SETDAB | Southend, Essex & Thurrock Domestic Abuse Board

Domestic Homicide Review
Executive Summary

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Colchester Community Safety Partnership

A Review into the death of Beth in January 2021

Report produced by Joanne Majauskis

Date 10th June 2022

SAFER COLCHESTER PARTNERSHIP

Preface

This is a Domestic Homicide Executive Summary referring to the life and death of “Beth”. This is a pseudonym and will be used throughout.

I would like to begin by expressing my sincere sympathies, and that of the panel, to the family and friends of “Beth”.

The review was commissioned by the Colchester Community Safety Partnership on receiving notification of the death of Beth in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004. It follows the guidance set out by the Home Office.

This review has been undertaken in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of this incident in a meaningful way and address the issues that it has raised. I would like to thank all those who contributed.

Contents

1. Review Process

1.1 This summary outlines the process undertaken by Colchester Community Safety Partnership (CCSP) Domestic Homicide Review Panel in reviewing the death of 'Beth', a 21-year-old US citizen who had been staying in the UK on a 6-month visa to visit her boyfriend, Zach. She was killed by Zach, in January 2021 in the multi-occupancy student accommodation in which they had been living.

1.2 The summary will use the pseudonym's "Beth" and "Zach" throughout.

1.3 The review process began when Essex Police notified SETDAB and Colchester Community Safety Partnership of the homicide.

1.4 The Domestic Homicide Review Core Group met to discuss the case on 25th February 2021. Following further enquiries and correspondence with the Home Office, a decision was reached that the homicide met the criteria for a Domestic Homicide Review (DHR) in May 2021.

1.5 Where it was established that there had been contact, agencies promptly secured all relevant documents, and those who could make an appropriate contribution were invited to become panel members.

1.6 Agencies that were deemed to have relevant contact were asked to provide an Individual Management Review (IMR) and a chronology detailing the specific nature of that contact. The aim of the IMR is to look openly and critically at individual and organisational practice to see whether changes could or should be made to agency policies and practice. Where changes were required then each IMR also identified how those changes would be implemented.

1.7 It was apparent that there had been very little agency contact with either Beth and Zach and that information available to the panel was limited.

1.8 The chair discussed the possibility of meeting with Zach, but it was felt by his mental health team that he was too unwell.

1.9 A partnership workshop was held on 8th March 2022 to consider the case and capture key issues for this report.

1.10 Information from records used in this review was examined in the public interest and under Section 115 of the Crime and Disorder Act 1998 which allows relevant authorities to share information where necessary and relevant for the purposes of the Act, namely the prevention of crime. In addition, Section 29 of the Data Protection Act 1998 enables information to be shared if it is necessary for the prevention and detection of crime, or the apprehension and prosecution of offenders. The purpose of the review is to prevent a similar crime.

2. Contributors to the Review

2.1 The following agencies contributed to this Review through submitting an Independent Management Review, a Chronology, and/or Summary Report:

- Essex Police
- University
- Sutton CCG
- North East Essex CCG
- Dyad Medical. Private Psychiatric Clinic

3. Involvement of family, friends and wider community

3.1 Beth's mother had passed away in recent years due to health problems, Beth's grandmother had cared for her following her mum's death but had also recently passed away.

3.2 Beth's step-grandfather was identified as her closest family member, he initially agreed to engage with the review but then declined when told it would have no bearing on the criminal case.

3.3 Police were able to provide information and insights from interviews with friends of Beth and Zach.

4. Review Panel

4.1 The panel for this review was made up of the following representatives:

Joanne Majauskis	Independent Chair
Val Billings	SETDAB Domestic Abuse Coordinator
Lisa Hobson	Colchester Safer Partnership
Jane Whitington	North East Essex CCG
Scott Kingsnorth	Essex Police
Matthew Dawson	GP Surgery (Colchester)
Tendayi Musundire	Essex Partnership University NHS Foundation Trust (EPUT)
Bev Jones	Next Chapter
Claire Beacham	Phoenix Futures

5. Domestic Homicide Review Chair and Overview Report Author

5.1 The Southend, Essex and Thurrock Domestic Abuse Board appointed Joanne Majauskis as DHR Chair and Overview Report Author in May 2021.

5.2 Joanne is an independent consultant and trainer with fifteen years' experience working in the Domestic Abuse Sector. Joanne has experience of working both in frontline and strategic management roles. Joanne has also Lectured for the National Centre for the Study and Prevention of Violence and Abuse (NCSPVA) at the University of Worcester having completed her Masters in Dynamics of Domestic Violence with Distinction in 2015.

5.3 Joanne completed Independent Domestic Abuse Chair Training with Advocacy After Fatal Domestic Abuse (AAFDA). AAFDA are a Centre of Excellence for Reviews after Fatal Domestic Abuse and for Expert and Specialist Advocacy and Peer Support.

5.4 Joanne has been working Independently for two years is not employed by, nor otherwise directly associated with, any of the statutory or voluntary agencies involved in the review.

6. Terms of Reference

Statutory Guidance (Section 2.7) states the purpose of the DHR Review is to:

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

6.2 Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

6.3 Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

6.4 Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

6.5 Contribute to a better understanding of the nature of domestic violence and abuse.

6.6 Highlight good practice.

Specific Terms of Reference

6.7 This report of a domestic homicide review will consider relevant past agency contact and involvement with Beth and Zach. In particular will focus on the time from 5th October 2019 until the time of the incident as initial intelligence suggested that this was when their relationship commenced. Subsequent information suggests the relationship may have been longer; Zach attended an appointment with his private psychiatrist in Sept 19 with his "American girlfriend" and stated they had been together for two years. However, all significant incidents involving police and other agencies fall without the initial timeframe identified for review.

6.8 The independent chair agreed the Terms of Reference for the Review with the Southend Essex and Thurrock Domestic Homicide Review Team, the Safer Colchester Partnership and panel members. The key issues identified were:

- The level of information agencies held and understand regarding Zach's: Mental Health and Disability status
- Any concerns known around controlling and coercive behaviour in Beth and Zach's relationship
- Knowledge of any potential risks posed to others by Zach
- Safeguarding procedures when someone makes a disclosure of mental health issues
- Procedures when someone refuses to engage in a risk assessment
- Decision making processes regarding identification of victims and perpetrators in domestic abuse cases

6.9 Agencies completing IMRs were required to analyse these issues in relation to their contact with Beth or Zach, with specific reference to:

- What policies, procedures and guidelines provide the framework for the agency's response to the above issues.
- What training is available to, and accessed by, staff in relation to responding to the above issues.

What communication should have taken place between agencies in relation to the above issues; whether this took place; the quality and outcomes of that communication.

7. Summary of the Chronology

7.1 This summary covers the period from 5th October 2019 up to the date of the homicide.

7.2 Between September 2019 and the time of the incident, Zach received several emails from his allocated wellbeing adviser at the University of Essex Student Wellbeing and Inclusivity Service (SWIS). These included offers to meet, which Zach did not appear to take up, and provided information on where he could access help and support pertaining to his mental health.

7.3 28th September 2019 – Zach is seen at Dyad Medical, Private psychiatric clinic. Zach had previously accessed the clinic and was seen several times during 2018 but stopped attending appointments and was discharged in July 2018. Zach reattends stating that his OCD has not improved, and he wants to restart medication. Zach is given a care plan, a prescription for Clomipramine and a follow up appointment for November that he doesn't attend.

7.4 5th October 2019 – Zach makes a 999 call to Essex Police at 03.47 to report that Beth has "gone crazy and punched him in the face." A female (assumed to be Beth) is heard crying and pleading in the background. Police attend the scene and on arrival Zach tells officers that he and Beth have had a verbal altercation, which led to her pushing him lightly once. He confirms that he has not been punched. Both parties had been out drinking. Zach does not support further police action and provides a statement to this effect. A risk assessment is completed and graded as Standard risk. Zach is provided with a Domestic Abuse Support advice leaflet.

7.5 11th December 2020 (2.50am) The night security at the University file a report stating that they received a call from the Wivenhoe House Hotel night porter with concerns about a resident at the hotel (Zach). They said he appeared distraught and was possibly suffering from Bipolar. They confirmed he was not a problem but made comment to his mental health and the fact he hadn't slept for a few days. The hotel had offered to request patrol officers to speak to him, but he did not want this. He had then gone to his room for the night. Zach checked out of the hotel at 10.30am.

7.6 12th December 2020 - 01.52am. Police receive a 999 call from one of Zach's friends. She tells police that she is concerned about Zach as he is acting unpredictably and that he had been "arguing with his girlfriend and acting very strange". She advises police that Beth is currently visiting a friend, Zach had left with a friend to go to back to the Wivenhoe House Hotel. She says that she is concerned about the friend due to Zach's state of mind. This is logged as 'Concern for Welfare' and graded priority response three (attendance within an hour). A THRIVE assessment is completed, and the risk categorised as high with Zach noted to be 'having an episode'.

7.7 12th December 2020 - 03.07am. The police log is updated with further information from the informant. She says she believed Zach was having a mental health episode, she had called an ambulance but was advised to call police. She expresses concerns about what Zach may do to himself and to the friend who is with him.

7.8 12th December 2020 - 03.08am. The police control room call the ambulance service, there is an estimated delay time of seven hours. The control room call staff at the Wivenhoe House Hotel to update them.

7.9 12th December 2020 - 08.19am. The police control room receive an update from the ambulance service stating that Zach had called them to say he did not want an ambulance, he wanted to sleep. It is recorded that 'he seemed quite angry'.

7.10 12th December 2020 - 08.27am. A further update is made to the incident record highlighted that police needed to deal with the domestic aspect from the original report.

7.11 12th December 2020 - 09.04am – 10.50am. Police attend Wivenhoe hotel and speak to Zach who says he wanted space from everyone. He was feeling down but did not wish to harm himself. A DASH risk assessment is completed with him and graded as standard.

7.12 The officer attempts to visit Beth but she is not at either of the addresses that they have for her on the system. Police manage to contact Beth by phone. She states she is not sure why police are involved but that she was worried about Zach.

7.13 January 2021 - Zach's father calls the Metropolitan Police to report his son had called him to say he had stabbed someone and they were dead. Police attend and find Beth with stab wounds and Zach as the only other person present.

8. Key Issues arising from the review

8.1 The questions raised in the terms of reference were grouped into three main themes for the purposes of analysis: the information that agencies held about Zach's mental health and

whether they had knowledge of any risks this may have posed, whether any agency was aware of coercive control in Zach and Beth's relationship and agency responses to domestic abuse. These themes are discussed below. Whilst not a theme of this report, given the period of time during which the murder took place it is also important that we consider whether the pandemic could have had any bearing on this case.

Information regarding Zach's Mental Health and potential risks

8.2 Zach's G.P. surgery in Colchester held very little information about him. The majority of their contacts related to dressing changes for a pilonidal sinus; no concerns were picked up by the nurses during their interactions with Zach.

8.3 The previous GP surgery Zach was registered with in Sutton held more information about Zach's mental health in their case notes. However, the two surgeries used different systems; 'EMIS' and 'System One'. It appears that there was a breakdown and lack of information sharing between practices on EMIS/ System One. It was discussed at the panel meeting that it is a reoccurring issue that EMIS and System One don't 'talk to each other' particularly well.

8.4 Neither G.P. surgery held any information that indicated that Zach may have posed a risk to himself or to others.

8.5 Zach was also seen privately by a psychiatrist located in Harley Street. There is no mention in the case notes, provided by the clinic, to suggest that Zach ever displayed any behaviour that could be regarded as concerning or that could have alerted his psychiatrist to any violent act. In fact, Zach was asked about intrusive thoughts and thoughts of wanting to harm himself or others at every visit and denied this.

University

8.6 It would appear that Zach self-referred to the University wellbeing team on enrolling at the University of Essex. It is apparent that the wellbeing team had very little information regarding Zach's mental health. Despite efforts to engage Zach, his wellbeing caseworker did not appear to have much contact with Zach.

Police

8.7 The first indication police receive that suggests Zach may be a risk to himself or others is from the call they receive from Zach's friend. to report that Zach had been arguing with Beth. In this call she says that he been acting strangely, his behaviour was unpredictable and expresses a concern that he presented a risk of harm to either himself and/or others; specifically; at that time another friend who he was going to the hotel with.

8.8 The incident log references mental health, depression, and anxiety and references 'Zach reported to be having an episode', but it is unclear to what extent any potential delusional behaviour and any associated risk were considered.

8.9 The attending officer sought to complete a DASH risk assessment with Zach, which he declined to co-operate. The officer completes the risk assessment based on their conversation and his observations, of note is the question relating to depression and suicidal

thoughts, where the following is recorded, 'Zach is feeling depressed and is not currently on medication.' The officer notes that Zach says he is feeling down but does not wish to harm himself. The risk identification was recorded as Standard. Advice was given by the officer in respect of Zach's mental health and Zach agreed that he would contact his GP.

8.10 Given the information available and the manner in which Zach presented the actions taken by the attending officer with regards to mental health appear to be proportionate.

Coercive and controlling behaviour

8.11 There was very little information about the nature of Zach and Beth's relationship available to the panel. Information provided by police was that Zach and Beth met online, and Zach first went to visit Beth in America approximately four years prior to her death. During the course of their relationship, Beth had been to visit Zach in the U.K. four times. When visiting, Beth stayed with Zach at his student accommodation. This was during a time when movement and mixing with others was restricted due to the pandemic. This may have further exacerbated any control that Zach may have had over Beth.

8.12 In police reports, friends of Zach and Beth refer to a 'deteriorating relationship' and indicate that Zach was controlling in the relationship. Despite the 999-call made by Zach to police in October 2019 police found no evidence to suggest Beth was abusive

8.13 Information from friends suggests that Beth may have been in the process of ending the relationship before returning to America in February. Separation is a known risk factor (Kelly, 2018; Richards, 2004).

8.14 Friends also report an increase in Zach's use of drugs in the months leading up to Beth's death. This could have exacerbated any abusive behaviour in their relationship. Research indicates that incidences of domestic violence are significantly higher in substance abusers than others and that there is an increased risk of homicide (Chopra et al, 2022; Potter, 2021; Bhatt, 2000; Dutton and Kropp, 2000).

Response to domestic abuse incidents

<u>Police</u>

8.15 Police were contacted on two occasions with regard to domestic incidents between Zach and Beth. The first incident on 5th October 2019 was when Zach called 999 to say Beth had punched him in the face. This was identified as a domestic incident requiring police attendance and the priority response grade 3 was applied. The Call Handler correctly assessing that there was a degree of importance or urgency associated with the call, but that an emergency response was not required.

8.16 However, the THRIVE assessment process, which concluded both Harm and Risk were 'minimal' is queried. The information received indicated both parties were still present together at the premises. A female voice can be heard crying and pleading in the background. The allegation is made of a physical assault involving the informant being punched to the face, with the description of 'the girlfriend' having 'gone crazy'. In these circumstances the potential for escalation and harm were greater than 'minimal'.

8.17 On arrival officers were presented with a changed account from Zach who told officers that Beth and he had been arguing and she had pushed him lightly once. Zach indicated that he had overreacted in calling the police, stating he got carried away in the heat of the moment

as he had drunk alcohol. No injuries were seen by the officers and both parties presented as calm. No counter allegations are recorded as having been made by Beth.

8.18 There is no record of any account from Beth. The only reference to Beth having spoken is contained within a supervisory comment on the Athena investigation log saying that she was making 'admissions' at the scene. Details of the admissions said to have been made by Beth are not recorded.

8.19 The absence of Beth's 'voice' in the log also suggests that Beth was not questioned about the crying or pleading that the call handler heard from a 'female' when the initial call was made. She is not recorded as making any allegations, but her status as the 'Suspect' meant she was not subject of a DASH risk identification assessment, meaning there was less opportunity to understand her perspective of the relationship and the drivers behind the events that occurred.

8.20 As the identified victim, Zach was subject to the DASH risk identification process but declined to engage in this. The subsequent assessment was therefore incomplete but recorded the risk as 'Standard'.

8.21 The second time police were made aware of a domestic incident was on the night of 11th December when Zach's friend calls 999 to report her concerns. She states in the call that Zach had been arguing with Beth and had left the property they were at together but had wanted Beth to go with him and she had refused. The call also contains information about Zach's state of mind. concerns about his behaviour, and concerns for the friend he is with.

8.22 A STORM incident log is created and allocated the header 'Concern for Welfare' recognising the need to check on Zach's welfare but failing to identify the domestic abuse element of the call meaning that the incident was incorrectly categorised, with implications for how police subsequently responded.

8.23 It is more than three hours later, when the case is referred to the Ambulance service that a member of the control room staff highlight that the initial information made reference to a possible domestic dispute between Zach and Beth and that this aspect of the call needed to be dealt with by police.

8.24 Police attend the Wivenhoe House Hotel and speak with Zach. The attending officer sought to complete a DASH risk assessment with Zach, which he declined to co-operate with. The risk identification was recorded as Standard.

8.25 In this incident, Zach should have been identified as the perpetrator. He was described as acting aggressively, shouting at his girlfriend, seeking to force her to go with him, acting unpredictably and posing a potential threat to others.

8.26 Although it cannot be known what might have been disclosed, had Beth been correctly identified as the victim in this case, the DASH risk assessment would have been completed with her and there may have been an opportunity to identify any hidden risks or controlling and coercive behaviour towards her.

8.27 Although, having spoken to both with Zach and Beth there were no grounds to indicate any likelihood of serious harm. It is unclear whether the risks were fully understood. Zach did not cooperate with the DASH risk assessment and the decision to categorise Beth as the Suspect

meant that no risk identification process was completed with her. There was therefore insufficient information obtained on which to base a reliable assessment of risk.

Impact of the Pandemic

8.28 Although the pandemic has not been identified as a contributing factor in this case, it is important to acknowledge that at the time of the incident in April 2021 the COVID-19 pandemic was at its height in terms of impact on day-to-day life in England.

8.29 From the information provided by agencies for the purposes of this report it cannot be known whether the pandemic had any significant impact in this case, however, a heightened risk of domestic violence has been associated with infection-reducing measures undertaken by governments during the COVID-19 pandemic (Gulati and Kelly, 2020).

8.30 It is also widely reported that it had a detrimental impact on some individual's mental health (WHO, 2022). Some research specifically focused on individuals presenting with obsessive compulsive disorder and found that they may experience heightened levels of stress or anxiety symptoms during a pandemic, including fear of infection, fear of contact with contaminated surfaces, compulsive handwashing, and checking and reassurance-seeking associated with pandemic-related threat (Ameringen et al, 2022; Matsunga et al, 2020).

9. Conclusion

9.1 It is important that we highlight and identify both good practice as well as where things could be improved. It can never be known whether different actions would have resulted in a different outcome, but we hope that the lessons learnt, and the changes made as a result of this review are able to provide some comfort to those who knew Beth that others will be better protected. Our thoughts are with her family and friends.

9.2 There was little information available to the panel, but certain themes emerged that are addressed here and in the recommendations.

Essex Police

9.3 Given the nature of Beth's murder and the finding that Zach was suffering from diminished responsibility, it cannot be said that within the limited contacts Essex Police had with Beth and Zach there were any opportunities to disrupt his offending or change the course of events.

9.4 Neither of the domestic incidents that took place in October 2019 and December 2020 gave any grounds to indicate that Zach was capable of such actions or that Beth was at risk of serious injury. On both occasions the Standard risk assessments were appropriate and this was the only assessment that staff could have reached based on the information available to them.

9.5 This case highlights that the dynamics of abuse are complex, and it may not always be clear who is the 'Victim' and who is the 'Suspect' as such it is imperative that both parties are spoken to and that officers remain professionally curious and refer to guidance if unsure.

9.6 In incidents where neither party claims to be the victim or there is no clearly identified victim or perpetrator, risk can only be fully understood and the absence or presence of offending confirmed, through the completion of risk assessments involving both parties.

9.7 Only post assessment should status be fully considered and in cases where no offences are identified, rationale should be provided on how the decision has been made in identifying who is the 'suspect' and who is the 'victim'.

9.8 It is important to reiterate that on both occasions Beth appears to have had an opportunity to raise any concerns and she did not do so. However, given the nature of DA offending and the potential for fear, intimidation, coercive and controlling behaviours and personal and cultural factors which may inhibit disclosure being made, it is important to provide every opportunity for such revelation. Engagement through completion of a structured risk assessment can be an effective means of doing this.

9.9 The other learning point regards the control room response and THRIVE Assessment from the second incident in which police were involved with Zach and Beth. The initial failure to recognise the domestic abuse element of the call and respond appropriately indicates there is an opportunity to provide feedback to control room staff for personal learning.

9.10 In addition, the police IMR highlighted the cursory nature of the THRIVE assessments that took place. An opportunity exists to debrief the staff directly involved in these incidents, but also to share more widely the learning from this review as part of ongoing Continuous Professional Development (CPD) to control room staff.

<u>Healthcare</u>

9.11 There is no evidence to suggest that either Zach's G.P. surgery or his private healthcare clinic could have had any indication that he was a risk to himself or to others. However, research into domestic homicide reviews highlights that mental health and substance misuse are present in the majority of cases (Potter, 2021) so this case does highlight the need to ensure that safety assessments are undertaken during mental health reviews and that screening for domestic abuse is imperative.

9.12 It is highlighted as good practice that the notes from Zach's private healthcare clinic evidence that on every contact he was asked about thoughts to harm himself or others. Enquiries were made as to the nature of his relationships and plans and guidance were given to Zach on what to do should his mental health deteriorate. Whilst tragically he did not follow this guidance there does appear to have been ample opportunities for him to make disclosures.

9.13 This review also highlighted the issue of information sharing between G.P. practices when someone transfers to a new surgery. Zach's previous GP surgery held information about Zach's mental health in their case notes that was not known to his current surgery. Zach's current G.P. Surgery in Colchester had no information in their records that would have alluded to Zach having a mental health diagnosis. Whilst within the other practice's records there were mentions of OCD, Bipolar and references to depression.

9.14 Although, it is unlikely that had Zach's G.P. surgery had knowledge of his mental health issues it would have had any bearing on this case, it does show that there the breakdown and lack of information sharing between practices on EMIS/ System One where vital information could be lost.

University of Essex

9.15 There is no evidence to suggest that the University had any knowledge of Zach's relationship with Beth or the nature of it. They also appear to have very limited information about Zach's mental health, mostly it related to his ability to function academically. The University wellbeing service did make attempts to engage with Zach but these do not appear to have been reciprocated by him. It was noted as good practice by the panel that the university night staff appeared to have knowledge of Zach's mental health and that safeguarding checks were carried out by them when he presented at the hotel on site.

9.16 It is also noted that the University work with SETDAB to ensure students are aware of support available should they experience abuse. It is unknown if Beth would have been aware of these services as she herself was not a student, but it is likely that their friends who attended the university would have known about it and would have also the undertaken active bystander initiative that the University provide as part of induction.

Pandemic

9.17 Lastly, it is important to acknowledge the unprecedented circumstances the world was experiencing in the year leading up to the tragic event January 2021. It is clear that the pandemic led to many people being isolated from both services and more informal support networks and that it had an acute impact on the deterioration in mental health of many people.

10. Recommendations

Recommendation One:

10.1 Essex Police should review its current Policy and procedure relating to the completion of DASH risk identification assessment process in cases where it is unclear who is the suspect and who is the victim and where it is also unclear that any criminal offence has taken place. The benefits of completing DASH assessments with both parties involved in order to holistically assess and understand risk should be considered.

Recommendation Two:

10.2 Essex Police should review its current working practice of recording those involved in non-crime DA incidents as either the 'Victim' or the 'Suspect'. In cases where no offences are identified, rationale should be provided on how the decision has been made in identifying who is the 'suspect' and who is the 'victim'.

Recommendation Three:

10.3 Learning from this IMR should be shared and debriefed by a manager within control room staff who were involved in Call Taking, Dispatch and Supervision in relation to STORM incident EP-20201212-0100.

Recommendation Four:

10.4 The use of the THRIVE assessment model should form part of future CPD for control room Call takers and Dispatchers, to assist them in completing the assessment process, including identifying the precise nature of the Threat, Harm and Risk and enabling them to utilise THRIVE to determine the incident Header and the incident response priority grading.

Recommendation Five:

10.5 Consideration should be given to the option of developing an assessment process, to assist front line officers in assessing the dynamics of abuse, who is the primary perpetrator and the presenting risks. This would require wide consultation given that DASH is used nationally by police forces and accredited by the National Police Chiefs Council.

Recommendation Six:

10.6 A review into NHS systems and the functionality of information sharing needs to be undertaken. How to transfer medical notes between G.P. practice's to ensure crucial medical information isn't lost should be considered.

Recommendation Seven:

10.7 Primary Care should consider how to ensure that screening for domestic abuse and safety assessments are carried out as standard practice when patients present with Mental Health issues and when mental health reviews are completed as standard.