Bath and North East Somerset Responsible Authority Group

Domestic Homicide Review

Executive Summary Into the death of Teddy (pseudonym) July 2016

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Section One - The Review Process

1.1. This summary outlines the process undertaken by Bath and North East Somerset domestic homicide review panel in reviewing the death of Teddy (pseudonym), who was a Bath resident.

1.2. The following pseudonyms have been used in this review for the deceased, her child, her ex-partner, her partner at the time of her death and her child's father to protect their identities and those of their family members: Teddy (the deceased), Star (her child), Raman (ex-partner), Adan (her partner at the time of her death), Marlon (Star's father).

1.3. Teddy who was of dual heritage was 30 years of age at the time of her death on 16th July 2016, her child Star was 11 years old and Raman who is an Iranian Kurd, was 34 years of age.

1.4. An Inquest was held and the Coroner, after considering evidence from Teddy's family, found that the cause of Teddy's death was suicide by ligature suspension.

1.5. The process began with an initial meeting of the Bath and North East Somerset Responsible Authority Group on 3rd August 2016 when the decision to hold a domestic homicide review was agreed. All agencies that potentially had contact with Teddy, Star or Raman prior to the point of death were contacted and asked to confirm whether they had involvement with them.

1.6. Thirteen of the forty-five agencies contacted confirmed contact with Teddy, Star or Raman and were asked to secure their files.

Section Two - Contributors to the Review

2.1. The agencies contacted are:

- Avon and Wiltshire Mental Health Partnership NHS Trust: This organisation had relevant contacts with Teddy and an IMR was completed. A senior member of this agency who is independent of any contact with Teddy is a DHR Panel member.

- Avon and Somerset Constabulary: This organisation had relevant contacts with Teddy and Raman and an IMR was completed. A senior member of this Constabulary who is independent of any contact or involvement with Teddy, Star or Raman is a DHR Panel member.

- Avon Fire and Rescue Service: This service notified the DHR that it had no relevant contacts to report.

- Bath and North East Somerset Clinical Commissioning Group: This organisation notified the DHR that it had no relevant contacts to report. A senior member of this CCG is a Panel member.

- Bath and North East Somerset Council: This organisation notified the DHR that it had no relevant contacts to report. A senior member of the Council is a Panel member.

- Bath and North East Somerset Council Children's Social Care: This organisation notified the DHR that it had no relevant contacts to report.

- Bath and North East Somerset Council Drug and Alcohol Action Team (DAAT): This organisation notified the DHR that it had no relevant contacts to report. The DAAT Manager is a DHR Panel member.

- Bath and North East Somerset Council Housing: This organisation notified the DHR that it had no relevant contacts to report.

- Bath and North East Somerset (B&NES) Council Preventative Services Commissioning Team: B&NES Council Commissioners had no contacts, but as a relevant service commissioner in Bath and North East Somerset has reviewed its current commissioning practice in the light of this DHR.

- Bath & North East Somerset Responsible Authority Group: This organisation which acts as the Bath and North East Somerset Community Safety Partnership notified the DHR that it had no relevant contacts to report.

- Bath and North East Somerset Safeguarding Adults: This organisation notified the DHR that it had no relevant contacts to report. The Safeguarding Adults Team Manager is a Panel member.

- Bath and North East Somerset Safeguarding Children: This organisation notified the DHR that it had no relevant contacts to report.

- Bath Citizens Advice Bureau: This organisation notified the DHR that it had no relevant contacts to report.

- Bath Mind Advocacy Service: This organisation notified the DHR that it had no relevant contacts to report. The organisation was invited to provide a Panel member but was unable to do so.

- Bristol Drug Project: This organisation notified the DHR that it had no relevant contacts to report.

- Bristol City Council Children's Social Care: This organisation had relevant contacts relating to Star and Teddy and an IMR was completed. A senior member of the Department who was independent of any contacts relating to Teddy or Star is a DHR Panel member.

- Bristol City Council Housing Solutions: This Department had minor contacts with Teddy and Raman and a report was provided.

- Bristol City Council, Safer Bristol: Safer Bristol had no contacts, but as a relevant service commissioner in Bristol has informed the Review of its current commissioning practice.

- Bristol Clinical Commissioning Group: This organisation completed an IMR in relation to the GP primary care services received by Teddy and an IMR was completed. A senior member of the CCG who had no involvement with any contacts with Teddy, Star or Raman is a member of the DHR Panel.

- Bristol Early Help: This organisation notified the DHR that it had no records of any relevant contacts to report.

- Bristol, Gloucestershire, Somerset, Wiltshire Community Rehabilitation Company: This organisation notified the DHR that it had no records of any relevant contacts to report.

- Bristol Sexual Violence Multi Agency Risk Assessment Conference (SV MARAC): This MARAC had relevant contacts relating to Teddy and a Report was completed.

- Children and Family Court Advisory and Support Service (CAFCASS): This organisation had relevant contacts relating to Teddy and Star and an IMR was completed with the permission of the Family Court.

- Curo Housing: This organisation notified the DHR that it had no records of any relevant contacts to report.

- Dear Albert, (Substance Misuse Support Service): This organisation had relevant contacts with Teddy and an IMR was completed.

- Developing Health and Independence (DHI): This organisation notified the DHR that it had no records of any relevant contacts to report.

- Star's School,[1] Bristol: This school had relevant contacts with Teddy and Star and a report was completed.

- Great Western Hospital NHS Foundation Trust: This organisation notified the DHR that it had no records of any relevant contacts to report.

- Home Office Immigration Enforcement: This organisation had relevant involvement with Raman and an IMR was completed. A senior official from the Home Office who had no involvement with the contacts relating to Raman is a DHR Panel member.

- Knightstone Housing: This organisation notified the DHR that it had no records of any relevant contacts to report.

- Probation Service: This Service notified the DHR that it had no records of any relevant contacts to report. A senior probation officer is a DHR Panel member.

- NHS England: This organisation notified the DHR that it had no records of any relevant contacts to report. NHS England and NHS England South West provided senior independent Panel members for the DHR.

- Next Link: This Charity, which supports domestic abuse and sexual violence victims, notified the DHR that it had no records of any relevant contacts to report, other that in connection with the Sexual Violence MARAC. The Charity's Safeguarding Officer is a DHR Panel member.

- NILAARI: This organisation had relevant contacts with Teddy, a report was completed. Support Counsellor was interviewed by the DHR Chair and provided a short report detailing her contacts with Teddy.

- North Bristol NHS Trust: This Trust notified the DHR that it had no records of any relevant contacts to report.

[1]The name of the school has been redacted.

- Rainbow Centre for Children: This organisation notified the DHR that it had no records of any relevant contacts to report within the scope of the review period.

- Reach Housing Options and Advice: This organisation notified the DHR that it had no records of any relevant contacts to report.

- Royal United Hospitals Bath NHS Foundation Trust: This Trust notified the DHR that it had no records of any relevant contacts to report.

- Sirona Care and Health: This organisation notified the DHR that it had no records of any relevant contacts to report. A senior manager is a DHR Panel member.

- Southside: This Family Support and Domestic Abuse Service notified the DHR that it had no records of any relevant contacts to report. A senior manager is a DHR Panel member.

- South Western Ambulance Service NHS Foundation Trust: This Service notified the DHR that it had no records of any relevant contacts prior to Teddy's death to report.

- Survive: This organisation notified the DHR that it had no records of any relevant contacts to report.

- United Communities Housing Association: This Housing Charity had relevant contacts with Teddy and a report was completed. A Senior Housing Officer who is independent of any direct contact with Teddy is a member of the DHR Panel.

- University Hospitals Bristol NHS Foundation: This Trust had relevant involvement with Teddy and a Report was completed.

- Victim Support: This Victim's Support Charity notified the DHR that it had no records of any relevant contacts to report.

2.2. The following also contributed to this Review:

- Teddy's father was in regular contact throughout the review, providing detailed information about Teddy's early life and acting as an advocate on behalf of the family. He provided a written Tribute to Teddy and read the reports carefully. He attended the final meeting of the review with other members of the family.

- Teddy's half-sister provided key information about Teddy and her relationships.

- Teddy's Grandmother and three of her aunts provided information and asked for particular issues to be considered.

- Star's father and grandmother provided the review with information relating to his relationship with Teddy, their child and his view point of Teddy's mental health.

- Teddy's partner at the time of her death, provided information about their relationship and his understanding of her involvement with Raman.

- Teddy's neighbour confirmed her knowledge of Teddy as a neighbour and that she had heard nothing on the night of Teddy's death.

Section Three - The Review Panel Members

3.1. The DHR Panel consists of senior officers, from the statutory and non-statutory agencies who are able to identify lessons learnt and to commit their organisations to setting and implementing action plans to address those lessons. None of the members of the panel have had any contact with Teddy, Star or Raman.

3.2. The Panel members are:

- Andrea Maine: Detective Inspector, Avon and Somerset Constabulary
- Daniel Badman: Interim Quality Director, Avon and Wiltshire Mental Health Partnership NHS Trust
- Sarah Jeeves: Adult Safeguarding and Quality Assurance Nurse, Bath North East Somerset Clinical Commissioning Group
- Samantha Jones: Inclusive Communities Manager, Bath North East Somerset Council
- Sue Tabberer: Team Manager Safeguarding Adults Quality Assurance, Bath North East Somerset Council Adult Safeguarding
- Carol Stanaway: Commissioning Manager, Bath and North East Somerset Council (Drug & Alcohol Action Team)
- Paulette Nuttall: Designated Safeguarding Adults and MCA Lead Nurse, Bristol Clinical Commissioning Group
- Fiona Tudge: Service Manager Children and Families, Bristol City Council
- Linda Mellows: Safeguarding Officer, Missing Link Housing (Next Link)
- Helen Chrystal: Designated Nurse Safeguarding, NHS England
- Carole Crocker: Assistant Nurse Director Quality & Safety, NHS England South West
- Kevin Day: Senior Probation Officer, National Probation Service
- Geoff Watson: Professional Lead for Social Work, Sirona Care and Health
- Debbie Sheppard: Family Services Manager, Southside
- Femi Robinson: Senior Housing Officer, United Communities. Due to organisational changes, Jayne Whittlestone: Communities Manager took over from Femi Robinson as the panel member for United Communities.
- Kenny Chapman: Assistant Director, Immigration Enforcement
- David Warren: Domestic Homicide Review Chair
- Mark Hayward: Business Support Manager, Bath and North East Somerset Council, Review Administrator
- Panel Adviser re Bristol SV MARAC: Charlotte Leason: Domestic & Sexual Violence Coordinator, Multi-Agency Risk Assessment Conference (MARAC)
- Observer: Andrew Sutherland: Quality and Safety Manager: NHS England.

3.3. The DHR Panel met formally five times. The schedule of their meetings are:

- 13th September 2016, The Guildhall, Bath
- 25th October 2016, The Guildhall, Bath
- 13th December 2016, Cadbury Room, Somerdale Pavillons, Keynsham
- 7th February 2017, The Guildhall, Bath
- 4th April 2017, The Guildhall, Bath

Section Four - Chair of the Review and Author of the Overview Report

4.1. The Chair of the DHR Panel is a legally qualified and accredited Independent Domestic Homicide Review Chair. He has passed the Home Office approved Domestic Homicide Review Chairs' courses and possesses the qualifications and experience set out in paragraph 37 of the Home Office Multi-Agency Statutory Guidance (2016).

4.2. He has an extensive knowledge and experience in working in the field of domestic abuse and sexual violence at local, regional and national level. He has provided pro-bono legal work for a local Refuge and its residents; been responsible for the funding and monitoring the delivery of domestic abuse services across the South West Region of England between 2004 and 2010 and was a member of two Central Government committees, one responsible for the development and monitoring Violence Against Women and Children policies and services and the other for the funding of local domestic and sexual abuse services, during the same period.

4.3. The Chair has no connection with the Bath and North East Somerset Responsible Authorities Group and is independent of the agencies involved in the Review. He has previously served as a senior police officer in Avon and Somerset Constabulary until 1999. More recently he has been the Government Office South West Regional Criminal Justice Manger and in a voluntarily capacity he has been the Chair of a substance abuse charity. Since 2011 he has chaired numerous statutory reviews including serious case reviews, mental health reviews, drug related death reviews and domestic homicide reviews.

4.4. He has had no previous dealings with Teddy, Star or Raman.

Section Five - Terms of Reference

5.1. This Domestic Homicide Review which is committed, within the spirit of the Equality Act 2010, to an ethos of fairness, equality, openness, and transparency, will be conducted in a thorough, accurate and meticulous manner.

5.2. Agencies that have had contacts with the deceased Teddy (pseudonym), her child Star (pseudonym) or Raman (pseudonym) should identify any lessons to be learnt from those contacts and set out provisional actions to address them as early as possible for the safety of future victims of domestic abuse particularly those who are vulnerable through mental health issues and/or substance misuse.

5.3. The Domestic Homicide Review will consider:

5.3.1. Each agency's involvement with the following from 1st January 2012 to the death of Teddy on 16th July 2016, as well as all contacts prior to that period which could be relevant to domestic abuse, violence, substance abuse issues, self-harm or other mental health issues.

a. Teddy 30 years of age at time of her death

b. Raman aged 34 at date of incident

c. Teddy's child, Star aged 11 at the time of the incident.

5.3.2. Whether there was any previous history of abusive behaviour towards the deceased or her child, and whether this was known to any agencies.

5.3.3. Whether family or friends want to participate in the Review. If so, ascertain whether they were aware of any abusive behaviour towards Teddy or Star, prior to the homicide.

5.3.4. Whether, in relation to the family members, there were any barriers experienced in reporting abuse?

5.3.5. Could improvement in any of the following have led to a different outcome:

a) Communication and information sharing between services

b) Information sharing between services with regard to the safeguarding of adults or children.

c) Communication within services

d) Communication and publicity to the general public and non-specialist services about the nature and prevalence of domestic abuse, and available local specialist services

5.3.6. Whether the work undertaken by services in this case are consistent with each organisation's:

a) Professional standards

b) Domestic Abuse policy, procedures and protocols

5.3.7. The response of the relevant agencies to any referrals relating to Teddy, Star or Raman concerning domestic abuse, harassment, other significant harm, mental health, substance abuse issues, sexual exploitation or any Safeguarding issue. It will seek to understand what decisions were taken and what actions were carried out or not and establish the reasons. In particular, the following areas will be explored:

a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with Teddy, Star or Raman

b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made

d) The quality of any risk assessments undertaken by each agency in respect of Teddy, Star or Raman.

5.3.8. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective individuals and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.

5.3.9. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner.

5.3.10. Whether, any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.

5.3.11. The review will consider any other information that is found to be relevant.

Section Six - Summary Chronology

6. The facts and background information obtained from the IMRs, Chronologies and Teddy's family and friends are summarised as follows:

6.1. Teddy's father gave the DHR a resume of Teddy's early life, explaining that when Teddy was a baby he and her mother split up. Teddy's mother had another daughter when Teddy was ten and they lived in Bristol until Teddy's step-father died. Her mother later married an American and they moved to the USA. Her mother's new husband was violent to her and after Teddy was raped by another man, her mother decided to return to the UK without her husband. They moved in with an older man in Bristol who, according to Teddy's half-sister, introduced Teddy to drugs. Some years later, Teddy told her father that when she was fourteen years of age this man raped her.

6.2. Teddy told Adan, her partner at the time of her death, that later in her life she would often visit this older man and that he would sexually abuse her, then give her money. Teddy's NILAARI support worker was so concerned, after Teddy confided about this man, that she made a referral to the Bristol Sexual Violence MARAC in January 2014. Teddy, who did not know about this referral, never gave up this man's name and her father only knew of him by a street name.

6.3. In 2001 Teddy whilst being seen at a Bristol hospital revealed that in December 2000 she had been sexually assaulted by a 38 year old man whilst on holiday with her aunt in Oman. She told the hospital neither her aunt nor her mother knew about the assault. It is not clear if the perpetrator was a local man in Oman or if it was the Bristol man referred to in the above paragraph.

6.4. In about 2003 Teddy began a relationship with Marlon whom she had known at school. Their child, Star, was born in May 2005. Later Teddy and Marlon broke up although Marlon continued to visit her for access visits to his child. During those visits there were often heated arguments. Teddy claimed Marlon hit her on one occasion. Marlon de-

nies this but did recall breaking her door open once in 2007 when he said Teddy would not let him in to see Star. The police were called on that occasion but he was not charged with any offence. On reading this report, Teddy's father added that as Marlon refused to repair the door, Teddy felt vulnerable and frightened. She was concerned for Star's safety and asked her father to repair the door, which he did.

6.5. During 2008 Teddy was having difficulties coping as a single mother and she saw her GP for depression, she informed him that she had been self-harming in the past. She was prescribed antidepressants and given another appointment. She did not turn up to that appointment and when the practice contacted her she claimed the medication had worked and she felt well. However a month later, she took an overdose of paracetamol and was treated in hospital. She claimed that this was an accidental overdose and not a suicide attempt. She received further treatment for depression during the year and later reported that her moods had improved and she had started counselling with a single parent action network.

6.6. According to Teddy's father during 2012 she had started a two year relationship with Raman, who had allegedly been supplying her with illegal substances. During 2014 she commenced a relationship with Adan although he did not live with her.

6.7. In September 2012 Teddy again saw her GP after self-harming by cutting her left arm. She told the GP that she felt low as she had recently been made redundant and she was battling to stop using cannabis.

6.8. Teddy's father told the DHR that early in May 2013 Teddy's mother asked Teddy for a loan of money which she did not have to give; not long afterwards her mother took her own life by hanging. Teddy was deeply distressed and attended several sessions of bereavement counselling with NILAARI.

6.9. On 20th September 2013 Teddy's ex-partner (not named) took her to a hospital Accident and Emergency Department after she disclosed suicidal thoughts. She was seen by the mental health liaison team and she told them, she was in an abusive relationship and was struggling with low mood, suicidal thoughts and disturbed sleep since her mother committed suicide four months earlier. Teddy was given an assessment and she described thoughts of hanging herself with her dressing-gown cord. She said that concern for her child stopped her from acting on those thoughts. Teddy admitted that as a coping mechanism she was using drugs and alcohol regularly after her child was in bed (alcohol and cannabis) and weekend crack cocaine use when Star was in the care of Marlon (father). [2]

6.10. During following contacts with BIT, Teddy disclosed sexual abuse when she was fourteen years of age by "a man in position of trust". She had told the team that the perpetrator was retired but she declined to disclose any further detail or to give his identity. The BIT Liaison staff explained their duty to share the information with Bristol Social Services; subsequently Teddy stopped all contact with the team. After numerous attempts, contact was made on 25th October 2013 when she reported improvements in her mental state. She was later discharged as she did not respond to further telephone calls or to a letter asking her to confirm that she wanted to continue in treatment.

6.11. In January 2014 Teddy was found to have tied a ligature around her neck. She told the mental health team that although she was in a "dark place" she was not suicidal, she had only done it to 'see what it felt like' as she was thinking about her mother's suicide.

[2]To be redacted prior to publication

The team, whilst aware of Teddy's historical self-harming by cutting and her suicidal thoughts, concluded that this incident was not a serious suicide attempt. Teddy again said caring for her child stopped her from self-harming and she claimed she had an emergency/safety plan developed with a named worker at NILAARI.

6.12. On 12th February 2014 the mental health service carried out an assessment on Teddy and discharged to her GP with a plan to contact BIT or NILAARI if distressed. Marlon contacted Bristol Children's Social Care with concerns that Teddy was not coping well and he was worried about Star's safety.

613. On 9th December 2014 the police received a third party report of an argument between Teddy and her ex-partner. Teddy was contacted but refused to give any details of the incident other than to confirm that she had had an argument with her unnamed ex-partner. She refused to provide details of him and did not want to speak with the Police any further.

6.14. On 16th March 2015 Teddy moved from her rented accommodation in central Bristol to rented accommodation in Bath. She had told her father and sister that she was moving as she wanted to get away from people whom she felt were bad influences in her life and to enable her to more easily stop using illegal substances as she was worried about losing access to her child Star. It is noted in the United Communities records that the reason given for the transfer request was that she wanted to move because of problems with her neighbour.

6.15. On 7th April 2015 an unknown offender threw a brick through a window of Teddy's car while it was parked near her new address in Bath. Teddy initially suspected that the damage might have been caused by her ex-partner, Raman, but had no evidence to support this. She later told the Police that Raman was not involved in the incident and was not stalking or harassing her, the case was filed with no further police action.

6.16. On 17th July 2015 a Family Court Order was made that Star should live with Marlon and have contact with Teddy, each weekend from after school on Friday's to school on Monday and half the school holidays. Teddy had argued that her mental health had improved and therefore Star should live with her.

6.17. On 3rd September 2015 Teddy saw her Bristol GP informing him that she was feeling very low. As she was then living in Bath, she was advised to register with a GP in Bath so that she could receive help from local services. However she asked to remain with her Doctor in Bristol whom she trusted until she felt stronger. On 20th October 2015 Teddy's GP made an emergency referral to the mental health service requesting an assessment of her suicide risk. Teddy did not respond to telephone contacts from the mental health service and a police welfare visit was made. She confirmed she felt fine and would contact the mental health service. However she did not do so and despite several telephone calls from BIT no contact was made until three days later. A triage assessment was carried out and a plan agreed that she would re-engage with psychological services. Teddy did not attend her appointments and on 4th November 2015 the police were again requested to carry out a welfare check. When seen Teddy told the police officer she would contact the mental health services to say she no longer wanted to engage with their service. Although a number of calls were made to her, she did not respond and on 18th December 2015 the referral to the mental health service was closed.

6.18. Teddy's GP notes disclosed that on 4th December 2015 she was seen by a consultant regarding lumps on her breast which were found to be non-cancerous. Whilst she felt

depressed as she was concerned about the history of breast cancer in her family, she said she did not feel suicidal.

6.19. On 25th January 2016 Teddy called the police stating her ex-partner, Raman had assaulted her. He had visited her house and hit her following a verbal argument. Teddy requested that the police did not attend as she felt ashamed and embarrassed. The information was forwarded to the Police victim support service, Lighthouse, and Teddy was contacted by them, however she refused a visit from the police but agreed to attend a police station. Teddy told the officers that Raman had threatened to go and make problems with the father of her child, he had done that previously about three to four months earlier, but she refused to have any further police involvement (Marlon, Star's father has told the review that he had never had any contact from Raman).

6.20. On 1st June 2016 Teddy again contacted the police reporting that she had been assaulted by Raman. He had attended her house in the early hours of the morning, but later refused to leave which led to an argument. He had accused her of being in a relationship with another man over the past two years. During the argument he had slapped her to the rear of the head causing no visible injuries. Officers attended and Raman was arrested, however Teddy refused to pursue the complaint. A treat as urgent marker was placed on the address. Raman was released and a referral made to the Bristol Mental Health Team. Star, her child had not been present during the incident.

6.21. At the end of June 2016 Teddy's father became increasingly concerned that in spite of Teddy's good intentions and efforts she was not able to stop taking illegal substances. On her behalf he contacted the national substance abuse support organisation "Dear Albert" as she did not want to seek help locally. A support worker contacted Teddy by telephone and as she expressed a wish to go into a residential treatment centre he explained the different processes to do so. She said she would discuss them with her father. She made no further contact with the organisation.

6.22. On 15th July 2016 Teddy's father who lives over two hundred miles from Bath, telephoned Teddy to finalise a visit to see her and Star the following day. He said she was in a good mood and was looking forward to his visit. Later that day Teddy travelled to Bristol and met with Raman. Raman told the police that she drove him back to Bath and during the evening they walked her dog before returning to her home. Raman told the police, he had lost his mobile during the evening and rose early on the morning of the 16th July 2016 and took Teddy's dog with him when he went to look for his phone. On his return, he found Teddy hanging from a door with a ligature around her neck.

Section Seven - Key Issues Arising From the Review

7. The Review Panel, having had the opportunity to analyse all of the information obtained from the family and friends of Teddy and from agencies about Teddy's life, considered the following to be the key factors in this review:

7.1. T**eddy's unstable and traumatic early life.**

7.1.1. It is apparent from the information provided by family members that both Teddy's mother and father loved her, however they separated whilst she was still a baby and although her father continued to see her regularly for a few years, her mother stopped those visits and her father later moved to a different part of the country.

7.1.2. Following that short period of stability, Teddy's mother had, to the rest of the family's knowledge, at least two relationships in which she was the victim of serious domestic violence which often took place in Teddy's presence. When Teddy was ten years old, her half-sister was born and Teddy spent much of her non-school time looking after her. Her step-father died and her mother entered a relationship with an American man.

7.1.3. The family's move to the USA when Teddy was about thirteen years of age was particularly stressful, with her new step-father regularly beating her mother and subsequently being arrested and imprisoned due to his involvement in violence, firearms and drugs. Whilst her step-father was in prison, Teddy was raped by another man and her mother brought her daughters back to the UK without reporting the rape to the police. They moved in with a man Teddy's mother knew, and Teddy later claimed this man introduced her to cannabis and cocaine use and when she was fourteen years old, also raped her. Again this rape was not reported to the authorities.

7.1.4. Early in 2001 when she attended a hospital clinic she disclosed the some weeks earlier she had been sexually assaulted whilst on holiday in Oman. She was 14 years of age.

7.1.5. Those traumatic events contributed to Teddy being prone to depression and anxieties. In the opinion of her family, they also adversely affected her education, which ended without her having any qualifications.

7.1.6. It is regrettable that the sexual abuse Teddy suffered as a child was not reported at the time, not only would the perpetrators have been dealt with, but children's services in both the UK and USA would have able to assist Teddy in dealing with the traumas she suffered. Research in the USA highlights that girls who are sexually abused are more likely engage in self-harming behaviour, and be a victim of intimate partner violence later in life.[3] If practitioners are made aware of the abuse at an early stage and are able to work to prevent further childhood abuse it can significantly reduce suicidal behaviour in later life.[4]

7.2. **Teddy's mental health**

7.2.1. The DHR Panel noted that most people who choose to end their own lives do so for complex reasons. In the UK research has shown many people (90%) who die by suicide have a mental illness, most commonly depression or an alcohol problem.[5] The NHS Choices website highlights that a number of things determine how vulnerable a person is to suicidal thinking and behaviour. These include:

- Life history – for example, having a traumatic experience during childhood, a history of sexual or physical abuse or a history of parental neglect
- Mental health
- Lifestyle – for example, drug or alcohol misuse
- Relationships - loss of a loved one.

[3] Factors Associated With Child Sexual Abuse - stacks.cdc.gov 2008; Kaufman & Widom, 1999; Trickett, Noll, & Putnam .Child Abuse & Neglect 2000 24 10 1257 1273 11075694 Trickett PK Noll JG

[4] Is impulsivity a link between childhood abuse and suicide? (2010)
M. Dolores Braquehais' ', Maria A. Oquendo, Enrique Baca-García, Leo Sher

[5] Mortality statistics in England and Wales by sex and age range (ONS) Dec 2015

There is also significant research evidence which shows a direct link between women's experiences of domestic violence and heightened rates of depression, trauma symptoms, and self-harm.[6]

7.2.2. It is therefore unsurprising that Teddy self-harmed and had suicidal ideation. At different times and to different people and organisations, Teddy described the causes of her low moods as being because: she was finding it difficult to cope as a single mother with little money; that she had been in an abusive relationship; that she had suffered sexual abuse as a child; that she was distraught over her mother's suicide and that she was worried about losing custody of her child.

7.2.3. Teddy did not seek medical help until 2008 when she was finding it difficult to cope as a single mother after her separation from her partner Marlon, by which time her anxiety and depression had triggered self-harming and suicidal thoughts. She claimed the treatment she received helped and it was not until 2012 that she again saw her GP after self-harming. Following on there were three separate contacts with mental health services that did not progress due to her non-engagement. . On each occasion she was referred due to suicidal thoughts and low mood. She told several professionals that she would not carry out any of her suicidal thoughts because of the need to care for her child.

7.2.4. The DHR Panel considered at length what if any additional lessons could be learnt in terms of information sharing, awareness of risks and encouraging Teddy to access the most appropriate service.

7.2.5. It was noted that Teddy's mental health treatment was characterised by how well she responded to medication and her habit of stopping taking her prescription and ceasing contact with her GP and the mental health service as soon as she felt better.

7.2.6. At the time of her death, in spite of attempts to maintain contact with her, Teddy had exercised her freedom of choice to disengage with the mental health service. In her desire to appear mentally well to help her reclaim further custody rights to her son, she hid the full extent of her anxieties from agencies. It was therefore accepted that no agency had sufficient information to justify seeking to have her detained under the Mental Health Act to treat her against her will.

7.3. **Teddy's substance abuse / vulnerability**

7.3.1. Teddy's father told the DHR that whilst Teddy's American step-father was a convicted drug dealer, her family believes she was introduced to illegal drug use as a teenager by the older man with whom her mother lived on their return from the USA.

7.3.2. Teddy, over a number of years regularly used cannabis and more recently crack cocaine and occasionally heroin, which she told her family and Adan, she was purchasing from Raman. After splitting up with Marlon, she made several attempts to stop using controlled drugs. According to her family her move from Bristol to Bath was an example of this; she wanted to make a fresh start, away from drugs, Raman and other undesirable friends.

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[6] Mental Health and Domestic Violence: 'I Call it Symptoms of Abuse'
Cathy Humphreys Ravi Thiara Br J Soc Work (2003) 33 (2): 209-226. **DOI:** https://doi.org/10.1093/bjsw/33.2.209 Published: 01 March 2003

7.3.3. In spite of her efforts and good intentions she found it difficult to abstain without help. In September 2013 she told the mental health team that as a coping mechanism she was using cannabis and alcohol after Star was in bed and crack cocaine when he was staying with his father.

7.3.4. Her family were aware of her desire and efforts to give up drugs and they informed the police that Raman was a drug supplier, in the hope that if he was arrested she would find it easier to abstain. Whilst the Police recorded the information it was insufficient for them to act upon. Her father also contacted the national drug charity, "Dear Albert", to seek help for her. She had telephone contact with a counsellor but she died before arrangements could be made for her to be considered for residential rehabilitation.

7.3.5. Whilst it was known to the Mental Health Service, her GP and Bristol Children's Services that she used controlled drugs, she underreported the level of her usage, emphasising she was taking steps to abstain. The agencies therefore had no reason to suspect that her use of controlled drugs may have made her vulnerable within the meaning of the Care Act.

7.4. **Teddy's relationship with Raman**

7.4.1. The Domestic Homicide Review has not been able to make any contact with Raman in spite of numerous efforts directly and indirectly. The information relating to him is therefore limited to the facts obtained from the Police and from the Home Office Immigration Enforcement, and from the opinions of Teddy's father, sister and partner.

7.4.2. Teddy's father and Adan, her partner at the time of her death, told the Review that Teddy had first got to know Raman as a drug supplier early in 2012, but later had a relationship with him for about two year before she met Adan in 2014. Neither of them knew she was still seeing Raman. Her sister said Teddy renewed contact with Raman after she moved to Bath, primarily to buy drugs from him and that occasionally he would stay over. She said she tried to warn Teddy to stop seeing him and they would often argue about this.

7.4.3. In September 2013 when it is known that Teddy was in a relationship with Raman, she told the mental health service that she was trying to break away from a psychologically abusive relationship and that she felt a sense of relief as a result, she did not, however, name her partner.

7.4.4. Raman had come to the attention of the police on a number of occasions, primarily for vehicle related offences but also on one occasion for possession with intent to supply controlled drugs. There were incidents in January 2016 and June 2016 when Teddy contacted the police, reporting that Raman had assaulted her by slapping the back of her head. On the first occasion she said she did not want the police to attend but on the second occasion the police attended and arrested Raman. Teddy refused to give evidence against him and as there was no visible injury no further action was taken.

7.4.5. Teddy's father telephoned the police on one occasion, to inform them that he suspected that Raman was a drug dealer but he did not know sufficient information for the police to be able to take any action other than to record the information he provided.

7.4.6. When the police attended Teddy's death, a notepad was found on the living room table open on a page, on which were written the words "shame on you shame, shame, shame if tonight doesn't". It is not clear when this was written. Raman told the police that

Teddy was low during the evening before her death, complaining about the lack of contact with her child.

7.5. **Teddy's relationship with an unnamed older man**

7.5.1. Teddy's father told the review about an older man, believed to be now in his sixties, who her mother, Teddy and her sister stayed with in Bristol when they returned from the USA. Teddy had told her father that this man had raped her when she was fourteen years of age. Teddy's sister had recounted, that this man introduced Teddy to cannabis and cocaine and that he would often masturbate in front of them when they were children.

7.5.2. After her mother committed suicide, Teddy, while receiving bereavement counselling from NILAARI, disclosed "a relationship with an older male known to her for several years". She reported that money was exchanged for sexual favours but she refused to identify this person. The Counsellor referred the information to the Bristol SV MARAC. Consideration was given to Teddy's vulnerability but it was concluded that she did not meet the threshold to be considered a vulnerable adult as it was clear she was able to make her own choices. Teddy's family and friends believe she continued to visit this man up to the time of her death.

7.6. **Custody of Star**

7.6.1. Teddy found it difficult to manage as a single mother after she split up with Marlon. Money was tight and emotionally she found it difficult to cope with a toddler, she became depressed and started to self-harm, before seeking medical help in September 2008. Although she admitted to having suicidal thoughts she stressed that the care of her child prevented her from acting on those thoughts.

7.6.2. In October 2013 Teddy's GP made a referral to Bristol Children's Services, (with Teddy's knowledge), raising concerns regarding Teddy's emotional health, in particular her feelings of depression and suicidal thoughts since her mother's suicide four months before. Teddy had told her GP that she sought support for herself and to protect her child. An assessment resulted in on-going social work support under 'Child in Need' procedures. Children's Services reported that Teddy engaged in this process and there were identified protective factors, which included Star and Teddy's close relationship together with the fact that Star had regular contact with Marlon and paternal family. Although concerns increased in January 2014 around Teddy's emotional health and stability these were safely managed within child in need procedures with Teddy engaging positively.

7.6.3. Although Marlon initially tried to resolve child care issues informally with Teddy, in January 2015 he made an application to the Court for Star to live with him claiming that Teddy was threatening to commit suicide and a prohibited steps order was made preventing Teddy from removing Star from Marlon's care other than for agreed contact.

7.6.4. According to Teddy's father, the fear that the mental health service and other support services could share information about her with Children's Services or CAFCASS inhibited Teddy from seeking help from local drug support agencies and was the reason she disengaged with the mental health service. She was worried that if it was known she continued to use drugs and suffered from depression she would be prevented from having contact with Star.

7.6.5. A CAFCASS Family Court Advisor (FCA) in preparing her court report noted that Marlon had raised risk issues regarding Teddy's mental health, stating that Teddy "was

alleged to have taken an intentional overdose in Sept 2013". Consequently the FCA sought information from Teddy's GP, the mental health service and from NILAARI about her mental health issues. Her GP "advised that although (Teddy) was not completely neglecting her mental health, she was not doing sufficient to manage it either".

7.6.6. In July 2015 a final Family Court order was made for Star to live with Marlon and to have contact with Teddy each weekend from after school Friday to school on Monday, and half the school holidays. One in four weekends were to be with Marlon and in that week Teddy was to have contact from Wednesday to Friday. Teddy who was represented, argued that her mental health was much improved therefore Star should live with her.

7.6.7. Whilst the FCA took care in ensuring that Teddy was given the custody recommendations tactfully and in a safe environment, without Teddy's consent, she was inhibited by Family Procedural Rules from warning Teddy's GP or mental health service provider of Teddy's vulnerability to suicidal thoughts after the formal loss of Star's custody. Teddy's father on reading this report, asked that it be added that Teddy had told him that she was upset as she felt that decisions had been made about Star's custody before the FCA had met with her. Also Marlon had been given personal medical information about her, by the FCA before this had been discussed with her.

7.6.8. Over the following twelve months Teddy ignored her family's pleadings to seek help, telling them of her aim to regain better custody rights to Star. After her death, Raman told the police that she had seemed depressed about not having custody of Star.

7.6.9. The Panel noted parallels in Teddy's life to findings of a research project based in Women's Aid outreach service[7] i.e. "…witnessing and experiencing domestic abuse, responding positively to support from voluntary sector, not engaging fully with mental health services and custody problems re her child. The research showed a direct link between women's experiences of domestic violence and heightened rates of depression, trauma symptoms, and self-harm. "Their experiences of mental health services were often found to be negative… offering medication rather than counselling support…….the negative, consequent effects on child contact and child protection proceedings if the woman is labelled with mental health problems. Alternatively, women found services, often in the voluntary sector, helpful when they provided the following interventions: helping women name domestic violence; actively asking about the abuse; attending to safety planning; responding to women's specialist needs; and actively working with women to recover from abuse experiences. Support for her children was also seen as very helpful."

7.6.10. As highlighted earlier in this section, there were a number of critical stresses in Teddy's life, but it was evident from the notebook found after her death and from what she told her father and Raman, that it was the formal loss of Star's custody, which dominated her thoughts over the last twelve months of her life.

7.7. **Non-Transfer of Services**

7.7.1. Whilst Teddy moved from Bristol to Bath in March 2015 she did not transfer Star to a school in Bath nor did she register with a local GP practice.

7.7.2. Star remaining at school in Bristol was a practical solution as the child was in the last year of junior school and stayed with Marlon in Bristol during the week. Later this ar-

[7] Women's Aid Annual Survey 2015

rangement was confirmed by a court order. Teddy's father wished to add that he believed: "Although Star stayed in junior school in Bristol, Teddy would have wanted Star to go to a Secondary School in Bath.' 7.7.3. Teddy not registering with a GP in Bath did however cause difficulties for the mental health service being able to facilitate face to face meetings with Teddy. She failed to attend meetings arranged in Bristol and the service had to rely on telephone contact with her. It was highlighted in the mental health service IMR that such engagement was not conducive to Teddy being able to build a rapport with a key worker through personal meetings.

7.7.4 Teddy was advised by her tenancy sustainment officer on three separate occasions of the advisability of arranging her GP to be one in Bath.

Section Eight - Conclusions

8.1. The Review Panel assessed the Individual Management Reviews and other reports as being thorough, open and questioning from the view points of Teddy and/or Star. It is satisfied:

- That those organisations which conducted all of their contacts with Teddy, Star or Raman in accordance with their established policies and practice have no lessons to learn.

- That the other organisations have used their participation in the Review to properly identify and address key lessons learnt from their contacts with Teddy, Star or Raman in line with the DHR's Terms of Reference.

8.2. The Panel highlights the support of the Bristol District Family Court Judge in permitting CAFCASS to contribute to this review.

8.3. Due to Raman leaving his last known address after Teddy's death and not responding to letters or voicemail messages, the DHR has had no opportunity to seek his view point on his contacts with agencies.

8.4. The Panel is satisfied that the implementation of the recommendations made during the Review will address needs identified from the lessons learnt and make life safer for victims of domestic abuse, particularly those with mental health or substance abuse problems. The Panel acknowledges the sentiments of Teddy's family that whilst it is essential that key domestic abuse, substance abuse and mental health services are locally available; individuals with needs must exercise their free choice to access and maintain contact with those services. The Panel, nevertheless, recommended that agencies remind staff to strive to retain vulnerable patients/clients in services.

8.5. The Panel considered that Teddy's death was predictable. She had a known history of self-harming and making suicide plans and she no longer had full custody of her child, whose care had been the reason she gave for never previously carrying out her suicidal thoughts. However the Panel noted that Teddy had hidden the full extent of her anxieties and mental health problems and at the time of her death she had stopped having contact with any of the agencies that might have been able to have foreseen from her moods that she was contemplating to self-harm or to take her own life. Teddy's father told the Review that although Teddy's distrust of agencies sharing information about her, made her disinclined to seek local help, she had been making positive efforts, on her own, to deal with her mental health and drug problems so that she could show that she was able to safely care for Star.

8.6. The Panel notes that Teddy had been the victim of domestic abuse during the six months prior to her death and research indicates that: "Violent behaviour in the last year of life is a significant predictor of suicide".[8] In Teddy's case, the Panel does not believe there were sufficient grounds, (other than with the benefit of hindsight), for agencies to have considered that the domestic abuse she was subjected to by Raman, increased her vulnerability to suicidal thoughts.

8.7. The question if Teddy's death could have been prevented was also considered. The Coroner's inquest found no evidence of any possible involvement in Teddy's death by Raman; nor was anything found to indicate that Raman could have sought help for Teddy sooner. Police enquiries did not reveal any evidence of violence or domestic abuse having taken place during the evening before Teddy died. The Pathologist found no evidence that Teddy had suffered any recent assault. There were no records or any calls to the emergency services during the night and the neighbour did not hear any noise from Teddy's address.

8.8. The Review Panel notes the current calls on the Government to develop a legal route for the successful prosecution of domestic violence perpetrators whose victims commit suicide; but the Panel is satisfied that in this case there is no evidence to indicate that Teddy committed suicide as a means of escaping abuse.

8.9. Teddy's father informed the DHR that he had spoken to her, on the telephone, the day before she died to make arrangements about visiting her and Star the following day and she seemed to be happy and looking forward to seeing him. The Panel has therefore concluded that there were no warning signs that Teddy was intending to attempt to take her own life on 16th July 2016 and no single agency had sufficient information to have enabled them to take action which might have prevented Teddy's death at that time.

Section Nine – Lessons To Be Learnt

9.1. **Avon and Somerset Constabulary (ASC)**

9.1.1. The police had a total of fifteen contacts with Teddy and received information concerning her vulnerability via a third party following the Sexual Violence MARAC meeting where she was referred as being at risk of serious sexual violence. Although recorded as "intelligence" in relation to Teddy on "Guardian" (the ASC crime and incident recording system at the time, later replaced by "Niche"), this information was not entered onto the Police National Computer (PNC). PNC does contain a section headed 'Police Print of Intelligence Information' however research indicates that this is not routinely populated with intelligence regarding MARAC discussions/referrals. If this was the case, officers attending incidents could cause enquiry to be made for individuals known to be at the scene. This would ensure that officers have timely information when at the scene and could deal with victims identifying vulnerability early and the efficiency in making appropriate and timely referrals improved. Although the intelligence regarding the Sexual Violence MARAC discussion was recorded against Teddy's profile on "Guardian" and "Niche", this was not referred to in any of the subsequent dealings with her and therefore it is not possible to say that it was taken into consideration. This is likely to have been because it was not a Domestic Abuse MARAC. However, as Teddy was identified as vulnerable as a result of the

[8] Violence, Alcohol, and Completed Suicide: A Case-Control Study. (2001) Kenneth R. Conner, Psy.D., Christopher Cox, Ph.D., Paul R. Duberstein, Ph.D., Lili Tian, M.A., Paul A. Nisbet, Ph.D., and Yeates Conwell, M.D.

MARAC, this presented an opportunity for such to be taken into account when dealing with her on subsequent occasions. It is possible that referrals/risk assessments might have been different if the intelligence had been considered. In particular, more persistent efforts might have been made to engage with Teddy and/or additional referrals could have been considered to support her.

9.1.2. When safeguarding checks are carried out in relation to any individual, it is important that both “Niche” and the Police National Computer (PNC) are researched. At the time of the contacts between Teddy and the police during the period of this review “Guardian” was flagged in relation to the Sexual Violence MARAC discussion. However it was routine for such flags to be set for the duration of twelve months, as any further involvement with the parties would have given rise to a repeat referral to MARAC where such occurred within twelve months. Current practice is to flag MARAC discussions and referrals on Niche a) indefinitely (Force Northern Safeguarding Unit (SCU)) b) for fifty years (Bristol SCU) and c) indefinitely (Southern SCU). Consideration should be given to standardising this with officers and staff required to ensure that this is notified for inclusion on PNC where appropriate and actioned from the MARAC meeting if proportionate to do so.

9.1.3. There was no record on police systems regarding any details of Star being taken into care or living with Marlon (father). Therefore there was no record or understanding by police that Teddy’s mental health may have been adversely affected by Star’s removal from her care which could have been taken into account when police were in contact with her. This information could have been shared with police by partner agencies especially if there were further concerns for Teddy’s mental health. This would have enabled the police to make more informed decisions when dealing with Teddy in relation to her contacts with them. There was no record of a child at most of the incidents police attended, presumably as Star was not present. However if it was recorded that vulnerable parties had children and details were taken, this information could be shared with partners, allowing a bigger picture of risk and vulnerability for that child to be considered.

9.2**. Avon and Wiltshire Mental Health Partnership NHS Trust**

9.2.1. A DASH risk assessment should have been completed by staff in 2013.

9.2.2. Advice should have been sought from the Trust’s Safeguarding Team when current difficulties were mentioned with past and current alleged abusive relationships.

9.2.3. When requesting a welfare check clinicians should ensure that they inform the police of any dependents of the subjects of the welfare checks.

9.3. **Bristol City Council Children's Social Care**

9.3.1. Whilst Bristol City Council Children's Social Care has no direct lessons to learn, the Department has identified a lesson from the circumstances of Teddy's suicide. Where a social worker is aware that a parent, who is involved in child protection enquiries, has mental health problems, or a history of self-harming or suicide attempts; the social worker should consider encouraging the parent to inform his/her GP or mental health service provider that they may be at risk of added stress due to the child care proceedings.

9.4. **Bristol Clinical Commissioning Group re Teddy’s GP Practice**

9.4.1. In September 2015 Teddy told her GP that she was living in Bath, which was outside of the GP Practice locality in Bristol. Her GP asked her to change to a GP practice near to where she was living as this would enable her to access other local NHS services; however she chose not to do so. Over there following months her GP continued to see her for different ailments during which time there were missed opportunities to encourage Teddy to move to a Bath GP Practice.

9.5. **Children and Family Court Advisory and Support Service (CAFCASS)**

9.5.1. The Family Court Advisor could have been clearer in the Section 7 report about the rationale for considering the past domestic abuse to not be a barrier to Star's safely remaining with his father. (The FCA's closing summary does clarify that she properly considered the effect of domestic abuse on a child).

9.5.2. It would also have been helpful for the FCA to reinforce her risk assessment with reference to a risk assessment tool such as SafeLives-DASH or the Barnardos DV Risk Identification Matrix.

9.5.3. There was good practice by the CAFCASS Family Court Advisor CAFCASS in seeking information from Teddy's GP, the Mental Health Service and NILAARI about her mental health and in taking Teddy's suicidal ideation into consideration in the manner she was informed about the Family Court decision on the custody arrangements for Star. However whilst CAFCASS Family Court Advisors are permitted to **seek** information from external agencies as part of their reporting duties, the Family Procedure Rules dictate that Family Court Advisors can only **share** information from private family law proceedings if doing so is to a professional in furtherance of child protection (this is likely to be restricted to a local authority social worker or a police officer). There is a lesson to be learnt from Teddy's suicide, that when it is known that a parent has a history of self-harming or of suicide attempts, there is a duty of care to share information about custody decisions with the parent's GP.

9.6. **Dear Albert**

9.6.1. The lessons taken from this review is the need to review policy of not taking notes during preliminary soundings or until agreement on undertaking full assessment is agreed.

9.6.2. It is apparent there is a need to review the policy on when to call emergency or other services when suicide is mentioned. (Counsellors have now completed an independently provided Suicide Awareness training programme.)

9.6.3. There is a need for further training around suicidal ideation.

9.7. **United Communities Housing Association**

9.7.1. In this case, the Association had no reports or indications of domestic abuse. There are however areas that can be improved around sharing information, communication, training and insight.

9.7.2. Whilst United Communities has an open and easy to use database, the information on it is not in a standard format and not easy to identify the action listed.

9.7.3. It was unclear from the records at United Communities what information each team held on residents. Examples in this case were around Star living with Teddy and the in-

come/work details for Teddy. Some of this information was known to the Tenancy Sustainment Officer but was not apparently shared with the housing/income team.

9.8. University Hospitals Bristol NHS Foundation

9.8.1. When Teddy reported sexual assaults in 2001, whilst support was provided Children's Social Services, and the Police were not formally notified, although representatives from both services were on a Multi-Agency Group when the assaults were discussed. Policy and practice has changed and the Children's Social Services and the Police would be formally notified.

9.8.2. Teddy should have been questioned about domestic abuse when she attended at a hospital department in October 2014 after reporting that she had fallen having been pushed by her partner. The foundation now has a fit for purpose domestic abuse policy and questions would routinely be asked about domestic abuse in such circumstances.

Section Ten - Recommendations from the Review

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Tar get dat

That the Family Court Procedure Rules are amended to enable CAFCASS Family Court Advisers to share information (with or without consent) with a parent's GP or mental health service where it is known the parent has mental health problems, self-harms or has suicidal ideation and may be more vulnerable due to child custody decision which has gone against them in a Private Law case	National	Chair of the Bath and North East Somerset Responsible authority Group to write to Dept. Justice with this recommendation; pointing out that in cases where there is no evidence of direct impact on a child, a FCA cannot share information with a GP when it is known that a parent has a history of mental ills less, self-harming or suicidal ideation that may be adversely effected by private law child custody decision.	Department of Justice, Family Court's Division	letter to be sent by 30th April 2017 The Dept Justice adds this permissible disclosure to the table of information set out in Practice Direction 12G of The Family Procedure Rules 2010	31/ 17
Ensure that the warning markers, attached to subjects on police systems to enable effective safeguarding measures to be taken, are fit for purpose	Local	Review the range of warning markers that are attached to subjects and, where necessary, introduce additional warning markers. Conduct checking and testing to establish compliance with their use	Avon and Somerset Constabulary		07/ 201

The planned review of the ASC Domestic Abuse Procedural Guidance (scheduled for June 2017) is brought forward to ensure that effective guidance is provided in relation to the use of Niche in dealing with Domestic Abuse.	Local	Carry out a review of the ASC Domestic Abuse Procedural Guidance in accordance with APP	Avon and Somerset Constabulary		07/ 201 Fur the rev sio con ple 8/0 018
Officers are reminded that when attending incidents where domestic abuse is suspected or reported, they should always explore whether the parties have children, whether present or not, and that this is to be recorded on Niche. Any children identified should be linked to the relevant party on Niche.	Local	Audit of DA referrals to ensure child safeguarding is actioned and recorded	Avon and Somerset Constabulary	(Outcome – better recording, linking and sharing of correct information informing better risk assessments and sharing of relevant information predicting future risks)	31/ 201
That the Domestic Abuse training programme which commenced at the end of 2015/16 should as a matter of policy by embedded as a key training requirement for all personnel.	Local	Training programme to continue to be delivered and updated as necessary to reflect new legislation etc to ensure that all existing and new staff understand their responsibilities relating to DA in accordance with AWP Plolicy	Avon and Wiltshire Mental Health Partnership NHS Trust	Continuing Training programme	 Tra ing pro gra me ope tion Sta trai ing be ong ing

Review the Guidance for information sharing with police when Welfare Checks are requested to ensure that key information is shared.	Local	Information sharing police document will be amended to include specific guidance relating to Welfare checks	Avon and Wiltshire Mental Health Partnership NHS Trust		31/ 17
AWP to review it's Safeguarding Training to ensure it includes recognition of vulnerability through abusive relationships and sexual exploitation.	Local	amendments made	Avon and Wiltshire Mental Health Partnership NHS Trust		31/ 17
If a third party accompanies a patient to a referral, they will be asked to identify themselves and their details recorded.	Local	Added to personnel Guidance	Avon and Wiltshire Mental Health Partnership NHS Trust		28/ 18

That Bristol City Council Children's Social Care acknowledges that whilst a child's safety and welfare will always be of paramount important; where a parent involved in child protection enquiries is known to have a history of mental health problems, self-harming of suicidal ideation, current guidance should include practice about encouraging the parent to notify their GP or mental health service provider that they may be vulnerable to added stress because of the child protection enquiries/proceedings. It the parent refuses to seek such medical support, the social worker should discuss the risks with a supervisor on whether the information should be shared without consent. In accordance with Data Protection each case must be considered on its individual circumstances relating to the level of risk of serious harm to the parent. All social workers would be informed about this guidance	Local	This will be embedded into the procedures and current guidance when work within child protection. This will be provided to all social workers.	Bristol City Council Children's Social Care	– Additions made to the guidance by June 2017 To draw to attention of all social workers by July 2017 Include in future training.- ongoing.	
That Bristol CCG/NHS England remind GP Practices that if a patient who is accessing ongoing secondary health services, moves outside the Practice area it should be clearly explained to them that they should move practice to the locality where they live to enable them to access other local NHS services.	Local	Letter to GP practices to be drafted and circulated explaining the issue and setting out need to remind all patients if they are not already doing so.	Bristol CCG/ NHS England		31/ 017

Review policy of not taking notes during preliminary soundings or until agreement on undertaking full assessment.	Organisation wide nationally	Policy to be rewritten to ensure that clear notes of initial contacts are consistently made	Dear Albert		31/ 20
Review policy on when to call emergency or other services when suicide is mentioned.	Organisation wide nationally	Policy to be rewritten to set out policy and good practice in sharing information and advising clients	Dear Albert		31/ 20
To include further staff training around suicidal ideation so that front line personnel fully understand the new policy and good practice.	Organisation wide nationally	New Training Programme to be developed and delivered to all key personnel.	Dear Albert		31/ 20
Nilaari is working towards becoming a paper free organisation. Plans for client files and all associated papers to be held on a secure database in line with data protection are underway.	local	Introduction of electronic filing system	NILAARI		31/ 201
It is recommended that the United Communities database system is reviewed so that information is recorded in a more concise, clear manner and includes visits, phone calls, emails etc. This will make any further reviews easier to follow.	Local	Review how information is stored and create a format for this.	United Communities		31/ 201

It is recommended that United Communities considers widening its database so that key information relating to tenants can be shared internally where relevant and indicate when it is shared. The review of information is part of a wider consideration that United Communities is considering around customer data and CRM.	Local	Review how information is shared internally and note the person / team it is shared with.	United Communities	United Communities will consider internal data sharing from the information retained and how this is shared with other officers	31/ 201
It is recommended that a policy is written setting out support procedures for residents who are known to have suicidal ideation and that this together with the existing safeguarding policy is cascaded to all personnel as part of structured a training programme	Local	Develop policy and update all staff on Association's approach on suicide	United Communities		31/ 201

United Communities has a Domestic Abuse policy and has in the past held training through BAVA for staff. It is recommended that refresher training on Domestic Abuse. . is carried out for all staff.	Local	This is to be led by the Head of Housing within the next 6 months. It is a challenge for staff to both identify the signs around abuse and ask residents if abuse is occurring. The association needs to consider how it can do this in a wider context and possibly offer training to contractors to identify the signs when carrying out repairs for the association in residents homes. Also to consider how the support teams ask residents questions about abuse in a sensitive and useful way if there are any signs of this.	United Communities. This is to be led by the Head of Housing within the next 6 months		31/ 201
United Communities recommends that other agencies involved in domestic abuse cases engage with social housing providers whose input may be able to enhance the safety of domestic abuse victims living in social housing, especially if there is a risk to the tenancy.	Local Cross agencies	Partnership organisations to All to consider referring information to the social housing provider.	BANES RAG		31/ 201