Test Valley Partnership
Hampshire Safeguarding Adults Board

# Joint Domestic Abuse Related Death Review and Safeguarding Adults Review

# **Executive Summary** of
Report into the Death of Max (June 2023)

**Author: Eleri Butler MBE**
**March 2025**

## From Max's[1] family

From Max's adult children:

*"They told me police had been around to say Dad's dead. I couldn't breathe probably, didn't believe it and sobbed. My chest hurt, I didn't sleep well…I was devastated."*

*"We had our arguments and our disagreements as any other family would. However, despite that, he was my best friend… he was a good man. He was always excited to see [us] and his grandchildren."*

*"When I was a child all I had ever wanted was a fulfilled life with my father at my side. He wasn't the best, but he was what I had, and I cherished every moment with him. Now, I experience sleepless nights, trying to remember, and failing to forget…"*

*"I have never experienced depression quite like this. Yet, my family has been splintered, my heart aches, and now, I won't ever hear or see him again. I wasn't even able to say good-bye to him. It hurts…There is a hole in my heart, a hole that won't ever heal, time slips through it, and I will forevermore struggle to persevere in this life, knowing my dad, and best-friend, isn't here anymore, with his hand on my shoulder, to help me get through it."*

"*I don't want him to be remembered as a victim he wasn't just a victim he was so much more".*

*"Max was a loving father, and we had some great family times together in the early years."*

*"He wasn't a victim; he was a dad and grandad. He was a victim of circumstance."*

**From Max's wife:**

*"Max was a kind person. He was the father of my children, and I still loved him."*

*"Anyone who knew Max, knew that without the drinking he was a great bloke and wouldn't hurt anyone. He was the nicest person. It was the drink that kept him apart from people who cared about him."*

*"He'd bought some little cars and trains for his grandchild and left them in a bag in his drawer. It really hurt when we found them. Max thought so much of his grandchildren. Now they say that 'grandad is in the sky'. I can see them together in my mind, playing together and getting into mischief together."*

*"He lived his life the way he wanted to, and no-one had the right to take that away from him."*

[1] Not his real name

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# Executive Summary of Report into the Death of Max (June 2023)

## Preface

The Independent Chair, Domestic Homicide Review Panel members, Test Valley Partnership and Hampshire Safeguarding Adults Board offer their deepest sympathy to all who have been impacted by the death of Max (not his real name) and acknowledge how distressing these events have been for the family. We thank those family members who generously participated in the Review. That they were willing to contribute following the trial, whilst continuing to grieve, is deeply appreciated.

## 1. Introduction: The Joint Review Process

1.1 Domestic Homicide Reviews / Domestic Abuse Related Death Reviews (DARDRs)[2] came into force in April 2011, to review the circumstances of the death of a person, where the death has or appears to have resulted from domestic abuse, within the meaning of the Domestic Abuse Act 2021, to identify the lessons learnt from the death.

1.2 This Review examined the circumstances leading to the death of Max, who was killed by Amber (not her real name) in June 2023. Amber was arrested soon after, and following the trial, in Summer 2024, she was sentenced to life imprisonment with a minimum term of 23 years.

1.3 Test Valley Partnership was notified by Hampshire and the Isle of Wight Constabulary (HIOW Police) of Max's murder in July 2023. Following consultation with partner agencies, including domestic abuse services, it was agreed to conduct a Review, and the Home Office was notified a few days later. All agencies that potentially had contact with Max or Amber were asked to confirm involvement and secure files. An Independent Chair was appointed in November 2023, when it was also agreed to conduct a Joint DARDR and Safeguarding Adults Review (SAR).[3]

1.4 Agencies across Test Valley, Hampshire, Berkshire, and Wiltshire informed the Review, and the Panel held its first meeting in December 2023, where Individual Management Reviews (IMR) were commissioned. The Panel held five meetings before the trial and two after the trial in November 2024 and February 2025. The Panel finalised the reports and action plan in March 2025, they were presented for approval by the Test Valley Partnership and Hampshire Safeguarding Adults Board between April and June 2025, sent to the Home Office in July 2025, and approved for publication in February 2026.

1.5 Several agencies reported Max was estranged from family members. However, contacts for Max's ex-partner and adult children emerged for the trial, and the Chair sent his family a letter in April 2024, inviting them to participate, which some did from September 2024. Other family members contacted by letter did not respond. The letters included information about Advocacy After Fatal Domestic Abuse.[4]

1.6 Preventing domestic abuse is a priority for Hampshire County Council and Test Valley Borough Council. The Hampshire Domestic Abuse Partnership tackles domestic abuse through a co-ordinated community response, and the Domestic Abuse Strategy 2023-2025[5] places it at the forefront of system priorities. Test Valley Borough Council's Domestic Abuse Strategy was under review at the time of

[2] In May 2024 the Victims and Prisoners Act 2024 amended the Domestic Violence Crime and Victims Act 2004 Section 8 to rename Domestic Homicide Reviews as Domestic Abuse Related Death Reviews (S8 not yet enacted at the time of writing). https://www.legislation.gov.uk/ukpga/2024/21/section/19

[3] A SAR is conducted when an adult died following known or suspected abuse or neglect, and there is concern that agencies could have worked more effectively to protect the adult and keep them safe.

[4] https://aafda.org.uk/

[5] https://documents.hants.gov.uk/public-health/domestic-abuse/domestic-abuse-strategy-2023.pdf

writing. It included working towards accreditation of a whole housing approach to address domestic abuse, to improve the response across all tenure providers that the local authority collaborates with.

1.7 This Review was undertaken in accordance with HSAB Safeguarding Adult Review Policy.[6] It was also informed by findings from a local thematic review on 'cuckooing' in July 2024,[7] and two DARDRs in 2018 and 2020 were also considered for similarities and cumulative learning. Also relevant to this Review was how the needs of veterans, of male victims and of women who experience multiple disadvantages are met in Hampshire.[8]

1.8 Neither person involved in this Review had contact with local domestic and sexual abuse services, other than being referred to the Multi-Agency Risk Assessment Conference. Local services and risk management systems include Finding Freedom from Abuse,[9] Stop Domestic Abuse,[10] Aurora New Dawn,[11] the Multi-Agency Risk Assessment Conference (MARAC) and daily High-Risk Domestic Abuse (HRDA) meetings. There are also a range of other services including an Independent Sexual Violence Adviser service and therapeutic support victims of rape and sexual offences;[12] a Victim Support Victim Care Hub;[13] Yellow Door domestic abuse services,[14] and Hampton Trust Cautioning and Relationship Abuse (CARA) programme.[15]

**Summary of incident and people involved in this Review**

1.9 The last known sighting of Max was the third week of June 2023. Towards the end of June, Max was found murdered in his home after a neighbour called police. Max had been stabbed 27 times and strangled. Confession notes and a diary belonging to Amber were found at the scene. Amber was arrested at the end of June 2023 after she used Max's bank card in another area. On Amber's arrest, she made several statements including that she had been abused and sexually assaulted. On sentencing, the Judge said she was "*satisfied there was no sexual exploitation*" of Amber and said that "*if there was any level of control and coercion, that came much from you toward him than the other way round*".

1.10 The only people involved in this Review are Max and Amber. Max had children from two previous marriages. He was still legally married to his second wife after separating 17 years before and was still in contact with her, their two adult children and two grandchildren. Amber had no known dependents.

| Pseudonym | Who | Age at incident | Ethnicity |
|---|---|---|---|
| Max | Male victim | 62 | White UK |
| Amber | Female perpetrator | 36 | White UK |

## 2. Contributors to the Review

**Summary of methodology and prior agency involvement**

2.1 Twelve organisations provided Individual Management Review reports informed by their prior involvement with Max and Amber during the period under review. The reports were quality assured by an independent senior manager.

[6] https://www.hampshiresab.org.uk/wp-content/uploads/HSAB-Safeguarding-Adult-Review-Policy.pdf
[7] https://hampshiresab.org.uk/safeguarding-adult-reviews/
[8] See, for example, the Hampshire Joint Strategic Needs Assessment https://documents.hants.gov.uk/public-health/jsna-2023/inclusion-health-groups.pdf
[9] https://www.findingfreedom.org.uk/
[10] https://stopdomesticabuse.uk/
[11] https://www.aurorand.org.uk/
[12] https://www.hampshirerasac.org.uk/ and https://yellowdoor.org.uk/about-us/
[13] https://www.hampshireiowvictimcare.co.uk/
[14] https://yellowdoor.org.uk/
[15] https://hamptontrust.org.uk/program/cara/

2.2 Each report was scrutinised by the Panel and, where required, additional clarifying information was sought. Relevant policies, procedures and documents referenced were also considered. A rapid review was also undertaken to check that all participating agencies had relevant and up to date policies in place, that training was being provided to staff and that there was appropriate participation in local relevant partnerships.

2.3 The Report and Executive Summary is informed by the information and facts gathered from the reports and documents provided, by the criminal investigation, conversation with family, and Panel discussions. Expert input was provided by local and national agencies (see 4.2 below).

2.4 All agencies listed below had some involvement with Max, Amber, or both, between January 2021 and June 2023, and were asked to complete a chronology, IMR, or summary report.

| Service/agency | Summary of involvement |
|---|---|
| Aster Housing Group (Aster) | Max was known to Aster between 2014 and 2023. In November 2014 Max took on a tenancy with Aster, who continued as his landlord to June 2023. |
| Berkshire Healthcare NHS Foundation Trust (BHFT) [16] | Max used the veterans' mental health services between 2017 and 2021. In 2021, Max was assessed as high risk of self-harm and suicide and was considered too high-risk for ongoing work, so referrals were made to Inclusion Recovery Service, Southern Health Community Mental Health Team, and the Acute Mental Health Team. |
| Hampshire County Council - Adults Health and Care (AHC)[17] | Max was referred several times to AHC between 2021 and 2023 but had no direct contact with the service. Referrals related concerns about mental health, cuckooing and domestic abuse. In 2021, four police Public Protection Notices[18] were received but AHC decided safeguarding enquiry thresholds were not met. Two Ambulance referrals in March (for cuckooing) and April 2023 (for domestic abuse) were also closed.<br><br>Amber was known to AHC between 2022 and June 2023. In December 2022, Amber had tried to take her own life, and was placed on a six-months waiting list for a Care Act assessment. Amber self-referred for help following domestic and sexual abuse, and in June 2023 AHC opened a safeguarding enquiry, which was subsequently closed. |
| Hampshire Hospitals NHS Foundation Trust (HHFT) | Max attended the Emergency Department four times between 2021 and 2023. This included twice in March 2022 which led to inpatient episodes, and in November 2022 and April 2023, he was assessed and discharged home.<br><br>Amber attended the Emergency Department three times between 2021 and 2023 but left without being seen twice, on receipt of pain killers. |
| Hampshire & Isle of Wight Constabulary (HIOW Police) | Between April and June 2023 HIOW Police had contact with Max and Amber four times.<br><br>Max was also known for 120 recorded incidents between 1997 and 2023. His address was subject to monitoring for 'cuckooing' between October 2018 and June 2022, and in 2023, increased drug use and supply was noted at his address.[19] Max was also recorded as a perpetrator of domestic abuse, in relation to four women, and discussed at a MARAC in 2023. In April 2023 he was recorded as a victim when he reported being slapped by Amber. |

[16] BHFT provided the veterans mental health Transition Intervention and Liaison Service (TILS), veterans mental health Complex Treatment Service (CTS) and the veterans mental health High Intensity Service (HIS), along with the Criminal Justice Liaison Diversion Service to Hampshire. From 2022 TILS CTS and HIS formed Op COURAGE, the national NHS Veterans' Mental Health and Wellbeing Service, providing assessment, treatment and support for serving personnel, veterans and their families. https://www.nhs.uk/nhs-services/armed-forces-community/mental-health/veterans-reservists/

[17] Hampshire Adults' Health and Care incorporates Adult Social Care and Public Health and is responsible for providing social care services to those with eligible needs.

[18] A Public protection Notice (PPN) is an information-sharing document that records safeguarding concerns and are shared with partner agencies to inform a multi-agency response.

[19] Operation Fortress is HIOW Police's response to drug-related harm. Max was identified as a vulnerable adult who was at risk of being exploited to sell, move, and store drugs and other commodities. His address had previously been 'cuckooed' - a practice where people take over a vulnerable adult's home and use their property to facilitate exploitation.

| | |
|---|---|
| | Amber was known for 97 recorded incidents between 2020 and 2023, linked to drug use and supply, and to reports of rape, domestic and sexual abuse. Police also recorded mental health concerns and incidents of self-harm and suicide attempts in 2021 and 2022. In 2021, Amber had threatened to kill someone she believed had poisoned her dog, which was recorded as a mental health episode. |
| Midlands Partnership University NHS Foundation Trust - Inclusion Recovery Service Hampshire (Inclusion | Max was known to Inclusion services in 2021 and 2023. He was referred between February and July 2021, but his case was closed following failed attempts to engage him. He was referred in May 2023 but did not attend further appointments in June 2023. Max had previously used the service in 2016 and 2017 for treatment, after which he achieved periods of abstinence.<br><br>Amber was known to Inclusion in May 2022 following a referral for use of prescribed medication, but she did not attend an assessment. In May 2023, Inclusion received a joint assessment referral, but Amber said she was not using drugs, so this did not happen. |
| Salisbury NHS Foundation Trust | Amber attended the Emergency Department 14 times between March 2020 and April 2023. These were self-referrals, and most included drug seeking behaviour. |
| South Central Ambulance Service (SCAS) | Max had five contacts with SCAS between 2022 and 2023, four of which were in 2022 and he was taken to hospital twice. In Spring 2023, SCAS made two safeguarding referrals to AHC relating to Max, including following disclosure of domestic abuse.<br><br>Amber had twelve contacts with SCAS between 2022 and 2023. In July 2022 Amber cut her wrists and a safeguarding referral was made, and in December 2022 she had tried to take her own life. A mental health assessment in February 2023 was followed by two calls in April 2023 including for an anxiety attack, and in June 2023 she was taken to hospital. |
| Southern Health NHS Foundation Trust (SHFT).[20] | Max was known to SHFT mental health services between 2017 and 2023. due to suicide and self-harm risks. Max was discharged in July 2022, and in April 2023, at the hospital Max disclosed he felt suicidal, and was discharged to his GP.<br><br>Amber was known to SHFT mental health services between 2021 and 2023. In April 2021 Amber's GP referred her for self-harm, but attempts to contact her failed. In 2022 several referrals were made to the crisis and community mental health teams following suicide attempts and self-harm, but services failed to complete an assessment. In January 2023 the service signposted Amber to Inclusion for support. |
| St Mary's Surgery (GP Practice - Max) | Max was seen eight times in 2021 and five times in 2022. Four notifications in 2021 related to self-harm and mental health service involvement. Notifications in 2023 related to Max perpetrating domestic abuse (March 2023), a hospital mental health assessment (April 2023) and being slapped (May 2023). The Practice made attempts to book an appointment, but Max did not attend. |
| Stockbridge Surgery, (GP Practice - Amber) | From January 2020 Amber had several contacts, predominantly to replace lost or stolen pain relief medication. The GP Practice identified a pattern of drug seeking behaviour and referred Amber for mental health assessments and support. |
| Test Valley Borough Council (TVBC) | Max had several interactions relating to Council Tax between October 2021 and June 2023.<br><br>Amber was known to TVBC between 2020 and 2023, mainly for Council Tax, and Housing Options (February to June 2023) in relation to homelessness and domestic abuse. |

**The Review Panel**

2.5 The Panel was comprised of the following statutory and community service organisations:

| Name | Position, organisation |
|---|---|
| Eleri Butler | Independent Chair and Report Author |

[20] Southern Health provided mental health, physical health and learning disability services for people across Hampshire, and from October 2024 merged with Solent to form Hampshire and Isle of Wight Healthcare NHS Foundation Trust.

| | |
|---|---|
| Melanie Thornton | Specialist Safeguarding Nurse, Southern Health NHS Foundation Trust |
| Greg Downs | Antisocial Behaviour Service Manager, Aster Group |
| Sue Carrington | Specialist Domestic Abuse lead, Berkshire Healthcare NHS Foundation Trust |
| Cheryl Chalkley | Head of Outreach, Finding Freedom from Abuse (Andover) |
| Hollie Bradshaw (to June 24) | Domestic Abuse Partnership Board/Public Health, Hampshire County Council |
| Tracy Williams | Quality and Assurance Manager, Hampshire County Council Adults Health and Care |
| Briony Hill | Learning and Review Manager, Hampshire County Council Adults Health and Care |
| Dawn Oliver | Associate Director All Age Safeguarding, Hampshire Hospitals NHS Trust |
| Susan Wheeler | Named Nurse Safeguarding Adults, Hampshire Hospitals NHS Foundation Trust |
| Vicki Fisher | Associate Designated Nurse Safeguarding Lead, Integrated Care Board |
| Fiona Holder | Senior Designated Nurse / Safeguarding Director, Integrated Care Board |
| Amanda Atherton | Safeguarding and Domestic Abuse lead Midlands Foundation Partnership NHS Trust |
| Carly Goodson | Clinical Lead, Inclusion, Hampshire (Midlands Foundation Partnership NHS Trust) |
| Grace Mason | Serious Case Reviewer, HIOW Constabulary |
| Hannah Powell | Deputy Head Hampshire N&E Delivery Unit, Probation Service, Hampshire |
| Jackie Osborne | Adult Safeguarding Lead, South Central Ambulance Service |
| Dr Francine Thompson | GP, St Mary's Surgery, Andover |
| Ann Spooner | Practice Manager, Stockbridge Surgery |
| Kathryn Lynch | Housing Options Officer, Test Valley Borough Council |
| Andrew Pilley (to May 2024)<br>David Growcott | Community Engagement Manager, Test Valley Borough Council<br>Community Manager, Test Valley Borough Council / Test Valley Partnership |
| Carrie Voyle | Safeguarding Adults Review Coordinator, Hampshire Safeguarding Adults Board |
| Louisa Rice | Community Engagement & Safeguarding Lead Test Valley Borough Council |

2.6 The panel met seven times between December 2023 and February 2025, which included a pause for the three-month trial. Finding Freedom From Abuse, the domestic abuse specialist service which supports male and female victims in Test Valley, joined the Panel to provide expert input. Presentations and expert information were also provided by Respect,[21] Op COURAGE,[22] Public Health and Hampshire Domestic Abuse Partnership within Hampshire County Council.

2.7 Feedback from family members involved in the Review also informed the Report. Following Panel notification of the Review, written feedback was also provided from Amber, via the Prison, which also informed the Panel's learning.

## 3. Independence

3.1 The independent Chair and Author of this report, Eleri Butler, is a trained accredited Chair of domestic abuse related death reviews, having completed the Certificate in Chairing a Domestic Homicide Review.[23] Eleri is independent of all agencies involved, had no prior contact with family members, and has not previously undertaken such Reviews in Test Valley. Eleri is an Independent Consultant who has worked in the UK, Europe and Australia on domestic abuse prevention and response, and whose work spans 35+ years in public services and the specialist sector. Eleri's consultancy includes work on gender-based violence, DARDR chairing, research and evaluation, safeguarding, strategy and policy. Prior to freelance work, Eleri led Victoria Government's family

[21] https://mensadviceline.org.uk/male-victims/?gad_source=1&gclid=EAIaIQobChMItd7YnufeiQMVv6hoCR3fRyfPEAAYASAAEgIC1PD_BwE
[22] https://www.gov.uk/support-for-veterans/op-courage-the-veterans-mental-health-and-wellbeing-service
[23] https://aafda.org.uk/training/home-office-funded-dhr-dardr-chair-training

violence work (2020-23) and was Welsh Women's Aid CEO (2014-20).

3.2 Other than GP Practices, all Panel members and report authors were independent of direct contact with the subjects of this Review and were not the immediate line managers of anyone who had direct contact. Panel members from GP Practices had minimal contact, and their individual reports were also reviewed, and quality assured, by the Integrated Care Board, also on the Panel.

## 4. Terms of Reference and Scope

4.1 The full Terms of Reference can be found in the full Report. The Panel reviewed each agency's involvement with Max and Amber **between January 2021** and Max's death in **June 2023,** and a summary of their agreed lines of inquiry are as follows:

- Whether improved communication and information sharing might have led to a different outcome.
- Whether service responses were consistent with each organisation's professional standards, domestic violence and safeguarding policies, procedures, assessments, and protocols.
- The effectiveness of agency responses relating to domestic abuse, safeguarding or other significant harm, and whether there were missed opportunities.
- How Max's wishes and feelings, safety and needs were ascertained and considered.
- What was known about Amber.
- How accessible were services for Max and Amber and were responses sensitive to diversity issues and to their protected characteristics[24], or any other special needs.
- What training was provided, was this taken up, and refresher training also provided.
- Whether thresholds for intervention were appropriately applied, by agencies, and were issues escalated internally or to other organisations and professionals, in a timely way.
- Whether there was any impact of organisational change during the period under review.
- What was known about their relationship including whether any co-dependency risks were assessed, whether either was exposed to domestic abuse, including coercion control and economic abuse, and whether they were exposed to information about healthy relationships or accountability for violence prevention.
- Whether agency responses were in accordance with safeguarding adults' legislation, policies and procedures, and if agencies cooperated as required.
- What did family members or friends know about any abuse, and if so, what they did and how would they know what to do with that information.
- What learning was identified, including any recommendations for individual agencies and multi-agency partnerships, to avoid such tragedies occurring in the future.

## 5. Summary of Chronology: Key Events

5.1 A more detailed chronology is included in the full Report, and what follows is a summary of events that led to Max's murder.

5.2 Max was a British Army veteran, having joined aged 17, and he was discharged aged 30. Max was one of ten children, and he was estranged from several family members. He had a history of alcohol use and of physical and mental health issues, and was known to agencies for alcohol related incidents, for vulnerability to 'cuckooing',[25] and for domestic abuse in four relationships. Although Max separated from his second wife in 2006, they never divorced and remained in contact. Following periods of him being estranged from their children, he regained contact before his death, and his family supported him

[24] These are a person's: age; disability; gender reassignment; marriage or civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation.

[25] Cuckooing is when drug dealers use violence, exploitation and intimidation to take over the home of a person in order to use it as a base for drug dealing or criminal activity. https://www.hampshire.police.uk/advice/advice-and-information/cl/county-lines/

with shopping, cooking, and appointments. Agencies were not aware of his contact with family, and their contact also diminished due to his relationship with Amber.

5.3 Amber had moved to Hampshire at the end of 2019, after her ex-wife died, and she lived with her mother until she passed away at the end of 2022. Amber had a history of mental health issues and had made several reports of abuse to police by people known to her.

5.4 **Through 2021,** Max was reported to his landlord Aster's Anti-Social Behaviour service, and to Police, several times. Men known for drug use and supply were regularly found at his address, and on one occasion an ambulance was called for a woman who was found unconscious. Interventions included gathering evidence for an injunction to prevent visitors; discussion at community multi-agency risk assessment meetings for anti-social behaviour; and police notices issued to his GP and to Adult Health and Care (AHC) relating to drug and alcohol use, financial difficulties, and mental health concerns. On many occasions Max was held responsible by agencies for turning visitors away and for not engaging with services. At one point, Police initiated an anti-social behaviour closure order application,[26] based on evidence of anti-social behaviour, criminal damage, and weapon possession.

5.5 At the beginning of the year, Max attended an assessment at Inclusion for support with drug and alcohol use, and he was provided with harm reduction advice. Max was referred to the veterans' mental health service and in May, disclosed that he tried to hang himself the night before, but was no longer feeling suicidal. He was referred to the Veterans High Intensity Service, supported by weekly calls, and referred to the Community Mental Health Team for ongoing support. Police heard of the attempted suicide and also made a safeguarding referral for Max to AHC, who noted Max had been referred to mental health services, so they decided he had no other unmet social care needs.

5.6 During this period, Amber's GP and Emergency Departments in the region became aware of Amber's drug seeking behaviour. In April 2021, Amber called NHS 111 as her mental health had worsened, and said she intended taking an overdose. The Ambulance Service also called HIOW Police to advise that Amber had made threats to kill someone she thought had poisoned her dog; officers assessed Amber and her mother were safe and well. A few months later Amber disclosed to police officers that she had difficulties with mental health, depression, anxiety, and post-traumatic stress disorder, but no Public Protection Notice was issued. Her GP had also deemed Amber to be 'severely mentally impaired' and advised the local authority of this.

5.7 In June 2021, Max disclosed a five-day alcohol binge, and was assessed by Inclusion. Later in July 2021, Max called NHS 111 saying he felt suicidal and wanted to kill people. HIOW Police were called, graded the incident for an urgent response, and it was transferred to mental health services. Police also received reports of his money and his phone going missing, and that he was being taken advantage of. In September, Max completed a housing exchange, arranged by him, and agreed by Aster. Max's GP was advised that the Crisis Resolution Home Treatment service was supporting Max.

5.8 In Autumn 2021, Max initially told the Community Mental Health Team he had settled in well after the move and that he was keen to attend the High Intensity Service for help. However, by November 2021, Police had been called due to people using the address for drug dealing and they also located weapons, and people reported missing and at risk of exploitation. Max was given safety advice and personal alarms, and a safeguarding referral was made, which noted Max's continued vulnerability to cuckooing. AHC did not speak with Max but assessed that because he had capacity to meet his own needs, neighbourhood police visited, he was able to contact services, they determined no further action

[26] These are led by police if they are satisfied, on reasonable grounds, that the use of a property has resulted or is likely to result in nuisance to members of the public, or that there has been or is likely to be disorder associated with it, and that the order is necessary to prevent the nuisance or disorder from continuing, recurring or occurring. A closure notice prohibits access to the premises for a period specified in the notice and may prohibit access by all persons except those specified, at all times and in all circumstances.

was needed. Around the same time, at the end of the year, Amber called Police to report five men with baseball bats surrounding her home, but there was no evidence of an offence, and the matter was filed.

5.9 **In early 2022,** Max told HIOW Police his drug use had reduced, and he was supported by the Community Mental Health Team, and monitoring of his address stopped. Later in Spring 2022 he suffered five seizures over two weeks, was found unresponsive by a neighbour, was twice admitted to hospital relating to alcohol use and diagnosed with significant physical health conditions. He told the hospital he was supported by the Community Mental Health Team and declined a referral to Inclusion. Max had occasional contact with the High Intensity Service for veterans until he was discharged a month later, and his monthly calls from the Community Mental Health Team were reviewed. Max continued to have contact with his GP and the local authority about Council Tax arrears.

5.10 Around the same time, Amber called Inclusion to request support for drug use, but she was unable to make the suggested phone appointment because she was "*in a bad way*". A month later Amber called 999 and reported pain and vomiting. Amber also attended Salisbury Emergency Department for toothache, seeking pain relief medication.

5.11 In Summer 2022, Amber called 111 and said she felt she was going to hurt someone or herself, and that she had cut her wrists, so a safeguarding referral was made. HIOW Police determined this was a medical matter. They later received a report from the Ambulance service that Amber had been assaulted and strangled, and she had said she wished he had killed her. Amber did not support a police investigation and the matter was filed. AHC considered the notification and decided on no further action, because Amber was with her mother, and both had the means to call for help. Later, Amber saw her GP and disclosed a suicide attempt. She was referred to the Crisis Resolution Home Treatment team, which was unable to contact or assess Amber, so she was transferred back to her GP.

5.12 Meanwhile, Max was discharged by the Community Mental Health Team for non-engagement, and his care was transferred back to his GP. Information was shared between Police and AHC that he was being abusive to a woman he knew, but there was no record of any further action being taken.

5.13 In Autumn 2022, Amber's GP again referred her to mental health services, but they were unable to contact Amber, so she was transferred back to her GP with advice to reduce medication. Police recorded that Max was being cuckooed again. Max called Police to report a woman refused to leave his flat; no offences were disclosed, and the matter was filed. Max was also sent a Notice of Seeking Possession for rent arrears, and around the same time he was taken to hospital for falling whilst intoxicated. The anonymous caller expressed concern about bruising to his back, but his body map was clear except for a head wound. Max declined advice regarding stopping using alcohol.

5.14 Towards the end of the year, Amber was distraught to have found her mother had died. Amber's GP made several attempts to contact her and referred her to the Crisis Resolution Home Treatment team. Following several failed attempts to make contact, Amber was transferred back to her GP. Later Amber called an Ambulance to report she intended to end her life by carbon monoxide poisoning. She was taken to hospital and disclosed using crack cocaine and heroin since her mother died, and Police were also notified of cuckooing concerns and financial abuse. AHC opened a discretionary S42 Care Act safeguarding enquiry,[27] and several attempts were made to contact Amber by phone, text, letter, and email. Amber told them she was safe and would not self-harm, and she consented to a Section 9 Care Act assessment of her needs,[28] so she was put on an assessment waiting list.

[27] S42 Care Act: where a local authority has reasonable cause to suspect that an adult in its area (a) has needs for care and support (whether or not the authority is meeting any of those needs), (b) is experiencing, or is at risk of, abuse or neglect, and (c)as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

[28] The purpose of the needs assessment is to identify with the adult the person's needs and how they impact on their wellbeing; the outcomes that matter to the person; and the person's other circumstances. The local authority has the duty to

5.15 **In early 2023,** Amber emailed her GP about her mental health and said she was being taken advantage of, and a mental health referral was made. Due to missing an appointment and history of non-attendance the mental health service discharged her care back to the GP. Around this time, Police had seized knives from her address, and they recorded she was associated with dealers, had been threatened with violence, reports of rape, and a risk of cuckooing. Amber did not provide a statement, said she wanted to move out of the area, and was provided with safety information.

5.16 In February, Amber reported stalking, harassment, and sexual assault over a three-year period, and that there were "*too many*" other times to report. She said she felt suicidal and was advised to call an Ambulance, mental health service or The Samaritans. A safeguarding referral was made and sent to Amber's GP and to AHC, who noted Amber's substance use, previous suicide attempt, and mental health diagnosis. During this time, Amber was in contact with mental health crisis triage team, Police, and local authority because she was threatened with being homeless. During the initial housing assessment, she disclosed mental health support needs, sexual abuse, stalking and harassment and said she wanted to move out of the area. Private rented options were discussed, and information shared, and Amber also said she had no access to money or food. Meanwhile, reduced capacity amongst female specially trained police officers led to significant delays before Amber was later contacted relating to reports of abuse. It was around this time, that Amber met Max.

5.17 In March, Amber told the local authority she was staying with friends, and she asked for help to move out of the area. She also reported she had been burgled and her home vandalised; disclosed verbal, emotional and physical abuse including strangulation by an ex-partner; and asked for support with her mental health. Amber was assessed as high risk of harm, and two Public Protection Notices were completed; one was less detailed and shared, the other was detailed but not shared with agencies. Her ex-partner was arrested, denied assault or criminal damage, and was released on police bail with conditions not to contact her. Amber was later contacted by a domestic abuse officer but said she did not support a police investigation nor a referral to a support service. The Hampshire High Risk Domestic Abuse meeting discussed Amber's experience of domestic abuse, noted financial concerns, delayed assessment, risks of cuckooing, mental ill-health and use of drugs and prescribed medication. A MARAC referral was made and AHC were asked to urgently conduct an assessment, but this was not prioritised because Amber was already on the waiting list.

5.18 Meanwhile, it was reported to the Ambulance service that Max was at risk from people in his home who used him to get money and drugs. A safeguarding referral to AHC led to no further information being sought. Max's ex-partner, following a brief relationship, reported him for abuse and was assessed as high risk, but did not support an investigation. He was arrested, denied the allegations, and indicated it was he who was abused, but refused to make a statement. No action was taken, and no risk assessment or protection notice was completed.

5.19 Around this time, Police identified that a dealer associated with Amber had visited Max and neighbourhood teams were informed, due to previous cuckooing concerns. Amber's association with Max was not explored further. Four days after Amber was discussed at the high-risk domestic abuse meeting, Max's abuse against his ex-partner was discussed, and this was escalated to a MARAC. Due to a system error, further consideration was delayed to May. As the meeting had determined there were no actions for AHC, the referral relating to Max being cuckooed was also closed with no further action.

5.20 Following an assessment with the Community Mental Health Team, Amber disclosed domestic abuse, being cuckooed, homeless, a miscarriage, and multiple psychiatric diagnoses. She said she felt manic, angry and had fluctuating moods; had previously self-harmed and attempted suicide, and had thoughts to harm others. The Community Mental Health Team noted she presented a risk to herself

undertake an appropriate and proportionate assessment if there is an appearance of need, and the information gathered during the assessment will enable the local authority to undertake a determination of eligibility for support.

and others. The outcome of the assessment was to discuss her case at a multi-disciplinary team meeting, to offer Amber a psychiatrist appointment and complete a supporting letter for rehousing. On the same day, Amber reported domestic abuse, including strangulation, to the local authority, who provided Amber with information about refuges and injunctions, and suggested she could refer herself to another area. TVBC made a safeguarding referral to AHC, but their email was not recorded as a safeguarding referral by AHC.

5.21 In April, Max had contact with Aster about rent arrears, contacts with HIOW Police in relation to his ex-partner and had referred himself to Inclusion as his substance use had escalated. Amber was discussed at a MARAC meeting, there were no identified health actions, and nothing recorded about her ex-partner or their whereabouts including the association with Max. HIOW Police knew Amber's ex-partner was staying at Max's flat. They also contacted Amber to follow up on earlier reports of sexual assault, then due to long term staff absence, the case was not reallocated for another six weeks, when Amber no longer supported the investigation.

5.22 Three incidents at the end of April, involving Max and Amber, included Max reporting that he was being threatened with firearms. Amber also called police on Max's phone, heavily intoxicated, and reported men kicking the door and trying to kill her. This was graded urgent, but police units were unavailable. Several further calls ensued, an Ambulance attended and advised they both had capacity and there were no medical concerns, and officers concluded they were intoxicated, had mental health issues and were safe, so closed the case. The second involved Max asking a bank security officer to call police because a gang was after him, so the Police High Harm Team attended. Max said he had no memory of recent events, other than that Amber had told him he was in danger. The third involved Max reporting to Police he had been slapped in the face by his girlfriend Amber, and he had no memory of the previous five days, and asked for help with his mental health. Max also called an Ambulance and reported being hit in the face and verbal abuse, and a human bite mark on his arm. During his hospital admission, multiple bruises and a bite mark were documented, but there was no record of anyone having a conversation with him about the injuries. It was noted Max was confused, alcohol and cocaine dependant, and feeling suicidal, and his GP was notified of domestic abuse, suicidal ideation, and of needing a medication review and primary care mental health support.

5.23 In May, Max confirmed that Amber had slapped him, but he did not support a police investigation. He was assessed as standard risk of harm and his GP was notified, and although further monitoring of his address was discussed, this was not acted on. Police followed up on the domestic abuse report with Amber in June. Meanwhile Aster received reports that Max was vulnerable, used drugs and was being taken advantage of. Max missed his appointment with Inclusion, so his case was closed, and he also had not attended a pre-arranged appointment with his GP. A MARAC meeting heard the case of Max and his ex-partner, but there was little mention of Max and information shared was from the earlier March meeting. Aster also received reports of increased disturbance in May, along with verbal abuse and noise from Max's address, and they visited with neighbourhood officers. An appointment was arranged for Max at Inclusion, and during the assessment he disclosed using alcohol, cocaine, heroin, and ketamine over four months. Harm reduction advice and an alcohol reduction plan were discussed, and Max denied any safeguarding concerns.

5.24 Also in May, Amber reported being drugged and raped whilst at Max's address but denied he was involved; she mentioned losing her memory for a week, and reported money going missing. A timeline was difficult to determine by police officers, and a specialist sexual violence team were notified. There were around fourteen unsuccessful attempts by police officers to contact Amber by calls, texts, email, and visits over a two-week period. A protection notice was completed a month after the initial report, but it was not shared with another agency. Later, Amber was told by HIOW Police that earlier reports of strangulation, burglary and criminal damage were closed with no action due to no supporting evidence. Amber contacted community mental health services, and told the local authority said she had stayed at Max's address but left because of abuse, so was sleeping in a tent.

5.25 In June, Max did not attend his follow up appointment with Inclusion. Police visited Max and he said he had been heavily intoxicated and denied being assaulted. Amber denied the allegation at a voluntary interview a few days later. On the same day, anti-social behaviour and neighbourhood officers visited Max, but he would not let them in as he said he had a girlfriend there. Aster sent Max a home visit appointment letter, for mid-June. Two days later, Amber called 999 and reported severe pain; an ambulance attended, she was assessed and discharged home. Two days after that, Amber's housing options assessment was updated and she was referred to a hostel, but did not respond to them contacting her. Amber told AHC's mental health team she felt '*psychotic'* and was being financially abused. Her speech was slurred, and she gave conflicting accounts of her situation. A Section 42 Care Act safeguarding enquiry was opened, AHC were unable to contact Amber and requested that the Community Mental Health Team attend a joint home visit as part of the enquiry. The Community Mental Health Team declined this statutory request, due to her previous non-engagement.

5.26 Max did not attend his appointment with Inclusion. He told them he was "*off the drugs"* and his alcohol use had decreased, but he agreed to attend another appointment at the end of June. In mid-June Max was visited by anti-social behaviour and neighbourhood officers who noted he seemed well. He introduced them to his girlfriend, and he told them he was not drinking or taking drugs, and was being supported by Inclusion. Aster flagged concerns about Max's girlfriend with HIOW Police, specifically that it seemed she was taking advantage of him and that he may have been cuckooed. This concern was raised locally and shared with AHC towards the end of June.

5.27 Amber called 999 and reported waking up with pain and breathing problems, and was taken to hospital where she was given pain relief and self-discharged. Around the same time, AHC reviewed the Section 42 enquiry and, because they could not get in touch with Amber, decided to close the case. The next day Amber reported an assault to HIOW Police, as a woman had punched her and spat in her face, resulting in injury, after Amber found and retrieved her lost dog at the woman's house. The report was not assessed by Police for seven days.

5.28 The next day was the last known sighting of Max. He was found murdered in his home towards the end of June, after a neighbour called police. Max was found wrapped in a blanket, surrounded by several notes. Amber was arrested at the end of June 2023 after she used Max's bank card in another area. On Amber's arrest, she made several statements including that she had been abused and sexually assaulted. Amber's arrest record stated she had diagnoses of split personality disorder, borderline personality disorder, depression, anxiety, and a history of substance use, self-harm, and suicidal ideation.

## 6. Key Findings and Lessons Learned

6.1 This section addresses the overarching lessons that have been learned from this Review. Agencies also identified their own lessons following consideration of lines of inquiry, that led to single agency recommendations, which feature in the full Report.

### Key finding 1: Responding to male victims of domestic abuse required improvement.

6.2 There are specific barriers to accessing help for men who experience domestic abuse, and women's violence may not always be recognised by agencies. Agencies need to be competent in distinguishing between primary perpetrators and victims who use resistance, mutual violence, or unreasonable behaviour in relationships.

6.3 Max was known to agencies as having perpetrated domestic abuse. When he later reported abuse from a female partner, it was vital agencies could effectively assess disclosures made. However, health services made no referral to the co-located specialist domestic abuse service, on disclosure, and a domestic abuse report to police resulted in a delayed risk assessment and he later denied the assault

had occurred. Max separately disclosed being drugged and that money was stolen from him, but no protection notice was completed that could have flagged vulnerabilities and financial exploitation.

6.4 Agencies' learning included ensuring that stereotypes and gendered perceptions do not impact on safeguarding responses offered, so that the needs of older men at risk or experiencing abuse, are met. The Panel noted there are now specific commitments in the Hampshire Domestic Abuse Strategy to improve awareness of and response to older men being abused. Information on support services for male victims, including access to national support services such as the Men's Advice Line,[29] is also now published on the Hampshire Domestic Abuse Partnership website, with other services. Dispersed accommodation is now available for male victims, and specific training funded by Public Health on domestic abuse and male victims, economic abuse, and responding to disclosures is publicised online.

6.5 The Panel noted that services should continue to be supported to develop specific responses for older men, including therapeutic and peer support. Organisations should ensure their assessment processes are consistent for male and female victims, in line with the national Male Victims Toolkit.[30] The practice of frontline services should also align with the national Male Victims Standard, the accreditation framework for work with male victims.[31] Agencies should also be encouraged to use the DASH risk assessment tool in parallel with the male victims' toolkit – the latter focusses on the dynamics of the relationship, considers where the victim may use violent resistance or where a perpetrator may be using harmful behaviours, and also helps assess situational violence, mutual violence, patterns of power, coercion and control, and helps agencies address counter allegations of abuse.[32]

**Key finding 2: Awareness and response to veterans' needs required improvement.**

6.6 Veterans in the UK are thirty percent more likely to suffer from mental health disorders, twice as likely to suffer post-traumatic stress disorder and alcohol problems, when compared with the general population,[33] and services need to improve access to support and responses to veterans.[34] In Hampshire, the prevalence of anxiety, depression and alcohol-related mental health problems exceeds the general population for veterans, with many also experiencing social isolation and loneliness.[35]

6.7 Max was offered specialist veterans' support before and during the earlier period under Review, including from the Veterans' Mental Health Transition, Intervention and Liaison Service, Veterans' Mental Health Complex Treatment Service and Veterans' Mental Health High-Intensity Service.[36] Max had not disclosed relationships, family contact, or social networks but had mentioned conflicts with neighbours and thoughts of taking his own life, which led to weekly phone support at one point. However no parallel adult safeguarding referral was made, despite vulnerabilities related to alcohol and drug use, mental health needs, and cuckooing, as it was assumed that Police and AHC services were aware. The adult safeguarding service had closed the notification in 2021 because Max was already in contact with veterans' services. A follow-up safeguarding referral could have provided a fuller picture of his care and support needs and may have led to a coordinated plan for support at that time.

6.8 It was also not evident that Max's veteran status was considered during recent mental health assessments, nor was it clear why Op COURAGE were not involved, given Max's previous positive

[29] https://mensadviceline.org.uk/
[30] https://www.respect.org.uk/resources/19-respect-toolkit-for-work-with-male-victims-of-domestic-abuse
[31] https://www.respect.org.uk/pages/respect-male-victims-standard
[32] It is recommended that a self-paced online training course and more detailed training is available, to support agencies use these resources. https://www.respect.org.uk/resources/19-respect-toolkit-for-work-with-male-victims-of-domestic-abuse
[33] Rhead R et al (2020) 'Mental health disorders and alcohol misuse among UK military veterans and the general population'.
[34] Hitch C (2023) Enablers and barriers to military veterans seeking help for mental health and alcohol difficulties: A systematic review of the quantitative evidence.
[35] HCC (2023) Inclusion Health Groups chapter from Joint Strategic Needs Assessment https://documents.hants.gov.uk/public-health/jsna-2023/inclusion-health-groups.pdf
[36] These services have since been renamed as Op COURAGE, which is NHS England's mental health treatment pathway for veterans that involves NHS staff working with charities to deliver therapy, rehabilitation, and inpatient care, for veterans.

engagement with the veterans' mental health service. In 2023, Max had also not benefitted from the Police veterans' policy by accessing the Liaison and Diversion Service, because he was released following questioning before being seen. Recent policy changes from December 2023 have led to the availability of substance use workers in police custody, and Operation Nova[37] caseworkers for veterans who can be seen in custody or in the community. Frontline professionals working with veterans also have access to Suicide Prevention Awareness training and an audit of services led to greater awareness of services for veterans. Although not specific to veterans, awareness raising of domestic abuse amongst the Armed Forces is gradually increasing. There is now a dedicated domestic abuse service for Armed Forces serving officers and their dependents, available nationally, and locally people can access telephone and in-person support or video calls.[38]

6.9 The Panel noted the Armed Forces Covenant Legal Duty requirements[39] and expert information was also provided about the support needs of veterans, to help improve consistency of agencies' responses to veterans in future, especially where safeguarding concerns may be identified. Max's family also thought that specialist veterans' services would have been more helpful to Max than regular services, and suggested access to 'buddy' or peer support service in the community, which would help veterans, especially older men, discuss issues and what support they need, in an informal setting.

### Key finding 3: Alcohol and drug use impacted access to help and agencies' response.

6.10 Although Max had achieved periods of abstinence from alcohol and discharged from Inclusion services in 2018, by Summer 2021, Max was using heroin, crack cocaine, ketamine, and drinking 30 alcohol units daily. Problematic substance use impacted Max's access to local services, and the support he told services he had available was not always in place. He did not engage with the service again to the point of having a full assessment, and although he self-referred in May 2023, follow up appointments made for June 2023 were not kept. The self-referral for support had followed Max's disclosure of domestic abuse, and was also at a time when cuckooing concerns were identified.

6.11 Although Amber contacted Inclusion in May 2022 for help with prescription medication, she had not otherwise engaged with the service. Amber fed-back to the Panel that services should give people who use drugs '*more of a chance'*, and that people with lived experience of addiction should work in services to help increase their understanding of women's support needs. In Hampshire, Inclusion advised that they deliver a volunteer support and mentoring scheme which encourages those with lived experience to be trained to provide buddying support to help others. Inclusion has also worked with the Hampshire commissioned domestic abuse service to develop a joint pathway to access support.

6.12 Max's family said they were concerned his alcohol was being withheld by Amber, that his drug use increased, and that she controlled his contact with others. They reiterated the importance of in-person support for male victims, from someone they trusted and who would notice changes in health and wellbeing. Having domestic abuse advocates co-located with Alcohol Liaison teams in hospitals or substance use treatment services, would help victims disclose abuse when using those services and is recommended in the Domestic Abuse Act Statutory Guidance.[40] It also states that local areas should develop initiatives to address alcohol and drug related domestic abuse, including women-only services, cross-sector working, and domestic abuse advocates providing outreach at treatment services.

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[37] Operation Nova was delivered by the Forces Employment Charity and commissioned by NHS England, provides support for veterans who are in contact with the justice system, enabling them to access the services they need.
[38] Aurora New Dawn Armed Forces dedicated service - https://www.aurorand.org.uk/services/the-armed-forces/
[39] The Armed Forces Covenant , published in May 2021 and enshrined in law by the Armed Forces Act 2011, intended to ensure members of the Armed Forces community should face no disadvantage and have the same access to Government and commercial services and products as other citizen, across health, education, employment, housing and financial services.
[40] https://assets.publishing.service.gov.uk/media/62c6df068fa8f54e855dfe31/Domestic_Abuse_Act_2021_Statutory_Guidance.pdf

6.13 The Panel noted recommendations from a Hampshire thematic safeguarding review, that had focussed on alcohol use, domestic abuse, and access to services, should also be consistently applied, to ensure a coordinated focus on systems and service improvement.[41]

**Key finding 4: 'Cuckooing' was not well understood or responded to by agencies.**

6.14 'Cuckooing', a form of criminal exploitation when "people take over a person's home and use the property to facilitate exploitation",[42] predominantly involves drug dealing, but may also involve violence, sexual exploitation or trafficking, storing weapons or stolen goods. A person may be targeted if they are vulnerable through alcohol or drug use, are older or disabled. Sometimes this may begin as consensual, in exchange for drugs, but become exploitative. Once someone gains control through drug dependency, debt or a relationship, larger groups may move in, and use threats, financial abuse, violence, or coercion, to maintain the exploitation.

6.15 Max was at a heightened risk of cuckooing however action to effectively address this and support him to be safe, was limited. In 2021 actions largely involved a focus on anti-social behaviour procedures and Max was inappropriately held responsible for turning visitors away or preventing their attendance. His address was periodically monitored by police and although Max also moved property, he was soon being exploited again and drugs, weapons and people were found at his new address.

6.16 In Autumn 2022, police also noted evidence of cuckooing and weapons at Amber's property, and although adult safeguarding services discussed these risks in December 2022 and again at MARAC in April 2023, Amber was only placed on a waiting list to be assessed, which never happened. Similarly, a safeguarding referral for Max resulted in no further action because it was thought he was subject to police monitoring.

6.17 Although agency responses to cuckooing concerns were mainly led by police, and intelligence was gathered and safeguarding alerts raised, at no point was there an investigation into crimes associated with exploitation, that led to prosecution. There was also no evidence of multi-agency evidence gathering, to inform action to meet either Max's or Amber's care and support needs. Locally a thematic review into deaths associated with cuckooing[43] found similar concerns, including gaps in understanding and response to cuckooing, the need for tailored responses, and an absence of a coordinated multi-agency adult exploitation strategy.

> *"Why weren't they dealt with … Nothing happened at the time, even when they knew they had knives and everything. Them doing nothing cost someone their life." (Max's family)*

6.18 Nationally, cuckooing is intended to become a criminal offence, under the Crime and Policing Bill (still proceeding to completion at the time of writing). In the meantime, agencies should make use of a national toolkit[44] and develop a coordinated multi-agency response, to help local services to identify and improve support available for people at risk of cuckooing. The panel noted that the National County Lines Strategy 2024–27[45] also aims to share best practice with local areas. The Hampshire Safeguarding Adults Board has also since contributed to national work to raise awareness of cuckooing and to Home Office guidance, informed by learning from this and other Reviews.

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[41] https://hampshiresab.org.uk/wp-content/uploads/2025/06/Catherine-Jeremy-and-Sarah-Alcohol-Harm-Thematic-June-2025.pdf

[42] See National Police Chiefs Council National County Lines Coordination Centre - https://www.npcc.police.uk/our-work/work-of-npcc-committees/Crime-Operations-coordination-committee/national-county-lines-co-ordination-centre/

[43] The Hampshire Safeguarding Adults Board Thematic Review was published in July 2024 https://www.hampshiresab.org.uk/wp-content/uploads/Cuckooing-SAR-Katie-James-and-Luke-July-2024.pdf

[44] Researchers at the University of Leeds designed the Toolkit with West Yorkshire Police, Leeds City Council, and Groundswell, The toolkit is available at: https://essl.leeds.ac.uk/downloads/download/250/preventing-and-disrupting-cuckooing-victimisation-professional-toolkit

[45] https://www.npcc.police.uk/SysSiteAssets/media/downloads/publications/publications-log/national-crime-coordination-committee/2024/disrupting-county-lines-policing-strategy-2024-to-2027.pdf

### Key finding 5: Responses to rape and sexual assault reports were inconsistent.

6.19 During the period under Review, several reports of rape, sexual assault, harassment, or exploitation were noted within agency reports, but no consent given to be referred to specialist support services. Issues identified included an allegation of sexual assault in Spring 2023, that resulted in no further action, because Max was being interviewed for perpetrating domestic abuse. Sexual assault and rape allegations made by Amber in February and April 2023 did not proceed due to several procedural failings (including lack of access to female specially trained officers, lack of cover for officer leave, and delays in case allocation) that led to withdrawal of support for an investigation in June 2023. Parallel and earlier reports of high-risk domestic abuse, sexual abuse and harassment, strangulation, threats, and burglary had also not proceeded.

6.20 In October 2022, HIOW Police were involved in the expanded roll-out of 'Operation Soteria', a national model to transform responses to rape and serious sexual violence. The Panel were advised that specially trained officers are now based in specialist teams, are predominantly female, and that victims are referred to a specialist advocate, with consent. It is vital that local responses to sexual violence ensure a victim-centred and suspect-focussed police and community approach to rape and sexual abuse response and prevention, alongside provision of specialist support services.[46] This should be a strategic priority for leaders locally and sustainable funding should be prioritised for its delivery.

### Key finding 6: Economic abuse was not effectively identified or addressed.

6.21 Although extensive financial abuse wasn't evident from agency reports, several issues raised by Amber and Max related to debt, theft, stolen bank cards, or lack of access to money for food, but led to no further exploration by agencies. Potential intimate partner economic abuse was also not explored. Max's family said his bank and other agencies should have suspected financial abuse, given he never had any money, his cards were used by others, and he kept losing or having to change bank cards.

6.22 Had safeguarding enquiries been instigated earlier, these issues may have been more effectively identified, connected to exploitative behaviour, and acted on. The Care Act 2014 definition of 'abuse' includes financial abuse, but it was evident that agencies should have better awareness of financial and economic abuse, and how to identify it early, provide support and disrupt further abuse. Had safeguarding enquiries also been conducted effectively, the financial abuse may have been identified and a coordinated plan agreed, to prevent such abuse from taking place.

6.23 In the UK, the 2021 Financial Abuse Code for Banks[47] focuses on guidance on how to support victims of financial and economic abuse, and how to apply principles of the Code in practice. Those implementing this Code should work with community safety and safeguarding agencies to deliver a coordinated response to victims vulnerable to domestic abuse and exploitation, including cuckooing.

6.24 Max's family also raised concerns that after Max's murder, the Ministry of Defence, local authority and Max's landlord contacted them to demand money they felt was owed by Max be repaid. It was recommended that agency policies that govern recovery action against family members be revised, so that families are not financially penalised following domestic homicide.

### Key finding 7: Responses to health support needs were inconsistent.

6.25 Mental health support needs are not a cause of domestic abuse; however, it can be a risk factor for perpetrating abuse, and can lead to an increased risk of being a victim.[48] Understanding a person's mental health history and whether they have experienced repeated trauma is important for assessment,

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[46] HMICFRS (2024) Progress to introduce a national operating model for rape and serious sexual offences - https://hmicfrs.justiceinspectorates.gov.uk/publications/progress-to-introduce-a-national-operating-model-for-rape-and-other-serious-sexual-offences-investigations/

[47] https://www.ukfinance.org.uk/system/files/2022-12/Financial-Abuse-Code-2021_Updated_2022.pdf

[48] Bacchus et al (2018) Recent intimate partner violence against women and health: a systematic review.

support and intervention, and mental health services should be trained, equipped and confident in identifying and responding to domestic and sexual abuse.

6.26 Max's mental health diagnoses and support needs were significant. His GP noted escalating mental health concerns in 2021 but no care plan was shared with them. Around the same time, poor coordination between hospital mental health services and the GP Practice about access to mental health support was also evident. Mental health care planning was not coordinated, and Max's needs were not discussed at multi-disciplinary case reviews. To ensure continuity in safeguarding practice, a Practice Safeguarding Care Coordinator has since been appointed by the GP to oversee consistency of communication and strengthen safeguarding systems and processes.

6.27 Amber had several prior diagnoses, and her experience of emotional dysregulation likely impacted her engagement with services. Amber's GP Practice raised concerns about drug seeking behaviour, and lack of continuity of psychiatric support. Learning included the need to make safeguarding referrals earlier, without assuming police made referrals. The Practice has since improved engagement with Community Mental Health Teams, clarified the response to a police notification, and police and mental health services now regularly attend Practice Safeguarding meetings so that issues are addressed early. The Practice will also review domestic abuse training available.

6.28 Domestic Abuse Policy and protocols had not informed assessments of Amber's mental health support needs, by the Community Mental Health service, nor had they considered prior reports of sexual abuse and harassment. Despite several referrals, a comprehensive risk assessment that considered the risk of violence towards Amber and by her to others, was not conducted, as required by policy. There was also no safeguarding referral made, in accordance with the Safeguarding Policy. Community Mental Health service improvements recently introduced include a consistent approach to multi-disciplinary team discussions and a communication tool to support team discussions. Continuity in contact and care should also be prioritised, and unconscious bias (related to prior lack of engagement and assumptions that this would continue) should be addressed.

6.29 The IRIS[49] domestic abuse training support and referral system for health services has not been commissioned locally in GP Practices, in accordance with Domestic Abuse Statutory Guidance.[50] Routine or targeted enquiry and response should be a priority in relevant health settings[51] and this approach is encouraged by the Hampshire domestic abuse referral pathway, which advocates proactive routine enquiry and referral to specialist services.[52] Following this Review, the Integrated Care Board plans to support GPs to identify victims, intervene earlier and refer to specialist services appropriately, provide domestic abuse training for primary care, and develop a Domestic Abuse Policy that Practices are encouraged to adopt. Further work is needed to clarify GP practices' engagement with MARAC and action following notifications and minutes. Information about the Veteran Friendly Accreditation for health services will also be shared to encourage GPs to identify, understand, and support veterans and ensure effective access to specialist health services.

6.30 Hampshire now operates an adult community mental health transformation programme, called 'No Wrong Door',[53] so that care can be provided locally, and support can be received in several settings. This aims to remove barriers between primary and secondary care, mental and physical health, and health and social care to deliver integrated, personalised, coordinated care. Primary Care Networks now have mental health and well-being practitioners to provide support to those who might not meet thresholds for secondary mental health services, and it is envisaged that this 'no wrong door' programme may address barriers facing people with alcohol and substance misuse support needs.

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[49] IRIS is an evidence-based primary care intervention https://irisi.org/about-the-iris-programme/

[50] Home Office (2022) Domestic Abuse Statutory Guidance, see pp 96-97 https://assets.publishing.service.gov.uk/media/62c6df068fa8f54e855dfe31/Domestic_Abuse_Act_2021_Statutory_Guidance.pdf

[51] See Department of Health (2017) 'Domestic Abuse: resource for health professionals.'

[52] https://documents.hants.gov.uk/adultservices/DomesticAbuseReferralPathwayforHampshire.pdf

[53] https://www.hantsiow.icb.nhs.uk/your-health/mental-health-services/no-wrong-door

### Key finding 8: Connections between suicide risks, self-harm and abuse were not made.

6.31 Severity and duration of abuse, and existing mental health needs, may be specific risk factors for suicide. Among people who have attempted suicide in the past year, 49% had experienced intimate partner violence at some point, and 23% had experienced abuse in the past year. One in three women and one in ten men who attempt suicide have experienced abuse in the past year. Experience of sexual violence was ten times more common in women than men, with this form of abuse being particularly associated with self-harm and suicide.[54] National data from 2022-2023 and 2023-24 showed that the number of suspected victim suicides following domestic abuse had overtaken intimate partner homicides, perhaps because these are now being recorded.[55]

6.32 Max had a history of attempts to take his own life, which in 2017 led to a hospital admission, and similar attempts were made in 2018 and 2021. Whilst Max's vulnerabilities were recognised, his specific care and support needs in relation to mental ill-health, alcohol and drug use, exploitation, and domestic abuse, alongside suicidal thoughts, were not assessed or well recorded on agency systems.

6.33 Amber also had several referrals to mental health services, associated with suicide risks and attempts, including in 2021 and 2022, however the service failed to engage her effectively. Around this time, she had also threatened to murder someone she believed had poisoned her dog, which was noted by police as a mental health episode. In March 2023 a phone assessment determined Amber presented a risk to herself and others. No connection was made between this and earlier suicide attempts or threats to harm others, and because she was known to MARAC it was wrongly decided that a safeguarding referral was not needed.

6.34 It is vital that health, social care, domestic abuse, and welfare professionals ask people who have self-harmed, who have attempted or are at risk of suicide, if they are experiencing domestic and sexual abuse, and professionals should be prepared, and supported, to respond accordingly. Agencies should also better prioritise access to talking therapies and support when referrals indicate a history of domestic abuse and suicide attempts. Services that meet immediate needs, provide long term support, and offer a vision for the future, may be more helpful in the context of suicidality and domestic abuse, than short-term, risk focused service responses.[56]Agencies should also ensure that policies and guidance on domestic abuse and suicide prevention and response align with each other, to support frontline teams addressing the co-occurrence of both.

### Key finding 9: The Multi-Agency Risk Assessment Conference system was inadequate.

6.35 A domestic abuse Multi Agency Risk Assessment Conference (MARAC) system has been recommended as a response to high-risk domestic abuse for over two decades in England and Wales. Nationally MARACs were designed to focus on managing and reducing the risk of a person experiencing serious injury or death, and their effectiveness were underpinned by the DASH[57] risk assessment tool, designed to identify victims at high risk of harm or homicide. However there is no unanimous evidence nationally of MARACs' effectiveness or of the tool's accuracy or validity.[58]

6.36 Max has been identified as a perpetrator of high-risk domestic abuse against an ex-partner towards the end of March 2023, and the case was subsequently referred to the next MARAC meeting. However, there was a delay in referral of seven weeks, due to it being wrongly assigned, and it was allocated to the May MARAC. It was not evident at that meeting that Max's needs, risks, or any interventions, were

54 McManus et al (2022) Intimate partner violence, suicidality, and self-harm.
55 Vulnerability Knowledge and Practice Programme (2024) Domestic Homicides and Suspected Victim Suicides 2022-2023, NPCC and College of Policing. https://www.vkpp.org.uk/vkpp-work/domestic-homicide-project/
56 Smith et al (2018) Building a temporal sequence for developing prevention strategies, risk assessment, and perpetrator interventions in domestic abuse related suicide, honour killing, and intimate partner homicide
57 The Domestic Abuse, Stalking harassment and 'Honour'-based violence (DASH) risk identification checklist is the most widely used risk assessment tool in England and Wales, utilising a checklist of 27 risk indicators.
58 Phillips (2018) Not Everyone is Created Equal Under the MARAC Model': A Literature Review of Domestic Violence Risk Management Process for High, Medium and Standard Risk Cases in the UK, University of Manchester

discussed nor what support he was receiving. There were gaps in attendance from mental health and substance use services, and recorded that there was no safeguarding role required. Max had also disclosed domestic abuse, at the time of the MARAC meeting, and there were also known risks of cuckooing, yet these concerns were not considered nor adequately addressed

6.37 Amber's experience of high-risk domestic abuse from an ex-partner was discussed in April 2023, and meeting notes were sent to the wrong contact email for her GP Practice. Given the concerns around drug use, dealing and cuckooing, safeguarding input from a specialist drug and alcohol service would have been beneficial whether or not she was using the service. Regardless of current involvement, multi-agency representation is needed to ensure a robust and effective action plan, as outlined in the Authorised Professional Practice guide from the College of Policing.[59]

6.38 Not only should there be system checks in place to prevent administrative errors that delay victims being heard, but there should also be relevant agencies at meetings, and sufficient information sharing that enables analysis and action-planning around complex and multiple needs. If that weren't possible at MARAC then consideration should have been given to holding a Multi-Agency Risk Management (MARM) or S42 safeguarding process, noting that safeguarding enquiries can run alongside MARACs[60]. There was no apparent connection made or joined-up action taken in response to suicide risks, domestic abuse risks, risks associated with mental ill-health, problematic substance use, and exploitation through cuckooing. The Panel noted that significant action is needed to address shortfalls in MARAC systems at individual agency, and strategic levels. This is reflected in the Action Plan for agencies, and this should include a review of the MARAC process by the partnership, with all relevant agencies contributing. Locally, Public Health has agreed to facilitate system partners to come together to consider how the MARAC operates.

**Key finding 10: Safeguarding responses to multiple presenting needs were ineffective.**

6.39 Max and Amber each had multiple presenting needs in addition to domestic and sexual abuse, including mental health concerns, self-harm and suicide risks, physical health problems, addiction to alcohol and problematic substance use, financial abuse, being involved in criminal activity, being at risk from exploitation and cuckooing and involvement in County Lines. Additional risk identified for Max included risks to physical health due to alcohol dependence and to mental health due to reported diagnosis of post-traumatic stress disorder, and limited engagement with veteran's mental health services. He was also identified as being at risk to himself due to occasionally being in a highly distressed state when intoxicated.

6.40 Agencies including Police often responded to the most presenting immediate need, which was often their mental health. However, it was evident that responding to one need in isolation led to an ineffective outcome. There were missed opportunities to make enquiries and bring agencies together to share information under the S42 pathway. Safeguarding concerns raised in March and April 2023 were not fully explored or considered to have met the criteria for an enquiry. Due to discussions at MARAC, the risks highlighted to adult safeguarding services were not assessed and cases were inappropriately closed. This learning has led to a practice improvement review focussed on the interaction between high-risk domestic abuse meetings, MARAC and safeguarding concerns.

6.41 With regards Amber, there was a significant delay in allocation to carry out the S9 assessment, which never took place whilst she waited six months on a list. A robust risk review and management approach for waiting lists has now been introduced to address this issue. Another significant issue related to adult safeguarding services, in June 2023, requesting the community mental health team conduct a joint visit

[59] College of Policing (2021) Domestic Abuse Authorised Professional Practice - Victim Safety and Support guide https://www.college.police.uk/app/major-investigation-and-public-protection/domestic-abuse/victim-safety-and-support#referral-to-marac

[60] Where the S42 criteria is met, a MARM is not appropriate, and a S42 enquiry should take precedence. Where S42 criteria is not met, but risks remain which would benefit from a multi-agency framework and they are not being addressed by an alternative framework, then a MARM would be appropriate.

with Amber, but they declined due to her prior non-engagement. That rejection of a statutory request was not escalated, and the enquiry was then inexplicably closed, along with Amber's case. Learning has resulted in more regular monitoring of training take-up and training compliance in relation to Safeguarding and Domestic Abuse. Reflective practice sessions between safeguarding services and the mental health team, to review decisions and case closures, has been introduced and a mental health thematic review has resulted in a mental health transformation plan across Hampshire.

6.42 Significant safeguarding and domestic abuse issues were identified when Max's disclosure of domestic abuse at the hospital was not acted on nor referred to the Safeguarding Adults team. Actions include, for example, reinforcing Emergency Department domestic abuse policies; safeguarding and domestic abuse teams providing supervision and guidance; and meeting to identify and review regular attenders. Safeguarding and Alcohol Liaison teams have also improved joint working to identify patients who may be at risk of abuse or neglect. There has also been an increase in awareness of patients who have care and support needs relating to alcohol dependency.

6.43 There was little evidence that the enduring experiences of Max and Amber were fully analysed and considered by those responding, including how these impacted on each other once their relationship became known. Police, for example, noted that the impact of multiple intersecting care and support needs was not always understood by officers and staff. Mental health difficulties and substance use were more commonly identified, but issues with finances, the impact of homelessness, and concerns about exploitation and cuckooing, violence, and coercion along with histories of domestic abuse were less commonly considered as cumulative harms for them both. There was also an issue with the timeliness of notifications made in may and June 2023.

6.44 Although there was some evidence of a multi-agency response for Max or Amber during the last few months of the review timeframe, but it was largely ineffective and had little productive impact on the way agencies worked or on the safety, risk reduction and support available for Max or Amber. Many agencies had known that repeated safeguarding referrals led to no further action, and in hindsight, the Multi Agency Risk Management (MARM)[61] approach between agencies could have been instigated, based on the unmanageably high risks and multiple and intersecting needs Max and Amber had. It was suggested by several agencies that arranging a MARM would have prevented missed opportunities to submit safeguarding referrals and may have developed a multi-agency collaborative plan of action to support Max and Amber, if they remained below statutory safeguarding thresholds.

6.45 Max's family also offered some reflections on safeguarding and how services might be improved. They said that people in the community may have been more helpful than agencies, had they been given the opportunity. These would include places where Max would have felt comfortable to talk to someone of his own age. They recommended that to improve safeguarding practice in future, home visits and a buddy system should be provided, for people where there are safeguarding risks.

6.46 The family's feedback focussed on encouraging a shift in approach from being '*known to services'* to being '*known by professionals'*. This is similar in approach to 'contextual safeguarding'[62] for young people, which aims to shift the focus from a solely criminal just response to exploitation to a welfare-based response to understand and respond to significant harm beyond the home, recognising different relationships in peer groups, online and in the community, particularly for those at risk of exploitation and violence. Learning from this approach to safeguarding young people, that targets the social and

[61] Hampshire 4 Safeguarding Adults Boards (2023) Multi-Agency Risk Management guidance https://www.hampshiresab.org.uk/wp-content/uploads/4LSAB-MARM-Multi-Agency-Risk-Management-Framework-June-2023-Final.pdf and https://www.hampshiresab.org.uk/wp-content/uploads/Quick-Guide-to-Multi-Agency-Risk-Management-MARM-Final.pdf

[62] See the work of Prof Carlene Firmin who initiated this work and resultant practice resources and research programme: https://www.contextualsafeguarding.org.uk/

physical contexts of extra-familial risks and harms directly, may be relevant to the contexts facing older adults at risk, where abuse, exploitation, cuckooing, and other vulnerabilities coexist.

**Key finding 11: Ineffective housing responses and lack of safe suitable housing.**

6.47 The issues raised with Aster Housing Group by third parties were primarily managed through Anti-Social Behaviour procedures, and Max was identified as the perpetrator of such behaviour, and held responsible for his visitors and their behaviour. There were no safeguarding concerns identified by Aster at the time, and as his landlord, they received no requests for information-sharing or reports of Max being a victim of domestic abuse or requests about meeting his care and support needs. This was a missed opportunity to involve Max's landlord in addressing domestic abuse related behaviour and to ascertain whether anyone was living with Max at his rented home, between March and June 2023. Domestic abuse often co-exists with, or can be mistaken for, Anti-Social Behaviour, and victims are four times more likely than the general tenant population to receive anti-social behaviour complaints, so it is vital that housing providers have clear procedures for distinguishing both issues and addressing them simultaneously if needed.

6.48 Aster's new Domestic Abuse Policy (2024 – 2027), in accordance with the Regulator of Social Housing[63] requirements, states firm action will be taken against perpetrators. It is not clear how this may be achieved, but could, for example, include partnering with agencies to deliver interventions to manage and reduce risk and prevent abuse. At the time of this Review Aster did not have mandatory domestic abuse awareness training for frontline staff and managers, and the benefit of attaining Domestic Abuse Housing Alliance accreditation were identified in agency recommendations.

6.49 Test Valley Borough Council (TVBC) did not have a domestic abuse policy at the time (as recommended by the Code of Guidance);[64] nor was a domestic abuse risk assessment carried out by the housing options service, and the housing service was not consistently represented at the MARAC. This was contrary to Homelessness Code of Guidance recommendations relating to MARAC and to its recommendation that housing officers pay regard to the Serious Violence Duty and work with police and other partners to reduce the risk of such violence, including by participating in joint casework or attending multi-agency meetings, to provide support for victims.[65]

6.50 TVBC had an interim duty to secure accommodation for Amber, whilst making enquiries, which was discharged by talking through private rented housing options. There was no evidence of whether the risks of violence and of high-risk domestic abuse were considered in TVBC discharging its interim housing duty, nor was there evidence that these risks informed decisions that Amber was not eligible for a Main Housing Duty or for the Relief Duty.[66] There was also no formal confirmation provided of her status at that time. The service advised the Panel it failed to effectively engage Amber to confirm legislative thresholds to their satisfaction. However, several agencies had provided corroborative information about risk and vulnerabilities, and when Amber called the service in May, there appeared to be no record of her being asked about where she lived nor about why she had to leave.

6.51 The Panel noted that TVBVC Housing services should in future be trained on domestic abuse risk assessments and improve communication with the MARAC, other departments and services. Action to

[63] Social Housing (Regulation) Act 2023 aims to reform the regulatory regime to drive significant change in landlord behaviour and was enacted from April 2024.
[64] Chapter 21, 21.12 and 21.13, Homelessness Code of Guidance – Domestic Abuse
[65] The Hampshire Domestic Abuse Strategy recognises that the Serious Violence Statutory Duty (which commenced 31 January 2023) informs work on domestic abuse locally. See Home Office (2023) Serious Violence Duty Statutory Guidance https://assets.publishing.service.gov.uk/media/639b2ec3e90e072186e1803c/Final_Serious_Violence_Duty_Statutory_Guidance_-_December_2022.pdf
[66] The main housing duty is a duty to provide temporary accommodation until such time as the duty is ended, either by an offer of settled accommodation or for another specified reason. The relief duty involves taking reasonable steps to help secure suitable accommodation with a reasonable prospect that it will be available for their occupation for at least 6 months.

improve understanding of internal safeguarding reporting procedures had happened, and achieving DAHA accreditation would further improve the response to domestic abuse. From July 2024, a specialist domestic abuse post was introduced in the Housing Options service.

6.52 Hampshire Domestic Abuse Strategy[67] (which includes the statutory safe accommodation strategy priorities) commits the region to deliver inclusive, quality, affordable, and appropriate safe accommodation support to all victims of domestic abuse irrespective of their needs and background. It aims to improve domestic abuse identification, prevention, and effective and efficient use of safe accommodation referral pathways. It also aims to ensure the most relevant principles and components of the Whole Housing Approach are applied, to enable a range of safe accommodation options that are alternatives to refuge provision. Since October 2024, Hampshire County Council Public Health has commissioned a dispersed accommodation service providing specialist domestic abuse support for people who may not be able to access refuges. All housing providers in Hampshire and Test Valley would benefit from identifying a network of Domestic Abuse Champions and adopting a *Whole Housing Approach* to domestic abuse across all tenure types, to improve the local housing response to future victims of domestic abuse.[68] All districts and boroughs in Hampshire have now been offered, and taken up, funding from UK Government allocation (via Hampshire County Council Public Health team) for the Whole Housing Approach to domestic abuse, in adherence to the Domestic Abuse Statutory Guidance.

**Key finding 12: Criminal justice responses and access to protection were inconsistent.**

6.53 Most investigations within the period under review resulted in no further action, due to perceived non-engagement by Max or Amber. Whilst officers showed persistence and varied communication methods, there was little consideration given to the complexities of their lives, who else they may be engaging with and the level of contact they may be receiving from other agencies. Not wishing to support a police investigation or engage with a support service could also be a potential symptom of trauma, poor mental health, feeling overwhelmed by multiple-agency contact, or prioritising what they perceive to be their immediate concern, such as safety, housing, food, money, over a criminal prosecution. On the occasions when Max or Amber were initially engaged, there were delays in deployment due to an error in allocation or a lack of available officers or staff and delays in progressing an investigation. Both Max and Amber also had frequent police contact, which could have attracted stigma and unconscious bias.

6.54 There were four occurrences in which police had contact with Max and Amber during their relationship, three of which resulted in identified learning by police. In April 2023, when Max called police, heavily intoxicated and hallucinating, with concerns about being threatened, the ambulance attended but police should also have attended to confirm no offences had taken place. This would also have flagged Max and Amber's new relationship with other agencies at the earliest opportunity. The next day a domestic abuse report by Max was graded urgent but incorrectly tasked to the High Harm Team, who were off duty and visited four days later. This response was not in line with positive action duties and resulted in missed opportunities to ensure Max's safety and gather evidence in support of a police investigation. In May 2023, there was significant delay in contacting Amber by a female specialist officer, by which time Amber advised she no longer supported an investigation. Concern for Amber's mental health was recorded but not shared with her GP, and this presented a further missed opportunity to share information with other agencies regarding Max and Amber's relationship.

6.55 Police advised that further learning includes ensuring that perceived non-engagement by victims, or their continued contact with perpetrators, should not be a reason for concluding an investigation; conversely in many cases this is an indicator of increased risk. It was also noted that there was evidence that the Victim's Code was not consistently applied, because vulnerable and intimidated

[67] https://documents.hants.gov.uk/public-health/domestic-abuse/domestic-abuse-strategy-2023.pdf
[68] https://www.dahalliance.org.uk/membership-accreditation/what-is-daha-accreditation/ . The 'whole housing approach' project has, since 2018, advocated work across all tenures to address the full range of housing needs victims of domestic abuse will have. See https://www.standingtogether.org.uk/housing-whole-housing

victims have enhanced rights that include being updated frequently and being referred to specialist support services, which had not happened in this case.

### Learning reflects themes from other reviews.

6.56 The themes and learning from this Review also highlight recurrent themes from parallel thematic safeguarding reviews and domestic abuse related death reviews nationally and locally, even though the circumstances of those who died or were murdered were different. For example, nationally recurring themes, like those found in this Review, include the need for more effective information sharing where there are issues relating to safeguarding and domestic abuse; the need for shared plans to mitigate risks that perpetrators pose; for trauma informed services and assertive outreach for women with multiple support needs, and improvements to MARAC operating systems.

6.57 Although outside the temporal scope of this Review, family also fed-back that two months after the homicide they experienced additional trauma on entering the property, after its release as a crime scene. The condition of the crime scene is an issue that has been raised by other families involved in domestic homicide reviews nationally, so the Panel explored the issues raised further. The Panel recognised that this had been deeply traumatic for family, and that their bereavement was inevitably compounded by their experience at the scene. No family should have to go through the distress of cleaning up a domestic homicide crime scene, and further consideration was given by the Panel to recommendations that might help prevent families being faced with such trauma in future.

## 7. Conclusion

7.1 Max was murdered in June 2023 by Amber, who he referred to at the time as his girlfriend. They had known each other for around four or five months, and Amber often lived with him during the three months before he was killed, although she denied to agencies that they were in a relationship.

7.2 Both Max and Amber had significant involvement with several agencies before they met each other. This involvement variously related to mental health diagnoses and support needs, problematic substance use, suicidal ideation and attempts to take their own lives, insecure and unsafe housing, involvement in the criminal justice system, financial issues, exploitation associated with dealing drugs and weapons, and reports of perpetrating domestic abuse and experiencing rape and sexual violence.

7.3 Several agencies knew very little about their relationship or about any signs of domestic abuse prior to the homicide, but records also showed there had been clear disclosures of abuse made by Max against Amber, and by Amber against others, alongside concerns about exploitation associated with drug use. Agencies had failed to identify their relationship early on. Their association with the same networks were evident from records, but professionals involved in multi-agency safeguarding systems did not identify this connection until a couple of months before Max was killed. Had they done so earlier, risks associated with exploitation, abuse, mental health and drug use, might have been better identified and managed. Instead, assessments of care and support needs were delayed, there were inconsistent responses by police and safeguarding services, and several referrals relating to concerns for both, failed to identify actions that would have safeguarded, supported, and protected Max and would have met Amber's complex needs. This Review also revealed that agencies inadequately identified and responded to domestic abuse reported by an older man from a younger woman, which suggests greater attention is needed to ensure services are accessible for men, as for women, and that interventions are effective to hold both male and female perpetrators accountable for their behaviour.

7.4 Ultimately, services lacked professional curiosity, overly relied on an assumption that other agencies were monitoring or responding to concerns raised, and responses tended to address mental ill-health, problematic substance use and domestic abuse in silos. Their complex and intersecting support needs, vulnerabilities and risks were not adequately holistically recognised and met. There was also a distinct

failure by professionals to identify and work with family members of Max to maximise his access to support and help mitigate the risks he faced.

7.5 The analysis by the Panel of the last few years of Max's involvement with agencies can only ever be a partial account of his lived experience and is summarised in this report. However, his family do not want Max to be remembered as a victim. He was a father and husband, a proud man who thought the world of his grandchildren, an accomplished veteran, and a loyal friend, who left a lasting impression on those he met.

7.6 Twelve substantive key findings from this Review and several lessons learned by agencies have led to almost 50 recommendations. The Panel hopes their significant learning and action from this Review will create a real change for domestic abuse victims, some of whom may also be military veterans, and whose experience of problematic substance use, and mental health support needs demands a complex and multi-faceted response from systems and services in Hampshire.

## 8. Recommendations

**Aster Housing**

- Provide tenancy sustainment support to new tenants especially if known vulnerabilities and risks.
- Ensure Aster attends domestic abuse MARACs and is involved in safeguarding enquiries and information sharing.
- Undertake the Domestic Abuse Housing Alliance accreditation for registered housing providers.
- Develop domestic abuse policy and mandatory training on responses to victims and perpetrators.

**Primary care**

***Integrated Care Board***

- Support GP practices to have the tools and confidence to identify and respond to domestic abuse.
- Deliver a domestic abuse care pathway and develop strong working relationships with local domestic abuse services.
- Roll out the Veteran Friendly Accreditation developed by Royal College of GPs and NHS England, across GP Practices to identify, understand and support veterans and refer to specialist health services.

***Stockbridge Surgery***

- Clarify actions need to be taken following receipt of a Police Protection Notice
- Identify and deliver domestic abuse training for the clinical team.

***St Marys Surgery***

- Ensure GP Practice correctly codes and flags vulnerable adults to inform effective response.
- Appoint a safeguarding co-ordinator to manage safeguarding processes.
- Participate in new service which caters for patients with mental health needs (particularly with regards to prescribing mental health medications) in the context of substance misuse.

**Hampshire County Council – Adults Health & Care**

- Improve interaction between AHC and HRDA/MARAC, to ensure appropriate identification and response to safeguarding concerns and care and support needs of individuals (Care Act 2014).
- Deliver increased training compliance in relation to domestic abuse.
- Improve Care Act compliance demonstrated by evidence-based decision making, particularly within S42 enquiries.
- Deliver consistent and timely application of Care Act 2014 particularly regarding identification of care and support needs for adults experiencing domestic abuse and undertaking Care Act S9 assessments.

**Hampshire Hospitals NHS Trust**

- Improve system to ensure an increase in safeguarding adults' referrals to Adult Service and involvement of HHFT Safeguarding Adults team.

- Improve and monitor effectiveness of referral pathways to STOP Domestic Abuse hospital teams.
- Implement routine enquiry for domestic abuse, in accordance with statutory guidance and in partnership with the commissioned domestic abuse service.
- Ensure domestic violence training is mandatory across Levels 1-3, and completion to be monitored.

**Inclusion Hampshire**

- Improve earlier information sharing with consent to ascertain agencies involved in supporting a person.
- Increase awareness regarding signs of domestic abuse, relating to both perpetrators and victims, leading to increased confidence of staff to manage and support both victims and perpetrators.

**Police: Hampshire and IOW Constabulary**

- Ensure that the decisions of priority and repeat victims are clearly recorded, including their reasons for not wishing to support a police investigation or later withdrawing their support.
- Domestic Abuse lead to consider a dip sample of outcome 16 (suspect identified, victim does not support or has withdrawn support) high risk domestic abuse investigations to ensure that all key lines of enquiry were followed, full use of the PACE custody time limits and opportunities for evidence led prosecution were fully explored.
- Domestic Abuse lead to increase awareness amongst frontline officers and staff of the effect that multiple and complex care and support needs can have on victims of domestic abuse, including how this can impact on their mental capacity, recollection, decision making and increased vulnerability.
- The Head of Public Protection to remind MASH coordinators that where PPNs for adults at risk evidence multiple care and support needs, PPNs should be routinely shared with both health and social care partnership agencies.
- Domestic Abuse lead to consider the implementation of an older adults DASH risk assessment for use with domestic abuse victims over the age of 60.
- Promote the Paragon Male Pattern Changing Course, the Men's Advice Line and toolkit provided by Respect and the national male victim standards on the force intranet and via internal communications to increase officer and staff awareness of support for male victims of domestic abuse.
- The 'Amberstone' force lead to ensure victims of rape and serious sexual offences have access to suitable provisions, including contact with a SOIT, that referrals to external specialist services are made where appropriate and that the number of SOITs in the Constabulary is sufficient in meeting demand.

**SHFT - Community Mental Health Team**

- All staff in the local Community Mental Health Team, including long term agency staff, complete safeguarding adults' level 3 training.
- Improve practitioner responses to domestic abuse and safeguarding enquiries.

**Test Valley Borough Council**

- Improve housing engagement with MARACs to focus on actions that reduce risk and harm.
- Clarify the links between domestic abuse and community (anti-social behaviour) multi-agency partnerships to avoid confusion between both.
- Improve information and awareness about domestic abuse amongst TVBC customers.
- Ensure compliance with the Hampshire County Council Domestic Abuse Strategy and relevant housing specific domestic abuse policy and procedural guidelines.
- Improve safeguarding adults and children system of referrals and response, when led by housing services to ensure cases can be cross referenced for any other concerns flagged across TVBC services.

- Ensure staff are aware of the process for making safeguarding referrals, recording of safeguarding referral information and outcomes.
- Improve information sharing between TVBC Revenues & Welfare team and Housing Service with regards residents identified as vulnerable.
- Review training package, and incorporate additional or bespoke content, where needed, in relation to safeguarding, domestic abuse and multiple and complex needs.
- Develop a 'whole housing approach' to addressing domestic abuse, to improve service response to domestic abuse across all tenures that TVBC collaborates with, as recommended in the Domestic Abuse statutory guidance.

**Multi-agency recommendations**

The Panel supported recommendations made in the Hampshire thematic cuckooing review, that included the need for a coordinated and formalised multi-agency adult exploitation strategy, to include cuckooing, that focusses on victimisation instead of 'anti-social behaviour' and on holding perpetrators of cuckooing to account. This should include providing frontline practitioners with a coordinated framework to safeguard adults at risk of exploitation through 'cuckooing', including where there is domestic abuse. These recommendations are therefore not repeated here. Actions for all agencies:

- Audit delivery against the good practice expectations set out for respective agencies in the Domestic Abuse Statutory Guidance ('Role of Agencies'), and report annually on the organisational change achieved, to the Hampshire VAWG Strategic Board.
- Strategic review of HRDA and MARAC processes to ensure the system maximises victims' safety, holds perpetrators accountable, and integrates robust actions to identify and address domestic abuse and associated risks and needs for female and male victims, alongside MARM or Safeguarding enquiries.
- Improve agencies' use of Hampshire 4LSAB MARM framework, and family involvement, in cases of domestic abuse where there is "unmanageable high risk" and concerns that do not meet statutory criteria (s. 42) Care Act 2014.
- Review how services can better meet the circumstances of older men who experience domestic abuse, including ensuring that policies and procedures do not dissuade or prevent older men from accessing help.
- Clarify and raise awareness of pathways to support between specialist veterans' services, domestic abuse and safeguarding responses.
- Promote access to domestic abuse training (where not already available) that includes a focus on (1) economic abuse identification and response and (2) improving skills and competency to identify and reduce risks of suicide or self-harm amongst people impacted by domestic abuse.
- Ensure trauma informed policy and practice guidance supports bereaved families following a domestic homicide, including supporting their re-entry to the property after it has been cleaned so that no evidence of the murder remains.

**National recommendations**

- Panel to write to Ministry of Defence to recommend a review their domestic abuse policy and procedures alongside a review of their procedures that govern financial recovery action against family of victims of domestic homicide, to ensure that families aren't financially penalised following domestic homicide.
- Panel to write to Domestic Abuse Housing Alliance (DAHA) to advise of the learning and recommend the housing accreditation system is reviewed to include housing providers' review of domestic abuse and financial recovery policy and procedures to ensure that families aren't pursued or financially penalised following domestic homicide.
- Panel to write to College of Policing, NPCC and DAHA to recommend standards for police and housing providers to ensure families of domestic homicide victims are supported with their re-entry to the property in which no evidence of the murder remains.