EXECUTIVE SUMMARY of the DHR in respect of IZZY

(Anonymised for publication and dissemination: the name Izzy as a pseudonym for the victim was chosen by the family to protect her anonymity. The perpetrator is known as Colin to protect the anonymity of the victim and her family. Specific dates and other identifying facts have been generalised or removed.**)**

1. THE REVIEW PROCESS

This summary outlines the process undertaken by the City of Bradford Domestic Homicide Review Panel in reviewing the murder of a local woman in December 2016.

Criminal proceedings have been completed and the perpetrator has been sentenced to life imprisonment with a tariff of 23 years.

Following a scoping of all agencies and victim and domestic abuse services in the area in which the victim lived, the following agencies were identified as having been involved with the victim, her children, or the perpetrator:

Agencies providing Independent Management Reviews:

- City of Bradford Metropolitan Borough Council (CBMBC) Local Authority Children's Social Care (CSC)
- West Yorkshire Police Service (WYP) which had significant contact as follows:
    - The Public Protection Unit: the perpetrator was a Registered Sex Offender
    - The Safeguarding Unit
    - Bradford District
- Bradford Districts Clinical Commissioning Group (CCG) on behalf of the GP
- The Bridge Project drug treatment service.
- Bradford District Care Foundation NHS Trust (BDCFT)

Agencies which had some contact and were asked to provide information:

- National Probation Service West Yorkshire
- City of Bradford Education (Access and Inclusion Services)

No victim or domestic abuse services were involved at any time with any of the persons concerned in this review.

Housing services was not involved with members of household during the timescale.

Others participating in this case review were:

- Representatives of the family
- A number of Izzy's colleagues
- Representatives of Izzy's employer

2. KEY ISSUES ARISING FROM THE REVIEW

2.1 Awareness of domestic abuse services:

There was no indication that Izzy saw herself as a victim of domestic abuse or wished to report abuse. Izzy left an unhappy, verbally abusive marriage in early 2014 to start a relationship with the perpetrator. Her accounts to family and colleagues all related to her happiness in this new relationship and described the ongoing conflict as being with her husband, arising from disagreements about the residence and contact with her youngest child. A number of domestic incidents involving police evidenced that there was ongoing dispute. In these, Izzy was recorded as perpetrator, and as subject, of domestic abuse. These incidents evidence that she was willing and able to call for assistance. When her family and colleagues noted her bruises, Izzy gave reasons such as falling, or blamed a confrontation with her husband. She disclosed domestic abuse to her GP, citing her husband as the perpetrator. Izzy obtained a Non-Molestation Order against her husband.

Izzy's father believed she was being abused and sought advice: he spoke to the Social Worker undertaking a Section 37[1] report in mid-2014. The Social Worker did not act on this information. This was clearly a missed opportunity. Subsequently, Izzy broke off contact with her father, partly because of disagreements over his concern for her safety and his disapproval of Colin.

Her father attended the police station to ask for information about Colin because he was worried about his daughter. This was in 2014 when Sarah's Law[2] was being implemented; whilst he was not eligible for a disclosure, WYP accepts that he should have been properly

[1] A Section 37 Report requires a social worker to investigate a child's circumstances and make recommendations to the Court to inform its decisions about residence, contact and other arrangements; a Guardian is usually appointed to represent the child.

[2] The Child Sex Offender Disclosure Scheme, known as 'Sarah's Law', allows a member of the public concerned for the welfare of a child, to visit a police station to ask the police whether someone who has access to a child, has child-related sex offences.

advised. The family has made observations about the need to improve public awareness which are referenced in the recommendations.

In October 2016, Izzy was arrested and charged with neglect in an incident when Colin had gained access to, and allegedly assaulted, her youngest child. Officers interviewing her sought to explore the nature of her relationship with Colin and the solicitor stopped this discussion and refocussed the interview onto strictly evidential issues. This could have been a barrier, had Izzy wished to disclose, however, the record of the interview indicates that Izzy defended Colin against the allegation and was very positive about their relationship.

2.2 Information sharing procedures:

When Colin transferred drug treatment from Kirklees to Bradford, there was no information sharing by Lifeline (the provider in Kirklees) with the Bridge Project (the provider in Bradford) during the referral process. This meant the Bridge Project had no information on his history of violent or sexual offending and their risk assessment was therefore not accurate. Lifeline has since gone into liquidation, and the Bridge Project has developed a new transfer protocol, however, the proper transfer of information between providers is a lesson learned for commissioners and providers of substance misuse services.

The PPU[3] attempted to share information with Lifeline and was told this was not possible due to client confidentiality. Had information been shared effectively by Lifeline, the PPU's risk assessment would have been more accurate. This gap in information sharing also led to Bridge Project being unaware that his previous partner was being supported by MARAC[4] in June 2014 due to a serious incident of domestic violence after he left her and was living with Izzy. This information would have led to an updated risk assessment and a more assertive intervention later, when the drug worker became aware of his dependence upon Izzy. Bridge Project staff understood the true picture of his lifestyle and history only after September 2015 when the PPU learned that his treatment had been transferred there, and regular information sharing then took place.

[3] The Public Protection Unit (PPU) is responsible for the assessment and monitoring of Registered Sex Offenders. The PPU falls within the remit of West Yorkshire Police (WYP). The Public Protection Officer (PPO) is the offender manager.

[4] Multi-Agency Risk Assessment Conference (MARAC) is a multi-agency meeting responsible for planning the support of people who are at high risk of domestic abuse, by allocating actions to statutory agencies and to other agencies working with domestic abuse.

MARAC is a victim-focused process, so the information about the perpetrator's abuse of his previous partner did not follow him to Bradford. This left a significant gap in information sharing in this case, and consideration should is given to this in the recommendations.

2.3 Assessment and decision making:

In April 2014 information indicated Colin was no longer living at his registered address, with his previous partner. No tasking was undertaken to have either address checked, e.g. in the early hours, to establish where he was actually living. This should have been a priority given the presence of children at Izzy's address. When a statement was obtained from his previous partner in May 2014 to the effect that he was no longer at her address, he was arrested and released without charge on the basis that she was not a reliable witness. Enquiries to corroborate the previous partner's account were not completed, e.g. speaking to Izzy's eldest child who had earlier left home because of Colin's presence there, and there were no house to house enquiries with current or former neighbours. This indicated a failure to exercise professional curiosity or to be proactive in managing Registered Sex Offenders and has been a theme of several internal WYP reviews conducted over the past year. This learning should now be collated and used to improve the management of Registered Sex Offenders.

Once Colin had registered his address as Izzy's, the offender manager ensured he disclosed his sex offending history to Izzy. However, his previous partner subsequently disclosed a ten-year history of coercive control and physical assault and reported continuing threats after he had left her. The offender manager did not consider initiating a Clare's Law[5] disclosure to Izzy. This would have been an appropriate action to promote her safeguarding. Guidance will be issued to offender managers to implement Clare's Law disclosures where appropriate.

Throughout the period under review, however, the offender manager assessed him as medium risk on Matrix 2000[6] but graded his actual risk as Very High due to his lifestyle and continuing/ escalating drug use, which was good risk assessment practice.

[5] The Domestic Violence Disclosure Scheme, known as 'Clare's Law' after the landmark case that led to it, gives any member of the public the right to ask the police if their partner may pose a risk to them. Under Clare's Law, a member of the public can also make enquiries into the partner of a close friend or family member.

[6] Risk Matrix 2000 (RM2000) is the standard sex offender risk assessment tool applied to Registered Sex Offenders.

The perpetrator was on bail for an alleged assault on Izzy's youngest child, and breached bail by failing to report, three days before the homicide. No tasking of this breach appears to have taken place although a briefing item was automatically generated. This was a concern for the family and was explored further; it was found unlikely that any urgent action would have been taken in these three days due to it occurring at a weekend, and there being no information about domestic violence. However, improvements to this tasking system are recommended.

There was an opportunity to refer Izzy to a domestic violence support service in November 2014, following an incident in the street when police were called by a neighbour who witnessed Colin assaulting Izzy. However, Izzy denied domestic violence and was defensive of Colin to the point of being arrested for obstruction. He received a caution. Izzy's parents were concerned that this was a missed opportunity for a victimless prosecution; it was agreed that the police had taken all appropriate action by administering the caution so that this offence was now on his record. There had been previous opportunities to refer Izzy for support, in domestic incidents involving her husband; however, Force policy states that victims of domestic abuse can be referred to support agencies only with their explicit and informed consent, which Izzy did not give. Izzy could have been referred to MARAC had she been identified as High Risk under the DASH;[7] however, risk was assessed as Standard or Medium.

There had been one incident, in February 2014, in relation to Izzy's abuse in her relationship with her husband, and not in her new relationship, in which she consented to being referred to a support agency and this had not been completed due to a tasking error. As a result of this finding, WYP has implemented a new 'master task' facility from September 2018.

Izzy was referred by her GP for support but did not opt in. The Bridge Project staff offered Izzy an independent support service on a number of occasions, which she did not wish to take up.

[7] The Domestic Abuse Stalking and Harassment template is a risk assessment in use since 2009 by professionals working in the field of domestic abuse. It is an evidence-based, proactive tool for assessing and managing risk in domestic incidents. Policy requires that police attending a domestic incident complete a DASH unless the reason this cannot be done, is recorded and agreed managerially.

Family, colleagues, and the PPU officer, noted a deterioration in Izzy's health and presentation; however, this was consistently explained and understood to be due to stress from her relationship with her husband, not relating to Colin.

There were missed opportunities between October and December 2016, when Colin was on remand for the alleged assault against her youngest child. The PPU offender manager intended, but did not, speak to Izzy about her relationship. There was a Section 47[8] investigation relating to the alleged assault, and the Social Worker failed to interview Izzy. Anecdotal information led reviewers to believe Izzy was reflective and determined to improve her circumstances at that time, when she was in the early stages of pregnancy, and these missed conversations may have led to her disclosing, and accepting support.

2.4 Interventions:

Interventions concerned the perpetrator, via PPU and the Bridge Project. There was evidence of appropriate challenge, including when drug workers noted that Izzy was acting in collusion with his drug taking, and steps were taken both to stop this happening, and to offer support to Izzy as a 'concerned other'.

The key opportunities for agency intervention in relation to domestic abuse that were missed, were, as related above, in October – December 2016.

2.5 Policies and procedures:

There was a missed opportunity for CSC to ask Izzy, in 2014, if she felt under pressure from Colin, after her father had raised concerns with the Social Worker. There was a missed opportunity at the same time, between her child's school and CSC when the school reported that Izzy had attended school with "an egg sized lump on her forehead with cut down the middle". The focus by CSC appeared fixed on recording domestic abuse accounts given by Izzy about her husband and vice versa. More detailed discussions could have been held with Izzy about support for her as the victim of domestic abuse, and encouragement given for her to access support from relevant agencies and being asked about a MARAC referral. Other information indicates that Izzy would not have admitted to being abused by Colin at this stage and would not have taken up offers of advice. However, these are clear missed

[8] A section 47 inquiry (s47) is a child protection investigation. CSC must carry out an investigation when they have 'reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm'. The enquiry will involve an assessment of the child's needs and the ability of those caring for the child to meet them. The aim is to decide whether any action should be taken to safeguard the child. The timescale for a s47 inquiry is 45 days.

opportunities to follow policy and procedure and guidance will be provided to staff to develop a greater awareness of the links between domestic abuse and safeguarding children.

In 2016 following the arrest of Izzy and Colin in respect of the allegation by Izzy's child, there was a Section 47 investigation. The investigating Social Worker did not interview Izzy. Whilst it is noted that Izzy was charged with neglect in that incident, it would have been proper procedure to have interviewed her. Reviewers identified a potential window of opportunity during the time she was on bail, he was remanded in custody, and afterwards, when she found she was pregnant and wrote a letter to Colin in which she pleaded with him to change.

The Bridge Project has a separate service to provide confidential support for Concerned Others, affected by substance misuse of a family member or friend, and in accordance with policy and procedure, Izzy was encouraged to attend on five separate occasions, which demonstrated good practice. Had she done so, this may have led to Izzy finding support in her own right which may in turn have led to her identifying the risks within this relationship. However, Izzy did not wish to attend.

The NHS agency which employed Izzy was fully engaged in this Review and has shared lessons learned by managers. It is recommended that these are considered by all agencies in the Partnership.

2.6 Practitioner skills and training:

Drug practitioners evidenced good practice in speaking to Izzy independently of Colin to offer the support of the 'Concerned Other Service'. These interactions were not documented as they were opportunistic and occurred outside of any sessions held with Colin; guidance is to be provided for the recording of third-party contacts.

Practitioners in PPU and the Bridge Project evidenced good practice, such as in challenging Colin in his over-reliance on Izzy, challenging his accounts, and offering support to Izzy.

Izzy's GP evidenced good practice in making several attempts to follow up and refer her for support.

In WYP, relevant staff had not participated in recent domestic abuse training including the coercion and control training during 2016 and 2017. There is a recommendation to rectify this.

2.7 Safeguarding Children:

There were several referrals by WYP to CSC in relation to domestic incidents in 2014 in which the CSC made decisions for no further action. These decisions were reviewed and

found to be consistent with policy for the Duty Suite of the Multi Agency Safeguarding Hub[9]. CSC shared information with schools to alert them to a child suffering/ witnessing domestic abuse.

WYP made a referral to CSC following a domestic incident between Izzy and her husband in June 2014, in which Colin was present, but he was not identified as a registered sex offender. This was key information that should have been shared with CSC. However, CSC had been informed on other occasions of his registered sex offender status and noted that as this conviction did not involve children he was not assessed as a risk to children.

The report taken by WYP in August 2016 that Colin had contact with the youngest child during an unsupervised trip to the seaside resulted in the submission of a child protection occurrence. Colin was not linked to the occurrence on the log and consequently no notification was sent to the PPU offender manager. Similarly, Colin was recorded as being present, but not linked to child protection or domestic abuse occurrences submitted in September 2016 and consequently no notification was passed to the PPU offender manager. This was a failing as receipt of this information may have resulted in a re-assessment of Colin's risk of harm. There is a recommendation stressing the importance of linking the record of registered sex offenders to the record of occurrences.

In 2015, Izzy and Colin asked the Bridge Project to undertake drug testing in order to provide evidence of Colin's stability for a private court matter (Izzy was hoping to regain residence of her youngest child). The Project agreed to provide drug tests to the same standard as a Child Protection case. This action demonstrated that the practitioner and the manager were alert to risks to children and would implement the same standard of practice despite the private nature of the dispute in question.

The youngest child was referred to CAMHS[10] by the GP due to the father's concerns about the impact of the current situation. The School Nurse was then asked to support the child in school. This service was found to be prompt, supportive, and to have followed best practice.

When the School Nurse learned of the supervised contact order, it was recorded that this was in place 'due to risk'. There was a missed opportunity to gain clarity of these risks from

[9] The Duty Suite is the system whereby incoming referrals are reviewed by a team on duty, and decisions made, within the MASH. Multi Agency Safeguarding Hubs (MASHs) were set up after 2014 as part of new governmental guidance, to mitigate the risk of anyone slipping through the safeguarding net. Staff from all statutory agencies are co-located in order to share information and act effectively.

[10] CAMHS is the NHS Child and Adolescent Mental Health Services.

the Social Worker, in order that any additional support needs might be identified. In October 2016, when the youngest child alleged an assault by Colin, this information was not shared with the school nursing service until December 2016. This was a delay in communication and a missed opportunity to assess any needs and offer support for any emerging health needs.

The Review noted that Izzy's eldest child as a teenager experienced conflict in the home and was concerned about the support offered to older young people living with domestic violence.

3. PANEL CONCLUSIONS

Izzy thought Colin was her 'rescuer' from an unhappy marriage, whereas the information available to the Review suggests he was her jailer. After a brief period of happiness, when she left her marriage, Izzy became subject to increasingly controlling behaviour, and did not recognize this, defending him against others who had a more objective view of his risks. Over a short period in 2014, he established control of her behaviour, changing her norms, causing her to behave in ways she would not previously have tolerated. He went on to control her belongings and her finances. He stalked her through her working day, demanded her complete attention to his needs, isolating her first from friends, then from any family member who was not in agreement with him. He 'groomed' relatives who were supportive of the relationship if only for Izzy's sake.

Izzy loved her children, enjoyed her career, and was financially independent. She was manipulated into circumstances in which she lost her children, got into debt, could not afford to eat, and pawned her belongings. She was coerced by him to use her strengths and her qualities to support him to the exclusion of her children, her family, her career and her own independence. She created a fictional life in which she had care of her children, and was in dispute with her husband, to explain the increasing chaos in her working and home life.

There is no information to indicate that Izzy considered herself a victim of abuse by Colin. The reviewers suggest that Colin used his vulnerabilities to control Izzy: he was not well educated, had few skills and little employment history; was a long-term drug abuser with a history of offending including being a registered sex offender. As such, Izzy was the strong person in this relationship. She supported him in every aspect of his vulnerabilities, deprioritising her own needs, and even her own children, in order to try make the relationship work.

Around October 2016, coinciding with his remand, even though she had lost contact with her youngest child and was facing a charge of neglect, there was evidence that Izzy's emotional state improved; she had been low for a long time, particularly since her miscarriage in May 2016. Now, she was supported by anti-depressants, found she was pregnant, and a new, positive approach became evident to her colleagues. This must have been a period of intense pressure for Izzy, while she awaited trial for a charge of neglect arising from the perpetrator's actions, unable to share this situation with her family. The reviewers hypothesised that she had some respite from him, while he was on remand: time to reflect on what she had lost, and what might be possible, and decided to make changes. She confided in her mother that she might lose the baby to Social Care. She wrote him a letter,

pleading with him to change. This letter may have been one of a number of positive steps she took to try to change things in her relationship; having seen the letter, we believe her aim was to secure her future, with her children, at the same time as being committed to the relationship.

This more positive and determined mood could have been the trigger to the tragic event when Colin reinstated his complete control. Later, he would allege that Izzy had another man in her life: there is no evidence whatever to support this.

If the most important indicator of domestic abuse is a history of domestic abuse, then the most significant gap in this case could be the lack of knowledge of the perpetrator's ten-year history of abuse of a partner. However, there was information from family members that Izzy knew about the allegations from Colin's previous partner, and her account of this to her mother indicated that he had minimised and blamed the victim, and that Izzy believed his account.

There were missed opportunities, particularly in 2016 when, during the Section 47 investigation, the social worker failed to interview Izzy; and the PPU offender manager intended, but did not, speak to Izzy about her intentions in the relationship, when Colin was released on bail.

4. OBSERVATIONS FROM FAMILY

The draft Report was shared with family members who then met with the Overview Panel. A number of their concerns detailed in this Report were discussed and clarified, in addition to which family members made the following observations:

- When Izzy's father attended the police station to seek disclosure he was not adequately advised. This visit was not recorded or passed to the right department. The WYP accepted that Izzy's father should have been given information about the correct procedure and advised that as Izzy was an adult with capacity, this information could not be disclosed. His request should have been recorded.

- The family finds it difficult to understand how Colin would have been bailed in November 2016, given the clear information about his risks.
  There was no information at the time of the bail decision to suggest that Colin was a risk to Izzy. The discussion concluded that there may be insufficient attention by practitioners to multi-dimensional risk assessment. The risks presented by this perpetrator are of violence, sex offending, and domestic abuse, and these were

managed as specific risks towards specific target groups. Taken together, in retrospect, the information available to the Review indicates that he presents a very high risk of violent and sex offending generically, not only to a specific group he has targeted in the past.

- The family felt that CSC had been hostile towards Izzy, and not supportive of her in her attempts to have contact with her youngest child.
  CSC accepts that, during the Section 47 process in 2016, the social worker did not interview Izzy, and this was a potential missed opportunity. Parents who do not have care of the children can be missed in the safeguarding process, and important learning for CSC from Izzy's case, is to ensure that absent parents are included. Practitioners should consider how parents who appear not to understand or accept the risks that a partner presents to their children, and who appear to be neglectful and unable to safeguard their children, may be acting under the coercive control of that partner.

- What can parents do?
  The family challenged the Panel members to consider how they would respond if an adult child was being abused. For the family, the statement in the Report which stood out as most meaningful to them, is in Section 22 above:
  *Reflecting the frustration of parents who can do nothing to influence a daughter living with a controlling man who has isolated her, the author points out that where isolation from family has occurred, there is very often control: '**If family are worried they should be taken seriously'.***

  (Monckton-Smith in *Interviews with Victims*)

  This discussion highlighted that there could be better information on the internet to assist parents to support their children, including helping them to understand why their child might be isolated by a controlling partner, and to enable them to respond.

As a result of these discussions, actions were agreed with family and are included in the Recommendations below.

5. RECOMMENDATIONS

5.1 Local Agency Recommendations – based on IMR findings:

WYP 1.	Communicate to staff the importance of linking RSO nominals involved in an occurrence to the occurrence to ensure notification of the report to ViSor staff and via them to PPUs/ PPOs.
WYP 2.	Review the need for whether additional training in domestic abuse, and particularly Clare's Law and Coercion and Control, by officers working in offender management and child protection roles and if required, plan to deliver training.
WYP 3.	Re-circulate local policy on the tasking of breach of bail suspects and monitor its implementation in Bradford District.
BDCFT 4.	When there is an indication of risk for a child, BDCFT staff must engage with multi-agency services to gain clarity around this risk where possible. This will be implemented through safeguarding supervision, training and duty.
BDCFT 5.	The recognition of the key learning from this DHR for BDCFT staff includes: 1) Risks to adolescents & boys to be given the same consideration & responses as those risks to younger children & girls 2) That staff professional curiosity is extended to adolescents including boys ensuring that they're given the same safeguarding responses to younger children & girls.
BRIDGE 6.	Improve referral processes to ensure a consistent standard of risk information is provided by agencies transferring care packages in to the Project, as well as agencies referring to the Project.
BRIDGE 7.	Record all contact with family members and friends of service users in the service user record (as suppressed third party contact) irrespective of the type of contact and presence of the service user. The rationale for this contact should be recorded along with the interventions provided and whether the service user was present or aware of the contact.
CSC 8.	The learning from this DHR will be used as an anonymized example in training and supervision to highlight the importance of addressing domestic violence with parents who don't have full time care of their child/children.

CSC 9.	Child and Family assessments will consider past and present domestic abuse of all adults in past and present relationships as well as the current conflict and how this may impact on the child. This will include consideration of the environment that the child lives in and visits regardless of whether the perpetrator is there to identify the impact on the quality of the child's contact with a parent.
CSC 10.	Victims of domestic abuse, or where domestic abuse is considered to be a possibility, will be given the opportunity to speak to professionals alone and in a safe space.
CCG/GP 11.	All GP practices will have a current Domestic Violence Policy which includes reference to how staff will be supported if they are experiencing domestic abuse.

5.2 Panel Recommendations

Reflecting discussions in the Overview Panel, of the themes and lessons learned in this DHR:

Recommendation 12: Disseminating the learning from this Review

The learning from this DHR is to be disseminated across all relevant staff groups in order that individual practitioners and managers can develop awareness and knowledge of coercive control and apply the lessons learned from this process.

ACTION: ALL AGENCIES AND THE BRIDGE PROJECT

Recommendation 13: Employers learning from this Review

Partnership agencies as employers can learn from this DHR to develop processes to support staff experiencing domestic abuse, and it is recommended that the agencies in the Community Safety Partnership consider examples such as: developing return to work interviews to include asking a routine enquiry about domestic abuse; and when any information indicates that a member of staff is experiencing domestic abuse, to be able to signpost staff to resources for their assistance, counselling or action to keep them safe; and to offer support for work-related issues to enable an employee to return to work and/or prevent further absence occurring.

ACTION: COMMUNITY SAFETY PARTNERSHIP

Recommendation 14: Improved DHR processes

This DHR was delayed in part in order to achieve meaningful engagement with the family but also because there were examples of IMRs that were of insufficient quality. Conversely this allowed the IMR author group to work together to identify lessons learned in a way that was helpful to this process.

The Panel therefore recommends that Bradford CSP develops its DHR process to enable the Independent Chair and Domestic Abuse Team to deliver a briefing to IMR authors before preparing IMRs, and a lessons learned workshop after completion of IMRs, with the aim of improving the cross-agency analysis.

ACTION: COMMUNITY SAFETY PARTNERSHIP (DSV TEAM)

Recommendation 15: Sharing MARAC information

Whilst recognising that MARAC is a victim-centred process, this Review identified that sharing information about the perpetrator could have resulted in a Clare's Law disclosure at an earlier point in time. Therefore, the Local Authority Domestic Abuse Team will work across West Yorkshire, and share this lesson learned nationally, with Safe Lives, to look for ways in which information can be shared.

ACTION: COMMUNITY SAFETY PARTNERSHIP (DSV TEAM)

Recommendation 16: Engaging with the judiciary

As part of its dissemination of the learning of this and other DHRs, the Overview Panel will engage with the judiciary, to seek ways in which information about offender risk can be shared and challenged, to inform bail or other hearings. This will be an opportunity to discuss with the judiciary and legal representatives, the development of domestic abuse legislation, policy and practice.

ACTION: COMMUNITY SAFETY PARTNERSHIP (DSV TEAM)

Recommendation 17: Young people growing up in abusive households:

This DHR was concerned about the 'invisibility' to services, of young people in transition from childhood to adulthood, particularly boys, living in abusive households, and the potential impact of this lack of recognition of the need for support, on future adults. This was emphasised through the voice of Izzy's eldest child.

The CSP will therefore seek assurance that the voice of older young people in households where there is domestic abuse, is not ignored. Further, that service providers consider developing specific pathways for additional age-appropriate support.

ACTION: COMMUNITY SAFETY PARTNERSHIP (DSV Team, LSCB and SAB)

Recommendation 18: Multi-dimensional risk assessment
This recommendation emerged from discussions with family:

When assessing risk, it is important to take a multi-dimensional view of risks posed by individuals. The questions in the DASH template are multi-dimensional and can be used to encourage practitioners to think laterally about risk.

This learning is to be promulgated across agencies through debriefing from this Review.

ACTION: COMMUNITY SAFETY PARTNERSHIP

Recommendation 19: Information for parents concerned about their children:
This recommendation emerged from discussions with family:

The Domestic Abuse Team will review the CBMBC website and improve information, to include Clare's Law guidance, and advice for family members who feel isolated and unable to offer a source of support to a child.

ACTION: COMMUNITY SAFETY PARTNERSHIP (DSV TEAM)

5.3 Recommendations of national relevance

Izzy's family wants to see greater public awareness of how abusers use isolation as part of a pattern of control. They want families to understand that if a daughter or other family member is withdrawing from them, or behaving out of character, they may be acting under coercion, and families in this situation need information and advice to help them find ways of maintaining contact and offering a source of support. Above all, they want families who are worried, to be taken seriously by professionals.

The Review noted that 'grooming' some family members whilst isolating Izzy from those who disapproved of him, was a feature of this case. In safeguarding, grooming is recognised as a precursor to exploitation, and members of the public have, through safeguarding, gained an understanding of the term. The Panel believes it would help the public to develop awareness of coercive control, if this terminology was reflected in national discussions of domestic abuse.

Overall, this Review highlights the need to continue to raise public awareness of coercive control, with the aim of individuals recognising when they are in a relationship that is

abusive, or where family or friends may be in that situation. Recent DHRs in this area reinforce that this remains an issue of national relevance.