STROUD COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Report into the death of Patrick

July 2020

Independent Chair and Author of Report: James Rowlands
Associate, Standing Together Against Domestic Abuse
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A cup of coffee with Patrick

I think everyone here at some point will have had the lovely experience of having a cup of coffee with Patrick, whether that be at his flat, in your own home or meeting him in a coffee shop.

So, you will know and share with me just how special those coffee shop moments were. Just sitting and chatting with Patrick was, for me, always precious. He had this amazing knack for talking to anyone with ease and saying the right thing at the right time, making you feel better about any worry you had or giving a subtle compliment that made you feel special and valued. BUT most of all Patrick would listen and remember, a quality that is rare in many but so valuable and important to any individual. This has shone through in the lovely comments and memories people have shared about him and the value of his friendship and kindness.

But coffee with Patrick was not always serious and more than often involved much laughter and I mean full on belly laughter. Patrick would tell tales of the crazy things he had done or things that had happened to him in a way only Patrick could tell a story. Most recently I have been in Costa Coffee with him teaching my son how to blow bubbles after buying him bubble gum for the first time. Patrick sat puffing out his cheeks, demonstrating how to do this. Realising this was causing quite the audience and getting strange look, instead of being deterred Patrick laughed with delight and later laughed with me about what people must have thought about him. But do you know what Patrick, it was worth it, because [my son] can now blow bubbles and you taught him that!

Keeping with the laughter theme, one of Patrick's favourite topics was the crankiness and quirks of his family! Oh yes, he really liked to tease us but was also more than happy to laugh at himself. When we were younger there were times when we were listening to music and myself, he or [our brother] would get up and start to dance and Patrick would start chanting "*go Britney go Britney*" and we would try to outdo ourselves with crazy dancing. That has followed us into our adult years. It is safe to say Patrick you won hands down, you were the Britney champion!

Patrick has also shared the tale of a time when he was helping his aunty contact a company on the phone. During the phone call Patrick needed to ask [his aunty] a question and instead of saying to the person on the phone, could you just wait a minute he said, "*bear with*" (for those that have watched Miranda, Patrick was a fan). He realised straight away what he had said: his face was a picture, the room erupted with laughter, and he never lived down the moment.

Sharing memories of the time he took my gran to Spain, drinking Sangria with her and laughing the evening away. I need to point out that my gran would have been wearing a dress chosen and purchased by Patrick. He had an amazing eye and the ability to buy us all clothes, especially my gran. He made her look a million dollars and told her she looked 'class'.

Patrick has also laughed to the point of tears about the time he and my brothers thought it a good idea to push my soon to be husband in a trolley along the seafront in Spain. This incident resulted in [my husband] getting stuck, the police arriving and a mad panic involving Patrick trying to get [my husband] out of the trolley. Patrick felt this gave [my husband] a good introduction to the family.

Amongst the laughter, there were more serious aspects to Patrick. He cared deeply about healthy living, looking after the environment, and showing kindness and care to all. Patrick never judged or made light of anybody's circumstances or struggles and if he could help in any way

he would. This included noticing a lady in Stroud that would regularly sit on a bench on her own, asking her if she wanted a coffee and spending time just talking to her. Giving money to the homeless or helping others during times when they were down or struggling with their mental health. Patrick would describe how you never know a person's life or journey and everyone at some point in their life needs help and kindness.

Patrick has always had this quality and ability to help others. One of my childhood memories of him is a family holiday when my mum had taken the four of us to the seafront to have chips, using the only money she had left in her purse. Patrick did not start eating his and it was soon apparent why when Patrick got up from the bench where we were sitting on and gave his chips to a homeless man. My mum had no money to buy him anymore. He said it did not matter and that he could not sit and eat knowing someone was hungry.

There is so much to learn from my brother and his ability to recognise those that are struggling and to do what he could to try and make someone else's life easier. Even when Patrick did not have much, he would find a way to give. This brings me back to even if this meant giving someone his time and buying them a cup of coffee.

I could go on forever about the many qualities of Patrick, but I feel it important to also share the things Patrick enjoyed doing. Patrick had a dog who he absolutely adored. I am sure there were days when he wished he had never bought her a ball and encouraged her to chase a ball. As many of you will know, that is all she ever wants to do! But Patrick took solace in [his dog] and she has been an amazing companion for him, and a companion Patrick has loved and cherished. We will continue to look after and love her and every now and then throw her a ball.

Patrick loved to swim, cycle and run and annoyingly he was really good at all three. He would often describe how he loved the Stroud area and its beauty and how walking or running was a gift. He was also able to challenge and support others, I know he has helped run with many beginner runners, never running ahead but sticking with them giving them the confidence to go on. He has also completed runs with his brothers and friends. This included running the Stroud half marathon whereby again he never ran on, sticking with his brother to cross the line to ensure they finished together. It was always a mission of Patrick and [his brother] to complete a park run in 21 minutes which has yet to be completed but don't you worry Patrick, [your brother] has said he will not give up until he has done this, and it will be completed in honour of you.

Patrick loved a challenge and if he decided to do something or learn something new, he would read and research until he was able to complete or do something. Spain, and talking Spanish, was one of his passions. Patrick went to college to learn Spanish and would love to share his Spanish knowledge. One of his friends recently told us of how he would use Spanish words to make them laugh or feel good such as telling them they were 'fabulous' in Spanish.

In all that I have so far described about Patrick for him, it has never been about winning or being the best but when it came to looking good… there was no holding back. Patrick liked to look good and just to remind you on the order of service there is a picture of Patrick in his suit. I think we can all agree, wow could Patrick wear a suit and yes, he looked good. This particular picture was taken at my wedding and there are many photographs of Patrick and others laughing and the laughter was about Patrick inevitably telling us how hot he looked that day.

There was also no holding back in relation to Patrick and his friendships and this was a part of Patrick that was his own and one I do not know much about and one where I cannot do justice to his friends' memories other than to say he always spoke so highly of [them]. I would like to say thanks to Patrick's friends for all of the good times they shared with him but also for the times they have shown him love when he has needed it. As a family, we are overwhelmed but not shocked by the many lovely things you have described about Patrick of which one is very consistent: he was considered a valued, loved and very cherished friend.

Then there was Patrick and my mum and as you will know Patrick's relationship with my mum was like no other, there was nothing he would not do for my mum, or she would not do for him. During lockdown, my mum needed to shield, and Patrick would visit her daily to make sure she had food, a mask, saw a friendly face and spent time to check she was ok. Now not only is this again an example of Patrick's ability to care for others and do the little things that really matter but a reflection and mirroring of the love and care my mum has shown Patrick. I want to share how during this same time my Mum had her birthday and how do you celebrate a birthday in lockdown? Well, Patrick had it sussed. He took my mum to [a local park], socially distanced. Ensuring the safety of his mum by wearing a mask, anti-bacing his hands, they went for walk, [with Patrick] pointing out flowers and views for my mum to take photographs, something she loves to do and finally sitting down to watch the sunset together and just chat and enjoy the view. They both took pictures of each other watching this sunset and when you look at these pictures you can see the ease and happiness in Patrick's face. The simple ease and happiness he found in his relationship with mum.

Now, this is the point where you would be laughing at me and calling me your cranky sister, later on laughing with others saying you will not believe what my sister did! But I am going to do this Patrick and here it is, yes, I am going to liken you to a cup of coffee as, after all, this is the theme to this reading…….

Just like a cup of coffee you have great warmth and an amazing ability to give people energy and motivation for the day. Although you would never say it about yourself. you are strong, the strongest person I know and give others the strength.

Coffee makes you laugh, gives you happiness and can at times make you hyper and full of laughter, it makes you smile and if you catch a cup of coffee on a fancy day, looks good and always smells good. Coffee can calm you when you are worried and nervous and gives you that lovely fuzzy feeling. The thing about coffee is that even on a bad day, or when it is not at its best, it is still good!

So finally, this is my promise to you Patrick and one that I invite others to share. Every now and then I will sit with my cup of coffee, smile, laugh and celebrate the memories I have of you. I want you to know how incredibly proud I am to say you are my brother and I hope in all that I have said it is obvious, in the end, it is not about possessions or the little things we did or didn't do, it is the ability to look back and know you had the greatest gift anyone can ever have, look back and know you were loved and Patrick wow were you loved by so many. My amazing and wonderful brother Patrick x

A Pen Portrait prepared by Patrick's family

Executive Summary

1. Preface

1.1 The Review Process

1.1.1 This Domestic Homicide Review (hereafter 'the review') examines agency responses and support given to Patrick[1] prior to the point of his death by suicide in a town in the Stroud District of Gloucestershire in July 2020. Given the circumstances of Patrick's death by suicide, a DHR has been commissioned but it is described as a 'Domestic Abuse-Related Death Review'.

1.1.2 Late on evening one a day in July, Patrick's mother contacted the Gloucestershire Constabulary, saying that Patrick was at her home and was experiencing a mental health crisis. Sadly, the following day, Patrick died from self-inflicted injuries.

1.1.3 Patrick had previously been in a relationship with Jakub.[2] Their relationship began around August 2017, but they had separated by the end of 2018 or early 2019, although there were periods of reconciliation. Since their separation, there had been numerous reports of domestic violence and abuse.

1.1.4 The following pseudonyms have been used in this review to protect the identities of the victim, those of their family members, other parties, and Jakub:

Name	Relationship to Patrick
Patrick	Victim
Jakub	Former partner
Sarah	Mother
Charlotte	Sister
Matthew	Brother
Paul	Uncle

1.1.5 Sarah chose the pseudonym used for her son in this report. At Sarah's request, the Chair chose the remainder of the pseudonyms.

1.1.6 Given the circumstances of this case, the Chair and Review Panel have recommended that only the Executive Summary is published.

1.1.7 The Review Panel has considered what Jakub's status should be in the review given he has never been found guilty of any offences related to domestic abuse and Patrick died by

[1] Not his real name.

[2] Not his real name.

suicide. Considering this, the Review Panel has operated on the assumption that Jakub was more likely than not to have been responsible for domestic abuse towards Patrick. He will therefore be referred to as the (alleged) perpetrator of domestic abuse.

1.1.8 This review was commissioned by the Stroud District Council Community Safety Partnership (CSP) in collaboration with Safer Gloucestershire. The decision to undertake a DHR was made via the Suicide Prevention Group, which identified that Patrick's death may have met the statutory guidance. Subsequently, the Stroud District Council CSP confirmed this decision in September 2020 and the Home Office was notified of the decision in writing in the same month.

1.1.9 All agencies that potentially had contact with (victim/perpetrator) prior to the point of death were contacted, asked to confirm whether they had involvement with them, and instructed to secure their records.

1.2 Contributors to the Review

1.2.1 This Review has followed the 2016 statutory guidance for Domestic Homicide Reviews which was issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. In undertaking this review, the Review Panel has struggled with the limited guidance available in relation to how to conduct a review into a death by suicide, particularly with reference to what this means for information sharing about, or engaging with, the (alleged) perpetrator of domestic abuse.

1.2.2 A total of 22 agencies were contacted to check for involvement with the parties concerned with this DHR. Of these, 6 had only limited contact and submitted a Summary of Engagement (SoE) / Short Report. However, 7 had more extensive contact and were asked to submit Individual Management Reviews (IMRs). A narrative chronology was also prepared.

1.2.3 The following agencies were contacted, but recorded no involvement with victim or (alleged) perpetrator:

- Change Grow Live (drug and alcohol service);
- Community Rehabilitation Company;
- Gloucestershire Children's Social Care Services;
- GayGlos (which provides support services for Gloucestershire's Lesbian, Gay, Bisexual, Trans, Queer+ (LGBTQ+) communities);[3]
- Gloucester City Council;
- Gloucestershire Education Service;
- North and West Gloucestershire Citizens Advice;
- Probation Service;
- Restorative Gloucestershire.

[3] For more information, go to: https://www.gayglos.org.

1.2.4 The following agencies and their contributions to this review are:

Agency	Contribution
Gloucestershire Constabulary	IMR and Chronology
Gloucestershire Health and Care NHS Foundation Trust (GHC)[4]	IMR and Chronology
Gloucestershire Domestic Abuse Support Service (GDASS)[5]	IMR and Chronology
Gloucestershire Rape and Sexual Abuse Centre (GRASAC)[6]	IMR and Chronology
Independence Trust[7]	IMR and Chronology
Independent Stalking Advocacy Caseworker (ISAC) service (provided by Splitz)[8]	IMR and Chronology
The Medical Centre (GP for Patrick)	IMR and Chronology
Gloucestershire County Council Adult Social Care	Short Report and Chronology
Gloucestershire Royal Hospital (run by the Gloucestershire Hospitals NHS Foundation Trust[9])	Short Report and Chronology
NHS 111	Summary of Engagement
Stroud District Council (Housing)	Short Report and Chronology
South Western Ambulance Service Foundation Trust (SWASFT)	Short Report and Chronology
Victim Support	Short Report and Chronology

1.2.5 Additionally, several national helplines offering specialist domestic abuse support were contacted, including the National LGBT+ Domestic Abuse Helpline (provided by Galop)[10], the Men's Advice Line (provided by Respect for male victims),[11] and the National Stalking

[4] Provides physical health, mental health, and learning disability services in Gloucestershire. For more information, go to: https://www.ghc.nhs.uk.

[5] For more information, go to: https://www.gdass.org.uk.

[6] For more information go to https://www.glosrasac.org.

[7] Provides a range of services supporting emotional and physical wellbeing, including a Community Advice, Links & Mental Health Support Service. For more information, go to: https://www.independencetrust.co.uk.

[8] For more information, go to: https://www.splitz.org.

[9] Provides acute secondary healthcare to the population of Gloucestershire and runs the Royal Hospital, Cheltenham General Hospital and Stroud Maternity Unit. For more information, go to: https://www.gloshospitals.nhs.uk.

[10] For more information, go to: https://galop.org.uk/get-help/helplines/.

[11] For more information, go to: https://mensadviceline.org.uk.

Helpline (provided by the Suzy Lamplugh Trust).[12] The Mankind Initiative, which provides a helpline for men, was also contacted.[13] All these agencies reported having no contact with either Patrick or Jakub.

1.2.6 Finally, a report was provided by the County Domestic Abuse and Sexual Violence (DASV) Strategic Coordinator detailing the local response to LGBTQ+ and/or male victim/survivor, as well as the Stalking Clinic and links to the MARAC.

1.2.7 *Independence and Quality of IMRs*: he IMR and Short Reports were written by authors independent of case management or delivery of the service concerned. The IMR from the Medical Centre (the General Practice (GP) of Patrick[14]) was written by the GP Partner (who is also the GP Safeguarding Lead) at the centre but quality assured by the Clinical Commissioning Group (CCG) Named GP for Safeguarding Children and Adults.[15]

1.3 The Review Panel Members

1.3.1 The Review Panel members were:

Name	Job Title	Agency
Amanda Robinson	Safeguarding Business Manager	SWASFT
Annette Blackstock	Safeguarding Lead	CCG
Clare Woodhouse	Deputy Manager	GDASS
Cynthia Kerr	Senior Operations Manager	Independence Trust
Emily Denne[16]	Director of Services	Splitz
Dr Emma Masters	GP Partner and Safeguarding Lead	Medical Centre
Gordon Benson	Quality Lead	Gloucestershire Suicide Prevention Steering Group (GSPPF)
Heather Downer	Service Manager	GDASS
Jeanette Welsh	Lead for Safeguarding Adults	Gloucestershire Hospitals NHS Foundation Trust
Jo Bridgeman	Safeguarding Specialist Nurse	CCG
Jolene Fear	Manager	Nelson Trust
Jon Thompson	Detective Inspector	Gloucestershire Constabulary

[12] For more information, go to: http://www.stalkinghelpline.org.

[13] For more information, go to: https://www.mankind.org.uk/help-for-victims/.

[14] The name of the Medical Centre has been anonymised to protect Patrick's identity.

[15] Since July 2022, the CCG has been replaced by the NHS Gloucestershire Integrated Care Board. See: https://www.nhsglos.nhs.uk/about-us/who-we-are-and-what-we-do/our-visions-and-values/.

[16] Replaced Rachel Wetton in summer 2022.

Julian White	Housing Advice Manager	Stroud District Council
Liz Emmerson[17]	Head of Safeguarding & Named Nurse for Safeguarding Children and Young People	GHC
Maggie Stewart	Director	GRASAC
Moira Wood	Principal Social Worker (Adults)	Gloucestershire County Council
Nikki Humphries	Principal Community Services Officer	Stroud District Council
Paul Cruise	Chair of the CSP	Stroud District Council
Pippa Stroud	Head of Strategic Housing Services	Stroud District Council
Robin Agascar MBE	Trustee	GayGlos
Sophie Jarrett	County DASV Strategic Coordinator	Gloucestershire Constabulary / Gloucestershire County Council
Wayne Stevens	Area Manager	Victim Support

1.3.2 *Independence and expertise*: Review Panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case.

1.3.3 The Review Panel met a total of four times, with the first meeting of the Review Panel on the 13th January 2021. There were subsequent meetings on the 19th May 2021, the 8th November 2021 (a meeting on the 17th September 2021 had to be cancelled), and the 24th March 2022. Thereafter, in May 2022 a final version of the report was completed and then circulated electronically for sign-off and agreement in August 2022.

1.3.4 Patrick's family also contributed to the review, including his mother (Sarah) and his sister (Charlotte). Sarah and Charlotte provided a Pen Portrait (along with Patrick's brother Matthew), and both identified a range of issues that they wanted the review to consider. Later, Sarah was interviewed and saw a draft of the Overview Report. Sarah provided feedback via the AAFDA advocate, thanking the independent chair and the Review Panel, and saying that she was satisfied with the Overview Report and did not want any changes. Charlotte shared comments at the start of the review. The family were offered the chance to meet with the Review Panel but chose not to do so.

1.3.5 The Chair wishes to thank everyone who contributed their time, patience, and cooperation to this review.

[17] Replaced Alison Feher at the end of 2021.

1.4 Chair of the DHR and Author of the Overview Report

1.4.1 The Chair and author of this DHR is James Rowlands, an Associate of Standing Together. James is a qualified Social Worker and Independent Domestic Violence Advisor (IDVA) and has worked in a variety of frontline and strategic roles in the domestic abuse sector since 2004. James has received Domestic Homicide Review Chair's training from Standing Together and has chaired and authored 15 previous DHRs.

1.4.2 *Independence:* James has no connection with Gloucestershire or any of the agencies involved in this case. During the review, there was discussion of Respect, a UK charity that works with perpetrators, male victims and young people using violence and abuse.[18] James is a Trustee of Respect and declared this during the review. The Review Panel felt this was not a conflict of interest but agreed it should be recorded.

1.5 Terms of Reference for the Review

1.5.1 At the first meeting, the Review Panel shared information about agency contact with the individuals involved, and as a result, established that the time to be reviewed would be from August 2017 to the date of Patrick's death in July 2020. August 2017 was chosen as a start date because this is when Patrick and Jakub's relationship was believed to have begun. Agencies were asked to summarise any relevant contact they had had with either Patrick or Jakub outside of these dates.

1.5.2 *Key Lines of Inquiry: Key Lines of Inquiry:* The Review Panel considered both the generic issues as set out in the statutory guidance and identified the following as key lines of enquiry:

- The communication, procedures and discussions, which took place within and between agencies;
- The co-operation between different agencies involved with Patrick or Jakub [and wider family];
- The opportunity for agencies to identify and assess domestic abuse and/or stalking risk;
- Agency responses to any identification of domestic abuse and/or stalking issues;
- Organisations' access to specialist domestic abuse and/or stalking agencies and associated pathways (including the Multi Agency Risk Assessment Conference (MARAC) and the Stalking Clinic[19]);
- The policies, procedures and training available to the agencies involved on domestic abuse issues;
- Any evidence of help seeking, as well as considering what might have helped or hindered access to help and support; and
- Specific consideration to the following issues:

[18] For more information, go to: https://www.respect.uk.net.

[19] The Stalking Clinic brings together a range of agencies to identify and support high risk victims of stalking.

- The extent to which services are able to identify and respond to the experiences of men in same sex relationships;
- The impact of and service response to historical trauma;
- The impact of and response to mental health, including Patrick's access to services and support for family members;
- The impact of the Covid-19 pandemic.

1.5.3 To address the issues in this case (including in relation to equality and diversity) the following agencies were invited to be part of the review due to their expertise:

- GayGlos, and
- Independence Trust. (The Independence Trust also had contact with Patrick).

1.5.4 Additionally, specialist domestic abuse, sexual violence and stalking services were involved. In addition to their expertise, each service had contact with Patrick: GDASS, GRASAC, and the ISAC service provided by Splitz.

2. Summary of Chronology

Contact with Patrick

2.1.1 Patrick had contact with a range of local services, including criminal justice agencies (Gloucestershire Constabulary), a range of health providers (including Gloucestershire Hospitals NHS Foundation Trust, the Medical Centre, SWASFT, mental health providers (GHC and the Independence Trust), as well as specialist domestic/sexual abuse and stalking services (ISAC provided by Splitz and GDASS's IDVA service, as well as GRASAC), and local authority services (including Gloucestershire Council Adult Social Care and Stroud District Council Housing).

2.1.2 In terms of criminal justice agencies, Gloucestershire Constabulary had contact with Patrick and/or Jakub on numerous occasions. These related to reports of domestic abuse. However, while the individual response could be to a good standard (for example, prompt dispatch of officers, or the completion of risk assessments), there was a limited understanding of domestic abuse, and these incidents were treated in isolation. Police officers did not recognise the broader pattern of abuse that Patrick was disclosing, including coercive control, or a course of conduct, despite repeated incidents and clear evidence that Jakub's behaviour, as reported, was fixated, obsessive, unwanted and repeated. Another notable feature of police officers' contact with Patrick was that, although mental health concerns were recognised, this was rarely followed through. For example, mental health was not identified on risk assessments, nor was Patrick ever identified as an 'adult at risk'. (On one occasion, at the MASH, Patrick's mental health was identified as a concern. However, although a referral was recorded as being made to Gloucestershire County Council Adult Social Care, this was not received. It may be that this had been diverted to GHC, as Patrick's case was known to them at the time). Finally, while there is no evidence that Patrick was subject to any direct or indirect discrimination as a gay man, the Review Panel felt that this case may have been affected by the level of understanding of both the specific issues facing LGBTQ+ victim/survivors, as well as the management of issues like dual or counter-allegations.

2.1.3 This limited recognition of what was being reported affected responses to incidents, and also meant that subsequent reviews of the case – including at Daily Meetings where incidents are reviewed by Gloucestershire Constabulary and other agencies including GDASS – were also ill-informed. This also meant other measures, including a referral to the MARAC, were not made.

2.1.4 Several single agency and multi-agency recommendations have been made for Gloucestershire Constabulary to address learning in this case, including in relation to risk assessment, as well as staff training.

2.1.5 In terms of health providers, Gloucestershire Hospitals NHS Foundation Trust and the Medical Centre had relatively limited contact with Patrick. Critically, for both these health providers, they were aware of GHC's involvement with Patrick and, as a result, GHC would have been the lead provider under principles of shared care (i.e., where the most appropriate health provider takes responsibility for continuing care or treatment). For example, when Gloucestershire Hospitals NHS Foundation Trust treated Patrick in incidents involving mental health issues, his ongoing care would have been transferred GHC. As a result, no learning was identified specifically although the trust did recognise that, generally, it may be that there could be unconscious bias against recognising male victims of domestic abuse by other men.

2.1.6 The Medical Centre also had some contact with Patrick and was kept aware of his ongoing care from GHC. However, the centre has identified that there were inconsistencies in his history that could have been explored. Additionally, Patrick had frequent changes of address. The Medical Centre was aware of one of these but would not have automatically been notified of others if other health providers updated NHS records. A single agency recommendation has been made to address this.

2.1.7 SWASFT also had contact with Patrick, although on each occasion this involved conveying him to hospital. In these contacts, there were no disclosures of, or concerns identified about, domestic abuse

2.1.8 As a mental health provider, GHC had contact with Patrick throughout the period covered by this review. GHC's contact with Patrick triggered a Serious Incident (SI) investigation, in addition to its contribution to this review. During his contact with GHC, Patrick had contact with different teams and, overall, much of this treatment seems to have been to a good standard. There was also evidence of good communication with Patrick and his family. However, there were numerous issues with documentation, including Crisis and Contingency and Care Plans not always being up to date. There was often limited, if any, contact with other agencies to clarify what they were doing. For example, there was limited information about Patrick's contact with GDASS's IDVA service or the ISAC and it is unclear what, if any, consideration was given to how to explore this with Patrick, or if – given the domestic abuse concerns – information could have been shared without consent.

2.1.9 More broadly, staff at GHC were aware of a range of violent and abusive behaviours that Patrick reported having experienced at the hands of Jakub, but these do not appear to have been risk assessed. Nor was there any consideration of a MARAC referral.

2.1.10 A final issue is that while GHC had contact with Patrick's family and undertook a carer's assessment with Patrick's mother (Sarah) early in its contact, there was little evidence of any sustained consideration of their needs.

2.1.11 Several single agency and multi-agency recommendations have been made for GHC to address learning in this case, including practice and policy around domestic abuse.

2.1.12 The Independence Trust provided support to Patrick, focused on his finances and housing, and he also used their drop in. Learning identified for the Independent Trust includes its engagement with other services, in particular GHC, but also its capacity to identify, assess and respond to domestic abuse concerns. As a result, several single agency recommendations have been made for the Independence Trust to address learning in response.

2.1.13 There has been considerable learning for GDASS's IDVA service and the ISAC service provided by Splitz, given both services had period of sustained contact with Patrick. While there was evidence of good practice, including effective relationships being built with Patrick, this review has identified concerns about both the shared understanding of risk between these agencies, as well as the robustness of joint working arrangements (particularly in terms of coordinating risk assessments and work, and their respective links to into multi-agency arrangements (the Stalking Clinic and MARAC respectively). Additionally, this case has also underlined the importance of GDASS having the capacity to identify and respond to counter-allegations. Several single agency and multi-agency recommendations have been made to address this learning.

2.1.14 GRASAC had a period of contact with Patrick when he accessed the service for emotional support. The key issues identified in this contact include a lack of management oversight of new members of staff, including around practice such as response to mental health disclosures or concerns around domestic abuse. Additionally, GRASAC has identified that the service does not currently have a stand-alone domestic abuse policy. Single agency recommendations have been made to address this.

2.1.15 In terms of other agencies, Gloucestershire County Council Adult Social Care had very limited contact with Patrick and his family, and this appears to have been positive, relating to his needs at a point prior to the period considered by this review. In contrast, Stroud District Council was approached relating to Patrick's needs, but this did not trigger any consideration. This has led to a recognition of the need for action within the department, including to better record contact and specifically consider safeguarding including around domestic abuse. Several single agency recommendations have been made to address this learning.

2.1.16 There was a range of cross-cutting learning identified by the Review Panel, and multi agency recommendations have been made in response. In summary, this learning includes:

- A tendency by agencies to base their knowledge of the involvement and actions by other agencies on reports of their involvement by Patrick himself.
- Examples of agencies not being aware of concerns (for example, the Medical Centre were never informed of any domestic abuse concerns, nor were the Independence Trust), and a lack of exploration of others (for example, while learning has been identified for Stroud District Council Housing it is notable that no other agency appears to have approached them directly about Patrick's housing concerns).
- The treatment of disclosures by Patrick in isolation, meaning domestic abuse was not addressed on a multi-agency basis. Multiple agencies could have triggered a MARAC referral but did not do so, in part because of practice at the time relating to how these cases were considered at the Gloucestershire Constabulary Daily Meeting, rather than automatically being re-referred. Moreover, when a referral to the Stalking Clinic was not taken forward, there was no consideration of whether Patrick's case should have been heard at the MARAC.
- The level of awareness, understanding of the needs of, and response to, LGBTQ+ and male victim/survivors. Several agencies were able to provide examples of good practice in this area. For example, most agencies were aware that Patrick was a gay man, although they were not necessarily able to show how this was specifically considered. In some cases, there was also specific evidence of the steps being taken to engage with and respond to the needs of LGBTQ+ victim/survivors, for example by agencies like GDASS and the local partnership with respect of victim/survivor engagement work that has included LGBTQ+ and male victim/survivors. Nonetheless, the Review Panel identified that there was an opportunity to support best practice with respect of these communities including, for example, the explicit consideration or assessment, of the unique risk factors that gay men (and LGBTQ+ people more generally) may experience, as well as targeted communications campaigns.

Contact with Jakub

2.1.17 As Jakub was not approached as part of the review, there has been limited consideration of agency contact with him specifically, outside of the criminal justice response. One agency that did have contact with Jakub in his own right was Victim Support, which responded to reports of allegations of harassment and other disclosures by providing emotional support and appropriate onward referral.

3. Conclusions and Lessons to be Learnt

3.1 Conclusions

3.1.1 Patrick was a much-loved son, brother, and friend. His warmth, humour and compassion are evident from the accounts of those who knew him. Patrick's death was a tragedy, and the Review Panel extends its sympathy to his family and those who knew him.

3.1.2 The Review Panel has sought to try and understand Patrick's lived experiences and consider the issues he faced to try and understand the circumstances of his death by suicide and identify relevant learning. It is not possible to say how Patrick's relationship and experience of abuse affected his death, but nonetheless it is likely that these provided an important background to his decision to die by suicide. In particular, there is clear evidence of Patrick reporting how Jakub's behaviour made him feel, including a sense that he was trapped.

3.1.3 Complicating this review is the fact that Jakub, the (alleged) perpetrator, has never been found guilty of any offences related to domestic abuse and Patrick died by suicide. With respect to this, the Review Panel has operated on the assumption that Jakub was more likely than not to have been responsible for domestic abuse towards Patrick. He has therefore been referred to as the (alleged) perpetrator of domestic abuse.

3.1.4 Nonetheless, there has been significant learning identified during this review in relation to how agencies identified and managed Patrick's potential risk and needs, and how they worked together. While it is not possible to say if an improved response could have averted Patrick's death, it is vital that the appropriate agencies and partnerships consider this learning to develop responses. This is summarised below.

3.2 Key Themes and Learning Identified

3.2.1 The learning in this case has both been particular to individual agencies but also cut across agencies and the wider local partnership.

3.2.2 The specific learning for individual agencies has been described in detail and has included issues relating to policy and procedure, as well as the response of staff in specific circumstances, both internally and concerning multi-agency working.

3.2.3 The broad issues identified cut across agencies and relate to several areas.

3.2.4 First, the understanding and response to *domestic abuse*. While Patrick was positive about some of his support (for example, from GDASS), there has nonetheless been learning in this case. A common issue for those agencies that had contact with Patrick – and to whom he either made disclosures or where they were aware of incidents – was that they did not always consider this in the round. As a result, even if risk assessments were undertaken, these did not consider issues like disclosures of abuse over time, escalation, or evidence of a course of conduct in Jakub's reported behaviour. This meant that agencies were not able to identify Patrick as being at high risk of domestic abuse, including with respect to evidence of coercive control and stalking. Furthermore, inadequate assessments of risk affected later decision making, meaning agencies were often working with an incomplete picture of Patrick's risks and needs. Most notably, multiple agencies could also have triggered a referral to the MARAC but did not do so.

3.2.5 In making this observation about domestic abuse, it is important to highlight how in this case, concerns about Patrick's mental health appear to have overshadowed his experience of

domestic abuse or these were seen separately. This 'overshadowing' is relevant with respect to the involvement of GHC, which neither adequately considered nor responded to domestic abuse.

3.2.6 Additionally, although there was no evidence of a direct impact of Covid-19, this did affect agency responses at times and would also have provided a context to Patrick's experiences including, perhaps, a sense of isolation.

3.2.7 Second, the effectiveness of *multi-agency working*. There was often a reliance by individual agencies on Patrick to be the source of information about what other agencies were involved and doing. While Patrick had the capacity and option to tell agencies what he felt was appropriate, nonetheless it would have been appropriate for agencies to discuss this with Patrick and explore whether specific inter-agency dialogue would have been appropriate. This could have been relevant to both Patrick's reports about domestic abuse, but also his ongoing care in relation to his mental health, as well as his housing needs.

3.2.8 Even where there was multi-agency working, this was not always consistent. There has been learning in this review about how domestic abuse and stalking services develop a shared understanding of risk assessment and coordinate their interventions both individually and with respect of multi-agency work like the MARAC and Stalking Clinic.

3.2.9 Third, the response to *LGBTQ+ victim/survivors*. While there is evidence of some good work locally, including services and local partners taking specific steps to engage with LGBTQ+ victim/survivors, the review has identified the importance of ensuring this is consistent and embedded. That includes both generic measures (for example, monitoring of sexual orientation) but also steps specifically related to domestic abuse (for example, community engagement, as well as ensuring professionals have the knowledge and skills to respond appropriately, including to the unique needs LGBTQ+ victim/survivors may have).

3.2.10 Fourth, *the consideration of carers*. The review has identified limited evidence of explicit consideration of the needs of Patrick's family, especially his mother (Sarah). This is despite GHC recognising that his family were an important source of support.

3.2.11 Despite this range of learning, good practice has also been identified. In response to specific issues, individual agencies provided timely and appropriate support to Patrick. For example, there were sustained efforts by a range of providers to support Patrick with respect to his mental health, while specialist services (including GDASS, GRASAC, the ISAC) offered a range of interventions. It is also clear that, although there has been learning about the response to LGBTQ+ victim/survivors, as a gay man, Patrick was able and confident to access local provision.

3.2.12 Following the conclusion of a review, and in response to the learning and recommendations, there is an opportunity for agencies to consider the local response to domestic abuse. This is relevant to agencies both individually and collectively. The Review Panel hopes that this work will be underpinned by a recognition that the response to domestic abuse is a shared responsibility as it is everybody's business to make the future safer for others.

4. Recommendations

4.1 Single Agency Recommendations (Identified by Individual Agencies)

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

4.1.2 These recommendations should be acted on through the development of an action plan, with each agency reporting on progress to Safer Gloucestershire.

GHC

4.1.3 **Single Agency Recommendation 1:** To deliver Domestic Abuse training specific for GHC's Recovery Teams and extend this Trust-wide to all staff groups/teams within GHC NHS Trust.

4.1.4 **Single Agency Recommendation 2:** Review GHC Domestic Abuse and Sexual Violence Policy and Procedures.

4.1.5 **Single Agency Recommendation 3:** Promote the use of the DASH RIC within GHC.

4.1.6 **Single Agency Recommendation 4:** Promote multi-agency 'sharing information' guidance, where there are concerns about domestic abuse.

4.1.7 **Single Agency Recommendation 5:** Record household information and relationship information on RiO [the recording system used by GHC].

Gloucestershire Police

4.1.8 **Single Agency Recommendation 1:** Officers should be reminded that the Crisis team should be briefed when an individual comes into contact with the police following a mental health crisis, even if the officers are not considering their powers under S136.

4.1.9 **Single Agency Recommendation 2:** Officers should be reminded that the VIST form can capture more than one concern.

4.1.10 **Single Agency Recommendation 3:** Where a decision is made by the MASH not to record individuals as perpetrators and victims of domestic abuse, this decision should be reviewed when further information comes to light indicating that domestic abuse is actually an issue in the relationship.

4.1.11 **Single Agency Recommendation 4:** Officers should be reminded to treat domestic abuse as a pattern of behaviour, rather than as a series of isolated incidents. They should be reminded of the importance of recording partner agency referrals on to the VIST and incident reports and to consider all domestic assaults as serious offences.

4.1.12 **Single Agency Recommendation 5:** The Constabulary should consider whether there are any local or national support agencies that can offer a specific service to gay people suffering domestic abuse.

4.1.13 **Single Agency Recommendation 6:** The Constabulary to ensure police officers understand the new offence of Non-Fatal Strangulation, including how it presents, what questions to ask and what the new legislation enables.

GRASAC

4.1.14 **Single Agency Recommendation 1:** All staff to receive a regular review of casework – this will be completed with SMART objectives including measurable objectives.

4.1.15 **Single Agency Recommendation 2:** GRASAC to develop a stand-alone domestic abuse policy is in place to support all casework staff and client work. This should include ensuring that all staff are able to ask and act in response to domestic abuse, including undertaking a DASH RIC and providing appropriate safety planning advice or onward referral.

Independence Trust

4.1.16 **Single Agency Recommendation 1:** Promote regular communication with other agencies involved.

4.1.17 **Single Agency Recommendation 2:** More assertively seeking risk assessments from referring agencies. If agencies do not comply, the Independence Trust need to record this and report to the appropriate source.

4.1.18 **Single Agency Recommendation 3:** A review of training to ensure that Safeguarding Training is completed every three years.

4.1.19 **Single Agency Recommendation 4:** Session with all staff to go through the outcome of this review.

4.1.20 **Single Agency Recommendation 5:** All staff to update their Domestic Abuse training over the next year (depending on when previously completed).

4.1.21 **Single Agency Recommendation 6:** Implement regular Safeguarding briefings for the teams (general and specific safeguarding issues).

4.1.22 **Single Agency Recommendation 7:** The Independence Trust to develop a Domestic Abuse policy. This should include ensuring that all staff are able to ask and act in response to domestic abuse, including undertaking a DASH RIC and providing appropriate safety planning advice or onward referral.

ISAC (provided by Splitz)

4.1.23 **Single Agency Recommendation 1**: The ISAC to be provided with clear guidance as to what tasks are allocated to which agency and the service to introduce a checklist of actions that it must undertake, and actions other involved agencies will undertake, including timeframes and rationale for actions not undertaken.

Medical Centre

4.1.24 **Single Agency Recommendation 1:** Consider frequent address changes as a marker of vulnerability. Recommendation for this to be addressed as part of the Medical Centre's Significant Event review.

Stroud District Council – Housing

4.1.25 **Single Agency Recommendation 1:** All Neighbourhood Management Officers to be urgently briefed regarding the importance and implications of poor or non-existent diary notes.

4.1.26 **Single Agency Recommendation 2:** Any cases of this nature are to be reported to the Housing Manager so that they can monitor activity as appropriate and include multi-agency

approaches to cases where there are risks, safeguarding and/or concerns regarding threats to life.

4.1.27 **Single Agency Recommendation 3:** A wider release to all staff in Tenant Services and Contract Services regarding the importance of documenting concerns when dealing directly with residents.

4.1.28 **Single Agency Recommendation 4:** A Multi-Agency Debrief meetings to be convened following cases, focusing on lessons learned and changes that are required (policy, cultural, relationships between partner agencies)

4.2 Multi-Agency Recommendations (Developed by the Review Panel)

4.2.1 The Review Panel has made the following recommendations during this review in response to learning identified.

4.2.2 Safer Gloucestershire is responsible for overseeing the development and monitoring of an action plan.

4.2.3 **Multi-Agency Recommendation 1:** The Home Office should revise the statutory guidance to address the specific challenges of reviewing a death by suicide.

4.2.4 **Multi-Agency 2:** Safer Gloucestershire should produce and publish a learning summary, as well as facilitate a range of disseminating events, to share the learning from this review.

4.2.5 **Multi-Agency 3:** Safer Gloucestershire to ensure a thematic review is undertaken. The aim of the thematic review should be to bring together the learning from all suicide reviews in the county and ensure links are made with the GSPPF to develop a multi-agency plan for local activity to respond to common themes and share learning.

4.2.6 **Multi-Agency 4:** Gloucestershire Constabulary to consider the roll out of the Domestic Abuse Matters programme within the force and/or to invest in and develop a robust domestic training programme for all officers and staff to ensure an understanding of domestic abuse and the response required (ensuring training covers key issues raised in this review).

4.2.7 **Multi-Agency 5:** To review the current VIST and consider improvements that can be made to ensure risk assessment scores consider any pattern of incidents. In particular. To ensure supervisor sign-off considers any such pattern before approving the risk assessment.

4.2.8 **Multi-Agency 6:** For a Continuing Professional Development schedule to be developed for Gloucestershire Constabulary's Domestic Abuse Safeguarding Team to further enhance and develop their expert response to domestic abuse, with particular focus on enhancing their knowledge around LGBTQ+ victims.

4.2.9 **Multi-Agency 7:** NHS Digital to identify whether it is possible to ensure that frequent changes of address to NHS records can be flagged for further consideration where appropriate.

4.2.10 **Multi-Agency 8:** GHC to develop a business case with local health commissioners to ensure sustainable HIDVA provision, including within mental health services.

4.2.11 **Multi-Agency 9**: GHC to review learning with respect to carer support in this case and conduct a wider audit of carer assessments to explore any issues identified around the consistency or quality of support offered.

4.2.12 **Multi-Agency 10**: GDASS to work with Gloucestershire Police and other partners to become a member of the local Stalking Clinic and ensure there is a consistent process in place identify any cases known to the service when these are referred.

4.2.13 **Multi-Agency 11:** GDASS to review the implementation of its 'Managing Conflicts of Interest and Dual Allegations' in line with national best practice.

4.2.14 **Multi-Agency 12:** The ISAC service to sign up to the MARAC and ensure there is a consistent process in place identify any cases known to the service when these are referred.

4.2.15 **Multi-Agency 13:** To develop clear criteria (through the recommissioning process) that outlines the skills and knowledge, role, and remit of the Splitz ISAC and GDASS IDVA roles to ensure victims receive the right support from the right service, with clear ownership and joint working processes in place.

4.2.16 **Multi-Agency 14:** The Domestic Abuse Local Partnership Board to ensure that existing plans to develop the local training pathway and commissioning of provision through Lot 5 of the DA commissioning framework address the learning from this review including:

- Curiosity about professional networks;
- information sharing between agencies; and
- The provision of countywide stalking training.

4.2.17 **Multi-Agency 15:** Develop a clear criteria and approach between the Stalking Clinic and MARAC and develop a protocol for joint work where this is required/appropriate.

4.2.18 **Multi-Agency 16:** The Gloucestershire Domestic Abuse Partnership to develop specific awareness campaigns to engage with LGBTQ+ and male victims in consultation with relevant organisations and community groups.

4.2.19 **Multi-Agency 17**: The Gloucestershire Domestic Abuse Partnership to ensure service user and community feedback from LGBTQ+ and male victims is considered in any strategy and operational activity.

4.2.20 **Multi-Agency 18**: The Gloucestershire Domestic Abuse Partnership to consider any new commissioning guidance relating to services for victim/survivors with protected characteristics to ensure local services remain responsive to local needs and national guidance.