appropriate response for those affected.

- Minimising the long-term effects, not only on victims and perpetrators but also children and young people and the prevention of repeat victimisation.

5.7.3 The lawful basis for the sharing of personal information including privacy and information rights of individuals are protected by the following:

- The Crime and Disorder Act 1998
- The General Data Protection Regulations 2016/679 (May 2018)
- The Human Rights Act 2000
- The common law duty of confidentiality

5.7.4 Any decision to disclose or share information must be proportionate, legal, justified and proportionate.

5.7.5 National guidance includes that from the Violence against Women and Girls Strategy 2016 – 2020 i.e.

"Government cannot tackle the complexities of VAWG in isolation. We know that partnerships work across national, regional and local boundaries in helping victims and providing an effective first response to violence and abuse".

5.7.6 In terms of the reason for the sharing of information they seem to fall within two categories: details around individual incidents of reported domestic abuse and the emotional and suicidal thoughts shared with agencies at various times during the review period.

5.7.7 For example, in June 2011 Christopher made allegations to the police which it would appear were not fully investigated. Similarly no support referrals were offered to him. In January of the same year Christopher had indicated that the abuse in his relationship with Harriet was getting worse. Harriet confirmed in June that her fears had not relented. In October of the same year Harriet reported to police that she'd ended her relationship with Christopher due to increasing violence. She also reported that Christopher was 'having suicide thoughts'. Taken in isolation each incident represented a concern of its own, however taken as a whole it is clear that with wider, more dynamic information sharing there were opportunities to intervene or at least offer support to individual family members (including children) and the family network as a whole.

5.7.8 By the time the incident on 16 October 2011 had occurred it seems reasonable that a MARAC referral could have been made due to the following circumstances being raised and reported:

- Increasing violence
- Talk of death by suicide and similar threats
- Reports of depression and anxiety
- The presence of children during the various reported incidents

5.7.9 There were several contacts with CSC which resulted in referrals to the C&FP however it is impossible to say whether appropriate levels of information were either received or shared. Several reports were made by both Christopher and Harriet's fathers, raising concern about the health and wellbeing of Harriet; the family had a support network ready and willing to assist. Interviews with Christopher's family as part of this review suggest very little information was shared, although leaflets and advice regarding legal options were provided to Harriet's stepfather, as well as advice regarding legal pathways, such as residency orders. Whilst there is clearly a need to keep specific detail confidential, without the consent of individuals, the review feels that there is an opportunity, in circumstances like this to engage wider family members by signposting them to pathways for support from statutory, charitable, and volunteer organisations.

5.7.10 There seem to be various themes which could have benefitted Christopher had more enhanced information sharing taken place for example:

- On several occasions there is information, provided by the police, which suggest that Christopher was not having the allegations that he made investigated in the same way as those of Harriet, including incidents where apparent cross allegations were not considered.
- Routine reports to primary health regarding depression and anxiety.

5.7.11 The review has assessed the quality of investigations following reports to the police and whether enough was done to support the victims, regardless of whether it was Christopher or either of his partners. As mentioned previously, the DHR Chair has considered the HMIC report in 2014, and therefore focused his attention on incidents reported after that date. By 2014 Christopher and Harriet's relationship had ended and he was living with Isabelle and her mother.

5.7.12 The incident reported in paragraph 3.7.3 (An allegation from Christopher's father that Christopher had been assaulted by Isabelle) resulted in police officers attending Christopher's workplace and interviewing him. Christopher declined to engage with the officers and as a result he was provided with safety advice and the matter was recorded on the NICHE system as a 'Non-Recordable Domestic Incident'. The IMR author analysed this action as appropriate and given the circumstances this view is supported by the review chair.

5.7.13 In December 2017 (See Paragraph 3.8.10) Isabelle called 999 requesting that police attend her home and remove a male (Christopher) who was being intimidating and violent. Officers were immediately assigned and arrived at Isabelle's home within 12 minutes, during this time the police call handing centre remained on the phone until officers arrived. The call handler could hear a male voice in the background who appeared to be calm.

5.7.14 Officers spoke with both parties and Christopher told them that he was making arrangements to stay with his parents. Officers waited until Christopher left the property and provided Isabelle with safety advice in case he returned. Officers returned to the address approximately an hour later in order to speak to Isabelle, however she said she was not available until the morning as she was putting her

daughter to bed. The following morning officers made several calls to Isabelle, who did not reply so officers visited her address. Isabelle was described as being hostile and annoyed that officers had attended without making an appointment. She did not engage and made no allegations. As a consequence, the risk was graded as standard, and the matter was closed.

5.7.15 Given the circumstances it could be argued that the officers could have explored other options including using the original 999 recorded phone call and contacting neighbours as part of a potential route towards an evidence-based prosecution, without the need to directly involve Isabelle. However, considering that no allegations were being substantiated, this may not have been proportionate. That said, this increased level of investigative curiosity may have provided more information that could have been recorded on police intelligence databases and shared with partners.

5.7.16 **Recommendation 6:** All panel agencies review their information sharing policies and protocols to ensure that, with due regard to the legislation mentioned in Paragraph 5.7.3, there is a clear pathway for the sharing of information.

5.8 DASH RISK ASSESSMENT QUESTIONNAIRE AND PROFESSIONAL JUDGEMENT

5.8.1 The use of the DASH questionnaire and professional judgement in these circumstances is employed in order to identify risks presented within families living with domestic abuse.

5.8.2 In order to give context to various examples, learning points and recommendations in this review, the report will use the principles of the MARAC process in order to highlight them and try to provide context.

5.8.3 SafeLives guidance on MARAC referrals indicates using professional judgement is something for all agencies to consider when dealing with matters of reported or perceived domestic abuse i.e.

- Professional judgement involves an assessment of dangerousness based upon an individual practitioner’s consideration of a situation which will naturally use the information from the DASH checklist to inform this judgement. In addition to using this, it is crucial that professionals use their own full range of knowledge to make an assessment; this knowledge will usually be gained through experience, reflection, and deliberation. This form of assessment relies heavily on the skills and experience of the practitioner to make an informed decision of domestic abuse settings. Professional judgement will be informed by the knowledge of professionals and practitioners about domestic abuse and its manifestations.
- Referrals to MARAC can be made based solely on professional judgement, however, it is the practitioner’s responsibility to articulate what their concerns are and the reasons for the referral.

5.8.4 It is worthy noting that Thames Valley Police have reviewed their own working methodology in assessing the risk presented in domestic abuse incidents. More focus is now placed upon the use of professional judgement and less upon the '14 yes answers' principle.

5.8.5 There are various incidents recorded in the combined chronology in which professionals may have had the opportunity to consider asking further questions in relation to matters of domestic abuse within both of Christopher's relationships. Whilst many of these were several years ago it does seem reasonable that this review invites panel agencies to consider the benefit of using more in-depth professional judgement to consider whether onward referrals, for example MARAC may in fact support families like the ones that upon which this review is focused.

5.8.6 It's a basic principle to say that safeguarding is the responsibility of all agencies engaging with troubled families. The use of the DASH risk assessment, is something which potentially all agencies could consider using in order to enhance their own risk assessment processes. As with most parts of the country the predominant use of the DASH process is done by the police, however the opportunity remains available to all those in primary healthcare as well as voluntary and charitable organisations, to introduce a similar questionnaire when dealing with those vulnerable to domestic abuse. This review has identified that other agencies in Milton Keynes also use the DASH process including CSC, MK-ACT and CNWL.

5.8.7 Had the three matters referred to the police in 2011 resulted in a MARAC referral then a subsequent incident less than 12 months later would likely have led to a further referral. It's worth noting that one of those three incidents Harriet provided 16 yes answers to the DASH questionnaire which according to the SafeLives guidance could have triggered an immediate referral to MARAC, regardless of the other two previous incidents.

5.8.8 It is reasonable to assume that had Christopher and his relationships with Harriet and then Isabelle entered into the MARAC process, a more multi-agency approach to managing the safety and risk presented Christopher, Harriet, Isabelle and the children could have been introduced.

5.8.9 **Learning Point 6:** With regards to Christopher, it is also worth noting that there were three opportunities for a DASH risk assessment to be carried out, but it appears that on each occasion no such process was completed. This was discussed by the panel and concern was raised about how other people in similar circumstances *eg* those making 'counter allegations' were treated. Thames Valley Police have provided reassurances the Crime Data Integrity (CDI) process[27] now identifies cases where allegations are made by both parties following an incident (particularly involving domestic abuse) and ensures compliance with regards to the recording and reporting of such allegations. Therefore, this review will be making a recommendation to reassure itself that the CDI process is working

[27] https://www.thamesvalley.police.uk/SysSiteAssets/foi-media/thames-valley-police/policies/policy---crime-recording.pdf

appropriately. **Recommendation 7:** Thames Valley Police to review counter allegations of domestic abuse over the previous 12 months and ensure that all 'cross allegations' were properly recorded and investigated.

5.9 ANALYSIS OF AGENCY INVOLVEMENT

5.9.1 THAMES VALLEY POLICE

5.9.1.1 As part of its IMR Thames Valley Police have analysed each incident and identified areas where further support may have benefited both the deceased and his partners and areas where expectations were met, and policy criteria achieved at those given points in time.

5.9.1.2 Paragraph 3.2 records the details of the initial incident involving the police, in 2009, and the analysis of the IMR author notes that the matter was dealt with in accordance with service policy. The incident was interpreted as a low-level domestic argument and risk to both parties recorded as also being low. Details of Ch1 are recorded on the DASH report and there also are positive answers to questions of separation and financial issues. There are no other reported issues until January 2011, 13 months after this first engagement.

5.9.1.3 In the second incident, which took place on 16 January 2011, the analysis comments that Christopher is reported as having a bloody nose and that he declined to make a statement. This could have been an opportunity to encourage Christopher to discuss any concerns with regards to domestic abuse occurring in the household and for the attending officers to use their professional judgement to complete a DASH risk assessment. Harriet is recorded as being drunk and having two small children in her care but there is no acknowledgment of this being a potential child protection issue in the paperwork, even though there would have been an automatic referral to Children's Social Care. The author has noted this as a potential individual learning point, the review believes that this is an opportunity to share this learning to a wider audience. The new Domestic Abuse Bill 2021 promises more support for the victims of domestic abuse, and their children[28].

5.9.1.4 **Learning Point 7:** Police Officers must be aware of the stance taken within the new Domestic Abuse Bill 2021 in treating children as victims of domestic abuse in a similar way to adults. Children they must receive the same care consideration and be treated in a similar fashion. **Recommendation 8:** Thames Valley Police to ensure that officers are suitably trained and assessed in treating children as victims and witnesses when investigating domestic abuse cases.

5.9.1.5 On 23 June 2011 an allegation was made of an assault without injury. The IMR author comments there were no injuries to corroborate the allegations which Harriet made and because of this and other enquiries the decision was made to

[28] https://www.gov.uk/government/news/more-support-for-domestic-abuse-victims-and-their-children-as-domestic-abuse-bill-receives-royal-assent

take no further action against Christopher as there was insufficient evidence to proceed.

5.9.1.6 As part of their conclusions the IMR author notes that the allegations made by Christopher were not considered to be a cross allegation of assault and it is felt that it would have been appropriate for the officers to have completed a DASH risk assessment and offer some victim safety planning advice. The review supports this view and feels that this demonstrates an example of potential gender bias or stereotyping in dealing with potential victims of domestic abuse.

5.9.1.7 Whilst at the premises officers completed a DASH risk assessment, three of the questions were answered yes and the rest of the form was blank, the IMR author also reports that there is no paperwork relating to this investigation and so it is not possible to analyse things in any detail. The electronic records of this investigation do not have any record of a statement having been taken from Harriet.

5.9.1.8 There are no records of whether the detail of any of the children in their relationship were recorded. This apparent lack of engagement is a further concern with regards to how the children were considered and also the effects of living in a home where domestic abuse was a regular factor.

5.9.1.9 For the incident that took place on 23 September 2012, the attending officers graded the DASH as a Medium Risk but the IMR recorded that 'upon review by the referral centre was downgraded to standard'. The IMR author felt that the risk grading would have benefitted from remaining at medium, to reflect the risks that Harriet felt she was facing, and that she would have benefitted from some Victim Safety Planning. However, Thames Valley Police acknowledge that there is no record of the counter allegation made by Christopher being investigated, even though his brother advised officers that they were unaware of the couple's history, and that this line of enquiry should have been pursued. The fact that this information was not investigated further, and that no DASH was completed by Christopher as part of his allegation further highlights the points raised under the discussion of Male Victims of Domestic Violence.

5.9.1.10 There was an incident on 26 February 2014, and the true nature of what happened has never truly been established. Harriet alleged that Christopher had gone to the family home with their children and an argument had ensued resulting in her being assaulted with consequent pain to her wrist. Christopher made a counter allegation suggesting that he had gone to the property with Ch1 and Ch2, having had them to stay with him overnight. Harriet had refused to let them in, and he had taken Ch1 to school before taking Ch2 to his mother's house, as he had to go to work. Both matters were recorded, separately, by the police.

5.9.1.11 These reports included the completion of a DASH risk assessment. In the case of Harriet, she expressed concern over previous assaults and strangulations. She told the officers that these had previously been reported. She also told them of her eating disorder and mental health issues resulting in her being prescribed anti-depressants. In her statement Harriet indicated that Ch1 was present and

had fallen over. Whilst a referral was made to CSC there is nothing to indicate that either of the children were interviewed. The issue of the impact of domestic abuse on children is discussed above. See Impact of Domestic Abuse on Children and recommendations already made on this subject.

5.9.1.12 Thames Valley Police Operational guidance quotes, "Locate and speak to any children or vulnerable adults-at-risk who were present to establish where they were and the impact of the abuse. Children should be spoken to alone and their views recorded. Consent is not needed to speak to a child. Establish their safety and note what they say about what has happened but avoid directly asking them about the incident".

5.9.1.13 **Learning Point 8:** Any learning here, regarding the interviewing of children has already been identified however, the review feels it is important that reassurance is sought that TVP operational guidance is being put into practice.

Recommendation 9: Thames Valley Police should review previous reports of domestic abuse involving the presence of children and ensure that their own operational guidance is being adhered to.

5.9.1.14 Within the DASH completed by Christopher the IMR author notes that there are allegations of two separate assaults, neither of which have been recorded or investigated. It does not appear that the attending officers had probed these allegations and a more detailed investigation may have shed light on who the victim was in this instance. The IMR author rightly highlights that further engagement with Christopher could have resulted in signposting to other agencies for further support.

5.9.1.15 Current operational guidance for police officers attending reports of domestic abuse invite them to look beyond the obvious and understand that some victims may be reluctant to speak, and may minimise any abuse they are suffering. These will include minority groups, those from the LGBT community, and men.

5.9.1.16 Further guidance invites officers to "Consider who might be the primary perpetrator if both parties are claiming to be the true victim, that sometimes abusers manipulate the police against the true victim by making false reports, or a victim may snap in the face of sustained abuse and assault the perpetrator".

5.9.1.17 The review recognises the work done by Thames Valley Police in this area and therefore makes no additional recommendations.

5.9.1.18 At the time of this incident Ch1 was not spoken to. Consideration could have been given to attempting to obtain an account from Ch1 whether it was used evidentially or not. The nature and methodology of 'interviewing' in these circumstances is a matter for individual agencies to consider, dependent upon each different scenario *eg* Police, CSC etc. It is expected that Children's Social Care would be automatically notified, but again the incident does not appear in their IMR.

5.9.1.19 The review has considered the possibility of gender bias in these circumstances by Thames Valley Police, however the matters were recorded as a 'Non-Crime Domestic' incident and the view has been taken that this was not the case in these matters.

5.9.1.20 The incident that took place on 17 October 2014, involved Ch2 telling Harriet that she had been assaulted by Isabelle, following an argument with Christopher had happened during an overnight stay when Ch1 & Ch2 had been woken in the night due to the couple arguing. The children had got up to see what was happening. Isabelle had thrown an empty drink bottle at Christopher but had missed and it struck Ch2 instead.

5.9.1.21 The IMR author records that the police were struggling to resource the request for help, but it is good practice to the note the escalation process and that the duty inspector was consulted, and they found officers to attend Isabelle's home. Upon arrival officers spoke to Ch2 who confirmed that they had been struck by a plastic drinks bottle which had bounced off their father's back.

5.9.1.22 Harriet had initially reported that Ch2 had a fresh and prominent bruise, but officers could find no visible injury. A report was flagged as a Child Protection issue and so the IMR author believes that the matter would have been seen by the Referral Centre. However, no additional Child Protection report was created. This lack of reporting was discussed by the review panel and reassurances provided that the MASH processes ensure that such omissions no longer occur.

5.9.1.23 The Child Abuse Investigation Unit interviewed Christopher and Isabelle, who both denied that any physical or verbal abuse took place while the children were present, and no DASH forms were completed. A subsequent PNC check was completed regarding Isabelle which showed that she had received a previous caution for Battery. A potential history of violence may be an alert of future behaviours.

5.9.1.24 On 28 February 2016 Christopher's father reported that Christopher had been assaulted by Isabelle, causing a black-eye. Officers met with Christopher at his workplace, and he told them that the black eye was caused accidentally but didn't provide any further details. Christopher refused to engage with the DASH risk assessment process but was provided with safety advice and a 'frequently asked questions' leaflet.

5.9.1.25 The IMR author records that Christopher was interviewed at his workplace in order that none of the children were present when speaking to the police, however they were not reported or listed on the report. This is interpreted as an individual learning point however the earlier recommendation recognises the work being done within Thames Valley Police to enhance the performance of front-line staff to include the recommendations of those of the Voice of the Child policy. The IMR author records that the police response in this matter was appropriate and this review agrees with this assessment.

5.9.1.26 On 10 December 2017 Police received a 999 call requesting their assistance to remove somebody from Isabelle 's property. The call was cut off and the police called the number back. Isabelle confirmed that the male concerned was Christopher and he was refusing to leave and being intimidating and violent. She also confirmed Ch3 was in the house and that the male, believed to be Christopher appeared to be calm as they could hear his voice in the background. Officers went to the scene and discovered Christopher making arrangements to stay with his parents for the night, Isabelle confirmed that this has been a verbal argument and she was described as being intoxicated.

5.9.1.27 Later that evening the report of this incident was updated in that Isabelle had told the police she is not available until the following morning as she is putting her child to bed. The following day officers called Isabelle's number, but it went to voicemail. A message was left and when subsequently speaking to Isabelle she appeared to be annoyed as the police had attended her house without prior appointment and she did not wish to engage in any further process. As a result, this incident was graded as standard, and no offences have been disclosed.

5.9.1.28 The record created by the police officers listed Ch3 on the report and confirmed that they were spoken to by the police however whilst not being present the details of Ch1 and Ch2 were not recorded, and no CSC notification was made. The IMR author notes that this was in accordance with the agreement previously made between the CSC and the MASH manager. This incident provides a further learning point with regards to the recording of children's details on police records.

General analysis

1. The IMR author recorded that adequate information sharing took place between the police and CSC in relation to the children when they were listed in the report. Beyond that there were no communications with other agencies as the domestic abuse reports were not assessed as a risk level which would necessitate such referrals being made. As recorded above in the review notes, there were opportunities for MARAC referrals, and this would have encouraged a wider scope of referrals and interventions from statutory, commissioned and voluntary organisations. The recommendations in this review report seek to encourage a greater use of the MARAC process to facilitate such referrals.

2. The IMR author also noted the opportunities for the risks involved within the relationship between Isabelle and Christopher to be managed at the medium level and these would have allowed formal victim support planning to be carried out. However, this was not the case and therefore a recommendation is raised to ensure that the correct levels of risk assessments are completed to ensure the victims receive the appropriate level of support and planning to reduce the vulnerability and enhance their safety. SafeLives guidance supports the idea that assessed levels of risk should not be subsequently downgraded without a clear and documented rationale, the incidents reported to the police and

subsequent risk assessment processes clearly support this idea and the benefits.

3. In general, the reporting of the incident between Christopher and his partners could have been improved. Counter allegations made by Christopher were not recorded or investigated by attending officers and the opportunity for the completion of risk assessments was also missed. Had this been done correctly this would have led to Christopher receiving additional support from the domestic abuse investigation unit and being signposting to external agencies.

4. In terms of training, Thames Valley Police frontline staff receive domestic abuse input during their initial training course and receive regular updates as and when there are changes to legislation or internal policies. Operational guidance is available on the internal police Intranet service, and this is regularly updated.

5.9.2 THE MEDICAL CENTRE

5.9.2.1 Christopher registered at the GP surgery in October 2011, but the question has been asked about whether the registration process involves asking questions about domestic abuse. As mentioned earlier the review feels that this approach would help to increase awareness of the subject and encourage victims to come forward and potentially deter perpetrators. It appears that these types of questions are not currently asked at the point of registration. SafeLives provides guidance regarding the establishment of a domestic abuse care pathway. This includes the need to recognise patients whose symptoms make them more vulnerable to domestic abuse and that sensitive enquiries would enhance this process.

5.9.2.2 **Learning Point 9** Currently there is no process for discussing Domestic Abuse concerns when patients register at a GP surgery. The introduction of such a question could provide confidence to patients in coming forward to report such matters. The matter has been addressed in Recommendation 4.

5.9.2.3 The Medical Centre saw Christopher regularly between October 2011 and the end of May 2012. During these attendances the main cause of his ill-health appeared to focus on work-related stress. Between July 2016 and March 2017 Christopher had a series of appointments relating to matters of anxiety and depression. The IMR does not mention whether any one of these visits was to follow up on his attendance at MKUHFT for an attempted death by suicide, which occurred towards the end of May 2012. The practice acknowledges that Christopher did reference his domestic circumstances but that he never divulged any information regarding domestic abuse.

5.9.2.4 Other appointments appear to have been following attendances at MKUHFT or with Christopher seeking advice with regards to fertility treatment.

5.9.2.5 The Medical Centre acknowledges that their records do not hold any details as to whether direct questions were asked about domestic abuse during the period between July 2016 and March 2017, though it states that it would have been good practice to have discussed a patient's domestic situation. This is especially important when such a comment is often an indication of domestic abuse and the Medical Centre has recognised this is a learning point for them.

5.9.2.6 The Practice also confirmed that Domestic Abuse training, incorporating prompts within clinical templates, for all staff and nominating a Domestic Abuse Champion within the staff at the Practice have been introduced to uplift the awareness of doctors and staff as to the importance of recognising and identifying the signs of domestic abuse[29]. The practice is supported by a dedicated 'Safeguarding' nurse who is deemed as the subject matter expert.

Expected Practice

The panel is informed that GPs are now encouraged to ask questions from a prepared questionnaire whenever the subject of domestic abuse is disclosed, or a suspicion is raised. If a disclosure is made, then a referral to the commissioned services at MK Act can be made. This referral can either be done by the patient themselves or by the GP via a professional's line if the patient is reluctant.

Expected Practice

The GP surgery has carried out its own enquiries and research to help them understand the tell-tale signs of domestic abuse for example patients who disclose problems at work. The surgery is seeking to incorporate a prompt regarding domestic abuse within the templates for treating patients with depression.

5.9.2.7 The panel recognises that there is a need to review training to ensure that these messages are passed on to all frontline staff.

[29] Webmd.com/What are the signs of domestic abuse

5.9.2.8 During this review several other matters of good practice have been identified and it is important that they are recognised here:

- Local GP surgeries have in the past, encouraged those affected by domestic abuse to use the GP surgery address as a safe address in order that support, and ongoing contact does not need to be sent to a victim's home and therefore potentially be intercepted by a perpetrator.
- Several GP surgeries are also providing a safe space or haven for victims to meet IDVAs.
- The chair reviewed the CCG policy with regards to the safeguarding of children and adults. Included within this policy are clear pathways not only to emergency social workers but also to the MASH. There is clear guidance as to what to do if there are concerns about domestic abuse and when domestic abuse is revealed.

Single Agency Recommendations

The IMR author has made the following recommendations and they are supported by the review:

- Domestic abuse training for all clinical staff and consideration of a nominated domestic abuse champion who could link with the primary care specialist nurse for up-to-date information to cascade to team members at the surgery
- The incorporation of prompts about domestic abuse within clinical templates

The review does not propose to make any further recommendations regarding this agency.

5.9.3 MILTON KEYNES UNIVERSITY HOSPITAL FOUNDATION TRUST

5.9.3.1 MKUHFT had several encounters with both Christopher and Isabelle but no records of treating Harriet. When referring to Isabelle in particular, there were some significant issues. The greatest challenge to this review is accessing the medical history of Isabelle. As mentioned, several times in this report the chair has reached out to her, asking that she engages with the review and provide access to her medical records. Isabelle has never replied to these requests and therefore no such access has been granted.

5.9.3.2 The Trust has also commented that asking domestic abuse framed questions would be entirely based upon a patient's presentation and individuals having a plausible explanation of an injury or emotional state.

Learning Point 10. As with the GP Practice, perhaps there is a need for MKUHFT to enhance the training around domestic abuse for front line staff and to develop some questions built into clinical templates. This has also been addressed in recommendation 4.

5.9.3.3 There are examples of incidents where domestic abuse framed questions could have been used when Christopher attended the hospital emergency department. In June 2014 he self-referred presenting injuries of glass laceration to his right thumb, it is unclear whether any questions were asked as to how these injuries occurred and whether they may have been related to domestic abuse. Had more curiosity been demonstrated it is a possibility that a link could have been made.

5.9.3.4 Similarly in July of the same year Christopher again attended the ED department, this time with injuries to his left eye; these were reported as having occurred during kickboxing practice. Again there is no reason to suggest that his explanation was not true and to suggest that domestic abuse was the cause could be seen as an improbable link. However what is known is that, at the time, the relationship between Christopher and Isabelle could be described as volatile and therefore further curiosity may have revealed a different explanation *eg* domestic abuse.

5.9.3.5 Finally there is a third incident in August 2017 Christopher attended the ED department with neck and head injuries; he explained that this occurred at home when attempting to lift his 9 year-old child onto his shoulders. Christopher was treated by the emergency nurse practitioner, discharged, provided with an injury advice sheet and advised to 'return if your symptoms do not improve'. Once again questions around the possibility that these injuries had occurred as a result of domestic abuse may have given a different explanation from Christopher.

5.9.3.6 As mentioned earlier, Isabelle has not given her permission to discuss her details and therefore it is not possible to add any commentary or make recommendations in terms of the treatment or support she may have had when attending the MKUHFT.

5.9.3.7 It appears to this review that when patients and clients attend hospitals today, staff and practitioners are much more likely to seek opportunities to explore the subject of domestic abuse. This can include attendances at the emergency department, outpatients, and maternity wards. The recommendation raised in this section is intended to include all the areas of hospital life and could significantly increase the profile of domestic abuse and encourage victims and families to come forward and report incidents.

5.9.4 CHILDREN'S SOCIAL CARE

5.9.4.1 The Children's Social Care's IMR focussed on some of the alleged domestic abuse and concerns over the misuse of alcohol and controlled drugs by Harriet. They acknowledge that from the information on record, there is a lack of clarity regarding who the main aggressor was on some occasions and that inbuilt stereotypes related to gender may have enabled assumptions to prevail of the female solely as the victim, when there was a possibility that there was volatility on the part of both parties. The agency is correct in stating that the dynamics of the relationship were not clear.

5.9.4.2 There is an issue that some of the incidents that may have provided greater clarity of the relationship between Christopher and Harriet, which were referred by Thames Valley Police, do not appear in the chronology provided by Children's Social Care. Therefore, it seems reasonable that both the Thames Valley Police and CSC, review their information sharing pathways to ensure that all relevant reports are shared and discussed to confirm that maximum protection and security is provided to children living in a household where domestic abuse is an issue. The review panel has been reassured that this potential learning point has been addressed since the creation of the MASH.

5.9.4.3 The IMR author is quite correct when they state that the impact on children of living in a household in which domestic abuse is present, irrespective of whether it is witnessed directly, is well known but they maintain that despite this Ch1 and Ch2 were deemed to be at low risk of harm. As a result, there was limited and low-level involvement from the Children & Families Practice.

5.9.4.4 The opportunity, correctly identified by the IMR author, is that Christopher, was not involved in the care planning or assessments despite him having regular contact and his voice and views were absent. Indeed, it could be argued that the wider family had concerns, reported to CSC, at various periods of time and that their voices were not heard either[30]. It is often the case that in situations like this it is the wider family unit that are relied upon to provide support for the children.

5.9.4.5 In the IMR there was no specific consideration for the views of the children and that perhaps a Children's Advocate could have been used to ensure that their voice was heard. That being said, Social Care practice has become more robust in respect of ensuring the child's voice is heard and recorded. The IMR author correctly states that this follows a strong focus on the child's voice within:

- Signs of Safety (SOS) training and recording.
- The monitoring of children seen and seen alone in child protection and children in care cases; and formal case supervision.
- Specific questions within children's quality assurance case audits identify the voice of the child as a consistent strength.
- In addition, case reviews have identified, for all agencies, the need to exercise professional curiosity, challenge assumptions and ensure that the information and perspectives of all involved parties are explored'. The point being that in this case professional curiosity may have highlighted the adults involved as being vulnerable.

5.9.4.6 Children's Social Care spoke to Isabelle, who identified that she experienced depression, denied being in an abusive relationship and confirmed that her partner, Christopher, was not living with the family. Isabelle said that she knew where to turn to get help from her GP and mental health services and did not want assistance from Children's Services as Ch3 had support from her family and

[30] It is reported by Christopher's family that Harriet was present whenever the children were spoken to during social worker visits

school. Again, the review considered this was an opportunity to exercise professional curiosity.

5.9.4.7 Also, there is no mention in CSC records of other incidents which Thames Valley Police reported referring to them, involving Christopher, Isabelle, or her children nor any detail linking Christopher having had relationships with two of their clients (Harriet and Isabelle). There is a previous learning point and recommendation regarding these issues and so no further commentary is appropriate here.

5.9.4.8 Children's Social Care make the following recommendation which this review supports.

- Assessment, intervention, and planning should take account of the role of the family/father figure, so long as this would not place the children or other adults at risk.

5.9.5 MK-ACT

5.9.5.1 MK-Act is the specialist domestic violence service for MK, commissioned in 2008 by Milton Keynes Council and managed by Women's Aid.

They provide the following services for victims of domestic abuse:

- **Crisis Intervention Service (CIS):** helpline, access to information advice, support, emergency refuge. CIS service is for male and female clients escaping a partner, ex-partner (including same sex relationships) or a family member.

- **Emergency refuge:** purpose-built accommodation for 28 families with support from key workers. Refuge is for female clients and their children only.

- **Children and Young People's Service:** for residents of the refuge.

- **Group Work:** Freedom Programme, Ilam-El-Hifzat (devised by MK-Act for women from an ethnic minority background).

- **Training:** MK-Act offers specialist Domestic Abuse training for organisations and companies.

- **Fresh Start**: A programme of integrated individual sessions designed to change the behaviour of those who use domestic abuse, whilst providing support to the partners and ex-partners of the participants on the programme.

"*Fresh Start is a specialist domestic abuse prevention programme, which works to address the cause of the problem, by engaging with individuals who have issues in relation to violent, abusive, intimidating or controlling behaviours in*

their intimate or family relationships. The service aims to increase the safety of both partners and children and prevent further incidents of abuse.

In Milton Keynes Fresh Start offers a structured group work programme, a tailored 1-2-1 service and parenting interventions. All the interventions aim to change behaviour, promote responsibility and accountability, provide alternative behavioural strategies, improve communication skills, increase parenting capacity, and promote respectful relationships and attitudes.

Fresh Start is accessible by both men and women including those in same sex relationships. Alongside is an essential comprehensive, risk-informed partner support and advice service.

Offering one-to-one support to partners or ex-partners of those who have been referred on to Fresh Start, this enables them to have 1-2-1 emotional and practical support, promoting independence and empowerment.

It is essential that there is a partner support service working alongside the Perpetrator programme to prioritise safety and to ensure the intervention with the offender does not increase risk to the partners and children. However, the support offered is voluntary and the decision to accept or not does not impact the (ex) partner suitability for attending the programme".

5.9.5.2 The contact between MK-ACT and those concerned in this review has been minimal. Section 4.3 gives details of this engagement and the support provided appears to be entirely appropriate and timely, including the support during an application of Non-Molestation Order.

5.9.5.3 The review has also identified that MK-ACT supports victims when they attend GP surgeries and the MKUHFT.

5.9.5.4 Given that there was a good deal of contact between the police and family it would be useful to know whether there were routine referrals sent to MK-ACT from frontline officers and/or the Domestic Abuse Investigation Team. The details provided by the MK-ACT IMR author suggest that either this pathway was not routinely explored, or that details were provided, and the victims decided not to make contact.

5.9.5.5 The services provided by MK-ACT appear to be wide ranging and entirely suitable but for individuals and families to use them they must first be identified as being in need. This position reinforces the importance of agencies demonstrating suitable levels of professional curiosity to recognise the need for such a referral.

5.9.5.6 A recommendation with regards to this has already been made and as the contact between MK-ACT and those involved in this review was so small they have not made any recommendations of their own. Therefore, no additional learning or recommendations will be made here.

6 CONCLUSIONS AND LESSONS TO BE LEARNT

6.1 CONCLUSIONS

6.1.1 The interview with Christopher's family and employer confirmed he was a caring, loving son and father. He was a loyal and popular friend and employee who was well thought of by those around him. His death was a tragedy and has deeply affected friends and family.

6.1.2 For those close to Christopher this tragedy is made even more difficult because it appears that there were no clear indicators as to its likely happening. His family knew that Christopher had been involved in two difficult relationships with Harriet and Isabelle and this appears to have affected him quite deeply and whilst he never discussed or disclosed issues of domestic abuse several reports and records clearly document the challenges he faced in each of these relationships.

6.1.3 It has been a challenge for the review panel to understand the emotional and psychological impact that these incidents and challenges had upon Christopher. As the chronology and analysis shows there were several occasions in each relationship where the police and other agencies were involved not just with Christopher and his partners but also their children. There is no definitive link between Christopher's death and the issues of domestic abuse. We do not seek to find or lay blame at the door of either Harriet or Isabelle, however the impact upon men of domestic abuse is a subject which is in need of urgent review, analysis, and wider acknowledgement. Domestic abuse against any person is unacceptable and abhorrent; this review recognises that the impact of being in a relationship where it is a regular issue can be significant and potentially cause those involved to take the ultimate sacrifice.

6.1.4 The chair and panel wish to be explicit that they do not want to suggest or infer, in any way, that they believe either Harriet or Isabelle were responsible for the death of Christopher.

6.1.5 There has been concern raised by several panel agencies, throughout this review process, that blame could be inferred by the commissioning or content of this review. It is not the role of these statutory reviews to apportion blame or find fault. The content of the report simply reflects the findings of panel agencies and seeks to identify opportunities for learning and recognition of good practice. Harriet and Isabelle chose not to participate in this review and the chair wishes to point out that this fact must not be seen in a negative light. There is no obligation for individuals to take part and their decision is seen as a reasonable one.

6.1.6 Neither the police investigation nor coronial process found any link between Christopher's death and these relationships. This review supports these outcomes.

6.1.7 Information provided by the agencies involved in this review would appear to demonstrate that there are several themes that need to be considered because of Christopher's death. The report acknowledges that the more historical

incidents outlined above would now be dealt with differently and we thank agencies for providing accounts of how systems have changed due to self-evaluation and improvement.

6.1.8 There are various themes within the review including men as victims of abuse, the effects of domestic abuse on children, the sharing of information among statutory and non-statutory agencies and professional curiosity. Each of these have been explored during this process and the various learning points and recommendations are intended to support families facing similar difficulties and challenges as Christopher, his partners and children.

6.1.9 In approaching these learning points and recommendations the Review Panel has sought to try and understand what happened and recognise the issues in the lives of Christopher and his family that might help to explain why he reached the decision to take his own life.

6.1.10 The Review Panel would like to extend their deepest sympathy to all those affected by Christopher's death.

7 LEARNING POINTS & LESSONS TO BE LEARNED

Learning Point 1: The panel feels that the Home Office needs to consider the way in which incidents similar to this are reviewed and a more bespoke process introduced.

Learning Point 2: The review feels that there is an opportunity to enhance the support provided in this area and that men should be offered greater encouragement to come forward when they feel they are a victim of domestic abuse and/or coercive control.

Learning Point 3: When a report is made of domestic abuse by, or on behalf of, a male victim then a relevant referral should be offered.

Learning Point 4: The options highlighted in the NHS document referenced in this report give clear guidance about the pathway to promote the subject of domestic abuse and support victims.

Learning Point 5: Considering the volume and severity of the previously reported incidents this assessment of the level of risk is surprising and the review is seeking reassurances that current risk assessment processes within CSC are dynamic and robust and are based upon information whose provenance and accuracy are considered and assessed.

Learning Point 6: With regards to Christopher, it is worth noting that there were three opportunities for a DASH risk assessment to be carried out, but it appears that on each occasion no such process was completed. This was discussed by the panel and concern was raised about how all people in similar circumstances *eg* those making 'counter allegations' were treated. Thames Valley Police provided

reassurances the Crime Data Integrity (CDI) process[31] now identifies cases where allegations are made by both parties following an incident (particularly involving domestic abuse) and ensures compliance with regards to the recording and reporting of such allegations. Therefore, this review will be making a recommendation to reassure itself that the CDI process is working appropriately.

Learning Point 7: Police Officers must be aware of the stance taken within the new Domestic Abuse Bill 2021 in treating children as victims of domestic abuse in a similar way to adults; they must receive the same care consideration and be treated is a similar fashion.

Learning Point 8: Any learning regarding the interviewing of children has already been identified however, the review feels it is important that reassurance is sought that this operational guidance is being put into practice.

Learning Point 9: Currently there is no process for discussing domestic abuse concerns when patients register at a GP surgery. The introduction of a questionnaire could provide confidence to patients in coming forward to report such matters.

Learning Point 10: As with the GP Practice, perhaps there is a need to enhance the training around domestic abuse for front line staff and to develop some questions built into clinical templates**,** for MKUHFT.

[31] https://www.thamesvalley.police.uk/SysSiteAssets/foi-media/thames-valley-police/policies/policy---crime-recording.pdf

RECOMMENDATIONS

OVERVIEW REPORT RECOMMENDATIONS

Recommendation 1: The Home Office to be asked to review current methodology and consider introducing a stand-alone 'Death by Suicide following Domestic Abuse' review process.

Recommendation 2: Safer MK to become more proactive in encouraging male victims of domestic abuse to come forward and support service and advice lines should be advertised more widely.

Recommendation 3: Safer MK should review current policies and processes and ensure that there is a referral pathway available to all 'reported' or 'recorded' male victims of domestic abuse.

Recommendation 4: Healthcare agencies represented in the review should introduce the options contained in 'Domestic Violence a briefing for healthcare', particularly those in Paragraph 5.5.11.

Recommendation 5: CSC to ensure that current policies and procedures include suitable frameworks for the assessment of risk to all vulnerable children and that initial assessments are subject to regular, detailed review and management**.**

Recommendation 6: All panel agencies review their information sharing policies and protocols to ensure that, with due regard to the legislation mentioned in Paragraph 5.7.3, there is a clear pathway for the sharing of information.

Recommendation7: Thames Valley Police to review counter allegations of domestic abuse over the previous 12 months and ensure that all 'cross allegations' were properly recorded and investigated.

Recommendation 8: Thames Valley Police to ensure that officers are suitably trained and assessed in treating children and victims and witnesses when investigating domestic abuse cases.

Recommendation 9: Thames Valley Police should review previous reports of domestic abuse involving the presence of children and ensure that their own operational guidance is being adhered to.

Recommendation 10: Police officers should be reminded of the need to record details of all persons present when attending reports of domestic abuse.

APPENDIX 1 - TERMS OF REFERENCE

Terms of Reference
Statutory Review

1 Commissioner of the Statutory Review

1.1 The chair of the Safer MK Community Safety Partnership has commissioned this review, following notification of the death of Christopher.

1.2 All other responsibility relating to the review commissioners Safer MK, namely any changes to these Terms of Reference and the preparation, agreement, and implementation of an Action Plan to take forward the local recommendations in the overview report will be the collective responsibility of the Partnership.

1.3 The resources required for completing this review will be secured by the chair of the Safer MK Community Safety Partnership.

2 Aims of Review Process

2.1 Establish what lessons are to be learned from this death regarding the way in which local professionals and organisations work individually and together to safeguard victims.

2.2 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.

2.3 To produce a report which:

- summarises concisely the relevant chronology of events including:
  - the actions of all the involved agencies.
  - the observations (and any actions) of relatives, friends, and workplace colleagues relevant to the review
- analyses and comments on the appropriateness of actions taken.
- makes recommendations which, if implemented, will better safeguard people who experience domestic abuse, irrespective of the nature of the domestic abuse they've experienced.

2.4 Apply these lessons to service responses including changes to policies, procedures, and awareness-raising as appropriate.

3 Timescale

3.1 Aim to complete a final overview report by 26 October 2019 acknowledging that drafting the report will be dependent, to some extent, on the completion of individual management reviews to the standard and timescale required by the independent chair. Additionally, the criminal justice and coronial process may impact on timescale as well as the COVID 19 pandemic. The statutory guidance is clear a review such as this should be commenced and concluded as soon as

possible – and the Review Panel should be mindful of paragraphs 90 to 96 of the guidance.

4 **Scope of the review**

4.1 To review events up to the domestic abuse related death of Christopher in January 2019. This is to include any information known about his previous relationships where domestic abuse is understood to have occurred.

4.2 Events should be reviewed by all agencies for a minimum of eight years (*ie* from January 2011) preceding the death. Unless it becomes apparent to the independent chair that the timescale in relation to some aspect of the review should be extended.

4.3 To seek to fully involve the family, friends, and wider community within the review process.

4.4 Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends, and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.

4.5 Consider how (and if knowledge of) the risk factors surrounding domestic abuse are fully understood by professionals, and the local community – including family and friends, and how to maximise opportunities to intervene and signpost to support.

4.6 Determine if there were any barriers Christopher faced in reporting domestic abuse and accessing services. This should also be explored against the Equality Act 2010's protected characteristics.

4.7 Review relevant research and previous similar reviews (including those in Milton Keynes) to help ensure that the Review and Overview Report can maximise opportunities for learning to help avoid similar homicides occurring in future.

4.8 Key Lines of Enquiry for Agencies

- Set out the facts of their involvement with Christopher, Harriet, Isabelle, Ch1, Ch2 and Ch3.
- Critically analyse the service the family members were provided, in line with the specific terms of reference
- Identify any recommendations for practice or policy in relation to their agency
- Consider issues of agency activity in other areas and review the impact in this specific case.

5 Role of the Independent Chair

5.1
- Convene and chair a review panel meeting at the outset.

- Liaise with the family/friends of the deceased or appoint an appropriate representative to do so. *(Consider Home Office leaflet for family members, plus statutory guidance (section 6)).*
- Determine brief of, co-ordinate and request IMRs.
- Review IMRs – ensuring they incorporate suggested outline from the statutory Home Office guidance (where possible).
- Convene and chair a review panel meeting to review IMR responses.
- Write report (including action plan) or appoint an independent overview report author and agree contents with the Review Panel.
- Present report to the CSP (if required by the CSP Chair).

6 Liaison with Media

6.1 Milton Keynes Council as lead agency for domestic abuse for the Milton Keynes Community Safety Partnership will handle any media interest in this case.

6.2 All agencies involved can confirm a review is in progress, but no information to be divulged beyond that.

APPENDIX 2 - GLOSSARY

Glossary

MK	Milton Keynes
IMR	Individual Management Review
NGO	Non-Government Organisation
PCSO	Police Community Support Officer
TVP	Thames Valley Police
CFP	Children & Families Practice
CSA	Child Support Agency
CPN	Community Psychiatric Nurse
CNS	Complex Needs Service
CNWL	Central and North West London NHS Foundation Trust
MADD	Mixed Anxiety and Depressive Disorder
OHA	Occupational Health Assessment
MARAC	Multi-Agency Risk Assessment Conference
ONS	Office for National Statistics
MASH	Multi-Agency Safeguarding Hub
DSL	Designated Safeguarding Lead

APPENDIX 3 - OPERATIONAL GUIDANCE FOR OFFICERS ATTENDING DOMESTIC ABUSE RELATED REPORTS

4 Role of the attending officer

4.1 Ensure immediate safety

4.1.1 Follow the HBA Operational Guidance if there is any Honour-Based Abuse (HBA) or risk of Forced Marriage.

4.1.2 Check if there is a SIG flag or Niche person flag indicating any domestic history or previous risk level.

4.1.3 Separate the parties and debrief them whilst recording on body-worn video (BWV). Ask open questions to obtain an initial account to identify what has occurred. Check their welfare, provide any first aid, and protect them from further harm.

4.2 Provide reassurance and build rapport

4.2.1 Listen to and believe your victim. Look beyond the obvious and understand that some victims may be reluctant to speak. Consider if they are minimising the abuse.

Some victims may be more distrustful of the police because of their experiences or preconceptions:

- Victims from different cultural backgrounds
- Male victims
- Teenagers and young people
- Victims from Lesbian, Gay, Bisexual and Transgender (LGBT) community
- Victims with a disability
- Victims with an insecure immigration status
- Armed services families and those from emergency services

Adults facing sustained abuse from their child often struggle to report the abuse because they feel they are to blame for their child's behaviour. Be supportive - Don't judge or joke.

4.2.2 Consider who might be the primary perpetrator if both parties are claiming to be the true victim. Sometimes abusers manipulate the police against the true victim by making false reports, or a victim may snap in the face of sustained abuse and assault the perpetrator.

4.2.3 Record any previously unreported offences in line with the HoCR.

4.2.4 Locate and speak to any children or vulnerable adults-at-risk present to establish where they were and the impact of the abuse. Children in particular should be spoken to alone and their views recorded in the DASH Part A OEL entry.

Consent is not needed to speak to a child. Establish their safety and note what they say about what has happened but avoid directly asking them about the incident. Bear in mind that it may not be possible to speak to some vulnerable adults because of their limited means of communication.

Who is a vulnerable adult at risk?

This is aimed at identifying a small number of very vulnerable adults who live in the household and who are not the victim or the suspect but who **depend on someone for care and support**, *ie* they cannot live independently. They may have a physical disability, a learning difficulty, a serious illness, or a degenerative condition (such as dementia).

APPENDIX 4 - JOINT NPCC AND CPS EVIDENCE GATHERING CHECKLIST – FOR USE BY POLICE FORCES AND CPS IN CASES OF DOMESTIC ABUSE (DA)

Joint NPCC and CPS Evidence Gathering Checklist – For Use by Police Forces and CPS in Cases of Domestic Abuse (DA)

The Police to provide completed check list to CPS in every case where charging advice or a charging decision is sought. The form is an important part of the evidential file - it should be fully and accurately completed.

Ensure that timely decisions are made; a charging checklist is completed for each complainant where more than one is involved; the overall allegation is considered through the assessment of all available evidence including the role and behaviour of the suspect.

The checklist **does not** replace the MG3 - but should complement it. The CPS should comprehensively endorse the MG3 including addressing any evidential weaknesses.

The safety of the complainant and any children or other dependants should be the primary consideration. If IDVA or equivalent specialist service support is available, make a referral at the earliest possible opportunity.

The Police must refer to the College of Policing Authorised Professional Practice (link). Further information about charging domestic abuse cases is available here (link).

Have you collected **all available evidence**, including material other than the complainant's statement and given consideration to the **wider pattern of behaviour and its cumulative impact**?	YES	NO	COMMENT*
999 Call, Body Worn Video with current DASH.	○	◉	
Victim statement - refer to previous DA if relevant.	○	◉	
Photographs; of **scene** (broken door locks, evidence of tidying up) **and any injuries** (taken over time as injuries develop). Recover any possible **weapons** (sticks, footwear if victim has been stamped on). Consider **CSI advice.**	○	◉	
Admissions.	○	◉	
Medical evidence/DNA (if available at the time); signed consent form; medical exhibits i.e., hair.	○	◉	
Other statements – children, attending Officer (to include nature and seriousness of visible injuries, signs of struggle, attempts of choking/drowning, or isolation, disposition of victim/offender, IDs of other persons present), neighbours following house to house enquiries, support services. Consider threats made to other witnesses.	○	◉	

Passive data/Comms data/Financial data e.g., data mining footprints, social media/other electronic evidence, messages, diaries, spyware technology, apps, bank-records CCTV. Check all devices for incoming and outgoing data, WIFI and cell site data, (NB: communications data can be collected retrospectively from the service provide).	○	◉	
Is there any evidence of coercive and controlling behaviour? See College of Policing Authorised Professional Practice for further information (link).	○	◉	
Relevant information to include from **Police Records.**			
	YES	NO	COMMENT*
Risk of reoffending. Any previous DASH or equivalent risk identification checklist with outcome (i.e., MARAC case, high risk, standard risk).	○	◉	
Any civil orders/proceedings and whether there have been previous breaches (DVPOs / DVPNs).	○	◉	
Any previous allegations (with URNs and including other victims) and how these allegations were concluded (if case did not proceed why not?) DVDs.	○	◉	
Police to inform CPS of any breach or further offences, submit files to CPS and supply interview record in a timely way.	○	◉	
Were any firearms used? Does the suspect have any firearms licences or are there any intelligence reports linking suspect and household members to weapons?	○	◉	
Whether the Bail Amendment Act should be invoked in a custody case.	○	◉	
Information regarding the **victim and/or incident.**			
	YES	NO	COMMENT*
Victim Personal Statement; can be updated throughout case proceedings.	○	◉	
Safety of victim (victim's views and IDVA/specialist support service views).	○	◉	
Whether victim has been contacted by suspect/friends/family whether supportive or intimidating contact – detail within comments section.	○	◉	
Counter allegations/defence.	○	◉	
Restraining Order – does the victim want one and if so with what terms?	○	◉	
Bail conditions that do not restrict the victim and any children. Include locations to avoid.	○	◉	
Withdrawing support/retraction. There may be a number of reasons why the police might be asked not	○	◉	

to proceed further including fear of further harm or repercussions. See CPS Legal Guidance for further information and steps to follow including the need for an officer's statement on the appropriateness of a summons.			
Ability/willingness of victim to attend court, give evidence and any special considerations.	○	◉	
Special measures needed? And type (views of victim and IDVA/specialist support service) need to complete an MG2.	○	◉	
Information regarding any **children and/or dependants**			
(When a child is interviewed it should be done in safety and privacy and in no circumstances should a child be used as a translator for their parent).	YES	NO	COMMENT*
Safety of children (Police and Victim's views).	○	◉	
Whereabouts of children during incident (include relation to victim/suspect and age).	○	◉	
Child Protection Proceedings: include whether referral made to Children's Services.	○	◉	

* The comment box must be completed if no evidence available

CPS Prompts for Prosecutors

Prosecutors must refer to the CPS Legal Guidance on Domestic Abuse (link); however, the table below provides some helpful prompts for prosecutors to consider.

Provision and **gathering of wider information** in addition to this evidence gathering checklist.
If further evidence is required from the police, ensure this is articulated in a clear and concise action plan and discussed with the Officer as appropriate.
Find out whether there are any concurrent or imminent public law or private law family proceedings or civil proceedings and remedies involving the complainant or suspect.
Assessing the suspect/defendant.
Ensure timely applications for; hearsay evidence and/or bad character.
Has the credibility of the defendant been fully considered? E.g., Are there any previous instances of misconduct/convictions?
Are there any aggravating features?
What are the possible defences?
Consider the acceptability of pleas.
Victim and witness support following a decision to charge.
Victim Personal Statement obtained and updated throughout the case progression.
Timely consideration of; special measures, Pre-Trial Witness Interviews, expert evidence, and other support measures.
Identification and consideration of vulnerabilities (BME, physical or mental impairment, LGBT, age).
Ongoing communication through IDVA/Witness Care Units/other specialist services on case progression and any other useful information.
Where there is a withdrawal or retraction; see CPS Legal Guidance for further information on the possible reasons including fear or coercion, which should be fully explored with victim/WCU/IDVA/Specialist support.