Domestic Homicide Review

Review into the death of Amber

in September 2021

043 Overview Report

Dr Roxanne Khan

Director, onEvidence Ltd

Independent Chair and Report Author

On behalf of Safer Somerset Partnership

Approved by Safer Somerset Partnership:
5th May 2023

Approved by the Home Office:
28th November 2023

DHR 043

Memories of Amber, shared by her Father

Amber was a free spirit and loved all music… from classical to drum and bass.

She always had aspirations … she talked about wanting a career in clothes and fashion design.

She was always updating her home and was very creative. When I visited her, she would have repainted and included lovely designs.

Amber loved spending time with her friends and was really sociable.

Amber also loved holidays in Blackpool.

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1. Preface

The Independent Chair and the DHR Panel members offer their condolences to the many people who have been affected by the tragic death of Amber[1] and thank them for their contributions and support for this process.

Their deepest sympathies are with Amber's family – her three children, her father, other relatives, and her friends.

The Review Chair thanks each of the Panel members for the professional way in which they have conducted this Review, and the Individual Management Review authors for their honesty, meticulousness, and transparency in reviewing the conduct of their individual agencies. The Review Chair and Panel members extend their gratitude to Suzanne Harris for her efficient administration and sensitive contribution to this Review, as Senior Commissioning Officer (Interpersonal Violence) with Somerset County Council.

1.1 Introduction

1.1.1 Domestic Homicide Reviews (DHRs) came into force on 13th April 2011. They were established on a statutory basis under Section 9(3) of the Domestic Violence, Crime and Victims Act (2004).

1.1.2 The purpose of a DHR is to:

- Establish what lessons are to be learned from a domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and identify what needs to change to reduce the risk of such tragedies happening in the future to prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra- and inter-agency working.

1.1.3 DHRs do not take the place of the criminal or coroner's courts, nor does it take the form of a disciplinary process.

1.1.4 This DHR examines the circumstances leading up to the death of Amber, a 32-year-old woman who died by suicide in September 2021. Specifically, to identify any relevant background or history of domestic abuse before her death; to establish whether support was accessed within the community; and whether there were any barriers to accessing support.

[1] Not her real name.

1.1.5 This DHR will consider local agency contact or involvement with Amber and/or James[2], a 31-year-old man who she had been in an intimate relationship with for around eight months. Both Amber and James were residents of Somerset, living in separate bedsit rooms in a house in multiple occupation (HMO) run by a homeless charity. Amber had been a tenant at this address for four months before she and James began their relationship. Three months into their relationship, Amber was taken to hospital after taking an overdose. She disclosed the overdose was due to arguments with her partner that had built up, and that she 'couldn't take it anymore'. In the weeks prior to Amber's death, she also disclosed that James would not leave her room when she asked; that he had assaulted her on two separate occasions; and that he had physically injured her. Around 10 days before Amber's death, she told HMO staff about James's abusive behaviour towards her and sought to move away from him.

1.1.6 Amber was found dead in her room, by James, where she had hung herself with a homemade ligature. The South Western Ambulance Service attended, as did police officers from the Avon and Somerset Police, but tragically Amber was pronounced dead at the scene.

1.1.7 The Safer Somerset Partnership (SSP) was notified of a possible domestic abuse related suicide by Avon and Somerset Police on 29th September 2021. This was discussed with standing members of the Somerset Domestic Abuse Board, who provide oversight for Domestic Abuse and Sexual Violence in Somerset. It was then decided by the SSP Chair on 8th November 2021 that Amber's death by suicide did not meet the criteria for a DHR and instead proposed this should be subject to a multi-agency learning review, to ascertain learning from housing organisations on how to respond to alleged domestic abuse in homelessness accommodation.

1.1.8 The SSP notified the Home Office, which was referred to their DHR Quality Assurance Panel to review, as per paragraph 26 of the *Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews* (December 2016) - hereafter referred to as the *Statutory Guidance*.

1.1.9 The Home Office Quality Assurance Panel decision was that this case would benefit from a DHR, as Amber had disclosed domestic abuse in her relationship with James. On 9th April 2022, the SSP were notified by the Home Office of the decision that a DHR should be conducted, which is the 33rd DHR commissioned by SSP. Their published DHRs can be found at https://somersetsurvivors.org.uk/professional-resources/domestic-homicide-reviews/

1.2 Timescales

1.2.1 Adhering with the Statutory Guidance, SSP commissioned Dr Roxanne Khan to act as the Independent Chair (hereafter the *Chair*) and Overview Report Author for this DHR on 13th June 2022, once the decision to conduct the DHR had been made.

[2] Not his real name.

1.2.2 The completed Overview Report (and Executive Summary) was handed to SSP on 28th April 2023. It was signed off by the SSP Chair, before being submitted to the Home Office Quality Assurance Panel on 5th May 2023. On 25th October 2023, the completed report was considered by the Home Office Quality Assurance Panel. On 28th November 2023, the SSP received a letter from the Home Office Quality Assurance Panel approving the report for publication subject to final amendments (see Appendix 8.4).

1.2.3 Home Office guidance states that a DHR should be completed within six months of the initial decision to establish one. As outlined in 1.1.7 to 1.1.9, there were delays in commencing a review following Amber's death due to the initial SSP decision and awaiting Home Office Quality Assurance feedback. Subsequently, efforts were made to complete a thorough review in accordance with the six months outlined in the guidance. This timeframe was not met due to the first panel being held on 20th July 2022, and the fourth panel held on 1st February 2023 to discuss the final report, with the Overview Report (and Executive Summary) finalised and approved by end of February 2024.

1.3 Confidentiality

1.3.1 The findings of this DHR are restricted. Information is available only to participating officers/professionals and their line managers, until after the Overview Report (and Executive Summary) have been approved for publication by the Home Office Quality Assurance Panel.

1.3.2 In line with recommendation in the Statutory Guidance, this DHR has taken measures to protect the identities of those involved, and pseudonyms have been used as selected by the Panel. These are shown in section 2 (Background Information: The Facts), Table 4.

1.3.3 The specific date of Amber's death and the sex of her children have been removed (with anonymity further enhanced by the children being referred to as Child A, B, and C and identifying information removed). Only the Chair and Review Panel members are named.

1.4 Equality and Diversity

1.4.1 During the DHR process, the Chair and the Review Panel considered whether the following protected characteristics were relevant in this case: *age*, *disability*, *gender reassignment*, *marriage and civil partnership*, *pregnancy and maternity*, *race*, *religion and belief*, *sex*, and *sexual orientation.*

1.4.2 At the first meeting of the Review Panel, the protected characteristics of *sex* and *disability* required specific consideration.

1.4.3 The protected characteristics of s*ex* was considered because Amber was female, and James is male. An analysis of DHRs reveals gendered victimisation across both intimate

partner and familial homicides with females representing the majority of victims, and males representing the majority of perpetrators.[3]

1.4.4 The protected characteristics of *disability* was considered because Amber had suffered with mental ill-health and substance misuse for several years, which she advised had followed from her diagnosis and treatment for aggressive breast cancer, resulting in a double mastectomy six years prior to her death by suicide.

1.4.5 These issues are considered throughout this report and summarised in the DHR analysis (see section 5.4).

1.5 Terms of Reference

1.5.1 The full Terms of Reference are included in Appendix 1. This DHR aims to identify the learning from this case, and for action to be taken in response to that learning with a view to preventing domestic abuse related suicides and ensuring that individuals and families are better supported.

1.5.2 The Review Panel was comprised of agencies from Somerset, as Amber and James were living in that area at the time of her death. Agencies were contacted as soon as possible to inform them of the DHR, invite their participation and to ask them to secure their records.

1.5.3 At the first meeting, the Review Panel shared brief information about agency contact with the individuals involved. This established that the time period to be reviewed would be from 1st March 2019 to the date of Amber's death in September 2021. This date was chosen because agency contact with Amber had restarted at this time, after a year gap. Further, while child protection concerns had been ongoing, involvement with Children Social Care had become more involved at this time.

1.5.4 *Key Lines of Inquiry:* The Review Panel considered the *Statutory Guidance* and identified the following case specific issues:

A. Communication, procedures, and discussions that took place within and between agencies.
B. Co-operation between different agencies involved with Amber and/or James, and wider family.
C. Opportunities for agencies to identify and assess the risk of domestic abuse.
D. Agency responses to identifying domestic abuse issues.
E. Organisations' access to specialist domestic abuse agencies.
F. Domestic abuse policies, procedures, and training available to the agencies involved.
G. Specific consideration to the following issues: (1) *the impact of Covid-19*, which was relevant in the 18 months prior to Amber's death; (2) *disability* because Amber had suffered with mental ill-health and substance misuse for several

[3] In the latest analysis of 124 DHRs reviewed as part of the Home Office Quality Assurance process, which took place over 12 months from October 2019, "Eighty percent of the victims were female and 20% were male. For perpetrators, 83% were male and 17% female". Home Office, "*Key Findings from Analysis of Domestic Homicide Reviews*" (September 2021).

years and, in the months leading to her death, she reported that her health had worsened.

H. Any evidence of help seeking, as well as considering what might have helped or hindered access to help and support.

1.5.5 As Amber reported online gambling had a significant financial and psychological impact on her, the Review Panel sought input from a representative of GamCare,[4] who have brought expertise in relation to problem-gambling at previous DHRs. GamCare were unable to contribute on this occasion, due to time constraints. Nonetheless, the significance of problem-gambling by domestic abuse victims was considered by the Review Panel, who made a recommendation on this issue in line with a previous DHR.[5]

1.6 Methodology

1.6.1 This DHR has followed the Statutory Guidance issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004.

1.6.2 *Definitions*: In this Overview Report, the terms ‘domestic abuse’ and ‘domestic violence’ are used interchangeably. The report uses the statutory definition of domestic abuse as set out in the Domestic Abuse Act 2021. The definition states that domestic abuse is:

- *“Behaviour of a person (“A”) towards another person (“B”) is “domestic abuse” if—*
  - *a. A and B are each aged 16 or over and are personally connected to each other, and*
  - *b. the behaviour is abusive.*
- *Behaviour is “abusive” if it consists of any of the following—*
  - *a. physical or sexual abuse;*
  - *b. violent or threatening behaviour;*
  - *c. controlling or coercive behaviour;*
  - *d. economic abuse (see subsection (4);*
  - *e. psychological, emotional, or other abuse; and it does not matter whether the behaviour consists of a single incident or a course of conduct.*
- *“Economic abuse” means any behaviour that has a substantial adverse effect on B’s ability to—*
  - *a. acquire, use, or maintain money or other property, or*
  - *b. obtain goods or services.*
- *For the purposes of this Act, A’s behaviour may be behaviour “towards” B despite the fact that it consists of conduct directed at another person (for example, B’s child).*

1.6.3 *Identifying agencies*: On notification of the domestic abuse related suicide, agencies were asked to check for their involvement with Amber and James and secure their records. As there was agency involvement only known in Somerset, scoping was completed in this area. Agencies in this area were contacted to check for involvement

[4] GamCare provides information, advice and support for anyone affected by problem gambling.
[5] See Rowland, J. (2019) Overview Report into the death of Salma (Tower Hamlets Community Safety Partnership)

with the parties concerned with this DHR. A total of 16 agencies were contacted to determine if they had had contact with Amber and James.

1.6.4 *Individual Management Reviews (IMRs)*: Of these, seven agencies confirmed they did not have contact (see 1.7.1). Of the nine agencies that did have varying degrees of contact, seven were asked to submit Individual Management Reviews (IMRs), written by authors independent of case management or delivery of the service concerned (see 1.7.3). Agencies completing reports were asked to provide chronological accounts of their contact with Amber and/or James prior to her death. Where there was no involvement or insignificant involvement, agencies advised accordingly. The recommendations to address lessons learnt are listed in section 7 of this Overview Report.

1.6.5 The IMRs received were for the most part comprehensive and enabled the Review Panel to analyse the contact with Amber and James, and to produce the learning for this DHR. In some IMRs, a lack of detail meant that further questions had to be sent to agencies. Additionally, while Somerset West and Taunton Council provided an IMR with a timeline of contact with Amber and James, a detailed analysis of their involvement was not included.

1.6.6 Of the 7 IMRs submitted to the DHR, 6 IMRs made recommendations of their own, and in some cases reported changes in practice and policies over time. These are described in the Recommendations (section 7).

1.6.7 *Documents reviewed:* In addition to the IMR information detailed in 1.6.5, several other documents have been reviewed. These are referenced in this report.

1.7 Contributors to the Review

1.7.1 The following agencies were contacted but recorded no involvement with Amber or James:

- Adult Social Care
- Safe Link (ISVA)
- Somerset and Avon Rape and Sexual Abuse Support
- Somerset Integrated Domestic Abuse Service
- Somerset Safeguarding Adults Board
- Victim Support
- Yeovil District Hospital

1.7.2 The following agencies recorded involvement with Amber or James, but as this was limited or outside of the review period, an IMR or Summary Report was not requested:

- *Probation*: Amber was previously known to, and was managed by, the Community Rehabilitation Company (CRC) under a community order. As this ended in 2017, over two years outside of the scoping period, the panel decided that probation involvement would be unlikely to inform this DHR.
- *South West Ambulance Service NHS-FT*: The initial trawl found three contacts with this service for Amber. One was in 2017, outside the scoping period and unrelated to the DHR. The remaining two contacts were in 2021, within the scoping period

2021. The first in which Amber was treated after a suicide attempt and transported to Musgrove Park. The second, in response to a call from James, after her death.

1.7.3 The following agencies made contributions to this DHR:

Table 1: Contributing Agencies	
Agency	**Contribution**
Arc Inspire[6]	IMR and Chronology
Avon and Somerset Police[7]	IMR and Chronology
Children Social Care (CSC) [8]	IMR and Chronology
NHS Integrated Care Board (ICB)[9]	IMR and Chronology
Somerset Drug and Alcohol Service (SDAS)[10]	IMR and Chronology
Somerset NHS Foundation Trust (NHSFT)[11]	IMR and Chronology
Somerset West and Taunton Council[12]	IMR and Chronology

1.8 Review Panel Members

1.8.1 *<u>Independence</u>*: The Chair and author of this report, Dr Roxanne Khan, is independent of all agencies involved and had no prior contact with any family members. All Panel members and IMR authors were independent of any direct contact with the subjects of this DHR. Neither were they immediate line managers of anyone who had had direct contact.

1.8.2 The Review Panel members and the agency they represented are shown in Table 2.

Table 2: Review Panel Members and Attendees		
Name	**Agency**	**Role**
Rachael Overton	Arc Inspire	Pathway Support Worker
Jo Pearce	Arc Inspire	Head of Operations
Sam Williams	Avon and Somerset Police	Detective Chief Inspector
Su Parker	Avon and Somerset Police	Inspector
Angela Kellǂ	Avon and Somerset Police	Safeguarding Review Author
Sussanah Heywood	Children Social Care (CSC)	Family Safeguarding Team Manager
Cathy Jonesǂ	Children Social Care (CSC)	Operations Manager
Emma Read	NHS Integrated Care Board (ICB)	Deputy Designated Nurse Safeguarding Adults
Julie Masonǂ	NHS Integrated Care Board (ICB)	Designated Nurse Safeguarding Adults

[6] https://arcinspire.co.uk/
[7] https://www.avonandsomerset.police.uk/
[8] https://beta.somerset.gov.uk/education-and-families/social-care/
[9] https://nhssomerset.nhs.uk/about-us/integrated-care-in-somerset/
[10] https://www.turning-point.co.uk/services/sdas
[11] https://www.somersetft.nhs.uk/
[12] https://www.somersetwestandtaunton.gov.uk/

Suzanne Harris	Somerset County Council (SCC) Public Health[13]	Senior Commissioning Officer (Interpersonal Violence)
Jane Harvey-Hill†	Somerset Drug and Alcohol Service	Safeguarding Manager
Louise Smailes	Somerset NHS Foundation Trust (NHSFT)[14]	Deputy Named Professional for Safeguarding Adults
Heather Sparks*	Somerset NHS Foundation Trust (NHSFT)	Named Professional for Safeguarding Adults
Vicky Hanna†	Somerset NHS Foundation Trust (NHSFT)	Domestic Abuse Lead
Louisa Hill†	Somerset West and Taunton Council	Lead Specialist Homefinder
Lucy Harling	The You Trust[15]: current Somerset Integrated Domestic Abuse Service (SIDAS) provider	Paragon Manager

**Denotes attendee who stood in for Panel member at DHR meeting*
† Denotes IMR Author

1.8.3 The Review Panel met a total of four times as shown in Table 3. After meeting 3, the Overview Report and Executive Summary were agreed electronically. The Review Panel members provided comment on three drafts of the Overview Report and one draft of the Executive Summary before signing off the final reports by secure email during February 2023.

Table 3: Dates of Three Panel Meetings	
Panel Meetings	**Date**
Meeting 1	20 July 2022
Meeting 2	12 October 2022
Meeting 3	15 December 2022
Communication between Panel Members via Secure Email	
Meeting 4	1 February 2023
Communication between Panel Members via Secure Email	

1.9 Involvement of Amber's Family, Friends, Work Colleagues, Neighbours and Wider Community

1.9.1 At the first meeting, the Review Panel considered it important to take steps to involve Amber's family, friends, work colleagues, neighbours, and wider community.

[13] https://www.somerset.gov.uk/social-care-and-health/public-health/
[14] https://www.somersetft.nhs.uk/
[15] https://www.lighthousevictimcare.org/organisation/you-trust/

1.9.2 *Family*: In August 2022, Amber's father, who she was reportedly close to, was informed about the DHR taking place and was invited to participate. He considered this invitation and chose not to be directly involved in the DHR, with full respect and understanding from the Review Panel. The Review Panel gratefully received his reflections on Amber, which are on page 2 of this report. Throughout this DHR, no information was provided about Amber's mother – either in the IMRs or panel meetings. This information may have provided a more thorough understanding of Amber and further insight into her life and circumstances.

1.9.3 The Review Panel also considered engaging with Amber's children yet decided against this after they were informed by Children Social Care that the family were facing ongoing struggles after Amber's death, and one child was in foster care.

1.9.4 *Friends, Work Colleagues, Neighbours and Wider Community:* The Review Panel also considered approaching friends and others in Amber's wider community, and consequently, letters were sent to her neighbours inviting them to contribute. One neighbour, who was invited to contribute, did not want to be involved in the process. Two other neighbours, who had moved from the HMO property since Amber's death, were sent letters at their new address but they did not respond.

1.10 Involvement of James, his Family, Friends, Work Colleagues, Neighbours and Wider Community

1.10.1 *The Perpetrator, his Family, Friends, Work Colleagues, Neighbours and Wider Community*: The Review Panel also considered approaching James, his friends, neighbours, and wider community. James was not approached, and it was not possible to identify any of his network who could be approached. Therefore, there is no information directly from James, his family or wider network in this DHR.

1.10.2 One challenge of involving perpetrators in DHRs of domestic abuse related suicide is the absence of a criminal justice outcome.[16] Related to this DHR, "… specifically, that the (alleged) perpetrator would not have been convicted in relation to a victim's death and/or may not have previously been convicted of domestic abuse offences". While it is acknowledged that James's voice would provide a more holistic review, his involvement was considered in context of a common concern identified by participants of other DHRs of domestic abuse related suicide, when it is decided that contact with the perpetrator is not made. That is, that the perpetrator denies abusing the victim. Further, that "Perpetrators of domestic abuse will often use statutory services to make false allegations about victims or will make counter allegations to dismiss the victim's account of the facts."[17] Pertinently, key features of this DHR include instances in which

[16] Rowlands, J. & Dangar, S. (2023). The Challenges and Opportunities of Reviewing Domestic Abuse-Related Deaths by Suicide in England and Wales. *Journal of Family Violence*, 1-1. This study analysed interviews with 40 DHR participants, including independent chairs and review panel members (e.g., domestic abuse coordinators, domestic abuse services, and other agency representatives).

[17] Sharp-Jeffs. N. & Kelly, L. (2016). DHR Case analysis. Report for Standing Together Against Domestic Violence.

James denied domestic abuse and made both false allegations and counter allegations of domestic abuse (see section 5: Analysis, footnote 34).

1.11 Parallel Reviews

1.11.1 *The Coroner's Inquest*: The death of Amber was referred to the Coroner for Somerset. An inquest was opened in September 2021, and an inquest hearing took place in December 2021.

1.11.2 *Children:* There are no parallel reviews in relation Amber's children. At the first Review Panel meeting, it was noted that prior to her death, Amber's children were placed with their maternal grandfather and the ongoing care of the children was beyond the remit of the DHR. The Review Panel were informed that after Amber's death, the children's social worker was working to support them after their mother's death.

1.12 Independent Chair of the Review and Author of Overview Report

1.12.1 The Chair and author of this report, Dr Roxanne Khan, is an expert in domestic abuse and violence, and has been active in this area of research, policy, and/or practice for over two decades. Dr Khan has extensive experience of chairing multi-partnership panels and authoring reports on interpersonal harm and violence. Dr Khan has no connection with the local area or any of the agencies involved. Further information about Dr Khan can be found at onEvidence.co.uk

1.13 Dissemination

1.13.1 The Overview Report (and Executive Summary), once finalised by the Review Panel, was presented to the SSP for approval. Once approved, both the Overview Report (and Executive Summary) were sent to the Home Office to be assessed for quality assurance.

1.13.2 Once approved by the Home Office, the Overview Report (and Executive Summary) were shared with all the local organisations that contributed to this review. This was published on the SSP website, so it is freely accessible: https://somersetsurvivors.org.uk/professional-resources/domestic-homicide-reviews/

1.13.3 The DHR recommendations are owned by the SSP, who are responsible for monitoring the recommendations and reporting on progress.

1.13.4 The SSP will ensure learning points from this DHR are disseminated widely, as detailed in the Action Plan in Appendix 2.

2. Background Information. The Facts

Table 4: Principal People Referred to in this Report

Referred to in report as	Gender	Relationship to victim	Age at time of Amber's death	Ethnic origin	Faith
Amber	Female	-	32 years	White (North European)	None known
James	Male	Intimate Partner	31 years	White (North European)	None known
Child A	-	Child	13 years	-	-
Child B	-	Child	11 years	-	-
Child C	-	Child	9 years	-	-
Children's father	Male	Ex-Intimate Partner and Father of Amber's 3 Children (Child A, B, and C).	37 years	-	-

2.1 Amber's Suicide

2.1.1 In the 11 months prior to her death, Amber had lived in a bedsit room, which was a house in multiple occupation (HMO) run by a homeless charity in Somerset. Around four months after moving into this property, during the third national Covid-19 lockdown, Amber and James began an intimate relationship. He lived in a separate room at the same property and often slept in Amber's room.

2.1.2 Three months into their eight-month relationship, Amber was taken to hospital after taking an overdose, which she reported was due to arguments with her partner over the last month that had built up, and she 'couldn't take it anymore'. In the weeks prior to her death, Amber reported that when she asked James to leave her room on previous occasions, he had refused and become aggressive. This had been witnessed by HMO staff. In one incident, James's headbutted Amber, and another, a relative had helped her to remove him. About 10 days prior to her death, Amber had sought to move to another property. Two days prior to her death, HMO staff noted that James was in Amber's room during an unexpected fire drill, and that neither she or James left the room, despite being asked to do so.

2.1.3 In September 2021, eight months after her relationship with James had started, Amber hung herself with a homemade ligature. The ambulance crew who attended found James giving CPR (cardiopulmonary resuscitation) to Amber. The ambulance crew pronounced Amber dead at the scene.

2.1.4 The police found Amber's room to be in a significant state of disarray with evidence that she had smashed glass and other personal effects with a hammer prior to her death.

2.1.5 In James's account of events to the police, he described that they were up late the night before her death, smoking cannabis and watching TV. The next morning, he said that Amber had received a text message from her father, who looked after her three children. This text stated that he would walk away from Amber because she was hurting her children. That afternoon, Amber and James were returning to the house after being out. While walking down an alley way, Amber smashed a bottle of cider, and James recalled feeling intimidated. At this point, he walked away from Amber, eventually returning home after her.

2.1.6 After 10 minutes, Amber approached James's room. She was shouting, kicking, and banging the door to his room, and he told her to "fuck off". Over the next few hours, James periodically checked on Amber's room. She did not reply. Just after 17.00pm, James forced her door and found Amber hanging. James's account of this time is largely confirmed by CCTV in the building.

2.1.7 Neighbours recall that they heard arguing coming from Amber's room, both on the evening before her death and on the morning of her death.

2.1.8 Amber left three suicide notes for each of her children.

2.1.9 *Coroner's Inquest*: Following an Inquest into Amber's death, the medical cause of death was cited as "*Hanging"*. The Record of Inquest states that Amber "…. *deliberately suspended herself by the neck with the intention of ending her life*". The conclusion of the Croner as to the death was stated as "*Suicide"*.

2.2 Background Information on Amber and James (prior to the timescales under review)

2.2.1 *Background Information on Amber*. Amber was a white British woman, who was a mother to three children from a previous relationship. Aged 32, she was not working due to long-term sickness and, after a period of homelessness, was living in supported accommodation when she died. In 2015, Amber had suffered from breast cancer, which returned in 2019 following initial treatment and she had undergone chemotherapy treatment as a result. The impact of this treatment led Amber to have severe self-image issues.

2.2.2 At this time, Amber's three children were taken away from her care as she was unable to cope. Amber had a support worker at Somerset Drug and Alcohol Service (SDAS), who she saw twice a week for support with speaking to her children, help with money management, and alcohol and drug misuse.

2.2.3 Amber had historical contact with Avon and Somerset Police, with records going back to 2006. Some of these are as a victim of crime and some as a perpetrator. In 2012, there is one record of Amber being the victim of domestic abuse, by her ex-partner and father of her children.

2.2.4 *Background Information on James.* James is a white British man, aged 31 at the time of Amber's death. Prior to the timeframe of the review, he had a few police records for drug related offences and six police records relating to domestic incidents between him and his mother, in 2012.

2.2.5 *Synopsis of relationship between Amber and James*. Amber and James began an intimate relationship in February 2021, which is within the timescales under review - 1st March 2019 and 12th September 2021. In section 3, a narrative chronology is presented that overviews Amber's and James's relationship, while living in different bedsit rooms at the same HMO property run by a homeless charity in Somerset. Amber had lived at this property for approximately four months before the start of her relationship with James, and she died by suicide, in her room, seven months later. In the months leading up to her death, she had reported to multiple staff and multiple agencies that James had physically abused her, and that he had used controlling, coercive, and threatening behaviour and harassed her. Amber had sought to move away from him to another property.

3. Chronology

3.1 Time Scales Under Review - From March 2019 to September 2021 (Date of Amber's Death)

3.1.1 Drawing on information from the IMRs, this section provides an overview of the contact that agencies had with Amber, James, and their families. It summarises the information known to the agencies and professionals about them and any other relevant facts.

Significant contact prior to period included in the review (prior to 1st March 2019)

3.1.2 Other than Avon and Somerset Police, neither Amber nor James were known to other police forces in the UK.

3.1.3 In 2012, the police had six records of James relating to domestic abuse, between/against his mother.

3.1.4 Overall, there were 70 police records linked with Amber from 2006 onwards. These included records of Amber as a victim of crime and records of Amber as a perpetrator, with numerous records of verbal and physical assault by Amber. In 2012, there was one record of Amber being a victim of domestic abuse by her ex-partner and father of her children. In 2014 and 2015, Police records showed that Amber had 3 convictions for 5 offences. These were 2 offences against the person (Battery) and 3 offences relating to police/courts/prisons (2 of assaulting a police officer and 1 of failure to surrender to custody). Amber also had 2 not guilty disposals for battery (2005 and 2015).

3.1.5 Also in 2015, when Amber was aged 24 years, she was diagnosed with an aggressive form of breast cancer, which was treated with a bi-lateral mastectomy. In 2018, further cancer was found which required additional surgery, chemotherapy, and medication for a further 10 years. Amber also had an existing diagnosis of osteoporosis, a vertebral facture, and chronic pain as a result of this.

Significant contact during period included within the review (1st March 2019 to September 2021)

March and April 2019

3.1.6 James was known to mental health services during the review period, including two accident and emergency attendances related to mental health. In April 2019, the police recorded that James was assaulted by an acquaintance. Further, that James was intoxicated at the time and the details of the incident could not be corroborated. Officers attended and spoke with James, but there were limited lines of enquiry. James

did not seek to pursue a prosecution and the case was closed; no further action was taken.

3.1.7 Amber was in contact with a range of health services, during this period, for advice and treatment in relation to her physical and mental health. In March, she told her GP that she was not sleeping and had joint pains, especially after chemotherapy, and that she was more anxious than usual, about everything not just her illness. She told her GP she had booked to see a counsellor at the Beacon Centre[18], and the GP suggested increasing her antidepressant medication with a follow up in 2 weeks, and to call again before then if she needed. Amber was also seen by a district nurse for related clinical care and no safeguarding concerns were noted. In March, Amber did not attend three planned appointments with clinical oncology and/or Maxillo-Facial Surgery, and a district nurse was unable to contact Amber by phone, or to leave a message. Her GP was advised that Amber would therefore be discharged back to their care, but she would be reinstated should care be required in the future.

June and July 2019

3.1.8 During this period, Amber was again in contact with health services. In June, however, she did not attend a clinical oncology appointment, and no reason was provided.

3.1.9 During this period, police were in contact with James twice.

3.1.10 Firstly, on 28th June 2019, during an argument his mother, James assaulted her and pinned her arms to the wall while shouting in her face. James's mother expressed significant concern for James's mental health, and his drug/alcohol use. She disclosed his controlling behaviour and that he often demanded money from her, and that she was frightened of him and was at her wit's end. She told the police that she was worried he would end up killing himself if she threw him out of her house. James denied his mother's version of events, saying she attacked him, and that he acted in self-defence. James was arrested and taken to custody. A Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessment[19] was completed for James's mother (rated as 'Medium'), and injury photos and statements were taken. James was charged to court but found not guilty as no evidence offered. James was bailed, with conditions not to contact his mother or go to her house.

3.1.11 Four days later, on 2nd July 2019, there was a second incident, in which James's mother called the police to report that he had phoned her, contrary to his bail conditions, and implied that he would end his life by suicide. She did not know where he was and there were concerns for his welfare. A search for James was conducted in line with a high-risk missing person. He was located about 4 hours later, with his mother, and arrested for breach of bail. He was taken to custody before being taken to court the next day where he was found not guilty of this assault.

[18] The Beacon Centre at Musgrove Park Hospital holds outpatient clinics for Haematology and Oncology patients, and offers information, support, assessment, and treatment to people living with cancer.

[19] For more information on the DASH, go to: http://www.safelives.org.uk/node/516.

August and September 2019

3.1.12 In August, Amber's GP gave her the number to self-refer to Talking Therapies, after she requested counselling. At this time, she was due to start monthly injections as part of her hormone therapy, although she did not attend the appointment booked and no reason was provided.

3.1.13 Less than a week later, on 5th September, Children Social Care (CSC) requested a strategy discussion after Amber disclosed that she had hit her oldest child and was shouting and swearing at all three of her children. Following this, professionals agreed that there would not be a police investigation, as this was an issue of poor parenting that would be addressed by Children Social Care (CSC).[20] Background checks were completed on Amber, and on the children's paternal grandfather with whom they were staying, due to previous sexual offences against children. The following day, the children's paternal grandfather's convictions were disclosed to the children's father (which he was unaware of) and Amber.

3.1.14 Fewer than 3 weeks later, on 23rd September, Children Social Care (CSC) made another strategy request after Amber disclosed that she had slapped her middle child (Child B). There was a concern that the safety plan put into place by Children Social Care (CSC) was not working and things were escalating. Amber admitted to slapping the children and admitted to a cocaine addiction. After investigation, no further police action was taken, as it was decided that it was a case of over-chastisement, and an Initial Child Protection Conference (ICPC) would be held.[21] A social work visit took place the following day, as well as a child protection medical examination[22]. ABE (Achieving Best Evidence) assessments were conducted before the children were interviewed[23]. After Amber was interviewed regarding the incident, safety plans were put in place, and she moved out of the family home. A safeguarding note from the strategy meeting stated that Amber's three children were to stay with her on this night, but their father was to either stay with them, or ensure he is there in the morning, to get them to school. Following that, the social worker would visit with the police to ensure there was a robust safety plan in place.

3.1.15 The following day, Amber had a telephone consultation with her doctor, during which she asked for help with anger management, as she lost her temper with the children, and social workers were involved. The following day, Amber's self-referral for Talking

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[20] From Somerset Safeguarding Children Partnerships: "When the local authority social worker receives a referral and information has been gathered during an assessment (which may have been very brief), in the course of which a concern arises that a child maybe suffering, or likely to suffer, significant harm, the local authority is required by Section 47 of the Children Act 1989 to make enquiries. The threshold criteria for a Section 47 Enquiry may be identified during an early assessment or it may become apparent at the point of referral, during multi-agency checks or in the course of a multi-agency assessment".

[21] Somerset Intelligence (Safeguarding and Child Protection): Section 47 enquiries and initial child protection conferences: If the local authority identifies there is reasonable cause to suspect the child is suffering, or is likely to suffer significant harm, it will carry out an assessment under section 47 of the Children Act 1989 to determine if it needs to take steps to safeguard and promote the welfare of the child. If concerns are substantiated and the child is judged to be at continuing risk of harm, then an initial child protection conference (ICPC) should be convened within 15 working days".

[22] A child protection examination is carried out to look for signs that a child or young person has been abused or neglected. This is different from a clinical examination, which aims to establish what is wrong with the child or young person and what treatment may be needed.

[23] Somerset Safeguarding Children Partnership Procedures: "Visually recorded interviews must be planned and conducted jointly by trained police officers and social workers in accordance with the Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, and guidance on using special measures (Ministry of Justice)."

Therapies was received, during which she denied any concerns about domestic abuse. This assessment was completed on 7th November 2019.

October and December 2019

3.1.16 In October and November, Amber did not attend her monthly injections as part of her cancer treatment, and no reason was provided.

3.1.17 Amber had now moved in with a supportive relative, and on 22nd October, she attended the Somerset Drug and Alcohol Service for assessment, requesting support in reducing her cocaine use until she was abstinent. She reported using cocaine for the last 4 years to "escape" and feel confident to express her own feelings following diagnosis and treatment for aggressive cancer. Amber, who said that she smoked cannabis daily and used alcohol socially in pubs with an occasional fortnightly or monthly binge, was not identified at the time as alcohol dependant. She also said that she could lose herself for hours at a time with online gambling and that she had lost hundreds of pounds at any one time while gambling. Amber advised that about 6 years ago, following Crack Cocaine use, she took an impulsive mixed overdose with both prescribed and non-prescribed medications, but there were no current suicidal ideation or plan. Amber stated that she did not feel at risk from others, and while she was aware of County Lines, she was not involved in this. The service provided Amber with harm reduction advice, a 24/7 Talk to Frank Support line number, and signposting to SMART Recovery.[24]

3.1.18 On 5th December, Amber stated that she "forgot" a face-to-face GP appointment. She requested a call instead and said that would like to do her own injections. She also reported depression and that she still had panic attacks using beta-blocker medication, and agreed to increase this on a regular basis, then review.

3.1.19 Throughout December, Amber attended several sessions provided by the Somerset Drug and Alcohol Service. She was positive about the future and was about to start college and driving lessons.

January and February 2020

3.1.20 There was limited contact with services during this period, and it was noted that in January, Amber did not attend a GP appointment, and no reason was given. Also, in February, she did not respond to a check-in call by Somerset Drug and Alcohol Service (SDAS). Before Amber was closed to this service, a message was left for her to call if she had any issues.

March and June 2020

3.1.21 On 17th March 2020, a few days prior to the first national lockdown, Children Social Care (CSC) made a strategy request after Amber disclosed that she had physically and verbally assaulted her middle child (Child B), grabbing them by the neck and causing

[24] SMART (Self-Management and Recovery Training) Recovery is a charity that provides assistance to individuals seeking abstinence from addiction.

visible injuries. Amber had taken her other 2 children on an overseas holiday the week before and they had sustained full body sunburn with blisters due to neglectful care. The threshold for significant harm had been met, and it was agreed that a police investigation would be conducted. Following an ICPC (Initial Child Protection Conference) in April, it was unanimously agreed that the children should become subject to a child protection plan. A joint visit was held 2 months later which was delayed due to Covid, self-isolating and change of Social Worker.

3.1.22 Two weeks later, on 3 June 2020, Amber self-referred herself to Somerset Drug and Alcohol Service (SDAS) to get support for her cocaine use. They were unable to contact her, when they called on two occasions, later in June, so the file was closed. On 10 June, Children Social Care (CSC) made another Strategy request after Amber's middle child (Child B) reported that it was her father who had caused a visible bruise on her cheek. After background checks were made, a joint visit and a CP medical was completed for all three of Amber's children, it was agreed that this did not require criminal investigation, so the case was closed to Children Social Care (CSC).

August and October 2020

3.1.23 In August, Amber attended a health care appointment in relation to cancer treatment and presented concerns around increased pain. She reported the hormone injections upset her mental health and that she did not want to take them anymore. The result of an ultrasound scan was "reassuringly normal".

3.1.24 On 12th October, Amber began her tenancy at Arc Inspire, a house of multiple occupancy (HMO) run by a homeless charity, where she had a bedsit room and was assigned a support worker.

November and December 2020

3.1.25 On 12th November, one month after moving into this property, Amber told Arc Inspire staff that she had just visited her 12-year-old child (Child A) in hospital after they had taken an overdose. Amber wanted to see Child A more often, and to live with them again, and was very worried. She asked for help to deal with all of this. She was advised to contact MIND.[25]

3.1.26 On 16th December 2020, Amber's GP noted that there was a family member on the child protection register, under the category of emotional abuse. This later evolved into the family member being subject of a child protection plan.

January and February 2021

3.1.27 During January, Arc Inspire support staff noted that other residents in the HMO property were concerned for Amber, as a visitor could not get hold of her, and her room was in a bit of disarray, which was not usual. During a welfare check, Amber disclosed worries about her children, and where they were living, and that she had spoken to social services expressing these concerns. During February, it was noted

[25] MIND is a mental health charity that offers information and advice to people with mental health problems.

that Amber spoke to Arc Inspire staff on two occasions regarding her college work, and that she had spoken to a social worker about what had been happening and advised that she could be allocated a drugs worker if she needed the support.

3.1.28 On 25th February, Arc Inspire staff noted that Amber and James were seen together, and were in a new relationship, that she seemed very happy.

March and April 2021

3.1.29 On 17th March, during a follow-up home visit assessment with Somerset Drug and Alcohol Service (SDAS), Amber stated that she coped with her second round of chemotherapy by blanking the prognosis/ diagnosis and using cocaine. She was also worried about the possibility that her children may have inherited a genetic disorder. Amber felt that her mental health problems were solely related to her cancer diagnosis and related changes in body image and described flashbacks to both her biopsies and MRI scans. Amber reported that she had a close family and good relationship with her parents, sibling, and extended family. Professional support options for her children were also discussed, which she thought were a good idea. The same day, Amber told Arc Inspire support staff that she had an appointment with Somerset Drug and Alcohol Service (SDAS) the following day, and that she would be honest with her keyworker there about using drugs recently. She said she was doing a lot better than she was a few months back and was positive. Amber also said she was wondering about adding James to her Homefinder[26] account.

3.1.30 On 22nd March, NHS Foundation Trust received an email from the Somerset Drug and Alcohol Service (SDAS) relating to Amber's ongoing trauma. They made a specific request for counselling as Amber was struggling with body image following cancer treatment, and she had described surgery-related PTSD symptoms, which was having a serious impact on her mental health and sleep - a vulnerability that could lead her to relapse from a substance misuse perspective.

3.1.31 On 1st April, Amber confirmed to Somerset Drug and Alcohol Service (SDAS) that she had received a letter from the Department of Breast Care at Musgrove Park Hospital with an appointment the following week to discuss her concerns. Amber said that she was still smoking cannabis, which did not want to stop, and that she had a line of cocaine 2 weeks ago, which she regretted. Amber mentioned that she had a new boyfriend called James, who she felt was a great influence on her.

3.1.32 On 6th April, a Consultant from the Department of Breast Care reported to Amber's GP that she had attended the appointment and was referred to Bristol Genetics services for assessment, and she also self-referred to the Maxillofacial Department regarding restorative dentistry, and arrangements were made for to review in 6 months' time.

3.1.33 On the morning of 18th April, James reported to the police his concern for a vulnerable adult male at Arc Inspire, and that he was being exploited by a female who was taking money off him when he was intoxicated and offering him sexual favours. Officers attended and spoke to the vulnerable male and Amber. The male did not think he was

[26] Homefinder UK is a national web-based housing mobility service that enables social housing tenants to look for homes outside their local authority area.

being exploited and that he liked the company. A BRAG[27] was completed for the male and words of advice were given to the woman, and the case was closed as, no further action taken. That evening, police attended another incident at the Arc Inspire address, after an allegation that Amber and James assaulted another woman. CCTV showed that they had helped her up from the floor and moved her out of the address due to her being banned from the address. The force used was deemed to be appropriate, and the case closed.

3.1.34 On 23rd April, police attended another incident in which James reported a threat made to him by a female who had smashed a window at the Arc Inspire property. He declined to prosecute after she apologised. The case was closed but the female was prosecuted for criminal damage.

3.1.35 On 27th April, Arc Inspire staff received a phone call from a neighbour at the property, who reported shouting followed by a smashing noise. Security were called, and the police attended later but were unable to playback the CCTV. A glazier was called to board the window. James later rang Arc Inspire staff and said he and Amber were okay but were worried as they thought the person who did this had front door keys.

May and June 2021

3.1.36 On 4th May, Amber called her keyworker at Somerset Drug and Alcohol Service (SDAS) and apologised for her lack of contact and reported that she had not used cocaine. She also said that she attended the Breast Care appointment, and that they would arrange for her to have reconstruction surgery.

3.1.37 On 5th May 2021, police attended another incident at the Arc Inspire property in response to a 101 call from a resident who reported that he could hear a male trying to kick the door down and arguing with a female. All residents denied anything happening. The case was closed with no further was action taken. James was linked to this log as a previous victim of antisocial behaviour, but he was not confirmed to be involved.

3.1.38 On 6th May, when Arc Inspire staff spoke to Amber about the previous night's incident, she said that a male visitor was verbally abusive in the street and that was when neighbours called the police. It was noted that Amber was very unimpressed with the staff at Arc Inspire and said she did not get support, and that staff did nothing to help. Arc Inspire staff explained that these matters were with the police, and that until they had heard from the police, they could not action a response, and that they would contact her next week.

3.1.39 On 10th May, police attended another incident at the Arc Inspire address after a report that Amber has assaulted another female who she had seen hugging James. The victim sustained facial scratch wounds. Officers reviewed CCTV, which did not capture the assault, and the victim did not want to pursue the complaint, so the case was closed.

[27] Avon and Somerset Constabulary are expected to use the BRAG risk assessment tool (in conjunction with the DASH) to identify vulnerability and safeguarding issues involving vulnerable parties. A tiered colour coded rating is applied: Blue (low risk), Red (high risk), Amber (medium risk), Green (standard risk). For more information on BRAG, go to https://s3-eu-west-2.amazonaws.com/assets-hmicfrs.justiceinspectorates.gov.uk/uploads/peel-assessment-2021-22-avon-and-somerset.pdf

3.1.40 That same day, during a home visit by Somerset Drug and Alcohol Service (SDAS), Amber was described as agitated, with a bruise on the bridge of her nose. These record Amber as stating that: "This was the third time and that it was a group of 'druggies and alcoholics' who are associated with other people who lived at her accommodation'. Amber presented as though she was under the influence but denied any substance/alcohol use."

3.1.41 On 19th May, there was an open referral to Children Looked After (CLA)[28] nursing team, for Child A and Child C. The Initial Health Assessment was completed in June 2021, and they were later discharged in November 2021.

3.1.42 On 20th May, Amber told Arc Inspire staff that she had had a bad day yesterday as she went to court regarding her children. She said that she was happy they were staying with her father.

3.1.43 That same day, during a GP telephone consultation, Amber reported that she had been working with her drug counsellor and had managed to stop cocaine use altogether. Further, that her main problem was not sleeping since her children were placed into foster care. Amber also asked for advice about her contraception options following her breast cancer, as she did not want to get pregnant.

3.1.44 On 24th May, the police recorded an abandoned 999 call received from a phone linked to Amber. When they called back, it was reported as an accidental dial. That same day, Amber told her Arc Inspire support worker that she had an argument with James to end their relationship, and that her door was insecure. She said James had broken into her room, so she threw something at him in self-defence, then she left to stay with a friend. When she returned, her was door open, the lock broken, and her room trashed with items missing, which were now returned. Amber said that she did not feel safe in the property and that she would feel better when the lock was secure. In a similar response to Amber's concern on 6th May, no actions were recorded by Arc Inspire staff.

3.1.45 On 27th May, Amber was seen at the property by Arc Inspire staff, who noted that she looked stressed and unhappy. They asked Amber if she was safe and happy to be there given recent events, and when they saw James in Amber's room, they asked him to leave so they could speak to Amber alone. The record of this encounter states that after James displayed aggressive behaviour towards both the support staff and Amber, Amber said that "she was ok and happy to have James in her room".

3.1.46 On 28th May, at 00.15am, the police were called by the ambulance service after they heard an argument between Amber and James, while he was calling for an ambulance after Amber had taken an overdose. Both had been drinking. Amber told the police that she did not intend to harm herself but that she just wanted to sleep and that there were no threats between her and James, nor any physical violence. The case was closed after officers advised Amber and James to both remain separate. A DASH

[28] The Children Looked After (CLA) health team is a multi-disciplinary service made up of nurses and other healthcare professionals. They deliver direct clinical contact, advice, and support for looked after children, their carers, and social workers to address health issues unique to this group of children and young people. They work closely in partnership with social care and education services to help looked after children remain healthy both physically and emotionally. They arrange, co-ordinate and undertake Statutory Health Assessments in accordance with Department of Health Statutory Guidance.

was completed for both, and a BRAG completed for Amber.[29] A Lighthouse Support Unit (LSU)[30] referral made, and this incident was reviewed at DAT meeting. Amber was taken by ambulance to the Accident and Emergency Department, where it was recorded that she presented with an overdose with intent to end her life following an argument with boyfriend. Hospital records noted that she had a previous history of self-harm and was known to have depression. Her bloods and ECG were normal, and after she was observed in the department, she was then reviewed by the Psychiatric liaison service, and was assessed as medically fit to discharge. The Mental Health Service Consultation noted that "…this was following an argument with her partner and a build-up of relational stressors over the past month - says they have been arguing over 'little things' which had then built up until she 'couldn't take it anymore'. Does not believe that she wanted to die at the time and just 'wanted to feel some peace', 'an escape so my brain isn't so overloaded'."

3.1.47 Consequently, in plans for follow-up, the Psychiatric liaison services requested that Amber contact her the Somerset Drug and Alcohol Service (SDAS) support worker to arrange follow-up in the community, and also sent a written request to her GP to review her current antidepressant (increasing if necessary). The letter to Amber's GP, included the following:

Amber is a young woman that has some history with mental health services going back some years. Currently she is working with SDAS around her issues with alcohol and felt that her mental health had been stabilised for some time. For the past month she has experienced some relational difficulties which, combined with increased alcohol intake, led to tonight's impulsive overdose. She denies wishing to die at that time and has stated that she has no further thoughts or plans to end her life. She is willing to continue engaging with SDAS and has asked for her antidepressant to be reviewed by her GP. Amber feels that this was a reactive episode following ongoing relational stressors.

3.1.48 The same day, Arc Inspire staff records note that another client called, concerned for Amber's welfare, and that after a room check, Amber was not at the property.

3.1.49 Between 2nd to 10th June, the Somerset Drug and Alcohol Service (SDAS) received an email from Children Social Care (CSC) to advise that Amber had taken an overdose and was kept in hospital overnight. It was noted that this was possibly a drug and alcohol binge, and that Amber had spent all her money, and at one point hit her partner. Somerset Drug and Alcohol Service (SDAS) made several attempts to contact Amber during this time, and they received an email from a social worker to advise that Amber had not engaged with Children Social Care (CSC) or the care proceedings, so it was decided it could safely end offers of support, and the file was closed.

3.1.50 On 15th June, Arc Inspire staff knocked on Amber's door, but she was not in.

[29] When a victim has been identified as vulnerable via BRAG, they should be referred into Lighthouse Safeguarding Unit (LSU)

[30] Lighthouse is a team of staff from the police and victim support organisations, working together to guide, advise and support victims and witnesses. https://www.lighthousevictimcare.org/about-us/

3.1.51 On 22nd June, Amber's GP phoned to her review antidepressant dose and increase as needed, as requested by the Community Mental Health Team (CMHT) on 28th May, but as there was no answer on her landline or mobile, a voicemail was left.

July and August 2021

3.1.52 On two occasions in July, Arc Inspire staff spoke to Amber through her door: about playing her music loudly and about tidying up, which she said she would do but did not.

3.1.53 Amber also missed two appointments in July. Firstly, on 9th July, she made a self-referral to Somerset Drug and Alcohol Service (SDAS), as she was using cocaine and ketamine conjunction with alcohol, and was drinking every other day, yet she did not attend an assessment booked a fortnight later, nor did she respond to phone calls or a 7-day letter sent, and her file was closed. Secondly, on 27th July, Amber did not attend a planned gynaecology appointment, and a follow-up letter was sent to her on 16th August to advise of a further appointment.

3.1.54 On 3rd August, police responded to a 999 call from Amber who reported that James had headbutted her when she asked him to leave her room after he made a malicious comment about Amber's family. The police, who were unsuccessful in their efforts to secure a statement from Amber, noted that she had a swollen lip and wobbly tooth. James was arrested on suspicion of assault. James denied all allegations and provided an account whereby he was the victim of assault by Amber. Photos of Amber's swollen lip were taken, a DASH was completed (rated as 'Medium') and house-to-house enquiries were conducted in neighbouring properties, and in the Arc Inspire property. Amber told police that she had already contacted her support worker at Arc Inspire to arrange an immediate move to a different housing facility. After inspector consideration, it was decided that both versions were plausible but that the CPS threshold was not met, so the case was filed.

3.1.55 On 12th August, Amber disclosed to Arc Inspire support staff that last week, James had attacked her in her room. Amber said that James had been drinking whisky and 'not being nice'. She asked James to leave but he would not, and that is when he attacked her. Amber explained that she had phoned the police, and James was arrested, and that she did not press charges as James currently had a clean record, and she did not want to change that. Amber said that she was fine and did not want to talk about it further. Amber's Arc Inspire support worker reassured her that they could help her if she felt unsafe, and to contact police straight away if James was violent towards her again.

3.1.56 Two weeks later, on 25th August, police attended a 999 call from James who reported that Amber had assaulted him, when he was trying to get his property back. He later admitted that Amber had not assaulted him, and that he had sustained the injuries the night before after drinking, and that he had wanted police intervention to stop a verbal argument. A DASH and BRAG were completed, a referral was made to Lighthouse Support Unit (LSU) and the incident was reviewed at DAT, and it was determined that no onward referrals were indicated.

September 2021

3.1.57 On 2nd September, Amber told Arc Inspire support staff that she had been assaulted by James in his room again, and that she did not phone the police this time to report it. She said she got a 'fat lip' from him last week. She said she had been asking James to leave her room in the evenings, but he did not want to leave, and this is when arguments happened. Amber said a relative had come around recently, to help remove James from her room. The keyworker talked to Amber about her safety, moving away from the property, and to stop letting him into her room. Also, that if Amber had further problems with James physically assaulting her or verbally abusing her for not letting him into her room, that she should call the police, or Arc Inspire staff. They discussed putting Amber onto housing transfer list.

3.1.58 On 6th and 9th September, Amber did not leave her room when Arc Inspire staff spoke to her through her door and/or phoned her. Notably, on 9th September, Arc Inspire support staff spoke to Amber through her door because she would not come out of her room during an unexpected fire drill, and they noted that James was in Amber's room with her, and that he also refused to leave her room. During this time, Amber did not attend two medical appointments.

3.1.59 In September, on the day of Amber's death, the police received a call from the ambulance service requesting attendance after her apparent suicide. Officers attended and the Investigations team also attended. There were no suspicious circumstances.

4. Overview

4.1 Summary of Information from Amber’s Family, Friends, and Other Informal Network

4.1.1 *Family and Friends*: Unfortunately, it has not been possible to gather information from Amber’s family, friends, or neighbours (see 1.9 above).

4.1.2 *Employer*: As Amber had not been in employment, it was not possible to gather information from an employer or work colleagues.

4.2 Summary of Information from James

4.2.1 Unfortunately, it has not been possible to gather information from James (see **1.10** above).

4.3 Summary of Information known to the Agencies and Professionals Involved

4.3.1 Drawing on information from the IMRs, this section provides an overview of the contact between agencies and Amber and James. It summarises the information known to the agencies and professionals about them, and any other relevant facts. This summary is deliberately structured by agency as the chronology already provides a literal timeline. Where issues of relevance occurred outside the timeframe for this review, they have been included.

Avon and Somerset Police

4.3.2 A review of records (including those outside the timeframe of the review) showed that Amber was linked to a total of 70 reports in police records going back to 2006. Some of these were as a victim of crime, and some as a perpetrator. There were numerous records of verbal and physical assault by Amber, and one record of Amber being the victim of domestic abuse in 2012 by her ex-partner and father of her children.

4.3.3 Prior to the timeframe of the review, James had a number of records for drug related offences and 6 records relating to domestic incidents between him and his mother, in 2012.

4.3.4 Police National Database (PND) checks showed that neither Amber nor James were known to any other police force in the UK. Police National Computer (PNC) records showed Amber had 3 convictions for 5 offences; 2 offences against the person (Battery in 2014 and 2015) and 3 offences relating to police/courts/prisons (2 x assaulting an officer and failure to surrender to custody in 2014 and 2015 respectively). She also had 2 not guilty disposals for battery (2005 and 2015). Police National Computer (PNC) showed that James had no convictions and 1 not guilty disposal for battery, in 2019.

4.3.5 During the review period, Police had 20 incidents recorded that involved Amber and/or James. Many of these incidents have several records and involved more than one contact, and involved input from numerous staff from numerous departments, such as call handlers, safeguarding and victim support officers, supervisors, and incident assessors. There were 3 domestic incidents between James and Amber and one domestic incident between James and his mother during the timeframe of the review. A summary of all incidents in the chronology are presented as:

- 4 records relating to safeguarding Amber's children.
- 3 domestic incidents between Amber and James.
- 1 incident of domestic assault by James to his mother.
- 1 record for the sudden death of Amber.
- 4 incidents at Arc Inspire with other HMO residents/visitors.
- 1 incident where Amber is alleged to have assaulted another female.
- 1 incident concerning James and concern for his welfare and breach of bail.
- 1 incident when James was a victim of an assault.
- 5 miscellaneous incidents not relevant to the review.

NHS Somerset Integrated Care Board (ICB) and GP Practice

4.3.6 Amber had breast cancer first diagnosed aged 24 years old, which resulted in surgery in 2015. In 2018, a regular check-up found further cancer present which required additional surgery, chemotherapy, and medication for a further 10 years. She also had an existing diagnosis of osteoporosis, a vertebral facture and pain because of this. She was lost to cancer treatment follow up temporarily due to a change in residence and becoming homeless for what was thought to be around a year. In 2021, Amber faced multiple and significant challenges because of her cancer diagnosis, and she expressed concerns about the impact of treatment, on her and her family. She also expressed a desire for restorative dental surgery and breast reconstruction treatment, which was problematic due to having no fixed address, and the lengthy recovery time that requires home support, plus and a significant waiting list due to impact of Covid-19 pandemic.

4.3.7 Amber was known to smoke, use cannabis, and had previously used cocaine, although was reported to have stopped cocaine use in 2021 through support from her drug counsellor at Somerset Drug and Alcohol Service **(**SDAS).

4.3.8 During the timeframe as set out in the Terms of Reference, Amber had face-to-face contacts, telephone consultations, and failed to attend further appointments (either with her GP or other health services).

4.3.9 There were 5 successful contacts with Amber conducted by the GP within this timeframe, all of which were carried out by telephone rather than face-to-face appointments. None of these contacts related to, or include any reference to, domestic abuse.

4.3.10 A further 4 GP practice appointments were not attended by Amber and further appointments with secondary healthcare services were also noted not to have been attended by Amber.

Somerset NHS Foundation Trust (SomFT)

4.3.11 There was limited contact with Somerset NHS Foundation Trust (SomFT) services during the scope of this review. Prior to Amber's death, SomFT had direct contact with Amber on seven occasions, none of which related to domestic abuse. Five of these contacts were in relation to her physical health and cancer treatment; and two were in relation to her mental health including one presentation at SomFT acute hospital which included treatment for overdose and brief contact with Psychiatric liaison services.

4.3.12 James was known to SomFT in respect of his mental health. There was no reference to Amber or domestic abuse within his notes and SomFT confirmed that they did not have consent to share details of his contact with their services.

4.3.13 Amber's children had limited contact with SomFT services. There was a history of safeguarding children concerns noted, and it appears that from May 2021, the children were not in Amber's care.

Somerset Children Social Care (CSC)

4.3.14 Prior to the scoping period, Somerset Children Social Care (CSC) records show that there had been concerns relating to domestic abuse between Amber and her children's father, dating back to 2012. Amber was offered referral to the Somerset Integrated Domestic Abuse Service (SIDAS), and she declined all offers of this support during CSC involvement. There is no record of the risk level noted for Amber.

4.3.15 During the scoping period, CSC had continuous involvement with Amber, prior to her death. Since March 2019, CSC was involved due to concerns about parenting of Amber's children, parental drug use, and parental mental health. Amber and her children's father separated in September 2019, and then again in March 2020 and remained separated from March 2020. Since March 2020, CSC involvement with Amber was minimal - as she moved out of the family home, her level of engagement declined, and the children remained in their father's care. Neither Amber nor her children's father engaged in the legal proceedings relating to their children that commenced in May 2021.

4.3.16 There were no occasions in CSC records that related to domestic abuse regarding Amber and James.

Somerset West and Taunton Council

4.3.17 During the scoping period, prior to Amber's death, Somerset West and Taunton had contact with Amber on 8 occasions, and James on 2 occasions, none of which related to domestic abuse.

ARC Inspire

4.3.18 During the scoping period, prior to Amber's death, Arc Inspire had contact with Amber and James on 81 occasions (38 and 43 respectively), 5 of which related to domestic abuse.

Somerset Drug and Alcohol Service (SDAS)

4.3.19 During the scoping period, prior to her death, Somerset Drug and Alcohol Service (SDAS) had contact with Amber on 21 occasions, none of which related to domestic abuse. Throughout Amber's notes, James is only mentioned twice.

4.3.20 SDAS noted that Amber had endured a lot of traumas in her life, which may have contributed to her relapses to drugs and alcohol, and thus, may have had a big impact on her mental health.

4.3.21 Amber had been suffering from an aggressive form of cancer, which caused significant pain, and had required medication and surgery. Further, that Amber's substance misuse had a clear impact on her mental health. She stated that she often felt suicidal when she used cocaine, and that her alcohol would also have had affected her mental health. Amber informed SDAS that in July 2021, she self-harmed and this resulted in an overnight stay in hospital. Amber disclosed low mood and anxiety, which was being medicated for by her GP. She had been receiving mental health support from the breast cancer counselling team following a referral made by her SDAS family safeguarding worker in March/April 2021, she also had some support from the family safeguarding mental health worker at this time. Amber had severe self-image issues following the impact of aggressive chemotherapy. At one point, Amber also disclosed that she had a gambling issue and as a result, was in debt.

4.3.22 In Amber's her first treatment episode, she engaged well and achieved abstinence. The second episode was short, as there was no response to the offer of an assessment. In the third episode, she engaged well in 1-1 support with family safeguarding team initially, looking at alternative coping strategies and the impact of her substance use on her and her children. However, her mental health and substance use became more chaotic as issues with children social care deteriorated, and she disengaged. The fourth episode was again closed due to no response to offer of assessment.

4.3.23 During the scoping period, SDAS had one contact with James when he self-referred into the service for support around his alcohol and ketamine use. There was no mention of domestic abuse or any relationships. James did not engage in treatment; and as they were unable to contact him for an assessment, his file was closed.

5. Analysis

5.1 Analysis Overview

5.1.1 This section of the report provides an analysis of the information received by the Review Panel. This includes the information contained in the IMRs, and the discussions that took place during DHR panel meetings.

5.1.2 Any issues or concerns identified are a reflection of the evidence made available. In doing so, the Review Panel have been mindful of the guidance relating to the application of hindsight in DHRs and have attempted to minimise it, as much as possible.

5.2 Domestic Abuse and Violence

5.2.1 Drawing from the Government definition stated in section 1.6, information provided by agencies, and current knowledge that makes a direct association between domestic abuse victimisation and suicide,[31] it is clear that Amber was a victim of different types of domestic abuse by James, prior to her death by suicide.

5.2.2 Although it is not possible to understand the full extent of Amber's victimisation, at the very least, she appears to have been victimised by James in the following ways:

- *Physical abuse*: Amber reported that she had been violently assaulted by James. This included an incident in August 2021, around 10 months into their relationship, when Amber called 999 to report that James had shook and headbutted her following an argument, because he would not leave her room. She sustained physical injuries (e.g., swollen lip and/or wobbly tooth). Around 10 days later, Amber also reported this assault to support staff at Arc Inspire, the HMO that both she and James lived in. A few weeks later, Amber disclosed to the HMO staff that James had again assaulted her, and again, after she asked him to leave her room.
- *Controlling, coercive, or threatening behaviour, and harassment*: Several agencies had recorded Amber's accounts of James's use of coercive control or threatening behaviour, and incidents of harassment. A clear example is a sequence of reported occurrences during the period between 24th to 28th May 2021, around 3.5 months before she ended her life. Specifically, she appeared to have made an abandoned 999 call on the same day she told Arc Inspire staff that, following an argument about his refusal to leave her room, James had broken into her room. When she left the property and returned later that day, her door was open, the lock broken, and her room was trashed with items missing. Three days later, Amber took an

[31] From the British Medical Journal (2022), Keynejad et al state: "A coroner's inquest in England has concluded that the underlying cause of a 34-year-old woman's suicide was domestic abuse. She had previously attended an emergency department with cut wrists and expressed suicidal thoughts to police and other agencies, in the context of domestic abuse. The coroner recommended greater recognition of the link between domestic abuse and suicide among first responders and improved coordination between agencies to prevent future deaths. Although this is the first time that a coroner in the UK has cited domestic abuse as having a causal role in death by suicide, this case will be distressingly familiar to related services and researchers". https://www.bmj.com/content/379/bmj.o2890.full

overdose. When she attended the Emergency Department for a Mental Health Service Consultation for this, she disclosed during a Psychiatric liaison service consultation that she had taken the overdose following an argument with her partner, and a "build-up of relational stressors". Another indication of coercive behaviour was alluded to by Amber, after the incident described in the previous paragraph, in which James was arrested for headbutting her. Specifically, Amber's explanation for not wanting to press charges against James for attacking her, was that he had a clean record and that she did not want to change that. Following this, and around 10 days before Amber ended her life, she reported to Arc Inspire staff that James had assaulted her again, after she asked him to leave her room. This time, however, she did not want to report him to the police because the last time she had done so, James had injured her. The day before Amber ended her life, James was again in her room, and she did not leave the room despite an unexpected fire drill or HMO staff encouraging her to do so.

5.2.3 The extent of domestic abuse that James inflicted on Amber, as presented here, was not known to all agencies. However, different agencies knew, from their contact with Amber and James, that she was reporting and seeking help for the domestic abuse he was subjecting her to. This is discussed in more detail in the analysis below.

5.2.4 It is evident that James posed a significant risk to Amber, prior to her suicide. Specifically, all the types of abuse detailed in 5.2.2 are provided as examples of 'high risk' factors in the DASH risk assessment checklist.[32] It is also noteworthy that in an analysis of suspected victim suicides and domestic homicides during the Covid-19 pandemic, coercive and controlling behavior was a substantial risk factor in suspected victim suicides, where there is a history of domestic abuse.[33]

5.2.5 While the Review Panel cannot be sure of the full scale of the domestic abuse that James had inflicted on Amber, or the immediate antecedent for Amber's suicide in September 2021, the following factors were also noted.

- There are clear parallels between the types of domestic abuse reported by Amber and those reported by James's mother.
- In 2012, there were six police records of James relating to domestic abuse, between[34] him and his mother. Details of these incidents were not available for the DHR. Yet in 2019, when James's mother reported to the police that he had assaulted her, she also disclosed his controlling behavior and his threats to kill himself if she removed him from her house. She also said that she was frightened of him, and that she was at her "wit's end". James denied his mother's version of events to the police, and said that she attacked him, and he acted in self-defense.
- Similarly, the police recorded two incidents with James in August 2021, this time involving Amber. First, when James was arrested on suspicion of assault for headbutting Amber, he denied all allegations and provided an account whereby

[32] For more information on the DASH, go to: http://www.safelives.org.uk/node/516.
[33] Bates et al (2021). Domestic Homicides and Suspected Victim Suicides During the Covid-19 Pandemic 2020-2021
[34] The word 'between' is used with caution. It has not been possible to ascertain if all six records were of James's abuse of his mother, or whether any of these incidences were bi-directional, and how many of these were counterclaims by James, who had refuted his mother's account in at least one incident (in 2019) and had falsely accused Amber of assault (in 2021), which he later retracted.

he was the victim of assault by her. Two weeks later, James reported to the police that Amber had assaulted him. He later admitted that this was not true, and that he had wanted the police to intervene to stop a verbal argument between them.

- Also of note is that three months prior to this, Amber stated that James had broken into her room when she attempted to end their relationship, in May 2021. When she returned home later that day, her door was open, lock broken, room trashed, and items were missing. Soon after, James was again in Amber's room, where he was observed by HMO staff to be acting aggressively. Despite this, Amber said she was happy for him to be in room. This is especially pertinent, because separation, or even the possibility of it, is associated with significantly increased risk from a perpetrator.[35]

5.2.6 It appears that Amber told professionals at different agencies different accounts of events, at different times. Additionally, while Amber had discussed her concerns about James, including both vague and explicit disclosures of domestic abuse, at other times, she said and acted as if she was fine. The Review Panel noted this as an example of the complex challenges that domestic abuse victims can face when making sense of their experiences, and in disclosing this to others, against the backdrop of managing their safety. However, it is important to note that Amber did find ways to talk about what James was saying and doing to harm her, and sought professional support from several agencies, thereby overcoming many psychological, physical, social, and environmental barriers.

5.2.7 Although it is not possible to know what may have helped or hindered Amber in her efforts to seek help, she did seek advice and support from different agencies at various times in response to James' abusive behaviour. Therefore, it is important to view her help-seeking in context of her managing a range of significant and tragic co-occurring life events. This included coping with an aggressive and reoccurring cancer, intensive cancer treatment, and impact of this on her self-image and esteem. Further, she had increased doses of her GP prescribed antidepressants, and increased her alcohol intake, which she reportedly took to cope with 'relationship stressors', alongside other substance misuse.

5.2.8 The Review Panel also considered it significant that, prior to the start of Amber's and James's intimate relationship, she was homeless and separated from her three young children, who were in the care of her ex-partner and/or in foster care. One of whom was in hospital after they had taken an overdose. At this time, Amber disclosed that she was "very worried" and struggled to sleep as she missed her children and wanted to live with them again. A trauma-informed approach enabled the Review Panel to consider how Amber may have been affected by care proceedings and the removal of her children due to child protection concerns. Specifically, in view of her circumstances and intersecting vulnerabilities, and the impact of this on her maternal-identity. That Amber, as a victim of prior- and current domestic abuse, endured the trauma of child removal with co-occurring physical illness, mental health needs, psychological distress,

[35] Long, J. and Harvey, H. (2020). Annual Report on UK Femicides 2018.

substance misuse, homelessness, and suicidality. Studies show birth mothers suffer a "combination of collateral consequences" following child removal - a psychosocial crisis that includes profound emotional pain and devastation. That their grief "combines with social penalties (stigma and restrictions on kin relationships) and civil disqualifications (housing, employment, and welfare benefit restrictions) which together impact on longer-term life chances."[36] Elements of this are reflected in what is known about Amber's circumstances prior to and during her relationship with James.

5.2.9 The Review Panel also considered it important Amber intimated she was in debt due to online gambling, and her rent was in arrears. Specifically, in 2019 prior to her relationship with James, she reported in a SDAS assessment that she could 'lose herself' by gambling, during which she had lost hundreds of pounds at any one time (see 3.1.17). There is a strong association between gambling and domestic abuse victimisation by a former and current intimate partner. Studies show that for women, having a gambling problem both increases the likelihood of being a victim of domestic abuse and can also be a response to domestic abuse.[37] Women who are victims of domestic abuse report they gamble to cope with the trauma associated with coercive and controlling behaviours, as it helps them to psychologically "escape" and regain some control over their lives, and/or the legacy of past abuse after separating from an abusive partner.[38] Amber's circumstances can be understood in this context, and as studies find women who gamble with electronic gaming machines report it helps them numb emotional pain and dissociate (a state described as "the zone") where reality is suspended, life's problems and worries are alleviated.[39]

5.2.10 These issues are all discussed within the context of the IMR analysis, in section 5.

5.3 Analysis of Independent Management Review (IMRs)

5.3.1 The following section responds to the key lines of enquiry identified by the Review Panel as case specific issues (see section 1.5.4) as set out in the Terms of Reference (Appendix 1). Given the information available in this case, the analysis relating to these lines of enquiry are presented thematically, to consider:

A. Communication, procedures, and discussions that took place within and between agencies.

B. Cooperation between different agencies involved with Amber and/or James, and wider family.

C. Opportunities for agencies to identify and assess the risk of domestic abuse.

D. Agency responses to identifying domestic abuse issues.

E. Organisations' access to specialist domestic abuse agencies.

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[36] Broadhurst, K., & Mason, C. (2020). Child removal as the gateway to further adversity: Birth mother accounts of the immediate and enduring collateral consequences of child removal. *Qualitative Social Work*, *19*(1), 15-37.

[37] Hing et al (2022). An integrative review of research on gambling and domestic and family violence: Fresh perspectives to guide future research. *Frontiers in psychology*, *13*, 987379.

[38] Suomi et al (2019). Patterns of family and intimate partner violence in problem gamblers. *Journal of Gambling Studies*, *35*, 465-484.

[39] Hing et al (2023). Seeking solace in gambling: The cycle of gambling and intimate partner violence against women who gamble. *Journal of Gambling Studies*, *39*(2), 795-812.

F. Domestic abuse policies, procedures, and training available to the agencies involved.

G. Any evidence of help seeking, as well as considering what might have helped or hindered access to help and support.

H. Specific consideration to the following issues: (1) *the impact of COVID-19*, which was relevant in the 18 months prior to Amber's death; (2) *disability* because Amber had suffered with debilitating physical and mental ill-health and substance misuse for several years, and in the months leading to her death, she reported that her health had worsened.

Lines of enquiry
A. Communication, procedures, and discussions that took place within and between agencies.
B. Co-operation between different agencies involved with Amber and/or James, and wider family.

5.3.2 Agency IMRs identified several issues relating to communication and discussions about Amber and James, both within and across agencies. A reoccurring theme was the need to improve agency awareness and co-operation, in relation to domestic abuse vulnerabilities in the specific context of HMO properties and homelessness.

5.3.3 In one example, NHS Somerset Integrated Care Board identified that, within the scoping period, Amber's GP did not appear to have clear knowledge of her homelessness, so that her homelessness status was not referenced or clarified despite this being indicated as a factor that impacted on her care by external health partners. They also noted that there was no information sharing between Amber's GP and SDAS, despite available information regarding their ongoing involvement in supporting Amber. SDAS noted that unless Amber had specifically requested that they contact her GP, they would not do this unless she was receiving 'pharmacological' support.

5.3.4 Although Amber's chronic pain was noted, it was not documented as likely to be a factor in her substance misuse, in terms of pain management. It was also noted that following Amber's overdose in May 2021 that required her to attend the Emergency Department, there was a delay by the GP practice to contact her to review her anti-depressant medication, and no further attempts at contact were made prior to her taking her own life.

5.3.5 The importance of recognising Amber's vulnerabilities, due her homelessness, was also considered by Somerset NHS Foundation Trust. They noted that Amber's contacts with health services during the scoping period were mainly linked to her physical health, and the impact of her cancer diagnosis. Amber had raised concerns that her ongoing cancer treatment was upsetting her mental health, and she was keen to explore alternative options, and subsequently did not attend several medical appointments. However, it was later identified that Amber had been temporarily lost

to follow-up because of a change in residence due to being homeless, and then when she moved to a hostel awaiting a more permanent address.

5.3.6 During the scoping period, Amber had made two approaches for assistance with homelessness with Somerset West and Taunton District Council. In the second approach (18th September 2020), her drug/alcohol issues and significant health issues were noted, including her completion of chemotherapy, awaiting surgery, difficulty in walking long distances, and not working due to long-term sickness. It was also noted that Amber had made previous suicide attempts. Although it is not known whether Amber disclosed domestic abuse as part of her application to housing, despite Children Social Care's recorded concerns relating to her being a victim, her clear physical and mental health vulnerabilities, or support needs were not identified, and she was referred to Arc Inspire for accommodation in September 2020.

5.3.7 The Review Panel discussed whether the meeting between Amber, social services, and her landlords (LiveWest), was a missed opportunity to alert Amber to the potential consequences of relinquishing her tenancy. Specifically, the detrimental consequences of living in supportive accommodation, and not her own accommodation, or living independently with support.

5.3.8 Improved interagency communication may have alerted the Council and Arc Inspire to the risk of domestic abuse and violence, at the HMO. Although a relationship between Amber and James could not be foreseen, it may have been salient given his homeless approach, 14 months prior to Amber's homeless approach. Explicitly, on 4th July 2019, he advised the Council that he had been staying with his family but due to an assault on his mother, and consequent arrest, he was unable to stay there. It was also noted on the triage that James was under the care of mental health services and was suffering with depression and insomnia. He was successful at the interview in securing accommodation and moved to Arc Inspire the same day.

5.3.9 Arc Inspire noted 20 contacts with Amber and/or James, although it is unclear whether they were provided with information about James's arrest as described above (paragraph 5.3.8), for assaulting his mother. This highlights the need for clear communication in relation to new tenants' risk of domestic abuse (perpetration or victimisation). The sharing of key information held on Amber and James from other agencies could have enabled Arc Inspire to consider the best way to respond, including whether to offer and deliver enhanced tenancy, or to seek information from other agencies. As a minimum, it might have meant that HMO support staff were aware of potential concerns. A previous DHR ("Salma" in 2019),[40] identified this as a learning point, stating that the housing provider in that case had not been informed of any concerns, thus staff were dependent on relevant information being shared by the victim and the perpetrator, or identifying safeguarding concerns during their

[40] See Rowland, J. (2019) Overview Report into the death of Salma (Tower Hamlets Community Safety Partnership)

interactions with them. This highlights the importance of both initial contact with new tenants and then subsequent interactions.

5.3.10 Somerset Drug and Alcohol Service (SDAS) also noted Amber's disclosure in May 2021, during a home visit, that she was assaulted for a third time, by associates of other people living at the same accommodation as her, who she described as 'druggies and alcoholics'. Somerset Drug and Alcohol Service (SDAS) were unable to explore this further with Amber; specifically, they were unable to get hold of her, and believed her to be too agitated and under the influence at the time. However, they reflected that this could have been explored with Arc Inspire, the housing provider, to ascertain whether drug use in the HMO was a concern, and if they could provide any further information.

5.3.11 *Good practice:* The IMR analysis identified evidence of good practice in relation to communication and co-operation. The police considered that their multi-agency communication, in respect of child safeguarding/protection, to be timely, well recorded, and effective in supporting decision making. Specifically, in relation to cross-agency communication and co-operation during the incident on 3 August 2021, in response to Amber's overdose and disclosure that James had headbutted her after she asked him to leave her room. The Lighthouse Support Unit (LSU) officer notified Children's Social Care (CSC) of the domestic incident, even though the children were not present, as the care protection plan had recently ended, and they felt Children's Social Care (CSC) should be made aware of incidents involving Amber. Although not explicitly related to domestic abuse, there was evidence of good multi-agency communication on 22 March, when Somerset Drug and Alcohol Service (SDAS) emailed NHS Foundation Trust regarding Amber's ongoing trauma and made a request for specific counselling as she was struggling with body image following cancer treatment and had described surgery-related PTSD symptoms, that were having a serious impact on her mental health and sleep. SDAS communicated this as a vulnerability that could lead Amber to relapse, from a substance misuse perspective.

5.3.12 Interagency communication, which is discussed as a learning point in section 6, is also linked to the next line of enquiry - opportunities for agencies to identify and assess the risk of domestic abuse – specifically, the use of professional curiosity.

Lines of enquiry:
C) Opportunities for agencies to identify and assess the risk of domestic abuse**.**
D) Agency responses to identifying domestic abuse issues.

5.3.13 Several IMRs identified opportunities - those taken, and others missed - for agencies to identify and assess the risk of domestic abuse. This included Amber's and James's contact with agencies in which domestic abuse risk was overt, and those which were more subtle, thus leading the Review Panel to consider the importance of professional

curiosity. As this was a prevalent issue, the following paragraphs should be considered in light of the definition provided in Somerset Safeguarding Adults Board:[41]

- *Professional curiosity is the capacity and communication skill to explore and understand what is happening with an individual or family. It is about enquiring deeper and using proactive questioning and challenge. It is about understanding one's own responsibility and knowing when to act, rather than making assumptions or taking things at face value.*

5.3.14 The following barriers to professional curiosity include, but are not limited to:

- *'Knowing but not knowing'*. This is having a sense (or 'gut feeling') that something is not right but not knowing exactly what, so it is difficult to grasp the problem and take action.
- *Dealing with uncertainty*. This includes contested accounts, vague or retracted disclosures. As it is common for practitioners to be presented with concerns which are impossible to substantiate, which may lead to situations in which 'there is a temptation to discount concerns that cannot be proved' and concerns therefore going unrecorded.
- *Professional deference*. For example, when workers who have the most contact with an individual are in a good position to recognise when the risk to that person is escalating. However, they may defer to the opinion of a 'higher status' professional who has limited contact with the person, but who views the risk as less significant.
- *Accumulating risk*. This refers to seeing the whole picture, as it has been shown that professionals tend to respond to each situation or new risk discretely, rather than assessing the new information within the context of the whole person or looking at the cumulative effect of a series of incidents and information.

5.3.15 With regards to more subtle indications of domestic abuse risk, NHS Somerset ICB observed in the 5 contacts that Amber had with the GP that were all conducted by telephone (rather than face-to-face appointments), none of these related to, or included any reference to, domestic abuse. Amber did make disclosures during appointments of feeling more anxious than usual, problems sleeping, anger management issues, and panic attacks. It was also clearly noted that Amber had a history of self-harm (overdose), and on 28 May 2021, she attended Accident and Emergency following overdose of antidepressants, taken with alcohol with intent. What is unclear is the extent to which the GP was able to exercise their professional curiosity, both in considering Amber's symptoms or medication, and whether this may have helped to create an environment in which Amber may have discussed her experiences about James's abusive behaviour, as she had done with other agencies during that same period.

5.3.16 Similarly, it was also recorded that in Amber's seven direct contacts with the NHS Foundation Trust, there was no explicit reference to domestic abuse, aside from once,

[41] See Professional Curiosity (24.03.22), Adapted from guidance developed by Somerset NHS Foundation Trust:

when she explicitly denied any domestic abuse concerns at that time. This was in 2019, prior to her relationship with James, which began in 2021. Pertinently, during her engagement with the Psychiatric liaison service in May 2021 (four months before she ended her life), following her hospital presentation with an impulsive overdose, Amber disclosed arguments with her partner, over 'little things' which had then built up until she 'couldn't take it anymore'. Also, that she did not believe that she wanted to die at the time and just 'wanted to feel some peace', and to 'an escape so my brain isn't so overloaded'. The NHS organisation IMR noted that as Amber did not make an explicit disclosure of domestic abuse, they had discussions around professional curiosity and/or exploration around domestic abuse. This considered how to capture this information within notes to better understand and reflect someone's lived experience. On this occasion, however, due to Amber's declining engagement and the information provided, it was concluded that appropriate risks assessments had been undertaken and a follow-up plan was put in place. Therefore, Amber was discharged with a follow-up plan that included her GP to review her medication, as discussed in the paragraph above, and continued engagement with SDAS.

5.3.17 Somerset Drugs and Alcohol Services (SDAS) IMR also considered if they could be more professionally curious, with aim of capturing the bigger picture, and ascertaining that the correct pathway is followed, and support put in place. This reflection stemmed from an incident in which a social worker was sent a note from an unknown person, soon after Amber disclosed that she had attempted suicide. This note reported that Amber had hit James. However, no further information was provided, for example, whether a DASH was completed for James, whether it was self-defence etc.

5.3.18 The theme of professional curiosity was also reflected in Children Social Care (CSC) IMR, which noted that when Amber left the family home in March 2020, her level of her engagement with them, and with her children declined. Over time, this progressed to non-existent engagement and not engaging with the PLO process or care proceedings. CSC reflected that they could have increased their level of proactive engagement by visiting Amber, to engage her, rather than relying on phone calls and texts that she did not respond to. There was also a heavy reliance on finding out what was going on through her family, as Amber was not engaging. It was also noted that as there was little information recorded relating to James, it would have been beneficial to have been more professionally curious about that relationship and what that would mean for the children in the future. In essence, as Amber was withdrawing at that time - from the children's lives, and from working with CSC - there was a lack of interest in her life, and the impact that might have had on the children.

5.3.19 The police were involved in overt incidents of domestic abuse, which provided them with several opportunities to identify and assess the risk of domestic abuse. Their IMR demonstrated good practice in which DASH assessments were consistently completed when indicated, and officers seemed to demonstrate good professional judgement in

the process. Regarding the welfare of adults at risk, the Police used the BRAG to record and assess vulnerability as well as to determine onward action.

5.3.20 The IMRs analyses found further evidence of good practice, for example, the police's awareness of coercive control. While the police found no evidence of any coercive control within Amber and James's relationship, officers did recognise this in the relationship between James and his mother, and that this was recorded appropriately, and proportionate action was taken to safeguard her. Likewise, SomFT's IMR noted concerns regarding James's domestic abuse towards his mother, although Amber was not referenced within his records.

5.3.21 This highlighted a gap in knowledge across agencies about co-occurring domestic abuse, and the parallels between James's abuse of his mother, and his abuse of Amber. This indicates a need to improve agency awareness of parallels between co-occurring abuse. Further, the Review Panel noted that while police response to support James's mother was evidence of good practice, the officer's advice to Amber and James, after she attempted suicide on 28 May 2021, to 'remain separate' was not realistic when living in a shared house. This situation could have been communicated to Amber's support workers at the HMO.

Lines of enquiry

E) Organisations' access to specialist domestic abuse agencies.

F) Domestic abuse policies, procedures, and training available to agencies involved.

G) Any evidence of help seeking, as well as considering what might have helped or hindered access to help and support.

5.3.22 The Review Panel discussions on organisations' access to specialist domestic abuse agencies, and related policies and training, extended from the analysis of the first two lines of enquiry. That is, agency awareness of domestic abuse vulnerabilities in specific relation to tenancy in HMO properties and homelessness, in addition to access to specialist domestic abuse services with expertise in working with women who are homeless and/or are in supported accommodation.[42]

5.3.23 In Amber's case, she was not referred to a domestic abuse service by Arc Inspire support staff while she was a resident of the HMO accommodation. This was despite staff witnessing James's abusive behaviour towards her, Amber disclosing that James had abused her, and other residents in the HMO raising concerns for her welfare. Specialist domestic abuse services, in Amber's case, may have been better equipped and prepared to support Amber, who had left her family home and her three children, in quick succession, during periods of intense physical and mental health vulnerability.

5.3.24 Arc Inspire's IMR noted that Amber had one support worker during her tenancy at the HMO, who conducted welfare checks, followed up by text message/phone calls, and updated other staff in regular team handovers. This provided Amber with regular and

[42] Bimpson, E., Reeve, K., & Parr, S. (2020). Homeless mothers: key research findings. http://shura.shu.ac.uk/25905/1/homeless-mothers-findings-report.pdf

continuity of support. Another attempt to support Amber was the offer to add her to a housing transfer list on 2nd September 2021, although it is noted that neither she nor James was moved the same day, as no other rooms were vacant. This response to Amber's efforts to seek help and safety, indicates that there was at least some onus on her (as a victim) to leave the property, rather than on emphasis to remove James (as a perpetrator).

5.3.25 A critical issue that transpired from this review was the lack of Arc Inspire's organisational policy and staff training related to domestic abuse, and how this acted as a barrier to Amber in getting the help and support that she needed and had asked for. During her tenancy at the HMO, Amber reported that James had assaulted her in her room and would not leave her room (on numerous occasions) despite her protestations. James's aggressive behaviour was also witnessed by other residents and noted by staff. Despite this catalogue of incidents, over a period of many months, no actions were noted or taken beyond fixing Amber's door lock, after James had broken it, the day before Amber took an overdose on 28th May 2021. Amber's dissatisfaction with the support she received was noted by HMO staff several weeks prior to this, on 6th May 2021, and that she was 'unimpressed' and 'did not get support'.

5.3.26 The tragic death of Amber has led Arc Inspire to address their policy, procedures, and training. For example, the Arc Inspire's IMR considered staff core training and on-going training, such as DASH, safeguarding and drugs training. Their Safeguarding Policy and Procedure was reviewed and amended in March 2022. Their Substance and Alcohol policy has also recently been reviewed and was submitted to the Board on 20th September 2022 for approval. Other policies that will be assessed, include risk assessment policy, and self-harm and suicide policy. Further, license/house rules will be assessed to consider managing/moving individuals who are in a relationship that live in the same house.

5.3.27 The Review Panel noted Amber's disclosure to SDAS that her problem-gambling led to debt and rent arrears, was a missed opportunity to discuss domestic abuse, to support her, and to refer her to specialist agencies such as GamCare (see 3.1.17 and 5.2.9). In line with previous DHRs,[43] the Review Panel considered learning in this case around problem-gambling in domestic abuse victims. Specifically, that it was important for all professionals to be able to identify and respond to disclosures of problem-gambling, and to consider signposting or referral into gambling specialist support. As the lack of awareness on the link between problem gambling by domestic abuse victims is noted in previous DHRs, a recommendation was made on this issue to recognise its significance.

[43] As per footnote 5, see Rowland, J. (2019) Overview Report into the death of Salma (Tower Hamlets Community Safety Partnership)

Lines of enquiry:
H) Impact of Covid-19 and Disability

5.3.28 It is not possible for the Review Panel to fully understand or assess the effect of Covid-19 on Amber or James, individually or on their relationship. However, from the information available, it is reasonable to assume that Covid-19 did impact on their daily lives, and their interactions with agencies they engaged with.

5.3.29 In considering the impact of service delivery during the pandemic, Avon and Somerset Police continued to operate a universally accessible service with the same threshold for response based on Threat Harm Risk. There were some back-office changes in process only, none of which materially affected operational response.

5.3.30 The NHS Integrated Care Board considered Covid-19 to have had a significant impact on GP provision during the timeframe of review, in relation to ability to see patients face-to-face, and additional pressures of responding to Covid-19 related requirements, on top of providing ongoing support to existing population health needs. Somerset Foundation Trust also noted that one effect of the Covid-19 pandemic was a significant increase in the waiting times for delayed breast surgery but, as Amber's cancer had been treated, there was no immediate urgency for this surgery. It is not clear if or what ongoing impact the delayed surgery had on Amber's mental health. Arc Inspire noted their Working from Home Policy needed to be considered when supporting individuals with high support needs.

5.4 Equality and Diversity

5.4.1 At the outset, the DHR Panel identified the following protected characteristics of Amber and James as requiring specific consideration; *sex* and *disability*.

5.4.2 *Sex*: The protected characteristic of *sex* was considered as Amber was a woman, and James is a man. As noted in 1.4.3, domestic homicide is gendered; the majority of victims in both intimate partner and familial homicides are females and males represent the majority of perpetrators. This gendered pattern was found in an analysis of DHRs across both intimate partner and familial homicides.[44]

5.4.3 *Disability*: The protected characteristic of *disability* was considered because Amber had suffered with mental ill-health and substance misuse for several years, following her diagnosis and treatment for breast cancer, resulting in extensive surgery six years prior to her death by suicide. The debilitating impact of the treatments Amber received, on her physical and mental health, was a recurring theme in this review.

[44] In the latest analysis of 124 DHRs reviewed as part of the Home Office Quality Assurance process, which took place over 12 months from October 2019, "Eighty percent of the victims were female and 20% were male. For perpetrators, 83% were male and 17% female". Home Office, "*Key Findings from Analysis of Domestic Homicide Reviews*" (September 2021).

5.4.4 Given the salience of these equality and diversity issues in Amber’s life, during the coping period, they are considered throughout this report, and form the basis of Lesson 4 (Lessons to be Learnt, Section 6).

6. Conclusions and Lessons to be Learnt

6.1 Conclusions (key issues during this DHR)

6.1.1 Amber was a daughter, sister, and niece. She was also a mother of three children, who now face growing up without their mother, as a result of her domestic-abuse related suicide. The nature and impact of Amber's tragic death represents a significant trauma for them, her wider family and friends, and the Review Panel again extends its deepest sympathy to them.

6.1.3 Sadly, the Review Panel has been able to access relatively limited information from Amber's family and friends. In some sense, therefore, while Amber has been at the heart of this report, her voice is regrettably absent. The Review Panel has been able to get some sense of Amber as a person, and of who she loved, and was loved by.

6.1.4 By reviewing and analysing the information contained within the IMRs, the chronology of events, and other information provided, the Review Panel first sought to understand Amber's lived experiences and consider the issues she faced to understand the circumstances of her domestic abuse related suicide.

6.1.5 Drawing from this, the Review Panel also identified significant learning during this DHR. It is hoped that this will prompt individual agencies, as well as the appropriate partnerships, to engage in this learning to further develop their response to domestic violence and abuse, to improve support for victims. This learning is summarised below, and individual and multiagency recommendations have been made in response to these issues.

6.2 Lessons to be Learnt

6.2.1 **Lesson 1: Interagency communication.** This DHR found that on many occasions, communication and information sharing was disjointed. Agencies were often unaware of whether referrals had been made or not, so they could not consider what could be done to support Amber. For instance, Amber's GP did not appear to have clear knowledge of her homelessness, so that her homelessness status was not referenced or clarified despite this being indicated as a factor that impacted on her care by external health partners. Another example is Amber's approaches to Somerset West and Taunton District Council for assistance with homelessness. A broad range of vulnerabilities were noted, including completion of chemotherapy, awaiting surgery, difficulty in walking long distances, not working due to long-term sickness, and previous suicide attempts. It is not known whether Amber disclosed domestic abuse as part of her application to housing, yet Children Social Care (CSC) had recorded concerns relating to Amber's physical and mental health vulnerabilities, and that she was offered referral to the Somerset Integrated Domestic Abuse Service (SIDAS) previously, due to domestic abuse between her and her children's father. Improved

interagency communication, in this instance, may have alerted Somerset West and Taunton District Council and Arc Inspire to the risk of domestic abuse at the HMO. This may have been salient given James's homeless approach, 14 months prior to Amber's homeless approach, as he reported that he was staying with his family due to an assault on his mother.

6.2.2 The Review Panel also identified a tendency for agencies not to follow up correspondence, or enquire about outcomes, or respond promptly. Interagency communication tended to be via email, and issues causing confusion or concern may have been more readily resolved if communicated directly by telephone, or in person.

6.2.3 **Lesson 2: Identifying and responding to domestic abuse in relation to multiple, intersecting vulnerabilities.** The Review Panel identified *sex* and *disability* as two key protected characteristics of Amber that required specific consideration for this DHR. Due to Amber's multiple support needs, this review identified the intersection of these two characteristics along with other co-occurring vulnerabilities as critical learning points. This is because despite Amber's multiple and intersecting physical and mental health vulnerabilities, and concerns about domestic abuse in the relationship with her ex-partner, agency responses to her disclosures of domestic abuse by James were not always intersectional, victim-focused, or trauma-informed. For example, Amber and James were told by the police to 'remain separate', even though she reported to HMO staff that he would not leave her room and had assaulted her when she asked him to do so. Further, while the police were aware of James's use of coercive control in his relationship with his mother, this form of abusive behaviour was not identified in James's relationship with Amber. When aligned with *interagency communication issues* (Lesson 1), this meant that when there was an attempt to refer Amber to Lighthouse Support Unit (LSU) after she had taken an overdose, this was not considered in view of her hospital records, which noted that "…this was following an argument with her partner and a build-up of relational stressors over the past month - says they have been arguing over 'little things' which had then built up until she 'couldn't take it anymore'. Does not believe that she wanted to die at the time and just 'wanted to feel some peace', 'an escape so my brain isn't so overloaded'."

6.2.4 Another learning point is to understand why Amber did not take up offers for referral to domestic abuse support services, at that time - although it is important to acknowledge that this is possible, to a degree, with the benefit of hindsight. Nonetheless, an intersectional, victim-focused, trauma-informed view of Amber's tragic circumstance at that time is of a young woman who had endured a debilitating physical illness, with co-occurring mental health needs and psychological trauma, who was additionally vulnerable due to prior domestic abuse victimisation, substance misuse, homelessness, and suicidality. This DHR was concluded soon after the first coroner in the UK cited the direct association between domestic abuse victimisation and suicide, and thus a key learning point is greater recognition of the link between domestic abuse and suicide among first responders and improved coordination between agencies to prevent future deaths (see 5.2.1). Another significant learning point stems from the impact of further intersecting vulnerabilities, including the effect

of care proceedings on Amber and of her children being removed due to child protection concerns. Studies report how the grief of this process can impact on maternal self-identity, recovery from substance abuse, and ability to manage uncertainty.[45] The importance of this learning point is reinforced by a recommendation in a previous DHR ("Susan" in 2019),[46] which stated "Somerset Local Safeguarding Children Board to improve knowledge amongst Children's Services professionals of the available support for parents whose children have or are going through the process of formal adoption". There have also been calls, more broadly, for a better understanding of the impact on parents involved with child protection services, in relation to domestic violence, substance misuse and mental ill-health.[47]

6.2.5 **Lesson 3: Professional curiosity**. This DHR revealed that, at times, there was piecemeal contact between agencies (described in Lesson 1) and the response by professionals was not always intersectional, victim-focused, or trauma-informed (described in Lesson 2). Due to this, subtle and more overt indicators of Amber's domestic abuse were not detected or explored by agencies, despite her multiple vulnerabilities and complex needs. A learning point from this DHR is that a greater degree of professional curiosity is needed when working with potential victims. For instance, during Amber's engagement with the Psychiatric liaison service following her overdose and four months before she ended her life, Amber disclosed arguments with her partner, over 'little things' which had then built up until she 'couldn't take it anymore'. The NHS Foundation Trust IMR noted that as there was no explicit disclosure of domestic abuse, discussions around professional curiosity and/or exploration around domestic abuse ensued. Similarly, Somerset Drugs and Alcohol Services (SDAS) identified that they could be more professionally curious, with aim of capturing the bigger picture, and ascertaining that the correct pathway is followed, and support put in place. The theme of professional curiosity was also identified by Children Social Care (CSC), noting that when Amber left the family home in March 2020, her level of engagement with them, and with her children declined. It was reflected that an increased level of proactive engagement by visiting Amber, to engage her, rather than relying on phone calls and texts that she did not respond to. Perhaps this was exacerbated during lockdown, due to reduced face-to-face contact, when services faced unprecedented demands. Despite the challenging backdrop of Covid-19, there were many instances in which professional curiosity may have been used to identify the significant risk James posed to Amber. Unfortunately, Amber's case is not unique, and a lack of professional curiosity has been identified as a contributing factor in domestic homicide reviews.[48,49]

[45] Meier, J., & Edginton, E. (2020). The prenatal maternal representations of mothers at risk of recurrent care proceedings in the Family Drug and Alcohol Court: A thematic analysis. *Infant Mental Health Journal*, *41*(5), 628-641.

[46] See Stride, J. (2019) Overview Report into the death of Susan DHR 22 (Safer Somerset Partnership)

[47] Skinner et al (2021). The 'toxic trio' domestic violence, substance misuse and mental ill-health)?. *Children and Youth Services Review*, *120*, 105678.

[48] Home Office (2016) Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews. London: Home Office.

[49] Phillips, J., Ainslie, S., Fowler, A., & Westaby, C. (2022). Lifting the lid on Pandora's box: Putting professional curiosity into practice. *Criminology & Criminal Justice*,

7. Recommendations

7.1.1 This section of the Overview report sets out the DHR panel recommendations and single agency recommendations from the IMRs. Both sets of recommendations, which are presented in an Action Plan in Appendix 2, should be acted upon within the listed timeframe. The DHR panel recommendations are intended to address system-wide issues and to support and build upon those recommendations already made and being acted upon in the IMRs.

7.1.2 In making the following recommendations, it is hoped that the Somerset Community Safety Partnership will encourage learning from this case. The Review Panel has been mindful that they focus on rectifying the omissions and deficits in process, policy, systems, and practice that have been identified in the DHR. The panel is also aware that the recommendations may be similar to those seen in many other reviews in other parts of the country. This should not diminish their importance or the need to act on their implementation.

7.1 DHR Panel Recommendations

7.1.3 The Somerset Community Safety Partnership is to encourage learning about:

1. Increasing awareness among professionals on the links between and impacts of mental health, self-harm and/or suicidal ideation, with domestic abuse.
2. Responding to domestic abuse, so that agencies and professionals are equipped and confident to exercise professional curiosity, in a meaningful, empathic, and trauma-informed way.
3. Identifying and responding effectively to vulnerabilities, resulting from the intersection of protected characteristics, such as gender and disability.
4. Recognising co-occurring family violence, as a risk factor for domestic abuse, specifically, the parallels between domestic abuse of intimate partners with the abuse of other relatives.
5. Recognising disclosures of problem-gambling by prior/current domestic abuse victims as an important opportunity to provide support and to refer to specialist agencies, and
6. For any provider with a Local Authority issued contract to have a domestic abuse policy and procedure in place, as well as confirmation that training on domestic abuse will be provided to staff.

7.2 Single Agency Recommendations

7.2.1 The following single agency recommendations were made by the agencies in their IMRs.

Avon and Somerset Police: No Recommendations

7.2.2 “An opportunity has been identified to incorporate additional information into the sudden death policy to ensure relevant internal onward notifications are made. This is not because PSD were not notified, but simply because the author has observed this discrepancy in policy whilst conducting this review. This is not raised as a formal recommendation because the updated policy was under review and has now been published.”

NHS Somerset ICB and GP practice: 3 Recommendations

7.2.3 “Remind GP practices to ensure a request for counselling is accompanied by a review of mental health and any risks e.g., of self-harm.”

7.2.4 “When dealing with sleep problems there should be evidence of a more holistic assessment e.g., including mental health and social circumstances as well as a pain review.”

7.2.5 “When someone with complex presentation does not return initial attempts to make contact for a medication review that may impact on the risk that person may be exposed to as a result of lack of the review, further attempts to establish contact should be evidenced by the GP practice.”

Somerset NHS Foundation Trust: 1 Recommendation

7.2.6 **“**Somerset NHS Foundation Trust to continue to move forward with embedding routine enquiry within mental health services, including how and where this is recorded.”

Somerset Children Social Care: 1 Recommendation

7.2.7 “Continue to embed a focus on the absent parent.”

Somerset West and Taunton District Council: 1 Recommendation

7.2.8 **“**To look at reconfiguring the system for free text in addition to tick boxes.”

ARC Inspire: 6 Recommendations

7.2.9 “Report Safeguarding (not assuming another professional is taking lead).”

7.2.10 “To have a more robust transfer/move-on plan.”

7.2.11 “Liaise with the Local Authority, re DA concerns for place of safety. Rationale To Safeguard the client”

7.2.12 “Improvement with Multi Agency meetings. Rationale Communication/Sharing Information / Safeguarding client”

7.2.13 “Better communication / sharing of information with external agencies. Rationale To support the clients’ needs. Sharing of information.

7.2.14 “Domestic abuse staff training. Rationale To improve/gain knowledge and skills of their awareness of domestic abuse and violence. “

Somerset Drug and Alcohol Service (SDAS): 1 Recommendation

7.2.15 “Closer link with housing provider. Rationale: We may have been able to reduce the risk for Amber by raising with housing.”

7.2.16 “At the start of a new treatment episode, the most recent treatment episode to be reviewed by keyworker. Rationale: Highlight identified risks or safeguarding concerns that may warrant further action”

8. Appendices

8.1 Appendix 1: Domestic Homicide Review - Terms of Reference

This Domestic Homicide Review (DHR) is being conducted to consider agency involvement with Amber and James following the death by suicide of Amber in September 2021. The DHR is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

1. Introduction

1.1 The Chair of the Safer Somerset Partnership has commissioned this DHR in response to the death of Amber. The death is believed to be suicide, with the person causing harm being her ex-partner.

1.2 All other responsibility relating to the review commissioners (Safer Somerset Partnership) 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.

2. Aims of The Domestic Homicide Review Process

2.1 Establish the facts that led to the death in September 2021 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family

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 experiencing 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.

- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working

- Establish the facts that led to the incident and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to support or manage the person who caused harm.

2.5 Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

3. Scope of the review

The review will:

- Consider a 2.5-year period prior to the date of Amber's death, subject to any significant information emerging that prompts a review of any earlier or subsequent incidents or events that are relevant.
- Request Individual Management Reviews by each of the agencies defined in Section 9 of the Domestic Violence Crime and Victims Act (2004) and invite responses from any other relevant agencies or individuals identified through the process of the review.
- Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events. Noting that the coroners' inquest was completed in December 2021.
- Aim to produce a report within 6 months of the DHR being commissioned which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.
- 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.
- Examine the type and nature of training that local agencies access specifically for identifying and responding to domestic abuse in all its forms. And specifically, whether this training has been updated to reflect the requirements of the Domestic Abuse Act 2021 (DAA). Including the access to "safe accommodation" as defined by the DAA.
- To discover if all relevant civil or criminal interventions were considered and/or used.
- Determine if there were any barriers Amber or her family/friends faced in both reporting domestic abuse and accessing services. This should also be explored:
    - Against the Equality Act 2010's protected characteristics, noting that sex and disability maybe relevant factors.
    - In regard to children and any potential impact this had ensuring the safeguarding of any children during the review.
- Examine the events leading up to the incident, including a chronology of the events in question.
- Review the interventions, care, and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults.
- Review the communication between agencies, services, friends, and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.

- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.
- Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.
- Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of the family in decision making and how this was done and if thresholds for intervention were appropriately set and correctly applied in this case.
- Whether practices by all agencies were sensitive to the gender, age, disability, ethnic, cultural, linguistic, and religious identity of both the individuals who are subjects of the review and whether any additional needs on the part of either were explored, shared appropriately, and recorded.
- Whether the impact of Covid-19 restrictions had any impact on AMBER receiving care and support from any relevant agency or feeling able to access care and support.

4 Role of the Independent Chair (see also separate Somerset DHR Chair Role document)

- 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 IMR's.
- Review IMR's – ensuring that 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 SSP Chair)

5 **Liaison with Media**

- Somerset County Council as lead agency for domestic abuse for the Safer Somerset Partnership will handle any media interest in this case.
- All agencies involved can confirm a review is in progress, but no information to be divulged beyond that.

8.2 Appendix 2: Action Plan

DHR Panel Recommendations: Action Plan					
Recommendation	**Scope of recommendation: local, regional, national**	**Action required**	**Lead Agency**	**Target Date**	**Date of completion & outcome**
1-Increasing awareness among professionals on the links between and impacts of mental health, self-harm and/or suicidal ideation, with domestic abuse.	Local	• SCC Public Health to produce briefing for SSP newsletters and across Somerset Domestic Abuse Board agencies. • SCC Public Health to ensure included within multi-agency domestic abuse training	Safer Somerset Partnership	31.8.2023 31.3.2023	
2-Encourage learning on responding to domestic abuse, so that agencies and professionals are equipped and confident to exercise professional curiosity, in a meaningful, empathic, and trauma-informed way.	Local	• SCC Public Health to review and update the multi-agency domestic abuse training programme content to ensure adequately incorporates this	Safer Somerset Partnership	31.3.2023	
3-Encourage learning for professionals on identifying and responding effectively to vulnerabilities, resulting from the intersection of protected characteristics, such as gender and disability.	Local	• SCC Public Health to produce briefing for within SSP newsletters and across Somerset Domestic Abuse Board agencies. • SCC Public Health to ensure included within multi-agency domestic abuse training	Safer Somerset Partnership	31.8.2023 31.3.2023	

4- Encourage learning for professionals on recognising co-occurring family violence, as a risk factor for domestic abuse, specifically, the parallels between domestic abuse of intimate partners with the abuse of other relatives.	Local	SC Public Health to review training programme to ensure this theme is featured (both online and level 2 trainings) SC Public Health to produce a learning briefing for dissemination across the Domestic Abuse Board partnership including this theme.	Safer Somerset Partnership	31.5.24	TBC
5- Encourage learning for professionals on recognising disclosures of problem-gambling by prior/current domestic abuse victims as an important opportunity to provide support and to refer to specialist agencies.	Local	SC Public Health to review training programme to ensure this theme is featured (both online and level 2 trainings) SC Public Health to produce a learning briefing for dissemination across the Domestic Abuse Board partnership including this theme.	Safer Somerset Partnership	31.5.24	TBC
6-For any provider with a Local Authority issued contract to have a domestic abuse policy and procedure in place, as well as confirmation that training on domestic abuse will be provided to staff.	Local	SC Public Health to liaise with SC Commercial and Procurement team to review existing contracts, and to devise plan if appropriate for implementing this action	Safer Somerset Partnership	31.8.24	TBC

Single Agency Recommendations: Action Plan

Recommendation	Scope of recommendation: local, regional, national	Action required	Lead Agency	Target Date	Date of completion & outcome
Remind GP practices to ensure a request for counselling is accompanied by a review of mental health and any risks e.g., of self-harm.	Local	Briefing to be circulated re learning from this DHR and this specific action shared via ICB safeguarding newsletter, LMC weekly newsletter and via GP safeguarding leads best practice meetings and supervision sessions.	Designated Nurse Safeguarding Adults Somerset ICB	Within 1 month of publication of report	
When dealing with sleep problems there should be evidence of a more holistic assessment, e.g., including mental health and social circumstances as well as a pain review.	Local	Briefing to be circulated re learning from this DHR and this specific action shared vis ICB Safeguard newsletter, LMC weekly newsletter and via GP Safeguarding leads best practice meetings and supervision sessions	Designated Nurse Safeguarding Adults Somerset ICB	Within 1 month of publication of report	
When someone with complex presentation does not return initial attempts to make contact for a medication review that may impact on the risk that person may be exposed to as a result of lack of the review, further attempts to establish contact should be evidenced by the GP practice.	Local	Briefing to be circulated re learning from this DHR and this specific action shared vis ICB Safeguard newsletter, LMC weekly newsletter and via GP Safeguarding leads best practice meetings and supervision sessions.	Designated Nurse Safeguarding Adults Somerset ICB	Within 1 month of publication of report	

Recommendation	Scope of recommendation: local, regional, national	Action required	Lead Agency	Target Date	Date of completion & outcome
Somerset NHS Foundation Trust to continue to move forward with embedding routine enquiry within mental health services, including how and where this is recorded.	Local	To deliver Domestic Abuse Routine enquiry (DARE) workshop to mental health teams. DARE to be recorded on Dialog+ (Mental Health) assessment proforma.	Somerset NHSFT Safeguarding Team. Training and development lead (KG). Deputy named professional for safeguarding adults (LS).	31 March 2024	
Continue to embed a focus on the absent parent, as there is evidence of a lack of curiosity regarding Amber as the absent parent.	Local	Further CPD and learning from this case to be shared	Somerset County Council Children Social Care (CSC Operations Manager (Taunton)	1st June 2023	
To look at reconfiguring the system for free text in addition to tick boxes, to gain further detail of risks.	Local	To look at systems used, as well as staff training to ensure information is gathered and consistent throughout the assessment as well as shared appropriately with partners and accommodation providers.	Somerset Council (new unitary Local Authority vested April 2023)	April 2023 NB: The creation of the new unitary authority means systems are changing so April 2023, but staff training can be in the next month.	

Recommendation	Scope of recommendation: local, regional, national	Action required	Lead Agency	Target Date	Date of completion & outcome
Report Safeguarding (not assuming another professional is taking lead), for safety of client.	Local	Review Safeguarding Policy and Procedure	Arc Inspire (Service Delivery Managers)	April 2022	Completed April 2022 -Safeguarding Policy reviewed in April 2022, during DHR review. Since then, further staff training provided with client case studies for good practice. -Our internal Safeguarding procedure was rolled out (Jan 23) to staff for consistent practice. Senior Management meet weekly & review any live Safeguarding reports and manage any actions that are required.

Recommendation	Scope of recommendation: local, regional, national	Action required	Lead Agency	Target Date	Date of completion & outcome
To have a more robust transfer/move-on plan, to safeguard client	Local	Management to hold a client case review.	Arc Inspire (Service Delivery Managers)	April 2022 and ongoing	April 2022. -Since DHR, action taken in other cases to move/support individuals to a place of safety to safeguard them.
Liaise with the Local Authority, re DV concerns for place of safety.	Local	Comm's to Local Authority (Housing Team)	Service Delivery Managers	When required	April 2022. -Since DHR, in other client cases we have liaised with L/A (Housing Officers) when we had Domestic Abuse concerns.
Improvement with Multi Agency meetings	Local	Arc to take the lead or liaise with external agencies to have the knowledge of who is taking the lead on the meetings.	Service Delivery Manager and Pathway Worker	April 2022 and On-going	April 2022. -Since DHR, Improvements has been made in liaising with external agencies to better support clients.

Recommendation	Scope of recommendation: local, regional, national	Action required	Lead Agency	Target Date	Date of completion & outcome
					-Upon Referral management to contact agencies supporting client. On-going from Clients Induction, Pathway Worker to continue contact with agencies.
Better communication / sharing of information with external agencies.	Local	To contact relevant agencies regularly.	Pathway Worker	April 2022 and On-going	April 2022 -Since DHR, Improvements has been made with liaising with external agencies to better support clients
Staff training	Local	Arc Inspire staff to receive new or refresher training to improve/gain knowledge and skills of their awareness of domestic abuse and violence. To link up with professional external agencies (e.g., Nelson Trust) to build better partnership relationships.	Arc Inspire, Service Delivery Manager	To be implemented immediately	April 2023

Recommendation	Scope of recommendation: local, regional, national	Action required	Lead Agency	Target Date	Date of completion & outcome
Closer link with housing provider	Local	In future if client reports SG concern within accommodation, to liaise with housing provider. Possible multi-agency meeting.	Somerset Drug and Alcohol Service	December 2022 and on-going	Closer link with housing provider
At the start of a new treatment episode, the most recent treatment episode to be reviewed by keyworker.	Local	If safeguarding concerns are highlighted, discuss this with SDAS outreach harm reduction manager, and whether an assertive outreach response is needed. This may involve a home visit.	Somerset Drug and Alcohol Service	On-going	At the start of a new treatment episode, the most recent treatment episode to be reviewed by keyworker.
Closer link with housing provider	Local	In future if client reports SG concern within accommodation, to liaise with housing provider. Possible multi-agency meeting.	Somerset Drug and Alcohol Service	December 2022 and on-going	Closer link with housing provider

8.3 Appendix 3: Glossary

A&E	Accident and Emergency
BRAG	Blue, Red, Amber & Green (risk assessment status definitions)
CPR	Cardiopulmonary resuscitation
CSC	Children Social Care
CSP	Community Safety Partnership
DASH	Domestic Abuse, Stalking and Honour Based Violence (risk assessment)
DHR	Domestic Homicide Review
GP	General Practice
HMO	House in multiple occupation
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review
LSU	Lighthouse Support Unit
MARAC	Multi Agency Risk Assessment Conference
PND	Police National Database
PNC	Police National Computer
SIDAS	Somerset Integrated Domestic Abuse Service
SDAS	Somerset Drug and Alcohol Service
SSP	Safer Somerset Partnership

8.4 Appendix 4: Home Office QA Panel - Feedback Letter

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2 Marsham Street
London
SW1P 4DF

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

Suzanne Harris
Senior Commissioning Officer Interpersonal Violence
Somerset Council
County Hall
Taunton, TA1 4DY

28 November 2023

Dear Suzanne,

Thank you for submitting the Domestic Homicide Review (DHR) report (Amber) for Safer Somerset Partnership to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 25th October 2023. I apologise for the delay in responding to you.

The QA Panel felt the report is concise and easy to understand. The equality and diversity section is well considered, and the report highlights the importance of intersectionality. The understanding of suicide, domestic abuse and the removal of children is explored sensitively, and the report does not feel victim blaming in its tone. The report highlights the importance of professional curiosity for agencies, and the inclusion of research on the increased risks of domestic abuse during the pandemic is positive. The QA Panel felt that the report starting with the father's description of his daughter and her interests is moving and powerful. Although family engagement was declined, it was attempted, and the lack of wider involvement of the community and friends is explained well in the report.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

- It would be helpful to include the date when (and by whom) the family were informed of the decision to undertake a DHR, and which local specialists were consulted about the decision, as per the statutory guidance.
- The report lacks any information about the victim's mother and childhood. This information would help to build a more thorough picture of the victim and could potentially shed some more light into her life and circumstances.
- The victim had three children from a previous relationship, none of whom were in her care at the time of her death. It would be helpful to understand the impact this had on the victim.

- In Section 2, it is unclear why the perpetrator is described as an 'ex-intimate partner' when elsewhere in the report it suggests that the relationship was ongoing up to the point of suicide.
- Paragraph 3.1.54 appears victim blaming. Please consider rephrasing to indicate that the police were unsuccessful in their efforts to secure the victims support, as opposed to the case being dropped because of the victim not supporting it.
- The first example given in paragraph 6.2.1 is not an appropriate example of good practice. Please consider reviewing paragraphs 6.2.1 – 6.2.3 to avoid the incorrect impression that there was a balance between good and bad practise.
- Please review paragraph 6.2.5 to draw out the learning points more clearly.
- The victim disclosed that she had gambling issues which led to financial issues, but this was not analysed in any depth in the report.
- There was a missed opportunity by health to be more professionally curious when the victim was taken to hospital by ambulance where she disclosed that arguments with her partner and recent relational stressors had built up until she felt she 'couldn't take it anymore'.
- Where a chronology has not been provided by Somerset West and Taunton council, there is no explanation of why or what attempts were made to access this information.
- The QA Panel felt it was unusual that given the level of contact, no recommendations were made for the police. They expected more comment regarding referrals and what efforts were being made to support the victim to provide evidential accounts.
- The single agency considerations have no timeframe for embedding which would be helpful to ensure learning is implemented.
- The single agency recommendations are brief and are not included within the action plan, which only lists the multi-agency recommendations. It would be helpful for these to be added and actions highlighted.
- Suggestion for a recommendation: for any provider with a Local Authority-issued contract to have a domestic abuse policy and procedure in place as well as confirmation that training on domestic abuse will be provided to staff.
- Please include any plans for learning events or training materials that may be created from this case in the dissemination plans.
- The use of acronyms is not consistent, and some acronyms are not explained at the first citing (for example DASH and BRAG).
- The abbreviation 'DV' used in the recommendations should be replaced with 'DA' (domestic abuse).
- There are a number of specific dates in the report that could be better obscured.

- There is only a very brief description of the author of the report.
- Additional proofreading of both the Executive Summary and Overview Report would be beneficial as there are some grammatical and formatting errors throughout, and some sentences are complex and hard to follow.

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

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

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

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

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

Yours sincerely,

Home Office DHR Quality Assurance Panel

Domestic Homicide Review

Review into the death of Amber

in September 2021

043 Executive Summary

Dr Roxanne Khan

Director, onEvidence Ltd

Independent Chair and Report Author

On behalf of Safer Somerset Partnership

Approved by Safer Somerset Partnership: 5th May 2023

Approved by the Home Office: 28th November 2023

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1. Introduction

1.1 Review Process

1.1.1 This is a summary of the Domestic Homicide Review (DHR) into the death of Amber,[50] undertaken on behalf of Safer Somerset Partnership (SSP).

1.1.2 Amber, a 32-year-old white British woman, died by suicide in September 2021. She was a mother to three children from a previous relationship. Amber was not working due to long-term sickness, and after a period of homelessness, was living in supported accommodation when she died. In 2015, Amber had suffered from breast cancer, which returned in 2019 following initial treatment. She had undergone chemotherapy treatment as a result. The impact of this treatment led Amber to have severe self-image issues. At this time, Amber's three children were taken away from her care as she was unable to cope. At one point, Amber disclosed that she had a gambling problem and as a result, was in debt and her rent was in arrears.

1.1.3 Amber had been in an intimate relationship with James,[51] a 31-year-old man, for around eight months. Amber and James were both residents of Somerset, living in separate bedsit rooms in a house in multiple occupation (HMO) run by a homeless charity.

1.1.4 Three months into their relationship, Amber had taken an overdose and disclosed this was due to 'relational stressors' and arguments over the past month and she 'couldn't take it anymore'. In the weeks prior to Amber's death, she reported James would not leave her room when she asked, he had assaulted her on two separate occasions, and he had physically injured her. Around 10 days before Amber's death, she sought to move away from James, and reported and sought help for his abusive behaviour towards her.

1.1.5 SSP notified the Home Office of Amber's death by suicide. The Home Office Quality Assurance Panel decision was that this case would benefit from a DHR, due to Amber's disclosures of domestic abuse by James in their relationship.

1.1.6 This is the 43rd DHR commissioned by Safer Somerset Partnership.

1.1.7 A total of 16 agencies were contacted to determine if they had had contact with Amber and James. Of these, seven agencies confirmed that they did not have contact. Of the nine agencies that did have varying degrees of contact, seven were asked to submit Individual Management Reviews (IMRs), written by authors independent of case management or delivery of the service concerned. These seven agencies were asked to provide chronological accounts of their contact with Amber and/or James prior to her death (see Table 1).

1.1.8 Other sources included the Coroner's Inquest Report. Sadly, the Review Panel was able to access relatively limited information from Amber's family, friends, and

[50] Not her real name.

[51] Not his real name.

neighbours. Likewise, it was not possible to contact James, or members of his wider network.

Table 1: Contributing Agencies	
Agency	**Contribution**
Arc Inspire	IMR and Chronology
Avon and Somerset Police	IMR and Chronology
Children Social Care (CSC)	IMR and Chronology
NHS Integrated Care Board (ICB)	IMR and Chronology
Somerset Drug and Alcohol Service (SDAS)	IMR and Chronology
Somerset NHS Foundation Trust (NHSFT)	IMR and Chronology
Somerset West and Taunton Council	IMR and Chronology

1.2 Review Panel

1.2.1 The Review Panel met a total of four times. The Overview Report and Executive Summary were agreed electronically. The Review Panel members provided comment on three drafts of the Overview Report and one draft of the Executive Summary before signing off the final reports by secure email.

1.2.2 The Chair and author of this report, Dr Roxanne Khan, is independent of all agencies involved and had no prior contact with any family members. She is recognised as an expert in domestic abuse and violence having been active in this area of research, policy, and/or practice for over two decades and with extensive experience of chairing multi-partnership panels and authoring reports. Further information about Dr Khan can be found at https://onevidence.co.uk/about/dr-roxanne-khan/

1.2.3 All Panel members and IMR authors were independent of any direct contact with the subjects of this DHR. Neither were they immediate line managers of anyone who had had direct contact.

1.2.4 The Review Panel members and the agency they represented are shown in Table 2.

Table 2: Review Panel Members and Attendees		
Name	**Agency**	**Role**
Rachael Overton	Arc Inspire	Pathway Support Worker
Jo Pearce	Arc Inspire	Head of Operations
Sam Williams	Avon and Somerset Police	Detective Chief Inspector
Su Parker	Avon and Somerset Police	Inspector
Angela Kell[†]	Avon and Somerset Police	Safeguarding Review Author
Sussanah Heywood	Children Social Care (CSC)	Family Safeguarding Team Manager
Cathy Jones[†]	Children Social Care (CSC)	Operations Manager
Emma Read	NHS Integrated Care Board (ICB)	Deputy Designated Nurse Safeguarding Adults
Julie Mason[†]	NHS Integrated Care Board (ICB)	Designated Nurse Safeguarding Adults

Suzanne Harris	Somerset County Council (SCC) Public Health	Senior Commissioning Officer (Interpersonal Violence)
Jane Harvey-Hillǂ	Somerset Drug and Alcohol Service	Safeguarding Manager
Louise Smailes	Somerset NHS Foundation Trust (NHSFT)	Deputy Named Professional for Safeguarding Adults
Heather Sparks*	Somerset NHS Foundation Trust (NHSFT)	Named Professional for Safeguarding Adults
Vicky Hannaǂ	Somerset NHS Foundation Trust (NHSFT)	Domestic Abuse Lead
Louisa Hillǂ	Somerset West and Taunton Council	Lead Specialist Homefinder
Lucy Harling	The You Trust: current Somerset Integrated Domestic Abuse Service (SIDAS) provider	Paragon Manager

**Denotes attendee who stood in for Panel member at DHR meeting*
ǂ *Denotes IMR Author*

1.2.5 The Review Panel operated collaboratively to reach agreed conclusions. The Executive Summary, Overview Report, and recommendations are agreed by the whole Panel and signed off by Safer Somerset Partnership's Quality Assurance. The Executive Summary and Overview Report have been approved by the Home Office appointed national Quality Assurance Panel for Domestic Homicide Reviews.

1.3 Terms of Reference

1.3.1 The Review Panel established that the time period to be reviewed would be from 1st March 2019 to the date of Amber's death in September 2021.

1.3.2 The Terms of Reference reflect Home Office guidance, and the particular context for Amber's death by suicide. That is, to identify the learning from this case, and for action to be taken in response to that learning with a view to preventing domestic abuse related suicides and ensuring that individuals and families are better supported.

1.3.3 In summary, they were to review agency contacts with Amber for opportunities to identify or prevent domestic abuse, and report on lessons for improving services, and to invite the involvement of family and friends. The Review Panel agreed, in the light of initial information available, that questions should cover, in relation to domestic abuse: (a) communication and discussions about Amber and James, both within and across agencies; (b) opportunities to identify, assess, and respond to domestic abuse; (c) general/specialist policies, procedures, and training; and (c) the impact of Covid-19 and disabilities. The significance of this is because Amber had suffered with mental ill-health and substance misuse for several years, and in the months leading to her death, she reported that her health had worsened.

2. Findings

2.1 Summary Chronology (during the scoping period)

2.1.1 Amber was in contact with a range of health services, for advice and treatment in relation to her physical and mental health. The police were in contact with James twice, in relation to domestic abuse against his mother.

2.1.2 In the 11 months prior to her death, Amber had lived in a bedsit room, which was in a house of multiple occupancy (HMO) run by a homeless charity in Somerset.

2.1.3 Around four months after moving into this property, Amber and James began an intimate relationship. He lived in a separate room at the same property and often slept in Amber's room.

2.1.4 Three months into their relationship, Amber had taken an overdose and was taken to hospital by ambulance where she disclosed that arguments with James and relational stressors over the past month after arguments had built up, until she 'couldn't take it anymore'.

2.1.5 In the weeks prior to her death, Amber reported that when she asked James to leave her room on previous occasions, he had refused and had become aggressive. This had been witnessed by HMO staff. In one incident, James's headbutted her, and another, Amber's relative had helped to remove him.

2.1.6 About 10 days prior to her death, Amber had sought to move to another property, and two days prior to her death, HMO staff noted that James was in Amber's room during an unexpected fire drill. Neither Amber nor James left the room, despite being asked to do so.

2.1.7 In September 2021, seven months after her relationship with James had started, Amber hung herself with a homemade ligature. The ambulance crew who attended found James giving CPR *(cardiopulmonary resuscitation*) to Amber, who had removed the ligature and placed her on the floor. The ambulance crew pronounced Amber dead at the scene.

2.1.8 At the time of her death, Amber, as a victim of prior- and current domestic abuse, who had endured the trauma of child removal with co-occurring physical illness, mental health needs, psychological distress, substance misuse, homelessness, and suicidality.

3. Key issues arising

3.1.1 Drawing from the Government definition of domestic abuse and violence, information provided by agencies, and current knowledge that makes a direct association between domestic abuse victimisation and suicide, it is clear that Amber was a victim of different types of domestic abuse by James, prior to her death by suicide.

3.1.2 Although it is not possible to understand the full extent of Amber's victimisation, at the very least, she appears to have been victimised by James over a five-month period at least, in the following ways: *physical abuse, controlling, coercive, or threatening behaviour, and harassment.*

3.1.3 The extent of Amber's domestic abuse was not known to all agencies. However, different agencies knew, from their contact with Amber and James, that she was reporting and seeking help for the domestic abuse he was subjecting her to. It is evident that James posed a significant risk to Amber, prior to her suicide.

3.1.4 It appears that Amber told professionals at different agencies different accounts of events, at different times. Additionally, while Amber had discussed her concerns about James, including both vague and explicit disclosures of domestic violence and abuse, at other times, she said and acted as if she was fine. The Review Panel noted this is likely to reflect the complex challenges that domestic abuse victims can face when making sense of their experiences, and in disclosing this to others, against the backdrop of managing their safety. However, it is important to note that Amber did find ways to talk about what James was saying and doing to harm her, and sought professional support from several agencies, thereby overcoming many psychological, physical, social, and environmental barriers.

4. Conclusions

4.1.1 Amber was a daughter, sister, and niece. She was also a mother of three children, who now face growing up without their mother, as a result of her domestic-abuse related suicide. The nature and impact of Amber's tragic death represents a significant trauma for them, her wider family and friends, and the Review Panel again extends its deepest sympathy to them.

4.1.2 By reviewing and analysing the information contained within the Individual Management Reviews, the chronology of events, and other information provided, the Review Panel first sought to understand Amber's lived experiences and consider the issues she faced to understand the circumstances of her domestic abuse related suicide.

5. Lessons to be learnt

5.1.1 **Lesson 1: Interagency communication.** This DHR found that on many occasions, communication and information sharing was disjointed. Agencies were often unaware of whether referrals had been made or not, so they could not consider what could be done to support Amber. For instance, Amber's GP did not appear to have clear knowledge of her homelessness, so that her homelessness status was not referenced or clarified despite this being indicated as a factor that impacted on her care by external health partners. Another example is Amber's approaches to Somerset West and Taunton District Council for assistance with homelessness. A broad range of vulnerabilities were noted, including completion of chemotherapy, awaiting surgery, difficulty in walking long distances, not working due to long-term sickness, and previous suicide attempts. It is not known whether Amber disclosed domestic abuse as part of her application to housing, yet Children Social Care (CSC) had recorded concerns relating to Amber's physical and mental health vulnerabilities, and that she was offered referral to the Somerset Integrated Domestic Abuse Service (SIDAS) previously, due to domestic abuse between her and her children's father. Improved interagency communication, in this instance, may have alerted Somerset West and Taunton District Council and Arc Inspire to the risk of domestic abuse at the HMO. This may have been salient given James's homeless approach, 14 months prior to Amber's homeless approach, as he reported that he was staying with his family due to an assault on his mother.

5.1.2 The Review Panel also identified a tendency for agencies not to follow up correspondence, or enquire about outcomes, or respond promptly. Interagency communication also tended to be via email, and issues causing confusion or concern may have been more readily resolved if communicated directly by telephone, or in person.

5.1.3 **Lesson 2: Identifying and responding to domestic abuse in relation to multiple, intersecting vulnerabilities.** The Review Panel identified *sex* and *disability* as two key protected characteristics of Amber that required specific consideration for this DHR. Due to Amber's multiple support needs, this review identified the intersection of these two characteristics along with other co-occurring vulnerabilities as critical learning points. This is because despite Amber's multiple and intersecting physical and mental health vulnerabilities, and concerns about domestic abuse in the relationship with her ex-partner, agency responses to her disclosures of domestic abuse by James were not always intersectional, victim-focused, or trauma-informed. For example, Amber and James were told by the police to 'remain separate', even though she reported to HMO staff that he would not leave her room and had assaulted her when she asked him to do so. Further, while the police were aware of James's use of coercive control in his relationship with his mother, this form of abusive behaviour was not identified in James's relationship with Amber. When aligned with *interagency communication issues* (Lesson 1), this meant that when there was an attempt to refer Amber to Lighthouse Support Unit (LSU) after she had taken an overdose, this was not

considered in view of her hospital records, which noted that "…this was following an argument with her partner and a build-up of relational stressors over the past month - says they have been arguing over 'little things' which had then built up until she 'couldn't take it anymore'. Does not believe that she wanted to die at the time and just 'wanted to feel some peace', 'an escape so my brain isn't so overloaded'."

5.1.4 Another learning point is to understand why Amber did not take up offers for referral to domestic abuse support services, at that time - although it is important to acknowledge that this is possible, to a degree, with the benefit of hindsight. Nonetheless, an intersectional, victim-focused, trauma-informed view of Amber's tragic circumstance at that time is of a young woman who had endured a debilitating physical illness, with co-occurring mental health needs and psychological trauma, who was additionally vulnerable due to prior domestic abuse victimisation, substance misuse, homelessness, and suicidality. This DHR was concluded soon after the first coroner in the UK cited the direct association between domestic abuse victimisation and suicide, and thus a key learning point is greater recognition of the link between domestic abuse and suicide among first responders and improved coordination between agencies to prevent future deaths. Another significant learning point stems from the impact of further intersecting vulnerabilities, including the effect of care proceedings on Amber and of her children being removed due to child protection concerns. Studies report how the grief of this process can impact on maternal self-identity, recovery from substance abuse, and ability to manage uncertainty.[52] The importance of this learning point is reinforced by a recommendation in a previous DHR ("Susan" in 2019), which stated "Somerset Local Safeguarding Children Board to improve knowledge amongst Children's Services professionals of the available support for parents whose children have or are going through the process of formal adoption". There have also been calls, more broadly, for a better understanding of the impact on parents involved with child protection services, in relation to domestic violence, substance misuse and mental ill-health.

5.1.5 **Lesson 3: Professional curiosity**. This DHR revealed that, at times, there was piecemeal contact between agencies (described in Lesson 1) and the response by professionals was not always intersectional, victim-focused, or trauma-informed (described in Lesson 2). Due to this, subtle and more overt indicators of Amber's domestic abuse were not detected or explored by agencies, despite her multiple vulnerabilities and complex needs. A learning point from this DHR is that a greater degree of professional curiosity is needed when working with potential victims. For instance, during Amber's engagement with the Psychiatric liaison service following her overdose and four months before she ended her life, Amber disclosed arguments with her partner, over 'little things' which had then built up until she 'couldn't take it anymore'. The NHS Foundation Trust IMR noted that as there was no explicit disclosure of domestic abuse, discussions around professional curiosity and/or exploration around domestic abuse ensued. Similarly, Somerset Drugs and Alcohol

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[52] Meier, J., & Edginton, E. (2020). The prenatal maternal representations of mothers at risk of recurrent care proceedings in the Family Drug and Alcohol Court: A thematic analysis. *Infant Mental Health Journal*, *41*(5), 628-641.

Services (SDAS) identified that they could be more professionally curious, with aim of capturing the bigger picture, and ascertaining that the correct pathway is followed, and support put in place. The theme of professional curiosity was also identified by Children Social Care (CSC), noting that when Amber left the family home in March 2020, her level of engagement with them, and with her children declined. It was reflected that an increased level of proactive engagement by visiting Amber, to engage her, rather than relying on phone calls and texts that she did not respond to. Perhaps this was exacerbated during lockdown, due to reduced face-to-face contact, when services faced unprecedented demands. Despite the challenging backdrop of Covid-19, there were many instances in which professional curiosity may have been used to identify the significant risk James posed to Amber.

6. DHR Panel Recommendations

6.1.1 The Somerset Community Safety Partnership is to encourage learning about:

1. Increasing awareness among professionals on the links between and impacts of mental health, self-harm and/or suicidal ideation, with domestic abuse.
2. Responding to domestic abuse, so that agencies and professionals are equipped and confident to exercise professional curiosity, in a meaningful, empathic, and trauma-informed way.
3. Identifying and responding effectively to vulnerabilities, resulting from the intersection of protected characteristics, such as gender and disability.
4. Recognising co-occurring family violence, as a risk factor for domestic abuse, specifically, the parallels between domestic abuse of intimate partners with the abuse of other relatives.
5. Recognising disclosures of problem-gambling by prior/current domestic abuse victims as an important opportunity to provide support and to refer to specialist agencies, and
6. For any provider with a Local Authority issued contract to have a domestic abuse policy and procedure in place, as well as confirmation that training on domestic abuse will be provided to staff.

7. Single Agency Recommendations

Avon and Somerset Police	
Recommendation	**Action required**
None	-

NHS Somerset ICB and GP practice	
Recommendation	**Action required**
Remind GP practices to ensure a request for counselling is accompanied by a review of mental health and any risks e.g., of self-harm.	• Briefing to be circulated re learning from this DHR and this specific action shared via ICB safeguarding newsletter, LMC weekly newsletter and via GP safeguarding leads best practice meetings and supervision sessions.
When dealing with sleep problems there should be evidence of a more holistic assessment e.g., including mental health and social circumstances as well as a pain review.	• Briefing to be circulated re learning from this DHR and this specific action shared vis ICB Safeguard newsletter, LMC weekly newsletter and via GP Safeguarding leads best practice meetings and supervision sessions
When someone with complex presentation does not return initial attempts to make contact for a medication review that may impact on the risk that person may be exposed to as a result of lack of the review, further attempts to establish contact should be evidenced by the GP practice.	• Briefing to be circulated re learning from this DHR and this specific action shared vis ICB Safeguard newsletter, LMC weekly newsletter and via GP Safeguarding leads best practice meetings and supervision sessions.

Somerset NHS Foundation Trust	
Recommendation	**Action required**
Somerset NHS Foundation Trust to continue to move forward with embedding routine enquiry within mental health services, including how and where this is recorded.	• To deliver Domestic Abuse Routine enquiry (DARE) workshop to mental health teams. DARE to be recorded on Dialog+ (Mental Health) assessment proforma.

Somerset Child Social Care	
Recommendation	**Action required**
Continue to embed a focus on the absent parent, as there is evidence of a lack of curiosity regarding Amber as the absent parent.	• Further CPD and learning from this case to be shared

Somerset West and Taunton District Council	
Recommendation	**Action required**
To look at reconfiguring the system for free text in addition to tick boxes, to gain further detail of risks.	• To look at systems used, as well as staff training to ensure information is gathered and consistent throughout the assessment as well as shared appropriately with partners and accommodation providers.

Arc Inspire	
Recommendation	**Action required**
Report Safeguarding (not assuming another professional is taking lead), for safety of client.	• Review Safeguarding Policy and Procedure • Safeguarding Policy was reviewed in April 2022, during the DHR review and since then we have provided further staff training with client case studies for good practice. • Our internal Safeguarding procedure has also been rolled out (Jan 23) to staff for consistent practice. • Senior Management meet weekly and review any live Safeguarding reports and manage any actions that are required.
To have a more robust transfer/move-on plan, to safeguard client	• Management to hold a client case review. • Since the DHR we have taken action in other cases to move/ support individuals to a place of safety to safeguard them.
Liaise with the Local Authority, re DA concerns for place of safety. Rationale To Safeguard the client	• Comm's to Local Authority (Housing Team) • Since the DHR, in other client cases we have liaised with the L/A (Housing Officers) when we have had Domestic Abuse concerns.
Improvement with Multi Agency meetings Rationale Communication / Sharing Information / Safeguarding client.	• Arc to take the lead or liaise with external agencies to have the knowledge of who is taking the lead on the meetings. Since the DHR, Improvements has been made with liaising with external agencies to better support clients.
Better communication / sharing of information with external agencies. Rationale To support the clients' needs. Sharing of information.	• To contact relevant agencies regularly. • Since the DHR, Improvements has been made with liaising with external agencies to better support clients
Domestic abuse staff training	• Staff to receive new or refresher training to improve/gain knowledge and skills of their awareness of domestic abuse and violence. • To link up with professional external agencies (e.g., Nelson Trust) to build better partnership relationships.

Somerset Drug and Alcohol Service (SDAS)	
Recommendation	**Action required**
Closer link with housing provider Rationale: We may have been able to reduce the risk for Amber by raising with housing	• In future if client reports SG concern within accommodation, to liaise with housing provider. Possible multi-agency meeting.
At the start of a new treatment episode, the most recent treatment episode to be reviewed by keyworker.	• If safeguarding concerns are highlighted, discuss this with SDAS outreach harm reduction manager, and whether an assertive outreach response is needed. This may involve a home visit.