Test Valley Partnership
Hampshire Safeguarding Adults Board

Joint Domestic Abuse Related Death Review and Safeguarding Adults Review

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

Glossary

AAFDA:	Advocacy After Fatal Domestic Abuse.
AHC:	Adults' Health and Care (Hampshire County Council).
BHFT:	Berkshire Healthcare NHS Foundation Trust.
CRHT:	Crisis Resolution Home Treatment team (Mid & North Hampshire) – part of SHFT.
CTS:	Complex Treatment Service (Veterans Mental Health, part of BHFT).
DASH:	Domestic Abuse Stalking and harassment and Honour-based violence risk assessment.
DAHA:	Domestic Abuse Housing Alliance (partnership and accreditation system).
DARDR:	Domestic Abuse Related Death Review.
GP:	General Practice / General Practitioner.
HCC:	Hampshire County Council.
HHFT:	Hampshire Hospitals NHS Foundation Trust.
HIOW:	Hampshire and the Isle of Wight.
HIS:	High Intensity Service (Veterans Mental Health, part of BHFT).
HRDA:	High Risk Domestic Abuse (Hampshire daily multi-agency meeting).
ICB:	Integrated Care Board.
IDVA:	Independent Domestic Violence Adviser.
IMR:	Individual Management Review.
IRIS:	Identification and Referral to Improve Safety.
MARAC:	Multi Agency Risk Assessment Conference.
MARM:	Multi Agency Risk Management framework (for Safeguarding Adult Boards in Hampshire, Isle of Wight, Portsmouth and Southampton and partner organisations.)
MASH:	Multi Agency Safeguarding Hub - where safeguarding concerns to AHC are triaged and assessed involving professionals from several agencies in a multi-agency team.
PPN:	Public Protection Notice issued by police, to other agencies, where there are concerns about a person's wellbeing and safety.
RHCH:	Royal Hampshire County Hospital.
S9 Care Act:	An adult safeguarding assessment, under the Care Act 2014, by AHC to assess an adult's need for care and support.
S42 Care Act:	An adult safeguarding enquiry, under the Care Act 2014, by AHC to decide whether action is required for an adult to support and to safeguard them in their daily living.
SAB:	Safeguarding Adults Board (Hampshire).
SCAS:	South Central Ambulance Service NHS Foundation Trust.
SHFT:	Southern Health NHS Foundation Trust.
TILS:	Transition Intervention and Liaison Service (Veterans Mental Health, part of BHFT).
TVBC:	Test Valley Borough Council.

Contents

REPORT INTO THE DEATH OF MAX (JUNE 2023)

Preface

The Independent Chair and Review Panel members 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.

The Chair would also like to thank Review Panel members for the professional way they conducted this Review, and everyone who provided reports to inform the Panel's learning, to help make the future safer for victims of domestic abuse and adults at risk of harm.

Section 1

1. Introduction

1.1 Domestic Homicide Reviews / Domestic Abuse Related Death Reviews (DARDRs) were established on a statutory basis by the Domestic Violence, Crime and Victims Act 2004 and came into force in April 2011. A DARDR is a review of the circumstances of the death of a person, where the death has or appears to have resulted from domestic abuse towards the person, within the meaning of the Domestic Abuse Act 2021, with a view to identifying the lessons learnt from the death.[2]

1.2 This report reviews the circumstances leading to the death of Max, who was killed by Amber (not her real name) in June 2023. This is a joint DARDR and Safeguarding Adults Review (SAR). The report uses the definition of domestic abuse in the Domestic Abuse Act 2021.[3] The purpose of a DARDR[4] is:

a) To establish lessons from the domestic homicide regarding the way in which professionals and organisations work individually and together to safeguard victims.
b) Identify what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
c) Apply these lessons to service responses including changes to inform national and local policies and procedures.
d) Prevent domestic violence and homicide and improve service responses for all domestic abuse victims and their children, by developing a co-ordinated multi-agency approach to ensure domestic abuse is identified and responded to effectively at the earliest opportunity.
e) Contribute to a better understanding of the nature of domestic abuse, and
f) Highlight good practice.

1.3 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. Statutory guidance[5] sets out the purpose of SARs, and principles for their conduct. The primary purpose of a SAR is to identify organisational learning about how local agencies work together, to support improvement in practice, and what lessons can be learned and applied in future. Its purpose is not to hold any individual or organisation to account.

[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] Domestic Abuse Act 2021 - https://www.legislation.gov.uk/ukpga/2021/17/section/1/enacted
[4] Home Office, (2016) "Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews".
[5] Statutory Guidance to SARs under the Care Act 2014 - https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

Timescales

1.4 In July 2023 Hampshire and the Isle of Wight Constabulary (HIOW Police) notified Test Valley Partnership (TVP)[6] of Max's murder, which they believed met the criteria for a domestic abuse related death, defined by legislation. The TVP Chair consulted partner agencies, including domestic abuse services, and two days later agreed to hold a DARDR, and the Home Office was notified.

1.5 A DARDR Independent Chair was appointed in November 2023, after which the Hampshire Safeguarding Adults Board (HSAB) decided that this case also met the criteria for a SAR[7] and that this duty would be most efficiently discharged if merged with the DARDR. Liaison between the Chair, TVP and HSAB ensured that the needs of both reviews were reflected in the terms of reference and Panel membership. Throughout this report, the Review is used to mean the joint DARDR and SAR.

1.6 All agencies that potentially had contact with Max or Amber were asked to confirm involvement and secure their files. Agencies across several local authority areas (Test Valley, Hampshire, Berkshire, and Wiltshire) informed the Review, and the Panel held its first meeting in December 2023. Individual Management Review (IMR) reports were commissioned, and agencies were advised to implement early learning without delay. Five online Panel meetings were held before the trial in Summer 2024, with a further two meetings held after the trial, in November 2024 and February 2025. The Panel completed the Overview Report and Executive Summary in March 2025, which were presented for approval to the TVP and HSAB between April and June 2025, sent to the Home Office in July 2025, and approved for publication in February 2026.

1.7 Several agencies reported Max was estranged from family members. However, police had identified contacts for his ex-partner (legally his wife) and adult children, and the Chair wrote to them in April 2024, via police family liaison officers, to advise of the Review and invite their participation. Other family members were later identified, and the Chair also wrote to them, via police, in August 2024, but they did not respond. The letters included information about Advocacy After Fatal Domestic Abuse.[8]

1.8 At court, Amber pleaded not guilty to murder. The trial was held over twelve weeks in Summer 2024, and Amber was sentenced to life imprisonment with a minimum term of 23 years. In September 2024, Max's wife and two adult children came forward to meet the Chair and participate in the Review.

Local context

1.9 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[9] places it at the forefront of system priorities. Test Valley Borough Council's Domestic Abuse Strategy was under review at the time of 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.

1.10 This Review was undertaken in accordance with HSAB Safeguarding Adult Review Policy,[10] and informed by the local SAR toolkit, which collates reviews and lessons, to inform future practice. Of relevance to this Review was the 'Cuckooing Thematic SAR' published in July 2024.[11] TVP also published two DARDRs in 2018 and 2020, which were considered for any similarities and cumulative

[6] Test Valley Community Safety Partnership now forms part of the 'Test Valley Partnership', which is working to reduce crime and disorder, combat the misuse of drugs and alcohol, and reduce the fear of crime. https://www.testvalley.gov.uk/communityandleisure/communitysafety/test-valley-community-safety-partnership-test-vall .
[7] The criteria (at 1.3) is set out in Section 44 of the Care Act 2014.
[8] https://aafda.org.uk/
[9] https://documents.hants.gov.uk/public-health/domestic-abuse/domestic-abuse-strategy-2023.pdf
[10] https://www.hampshiresab.org.uk/wp-content/uploads/HSAB-Safeguarding-Adult-Review-Policy.pdf
[11] https://hampshiresab.org.uk/safeguarding-adult-reviews/

learning. Also relevant was how the needs of male victims, of women who experience multiple disadvantages, and of veterans, are met locally. Hampshire's Joint Strategic Needs Assessment identified that in 2021, there were 73,309 veterans locally; 33,529 were aged 16-64 years old, over half were aged over 65 and 85% were male; and around 2,500 may have experienced domestic abuse.[12]

1.11 In Hampshire it is estimated that 58,100 people aged over 16 were impacted by domestic abuse in 2023.[13] The following domestic and sexual abuse services are available in Test Valley and Hampshire, although neither Max nor Amber had contact with those services other than being referred to the Multi-Agency Risk Assessment Conference:

- Finding Freedom from Abuse,[14] which provides services across Test Valley, by phone, email, and in-person, including an outreach service for women, men and children, a refuge that can support up to 23 families, and provision of education and therapeutic programmes.
- Stop Domestic Abuse,[15] commissioned by Hampshire County Council, which provides community support for women and men at medium and high risk of harm, refuges, support for children and young people, and for those who use abusive and unhealthy behaviour. The service receives high-risk police referrals and provides services for victims across Hampshire.
- Aurora New Dawn[16] offers safety support and empowerment to survivors of domestic abuse, sexual violence, and stalking, support for women in the criminal justice system, and an Armed Forces Advocacy Service.
- A Multi-Agency Risk Assessment Conference (MARAC) administered by HIOW Police. High risk victims are discussed at daily 'High Risk Domestic Abuse' (HRDA) meetings.
- Independent Sexual Violence Adviser service, and a pan-Hampshire therapeutic service for victims of rape and sexual offences.[17]
- Victim Support Victim Care Hub and trauma-informed practitioners who attend with police.[18]
- Yellow Door domestic abuse services, which provide educational programmes and support for victims of domestic abuse.[19]
- Hampton Trust Cautioning and Relationship Abuse (CARA) programme, commissioned by Hampshire County Council, provides domestic abuse behaviour-change interventions for offenders assessed as standard risk who have received a caution and accept responsibility.[20]

2. Overview

2.1 The 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, 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

Summary of the incident

2.2 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

[12] HCC (2023) Inclusion Health Groups chapter from Joint Strategic Needs Assessment https://documents.hants.gov.uk/public-health/jsna-2023/inclusion-health-groups.pdf
[13] Hampshire Domestic Abuse Partnership Strategy https://documents.hants.gov.uk/public-health/domestic-abuse/domestic-abuse-strategy-2023.pdf
[14] https://www.findingfreedom.org.uk/
[15] https://stopdomesticabuse.uk/
[16] https://www.aurorand.org.uk/
[17] https://www.hampshirerasac.org.uk/ and https://yellowdoor.org.uk/about-us/
[18] https://www.hampshireiowvictimcare.co.uk/
[19] https://yellowdoor.org.uk/
[20] https://hamptontrust.org.uk/program/cara/

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.

2.3 Amber had only recently met Max, around February 2023. Amber lived with him after she became homeless and, between April and June 2023, Max occasionally referred to Amber as his girlfriend. In April, he disclosed domestic abuse from Amber, which he later denied. During that time, Amber had also reported being raped and assaulted by other men.

2.4 In August 2024, after a twelve-week trial, Amber was sentenced to life for murder, and she was ordered to serve a minimum of 23 years, and a concurrent eight months for fraud. 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*".

Summary of prior agency involvement

2.5 All agencies below had some involvement with Max, Amber or both, between January 2021 and June 2023, and they completed a chronology and 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) [21]	***Max used the veterans' mental health services between 2017 and 2021***. This included assessment and signposting, and treatment for trauma, depression, and anxiety between 2017-2018. In 2019, Max was arrested for assault and had contact with the diversion team. 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 the Inclusion Recovery Service and Southern Health Community Mental Health Team, who referred him to the Acute Mental Health Team.
Hampshire County Council - Adults Health and Care (AHC)[22]	***Max was referred several times to AHC between 2021 and 2023,*** due to concerns about mental health, cuckooing and domestic abuse. He was previously known to AHC from 2007 and 2017. In 2021, four police Public Protection Notices[23] 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 closed and issues of concern raised by TVBC were not responded to. AHC had no direct contact with Max. ***Amber was known to AHC between 2022 and June 2023***. Her first contact in July 2022 related to Ambulance referrals following a mental health crisis and assault. In December 2022, Amber had tried to take her own life, and she was placed on a waiting list for a Care Act assessment; six months later an assessment had not occurred. Amber also self-referred for help following domestic and sexual abuse. In June 2023, AHC opened a safeguarding enquiry, which was later closed, along with her case.
Hampshire Hospitals NHS	***Max attended the Emergency Department four times between 2021 and 2023.*** This included twice in March 2022 which led to inpatient episodes. In November 2022 and April 2023, he was assessed then discharged home.

[21] 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/

[22] 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.

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

Foundation Trust (HHFT)	***Amber attended the Emergency Department three times between 2021 and 2023.*** This included in September 2021, March, and July 2023. She left without being seen twice, on receipt of pain killers. The third time Amber was discharged to police custody.
Hampshire & Isle of Wight Constabulary (HIOW Police)	***Between April and June 2023 HIOW Police had contact with Max and Amber four times. Max was also known for 120 recorded incidents between 1997 and 2023***. His address was subject to monitoring for 'cuckooing' concerns between October 2018 and June 2022, and in 2023, police knew of increased drug use and supply at his address (via Operation Fortress).[24] Max was recorded as a perpetrator of domestic abuse and was discussed at a MARAC in 2017 and 2023. Police recorded incidents in relation to four women. Max was also recorded as a victim of domestic abuse when he reported being slapped by Amber, in April 2023. ***Amber was known for 97 recorded incidents between 2020 and 2023***, linked to drug use and supply, and to reports of rape, domestic abuse, 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 in 2021 and 2023.*** He was referred between February and July 2021, but his case was closed following failed attempts to engage him to conduct a full assessment. He was also referred in May 2023, and had an initial assessment, but did not attend further appointments in June 2023. Max had previously used the service in 2016 and 2017 for treatment, counselling, and relapse prevention support, after which he achieved periods of abstinence and was discharged in 2018. ***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 from the Community Mental Health Team, but Amber said she was not using drugs, so the joint assessment 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 2023, SCAS made two safeguarding referrals to AHC relating to Max, including following disclosure of domestic abuse. ***Amber had twelve contacts with SCAS between 2022 and 2023.*** These included in July 2022 when Amber had cut her wrists and a safeguarding referral was made, and in December when she had tried to take her own life. In February 2023 a mental health assessment call was followed by a cancelled call. Two calls in April 2023 included an anxiety attack whilst at Max's address, and in June 2023 Amber was taken to hospital.
Southern Health NHS Foundation Trust (SHFT).[25]	***Max was known to SHFT mental health services between 2017 and 2023.*** He had previously contacted the hospital mental health service and Community Mental Health Team between 2017 and 2019 due to suicide and self-harm risks when intoxicated. Max was discharged in July 2022. In April 2023, Max was seen at the Emergency Department when he disclosed he felt suicidal, and he was discharged to his GP. ***Amber was known to SHFT mental health services between 2021 and 2023.*** In April 2021 Amber was referred by a GP, for self-harm, to the Crisis Resolution Home Treatment team 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-

[24] 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.

[25] 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.

	harm, but services failed to complete an assessment. In January 2023 the service signposted Amber to Inclusion for support.
St Mary's Surgery Andover (GP Practice - Max)	***Max was seen (in person/by phone) eight times in 2021 and five times in 2022.*** Four notifications in 2021 related to self-harm and involvement from mental health services. Notifications received in 2023 related to Max perpetrating domestic abuse (in March 2023), a hospital mental health assessment (April 2023) and being slapped (May 2023), after which the GP called Max to make an appointment. He did not attend so a follow-up text was sent to rearrange it. In June 2023, Max made an online request for medication and was also sent a text to request a review appointment.
Stockbridge Surgery, Stockbridge (GP Practice - Amber)	***From January 2020 Amber had several contacts during the period under review,*** predominantly related to pain relief medication and to replace lost or stolen medication. The GP Practice identified a pattern of drug seeking behaviour and referred Amber to SHFT for mental health assessments and support.
Test Valley Borough Council (TVBC)	***Max had several interactions in relation to Council Tax between October 2021 and June 2023***. He was known to TVBC Revenues and Welfare Service from 2006. ***Amber was known to TVBC between 2020 and 2023***. This included involvement with the Revenues and Welfare Service for Council Tax (December 2020 to August 2021); with the Housing and Environmental Health Service in relation to a dog (November 2022), and with Housing Options (February to June 2023) in relation to homelessness and disclosure of domestic abuse.

3. Parallel Reviews

3.1 The Coroner suspended their investigation in July 2023 when Amber was charged with murder, and they were subsequently notified that this Review was taking place. Following the trial, the Coroner made the decision not to resume the investigation and the file was closed.

3.2 SHFT conducted a serious incident investigation on behalf of NHS England following Max's death, which was led by an internal Serious Incident Investigating Officers. The investigation concluded no factors had contributed to the incident being investigated. Midlands Partnership University NHS Foundation Trust also conducted a review of Max's contact with Inclusion, in line with NHS England's Serious Incident Framework. The review did not identify service-related causes but identified service delivery issues relating to harm reduction and risk management, and the need for contact in between missed assessments and discharge. Service recommendations were made, to be addressed locally.

3.3 The circumstances of this case did not meet the threshold for any other statutory reviews.

4. The Review Panel

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

Name	**Position, organisation**
Eleri Butler	Independent Chair and Report Author
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) David Growcott	Community Engagement Manager, Test Valley Borough Council 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

4.2 Although they had no contact with Max or Amber, expert advice was provided on domestic abuse by Finding Freedom From Abuse, the domestic abuse specialist service which provides support for male and female victims in Test Valley. To enhance knowledge and understanding about risks, needs, and responses to older male victims, and about veterans' support needs, presentations and expert information were also provided by Respect[26] and Op COURAGE,[27] and expert input was provided by Public Health and Hampshire Domestic Abuse Partnership within Hampshire County Council.

5. Independence

5.1 The independent Chair and Author of this report, Eleri Butler, is a trained accredited Chair and has completed the Certificate in Chairing a Domestic Homicide Review.[28] Eleri is independent of agencies involved, had no prior contact with any family members, and has not previously undertaken DARDRs or SARs in Test Valley Borough Council. Eleri had previously Chaired a Domestic Homicide Review in a unitary authority in Hampshire, so has had prior contact with some local agencies in that capacity.

5.2 Eleri is an Independent Consultant who works in the UK and internationally primarily on preventing domestic and sexual violence, and violence against women, and whose work spans 38+ years in public service, government, and the specialist sector. Further details are provided in Appendix B.

5.3 Other than GP Practices, all Panel members and IMR 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.

6. Terms of Reference and Temporal Scope

6.1 The full Terms of Reference can be found at Appendix A. The Panel's agreed lines of inquiry were included in full in the Terms of Reference and were used to inform the Panel's analysis (see Section 13). They are summarised as follows:

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

- Each agency's involvement with Max and Amber **between January 2021** and Max's death in **June 2023.**
- 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 abuse 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[29], 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 held to account 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.

7. Confidentiality

7.1 Throughout this Review, the reports and findings were restricted to participating professionals and their line managers or senior leaders who quality assured reports and were briefed on immediate learning. Members of the victim's family met with the Chair to discuss the content of this Report and were also provided with the draft report, and any feedback provided was incorporated.

7.2 Full dissemination of Report findings will occur only after the Report is approved for publication by the Home Office.

7.3 As recommended within the Home Office '*Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*', to protect the identities of those involved, pseudonyms have been used, and any reference to precise dates have been obscured. The Executive Summary of this report has also been anonymised.

8. Dissemination

8.1 Once permission is granted by the Home Office to publish, the Report and Executive Summary will be published and disseminated locally to agencies in Test Valley and Hampshire. These include but are not limited to Panel members; Test Valley Partnership and Hampshire Safeguarding Adults Board members; Hampshire Domestic Abuse Board; Hampshire Coroner; Hampshire Police and Crime Commissioner, and the Domestic Abuse Commissioner for England and Wales.

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

8.2 Max's family will be advised of publication and dissemination plans and consulted regarded key dates to avoid, and whether any support will be required for them during this period. The Report and Executive Summary will be published on Test Valley Borough Council and the Safeguarding Adults Board websites (https://hampshiresab.org.uk/safeguarding-adult-reviews). Actions and learning events will be taken forward in the context of the wider partnerships. This process will be coordinated by TVP and HSAB review leads.

8.3 Learning summaries will be created for professionals and this Review may be used in domestic abuse training to aid learning across the partnership. A learning summary will be produced and lessons from this Review, and other relevant reviews, will inform thematic dissemination and future 'lunch and learn' sessions open to all partners.

8.4 Dissemination of the learning will also take place through safeguarding adults' mechanisms, via Board members disseminating learning in agencies, and HSAB 'learning from practice' sessions. The ICB and Health Trusts will also share the learning with relevant teams.

8.5 Once permission is granted by the Home Office to publish, the recommendations will be owned by Test Valley Partnership and the Hampshire Safeguarding Adults Board. Delegated responsibility for monitoring progress on implementing the action plan, on behalf of the Partnership, will be held with local partners and the HSAB will seek assurance of impact.

9. Methodology

9.1 Initial DARDR and SAR scoping exercises were conducted and then combined for the purposes of this Review. Agencies that had contact were asked to secure their records and produced detailed chronologies. Twelve agencies in Hampshire, Berkshire, and Wiltshire provided Individual Management Review reports that analysed involvement with Amber and Max (see 2.10). They were quality assured by an independent senior manager.

9.2 Seven Panel meetings over fourteen months were held, which included a pause for the trial which lasted three months. Panel members analysed agencies' reports and sought additional information to inform their learning. Some family members also allowed the Panel access to statements, and they met with the Chair directly (see below).

9.3 A rapid review was undertaken to check that agencies had up to date policies, that training was being provided to staff and that there was appropriate participation in relevant partnerships. The result of these 'spot check' reviews were compiled and reviewed by the Panel (see Appendix C).

9.4 This report is therefore informed by information and facts gathered from the reports and documents referenced above, the Police Senior Investigating Officer and criminal trial, and conversations with the victim's family. Panel members' discussions were also enhanced by expert input on domestic abuse, male victims, and the needs of veterans.

10. Involvement of family and others

10.1 Members of Max's family were informed of the Review through Police Family Liaison Officers in Spring 2023, and an introduction letter from the Chair and copy of the terms of reference was also shared and comment invited. Family were invited to meet with the Chair following completion of the court proceedings, and other options for involvement after the trial were presented. They were also provided with relevant Home Office leaflets and information about Advocacy After Fatal Domestic

Abuse (AAFDA) with the introduction letter and after the trial.[30]

10.2 After the trial, the Chair met with family members in September 2024, along with the family liaison officer. Family witness and impact statements were made available, and notes summarising the Chair's discussions with family were shared with the Panel, which informed the Review. The family's contribution was much appreciated, especially as they had just been through a lengthy trial containing distressing evidence. The Chair also met with the family in December 2024, to discuss the Panel's learning and seek further input, and again in February 2025, to discuss the draft Report.

10.3 The family were invited to provide a 'pen portrait' of Max, and views were also sought on the selection of pseudonyms. A referral to AAFDA was made by the Chair at the family's request. The draft Report and Action Plan was discussed and made available, before submission, and feedback was encouraged. The family was kept informed up to the report's submission and publication.

10.4 Amber had no known family members to contact to inform them of the Review. When the Panel notified Amber of the Review by letter, it indicated how she might want to participate, informed by advice from the Probation Service. A letter from the Chair to a Prison Offender Manager, via the Probation Service, was sent four months after sentencing, informed by their advice. The Panel received written feedback from Amber, via the Prison, towards the end of January 2025. This was summarised and is included in the Report, and key points made also informed the Panel's learning.

Section 2

11. Chronology

11.1 Max joined the British Army, aged 17, and served in Ireland and the Falklands, before he was discharged, aged 30. Max had a history of alcohol use and of physical and mental health issues. He had used treatment services, and he was known to police and other agencies for alcohol related incidents, for vulnerability to 'cuckooing',[31] and domestic abuse in four relationships. Max was one of ten children and, according to his second wife, he was estranged from several family members. Although Max separated from his second wife in 2006, they never divorced, and they remained in contact. Following periods of him being estranged from their children, he regained contact in the year before his death, and between them they would support him with shopping, cooking, and appointments. Agencies were not aware of his contact with family, at the time.

11.2 At the end of 2019, Amber moved to Hampshire, 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 police reports of abuse by people known to her. She met Max around February 2023, and between April and June 2023, Max's family contact diminished due to his relationship with Amber.

Summary of events prior to the period under review (2017-2020)

11.3 **In November 2017** Max took an overdose necessitating hospital admission. He was referred to the Berkshire Healthcare NHS Foundation Trust (BHFT) Veterans Mental Health Transition Intervention and Liaison Service (TILS) by the Criminal Justice Liaison and Diversion service. Max was assessed and referred to *Help for Heroes Hidden Wounds Service*[32] for depression and anxiety.

[30] AAFDA provide expert peer support to family members in the aftermath of a domestic homicide. www.aafda.org.uk
[31] 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/
[32] https://www.helpforheroes.org.uk/get-help/mental-health-and-wellbeing/

11.4 **In February 2018**, at a review appointment with TILS, Max was placed on a waiting list for Post-Traumatic Stress Disorder treatment, to begin once substance use work was completed with Inclusion.

11.5 **Between May and July 2018** Max had three further sessions with TILS and one missed session. He disclosed being mugged at knifepoint, relationships with neighbours deteriorating, drinking daily and he had missed treatment.

11.6 **In August 2018** Max told TILS he was angry, drinking excessively, and planned to hang himself. Police and the Community Mental Health Team were called, and he was also referred to Hampshire Acute Mental Health Team. HIOW Police suggested an Emergency Department assessment and contacting The Samaritans and completed a welfare check. Max's GP was notified he needed mental health support, whilst on a four-month waiting list for the second phase of his treatment. Max continued to disclose suicidal thoughts, and because TILS was not an emergency service, he was encouraged to seek immediate help from his GP and the mental health team. Later, Inclusion conducted an end-of-treatment call with Max, and he said he felt well. He was offered the second stage of his treatment at a future date, and Max was told who he should contact if he felt unable to keep himself safe.

11.7 **Between November 2018 and February 2019** Max had seven sessions with the Veterans Mental Health Complex Treatment Service (CTS). He disclosed there had been drug dealing from his property, by an acquaintance using Inclusion, that police and his landlord knew and had installed cameras and alarms on doors and windows. He disclosed wanting to harm neighbours and access to firearms. HIOW Police reviewed this, and it was decided to take no action due to insufficient information. Similar thoughts of violence to others and to himself featured in later CTS sessions, who assessed he was able to counter these. Max was later discharged from the service.

11.8 **Through 2019 and 2020**, significant anti-social behaviour from Max's address was reported to his landlord and police. In **August 2019** Max was arrested for common assault, re-referred to BHFT by the Criminal Justice Liaison and Diversion Service, and encouraged to get support for his mental health and alcohol use. In **October 2020**, Max was issued with a final warning on his 'Acceptable Behaviour Contract'[33] to not have visitors in his home, and he was discussed at a community multi-agency risk assessment meeting focussed on anti-social behaviour.

Period under review: January 2021 to June 2023

2021

January to March 2021

11.9 **In January 2021,** Max was reported to Aster's Anti-Social Behaviour service. HIOW Police were called, Max refused entry, and adults known for drug use and supply who were at his address were removed by police. Max was issued with a Fixed Penalty Notice for a breach of COVID restrictions.

11.10 During January, Amber had three GP phone appointments and missed three further appointments. Her GP wrote to Winchester and Salisbury Emergency Departments and South Central Ambulance Service (SCAS) to advise of drug seeking behaviour. Amber claimed a Severely Mentally Impaired exemption from Council Tax. HIOW Police received a report of Amber's non-payment of tattoos; no statement was provided, and the matter was not pursued. Amber attended Salisbury Emergency Department for infections and was given codeine.

[33] Acceptable behaviour contracts are voluntary agreements made between people involved in anti-social behaviour and the local police, housing services and other relevant state services. If breached, it can be used as evidence to illustrate that enforcement action is required as non-legal tools have been unable to successfully tackle the problem.

11.11 **In February 2021,** a community multi-agency risk assessment meeting noted more people were at Max's address, and that Aster was seeking evidence to support an injunction to restrict visitors. As Max was vulnerable and a victim of 'cuckooing', he received unannounced police visits to check on his wellbeing. HIOW Police issued a PPN to Adult Health and Care (AHC), that recorded drug and alcohol use, financial difficulties, and mental health concerns; this was shared with his GP. The referral was closed because AHC decided Max had no unmet social care needs and had regular GP contact.

11.10 Max attended an assessment at Inclusion for support with drug and alcohol use, and he was provided with harm reduction advice. Max reported daily alcohol use, recent self-harm, and wanted to access veterans' support services. He was given an antidote to opiate overdose, anxiety management was discussed, and an application for veterans' mental health services for counselling was made.

11.11 During February, Amber received a Council Tax Court Summons. AHC called Amber to advise of an initial appointment, and Amber said she wanted to move away from the area. At the end of the month, Amber called an Ambulance, reporting she had fallen down the stairs, although an unknown caller later cancelled the call. At the end of February Amber attended Salisbury Emergency Department seeking pain relief medication.

11.12 **In March 2021,** Max was called by BHFT to advise of a two-week wait for support. Max reported self-harm and said he was accessing Inclusion services. A week later, a disturbance at his address was reported to Aster. Max called HIOW Police because people refused to leave his home, and they found two men, and a woman who was unconscious and unresponsive, so an Ambulance was called.

11.13 HIOW Police initiated an anti-social behaviour closure order application[34] on Max's property, supported by evidence of anti-social behaviour since 2017, criminal damage, weapon possession and COVID breaches. HIOW Police records stated Max had not taken responsibility for turning visitors away and had not engaged with services to prevent their attendance. Later that month, people known for drug use and supply were seen to leave his address. He was issued with a fixed penalty notice.

11.14 Max missed a call from Inclusion and did not attend appointments with the TILS service. He was sent a letter asking that he make contact by the end of the month. At the end of the month, Inclusion called Max advising that if he made no contact that week, he would be discharged from the service.

April to June 2021

11.15 Amber failed to respond to calls by her GP and attended four phone appointments during this period. Amber's health was discussed at the GP multi-disciplinary meeting, and it was agreed that one prescriber would monitor her medication requests. Amber also attended Salisbury Emergency Department twice, seeking pain relief medication.

11.16 **In April 2021,** Amber called NHS 111 as her mental health had worsened, and said she intended taking an overdose. The Ambulance considered her to have capacity and able to remain at home.

11.17 SCAS contacted HIOW Police to advise that Amber had made threats to kill someone she thought had poisoned her dog. HIOW Police called Amber's mother who said the dog was with a vet following suspected poisoning, and that she had taken a knife from her daughter earlier that day. HIOW Police conducted a welfare check, spoke with Amber and her mother, and assessed both were safe and well.

[34] 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.

11.18 Inclusion closed Max's case. BHFT told Max he would be discharged if he did not use the service. Max saw his GP for chronic health management, discussed alcohol and drug dependence, his treatment at Inclusion and being on a police 'vulnerability' list. A few days later Max called Inclusion and contacted BHFT to confirm an upcoming appointment in May.

11.19 **In May 2021,** Max was assessed by TILS and said he had tried to hang himself the night before but was no longer feeling suicidal. TILS contacted the community mental health service and the Crisis Resolution Home Treatment (CRHT) team, who conducted a home assessment. Max was also referred to the Veterans High Intensity Service and supported by weekly calls, so was closed to TILS. His GP was updated, and he was referred to the Community Mental Health Team for ongoing support.

11.20 Max was visited by neighbourhood police officers, and he told them he had tried to hang himself a week before. A PPN was completed (although the content was insufficiently detailed) and shared with AHC. This was filed by AHC, because they noted Max had been referred to mental health services and they determined he had no other social care needs. Max had a routine phone review with his GP, and he also called Aster for advice about moving home, and mutual exchanges were discussed.

11.21 Amber reported to HIOW Police that she was threatened by a woman, and in her statement, she disclosed difficulties with mental health, depression, anxiety, and PTSD. No PPN was completed. Following arrest, the report was subject to no further action due to lack of evidence. Later, Amber's GP provided the Council with evidence to support her diagnosis of being 'severely mentally impaired'.

11.22 **In June 2021,** Max was called by the community mental health service, following a crisis team referral, and disclosed a five-day alcohol binge. A week later, Max contacted Inclusion and was assessed for binge drinking patterns. He reported no drug use, said he was being supported by a veterans' mental health service, and that his goal was to significantly reduce his alcohol use by the Autumn. Max also attended Inclusion for food vouchers.

July to September 2021

11.23 During this period, Amber attended four GP telephone consultations, and missed two GP calls, and a request to have medication dispensed early was declined. Amber also attended Salisbury Emergency Department three times for back pain and ankle injuries, seeking pain relief medication.

11.24 **In July 2021,** further complaints were made about verbal abuse, noise, and nuisance at Max's address. Max told Inclusion he would be moving soon, and failed to attend an agreed appointment, so he was discharged until he needed support.

11.25 Later that month, 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 spoke with SCAS about which agency should manage the incident. It was agreed that this be transferred to mental health services.

11.26 **In August 2021,** the Community Mental Health Team visited Max, who acknowledged that he had felt suicidal, but no longer did. Max later called 999 to report a theft, and that money had been taken by people visiting his flat. HIOW Police told him to deposit money in the bank, and due to no supporting evidence, the matter was filed. Someone reported that Max's phone had been taken, and he was being taken advantage of so HIOW Police visited him; he said he was fine.

11.27 **In September 2021,** 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.

11.28 Amber attended Royal Hampshire County Hospital Emergency Department with an ankle injury. She was given codeine for pain management and left without being assessed.

October to December 2021

11.29 Amber had three GP appointments and obtained codeine on two occasions.

11.30 **In October 2021,** Max agreed to repay £80 debt from his previous tenancy. He sought help from TVBC with changing housing benefit claims, as he had no internet access. At a home visit, Max told the Community Mental Health Team he had settled in well was keen to attend the High Intensity Service for help. The service planned to contact him every three weeks for support. Monthly telephone contact with Max continued from the Community Mental Health Team, to monitor his wellbeing.

11.31 **In November 2021,** Max was sent a Notice of Seeking Possession of his home, for rent arrears, and he agreed to repay this. Max finished using the veteran's mental health High Intensity Service, and the Community Mental Health Team advised his GP that his care plan should be reviewed.

11.32 HIOW Police received an anonymous report of people using Max's address to deal drugs and weapons. They attended within the hour and located drugs, weapons, and people (adults and child) reported missing and at risk of exploitation. Max was later visited and told officers he had been locked in his bedroom. He was given safety advice and personal alarms, and a safeguarding referral was made to AHC. Max was visited several more times and was reportedly in good spirits, said he wanted to *"get his life back on track*" and to be left alone. Another PPN was sent to AHC and Max was flagged as being vulnerable to cuckooing.

11.33 AHC gathered information to review cuckooing concerns and noted HIOW Police visited Max three times a week, and that he had previously engaged with Inclusion (until July 2021) and the veterans' mental health service. AHC did not speak with Max but assessed he had capacity to meet his own needs and was able to get support from services, so determined there was no further role for AHC.

11.34 **In December 2021,** HIOW Police checked Max's address and noted all was well, that his neighbour was aware of concerns regarding cuckooing, and they could call police if needed. Max called Aster to agree arrears payments in the new year.

11.35 At the end of the month Amber called HIOW Police to report five men with baseball bats surrounding her home and that her mother was there alone. Police found no one there other than her landlord, who had also been called by Amber. They had no knowledge of the incident and when Amber was told her mother was safe, she said her mother had mental health issues. Amber returned home with a partner and told officers they were followed and had their phones hacked. There was no evidence of an offence, and the matter was filed.

2022

January to March 2022

11.36 Amber attended three GP appointments and missed two in this period, and was prescribed codeine.

11.37 **In January 2022,** HIOW Police visited Max's address twice. He was alone and told them his drug use had reduced, that he was supported by the Community Mental Health Team and the High Intensity Service and would call if he had any concerns. At the end of the month his address-monitoring ended due to there being no cuckooing concerns in two months. Max called TVBC to advise he would need to settle money owed when he received his pension and TVBC agreed to put a hold on the account.

11.38 **In March 2022,** Max saw his GP for light-headedness and five seizures over two weeks. He had collapsed and was taken to Royal Hampshire County Hospital and admitted for four days. On assessment there was no evidence of wounds or other concerns. Max was also seen by the Alcohol Liaison team, and he disclosed post-traumatic stress from being in the Army. He declined inpatient support because he said he wanted to reduce alcohol use from home.

11.39 After he was discharged, Max called TVBC and said he could not make the Council Tax payment and could not afford to pay anything. A court summons was issued later in the month.

11.40 Towards the end of the month, Max was admitted to hospital by Ambulance after being found unresponsive by a neighbour. He was reviewed in Intensive Care, admitted to a medical ward, and was seen by an alcohol liaison team. Max said he had argued with someone, so his drinking had escalated. He was sd with Acute Kidney Injury, a possible heart attack and lung infection. Max said he was supported by the Community Mental Health Team and the veterans High Intensity Service, and he declined a referral to Inclusion.

April to June 2022

11.41 Amber had seven appointments or calls with a GP, predominantly to obtain codeine. It was decided this would only be prescribed if there was evidence from a dentist of a pain treatment plan.

11.42 **In April 2022,** Max told TVBC he had been in hospital, so the Council Tax Court Summons was withdrawn, and they agreed to spread arrears repayments over the year. Max told his mental health support worker that he was engaging well with the veterans' mental health service.

11.43 **In May 2022,** Amber called Inclusion to request support for drug use (Pregabalin, Mirtazapine, Diazepam, Tramadol). A phone appointment was arranged for later that day, but Amber said she couldn't make it because she was "*in a bad way*". Amber was discharged and texted to let her know she could re-refer at any time. She later called for an Ambulance, then cancelled it. The next day Amber called 999 and reported she was in pain and was advised to attend the Emergency Department.

11.44 Around the same time, Max called 999 and was seen for a nosebleed and discharged. He called Aster's anti-social behaviour team and said he was drinking less, not taking drugs, had no unwanted visitors and could turn people away if needed to. Max also attended the nurse-led clinic appointment at SHFT which was jointly run by the High Intensity Service for veterans. He was due to be discharged from the veterans' service, and he was advised his monthly calls from the Community Mental Health Team would continue but would be reviewed in two months.

11.45 **In June 2022,** Max called TVBC about his Council Tax arrears. He later called his GP and discussed his alcohol dependence. Max also called Aster, said that he had not touched a drink for a week, and agreed a repayment plan for his arrears.

11.46 Amber called 999 and reported pain and vomiting, and she was taken by Ambulance to Salisbury District Hospital. Amber also attended Salisbury Emergency Department for toothache, seeking pain relief medication.

July to September 2022

11.47 **In July 2022,** Amber called 111 and reported she had recently been attacked. She said she felt she was going to hurt someone or herself, that she had cut her wrists, and that her mother was abusive to her. Amber was advised to attend hospital, and a safeguarding referral was completed by the 111 team. Amber's mother also called an Ambulance to report Amber had cut her wrist and asked for a mental health assessment. SCAS called HIOW Police as Amber's mother was abusive and sounded scared. This was assessed as a medical matter, so police were not deployed. HIOW Police later received a report from SCAS that Amber had been assaulted, that she had visited a friend who had strangled and hit her and had left marks on her neck, and Amber said she wished he had killed her.

11.48 Amber was visited by HIOW Police but did not want to make a statement. She said she had been assaulted by a man she knew, and said she wanted support for her mental health. Officers advised they would complete a PPN requesting GP support for her. Amber did not support a police

investigation, and the matter was filed. AHC considered the notification and decided on no further action, noting that Amber was safe with her mother, and both had the means to call for help.

11.49 Amber saw her GP and disclosed a suicide attempt, and she was referred to SHFT's Crisis Resolution Home Treatment team. During the consultation Amber also said she had been assaulted by a man but didn't want to report it. She asked for pain killers. The mental health service was unable to contact or assess Amber, so she was transferred back to her GP.

11.50 In July, Max had not responded to an opt-in letter from the Community Mental Health Team and had not attended appointments, so he was discharged, and his care was transferred back to his GP.

11.51 **In August 2022,** it was reported to AHC that Max was being abusive (involving coercion, control, and aggression) to a woman he was in a relationship with. Relevant information was shared by HIOW Police with AHC. There was no record held by AHC of this being received or of any further action.

11.52 **In September 2022,** Amber's GP made a referral to mental health services for a medication review, but they failed to contact Amber by phone. Amber was transferred back to her GP in November with advice to reduce medication.

11.53 HIOW Police received third party reports that dealers were taking advantage of Max. He told police that a woman stayed with him and contributed to his shopping, and the likelihood Max was being cuckooed was recorded. Later in the month, Max called HIOW Police to report a woman refused to leave his flat, and police attended after overhearing shouting and screaming in the background. It was thought the person regularly attended his flat and that they drank together. Max was advised to call again if they returned, and no offences were disclosed, and the matter was filed.

11.54 HIOW Police received a crime report from another area related to Amber allegedly paying someone with forged banknotes for a dog, then attempting to reclaim the amount paid, with threats of violence.

October to December 2022

11.55 **In October 2022,** Max called HIOW Police because he witnessed domestic abuse, and although he initially made a statement, ten days later he retracted it. At the end of the month Max was sent a Notice of Seeking Possession for rent arrears.

11.56 **In November 2022,** a 999-call reported Max had fallen and hit his head after drinking; the caller told SCAS they were also concerned about bruising to his back. An Ambulance took him to hospital, but records did not reference bruising, and his body map was clear except for a head wound. Max declined advice regarding stopping using alcohol.

11.57 Towards the end of November, 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. She attended six GP appointments, and she missed six GP calls during this period.

11.58 Amber called TVBC to ask that a stray dog be removed by the Council. She disclosed that her mother had died, that she was distressed and *'unable to locate mum's body after her passing*' and wanted advice. The dog warden subsequently emailed Amber with details of those dealing with her mother's death, the Coroner and of local bereavement support services.

11.59 **In December 2022,** police visited Amber, who said she wanted support with her mental health. Later Amber called an Ambulance to report she intended to end her life through carbon monoxide poisoning. SCAS attended, HIOW Police spoke with Amber, and she was taken to hospital. She said

she had taken crack cocaine and heroin since her mother died. The Crisis Resolution Home Treatment team phoned Amber and advised her to self-refer to Inclusion for methadone. HIOW Police were notified of cuckooing concerns and financial abuse, and that AHC had been made aware.

11.60 AHC opened a discretionary S42 Care Act safeguarding enquiry,[35] and several attempts were made to contact Amber by phone, text, letter, and email. At the end of the month Amber spoke to AHC and told them she was safe and would not self-harm. Amber consented to a Section 9 Care Act assessment of her needs[36] so the discretionary enquiry was closed, and she was put on an assessment waiting list.

11.61 Amber did not attend an assessment with the Community Mental Health Team. A friend was contacted by the service to check on her welfare due to failed attempts to make contact and he confirmed she was "ok". Amber's GP noted her medication had not been collected and she was unable to be contacted.

2023

11.62 Between January to March 2023, Amber had eleven GP appointments and was discussed at a Practice meeting. Amber emailed her GP about her mental health and said she was being taken advantage of. Codeine was prescribed three times, a housing support letter was provided, and a mental health referral made.

January 2023

11.63 Amber missed phone appointment with the Community Mental Health Team, and due to her history of non-attendance the service decided to discharge her care to the GP. HIOW Police recorded she was associated with drug dealers and was involved in other criminal activity. Amber reported being threatened with violence, rape, and cuckooing. HIOW Police seized knives from her address, Amber was too scared to provide a statement, and she asked for support to move out of the area. Her address was flagged, and she was provided with alarms and other safety information. Amber also attended Salisbury Emergency Department for abdominal pain, seeking pain relief medication.

February 2023

11.64 Amber reported stalking, harassment, and sexual assault over a three-year period, and when HIOW Police attended she reported two recent sexual assaults and another a year earlier. She said there were "*too many*" other times to report. She said she recently felt suicidal and was advised to call an Ambulance, mental health services or The Samaritans. She said she had no money or food, would contact her GP the next day, and was too upset to provide evidence. HIOW Police noted inconsistencies in her disclosures, and a PPN highlighting safeguarding concerns was sent to Amber's GP and to AHC. AHC noted Amber's substance use, previous suicide attempt, and mental health diagnosis.

11.65 Amber later called HIOW Police to report difficulties with her mental health, being blackmailed and feeling suicidal. Police called for a mental health response, and Amber reported to the crisis triage team that she felt intimidated, had been abused mentally and physically and was being made homeless, then ended the call. The Community Mental Health Team sent Amber an opt-in letter for an assessment. Amber contacted TVBC Housing Options because she had been served notice to leave her home.

---

[35] 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.

[36] 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 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.

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 sharing requests sent to HIOW Police and the County Council Mental Health team. Amber contacted AHC because she had no food and said an ex-partner had taken her money, and she was advised about foodbanks, and to call police.

11.66 Five days after Amber's report, she was called by a male police specially trained officer,[37] and Amber asked for a call back from a female officer. Reduced capacity amongst female specially trained officers led to a week's delay before Amber was contacted again (in early March). At the end of the month Amber also self-referred to AHC for help. Amber left her home before the eviction notice expired. It transpired at trial, that Amber met Max around this time, in February 2023.

March 2023

11.10 Amber told TVBC she was staying with friends and TVBC tried phoning Amber without success. Later, Amber was called by a female specially trained police officer to follow up on the sexual assault reports, but she couldn't speak, and a female officer wasn't available to speak with Amber for another sixteen days. Amber emailed TVBC to ask for financial help to move out of the area and charitable help was suggested. The Council made enquiries with mental health services and Amber said she had an appointment with the Community Mental Health Team.

11.11 In mid-March, Amber reported she had been burgled and her home vandalised. An hour later HIOW Police visited Amber who said she had been pregnant but suffered a miscarriage, and she disclosed verbal, emotional and physical abuse including strangulation by an ex-partner. Amber said she was isolated and wanted support with her mental health. She was taken to a friend's address and safety measures and a domestic abuse service referral was discussed. Amber was assessed as high risk of harm, and two PPNs were completed – one was shared with agencies the next day and the other was more detailed but not shared with any agency. Follow-up welfare checks were made, and Amber's ex-partner was arrested, interviewed, and denied assault or criminal damage. Amber was notified of their release on police bail with conditions not to contact her or attend her address. Amber was later contacted by a domestic abuse officer but said she did not support a police investigation.

11.12 The following week, the Hampshire High Risk Domestic Abuse (HRDA) meeting discussed Amber's experience of domestic abuse. The meeting noted financial concerns, her waiting three months for an AHC assessment, risks of cuckooing, mental health diagnoses and use of heroin, crack cocaine and prescribed medication. Historic offences were mentioned including being managed by Multi Agency Public Protection Arrangements (level one)[38]. Actions included a referral to MARAC and for AHC to prioritise her case and conduct an urgent assessment. AHC contacted TVBC's Housing Options service to clarify moving plans and passed Amber's case to the Community Mental Health Team for assessment. However, this was not prioritised because Amber was already on the waiting list.

11.13 Amber emailed TVBC to report domestic abuse. She initially said she felt unsafe then confirmed she could stay locally. Amber did not respond to Housing Options' calls, so they contacted HIOW Police who confirmed she was high risk of harm from a perpetrator on police bail, that she was waiting for a Care Act assessment, and had declined being referred to domestic abuse support services.

11.14 Towards the end of March, a female specially trained officer phoned Amber about sexual assault reports, and made an appointment but was then unable to attend, so asked Amber to rearrange. HIOW Police received an anonymous call reporting Amber had been threatened by dealers demanding

37 Specially trained officers (STOs) at the time are now called Sexual Offences Investigation Trained (SOIT) officers.

38 Multi Agency Public Protection Arrangements at level one refers to ordinary agency management, where the offender can be managed by the lead agency in consultation with other agencies involved.

money. Advice to call 999 was given if threats escalated and officers visited twice and called several times, but there was no answer.

11.15 Meanwhile, in mid-March a patient told SCAS that Max had "*scary and dangerous*" people in his home; that they used him to get money and drugs, and that he often stayed elsewhere to get away from them. SCAS referred these safeguarding risks to AHC, who did not ask for further information.

11.16 A week later, Max's new partner ended their brief relationship. She called police and reported unwanted contact, threats, and sexual assault. This was assessed as medium risk, a PPN was completed, and safety advice provided, but an investigation was not supported. HIOW Police heard voicemails from Max demanding money owed to him, saying "*you haven't experienced hell from me yet*". Max was arrested, denied the allegations, and indicated it was he who was sexually assaulted, but he refused to make a statement or support an investigation. No action was taken and no risk assessment or PPN was completed. Max was referred from custody to the Liaison and Diversion Service, as per the veterans' policy, but they were unable to see him before his release. HIOW Police had simultaneously interviewed his ex-partner who disclosed being fearful of him and his associates, so she was assessed as high risk and referred to a MARAC. It was not apparent that the decision to release Max had taken that assessment into consideration.

11.17 Around this time, HIOW Police had identified that a known dealer, associated with Amber, had visited Max and his ex-partner, and neighbourhood teams were informed, due to previous cuckooing concerns. Amber's association with Max was not explored further.

11.18 Four days after Amber was discussed at the HRDA meeting, Max's alleged abuse against his ex-partner was discussed. There was little reference to Max in the minutes, but it was noted he had rent arrears; was no longer supported by Inclusion; and had not been supported by the Community Mental Health Team or the veterans' mental health service for some time. This was escalated to a MARAC and, due to a system error, the allocation was delayed to the May meeting.

11.19 Sixteen days after SCAS flagged concerns about Max's home being cuckooed, the referral was reviewed by AHC. It was closed with no further action because the recent high risk domestic abuse meeting relating to Max had determined there were no actions for AHC.

11.20 Towards the end of March, following several unsuccessful attempts by HIOW Police to contact Amber relating to malicious communications reports, she said she did not want to make a statement, and was going away, so the matter was filed. Separately, Amber text police officers dealing with domestic abuse reports to say she was being cuckooed and that weapons were left at her address.

11.21 At the end of March, Amber had a phone assessment with the Community Mental Health Team. Amber disclosed domestic abuse, being cuckooed, homeless, and a recent miscarriage. Amber said she had multiple psychiatric diagnoses; felt manic, angry and had fluctuating moods; previously self-harmed and attempted suicide and had thoughts to harm others. The Community Mental Health Team noted she presented a risk to herself 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. The service confirmed to TVBC that Amber was on AHC's waiting list for an assessment.

11.22 On the same day, Amber reported further domestic abuse, including strangulation, to TVBC. HIOW Police confirmed this and said they would support a move to emergency housing. TVBC advised AHC of high risk of domestic abuse, cuckooing, and flagged she was a vulnerable adult. AHC confirmed Amber was on a waiting list for assessment. TVBC provided Amber with information about refuges and

injunctions and suggested she could refer herself to another local authority. TVBC noted making a safeguarding referral to AHC, but their email was not recorded as a safeguarding referral by AHC.

April 2023

11.23 Between April and June 2023, Amber had two GP appointments, and requested her medication be sent to another pharmacy locally. She also asked for a letter of support to allow her therapy dog to live with her, and twice requested medication as she said hers had been stolen and lost.

11.24 In early April, Max's ex-partner called HIOW Police to report an argument regarding drug debts, and unwanted contact from Max. Officers warned Max not to make any further contact with her.

11.25 HIOW Police were unsuccessful in contacting Amber to collect knives and phones from her address. Amber was discussed at a MARAC meeting. Actions included that minutes be shared with her GP, police conduct cuckooing checks, and for The You Trust[39] to contact Amber regarding home safety measures (a month later they reported being unable to action this as Amber was already homeless). SHFT noted there were no identified health actions from the MARAC. There was also nothing recorded about the risks presented by her ex-partner or their whereabouts, or any association with Max.

11.26 Around this time, HIOW Police knew that Amber's ex-partner was staying at Max's flat. A few days later Amber reported they had contacted her, and she was advised to report this through 101 so that the crime would be recorded and investigated. The next day Amber called 999 and reported pain and difficulty breathing and was taken by Ambulance to Salisbury District Hospital. Later after discharge, she called 999 and reported pain again; the Ambulance attended, assessed, and discharged her.

11.27 In mid-April, Max's ex-partner called HIOW Police as he had demanded money she owed to be returned. Police deemed this not to be harassment and facilitated the return of his money. Officers initially assessed this as medium risk, but this was amended to high-risk, given the pending MARAC.

11.28 Max contacted Inclusion as his use of heroin, crack and alcohol had escalated, and he was given an appointment for early May. He also contacted his landlord about paying off his arrears.

11.29 A female specially trained officer tried calling Amber to follow up on sexual assault reports made in February 2023; there was no response. The officer then went off on a long-term absence, and the case was not reallocated for another six weeks, in early June 2023.

11.30 Towards the end of April, HIOW Police records flagged that Amber visited Max's address. Around that time Max called police several times in the early hours, heavily intoxicated, concerned about his girlfriend who was having a panic attack, and that he was being threatened with firearms. The call handler struggled to understand him and felt they were both hallucinating, and Max was advised to call an Ambulance. Max later told police it was a neighbour dispute and there were no guns. Amber also called police on Max's phone, heavily intoxicated, and reported five men kicking the door in trying to kill her. This was graded urgent, but police units were unavailable. A few hours later Max called again to report no-one outside; he sounded breathless and was difficult to understand. SCAS later confirmed they were with Max and Amber, that they had capacity and there was no medical concern. It was assessed by HIOW Police that they were intoxicated, had mental health issues and were safe, so the case was closed.

11.31 Towards the end of April, a Bank security officer called HIOW Police because Max was intoxicated, and told them that 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. Amber was seen by

[39] The You Trust, a charity that that supports vulnerable people across Hampshire, Dorset, Somerset, the Isle of Wight, and West Sussex, was not known to have had any contact with Amber.

police, denied knowledge of this, said Max had taken too many drugs, and that she was not in a relationship with him. Later Max reported to HIOW Police he had been slapped in the face by his girlfriend Amber, who had thrown him out, and he had no memory of the previous five days. Max asked for help with his mental health and was advised to call 111. Following review, a welfare check and domestic abuse risk assessment was requested.

11.32 Max called an Ambulance and reported being hit in the face and verbal abuse by a female flatmate, and that there was a human bite on the inside of his arm. Max was taken to the Emergency Department and said he could not remember the last few days. He had taken alcohol, cocaine and heroin, and said he was seeing Inclusion the following week. A body map was completed during triage and multiple bruises to his right and left forearms and bruising to his abdomen were documented, including a possible human bite on his arm. There was no record of a conversation about the injuries. SHFT's Mental Health Liaison team assessed Max and noted he was confused, alcohol and cocaine dependant, and felt suicidal. The GP notification referenced domestic abuse, suicidal ideation, no Inclusion referral, and requested a medication review and primary care mental health support.

11.33 At the end of April, Amber called 999 reporting anxiety. An Ambulance attended and discharged her to another address as she did not feel safe. Police attended Amber's address to locate the knives and phones, but found an abandonment notice on the door.

May 2023

11.34 Max was discharged home from hospital, having been assessed by SHFT's Mental Health Liaison Team to have capacity to make decisions, not to be high risk of suicide, and not needing a mental health assessment. HIOW Police visited Max about the domestic abuse report, and he confirmed Amber had slapped his face. He said she had left with his phone but was expected to return. He did not support an investigation and said that he used drugs and housed dealers. Max was assessed as standard risk of harm from Amber, and a PPN was completed and shared with his GP. Max already had alarms fitted and Operation Fortress was discussed to monitor his address, although no further action on this was taken. HIOW Police decided to voluntarily interview Amber.

11.35 Neighbours reported to Aster that Max was vulnerable and a drug user and was being taken advantage of. Later, Max did not attend his assessment appointment with Inclusion, so his case was closed. A letter was sent to him which said he could re-refer at any time. Max also had not attended a pre-arranged appointment with his GP, so he was contacted and offered another appointment.

11.36 A MARAC meeting heard the case of Max and his ex-partner, but there was little mention of Max in the minutes. Aster advised that he was their tenant, that there had been anti-social behaviour and AHC stated he was not open to them. There was no contribution from health representatives in relation to Max, and information shared was from the previous HRDA meeting in March 2023.

11.37 Amber was sent an appointment for a joint review with the Community Mental Health Team and Inclusion, for the end of June 2023. She reported to HIOW Police the theft of her phone and said at the end of April she was "*out of it*" for a week and was forced to withdraw money. She reported being raped at Max's address, when there were several people there drinking and taking drugs. Amber denied Max was involved and said he was drugged too. Officers recorded it was difficult to establish a timeline. Police spoke with Max who said he was given drugs; he tried to intervene when he saw Amber with two men and a woman but then he left. He also reported money missing from his account and police noted Amber had transferred money to Max's account. Officers advised both to keep the property secure, contact fraud lines relating to missing money, and to attend the sexual health clinic. Amber's report of rape was referred to a specialist police team.

11.38 Around fourteen attempts by HIOW Police to contact Amber by calls, texts, email, and visits over a two-week period were unsuccessful. A week later Amber texted saying she did not support an investigation, did not want a referral for support nor to be visited at the address. A PPN was completed for Amber, without her input, a month after the initial report, but it was not shared with another agency.

11.39 On the same day, Amber emailed the Community Mental Health Team to say she would not attend the proposed joint appointment with Inclusion because she did not want to see a "*drug person*". The Community Mental Health Team called Amber to say the assessment could go ahead without them, and she said: *"I'm homeless and I have an emotional support dog...I need help".*

11.40 Amber was told by HIOW Police that her reports of strangulation, burglary and criminal damage were closed with no action due to no supporting evidence. In mid-May Amber emailed TVBC to report violence from an unknown perpetrator. She later said during a call that she had stayed at Max's address but left because of abuse, so was sleeping in a tent. Later she emailed to say she was staying with a friend but did not provide details. TVBC raised concerns with AHC, who confirmed she was waiting for an assessment and a joint meeting with the Community Mental Health Team would be arranged. The Community Mental Health Team advised TVBC she had missed appointments, but they would not share information without consent. TVBC raised safeguarding concerns by email.

11.41 Max was visited by Aster's anti-social behaviour and neighbourhood officers and was supported to cancel cards and order a new bank card as he had no phone. TVBC called Inclusion, concerned that Max had been cuckooed and had no money or phone, and an appointment was arranged for Max at Inclusion towards the end of May. Around the same time, AHC records noted the decision to take no further action following the SCAS referral at the end of March was ratified by managers.

11.42 Neighbours reported increased disturbance, verbal abuse and noise from Max's address. Max attended an assessment with Inclusion and said he had used alcohol, cocaine, heroin, and ketamine over four months, and that people who had been in his home funded his alcohol and substance use but they had since left. He said he used alcohol daily but had no thoughts of self-harm or suicide. Harm reduction advice and an alcohol reduction plan were discussed. Safeguarding issues were explored, and Max denied any concerns. Another appointment was made for the beginning of June.

June 2023

11.43 Max did not attend his follow up appointment with Inclusion, and the service sent him a letter inviting him to another in-person appointment in mid-June. Amber provided the Community Mental Health Team with consent to share information with TVBC, and the service confirmed diagnosis, risks, and plans for an outpatient appointment. Another female officer tried to call Amber in relation to the sexual assault reports from February, and Amber texted her saying she no longer supported the police investigation. The investigation was closed with no further action taken.

11.44 HIOW Police visited Max and Amber at his address, to follow up on his domestic abuse report. Max said he had been heavily intoxicated and denied being assaulted by Amber. A voluntary interview was arranged a few days later with Amber and she denied assaulting Max and said he had taken heroin and cocaine and had made several allegations that were not true. 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.

11.45 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 to reflect she wanted to live locally, that she had nowhere to live, and had a history of overdose, mental ill-health, self-harm, and verbal aggression. Amber was referred by TVBC to a hostel for homeless people, but she failed to respond to them contacting her.

11.46 AHC reviewed their waiting list, and Amber was contacted by AHC's mental health team. She said she felt '*psychotic'* and that she 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 by AHC who contacted TVBC for Amber's address. Three calls to Amber went unanswered and her GP was asked for information. AHC also requested that the Community Mental Health Team attend a joint home visit with them as part of the enquiry, but the Community Mental Health Team declined the statutory request, due to Amber's previous non-engagement This was not escalated.

11.47 In mid-June, Max called Aster to discuss arrears repayments. He was visited by Aster's anti-social behaviour and neighbourhood officers who noted Max seemed well. He introduced them to his girlfriend, and he told them he was not drinking or taking drugs, was getting out more and swimming, 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 also raised at the Test Valley daily management meeting for local oversight, and the information was shared with AHC towards the end of June. Max did not attend his next 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.

11.48 Amber called 999, and reported waking up with pain and breathing problems. She was taken by Ambulance to the Emergency Department where she was given pain relief (morphine, diazepam, and diclofenac) but declined a body-map assessment. Amber self-discharged before further tests and after being advised of the risks. 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.

11.49 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 for response by Police for seven days (which was later than the target of 24 hours to triage reports). No connection was made between this and the report from 2021 when Amber had threatened to kill someone she had suspected of taking her dog.

11.50 The next day was the last known sighting of Max. The trial found Max was killed the following day. Amber used Max's phone to message two men she knew suggesting Max had raped her, then she went to a pub with a large amount of luggage and left her own phone there. Around that time, she also made TikTok posts suggesting she had done something that would lead to imprisonment. A few days later Amber travelled to the West Midlands.

11.51 Three days later, Max's address was visited by Aster's anti-social behaviour officers; there was no answer. Two days later, police reviewed Amber's report of assault made the week before. A safeguarding assessment was requested, and a letter was sent to Amber to notify her of no further action due to lack of evidence.

11.52 The same day around midday, a neighbour called 999 to report a bad smell from Max's address, and that there had been no visitors for two days. SCAS and police attended, and Max was found murdered, wrapped in a blanket, surrounded by several notes.

11.53 At the end of June, West Midlands Police located and arrested Amber after she used Max's bank card. She made several statements, including that she had experienced lifelong abuse and had been 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.

12. Equality and Diversity

12.1 There are nine protected characteristics[40] under the 2010 Equality Act and due consideration was given by the Panel to each one, as to whether they were applicable.

12.2 There was no evidence to suggest that gender reassignment, race, or religion or belief were significantly relevant to the circumstances of those involved in this Review.

12.3 Marriage was considered relevant only in so far as agencies had no knowledge that Max was separated but not divorced from his ex-wife, nor that she, their two children and his grandchildren were a source of support until their contact reduced in Spring 2023. Had they known the importance of these relationships, agencies might have considered family from his most recent marriage being a possible protective factor in his life.

12.4 Sex, age, disability and sexuality were also found to be relevant, by the Panel.

12.5 Sex was relevant because being female is a significant risk factor for experiencing domestic abuse. Women are more likely than men to experience higher levels of fear, coercive control, and life-threatening violence, and to be threatened, strangled, assaulted, and raped by known men.[41] Women who experience domestic abuse are three times more likely to have made a suicide attempt in the past year compared to those who have not experienced abuse.[42] Men are more likely to be perpetrators of domestic abuse, and to use repeated and severe forms of physical, emotional, and psychological violence, which result in injury. Agencies may therefore assume men don't experience such abuse, however, for the year ending March 2023, an estimated 751,000 men and boys (aged over 16) experienced domestic abuse, along with 1.4 million women and girls.[43] Neither Max or Amber benefitted from effective responses to their respective disclosures of abuse, and Max's reports of assault and sexual abuse were not taken seriously by health and criminal justice agencies at the time.

12.6 The relationship between sex and gender is also of relevance. The Convention on Preventing and Combating Violence Against Women and Domestic Violence ('Istanbul Convention'), to which the UK is a signatory, sets out how gender - the "*socially constructed roles, behaviours, activities and attributes that society considers appropriate for women and men*" [44] - can be used to reinforce traditional or stereotypical expectations of male and female behaviour. For example, men may be perceived as aggressive, violent, to dominate relationships, and feel shame about displaying emotions. Max's family said that he was a "*typical man*" who could "*put up a front*" and "*did not want to show his feelings unless he really trusted someone*". Having joined the Army as a teenager, Max would have been influenced by its traditional masculine culture, that reinforced physical and mental strength, power, aggression, control, self-discipline, and self-reliance. Traditional gender roles can serve to reinforce barriers for people to access help and support. For example, there may be social pressure on men not to seek help, and some men may believe that feeling depressed or suicidal are 'feminine' traits that they can't talk about or access support for. This may lead to men suppressing feelings and expressing them through stereotypical 'masculine' ways, like substance use and violence.[45]

12.7 Similarly, some women may use societal perceptions or stereotypes of traditional masculinity to

---

[40] These are: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation.
[41] Welsh K, (2022) *'Long-term partners - Reflections on the shifts in partnership responses to domestic violence'* International Review of Victimology March 2022
[42] Agenda Alliance (2023) 'Under-examined and under-reported'.
[43] Crime Survey for England and Wales, 2024.
[44] The Council of Europe Convention can be found at https://www.coe.int/en/web/istanbul-convention/text-of-the-convention
45 See the Respect Male Victims Toolkit (2019) and Male Victims Standard quality assurance framework that supports agencies improve their response to male victims of domestic abuse.

reinforce their abuse of men, like putting them down, denying them access to medication, controlling who they see and speak to, and saying no-one will take them seriously. Stereotypical gender roles also reinforce typically 'feminine' traits (such as compassion, empathy, weakness, non-violence) which may mean women's abusive behaviour is not always recognised by agencies and, unlike men's violence against women, is not supported by a culture that encourages them to be violent.

12.8 The culture that reinforces women's inequality, which is a cause and consequence of men's violence against women, deprives women of their liberty and makes it more difficult for them to enforce their rights. For example, women's inequality and violence against women intersect in relation to housing: women are more likely than men to struggle to afford or maintain safe housing and are more likely to be homeless due to abuse.[46] Amber experienced escalating risk associated with housing insecurity after her mother's death, and agencies were unsure where she lived or whether she was sleeping rough.

12.9 Women are also more likely to experience non-fatal strangulation, which presents significant risks of brain injury and associated long term injuries, like difficulties breathing, pain and numbness, stroke, loss of memory, nausea and dizziness, fits, and seizures. The impacts of traumatic brain injury and associated behaviours following strangulation can include non-attendance at appointments, appearing chaotic or unstable, anxiety, impulsiveness, problematic substance use and self-harm[47] and are often misconstrued by agencies as women being non-compliant or difficult to engage with. Amber had been strangled by an ex-partner, when she was assessed as high risk of domestic abuse, and also displayed some of the above behaviours. Traumatic brain injury, for example, can also be misinterpreted as intoxication. Such disclosures should result in women-specific health assessments that consider the likely impacts of strangulation, although that had not happened in Amber's case.[48]

12.10 Sex also intersects with age and Max may have experienced additional barriers to accessing support as an older man and a veteran. At one point, Max described himself as "*lonely*" and told officers that it may be "*too late*" for him to access support. In general, data on older people's experience of domestic abuse is scarce or inconsistent due to different definitions used (of 'older' and 'abuse') and under-reporting.[49] There was no evidence of agencies considering Max's age in any assessments that might lead to adjustments being made to service delivery. In some areas, local authorities use a bespoke domestic abuse DASH risk assessment[50] to use with older adults over 60 that captures additional age-related risk factors, including reference to grandchildren, family relationships, health issues and how they might be reliant on the perpetrator. The Centre for Age Gender and Social Justice in Wales has also co-produced, with older people and specialist domestic abuse services, an intensive support programme for older people experiencing domestic abuse aged over 60, including targeted support for older men. This integrates safeguarding and domestic abuse procedures for older victims and includes support for family members and families of choice, where safe, and parallel interventions with perpetrators.[51]

---

[46] Shelter (2021) "Fobbed Off: The barriers preventing women accessing housing and homelessness support, and the women-centred approach needed to overcome them".
[47] See for example, Brenner LA et al, (2023) Associations of Military-Related Traumatic Brain Injury With New-Onset Mental Health Conditions and Suicide Risk, JAMA Network.
[48] Ali S (2023) Domestic Abuse and Brain Injury: A Link Often Missed, Centre for Women's Justice; Brainkind (2024) 'Too Many To Count' https://brainkind.org/toomanytocount/#:~:text=Brainkind%20reveals%20that%201%20in,is%20approximately%201%20in%208
[49] See for example, OPC Wales (2022) Improving Support and Services for Older Men; Baker et al (2016). Interventions for preventing abuse in the elderly (Review); Melchiorre, M.G. et al (2016) Abuse of Older Men in Seven European Countries: A Multilevel Approach in the Framework of an Ecological Model.
[50] https://cccdasv.eschools.co.uk/storage/secure_download/Nk1zeW9KT2lIVkQ0WC9UckUrTTR4UT09
[51] See for example Dewis Choice Project in Aberystwyth University, https://dewischoice.org.uk/wp-content/uploads/2021/12/Practitioner-guidance-document-English-epdf_compressed.pdf and https://dewischoice.org.uk/information-and-advice/resources/

12.11 An Older People's Commissioner report[52] has found that barriers to reporting by older men may be due to shame, humiliation, vulnerability, and dependency, which exacerbated older men's risk of physical and psychological harm. It called for improved services, more awareness of older men's experience, training to recognise abuse, and better data on older men's experience of accessing support. While such feelings and barriers are not unique to male victims, a systematic review explored these issues further and found that barriers to heterosexual male victims' help-seeking were characterised by fear of disclosure, challenge to their masculinity and to their relationship, concern for the abuser, diminished confidence, and the perceived invisibility of services.

12.12 Agencies locally would benefit from reviewing how they assess, respond to and advertise services for older male victims, and whether in-person, 'buddying' or peer support should be available to build trust and encourage disclosure. Research found that services for male victims need to be more publicly advertised and contain images and wording that reflect different types of masculinity. Services need to be targeted and tailored towards different male socio-economic groups, reinforce confidentiality, and continuity of contact with a trusted professional. Services should also provide male victims with a choice of speaking with someone of the same sex, age, and sexuality where possible.[53]

12.13 As noted above, gender is constructed and reinforced at individual, institutional and societal levels, which positions heterosexual men as dominant and entitled with access to particular privileges. Yet domestic abuse also affects lesbian, gay, bisexual, transgender, and queer community members, although agencies tend to obscure the risk factors involved for individuals as they are not a homogenous group. It was recorded by some agencies that Amber was bisexual, which is relevant in terms of risks and access to services. Bisexual women in England and Wales are almost twice as likely to report past year intimate partner violence than heterosexual women, and nearly five times more likely to have experienced sexual violence by a current or former intimate partner.[54] There is also some international evidence to suggest that bisexual women are at increased risk of experiencing abuse if their intimate partner was male. Yet few studies and hardly any services disaggregate data or service delivery by sexuality or recognise that additional risk factors may include limited access to social support, lack of accessibility and visibility of appropriate support services, discrimination, and negative childhood experiences.[55] There was no evidence of Amber's sexuality being discussed or considered in assessments, and it was not known if Amber self-identified as bisexual or whether assumptions by agencies had been made.

12.14 The Panel considered the relevance of pregnancy, due to Amber's reported miscarriage in early 2023, although no other evidence verified that. A PPN was completed and shared with her GP and maternity services. However, there was no curiosity shown by officers as to whether the miscarriage was a result of, or linked to, experience of domestic abuse, given pregnancy is identified as increasing risk for women.

12.15 Amber was also identified by some agencies as neurodiverse and having needs related to disability specifically associated with previous mental health diagnoses, although the Panel noted it was difficult to know how mental illness impacted on daily activities to the extent it was considered a disability. Agencies in contact with Amber did not explore these support needs further in terms of any additional or tailored adjustments that might have been needed to support provision of care.

---

[52] Older People's Commissioner Wales. (2022). Improving Support and Services for Older Men Experiencing Domestic Abuse https://olderpeople.wales/wp-content/uploads/2022/08/Improving-support-and-services-for-older-men-experiencing-domestic-abuse.pdf

[53] Huntley et. al. (2019). Help-seeking by male victims of domestic violence and abuse: a systematic review and qualitative evidence synthesis. BMJ

[54] ONS. (2018). Women most at risk of experiencing partner abuse in England and Wales.

[55] Corey et al., (2022). Risk and Protective Factors for Intimate Partner Violence Against Bisexual Victims: A Systematic Scoping Review, Journal of Trauma Violence and Abuse

12.16 The Panel also considered the likely impact of other vulnerabilities in addition to protected characteristics, for example in relation to Max's and Amber's drug and alcohol use (see below at *Section 3: Key findings and lessons learnt).* As a veteran of the British Army Max should not have been disadvantaged when accessing or receiving healthcare or other public services, in accordance with the Armed Forces Act, 2021 which placed the Armed Forces Covenant on a statutory footing. Max was a veteran and services noted he engaged well with specialist veterans' mental health support before and during the temporal scope of this Review, but in later months he was less inclined to use their services or be referred. The panel discussed what learning might help victims of domestic abuse who are veterans, in future, which is expanded on below (see Lessons Learned).

13. Analysis: Lines of Inquiry

13.1 Information provided to the Panel by agencies involved with Max and Amber was analysed against each line of inquiry in the Terms of Reference. Some changes have already been made since the start of this Review, which are noted as having been 'completed' in the Action Plan.

Communication and information sharing with regards safeguarding and domestic abuse

13.2 Communication and information sharing is not an end in itsel,f and should be followed by effective multi-agency action to safeguard and minimise risks There were some examples of effective communication and information sharing between services, for both parties, particularly earlier in the timeframe under Review. However, there were some notable exceptions, which are outlined below.

13.3 In December 2022, information sharing resulted in AHC recognising that Amber needed a Section 9 Care Act Assessment, however she was still on a waiting list for this, six months later. In March 2023, SCAS appropriately shared information about cuckooing risks faced by Max with AHC but his case was closed two weeks later because the High-Risk Domestic Abuse meeting had not identified actions for AHC. In June 2023, the S42 enquiry relating to Amber was closed in the weeks before Max was murdered. Had agencies been brought together and had this enquiry proceeded, it may have prevented risks escalating, given Amber had been assessed at the end of March by the Community Mental Health Team as a risk to herself and others. Further analysis of why a S42 enquiry was not opened between April and June 2023 is included below (Section 3).

13.4 In April 2023, when Max told Ambulance and hospital staff about physical and verbal abuse by his female flatmate and this was passed on to the hospital by SCAS, Max had already disclosed domestic abuse by Amber to HIOW Police. Max's hospital records noted bruising, alcohol dependency and memory problems, and a possible human bite mark on his arm. However, these were not explored further, and the hospital safeguarding adults' team were not informed. In hindsight a referral to the team through the single point of access, and to AHC, may have led to additional support. The hospital also had a co-located domestic abuse advocacy service for men and women but no communication with advocates occurred. Had a referral been made, this may have led to Max disclosing his relationship, provided someone for him to talk to and an assessment on what he needed to maximise his safety.

13.5 SHFT identified missed opportunities for the Community Mental Health Team to submit safeguarding referrals when the risks increased for Amber, after she became homeless. They assumed that because she was discussed at a MARAC which identified no actions for health services, that a referral was not needed. There were also delays to communication and information sharing when the Community Mental Health Team was contacted by TVBC Housing Options service and information was not shared because consent had not been obtained, even though this was permitted for high-risk abuse and had been agreed by the MARAC in March 2023. Learning about information-sharing requirements in cases of domestic abuse has since been prioritised amongst the Community Mental Health Team.

13.6 After Max's self-referral to Inclusion in April 2023 there was limited communication with other services. In May 2023 TVBC supported Max to access an appointment but there had been no prior contact from police or safeguarding services with Inclusion which could have helped mitigate risks to Max, relating to cuckooing or domestic abuse.

13.7 When Max was referred into the Veterans Mental Health TILS service, prior checks were made to ensure they would accept the referral, given his alcohol addiction. It was good practice that the assessment was supported by Inclusion to enable it to happen. Having decided (in May 2021) that Max was too high risk for ongoing work due to a recent suicide attempt, liaison with the Community Mental Health Team resulted in Max being referred to the Acute Mental Health team, and then to the veterans' mental health High Intensity Service.

13.8 During their relationship there were four occurrences from which HIOW Police had contact with Max and Amber and the sharing of PPNs happened in most but not all cases (see also learning, Section 3). Following the calls made by Max and Amber at the end of April 2023, about threats, guns, and a panic attack, police did not attend to confirm whether any offences had taken place. Although an Ambulance attended, no PPN was raised that flagged this incident with other agencies, which would have alerted agencies to their relationship. For example, it would have helped inform the Community Mental Health Team's assessment, which identified the risks Amber posed to herself and others, and to risks she faced from others, but her connection with Max wasn't known. There was also an eight-day delay in police sharing safeguarding intelligence with AHC in June 2023, which would have confirmed the relationship and cuckooing concerns. This was shared four days before Max's murder was discovered.

13.9 Although meeting notes were shared from the MARAC and high-risk domestic abuse meetings, the effectiveness or otherwise of information sharing within meetings and quality of the notes was considered by the Panel, and is addressed in Section 3. TVBC noted that although information sharing was timely, liaison with the MARAC Chair should have happened more proactively. It was also unfortunate that the Housing Options service decided to deprioritise attendance at MARACs or review of MARAC papers, due to capacity, at that time.

13.10 Improvements to internal communications between TVBC's Revenues and Housing service has been agreed following this Review. It would further improve information sharing if registered landlords were involved in information-sharing arrangements. Aster had proactive communication with Max in the weeks before he was murdered, as evidenced by emails and case notes. Aster also shared concerns with HIOW Police about his new girlfriend and possible cuckooing, but this wasn't acted on in time. Aster participated in partnership meetings such as the Test Valley community multi-agency risk assessment committee[56] as well as the domestic abuse MARAC. However, Aster had not identified Max as an adult at risk, and was not invited to participate in safeguarding assessments, even though information sharing between Aster and police officers in relation to anti-social behaviour was evident.

Whether services' response was consistent with each organisation's professional standards, domestic violence and safeguarding policy, procedures and protocols.

13.11 Domestic abuse policies and procedures, professional standards and safeguarding procedures and requirements were met in many instances, with a few notable exceptions.

[56] The Community MARAC differed from a Domestic Abuse MARAC in that it covered anti-social behaviour concerns, not domestic abuse. Domestic Abuse MARACS are held and chaired in a separate forum. This caused some confusion amongst local agencies, and it was recommended that the anti-social behaviour forum change its name. The Community MARAC has been renamed and is now known as the Partnership Action Group. Terms of reference have been drawn up and partner agencies informed of the change.

13.12 Although in 2021, AHC's response to Max was mostly consistent with professional standards for safeguarding, the response between March and May 2023 did not lead to further information gathering or enquiry in accordance with Safeguarding Policy requirements. Similarly, AHC's response to Amber in 2022-2023 was not consistent with the Safeguarding Policy and procedures, given Amber was waiting for an assessment for six months and a S42 enquiry was closed without reason. Further analysis on this is included in Section 3.

13.13 BHFT noted professional standards were maintained, and whilst BHFT had a domestic abuse policy which supported safe enquiry about relationships and how to respond to disclosures, it seemed reasonable that further enquiry was not made. Max had not said he was in a relationship and had reported he was estranged from all family members and had difficulty maintaining relationships.

13.14 HHFT's Alcohol Liaison Team assessed Max during hospital admissions, which included offering referrals to Inclusion and the veterans' mental health service provided by MPHT, and a review of support networks. However, referrals did not happen when Max said he had an upcoming appointment, even though he was not using those services at the time. Each Trust has no access to the other's notes which impacted the effectiveness of their response. When the mental health team advised that he be discharged, prescribed promethazine[57] and receive community follow up, it was not documented whether that happened, and lack of join-up between health services' systems meant referrals and follow-up cannot be checked.

13.15 The hospital's Domestic Abuse and Safeguarding policies were not adhered to when Max disclosed domestic abuse in April 2023. This was a missed opportunity to ask what had happened, and to refer Max to the Domestic Abuse Advocacy service based at the hospital. No referral to the specialist service was made whilst he was in hospital, and the hospital safeguarding team was also not alerted. The triage team had not handed over the observation of bruising and marks, to ongoing team members; nevertheless, all involved in assessing patients would have had access to the clinical note and should have reviewed the body map. Action has been taken by HHFT to address these gaps (see Section 3).

13.16 Whilst there were no concerns about SHFT's compliance with professional standards, its Domestic Abuse Policy was not implemented because staff did not recognise there was domestic abuse, and the relationship wasn't known about. There were also no records of assessments with Amber related to homelessness, domestic and sexual abuse in 2023 and there was a missed opportunity for a safeguarding referral, in accordance with Policy. There was a lack of professional curiosity to undertake a comprehensive assessment and referral because it was assumed police were already involved.

13.17 Max had not disclosed domestic abuse directly to his GP, and the Practice learnt of this from other agencies. As the risk to Max was identified as 'standard', Max was not placed on the GP's adult safeguarding list nor were his records flagged. Since this Review, the Practice safeguarding framework has been changed to include a Safeguarding Care Coordinator who now reviews all safeguarding documentation.

13.18 Max used Inclusion services until 2021, then self-referred in 2023. That resulted in one brief contact, a missed appointment, and an assessment at the end of May during which risks were explored, but he did not disclose he was in a relationship. Inclusion advised that if any risks were known a safeguarding referral would have been made, in accordance with procedures.[58]

---

[57] Used for a variety of issues including as an antihistamine, as a sedative, nausea and it is also used by adult mental health services for the management of disturbed behaviour (which is not to be taken with alcohol) (https://www.nhs.uk/medicines/promethazine/) .

[58] Due to the broad geographical reach of MPFT it has agreed that it adopts the *"policies and procedures set out by Safeguarding Children and Safeguarding Adults Partnerships / Board"* and that all have a duty to *"operate within the policies relating to their area of practice and in the local authority in which they work."*

13.19 TVBC's procedures were followed in relation to Council Tax. Their safeguarding procedure required notifications be made and advice sought once concerns were identified. The Housing service was not required to liaise with TVBC's safeguarding team prior to a referral, but to keep a contemporaneous record. In March 2023, TVBC made a safeguarding referral to AHC for Amber (although it was not recorded as such by AHC), but the referral number was not recorded, and no feedback was received from AHC. TVBC also does not have a separate domestic abuse policy and said they followed the Homelessness Code of Guidance and relevant legislation (see Section 3 for further learning on this).

13.20 Aster's response was in line the Social Housing (Regulation) Act 2023, which introduced new consumer standards including the offer of alternative housing where a tenant's safety is threatened. Its Anti-Social Behaviour and Domestic Abuse policies do not include identifying, responding to or managing perpetrators of domestic abuse. Aster had no knowledge of domestic abuse concerns relating to Max's behaviour and were also not aware of safeguarding referrals and assessments by other agencies, nor of reports of domestic abuse to HIOW Police between Max and Amber. Behaviours of concern reported to Aster were investigated and managed in accordance with anti-social behaviour procedures through visits, police collaboration, and referrals to support from agencies such as Inclusion (see Section 3 for further learning around housing).

13.21 HIOW Police's response to domestic abuse reported by Max in April 2023, was not in line with positive action procedures, which led to missed opportunities to ensure safety and gather evidence that could have supported a police investigation. The response to Amber's allegation of rape at the end of April 2023 was also delayed and the limited availability of female specially trained officers meant that by the time contact was made, Amber did not support an investigation. The PPN completed over a month later failed to include all relevant risk information or to be shared with safeguarding agencies.

13.22 Other concerns relating to HIOW Police's response included inconsistent quality of the PPNs issued when safeguarding concerns relating to mental health arose. For example, in May 2021 after officers learned Max had tried to hang himself, the PPN failed to include observations, views and analysis, nor further detail about mental health or alcohol use. Police held records of Max attempting to take his own life in August and December 2018, and that contextual information was not included. Amber's vulnerabilities were identified twice in April and May 2021, but no PPN was submitted in line with force policy. Had a PPN been issued, the police multi agency safeguarding team would have assessed risk and shared actions for relevant agencies. At the end of December 2021, when Amber called HIOW Police about a disturbance at her home, she presented with vulnerabilities including mental ill-health, but she was not identified as at risk, and a PPN was not completed, contrary to policy[59] which states: *"It will always be the responsibility of officers and staff to initiate the submission of a PPN, whenever they come into contact with a vulnerable adult who is deemed to be 'at risk*'".

13.23 Police also noted issues with the response to Max's ex-partner reporting him for domestic abuse in March 2023, as the decision not to arrest him was informed by her wish for no investigation. After he was later arrested, Max was then released because the victim had not taken action to stop his behaviour. There was no evidence that officers had implemented relevant policies[60], and there seemed

[59] HIOW Police Policy - FPP 22000 'Safeguarding Adults', paragraph 3.1.1. Paragraph 2.4 also states 'an adult at risk may be a person who is old and frail due to ill health, has a physical disability or cognitive/sensory impairment, has a learning disability, has mental health needs including dementia or a personality disorder, has a long term illness/condition, uses substances or alcohol, is a carer such as a family member/friend who provides personal assistance and care to adults and is subject to abuse, is unable to demonstrate the capacity to make a decision and is need of care and support'.

[60] The force policy that relates is FPP 'Stalking and Harassment', paragraph 3.6, which states: *'Look for where the perpetrator has opportunities to stalk or harass the victim and put preventative measures into action. Investigators should not make judgements about victims who do not follow safety advice. Victim responses and behaviours can vary according to the victim's circumstances".*

to be a lack of understanding that the victim is not responsible for the outcome of an investigation, or that not responding to contact may in some cases escalate risk. His ex-partner was contacted to advise he would be released without charge with no conditions preventing him from contacting her. Safety advice was provided, and a warning marker was added to police systems, but there was no consideration given to issuing Max with a Domestic Violence Protection Notice, that could have afforded her additional safeguarding and reinforced the verbal warning given to Max.

Agency responses in relation to domestic violence, safeguarding or other significant harm.

13.24 The AHC response to PPNs regarding Max through 2021 appeared to be appropriate, given information available. However further referrals in March and April 2023 indicated safeguarding concerns that necessitated further action, which did not happen. Further information from SCAS was not sought, and Max's disclosure of domestic abuse, request for help in relation to alcohol and drug use and feeling suicidal, should have also been subject to a review of care and support needs relating to abuse, mental health and substance use. AHC attended the MARAC in May 2023, at which Max was discussed, and shared information that in April there had been concerns raised about cuckooing at Max's address and that the referral had been closed following the high-risk domestic abuse meeting. This should have alerted agencies to the connection between Amber and Max, however there was no acknowledgement of this, nor were there any actions to address risks of cuckooing, which involved Amber's ex-partner.

13.25 AHC also had information about Max perpetrating domestic abuse and wrongly relied on MARAC meetings determining no further action for AHC, to decide there would be no further action for the safeguarding referrals made. No consideration was given to the different reports, people and risks involved, nor of risks to Max and his view on his own safety. Workloads and backlogs were an issue and there was ineffective and inconsistent management oversight of referrals made. It was also likely both referrals were conflated, and it was assumed that one decision covered all concerns raised, which was inappropriate.

13.26 AHC's first opportunity to respond to concerns about Amber was in July 2022 following suicidal ideation and a reported assault. Based on police information and enquiries into Amber's ability to access services, no action was taken. Amber's attempt to take her own life after her mother died, and concern that she was at risk of cuckooing, led to a discretionary S42 enquiry being opened. AHC made repeated attempts to contact Amber which appropriately reflected the level of concern, and were assured by Amber's response and acceptance of an assessment. The discretionary enquiry was therefore closed, and Amber was put on a waiting list. Amber also self-referred in February after reporting sexual abuse, and AHC staff spoke to Amber and discussed her place on the waiting list and reviewed her housing situation before closing the case. There was an apparent failure to consider her safety and ability to protect herself, or to respond effectively to sexual abuse, while the assessment was pending.

13.27 AHC was tasked by the high-risk meeting, in March 2023, to establish where Amber was moving, and to urgently undertake the S9 assessment that she was waiting for. AHC safeguarding leads agreed the action for urgent assessment, but this was tasked to the team with oversight of the waiting list, and they wrongly determined that high risk domestic abuse and an action from the HRDA meeting was insufficient reason to prioritise the assessment. AHC were also not aware of the connection between Amber's ex-partner and Max's address. Contacts and levels of concern for Amber increased, and in May 2023 TVBC also raised concerns with AHC that Amber was homeless and vulnerable.

13.28 A review of the assessments waiting list took place in mid-June 2023 and Amber's conversation with AHC's mental health team (during which she mentioned financial abuse and feeling 'psychotic'), also led to S42 safeguarding enquiries being instigated. Information gathering was carried out with TVBC, her GP, HIOW Police and the Community Mental Health Team. A joint assessment visit by AHC

and SHFT to her address was requested, as part of a statutory S42 enquiry, but the mental health team indicated they were not clear this was a statutory request and declined to attend as care had been transferred back to her GP. This should have been challenged and escalated by AHC, but a management review decided to close the case and undertake no further enquiries. The decision was an indication of poor application of the Care Act, an over-reliance on a medical model of non-engagement as a reason to cease involvement, and a missed opportunity to enquire about adult safeguarding. It lacked a sound rationale and risk assessment and was contrary to the earlier decision to seek a joint visit due to the complexity of the risks. No other actions were taken following that limited information gathering exercise.

13.29 The Panel also noted the missed opportunity to escalate the Community Mental Health Team's decision not to participate, and to bring services together to gain a contemporaneous assessment of whether risks associated with Amber required agencies to intervene. This would have required S42 processes to remain open. The Panel also noted that the significant delay to the S9 assessment. Had Amber been assessed earlier in the year and actions and interventions delivered; this may have addressed risks and concerns before Amber was ever connected with Max.

13.30 SHFT's Community Mental Health Team had previously recognised safeguarding concerns in relation to drug dealing and cuckooing and had raised this with AHC and HIOW Police. However, it was assumed that because these agencies were previously involved, they did not need to raise further safeguarding or abuse-related issues, which was noted as a concern.

13.31 Max's non-attendance at GP appointments was not followed up in the community by someone independent from the GP. Hampshire Integrated Care Board does not have IRIS[61] commissioned for GP Practices, so there would not have been a specialist domestic abuse advocate to discuss this with. At the time, missed appointments were reviewed by the GP to decide whether to contact the patient, in line with the 'Did Not Attend' policy, however since the Review, a newly appointed Safeguarding Care Coordinator will in future coordinate safeguarding action and discussions at team meetings.

13.32 Although Amber was identified by her GP Practice as having high levels of mental health support needs and being at risk of suicide, a safeguarding referral had not been made by the GP practice. The GP also noted that whilst an appropriate report was sent to the MARAC, the process for sending MARAC reports to the named GP lead was not followed in this instance, as information was sent to an Administrator who did not send this on to the clinician and Practice safeguarding lead.

13.33 Most HIOW Police officers who responded to Max and Amber identified their vulnerabilities and completed quality and timely PPN submissions, although missed opportunities for assessment and intervention, and issues with timeliness and quality were noted (referenced above and addressed in the learning below). The Panel also noted that HIOW Police intelligence relating to both Amber and Max was not connected and considered with these assessments, to explore how their care and support needs impacted on each other, which should be addressed in future.

13.34 Aster knew about drug dealing from Max's flat and had three anti-social behaviour investigations relating to Max's tenancy between January 2021 and June 2023; each was managed promptly in accordance with policy. Actions such as the Acceptable Behaviour Contract, were followed up with proportionate next steps including formal warnings. Reports of criminal behaviour were followed up with police and referrals to services were informed by conversations with Max. A mutual exchange was permitted to remove Max from his home which had become a targeted address. Aster's focus was anti-social behaviour and the Panel noted that no domestic abuse concerns were raised by its customers, the public or by Max throughout 2023 or earlier.

[61] IRIS is an evidence-based primary care intervention for responding to domestic abuse https://irisi.org/about-the-iris-programme/

13.35 TVBC's contact with Max was through the Council Tax team but he did not disclose domestic abuse to them. TVBC do not include domestic abuse information as routine on Council documentation, other than on the website. Following this Review, TVBC will consider what routine information could be provided as standard for people using its services, for example, information on receipts, leaflets, or bills relating to council tax.

13.36 TVBC does not have a domestic abuse policy but follows legislative guidance. The Housing Options service had reason to believe Amber was homeless, vulnerable and in priority need that led to an interim duty to secure accommodation under s188 of the Housing Act.[62] Private rented housing locally and out of area were discussed and considered an appropriate discharge of the interim duty. Disclosures of domestic abuse, stalking, harassment, and mental ill-health led to the service contacting mental health services and HIOW Police. Amber advised she wanted to leave the area, then said she would stay locally, but had nowhere to live. In May 2023 she said she stayed at Max's address but then left due to abuse. Amber was provided with details of a local refuge or told to refer herself to another local authority, and in June 2023 she was referred to a hostel for street-homeless men and women. The service also made two safeguarding referrals for Amber to AHC but received no response. AHC noted they did not record the emails containing concerns as safeguarding referrals from TVBC, nor were they labelled as such by TVBC. This has been addressed in the recommendations.

Max's wishes, feelings, safety and support needs being ascertained and considered.

13.37 AHC had no direct contact with Max and his wishes and feelings were only considered through agencies. For example, in earlier years, AHC spoke with Police Community Support Officers who had built a relationship with Max, and who advised AHC of no concerns with capacity, and that he was using Inclusion and Veteran services, even though he was not always actively engaged with services. In March 2023 a referral had not led to any attempt to ascertain Max's wishes and feelings, safety and support needs and the case was closed with no action. Opportunities for AHC staff to contact Max, to act upon his expressed wishes and feelings, or to gather further information about them (as part of a *Making Safeguarding Personal*[63] *approach*), were not explored. If this had been opened to an enquiry, AHC should have had contact with Max in person to assess his wishes and feelings.

13.38 SHFT noted that although *Making Safeguarding Personal* encourages agencies to centre people's wishes and experiences, it was evident that SHFT had not effectively ascertained Max's wishes and feelings. He was not actively using the service and after being discharged in Summer 2022, his only other contact had been after feeling suicidal, in April 2023, when he was discharged back to his GP.

13.39 In contrast, BHFT noted in their 2021 assessment that Max actively participated in the meeting, he had the capacity to understand the information, contribute to decision making and consented to the treatment plan. He had also requested Inclusion attend the appointment with him which was permitted. Max did not have his own email and requested that correspondence be sent to the Inclusion service. Max's wishes were also sought by HHFT regarding his drinking. During both inpatient hospital admissions, his wishes were central to discussions about his management of alcohol. Max's consent was also sought before referrals to Inclusion and mental health services.

---

[62] Section 188(1) Housing Act provides: "If the local housing authority have reason to believe that an applicant may be homeless, eligible for assistance and have priority need, they must secure that accommodation is available for the applicant's occupation" and applies whether or not they have a local connection. The Homelessness Reduction Act 2017 introduced a duty to "help to secure" accommodation for all applicants: "*Helping to secure' does not mean that the housing authority has a duty to directly find and secure the accommodation, but involves them working with applicants to agree (where possible) reasonable steps that the applicant and the housing authority can take to identify and secure suitable accommodation… It remains open to the housing authority to secure accommodation for eligible applicants where appropriate."* 16.3 and 16.4 Code of Guidance https://www.gov.uk/guidance/homelessness-code-of-guidance-for-local-authorities/chapter-16-securing-accommodation

[63] A person centred and outcomes focused approach to safeguarding, this national approach advocated for over a decade, encourages conversations with people about how to respond in safeguarding situations in a way that enhances involvement, choice and control.

13.40 Aster advised that Max engaged well, and agreed to access support from Inclusion, although they did not know if he had engaged. Max told Aster he wanted to move, and Aster permitted a move, and worked with him to agree rent repayments.

13.41 At each contact with Inclusion Max seemed to have been met with a response to his needs, and he was offered harm reduction advice and support relevant to his reported alcohol and substance use. Max's wishes were considered when treatment options were discussed, which enabled him to make informed choices about his treatment.

13.42 Max had significant contact with HIOW Police High Harm Team and there was evidence of a good rapport between them: records noted he felt he "*could trust*" several officers and frequently opened up to them about his mental health, self-harm and suicidal ideation. When Max moved home, the same officers continued to visit Max, he remained responsive, and there did not appear to have been a barrier in Max contacting police. There was a missed opportunity to suitably record Max's wishes and provide him with support when he alleged sexual assault from a previous relationship, in March 2023 (see Section 3).

What was known about Amber, including management arrangements or orders in place.

13.43 Amber was not known to all agencies involved with Max, until after the murder.

13.44 SCAS knew about and had responded to Amber but was not aware of any domestic abuse history or MARAC involvement, because SCAS are not included in any MARAC meetings nor do they receive MARAC feedback, in Hampshire. This information sharing gap means crews are not aware of high-risk domestic abuse information when they attend calls. This is something SCAS aims to address in collaboration with agencies represented at MARACs.

13.45 AHC had no information that suggested Amber presented a risk of perpetrating domestic abuse, and held information about vulnerabilities, needs and behaviours that were shared as part of their safeguarding referrals. That Amber and Max were discussed at the same multi-agency risk management meetings, as victims and perpetrators of domestic abuse respectively (with other people), and had the same connections, had not been noticed by professionals at those meetings. The Panel noted this may be due to the volume of meetings and numbers being discussed each week.

13.46 Amber had attended the Emergency Department for pain relief, and on both occasions she left before assessment and against medical advice. HHFT was not aware of Amber's subsequent relationship with Max.

13.47 SHFT noted that although Amber was discussed at MARAC meetings, there appeared to be little awareness of her involvement with mental health services, and no actions highlighted for health or mental health services following discussion about high-risk domestic abuse. The service also noted that Amber felt aggrieved and ignored by various agencies, which suggested her wishes and feelings were not heard. The service was not aware of Amber's relationship with Max but identified an earlier missed opportunity to consider a Multi-Agency Risk Management meeting (see learning below, 15.97) that might have led to further interventions.

13.48 TVBC knew that Amber needed support with homelessness and for being a victim of domestic abuse at high risk of harm, in Spring 2023. She was also known to have a severe mental impairment, confirmed by her GP. Her GP had regular contact with Amber through the period considered by this Review, although nothing was known about her contact with Max.

13.49 Amber was well known to HIOW Police following reports of domestic abuse, rape and sexual abuse, and her relationship with Max was known as was her problematic substance use, and risks of

being cuckooed by dealers. Amber's mental health support needs and history was also known, and she had informed police that she had previously been married, but her wife had died around 2019. Police also knew that Amber had recorded offences in other areas of the United Kingdom. Prior to moving to Hampshire, she was arrested on suspicion of violent offences, threats to kill, theft, burglary, driving under the influence of alcohol and weapon possession. She had been sentenced to 12 months prison for Grievous Bodily Harm in 2009 and was subject to multi-agency public protection arrangements.

13.50 On sentencing Amber, the Judge acknowledged that Max was a vulnerable man, who had become isolated, and noted that Amber had five previous convictions. The Judge sentencing remarks concluded in relation to Amber:

"The killing was orchestrated in a forceful way. Your action remains merciless and remorseless … Your relationship with [Max] was anything but exclusive. You went there as and when it suited you. It was toxic. Despite the problems you had in your formative years, you held long term jobs and relationships. I'm not persuaded that the personality disorder has any meaningfully impact on you and the actions on [date of the murder]. It appears to me the use of Class A drug had an impact on that psychological condition. You were prepared to do or say anything to get what you wanted."

Aggravating factors included "*27 separate stab wounds, you were heavily intoxicated with drugs at the time, you had fixation on [him being] responsible for your dog escaping from the flat, that [he] was defenceless, you concealed your actions by covering his body … you bragged about killing [him], you made derogatory remarks of [him] long before his body was found, you left notes at the scene with limited explanation of your actions, you used his debit card to purchase more illicit drugs. … despite the heavy drug use, you cleaned up the scene, organised your travel, and left your mobile phone behind so that you couldn't be tracked."*

How accessible services were for both Max and Amber

13.51 Max's family said he was a very proud man who would not have found it easy to ask for help, which would have impacted on the accessibility of services for him. They said that had agencies taken time to see him and build trust to talk to him on his own, that may have helped professionals notice changes in his appearance or behaviour and help him disclose any concerns. They also felt that agencies may not have believed Max if he told them Amber was abusing him, because of their size difference and that he was much older than her.

"He wouldn't tell us if he was getting help from any agencies. It was not his style; he was a very proud and private man … He wasn't good at reaching out and asking for help. Why didn't someone go round and visit him, see him in person, that's what would have helped. They knew he was vulnerable … Knocking on his door and asking more when he says he's fine, digging deeper. He's old-school and didn't really use technology. He didn't have email or use online banking. Someone should have taken some time and gone and seen them rather than by letter or by phone. That generation is always face to face, they would rather speak with and see a person when they deal with services." (Max's family)

13.52 AHC advised that anyone could access services through the Contact and Resolution Team, which was the front door of the service and provided 24-hour cover. Records do not indicate Max was aware of AHC and their role and AHC had not made attempts to contact him. Safeguarding concerns raised with AHC were received directly by the Multi-Agency Safeguarding Hub. Amber had engaged with AHC following several attempts to contact her, and used the self-referral online form, email and phone. Barriers to accessing support were evident, when Amber was not satisfied with the service following her request for help in getting food, due to lack of transport. Amber had also been unable to access an assessment, from December 2022, and her case was inappropriately closed in June 2023.

13.53 Max reported a positive experience with TILS, and this would have contributed to him seeking further support from them when his mental health deteriorated in 2021. Max's engagement at that time was generally good and services demonstrated a level of persistence when trying to contact him. Max was not actively using SHFT services, but the service noted that had he or Amber called the NHS 111 number they could have accessed the Mental Health triage service. Learning from this Review has led to SHFT revising its format for multi-disciplinary team meetings, and greater recognition that face-to-face interactions are a crucial part of the assessment and support process.

13.54 Inclusion takes self and agency referrals, do not have a waiting list, and have no limitations with re-referrals. Inclusion enabled Max to access a video assessment appointment, as without that he may not have been assessed. Following Amber's self-referral in 2022 she was immediately contacted for a phone assessment, declined to engage, and was advised of how to re-engage. Max referred into Inclusion several times after his initial contact in 2016, and was offered prompt and ongoing regular appointments, accompanied by group work and peer support. Throughout his engagement Max was seen in the service and raised no issue with attending appointments.

13.55 TVBC had no evidence that services were inaccessible, although the housing service failed to effectively engage Amber following her disclosure of domestic abuse. Regular interactions took place with Max at the Council Tax service, in accordance with his requests for help or support.

13.56 Both Max and Amber regularly contacted police and there was evidence of responsiveness to their presenting needs at the time of contact. This also involved communication with mental health triage, housing, and other services e.g. local food banks, during the review period. The Victim's Code requires victims are provided a single point of contact to minimise the number of officers and staff contacting the victim, and had this been actioned with Amber and Max, there may have been more effective and coordinated investigations and oversight across multiple reports. Victims have the right to be referred to services for support and specially trained officers are responsible for maintaining contact with the victim, explaining options throughout an investigation, undertaking safeguarding actions and advice, and making referrals to other agencies.

13.57 Amber's feedback to the Panel indicated that she had contacted a range of agencies, and had asked for help and disclosed she was in danger but felt she had not been listened to and was not supported when she contacted agencies. The services referenced by Amber that had not listened to her requests for help included the local authority homeless service, GP, police, and Adult Health and Care. Amber said that the nature of communication on some occasions would have been more helpful if it were by phone or in person, instead of by text. She gave the example of police officers texting her to ask what she wanted to happen with her underwear following a report to police, which was inappropriate.

Training provided, take-up, and any refresher training provided.

13.58 The training provision in all participating agencies was checked (See Appendix C) and some agencies included a recommendation on further developing their training content in the IMRs. Some agencies subsumed domestic abuse training under safeguarding which means in practice that domestic abuse specific content is relatively low. Amber's feedback to the Panel particularly highlighted that she felt frontline professionals need training to ensure they listen to people and not judge them, to ensure they understand the needs of people who use drugs, and who experience abuse. The Panel noted the following training delivery, and recommendations have been made to address gaps.

- AHC had specific training pathways for each position and training uptake was monitored by supervisors and wider governance processes, but no information was available about the take-up of the training. AHC has recently added a day course in Domestic Abuse delivered by *Making Connections*. AHC also has a mandatory requirement for all staff to complete Domestic Abuse e-

learning. This was in place at the time of the incident, and staff are required to complete it again. Hampshire County Council also confirmed domestic abuse training is available via Hampshire safeguarding Children Partnership, and commissioned services also delivered targeted training.[64]

- Safeguarding Adults and Clinical Risk Management training is mandatory for BHFT's TILS and diversion practitioners and is refreshed every three years. Domestic abuse training is also available to all staff but is not mandatory. Suicide Prevention training is strongly recommended for practitioners and other training needs can be identified in their appraisal and can be accessed from outside BHFT if it is not provided internally. No information was available about its take-up.

- Safeguarding Adults Training at HHFT is mandatory and includes domestic abuse, and when and how to refer to domestic abuse and safeguarding teams. Stop Domestic Abuse deliver domestic abuse training for HHFT staff. The delivery of 'safeguarding adults' level 3 training includes training modified for clinical areas such as emergency departments, to ensure it is relevant, which includes issues and learning from domestic homicide reviews.

- SCAS include domestic abuse in the safeguarding induction delivered to all new employees, and it is included within safeguarding level two and three packs; the latter had 93% compliance across staff. Safeguarding supervision training is delivered to relevant staff, and access to external training also includes domestic abuse training. A standalone domestic abuse training package is in development, to reflect plans for policies for staff and service users to be amalgamated, strengthened guidance on coercive control, and reference to a MARAC flag system.

- SHFT's front-line clinical staff undertake mandatory eLearning on domestic abuse awareness, which is also available to wider Trust staff; this had 96% compliance across the Trust. Clinical staff are encouraged to complete Domestic Abuse Pathway eLearning, which is under review, and to do Safeguarding Adults Level Three which is not mandated. Level Two safeguarding training is mandated, alongside non-mandated Level Three to increase awareness of adult safeguarding. Safeguarding supervision is provided, and practitioners can contact SHFT Safeguarding Advice and Support line. The Trust has management guidance on supporting staff subject to domestic abuse.

- At Max's GP Practice, all clinical staff are Level Three safeguarding trained, and non-clinical staff are Level Two trained. This is provided online and includes domestic abuse. Amber's GP Practice receive domestic abuse updates and training and encourage staff to attend; currently a quarter have been trained. Clinical staff undergo eight hours of adult safeguarding updates over three years, and twelve hours of child safeguarding updates over three years and domestic abuse is included. Lead GPs do 16 hours of safeguarding training over three years, attends training and safeguarding meetings, and cascades this learning at monthly adult safeguarding team meetings.

- MPFT safeguarding services provides a Level Two domestic abuse awareness eLearning package which is mandatory for all professionals who have public-facing contact. It also provides a Level Three domestic abuse enhanced training for practitioners who undertake routine enquiry. It provides professionals with knowledge and skills regarding completing a DASH and making a referral to MARAC and the local authority if there are safeguarding concerns. This is completed every three years and monitored by the learning and development team. Inclusion is expected to complete both Level 2 and 3 domestic abuse training, and compliance rates were high.

- TVBC staff undertake in-person safeguarding training at induction and do refresher safeguarding training every three years. The Hampshire Safeguarding Children Partnership and Hampshire Safeguarding Adults training programme is also available. Domestic abuse training is mandatory for the housing and homeless service induction. Training will be reviewed to ensure domestic abuse training includes identification, response, risk assessment and referrals.

[64] https://www.hants.gov.uk/socialcareandhealth/domestic-abuse-partnership/professionals/domesticabusetraining

- Aster Customer Accounts teams received training on managing rent and available financial support, and the specialist anti-social behaviour team are trained in BTEC anti-social behaviour case management, and in specialist domestic abuse and safeguarding training, which is refreshed annually. Safeguarding training is mandatory and Aster monitors training uptake and attendance. Domestic Abuse training is not mandatory throughout the business, and no information was available about the take-up of the training. From 2025 domestic abuse training is also delivered for trades staff to support small groups to discuss issues and their responsibilities.

- HIOW Police deliver several training opportunities depending on roles. Domestic abuse and safeguarding training are mandatory for all frontline officers and staff are required to do regular refresher training. Police Staff Investigators, Community Support Officers, Police Constables, and other frontline staff receive mandatory 'Domestic Abuse Matters' training as part of their induction. They also receive mandatory training on vulnerability and risk, including victim support, hate crime, adult and child safeguarding, honour-based abuse and female genital mutilation. They also receive specific training on the completion of PPNs, how to best capture evidence and centre the victim's voice. Over 700 Domestic Abuse Champions also volunteer for specialist training in domestic abuse and safeguarding. Internal training is provided on recognising and responding to coercive and controlling behaviour and stalking, to frontline officers and staff, call handlers and Champions. This includes post separation abuse, suicide, and the importance of completing accurate PPN/ DASH risk assessments. The training includes specific case examples from Hampshire and learning from Reviews. The newly formed Priority Crime Teams have received additional training on the Domestic Homicide Timeline and the Domestic Violence Disclosure Scheme.

Thresholds for intervention being appropriately applied.

13.59 Most agencies involved reported that thresholds were appropriately applied during the period of this review. The exceptions are summarised below.

13.60 AHC thresholds for intervention were not appropriately applied, in relation to the offer and provision of S9 assessments and carrying out enquiries under S42 safeguarding duties. This is discussed further in Section 3.

13.61 From May 2023, HIOW Police noted increased concerns that Max was using drugs and was in a relationship with Amber who had links to drug networks. Further information received by police from mid-June indicated Max was being cuckooed again, which was shared with AHC eight days later. This should have been more promptly shared. The Panel also noted that this concern was already known to AHC and HIOW Police, following a referral in April 2023, and known by multiple other agencies as it was noted in the minutes from the MARAC meeting in May 2023. AHC had noted in the MARAC that a referral relating to cuckooing had been received in April but not actioned "*due to recent HRDA*"; the HRDA minutes noted this was "*not open to AHC*" when the case was progressed to MARAC. It seems not only that no action was taken by AHC on these concerns raised from April 2023 but also that no professionals at MARAC challenged the lack of multi-agency action to safeguard Max. No action relating to cuckooing was recorded in the MARAC minutes.

13.62 In March 2023, police failed to issue a Domestic Violence Protection Notice to Max following his arrest on suspicion of stalking and harassment and his subsequent release from custody with no further action, even though the threshold for issuing such a Notice was met. That was a missed opportunity to safeguard his ex-partner who, two weeks later, reported further unwanted contact.

13.63 HHFT noted that a safeguarding referral had not happened in relation to Max's care and support needs relating to alcohol dependency and mental health. Although he was referred appropriately to the Mental Health Liaison Team, notes were not available to the hospital regarding support or interventions

from community mental health services, and it was assumed any safeguarding concerns would have been raised by that service.

13.64 Although TVBC noted that thresholds were appropriately applied, and housing would usually refer to domestic abuse specialists on disclosure, the service had not benefitted from co-location of a specialist domestic abuse service. A Housing Options Domestic Abuse position has been appointed from July 2024, to meet demand for support, on disclosure of abuse.

Agencies' practice being sensitive to nine protected characteristics.

13.65 This is addressed in Section 12 above.

Issues being escalated if appropriate, and in a timely manner.

13.66 Escalation, where relevant, happened appropriately. The Panel also noted the following where learning was identified.

13.67 AHC identified evidence of a lack of escalation when health partners declined to respond to a request to work together under S42 Care Act safeguarding enquiry duties.

13.68 Whilst there were attempts to meet Amber's request for a female specially trained officer, this should have been escalated further to ensure Amber was receiving a minimum standard of service was delivered in line with the Victim's Code.

13.69 Amber's experience of increasing risks was not escalated to managers in SHFT, in accordance with the Trust's safeguarding policy and as reinforced in the Safeguarding Level 3 training provided to the Community Mental Health Team. This led to an internal serious incident review under SHFT's governance process.

13.70 Aster noted a de-escalation of action, before Max moved to his new home. Police had led on the start of a closure order, following receipt of evidence of anti-social behaviour and due to the amount of reports received on the number of visitors, length of stay and frequency, possible related to drug dealing. The closure order application was police led and Aster served the formal tenancy warning. However, the closure order application was not completed due to an improvement in behaviour.

13.71 There was some inconsistency in understanding thresholds for accessing mental health support. Max' assessment by the veteran's mental health service TILS in May 2021 identified him as being too high-risk for the service so he was referred to SHFT's community mental health service. They then advised the service would not be able to provide support, and BHFT escalated this and an urgent referral was for Max to the Acute Mental Health service. Max was also advised he had been referred to the High Intensity Service. These referrals were made the same day as the assessment which was appropriate given the identified risk.

13.72 Max's family questioned whether timeframes were appropriately applied, when responding to Max.

"*Were agencies following things up if they were told anything? If they were, was it in the right time or was it weeks, or months, later? There should be processes in place so that safeguarding issues should be followed up in 48 hours, and agencies should meet them, in person, and these should be checked by managers." (Max's family)*

"Too many agencies thought that another person would pick this up, or responses weren't checked by managers, so people thought we don't have to do it. There should be a central system. professionals may have meetings but there were no visits. When did they get round up to seeing him." (Max's family)

Any impact of organisational change

13.73 There were no significant organisational changes relevant to this Review and services delivered. It was noted that agencies were impacted by the Covid-19 pandemic including subsequent restrictions imposed in England on people's movement and the availability of services between March 2020 and December 2021, although there were differences across sectors.

- HHFT operated Covid restrictions in hospital, but there was no evidence that there was a significant incident at the time of Max's admission which would impact the service response.
- The pandemic had a significant impact on GPs, including an increased workload and surge in demand while maintaining safety protocols. Many GPs adopted telemedicine to reduce in-person visits and ensure patient care continued.
- AHC teams and services continued to experience high levels of demand. From July 2022, the MASH service underwent a transformation programme, which provided context for the pressure experienced by staff when carrying out their roles.
- In July 2022 there was a process change in the way PPNs were shared by HIOW Police. Before July, notification of an adult at risk would be shared with AHC. This led to a considerable volume of notices being received so it was agreed that a PPN raising concerns about mental health, physical health, medication, or substance use would be shared GPs. This was communicated force wide via internal communications and the force intranet, stressing the importance of gaining the GP Practice details and the person's consent to share information. This change was also shared with partner agencies via four local Safeguarding Adult Boards.
- TVBC's Housing Service was significantly under-capacity due to staff shortages whilst managing a fifty percent vacancy rate and several newly recruited positions. The impact of this was that TVBC did not attend MARACs during this period, and therefore any information pertinent to Max or Amber would have been missed.
- Inclusion established a 'No Wrong Door' service for people with co-occurring conditions in 2023 which improved joint working and communication between substance use and community mental health services. Amber was referred to Inclusion's 'No Wrong Door' by the community mental health team, however declined the referral.

What was known by agencies about Max's and Amber's relationship.

13.74 The Panel noted that many agencies had either not known Max and Amber were in a relationship, or living together, and where this was known, most had not known about domestic abuse. There were exceptions to this, as summarised below.

13.75 Although referrals to AHC had not included information that connected Max and Amber or would lead AHC to connect them, some agencies had known of their connection between April and June 2023, including that Amber's ex-partner stayed with Max for some of that time, and that Amber was associated with Max's address. AHC also knew about cuckooing concerns and that Max had disclosed domestic abuse. These connections might have become apparent in April had further enquiry been undertaken by AHC following a referral. Professionals at MARAC meetings also had the opportunity to share and connect all relevant information available to them, about Max and Amber, if they had focussed on the whereabouts of her ex-partner and Max's wider vulnerabilities and risks.

13.76 TVBC noted that whilst Amber was staying with Max, Amber called the housing service and advised she had moved out due to abuse. No other details about their relationship were recorded.

13.77 HIOW Police connected Max and Amber at the end of April 2023 following calls to police, although Amber's police record was not linked to the incident as her name and date of birth was not provided. When Max told police that Amber had slapped him, he said she was his "*girlfriend",* but Amber said they were not in a relationship. In May 2023, Amber reported rape to police officers but denied that Max was connected with the rape she reported from his address. In mid-June 2023, HIOW Police were told by Aster that Amber was taking advantage of Max and may be cuckooing him; that was shared at a daily management meeting and shared with AHC a week later.

13.78 Aster was not aware of Amber living with Max at their property. Amber came to their attention following anti-social behaviour reports in May 2023 and a subsequent home visit. The Anti-Social Behaviour team shared concerns about Max's girlfriend with HIOW Police but were unaware of who she was or that she posed a risk. Nothing had been flagged on Max's housing records about domestic abuse (even though Aster had attended the MARAC) and no further questions were asked about her or anyone else living with Max. At that time, Aster had not been notified of any concerns held by other agencies, so were unaware of these.

13.79 SHFT was not aware of the relationship, and during calls with Amber, there was no professional curiosity around her social networks, friends or acquaintances. Other organisations who were aware of the relationship with Max did not share that information. Inclusion and BHFT were also not aware of a relationship between Amber and Max. BHFT had previously known he had a difficult relationship with people living nearby and had discussed violence prevention, which had been shared with police. They also knew he had been a victim of cuckooing, but he told them that police were *'looking out for'* him.

Whether agency responses were in accordance with policies and procedures in relation to safeguarding adults, in particular s.42[65], and effectiveness of cooperation.

13.80 There were missed opportunities to carry out further enquiries under S42 in respect of Max and therefore to engage other agencies in this, as summarised below. Further assessment of the learning in relation to safeguarding responses are at Section 3.

13.81 During the earlier period under review, PPNs were shared with AHC when an adult at risk was identified by HIOW Police. However, that led to a large volume of information being shared and AHC were unable to process them effectively. In July 2022, it was agreed police safeguarding leads distinguish between pathways for support for vulnerable adults, so that concerns about mental health were shared with GPs (for consideration of a referral for mental health support) and concerns for adults with care and support needs were shared with AHC. Whilst that system change reduced the volume of information received, leaving HIOW Police to identify care and support needs inevitably led to complex nuances being missed, particularly where several needs coexisted but where one need appeared more overt than another.

13.82 Max would often tell officers that he had no concerns other than his mental health. That inevitably led some officers to prioritise GP notifications whilst not addressing the root cause of the problems he faced. This was similar for Amber where her reports often related to her mental health. However, Max also faced risks associated with being exploited, financial abuse, substance use, and being cuckooed by dealers. This was also the case for Amber who had been exploited, experienced sexual and

[65] S42 Care Act: where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)— (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. The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom. "Abuse" includes financial abuse; and for that purpose "financial abuse" includes—(a) having money or other property stolen, (b) being defrauded, (c) being put under pressure in relation to money or other property, and (d) having money or other property misused

physical harm, unstable housing, alcohol and drug use, domestic abuse, the previous death of her partner and more recently her mother. Had their care and support needs been fully recognised by attending officers and safeguarding coordinators, PPNs completed for Max and Amber should have been shared with AHC for a Care Act assessment.

13.83 In relation to Amber, responses were varied with regards adherence to safeguarding policies and procedures. Safeguarding concerns were raised and most discontinued with a rationale recorded for the decision, but there are examples where this was not the case.

- The S42 enquiry opened by AHC in June 2023 for Amber, sought to engage SHFT's community mental health service in a joint visit, yet the response was that they would not carry out a visit due to Amber's previous non engagement. SHFT had no record of this, and the email from AHC to the Community Mental Health Team advising of the Section 42 assessment request, and subsequent decision to decline it, was not documented on any clinical records.
- A joint assessment for Amber between housing services and the Community Mental Health Team failed to proceed because it was recorded that Amber was discharged from the service, although that was incorrect as an initial assessment had not yet happened.

13.84 Learning and action to ensure staff are aware of the statutory responsibilities of a Section 42 Care Act obligations has been implemented by SHFT. Agencies should also address the issue of being referred back to GPs following non-engagement, where there is known risk.

13.85 Following SHFT's last contact with Max in April 2023, when he was alcohol and drug dependent, had disclosed feeling suicidal and was at risk from drug users accessing his flat, it was determined by the mental health liaison team that he did not need a Mental Health Act assessment and had capacity to make decisions, that he felt able to keep himself safe and contact the police if required. The GP notification referenced domestic abuse, suicidal ideation and requested primary care mental health support.

13.86 BHFT noted they had not made a safeguarding referral in 2021 as relevant services were already involved with Max. BHFT were not contacted to contribute to a section 42 investigation, because a S42 concern was received, and further information gathered, but it did not progress to an enquiry.

13.87 The TVBC Animal Welfare service made an internal safeguarding report to the TVBC Safeguarding team, which assessed the nature of the concern and Amber she was given information on bereavement support. No AHC referral was made as there were no concerns identified that it met the Section 42 threshold for a safeguarding enquiry. Housing Options made a safeguarding referral into AHC at the end of March 2023 following Amber's disclosure of domestic abuse but had not received any response after that referral. AHC noted during this review that the emails were not identifiable as a safeguarding concern to the staff receiving them, and were not labelled as such by TVBC.

13.88 No safeguarding concerns were raised with Aster by Max, and at the home visit in mid-June Max reported feeling good, swimming and not drinking and that he had a new girlfriend, who was present. No safeguarding concerns had also been raised with Aster by any other agencies. It is vital that housing services are involved in enquiries and assessments, and in information sharing where concerns relate to vulnerable adults, domestic abuse and safeguarding.

What family or friends know about any abuse prior to the homicide; what they did with this information, and how would they know what to do.

13.89 There were no other references within agency records to family members or friends who may have known about the abuse; some reference was made to Max being estranged from family members. Agencies were not aware that Max was in regular contact with his wife from whom he had separated

many years earlier, and that they remained friends. His wife would still cook meals for him, took him to appointments, and regularly stopped outside his home for a chat. When she discovered Max was in a relationship with Amber, she stopped seeing him, although he continued some contact with his son.

13.90 Max's family said they weren't aware how many or which services had been involved with Max over the years. They didn't know what agencies Max was going to for help because he wouldn't tell them, although they knew that when he was drinking heavily he wouldn't have engaged with agencies or groups. They noted that agencies had believed that Max left the Army and started drinking but had not always known he was already a heavy drinker.

13.91 Max's wife knew that when he lived in his last two addresses, he had started taking drugs, and there were people around him who took advantage of him, which HIOW Police were aware of. She said on some occasions he would call her to go round and throw people out of his home. When he moved to his flat in 2022, there were also known dealers who lived in the building. His wife wouldn't visit him there because the same issues started again.

13.92 Max and his wife would meet at a local café and chat, and she would occasionally help him out with appointments, with going to the foodbank, or he would pay her to buy food. After he moved, he also got in touch with his son again, and they would occasionally meet or speak by phone. The last contact Max had with them was when he phoned in early June and asked to borrow money; then Amber came on the phone and pleaded for it because she said it was a drugs debt.

13.93 His wife found out a month before he was killed that Max was seeing Amber, and her contact with him stopped. She saw them together twice in the street. They later learned that Amber started having contact with Max around February, which became more consistent two months before June.

13.94 The family weren't aware of abuse at the time and said they didn't know until the trial that Max had reported Amber to the police for assault - *"If we knew we would have come forward. He didn't tell us anything. I don't know if agencies knew we existed. We used to do his shopping for him, cook his meals and put them in the freezer. He was no great cook." (Max's family)*

13.95 Max's family said they knew something wasn't right. They felt Amber controlled his phone and didn't let him use it, and they suspected he was scared. They also felt that Max was being manipulated and found out after his death that Amber would withhold his alcohol, as a control tactic. Family also said that even though he said she was his girlfriend, had agencies looked into what was going on, they would have realised she denied this when they were not together.

"When I saw Max with Amber together in the street, if I'd have said anything to him, it would have been an issue. The way he looked at me, he was scared, I know him, and he was scared. If she'd have realised who I was, he was scared of her reaction. She was very controlling." (Max's family)

"She was manipulating him…When someone saw them outside together, they should've seen through it. I knew instantly when I saw him in town that he was scared. Some of them would have known her background and who else she was involved with. How did agencies allow her to get into this with Max without helping him. It seems agencies only knew what she wanted them to know." (Max's family)

Whether there were any diversity issues

13.96 This is addressed in 12 – Equality and Diversity.

What learning can be identified and what changes could be suggested

13.97 Responses to this formed the basis of Panel discussions and are reflected in the findings and recommendations below.

14. Good practice

14.1 The Panel noted areas of good practice identified by agencies in their IMRs, some of which had emerged from learning or service reviews and are worthy of note. For example, services noted:

HIOW Police

- There were several occurrences within the review timeframe in which officers and staff responding to Max and Amber identified their vulnerabilities and completed PPNs.
- There were several instances within the review timeframe where officers displayed compassionate responses, identifying the specific needs of Max and Amber and spent a significant amount of time listening, offering support and completing follow up contact. Officers from the High Harm Team built a good rapport with Max through frequent visits.
- Officers displayed compassionate responses when responding to the death of Amber's mother in November 2022 and the subsequent support offered to Amber. This includes a supervisory review identifying Amber's vulnerabilities and how these could exacerbate her grief and requesting officers conduct a further welfare check. In February 2023, responding officers demonstrated an empathetic and understanding approach to Amber when she was experiencing difficulties in gathering supporting evidence for an investigation. It is evident that some officers listened to Amber, signposted her to services and sought ways to engage with her to gain best evidence.
- Despite being removed from the Operation Fortress list in January 2022, officers continued to check on his welfare and gather intelligence on those visiting his address. This is good evidence of a diligent response by neighbourhood and 'high harm team' officers.

Inclusion

- The service was responsive to Amber's initial contact with the service, when a same day telephone appointment offered. Inclusion was also responsive to Max making contact with the service. Appointments were offered in a timely manner with flexibility to change it or rebook in the event that Max did not attend or needed to change timings.
- Following contact from Housing in May 2023, raising concerns about Max's substance use and potential cuckooing the person taking the telephone referral was responsive to potential needs, and a prompt assessment appointment was offered.

SHFT

- The Community Mental Health team made many attempts to contact Amber, including conducting wellbeing checks, and provided additional support in terms of her housing.

BHFT

- Max gave positive feedback about his care and treatment with the TILS service. This positive experience influenced his decision to refer himself back into the service when his mental health deteriorated again. Having a service which is specific to veterans is to be commended and this has now been improved further with Op COURAGE.
- Risk assessments were personal to Max and there was clear evidence he had been involved in the assessment and the safety planning. Overall, he received a high standard of care for BHFT services, in line with policy and procedures.

HHFT

- HHFT's policy on domestic abuse identification and response includes access to a Domestic Abuse Advocate team for those who consent to referrals being made. If they are an inpatient, the team will visit the person in hospital and also continue to contact them once discharged.
- HHFT alcohol liaison team developed a positive working relationship with Max and he led on developing a plan for alcohol withdrawal whilst maintaining autonomy and maximising potential for engagement. Their assessments centred Max and were thorough, personal and individualised.

- Since this review, the Safeguarding Adults team meet regularly with Adult Services in Basingstoke Hospital to review and discuss ongoing referrals and any concerns, and these meetings have commenced with Adult Services at RHCH also and are held fortnightly.

TVBC

- The response from the Animal Welfare Officer to provide such a level of support and signposting to Amber when she was distressed about the death of her mother and that she did not know where she was, demonstrates good practice as consideration was given to the needs of Amber beyond the remit for original call out.

GPs

- Both GP Practices demonstrated good communication with Max and Amber, noting that neither have an IRIS service to identify and respond effectively to domestic abuse amongst patients.
- Max's GP promptly attempted to book appointments, including after Max had not attended.
- Clinicians at Amber's GP Practice provided responsive support to her throughout her period of registration and specifically after the unexpected death of her mother. Amber told her GP that she was homeless in May 2023, so whilst she remained registered locally, her prescriptions were sent electronically to Andover.

Section 3

15. Key Findings and Lessons Learned

15.1 This section addresses the overarching lessons that have been learned from this Review. Agencies also identified their own lessons, and these led to single agency recommendations (see 17.1 below).

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

15.2 There are specific barriers to accessing help for men who experience domestic abuse, and women's violence may not always be recognised by agencies. A common strategy by perpetrators is to assert that they are victims,[66] so it is vital that agencies identify who is doing what to whom and the impact of their behaviour, to effectively meet needs, mitigate risks and maximise protection for male and female victims. Agencies need to be competent in distinguishing between primary perpetrators, and victims who use resistance, mutual violence, or unreasonable behaviour in relationships.

15.3 Max was known to agencies as having perpetrated domestic abuse. When he later reported abuse from a female partner, it was vital agencies believed him and could effectively assess each disclosure made. When he reported abuse and had visible signs of bruising and a bite mark, the hospital failed to ask relevant questions about abuse. There was also no referral to the co-located specialist domestic abuse service offering support to male victims at the hospital. This was despite the hospital's policy and training on domestic abuse including a focus on male victims, and information resources on the organisation's intranet about help for male victims.

15.4 In March 2023, when Max alleged sexual assault by an ex-partner during a police interview, his report was not appropriately recorded, or risk assessed. In April 2023, Max reported domestic abuse, but that resulted in a delayed risk assessment by police (four days later). No referral to local domestic abuse support services for male victims occurred because he did not consent to a referral. Max was assessed as standard risk of harm, and he refused to support a police investigation and later he denied the assault had occurred.

[66] See for example, Respect (2019) Toolkit for working with male victims of domestic abuse - https://hubble-live-assets.s3.amazonaws.com/respect/redactor2_assets/files/96/Respect-Toolkit-for-Work-with-Male-Victims-of-Domestic-Abuse-2019.pdf

15.5 HIOW Police policy which advocates positive action in response to domestic abuse was adhered to when they decided to voluntarily interview Amber about the allegation, and Amber was simultaneously considered a vulnerable victim because two days earlier she reported she had been raped. However due to evidential difficulties, lack of support for a police investigation, and then denial that an assault had taken place, no further action was taken.

15.6 When Max was later interviewed following Amber's report of rape, he disclosed being drugged and that money had been stolen from him, but HIOW Police failed to follow up on this. No PPN was completed that would have identified vulnerabilities and possible financial exploitation. At the time, HIOW Police information on the intranet about services available for male victims was out of date and has since been updated. This would not have impacted his access to services had Max consented to information being shared.

15.7 Max's family felt that HIOW Police would not have taken him seriously if he reported being abused by a woman, and because he was known to police.

> *"I think part of it is, he's a man and people assume women won't abuse men, it's like it can't be that bad. Or they wouldn't believe him if he said a much younger woman was controlling him. His background as a veteran would also be relevant because he wouldn't find it easy to ask for help." (Max's family)*

15.8 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 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,[67] is now published on the Hampshire Domestic Abuse Partnership website, with other services. Dispersed accommodation is also 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.

15.9 Commissioners and domestic abuse services should continue to review how they meet the needs of older men, including ensuring that policies do not inadvertently dissuade older men from accessing help. Services should be supported to develop specific support 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[68]. For example, the organisation should ensure both female and male service users are proactively asked about their experience of abuse and their use of violence when assessed. A well-informed assessment of the different uses and impacts of domestic abuse will help practitioners protect male victims from further harm.

15.10 The practice of frontline services should align with the national Male Victims Standard, the national accreditation framework for work with male victims of domestic abuse.[69] Agencies should also be encouraged to use the DASH risk assessment tool in parallel with the male victims' toolkit – the latter looks at 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 consider situational violence, mutual violence and identify patterns of power, coercion and control. This combination of tools for frontline workers particularly helps agencies address counter allegations of abuse.[70]

---

[67] https://mensadviceline.org.uk/

[68] https://www.respect.org.uk/resources/19-respect-toolkit-for-work-with-male-victims-of-domestic-abuse

[69] https://www.respect.org.uk/pages/respect-male-victims-standard

[70] 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

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

15.11 Veterans in the UK are thirty percent more likely to suffer from mental health disorders, and twice as likely to suffer post-traumatic stress disorder and alcohol problems when compared with the general population.[71] Studies also show that alcohol use within the military was traditionally normalised for issues ranging from stress management, peer bonding, insomnia and relaxation; and suggest that excessive alcohol use and mental ill-health is an issue for many veterans, and help-seeking in the context of military culture is often delayed or avoided until a crisis.[72] A recent systematic review found that the severity of symptoms associated with post-traumatic stress was the main predictor of veterans seeking help, and that services need to improve access to early help, improve responses and service user experience for veterans.[73] In Hampshire, the prevalence of anxiety, depression and alcohol-related mental health problems amongst serving personnel is similar to the general population, but rates increase beyond the general population once people become ex-service veterans, with many also experiencing social isolation and loneliness.[74]

15.12 Max was offered specialist veterans' support before and during the earlier period of this Review. The Panel was provided with additional expert information that helped their understanding of the support needs of veterans, and to improve agencies' responses to veterans in future, including how to refer to Op COURAGE services. The diverse needs veterans may have, following transition to civilian life may include support for dealing with mental illness, substance use, injuries, relationships, employment, housing, or involvement in the justice system. The importance of trauma informed care underpinning any response to veterans was emphasised, which includes consideration of how assessments are formulated, how language is used, and how trust may be built. Post-traumatic stress associated with veterans' support needs may be evident from aggression, feelings of guilt or suicidal thoughts, and exist alongside depression, problematic substance use, anxiety, and physical health concerns. The importance of services not assuming veterans have the same support needs was also emphasised.

15.13 Since November 2022, the Armed Forces Covenant Legal Duty introduced requirements for certain public services (local authorities, education governing bodies, integrated care boards and NHS Trusts) to have due regard to the Armed Forces Covenant principles (enshrined in law from 2011)[75] when carrying out functions associated with healthcare, education, and housing.[76] This includes duties relevant to veterans, such as, ensuring local authorities identify veterans suffering from mental ill health and provide appropriate priority for social housing. There is also an NHS commitment that veterans may be considered for priority access to NHS services providing focused treatment for conditions arising from their Service, compared to other patients with the same level of clinical need. The NHS has also identified nine commitments to supplement the work already underway in regions and through integrated care systems to meet the goals and ambitions of its Long-Term Plan and runs a Veteran Aware accreditation programme designed to support NHS Trusts in meeting their needs.

15.14 The Covenant for veterans would not have been in place when Max left the Army in 1991, and the Panel had little information about his transition to civilian life when he was younger. It can be assumed

[71] Rhead R et al (2020) 'Mental health disorders and alcohol misuse among UK military veterans and the general population'.
[72] Murphy D et al, (2017)'Describing the profile of a population of UK veterans seeking support for mental health difficulties' Journal of Mental Health
[73] Hitch C (2023) Enablers and barriers to military veterans seeking help for mental health and alcohol difficulties: A systematic review of the quantitative evidence.
[74] HCC (2023) Inclusion Health Groups chapter from Joint Strategic Needs Assessment https://documents.hants.gov.uk/public-health/jsna-2023/inclusion-health-groups.pdf
[75] 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.
[76] This was introduced under the Armed Forces Act, 2021 https://www.armedforcescovenant.gov.uk/covenant-legal-duty/

that a personalised care plan was not provided to ensure he was effectively supported in civilian life. Between 2017 and 2021 Max had used BHFT's Veterans' Mental Health Transition, Intervention and Liaison Service, Veterans' Mental Health Complex Treatment Service and Veterans' Mental Health High-Intensity Service and provided them with positive feedback on his care and treatment.[77] When Max had contact with SHFT's mental health liaison service, he was signposted back to relevant veteran services and to Inclusion, with his consent. Max had not disclosed having any relationships, family contact, or social networks and only spoke of conflict with neighbours. In May 2021, Max disclosed thoughts of taking his own life, and was referred by BHFT to SHFT's community mental health and High Intensity Service, and at one point Max had weekly phone support from the High Intensity Service.

15.15 Learning from BHFT veterans' services included that although there was good liaison between services, Max was not subject to an adult safeguarding referral, despite vulnerabilities related to alcohol and drug use, mental health needs including suicidal ideation and self-harm, and cuckooing. There may have been an assumption made that as HIOW Police were already monitoring cuckooing risks, a safeguarding referral would have been completed. This does not seem wholly unreasonable as a PPN was completed and shared with AHC in May 2021. However, at that time its content was insufficiently detailed, and AHC filed the notification because Max was already in contact with veterans' services. Had a safeguarding referral also been made, that would have provided a fuller picture of the care and support needs Max had and may have led to a coordinated plan for support at that time.

15.16 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. In December 2023, changes were made to the referral pathways for those in police custody which included the introduction of substance use workers to police custody and Operation Nova[78] caseworkers for veterans. There is now one referral form and people are seen in custody or in the community. A referral can also be made in the public interest, based on previous history, risk assessment and observations made in custody.

15.17 Family noted that as a veteran, Max had complex support needs following his return to civilian life, but they also emphasised that his heavy alcohol use was present before leaving the Army. Max's family thought that specialist veterans' services would have been more helpful to Max than regular services. They also suggested ensuring access to 'buddy' or peer supporters in the community, which would help veterans, especially older men, access services and discuss issues they face in relationships and what support they need, in an informal setting with someone they trust.

15.18 The panel noted the importance of ensuring services can better meet the support needs of veterans in future, especially where safeguarding concerns may be identified. In Hampshire, the Public Health team now commissions Suicide Prevention Awareness Training for frontline teams working or volunteering with veterans. Improvements are also being made to information available for staff, following an audit of services for veterans, including provision of links to services offered to the Armed Forces community and veterans and domestic abuse information available externally. 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 communities, who may feel worried about seeking support. They have a specialist team who understand service life, and how difficult it can be to talk about what is happening, although this is currently targeted at supporting serving officers and their dependents, from across the UK and abroad. Locally people can also access telephone and in-person support or video calls.[79]

[77] 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.
[78] 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.
[79] Aurora New Dawn Armed Forces dedicated service - https://www.aurorand.org.uk/services/the-armed-forces/

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

15.19 Max used Inclusion's services in 2017, including counselling, and group support. He had achieved periods of abstinence from alcohol and was discharged towards the end of 2018. By Summer 2021, Max returned to Inclusion, as he was using heroin, crack cocaine, ketamine, and reported drinking 30 units of alcohol daily. He did not have a full assessment and was discharged due to non-engagement. In May 2023, Max self-referred to Inclusion, supported by Aster, and reported up to 37 units of alcohol daily and occasional heroin use, but he did not attend follow up appointments made for June 2023.

15.20 Problematic substance use impacted Max's access to local services, and the support he told services he had available was not always in place. For example, whilst in hospital in Spring 2023, Max told the Alcohol Liaison Specialist that he had friends who were worried about his drinking and that a neighbour would look after him on discharge. A withdrawal plan was made for him to slowly reduce drinking every three days, to avoid seizures, but when he left hospital, he relapsed. His family observed that Max may have said he was getting help when he wasn't or may just not attend appointments.

15.21 In April 2023, Max's disclosure of domestic abuse coincided with him seeking support for alcohol and drug use, and around that time cuckooing concerns were also identified. In May 2023, when he disclosed being slapped by Amber, it was also known Amber was linked to County Lines.[80] Around the same time, both reported being unable to recall events for a week, and Max disclosed he was housing drug dealers. He also said he was worried about Amber, who without him would have no home, and indicated that he was receptive to being subject to Operation Fortress again. However, that was not actioned by HIOW Police in the months before he was killed.

15.22 Evidence shows that people experiencing domestic abuse have higher rates of problematic substance use than people not being abused. Whilst some victims may medicate to deal with physical or emotional pain from the harm caused, others may be coerced into substance use. A victim's substance use can also be used as an excuse for violence by perpetrators or be used to undermine a victim's credibility. Perpetrators may also deny or control access to someone's alcohol or drugs to maximise their control or might encourage increased drug-taking to create dependency. Max's family said they were concerned Max's alcohol was being withheld by Amber, that she controlled his contact with others, and that his drug use increased before his death, which led to noticeable weight loss. Family reiterated the importance of in-person appointments and support for male victims of abuse to talk about concerns with someone they trusted and who would see changes in a person's health and wellbeing.

15.23 Although Amber contacted Inclusion in May 2022, for help with prescription medication, she had not otherwise engaged with the service. Between 2021 and 2023 HIOW Police had connected Amber with incidents relating to drug use and supply. In 2023, she was referred by the Community Mental Health service for a joint assessment but declined to go ahead with it. She told several services that she had an unstable personality due to her use of drugs, and Amber's GP had also raised concerns about her drug-seeking behaviour with other health services. 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.

15.24 Max's family reinforced the importance of a 'buddy' support system that addresses substance use, mental health, and domestic abuse. 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. This would be consistent with Domestic Abuse Act Statutory Guidance, which states

[80] County Lines refers to organised criminal groups moving and supplying drugs, usually from cities into smaller towns or rural areas. They exploit vulnerable people, including those with addiction issues, by recruiting them to distribute drugs and may also use a vulnerable person's home as their base ('cuckooing').

that alcohol or drug treatment programmes should also have parallel interventions to address power and control associated with domestic abuse.[81] The Statutory Guidance advises that local areas should develop initiatives to address alcohol and drug related domestic abuse, including women-only services and cross-sector working, and domestic abuse advocates providing outreach at treatment services.

15.25 In Hampshire, Inclusion prioritises recruiting people with lived experience across their services. They have a volunteer supporter and mentoring scheme which encourages previous service users and others to be trained to provide buddying-support to help others. Inclusion has also worked with Stop Domestic Abuse (commissioned by Hampshire County Council) to develop a joint pathway to access support. A Hampshire thematic safeguarding review had also been initiated (and was published in 2025), focussing on alcohol use, which also raised issues of domestic abuse, use of the Care Act and access to services.[82] The Panel noted that recommendations from that thematic review and this and other domestic homicide reviews should be consistently applied, to ensure a coordinated focus on systems and service improvement.

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

15.26 'Cuckooing' is a form of criminal exploitation when "people take over a person's home and use the property to facilitate exploitation",[83] which 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.

15.27 Max was known to be at a heightened risk of cuckooing,[84] however action to effectively address this and support him to be safe was limited. In May 2021 HIOW police worked with Aster to deal with such concerns through anti-social behaviour procedures and instigated a 'closure order' application on Max's property (which was not completed) informed by four years of anti-social behaviour reports, criminal damage, and weapon possession. Agency records also noted they held Max responsible for turning visitors away or preventing their attendance, without recognising risks or vulnerabilities he faced.

15.28 Max's address was periodically monitored by neighbourhood police under an operation to tackle organised crime ('Operation Fortress'). Max was often in contact with police officers in relation to cuckooing but also disclosed in early 2021 that their surveillance led him to self-harm. In September 2021 Max moved, through a mutual exchange, and two months later drugs, weapons and people were found at his address. At no point was there an investigation into crimes associated with exploitation, that led to prosecution. A safeguarding referral resulted in no further action because he was subject to police monitoring. Two months later, Max's address was removed from monitoring systems; eight months later he was being exploited again.

15.29 In Autumn 2022, HIOW police were notified of evidence of cuckooing and weapons at Amber's property. Amber also exhibited heightened risks of cuckooing, according to national guidance. Although those concerns were discussed by AHC in December 2022 and again at MARAC in April 2023, Amber remained on a waiting list for six months to be assessed, which never happened. There was also no

[81] https://assets.publishing.service.gov.uk/media/62c6df068fa8f54e855dfe31/Domestic_Abuse_Act_2021_Statutory_Guidance.pdf
[82] https://hampshiresab.org.uk/wp-content/uploads/2025/06/Catherine-Jeremy-and-Sarah-Alcohol-Harm-Thematic-June-2025.pdf
[83] 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/
[84] Heightened risk factors, identified by the National County Lines Coordination Centre, include lack of safe/stable home environment; social isolation or social difficulties; economic deprivation; insecure accommodation status; physical or learning disability; mental ill health, and substance misuse.

response by agencies to cuckooing concerns raised, maybe because she left her property, which she said was due to abuse, and began living with Max.

15.30 In March 2023, a known dealer associated with Amber was also linked with Max's address. A safeguarding referral was made about cuckooing concerns, and around this time several visitors to his flat were noted, and Max disclosed domestic abuse. Yet AHC closed the case without further action.

15.31 Agency responses to cuckooing concerns were mainly led by police, but although intelligence was gathered, and safeguarding alerts raised, there was no evidence of multi-agency evidence gathering, to inform action to meet either Max's or Amber's care and support needs, nor was the use of 'evidence-led' prosecution apparent.

15.32 It is vital that victims being cuckooed or at risk of such exploitation are supported and protected not only legally but also through multi-agency safeguarding that supports victims and disrupts perpetrators. Max's family also questioned why agencies weren't able to intervene to safeguard him, and why he moved to an area with known dealers. Family recommended improve responses to cuckooing, drug dealing and criminal behaviour, especially when those doing the cuckooing are known to police.

> *"Why was he moved somewhere where there are already problems with either drug or alcohol users. Why didn't neighbours pick it up and hear what was going one." (Max's family)*
>
> *"It's like placing an alcoholic to live in a flat above a pub. And this was the same with his recent move, there were people above dealing, they were also dealing from his flat, people openly cuckooing his flat, how did agencies let that happen?" (Max's family)*
>
> *"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)*

15.33 Nationally, cuckooing, and using children in criminal activity, were intended to become criminal offences, under the Crime and Policing Bill 2025 (which was still proceeding through the House of Lords at the time of completion of this Review). In recognition of its complexity and that it requires a multi-agency response, a national toolkit[85] for addressing 'cuckooing' was also produced for agencies (including police, health, local authorities and third sector organisations). This had been promoted by SCAS to its response officers, and agencies should use and also develop a coordinated multi-agency response, to help local services to improve support available for people at risk of cuckooing.

15.34 The National County Lines Strategy for 2024–27[86] also aims to develop national understanding of cuckooing and safeguarding, and to share best practice with local areas. Police have options, when cuckooing is identified, to work with Local Authorities and housing providers to evict offenders and support victims. The Strategy also commits to developing an effective consistent approach to cuckooing by police and make better use of tools such as the Vulnerability Assessment Tool and vulnerability markers to highlight safeguarding concerns and deliver proactive action.

15.35 Locally a thematic review into the deaths of three people who had experienced or were at risk of cuckooing[87] found similar concerns including gaps in agencies' understanding and response to cuckooing, that responses needed to be tailored to the relationship between victim and perpetrators,

---

[85] 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

[86] 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

[87] 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

and an absence of a coordinated multi-agency adult exploitation strategy. The review also noted that before criminal offences are introduced, Serious Crime or Modern Slavery legislation could be used to bring a prosecution, under restricted circumstances, where organised gangs were involved.[88] The Hampshire Safeguarding Adults Board is now contributing to national work led by the Board Managers and Chair networks to raise awareness of cuckooing, and to Home Office guidance development, informed by learning from this and other Reviews.

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

15.36 During the period under Review, several reports of rape, sexual abuse, harassment, or exploitation were noted within agency reports, although the only agency that responded were HIOW Police. Other agencies noted these reports as part of homeless applications, safeguarding notifications, or mental health assessments, but there was no evidence that Amber or Max were provided with support for this, nor did they consent to be signposted to specialist support services for victims of sexual abuse.

15.37 In October 2022, HIOW Police were involved in the expanded roll-out of 'Operation Soteria', the National Police Chief's Council and Home Office funded research and change programme to transform responses to rape and serious sexual violence. The national operating model has since been rolled out nationally. HIOW Police had already been working with others and the Crown Prosecution Service to improve responses to rape allegations.

15.38 Max's allegation of sexual assault in Spring 2023, that resulted in no further action, was made when he was being interviewed for perpetrating domestic abuse, so may have been assumed to be an attempt to influence the investigation. Nevertheless, further investigation should have happened, as reports of sexual assault should be progressed in parallel to interviewing a suspect.

15.39 Amber reported she had been raped around the end of April 2023, which coincided with reporting she had been "*out of it*" for a week and had lost money from her account. Amber said several people were at Max's flat and she suspected she was drugged but denied that Max was involved. Max was interviewed and said they had both been drugged, and he also had money missing. As their accounts varied, with differing times and dates, police noted it was difficult to investigate these reports.

15.40 Another allegation of sexual assault in February 2023 did not continue due to several procedural failings that led to Amber withdrawing her support for an investigation in June 2023 and requesting that all supporting evidence be burnt. There had been a five-day delay before she was contacted by a specially trained officer, during which the case was reviewed twice. The internal review resulted in a request for follow-up support due to lack of staffing, and for re-prioritisation due to mental health concerns, unstable housing, and financial issues. It was another week before it was allocated due to shifts and workloads. In early March Amber was unwell when she was contacted, and a female officer didn't make contact again for another sixteen days, when a visit was agreed for the following day. At that point, Amber had separately reported high-risk domestic abuse, strangulation, threats, and burglary. The female officer then couldn't attend and left a message asking Amber to rearrange. Another female officer called Amber a month later and left a message for Amber to contact police. The officer then went on long-term sick, and the investigation was not reallocated until June 2023, by which time Amber had lived with Max for around two months. The investigation was concluded with no further action taken. Earlier reports by Amber of sexual abuse, harassment, cuckooing and exploitation by known men, also did not proceed further.

[88] Section 45 of The Serious Crime Act 2015 requires three or more people to constitute an 'organised crime group'. Section 1 of the Modern Slavery Act 2015 is restricted in its use and would not apply to cases where the victim does nothing other than have drugs be supplied from the home, without being held in 'servitude' or being made to undertake forced labour. Advocates to strengthen this legislation and introduce a specific offence of cuckooing recently called for recognition that taking over someone's home should be an act of servitude, making cuckooing a criminal offence.

15.41 The six-week delay during which the sexual assault investigation was not progressed meant Amber never had face to face contact with a female specialist trained officer, even though she maintained contact with officers in relation to other matters. During this period, she faced eviction, burglary and damage to her home, strangulation and domestic abuse, threats from dealers and reported losing a pregnancy. Amber made several comments during calls with police indicating she may be seen in a "*bad light*" and that she didn't think she would be believed. The lack of face-to-face contact she experienced throughout this time was raised with the Panel as an issue, and Amber said agencies should address this to improve future practice. She emphasised that in-person contact would be more beneficial to women than receiving texts or phone communication.

15.42 The Panel were advised, at that time, that workloads of specially trained officers for rape and sexual assault were high and there were capacity challenges. The system has since changed, and specially trained officers (now Sexual Offences Investigation Trained – SOIT officers) are solely based in specialist rape and sexual assault teams, so it is rare that one is not available to see a victim as they are protected from other operations. There are 29 SOITs in HIOW Police, 26 of these are female and three are male. Sexual violence victims are also referred to a specialist advocate, if the victim gives consent, to ensure victims are consulted and at the centre of decision making as cases progress.

15.43 It is also vital that local responses to sexual violence are informed by the recent report[89] that called for system-wide change to 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. This should be a strategic priority for senior leaders in police and in partner agencies, and sustainable funding should be prioritised for its delivery.

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

15.44 Although extensive financial abuse wasn't evident from agency reports, the issue of money, financial abuse and debt appeared throughout agencies' involvement with Amber and Max, to warrant further consideration. For example, when Max was using veterans' mental health services, it was known he was in debt with no plan of how he was going to repay that amount. There was no exploration of how and why he was in debt at the time. Given concerns about his suicide risk it may not have been explored at that time, but nevertheless could have been flagged and explored further, had a safeguarding referral been made and followed up.

15.45 In August 2021, Max reported theft and that he believed people at his flat stole his bank card. He was advised to deposit money into his bank, and around the same time, police learnt his phone had been taken and that he was being taken advantage of. When police visited, Max said he was fine and didn't want to speak to them. Similar reports were made in April 2023 when Max said he had money missing from his account and believed that people at his flat stole his bank card.

15.46 In February 2023, Amber told police she had no money and struggled to buy food; they offered to source a food parcel for her. A PPN was completed and shared with her GP and AHC. Amber reported to AHC that an ex-boyfriend had taken her money, and she was unable to get to the foodbank. Other than being advised about foodbanks or to call police, it was not apparent that any other response was provided in relation to her lack of access to any money and potential economic abuse from a partner.

15.47 In March 2023, someone reported to SCAS that "*dangerous people*" in Max's flat were using him for money and to get drugs. SCAS made a safeguarding referral, that resulted in no further action. Money and unpaid debts were also referenced in April 2023 when an ex-partner of Max reported him for being

[89] 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/

angry because she had no money for alcohol, demanding she repay money and threatening her. Around the same time, someone reported that Amber was being threatened by dealers demanding money. Amber said at the end of April that someone had forced her to withdraw money and she also reported money going missing, and she had twice transferred money to Max's account.

15.48 There was no reference in agency records to the response from Max's bank in relation to financial transactions or lost and renewed bank cards. Max's family said that 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.

"The bank should have known. Why was his bank card always being lost there were constant calls to the bank about issues, transactions, problems with money in his account". (Max's family)

15.49 At the end of April 2023, Max approached a Bank when he was intoxicated, and asked them to call police because a gang were after him, and their security team promptly called police. In mid-May, Max was also supported by Aster to cancel and order a new bank card, and Aster noted he had no phone and needed to access a food-bank. Max's family believed Amber was with Max because of his pension.

15.50 Had safeguarding enquiries been instigated earlier, these issues may have been more effectively identified, viewed holistically as connected to exploitative behaviour, and acted on. The Care Act 2014 defines 'abuse' as including financial abuse, which would include having money or other property stolen; being defrauded; being put under pressure in relation to money or other property; and having money or other property misused. Agencies should have better awareness of such abuse, and how to identify it early, provide support and disrupt further abuse. Had safeguarding enquiries been conducted effectively, the financial abuse reported by Max and by Amber may have been identified and a coordinated plan agreed to address and prevent such abuse from taking place in future.

15.51 In the UK, the 2021 Financial Abuse Code for Banks[90] focuses on guidance on how to support victims of financial and economic abuse, and how to apply principles of the Code in practice. For example, this commits institutions to help victims of financial and economic abuse and provide guidance on what they can expect, to encourage them to engage early with their financial provider. This should include making referrals for specialist help where financial and/or economic abuse is suspected. It is not known how those implementing this Code work collaboratively with local community safety partners and safeguarding agencies to deliver a coordinated response to victims vulnerable to domestic abuse and exploitation, including cuckooing, and there may be scope for improving this.

15.52 Max's family advised 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. Aster's policy, for example, did not allow exceptional circumstances to waive any charge from the estate (they do not pursue next of kin directly). More recent access to anti-social behaviour information will now inform the appropriateness of pursual and the process is under review to ensure that any exceptional circumstances are highlighted to the team. 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.

"After the court case I had a letter demanding rent arrears and council tax arrears after he died...Nearly a year after he was killed, they were pursuing us for money...It shouldn't happen, that they pursue families, when someone may be distraught. This needs to change for everyone who unfortunately has to go through something like this." (Max's family)

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

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

15.53 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.[91] Some people may have enjoyed good mental health until they experience domestic abuse, whereas for others, trauma experienced as a child or young adult followed by abuse in adulthood may exacerbate mental ill-health. Abusers may also exploit mental ill-health and misdirect professionals by claiming victims' presentation is symptomatic of being mentally unwell, and discredit disclosures they make. Understanding a person's mental health history and whether they have experienced repeated trauma is important for assessment, support and intervention. It is therefore vital that mental health services are trained, equipped and confident in talking about and responding to domestic and sexual abuse.

15.55 Max's mental health diagnoses and support needs included anxiety, depression, Post Traumatic Stress Disorder, self-harm, and suicidal thoughts. His GP received reports regarding escalating mental health concerns in May and November 2021 from the Community Mental Health Team, and was advised he was having regular reviews from the veteran's high intensity service, which would result in a care plan review. However, a year later the Community Mental Health Team advised the GP he had not attended so was discharged. The GP Practice only noted during this Review that there had been no care plan shared with them. To ensure continuity in safeguarding practice, a Practice Safeguarding Care Coordinator has since been appointed to oversee consistency of communication, which has strengthened safeguarding systems and processes. The Practice wants to see this role be maintained.

15.56 Max's family said that Max had previously engaged well with his GP and would have felt comfortable to raise issues with them. In May 2023 the GP was notified Max had reported being slapped by Amber. It went on to state "no risks presented", no MARAC referral had been made and he was not in fear of further abuse. Max did not attend his next appointment, so a follow up was sent. In June 2023, and when Max requested repeat medication online he was sent a text asking him to make an appointment, but he did not attend, maybe because Max had limited access to a phone.

15.57 The GP Practice also noted that escalating drug and alcohol use and deteriorating mental health could have led to a 'vulnerable adult' code being flagged in patient notes indicating the need for extra support. The Practice had not flagged Max as an "adult at risk" but acknowledged he faced risks of self-injury and harm due to substance abuse, and a risk of harm from dealers. Around the same time, the hospital mental health liaison team noted that Max presented as 'too complex' for Psychological Therapies (IAPT), but as he did not have a severe or enduring mental illness that required Community Mental Health support, the hospital referred him back to his GP for medication and primary care mental health talking therapy.[92]

15.58 The GP Practice reflected during this Review that it was inappropriate to ask primary care to prescribe mental health medication alongside drug and alcohol use, which is a specialist area. They also highlighted an apparent misunderstanding of the role of the primary care mental health talking therapy, which saw patients with similar level of needs to Psychological Therapies. It was felt that having to see a GP to access that support also presented an unnecessary extra barrier for patients with complex support needs which made the chance of disengagement higher.

15.59 Mental healthcare planning was evidently not coordinated, given the community and primary care mental health teams hold multi-disciplinary case reviews, and Max's needs could have been discussed

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

[92] NHS Talking Therapies was formerly referred to as Improving Access to Psychological Therapies (IAPT). The programme addresses anxiety disorders and depression, may involve individual, in-person/phone or group therapy, and can be accessed through self-referral, community service referral, or primary or secondary care referrals. The integrated offer should include psychological therapies for severe mental health problems, as recommended by the NHS Long Term Plan for England.

at those, instead of being referred back to his GP. 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 engagement with the veterans' mental health service.

15.60 Amber also had several prior diagnoses, of Emotionally Unstable Personality Disorder in 2011, psychotic disorder, Asperger's, anxiety, and depression, and it was noted that her experience of emotional dysregulation likely affected her engagement with services. Amber's GP Practice instigated a review of her healthcare in 2020 due to concerns about her medication, drug seeking behaviour, and lack of GP and psychiatry continuity. Amber often contacted her GP for pain relief medication and was frequently unavailable when clinicians tried to make contact.

15.61 Learning identified by Amber's GP Practice included that they could have instigated safeguarding referrals and flagged Amber as an adult at risk with additional support needs, instead of assuming police made referrals. The Practice has since improved engagement with Community Mental Health Teams, understanding of the response to a police notification, and recognised the need for regular attendance at Practice Safeguarding team meetings by police and mental health services so that issues are addressed early. The Practice will also review domestic abuse training available.

15.62 SHFT identified that its Domestic Abuse Policy and protocols had not informed assessments of Amber's mental health support needs, nor considered reports of sexual abuse and harassment in early 2023. Despite several referrals, there was a failure to conduct a comprehensive risk assessment that considered the risk of violence towards Amber and by her to others, as required by SHFT's Assessment and Management of Clinical Risk Policy. The service also identified the need for a consistent approach to multi-disciplinary team discussions for Community Mental Health Team patients, an improvement plan has since introduced along with a communication tool to support team discussions. SHFT identified an unacceptable delay in Amber being contacted for an initial assessment, due to staff absences and have identified that continuity in contact and care should be prioritised, given that it is during long periods of no contact when risks can increase, and mental health can deteriorate. SHFT noted signs of unconscious bias related to Amber's lack of engagement, which led to assumptions that this would continue, and that was accompanied by a lack of professional curiosity to understand Amber's past trauma and forensic history. SHFT also identified a missed opportunity and lack of professional curiosity to undertake a comprehensive assessment and make a safeguarding referral, in accordance with its Safeguarding Policy.

15.63 It is a significant gap that the IRIS[93] domestic abuse training support and referral system for health services has not been commissioned locally in GP Practices (due to financial costs), which would shift the burden of reminding staff about domestic abuse away from Practice leads towards systems that ensure training and co-located specialist advocates. Doing so would be consistent with Domestic Abuse Statutory Guidance.[94] Routine or targeted enquiry and response should be a priority in relevant health settings[95] to ensure trained staff ask patients whether they have experienced domestic abuse, as a routine part of good clinical practice. This approach is encouraged by the Hampshire domestic abuse referral pathways, which advocates proactive routine enquiry and referral to specialist services.[96]

15.64 Following this Review, the Integrated Care Board plans to support GPs to have the tools and confidence to identify victims, intervene earlier and refer to specialist services appropriately, provide domestic abuse training for primary care, and develop Domestic Abuse Policy that GP 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

[93] IRIS is an evidence-based primary care intervention https://irisi.org/about-the-iris-programme/
[94] 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
[95] See Department of Health (2017) 'Domestic Abuse: resource for health professionals.'
[96] https://documents.hants.gov.uk/adultservices/DomesticAbuseReferralPathwayforHampshire.pdf

developed by Royal College of GPs and NHS England, will also be shared with GPs to encourage them to identify, understand, and support veterans and ensure effective access to specialist health services.

15.65 Locally the mental health system has since changed, and Hampshire now operates an adult community mental health transformation programme, called 'No Wrong Door',[97] 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 to accessing mental health services for people with alcohol and substance misuse support needs.

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

15.66 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. Past 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.[98]

15.69 National data from 2022-2023 showed that the number of suspected victim suicides following domestic abuse had overtaken intimate partner homicides, perhaps because these are now being recorded.[99] Known risk factors associated with people taking their own life include isolation and lack of social support, a history of trauma and abuse, failure of services and barriers to accessing help, and loss of care of children.[100] Key determinants for suicide also include despair and hopelessness, coercion, control and entrapment. Therefore, addressing or relieving these feelings or experiences would be important for agencies to focus on when addressing domestic abuse and suicide risks.

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

15.71 Amber had several referrals to SHFT's mental health services, associated with suicide risks and attempts, however the service failed to engage her effectively. Initial contact in April 2021 related to suicide risks. In July 2022, Amber's GP referred her to the Crisis Resolution Home Treatment team after she had cut her wrists and her mental health had worsened. 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. Several contact attempts by phone and emails failed and Amber was discharged back to her GP. Two months later she was referred again to the Community Mental Health Team for a medication review, but contact attempts failed. In 2022 Amber tried to take her own life after her mother's death, and her GP made another referral. She attended the Emergency Department for the suicide attempt but did not attend the follow up assessment and a phone appointment arranged for January 2023 was missed. At that point, Amber's care was transferred to her GP. In March 2023 a

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

98 McManus et al (2022) Intimate partner violence, suicidality, and self-harm: a probability sample survey of the general population in England

[99] 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/

[100] Aitken and Munro (2018) '*Domestic abuse and suicide : exploring the links with Refuge's client base and work force'* University of Warwick.

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 it was noted she was known to MARAC so safeguarding referrals were not made.

15.72 Health, social care, domestic abuse, and welfare professionals should 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.[101]

15.73 Agencies should also be alert to and act on suicide risks associated with domestic abuse and 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. Addressing and preventing domestic abuse could also have the potential to reduce suicide in the wider population, and should feature in suicide prevention strategies locally.

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

15.74 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[102] risk assessment tool, designed to identify victims at high risk of harm or homicide. Given there is no unanimous evidence nationally of MARACs' effectiveness or of the tool's accuracy or validity[103] it is important locally that agencies are clear about what happens to the information shared, and what they do with this information to reduce risk and enhance safety.

15.75 MARACs are often (although not always) led by police. The MARAC Chair is a vital role responsible for the effective running of MARAC meetings, along with partner agencies, and should be of sufficient seniority and experience to lead the meeting to ensure actions are identified to reduce perpetrators' risk of harm and maximise victims' safety. MARACs also benefit from strong strategic and operational systems, and oversight to monitor effectiveness.

15.76 Max has been identified as a perpetrator of high-risk domestic abuse against an ex-partner, at Hampshire's daily High Risk Domestic Abuse meeting towards the end of March 2023, and the case was subsequently referred to the next MARAC meeting. The daily meeting provided an opportunity for information-sharing and to determine if a MARAC referral was required. However, there was a delay in referral to the MARAC of seven weeks, due to it being wrongly assigned, following a breach of organisational procedure. When this was rectified in early April, it was allocated to the May MARAC.

15.77 There was very little mention of Max in the MARAC meeting notes. Aster advised he was their tenant and was associated with anti-social behaviour. The notes stated "*Max is getting the support from appropriate services and there does not appear to be a role for [adult safeguarding] at this time*", but it was not apparent what if any support he was actually receiving. It was also not evident that Max's

[101] 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
[102] 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.
103 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

needs, risks, or any interventions, were discussed. There was no representation from the Community Mental Health Team or Inclusion and given the substance use and mental health concerns for both Max and the victim, that was a significant gap in attendance. The only actions were to share notes with the GP and consider security measures at the victim's address.

15.78 The MARAC in April 2023 was similar, when Amber's experience of high-risk domestic abuse from an ex-partner was discussed. Notes indicated Inclusion may not have been present at the meeting. 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.[104]

15.79 Amber's GP noted that a report was sent to the MARAC meeting in April, to support information sharing. However, there was an issue with distribution of the meeting notes as they were sent to an Administrator's personal email and not to a clinician and the Practice Safeguarding Lead, as required. This error meant Amber's experience of abuse was not discussed with the wider team at the monthly Adult Safeguarding multi-disciplinary team meeting.

15.80 The effectiveness of individual and multi-agency risk assessments and of MARACs requires interrogation locally. 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 (see below), noting that safeguarding enquiries can run alongside MARACs[105]. Max and Amber had both been, at different times, at high risk of suicide. Max had also disclosed domestic abuse, at the time of the MARAC meeting, and there were also known risks of cuckooing, yet these concerns had not been adequately assessed through statutory safeguarding systems. 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. Professionals also failed to make the connection between the high-risk perpetrator associated with Amber being the same person staying with Max. 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.

15.81 Max and Amber each had multiple presenting needs in addition to domestic and sexual abuse, and being identified as perpetrators of abuse. Additional needs included 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 of 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, suicide attempts and limited engagement with veteran's mental health services. He was also identified

[104] 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

[105] 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.

as being at risk to himself due to occasionally being in a highly distressed state when intoxicated and at risk from others due to their use of his property for supply of drugs.

15.82 The Panel noted that there were occasions where HIOW Police responded to the most presenting immediate need, which was often their mental health. In line with force policy, concerns for a vulnerable adult's mental and physical health, medication issues or substance use were shared with GPs. However, responding to one need in isolation was unlikely to have an effective outcome, and the principles of *Making Safeguarding Personal* needed to be applied and understood in the context of domestic abuse. The police Standard Operating Procedures are clear on what constitutes a care and support need and an adult at risk under S42 of the Care Act 2014, and it was noted that both Max and Amber had several coexisting needs that met thresholds for a S9 and S42 assessment.

15.83 AHC acknowledged that in this case, 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. The assumption made (that because a MARAC determined there were no AHC actions then safeguarding concerns could be closed) led to the risks highlighted to AHC not being assessed. Services, under pressure to complete a high volume of decisions, also appeared to have been biased towards assuming these contacts were about the same circumstances or people, and this provided the resolution to enable them to close the case. This learning has led to AHC undertaking a practice improvement review focussed on the interaction between high-risk domestic abuse meetings, MARAC and safeguarding concerns.

15.84 There were also missed opportunities to 'Make Safeguarding Personal' and deliver a person-centred and outcomes focussed approach. Even though Max shared his wishes and feelings, safety and support needs with SCAS he was not offered an opportunity to express what outcomes he wanted. Decisions regarding safeguarding concerns should be subject to management oversight, however management review in March 2023 failed to recognise that risks were not assessed appropriately, and there was no oversight in April 2023. There was clearly a missed opportunity to enquire about domestic abuse and adult safeguarding in response to referrals appropriately made by SCAS in Spring 2023.

15.85 With regards Amber, there was a significant delay in allocation to carry out the S9 assessment, which in fact never took place. A HRDA meeting reinforced the need for AHC to do an urgent S9 assessment, but that did not lead to prioritisation. Waiting list numbers were high but there was a lack of review and associated mechanisms to reconsider priorities in light of increasing risks that Amber faced whilst she was awaiting an assessment. AHC has now implemented a robust risk review and management approach for waiting lists which would address this issue.

15.86 A safeguarding enquiry opened in respect of Amber in June 2023 and sought to engage SHFT's community mental health team in a joint visit, but they declined due to Amber's prior non-engagement. That was not escalated and the S42 enquiry was then inexplicably closed, along with Amber's case. That decision was subject to management oversight. AHC noted that cultural influences linked to a history of the service being health-led may have encouraged a bias towards accepting health-led decisions without challenge, in the context of S42 decision making. For example, where AHC had been unable to contact people or agencies, decisions to withdraw based on non-engagement were made, rather than identifying that as an increased risk which needed a heightened response.

15.87 AHC learning has also resulted in more regular monitoring of training take-up and training compliance in relation to Safeguarding and Domestic Abuse. AHC will also undertake a reflective practice session with the mental health team, to review decision making in respect of closure of S42 processes in circumstances of challenging engagement. A mental health thematic review of serious incidents has also resulted in a mental health transformation plan across Hampshire AHC.

15.88 HHFT noted that there was no evidence of professional curiosity relating to Max's disclosure of domestic abuse. These injuries were noted in records and on a body map but not handed over between triage and ongoing team members, and this was not referred to the HHFT Safeguarding Adults team. Actions to address these gaps in professional practice include discussing this further with relevant professionals and supervisors and working with Emergency Department teams to ensure domestic abuse policies are reinforced. This involves safeguarding and domestic abuse teams visiting the Emergency Department regularly to provide supervision and guidance 'on the floor' and attending High Intensity User Groups 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. Level Three safeguarding adults training has also been rolled out, including to Matrons, which includes domestic abuse and self-neglect. Awareness of abuse indicators have been included in training, and all staff are required to attend Domestic Abuse Awareness training as part of their Adult Safeguarding compliance.

15.89 The Panel also noted that anyone attending the Emergency Department with hypothermia and loss of consciousness would now have a safeguarding referral to trigger involvement of the hospital Safeguarding Adults team. There has been an increase in awareness of patients who have care and support needs relating to alcohol dependency and advice is sought from the Safeguarding Adults team, and bespoke training provided on self-neglect and domestic abuse and how best to respond.

15.90 SCAS advised that where domestic abuse was identified by the ambulance crew a DASH assessment was completed and safeguarding referrals submitted for Max. There were some missed opportunities to safeguard, for example, when Amber was advised to contact her GP, they could have considered speaking to her GP so that concerns were shared and follow up by the GP happened.

15.91 SHFT noted that Amber's reports of sexual abuse and harassment should have been addressed under the Trust's Safeguarding Policy. There was a lack of professional curiosity about allegations made and the impact of these on Amber's mental health and wellbeing, as the Community Mental Health Team assumed police involvement would meet her needs. There was also a lack of knowledge by the Community Mental Health Team as to when it was appropriate to share information after high-risk domestic abuse had been identified. Improving knowledge and working more effectively with partner agencies has been identified through learning, and features in agency actions.

15.92 BHFT's work with Max ended in May 2021, and it was not known if he was in a relationship, nor whether he had perpetrated or experienced abuse, despite practitioners asking about this. His vulnerabilities were recognised, acknowledged, and considered in planning his care but there was a gap in making a cross-authority adult safeguarding referral to Hampshire, and there was no recorded rationale for not doing so. It may have been assumed that as police were already monitoring concerns about cuckooing, that an additional safeguarding referral was not needed.

15.93 TVBC Housing Options made a safeguarding referral for Amber at the end of March, following disclosures of high-risk domestic abuse including strangulation. No response was received, and the service provided updated information about risks and concerns in May 2023, and it was understood that the Mental Health Substance Misuse team would arrange a joint meeting with the Community Mental Health Team for further support (which did not happen). Maintaining a central database of names of people that have a flagged safeguarding concern for TVBC Officers across the council, will in future enable a cross-reference check and ensure more coordinated working takes place.

15.94 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. Some accurately identified these but did not

complete a safeguarding notification. Others completed PPNs but safeguarding leads did not always recognise the range of presenting issues or the need to share it with multiple agencies. 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. For example –

- In May 2023 Max told police that he was on a "*downward spiral again and it may already be too late to help*", and he was identified as at risk of abuse and neglect with care and support needs. MASH[106] reviewed the PPN and shared it with Max's GP due to the concerns for his mental health, but despite the detailed PPN identifying the need for an assessment of care and support needs MASH did not make the link that between mental health needs and Max's other vulnerabilities that had made him subject to previous exploitation and abuse. The PPN should have been shared with AHC for consideration of an assessment.
- Police intelligence linking Max and Amber to active drug networks included reference to concerns that Max was being cuckooed by a new girlfriend, who matched the description of Amber. This was tasked to be shared with AHC in mid-June, but there was an inexplicable delay of eight days; police advised AHC of this information four days before Max was found murdered in his home

15.95 Police noted that Amber may have been using Max for housing, money, and drugs, but she had also recently experienced high risk domestic abuse, had made successive allegations of sexual offences, and experienced suspected burglary and damage to her property. Past experiences of abuse and trauma were also evident. For both Max and Amber this was set against a background of exploitation, sexual and physical harm, unstable housing, alcohol and drug use, domestic abuse and grief following recent bereavement, which do not appear to have been fully recognised by services to prompt and coordinate a multi-agency response.

15.96 There was no clear record held by police and AHC of what other agencies were involved with Max and Amber and to what extent. When there is no 'lead' agency, it is not uncommon for agencies to work in silos, which was evident in this case. 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. Although HRDA and MARAC processes were initiated, these had little productive impact on the way agencies worked or on the safety, risk reduction and support available for Max or Amber.

15.97 Many agencies had known that repeated safeguarding referrals led to no further action, and noted during this Review that in hindsight, the Multi Agency Risk Management (MARM)[107] approach between agencies could have been instigated, based on the unmanageably high risks and multiple and intersecting needs Max and Amber had. This is a non-statutory process for concerns that do not meet the statutory criteria Section 42 Care Act 2014, but would still apply the six principles of adult safeguarding – empowerment, prevention, proportionality, protection, partnership and accountability.

15.98 Any agency could have called a MARM meeting if there was legitimate need, and this would have brought together professionals from health, social care, police, housing, and others, with the person concerned if they had consented, and with relevant family members, if appropriate. This would result in an agreed risk assessment and management plan, whilst identifying needs or wishes, and clarified expectations about what each agency would do to fulfil their accountabilities. If Max or Amber hadn't

[106] The MASH share and process information to safeguard vulnerable adults and children. It includes partner agencies from Adult Social Care, Children's Social Care, Probation, housing, domestic abuse support services, mental health services and substance use support services. Agencies process and receive information from referrals and then share as required to inform a fuller picture of risk and aid multi-agency working.

[107] 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

consented to this process, the Care Act Guidance is clear that if the adult has the mental capacity to make informed decisions about their safety and they do not want action, this does not preclude the sharing of information with relevant professionals, to ensure they are not being unduly influenced, coerced or intimidated. It was suggested by several agencies that arranging a MARM involving TVBC, AHC, police, mental health, substance use services and primary care services, would have prevented missed opportunities to submit safeguarding referrals and developed a multi-agency collaborative plan of action to support Max and Amber, if they remained below AHC's statutory safeguarding thresholds.

15.99 Max's family 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 mentioned that young people may get help through support from peers or trained mentors where there were safeguarding concerns, and this type of response could have helped Max. 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 or concerns about abuse, or someone being exploited or cuckooed.

> "*Max would talk better to someone that was older, if a younger person spoke to him he wouldn't have liked it. He wouldn't dream of talking to someone in agencies other than someone of his age, who he could relate to. "The community knew her, knew them both, did they know the extent of what was going on? If someone had turned up at his door especially in the evening to offer support that would have helped." (Max's family)*
>
> *"The drugs had a big impact on him. The last few months you'd have thought he had dementia or something, unless you really knew him you wouldn't pick up on that. To notice a pattern and changes you have to be involved with a person for some time. Consistent support from someone who's the same person each time is also important." (Max's family)*
>
> *"He needed a buddy without him realising he was being given formal support - like a peer supporter but for older people, someone he could've turned to, who wasn't official, like they have in AA maybe. A mentor or a buddy to speak with him when he was most likely to open up, somewhere in the community. Max stopped seeing people, because he was with Amber, a buddy would've picked up on that maybe." (Max's family)*

15.100 The family's recommendations 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'[108] for young people, which aims to shift the focus from a solely criminal justice 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 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.

15.101 Aster Housing Group was Max's landlord from 2014, and due to cuckooing, a history of alcohol dependency and significant reports of anti-social behaviour, they supported an exchange to another property in the same town in September 2021. However, there was no tenancy sustainment plan available to him, for example, to provide support with setting up a new home and to remove some of

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

the stress with moving. This service was introduced by Aster in 2023, and had the service been available earlier, that would have benefitted Max following his move.

15.102 The issues raised with Aster by neighbours and others were primarily managed through Anti-Social Behaviour procedures, and Max was identified as the perpetrator of such behaviour, and inappropriately 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 in meeting his care and support needs. However, Aster had attended a domestic abuse MARAC at which Max's abuse against an ex-partner was discussed, but they had no knowledge of the partner, nor that abuse happened near his property, and no actions were raised for Aster by the MARAC.

15.103 This was a missed opportunity to involve Max's landlord in addressing domestic abuse related behaviour by one of its tenants, 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.

15.104 Aster's new Domestic Abuse Policy (2024 – 2027), in accordance with the Regulator of Social Housing[109] requirements, states Aster will take firm action against perpetrators where appropriate. It is not clear how this may be achieved, but could, for example, include partnering with agencies to deliver support or 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.

15.105 Aster may benefit from attaining Domestic Abuse Housing Alliance (DAHA) accreditation. By becoming DAHA accredited, as recommended in the Domestic Abuse Statutory Guidance, housing providers and services develop safe and effective responses to domestic abuse across the whole organisation. This is considered further in the recommendations.

15.106 TVBC noted the Housing Options service failed to effectively engage Amber, who also didn't always respond to contact attempts. Although TVBC follows homelessness legislation and adheres to the Hampshire Domestic Abuse Strategy, the Council did not have a domestic abuse policy (as recommended by the Homelessness Code of Guidance). A domestic abuse risk assessment was also not carried out by the housing service, and at that time, the housing service was not consistently represented at the MARAC (also as recommended by the Code of Guidance).[110]

15.107 TVBC had an interim duty to secure accommodation for Amber, whilst making enquiries, which it advised was discharged by talking through private rented housing options locally and out of area. TVBC does not own its own housing stock and worked with twelve registered providers and private landlords to discharge housing statutory duties.

15.108 Whilst the Homelessness Code of Guidance allows authorities to provide "help to secure" housing by working with applicants to agree reasonable steps they can take to secure housing themselves; it recognises that personal circumstances will affect someone's ability to secure accommodation; and states where appropriate the authority should secure that housing.[111] The housing options assessment form, completed in February 2023 and updated in early June 2023, noted Amber had disclosed violence from known men, experienced high risk domestic abuse, had nowhere to live, and had a

[109] Social Housing (Regulation) Act 2023 aims to reform the regulatory regime to drive significant change in landlord behaviour and was enacted from April 2024.
[110] Chapter 21, 21.12 and 21.13, Homelessness Code of Guidance – Domestic Abuse
[111] Homelessness Code of Guidance https://www.gov.uk/guidance/homelessness-code-of-guidance-for-local-authorities/chapter-16-securing-accommodation

history of overdose, mental ill-health, self-harm and verbal aggression. If TVBC had reason to believe Amber's homelessness and priority need was due to domestic abuse, the authority should have made interim accommodation available immediately whilst they carried out investigations.[112] Similarly if they had reason to believe Amber may have priority need due to violence or threats, TVBC should have been proactive in offering safe housing under the interim duty without delay.[113]

15.109 Amber was provided with information about refuges (at the end of March) and referred to a local hostel for street-homeless men and women (in June), which had shared facilities and full-board 12-hour support, which she did not take up. However, there was no recorded rationale by TVBC of the suitability of these options, for a woman who was vulnerable to exploitation and had reported multiple forms of abuse, and who had significant mental health and substance use support needs. In Amber's feedback to the Panel, she particularly highlighted the significant missed opportunity to support her when she repeatedly asking for help with housing but had not been listened to, including when she was sleeping in a tent. Amber also highlighted that she had reported to Adult Health and Care, before she had met Max, that she was not safe in the area she was living in due to her house being 'smashed up' after her mother's death, and felt that was also a missed opportunity to support her at that time.

15.110 Refuges and mixed-sex hostels are often unsuitable for survivors with complex support needs that include mental health and substance use. There was limited other access to safe and suitable housing for women with multiple support needs, and the County's Domestic Abuse strategy recognises this within its aims, which includes expanding the choice of types of safe accommodation beyond refuges, backed up with appropriate support. A shortage of supported housing for women with substance use support needs impacted by violence was also a national issue, with only three organisations (21 bed spaces) in England dedicated for women with substance use support needs.[114]

15.111 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 s193 Main Housing Duty or for the Relief Duty.[115] There was also no formal confirmation provided of her status at that time. TVBC said that was because Housing Options services 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 the address she stayed at (Max's address) and more about why she had to leave.

15.112 TVBC's failure to attend MARAC meetings or check who was referred to MARAC at that time, was also a particular gap at that time. This was due to the housing team being under capacity during that period. This non-attendance 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.[116]

15.113 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, in relation

[112] Chapter 21, 21.25, Homelessness Code of Guidance – Domestic Abuse
[113] Chapter 26, Homelessness Code of Guidance – Victims of Violence
[114] Women's Aid (2021). The Domestic Abuse Report 2020: The Annual Audit. Women's Aid England.
[115] 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.
[116] The Hampshire Domestic Abuse Strategy recognised 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

to domestic abuse, a person's capacity, mental health or other diagnoses. TVBC also noted that action to improve understanding of internal safeguarding reporting procedures had happened, and that achieving DAHA accreditation would improve the local authority's housing response to all victims of domestic abuse. From July 2024, a new specialist position focusing on domestic abuse started in the Housing Options service.

15.114 The Panel noted that actions in the Hampshire Domestic Abuse Strategy[117] (which includes the statutory safe accommodation strategy priorities) would also improve access to safe suitable housing for victims of domestic abuse and violence. It 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.

15.115 The panel noted that 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.[118] 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.

15.116 Male victims report to the Men's Advice Line nationally that they don't want to involve police, and don't think police will believe them or act. When victims feel unsupported or disbelieved themselves, they are less likely to support police action. Similarly, only around one in five women who experience domestic abuse report this to police. Many factors can prevent women from giving a full and frank account of what has happened. There may be distrust based on their previous experiences with the police or they may be traumatised by years of abuse or come to accept abuse as normal.

15.117 HIOW Police noted that 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 to contact Max and Amber, 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. Both Max and Amber had been victims of threatening behaviour, violence and harassment and frequent agency contact could have been difficult to deal with, and ignoring contact could be a protective mechanism. 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.

15.118 Max and Amber had experienced a significant amount of trauma in their lives and past experiences of abuse and trauma may lead to being fearful that they may be victimised again. This was recognised by several officers in the review timeframe, but not always correlated when considering investigation outcomes where the victim was perceived to not be engaging.

---

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

[118] 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

15.119 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/staff and delays in progressing an investigation through sickness absence and cases not being reallocated in a timely manner. This would likely have impacted on their confidence in the police response. Both Max and Amber also had frequent police contact, which could have attracted stigma and unconscious bias. At the point of initial contact with police, records are reviewed, and any warning markers would be flagged in relation to known risks. Amber had warning markers for her mental health, but these included descriptions such as "*delusions*", "*believes she is being hacked*" and "*imagined 5 men with baseball bats*". Whilst that information was taken from previous contact with Amber, it was likely that recorded information skewed perceptions of response officers that Amber's reports or presentations were solely mental health related. She was subsequently not holistically risk assessed. Comparably, Max had multiple warning markers for being a perpetrator of domestic abuse on multiple occasions with multiple partners, which may have accounted for why he was not effectively responded to as a victim when he reported assault and sexual abuse from different female partners.

15.120 Identifying the primary perpetrator and victim, or the nature of abuse in relationships, is vital to ascertain who is more likely to be harmed. Perpetrators can be highly manipulative in how they present their and the victim's behaviour, and it is a common tactic for them to get the victim identified as the abuser by agencies. This is just one way of perpetuating systems abuse against victims. College of Policing Guidance reinforces the importance of identifying the right person as the primary perpetrator[119] and acknowledges that a manipulative perpetrator may "*…draw the police into colluding with their coercive control of the victim. Police officers must avoid playing into the primary perpetrator's hands and take account of all available evidence when making the decision to arrest."*

15.121 Frontline officers should hold expertise in identifying use of self-defence, mutual or situational violence, and domestic abuse involving coercion and control. It is important not to assume the person making the disclosure or call is always the victim, to understand that malicious reports and systems abuse are tactics of coercive control, and look beyond incidents to the wider context.

15.122 During their relationship there were four occurrences in which police had contact with Max and Amber, three of which have identified learning by police.

- In April 2023, when Max called police, heavily intoxicated and hallucinating, with concerns for his girlfriend who was having a panic attack, the ambulance attended and confirmed both were safe and well, and this was assessed as caused by mental ill-health and substance use. It would have been best practice for police to attend to confirm no offences had actually taken place as during the call, there was an indication that Max and Amber were under threat. Officers could have also considered an assessment of Max and Amber's vulnerabilities, but because no PPN was created, this incident was not known to agencies other than SCAS, which also meant other agencies were not aware of Max and Amber's new relationship at the earliest opportunity.
- The next day, there was a poor response by police to a domestic abuse report by Max , who called to report he had been slapped in the face by his girlfriend and thrown out of his flat. Max said he had lost his memory and had been "*missing for 5 days*" but he was then let back in to his flat and it was difficult to gain further information by phone. Although graded urgent, this was incorrectly tasked to the High Harm Team, who were off duty. They visited Max 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 including any injuries, any damage to the property, the demeanour of those involved and any risks evident in their relationship.
- In May 2023, following a report of rape by Amber, they were both were offered safety alarms, but declined. There was significant delay in contacting Amber by a female specialist officer, by which

[119] College of Policing (2018) 'Arrest and other Positive Approaches' from the Authorised Professional Practice

time Amber advised she no longer supported an investigation. Without a victim statement, suspect or other lines of enquiry, the rape investigation was filed. Although a PPN for Amber had been completed, this was done a month after the report, without her input. This highlighted concern for Amber's mental health but was not shared with her GP as their details weren't known and no checks were made with previous PPNs which had included GP details, as had MARAC minutes. Not all the available information was reviewed by the officer completing the PPN to best assess the risk, and this presented a further missed opportunity to share information with other agencies regarding Max and Amber's relationship.

15.123 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 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.

15.124 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.

15.125 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. Almost half of the Domestic Homicide Reviews recently included recommendations for better assessment processes that incorporate more holistic thinking about victims' circumstances.

15.126 Locally, as mentioned above, a thematic review into cuckooing identified gaps in agencies' understanding of and response to cuckooing, and a gap in coordinated multi-agency adult exploitation/cuckooing strategies. Relevant similar findings also emerged from a thematic safeguarding review into alcohol use published in June 2025, which included learning related to the need for assertive outreach, multiagency escalation and risk management and increased understanding of the impact of co-occurring conditions.[120]

15.127 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 warrants further attention.

15.128 Family said that they felt they saw what happened from stains that remained; they cleaned visible blood stains from the kitchen and living room; and dealt with flies and what was left at the property. The landlord had offered to clear it, but they had wanted access to remove belongings. Concerns about what they saw were later raised with Police, and family emphasised to the Panel that they felt no-one else should go through what they had, when they entered the property.

15.129 The Panel recognised that this had been deeply traumatic for family, and that their bereavement was inevitably compounded by being able to visualise what had happened and being at the scene after its release. College of Policing guidance for managing investigations advises that the scene should be

[120] https://hampshiresab.org.uk/safeguarding-adult-reviews/hampshires-published-sars/catherine-jeremy-and-sarah-alcohol-harm-thematic-review-june-2025

‘cleaned and released’, and HIOW Police had instructed external cleaners to conduct a full crime-scene clean, in line with its policy (to a standard that complies with the Health and Safety Act and Control of Substances Hazardous to Health Regulations). However, the Panel were advised its completion was only reviewed by photos as it was not possible to attend in person. Aster had seen the property before the family entered, called family to warn them of the condition, and an officer went with them when they first attended. Aster agreed to instruct third-party cleaners to attend properties in future, unless family require access sooner. Accompanied visits will also be supported by referrals to other agencies such as victim support where appropriate. The Panel reinforced that no family should go through the distress of cleaning up a domestic homicide crime scene, and further consideration was given by the Panel to what recommendations might help prevent families being faced with such trauma in future.

16. Conclusion

16.1 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.

16.2 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.

16.3 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.

16.4 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.

16.5 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.

16.6 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.

17. Recommendations

17.1 Single agency 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 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.

17.2 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.

17.3 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.

Appendix A: DHR SAR Panel Terms of Reference [redacted to remove identifying details]

Overarching aim

The over-arching intention of this Review is to learn lessons from the death of the victim, in order to change future practice that leads to increased safety for potential and current victims of domestic abuse.

The Review will also integrate key lines of inquiry to ascertain whether agencies could have worked better to protect an adult with care and support needs from harm, in accordance with The Care Act 2014 Sec 44/45 (pertaining to safeguarding adults reviews where adults with care and support needs have died or suffered serious harm following suspected neglect or abuse and where there are concerns about whether agencies have worked together to safeguard the adult).

The Review will be conducted in an open and consultative manner, bearing in mind the need to retain confidentiality and not to apportion blame. Agencies will seek to discover what they could do differently in the future, and how they can work more effectively with other partner organisations.

Test Valley Community Safety and Hampshire Safeguarding Adults Board (HSAB) agree that conducting a combined Review, instead of running separate parallel Reviews, is the most effective and efficient way to establish what lessons are to be learnt about the way in which local professionals and organisations work individually and together to safeguard and support adults who are victims of domestic abuse. The HSAB determined that this review met the mandatory criteria for Review as set out in Sec 44 of the Care Act 2014.

Principles of the Review: Objective, independent & evidence-based; guided by humanity, compassion and empathy with the victim's voice at the heart of the process; asking questions, to prevent future harm, learn lessons and not blame individuals or organisations; respecting equality and diversity; and openness and transparency whilst safeguarding confidential information where possible.

The Review Panel (and Individual Management Report authors) will consider the following:
1. Each agency's involvement with the victim and perpetrator in the 2.5 years leading up to the death of the victim **in June 2023**, that is, between January 2021 and June 2023.

2. Whether, in relation to both parties, an improvement in any of the following might have led to a different outcome: **Communication** between services, and i**nformation sharing** between services, with regards to the safeguarding of adults.

3. Whether the work undertaken by services in this case was consistent with each organisation's professional standards; domestic violence policy, procedures, assessment tools and protocols; and safeguarding policy, procedures, assessment tools and protocols.

4. The response of the relevant agencies, to any referrals relating to the victim and perpetrator concerning **domestic violence, safeguarding concerns or other significant harm** from January 2021. In particular, what decisions were taken and what actions were carried out, or not, and the reasons, with specific regard to the following areas:

(a) Identification of the **opportunities for assessment, decision making and effective intervention** from the point of any first contact onwards.
(b) How **timely has decision making been** regarding response to referrals, and whether actions taken were in accordance with assessments and decisions made, and whether those interventions were informed, professional, and effective.
(c) Whether **appropriate services were offered/provided** and/or relevant enquiries made in the light of any assessments made.
(d) The **quality of the needs/safety/risk assessments** undertaken by each agency and the effectiveness of any multi-agency risk assessment conference (MARAC), multi-agency safeguarding process or other fora in respect of the victim and perpetrator.
(e) Any **missed opportunities** to enquire about domestic violence or adult safeguarding? Was there an awareness of the issues facing either person, and if so, what actions were taken?

5. When, and in what way, were the **victim's wishes and feelings, safety and support needs** ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they provided with a response that met their needs at the point of contact? Were they signposted to other agencies? Was advocacy support considered?

6. Was anything **known about the perpetrator**? For example, were they being managed under Multi Agency Public Protection Arrangements, and if so, how effective were these arrangements? Were they subject to a perpetrator behaviour change program? Were there any injunctions or protection orders that were, or previously had been, in place?

7. **How accessible were services** for the victim and perpetrator?
8. What relevant **training was provided to staff** and whether this was taken up, and refresher training provided as needed?
9. Whether **thresholds for intervention** were appropriately calibrated and applied correctly?
10. Whether practices by all agencies were sensitive to the nine **protected characteristics**[121] of both parties, and whether any special needs on the part of either person were explored, shared appropriately and recorded. Evidence needs to be provided for any assertions.
11. Whether **issues were escalated** to senior management or other organisations and professionals, if appropriate, and in a timely manner?
12. Whether **there was any impact of organisational change** over the period covered by the Review, had this been communicated well enough between partner agencies, and whether that impacted in any way on partnership agencies' ability to respond effectively?
13. What was **known about the relationship** between both parties? This includes whether it was known if
    (a) the relationship between the two was effectively identified by all agencies and whether co-dependency and risk was assessed?
    (b) either were exposed to domestic violence or other forms of abuse?
    (c) coercion and control or economic or financial abuse played a role?
    (d) they were exposed to information, interventions or programs about healthy relationships or accountability for violence prevention?

14. Whether agency responses were in accordance with all agency policies and procedures in relation to **safeguarding adults,** in particular with regards to s.42[122], and did agencies cooperate as required?
15. Whether **family or friends** of either the victim or perpetrator knew about any abuse prior to the homicide, and is it known what they did with this information? Were there any barriers experienced by them in reporting any abuse? How would they know what to do with this information?
16. Were there any **diversity issues** which impacted on the circumstances of either the victim or perpetrator and did these impact on either reporting or seeking help or agency responses?
17. What **learning** can be identified from this fatality?
18. What **changes** would you suggest, for individual agencies and multi-agency partnerships, to avoid such tragedies occurring in the future?

Panel Membership: The following agencies have been invited to sit on the Panel: Aster Group; Adult Social Care – Hampshire County Council; Berkshire Healthcare NHS Foundation Trust; Finding Freedom from Abuse; Inclusion Hampshire (Midlands Foundation Partnership Trust); Integrated Care Board and GPs; Police (Hants & IoW); Test Valley Borough Council; Probation Service; Southern Central Ambulance Service; Southern Health.

[121] These are a person's age; disability; gender reassignment; marriage or civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation.
[122] S42 Care Act: where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)—(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. The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom. "Abuse" includes financial abuse; and for that purpose "financial abuse" includes—(a) having money or other property stolen, (b) being defrauded, (c) being put under pressure in relation to money or other property, and (d) having money or other property misused.

Individual Management Review (IMR) Report and Authors: The aim of the IMR is to (1) allow agencies to look openly and critically at individual and organisational practice and the context within which people were working to see whether the homicide indicates that changes could and should be made. (2) To identify how those changes will be brought about. (3) To identify examples of good practice within agencies. IMR Authors will be offered a briefing to discuss requirements for the IMR template content.

Independent Chair and Author: Eleri Butler has been commissioned as the Independent Chair / Author for this Joint Review, who is independent of any agency within Hampshire.

Family involvement: The Review will seek to involve the family of the victim and the perpetrator in the review process, taking account of who the family wish to have involved as lead members, and to identify other people they think relevant to the review process. We will seek to agree a communication plan that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this. We will identify the timescale and process and ensure that the family are able to respond to this Review, endeavouring to avoid duplication of effort and without undue pressure. Contact with the family and other members of their social networks, in relation to the process and content of this Review, will be led by the Chair. No interviews, meetings or conversations will take place about the Review content until after any trial.

Disclosure & Confidentiality

- Confidentiality should be maintained by organisations whilst undertaking their IMR. However, the achievement of confidentiality and transparency must be balanced against the legal requirements surrounding disclosure.
- The independent Chair, on receipt of an IMR, may wish to review an organisation's case records and internal reports personally, or meet with review participants.
- A criminal investigation is running in parallel to this DHR, therefore all material received by the Panel before the trial must be disclosed to the SIO and the police disclosure officer.
- The criminal investigation is likely to result in a court hearing. Home Office guidance instructs the Overview Report will be held until the conclusion of this case. Records will continue to be reviewed and any lessons learned will be taken forward immediately.
- Individuals will be granted anonymity within the Overview Report and Executive Summary and will be referred to by a pseudonyms.
- Where consent to share information is not forthcoming, agencies should consider whether the information can be disclosed in the public interest.

Timescales: Subject to criminal proceedings, the Review will aim to conclude in line with the statutory guidance.

Media strategy: Pre-trial any media enquiries prior to the conclusion of the trial must be referred to HIOW Constabulary. Post-trial, enquiries should be directed to Test Valley Borough Council who will agree a strategy with the Chair and the lead officers for the CSP/SAB.

Appendix B: About the Chair and Report Author

The independent Chair and Author of this report, Eleri Butler, is independent of all agencies involved, had no prior contact with any family members.

Eleri is an Independent Consultant who has worked in the UK, Europe and Australia in a variety of capacities, predominantly on preventing domestic and sexual violence and violence against women.

Eleri is a trained accredited domestic homicide review/domestic abuse related death review Chair.

Eleri's work spans over three decades in public services, governments and the specialist sector. Eleri's consultancy includes work on gender-based violence prevention, Istanbul Convention implementation, DHR chairing, community engagement, research and evaluation, capacity building, strategy and business planning, systems services and policy design and implementation, governance, equity diversity and anti-discriminatory practice, survivor engagement and centering lived experience.

Formerly, Eleri was Deputy Secretary of the Department of Families Fairness and Housing in Victoria Government, and CEO of Family Safety Victoria, in Australia. Eleri led delivery of state-wide reforms on behalf of Ministers, which included acquitting the State's 227 Royal Commission recommendations to deliver systems and service improvements across prevention and response. This involved multi-agency collaboration to deliver system and service transformation across Government and local communities, in order to safeguard women and children, families and communities from domestic, family and sexual violence.

In the UK, between 2014 and 2020, Eleri was CEO of Welsh Women's Aid. Eleri has previously worked on helplines, in refuges and other community services, has established and led specialist services, women's centres and support for women in the justice system. She has also led national policy, strategy and program design and delivery in charities and whilst seconded to UK Government. She has advised on improvements to the criminal and family justice systems in several capacities, and has worked as Commissioner, expert Advisor, manager of European research programmes, and strategic coordinator to prevent violence against women.

There is no current or recent conflict of interest that Eleri has with services and partnerships in Test Valley or Hampshire.

Appendix C: Spot Check review of policies, training, partnerships – summary

Agency name	Do you have a separate domestic abuse policy?	If yes when was it last reviewed?	Is domestic abuse is subsumed in safeguarding policy?	If yes, when was it last reviewed?	Is there standalone domestic abuse training for staff?	The % of staff who attended in the past two years	Length of training?	Does training provided include a focus on perpetrators?	Are you involved in local domestic abuse partnerships?	Which partnerships?	Extra information
Aster Housing	Yes - Domestic Abuse Policy	Sept. 2022	No	N/a	No	Not known	No	No	Yes	DAHA SW region	*Aster is currently planning future DAHA accreditation and Domestic Abuse training for all employees*
Berkshire Health Foundation Trust	Yes	June 2022	No	N/a	Yes	Not known	1-3 hours	Yes	Yes	Six domestic abuse boards across Berkshire, all MARACs across Berkshire and Domestic Abuse Perpetrator Panel meetings	*Regular programme of domestic abuse training accessed by all BHFT. There is also bespoke domestic abuse training for certain staffing groups and in response to learning from homicide and safeguarding reviews.*
Finding Freedom from Abuse	Yes	November 23	No	N/a	Yes	All relevant staff	More than 7 hours	Yes	Yes	Local MARACs and High-Risk Domestic Abuse meetings	*FFFA is a domestic abuse charity providing outreach and refuge, and has three IDVAs, one CYP IDVA and two ISVA'S.*
GP Practice – St Marys	No	N/a	Yes	July 2023	Yes	100%	Less than 1 hour	Yes	No	N/a	
GP Practice – Stockbridge	Yes - Domestic violence and abuse policy	September 2023	No	N/a	Yes - domestic abuse is also included in level 3 adult safeguarding updates, but not recorded on electronic training records.	25% - excluding safeguarding updates which may include domestic violence (not recorded)	1-3 hours	Yes	No	N/a	*Don't attend MARACs but receive information from them, code notes accordingly and send any relevant information held. All cases are discussed at surgery Multi Disciplinary Team meetings with Health Visitors and School Nurses, including focus on children. Warnings alert clinicians to patients where domestic abuse is current.*

Agency name	Do you have a separate domestic abuse policy?	If yes when was it last reviewed?	Is domestic abuse is subsumed in safeguarding policy?	If yes, when was it last reviewed?	Is there standalone domestic abuse training for staff?	The % of staff who attended in the past two years	Length of training?	Does training provided include a focus on perpetrators?	Are you involved in local domestic abuse partnerships?	Which partnerships?	Extra information
Hants CC Adult Health & Care	No	N/a	Yes – adhere to 4LSAB Multi-agency Safeguarding Policy, Practice and Guidance,, into which domestic abuse is subsumed. AHC also provide a full suite of safeguarding practice guidance and domestic abuse practice guidance within Social Care Practice Manual.	2023	Yes	Not known	1-3 hours and 5-7 hours AHC's domestic abuse e-learning is 1-3 hours. AHC also offer a 6.5 hour course delivered by Making Connections.	Yes	Yes	Hampshire Domestic Abuse Partnership	Course content includes: *Identify domestic abuse and its impact, including effect on behaviour and choices. Identify how to respond to disclosures within adult safeguarding and AHC. Importance of assessment when working with victims and perpetrators/person alleged to have caused the harm [P.A.C.H] (includes MARAC, risk identification checklist, local and organisational procedures) Effective risk management, safety planning, and a whole family approach Minimising barriers to accessing domestic abuse services*
Hampshire Hospitals NHS Trust	Yes - Hampshire Hospitals NHS Foundation Domestic Abuse Policy	February 2022	Yes	Feb 2022	Yes	Average 84%	1-3 hours	Yes	Yes	Hampshire Domestic Abuse Partnership	
HIOW Fire & Rescue Service	No	N/a	Yes - Safeguarding Children, young people, and adults at risk.	Nov. 2023	No	None	none	No	Yes	Hampshire Isle of Wight Domestic Abuse partnership	*Domestic abuse concerns for the public are responded to in line with HIWFSR Safeguarding procedures and concerns for employees are responded to in line with wellbeing support systems and safeguarding procedures.*

Agency name	Do you have a separate domestic abuse policy?	If yes when was it last reviewed?	Is domestic abuse is subsumed in safeguarding policy?	If yes, when was it last reviewed?	Is there standalone domestic abuse training for staff?	The % of staff who attended in the past two years	Length of training?	Does training provided include a focus on perpetrators?	Are you involved in local domestic abuse partnerships?	Which partnerships?	Extra information
HIOW Police	Yes	October 2022	No	N/a	Yes	750 officers and staff attended Domestic Abuse training in last 2 years (DA Matters First Responder). Met target for training 2000 frontline responders in the first year of roll out in 2018 and continued to roll out training for new starters/ transferees. At the end of 2022, all frontline responders had been trained.	More than 7 hours	Yes	Yes	Hampshire Domestic Abuse Partnership, Hampshire Domestic Abuse Partnership Sub-Group, Hampshire Domestic Abuse Working Group	*Police have internal training in Coercive and Controlling Behaviour and Stalking. This has been delivered to frontline officers and staff, call handlers and Domestic Abuse Champions. Training has been rolled out to all investigation teams in the West and North of Hampshire and is ongoing to capture teams in the East of Hampshire. This training also covers post separation abuse, suicide, and the importance of completing accurate PPN/DASH risk assessment. The training includes specific case examples from Hampshire and learning from reviews. The newly formed Priority Crime Teams have received additional training on the Domestic Homicide Timeline and the Domestic Violence Disclosure Scheme.*
Inclusion Hampshire (part of MPFT)	Yes - Domestic Abuse, Standard Operating Procedure,	January 2023	No	N/a	Yes	In January 2024 compliance was 93.75% (Level 2), 87% (Level 3). In January 2025 compliance was 94.68% (Level 2) 94.95% (Level 3)	1-3 hours	No	Yes	MARAC and High Risk Domestic Abuse meetings.	MPFT safeguarding service has arranged additional face to face learning at the beginning of March 2025

Agency name	Do you have a separate domestic abuse policy?	If yes when was it last reviewed?	Is domestic abuse is subsumed in safeguarding policy?	If yes, when was it last reviewed?	Is there standalone domestic abuse training for staff?	The % of staff who attended in the past two years	Length of training?	Does training provided include a focus on perpetrators?	Are you involved in local domestic abuse partnerships?	Which partnerships?	Extra information
South Central Ambulance Service	Yes - Domestic Abuse Policy for patients and service users (2022). Domestic Abuse Policy for SCAS Staff (2023)	This is under review. This is due for review Aril 2025.	No	N/a	No - Domestic Abuse is included in Level 2 and 3 Safeguarding training provided to SCAS Staff.	92% level 3 training (includes domestic abuse)	Initial day plus 4 hours, and 1.5 hours supervision and CPD, to be completed in three years.	No	Yes	Wokingham DA Networking Group; Reading DA partnership Work across 12 Local Authorities in Domestic Homicide reviews when required.	*Working on amalgamating both policies, giving better guidance on consent, adding understanding around coercive control, FGM and child to parent abuse and including the MARAC flag system. Also working on adding DA training for staff.*
Southern Health Foundation Trust (community mental health)	Yes	June 2023	No	N/a	Yes - Domestic Abuse Awareness eLearning Training	95.7% compliance across Trust (All clinical staff mandated to complete DA eLearning) - 216 non-compliant staff out of the 5016 mandated. Clinical staff encouraged to complete Domestic Abuse Pathway eLearning. This is not mandated so no data on uptake/ compliance.	Less than 1 hour	Yes	Yes	Hampshire and Southampton and ICB implementation group.	*There is separate 'Management guidance on supporting staff who are subject to domestic abuse'* *Domestic abuse is now included as part of staff appraisals.* *Domestic abuse is now added to return to work interviews after sickness absence and staff one-to-ones.* *Trust has developed a domestic abuse poster signposting staff, patients and visitors to local domestic abuse services*.
Test Valley Borough Council	Yes	2021	Yes - TVBC Safeguarding Policy	2022	Yes –	100%	7 hours – followed up by shorter refresher sessions. Other training lengths will depend on staff roles.	Yes	Yes	Hampshire Domestic Abuse Partnership.	*Some DA awareness training is incorporated in Safeguarding training to all new staff with 2 yearly refreshers. Specific staff may also do DA training as part of their roles. Access to non-mandatory DA training was last provided for all staff in 2021.*

Appendix D: Action Plan September 2026 *(Note this is a live document and subject to change as delivered, and is available separately)*

Test Valley DARDR SAR (Max) – ACTION PLAN						
Recommendation	**Scope of recommendation**	**Action to take**	**Lead Agency**	**Key milestones**	**Target date**	**Completion Date and Outcome**
Sole agency recommendations						
Aster Housing						
Provide tenancy sustainment support for new tenants, especially where known vulnerabilities and risks.	Regional	Ensure tenancy sustainment continues to be available to new tenants especially where known vulnerabilities and risks.	Aster	*This action has been enacted since the period of this Review.*	December 2023	Completed December 2023 Tenancy sustainment remains in place and available to all tenants as required.
Ensure Aster attends domestic abuse MARACs and is involved in safeguarding enquiries and information sharing.	Local	Ensure Aster is involved with and represented on local high-risk domestic abuse MARACs. Ensure Aster is included in multi-agency information sharing and enquiries on domestic abuse and care and support needs when relevant, to enable tenant checks to happen.	Aster	*This action has been enacted since the period of this Review.*	December 2023	Completed December 2023 Aster attend all domestic abuse MARAC meetings. Aster is included in safeguarding related enquiries and information sharing.
Undertake the Domestic Abuse Housing Alliance accreditation for registered housing providers.	Aster	Prepare for accreditation and secure senior leaders agreement. Allocate resources to enable successful accreditation.	Regional	Senior leader meeting to agree in December 2024.	June 2026	Aster have decided not to resource and obtain the DAHA accreditation at this time as having explored this, it is felt that cases involving

						DA is already managed in line with the DAHA standards. Aster have signed up to the “Make a Stand” pledge in conjunction with many other RSL’s as recommended by the CIH.
Develop domestic abuse policy and mandatory training on responses to victims and perpetrators.	Local / regional	Fully implement new Consumer Standards regarding domestic abuse so tenants access appropriate support and advice. Assess how perpetrator signposting and risk management process can be included into Policy and training, and update accordingly. Deliver domestic abuse specific training package to to staff (mandatory for key staff).	Aster	Produce and implement a domestic abuse policy. Ensure policy includes identification and response to domestic abuse perpetrators. Develop specific domestic abuse training pack. Safeguarding training being rolled out to trades staff which includes domestic abuse. Simplify way for trades staff to report a safeguarding or domestic abuse concern via devices whilst in customer homes.	April 2025	Aster have fully implemented new consumer standards regarding Domestic Abuse. Tenants are able to access appropriate, specialist advice via ASB Team who can signpost / refer to relevant agencies. New legislation by way of social housing bill due to come into play in the near future in terms of managing perpetrators of DA. Policy and procedures will be amended to reflect these changes once it has been enacted. Safeguarding and domestic abuse training available to all staff. Trades staff can report DA / Safeguarding in a

						simplified way via their PDA's which has helped increase engagement and reporting.
GP Practices – Stockbridge and St Mary's, and Hampshire Integrated Care Board						
Clarify actions need to be taken following receipt of a Police Protection Notice.	Local	Review learning from Review Clarify amongst staff when safeguarding referral are made following receipt of PPN.	Stockbridge Practice	Discuss learning in Learning Event Meeting September 2024.	September 2024	Completed
Identify and deliver domestic abuse training for the clinical team.	Local	Seek appropriate domestic abuse training and arrange for staff to attend.	Stockbridge Practice	Deliver training to ensure that 80% of clinical staff have received bespoke domestic abuse training	December 2025	**June 2026:** 95% of both clinical and non-clinical teams have completed domestic abuse training.
Ensure GP Practice correctly codes and flags vulnerable adults to inform effective response.	Local	Share learning about coding of vulnerable adults at staff clinical meetings. Update adult safeguarding policy to include coding of vulnerable adults or adult at risk code to the medical records of any adult who is identified as having care and support needs that may put them at risk of abuse or neglect. Amend 'was not bought protocol to include vulnerable adults'.	St Mary's Surgery	Learning shared with clinical colleagues. Policy updated following learning discussion, and updates disseminated to inform practice. Share learning regarding coding and protocol for vulnerable adults who have not been bought to appointment.	November 2024	Completed St Mary's have shared this learning point at our clinical meetings. Policy reviewed in November 2024. The adult at risk 'was not bought policy' means when appointment not attended additional efforts will be made to make contact to check on well-being and

						encourage engagement.
Appoint a safeguarding coordinator to manage safeguarding administrative tasks.	Local	Funding to be secured and role to be filled.	St Mary's Surgery and Andover Primary Care Network	Safeguarding coordinator to be appointed.	September 2024	Completed The Andover PCN fund St Mary's safeguarding coordinator. Safeguarding documentation (including MARACs) now coordinated by one person, and improves/addresses identification of gaps.
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.	Local	Participate in new partnership service delivery across Hampshire – for people with mental illness and coexisting substance use.	St Mary's Surgery and Andover Primary Care Network	Engage and participate with No Wrong Door: adult community mental health transformation programme across Hampshire, Southampton, Isle of Wight, and Portsmouth.	Ongoing	Completed
Support GP practices to have the tools and confidence to identify and respond to domestic abuse.	Regional	Domestic abuse training for primary care.	NHS Hampshire and IOW	Domestic abuse training to be commissioned and delivered to primary care. Training to be delivered at Hampshire wide primary care training events.	December 2024	Completed Domestic Abuse training from Stop Domestic Abuse has been commissioned.
Deliver a domestic abuse care pathway and develop strong working relationships with local domestic abuse services	Regional	Continue to commission specialist domestic abuse service to healthcare professionals in Hampshire.	Hampshire CC Public Health / NHS Hampshire and IOW	Specialist service commissioned to be delivery partner across Hampshire.. Service to include - implementing care pathway for patients disclosing domestic abuse - designated position/	Training to happen by December 2024	Completed Service in place.

				service responsible for the initial assessment of victims. - commissioning training for practice teams on identification and response to domestic abuse.		
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.	Local and regional	Learning from this DHR to be shared with practices across Hampshire to encourage more practices to become veteran friendly.	NHS Hampshire and IOW	Learning to be shared with GP safeguarding leads in Hampshire	December 2024	Part-completed St Mary's is a veteran friendly service.
Hampshire County Council – Adults Health & Care (AHC)						
Improve interaction between AHC and HRDA/ MARAC, to ensure appropriate identification and response to safeguarding concerns and care and support needs of individuals in line with the Care Act 2024	Local – Hampshire	Review of process involving senior stakeholders to identify and deliver improvements so that there is effective joint working between AHC and HRDA/ MARAC, to ensure AHC identify and response to risk and need according to Care Act duties.	HCC	Learning and data about AHC interaction with MARAC / HRDA to be shared with Strategic Safeguarding Lead and Principal Social Worker. Ensure that AHC attendance at MARAC is by qualified practitioners. Implementation of Team Manager oversight for AHC Care Act decisions made within HRDA/MARAC	December 2024 April 2024 April 2024	Completed. The review has identified improvements which will now be taken forward through engagement with partner agencies. Completed Completed

				Reflective session for MASH practitioners around professional curiosity and recognising safeguarding concerns in high-risk complex domestic cases.	January 2025	A number of reflective sessions have taken place in team meetings over 2024. A further session is planned for January 2025.
Deliver increased training compliance in relation to domestic abuse.	Local – Hampshire	Initiate focused campaign to promote domestic abuse Training, led by Principal Social Worker Continue to offer domestic abuse training of high standard in variety of formats (e-learning, virtual and face-to-face)	HCC	Monthly review of training attendance figures Monthly sharing of training figures with operational managers	All staff to have completed training by 30 January 2025.	In December 2024, the Principal Social Worker launched the campaign, requiring all staff to complete the e-learning by January 2025. Additionally, AHC's Learning and Development Team and Strategic Safeguarding Team have been promoting further face to face and online courses, delivered both by AHC and by external partners.
Improve Care Act compliance demonstrated by evidence-based decision making, particularly within S42 enquiries.	Local – Hampshire	Increased audit of S42 enquiries for Mental Health Teams, through the AHC Quality Assurance Framework	HCC	Monthly review of S42 Quality Assurance Framework data	November 2024	Completed. The relaunched AHC Quality Assurance Framework now includes a specific audit for the quality of S42 enquiries. Practitioners are now required to be audited on an increased minimum of three cases across the year. Data and trends are monitored via the Practice Improvement Network.

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	Local – Hampshire	Initiate 'Priority Resolution Team', a project team to reduce Mental Health team waiting list numbers/ complete Care Act S9 Assessments and respond to high-risk priority cases. Develop prioritisation criteria, revised allocation screening processes, practitioner guidance and governance/minimum standards for Mental Health Teams' duty functions and waiting lists.	HCC	Monthly review of waiting lists by operational service managers Monthly reporting of waiting list figures to performance and governance structures	March 2024 November 2024	Completed. Completed. The criteria, process and guidance was launched in November 2024 and applies to all care groups.
Hampshire Hospitals NHS Trust						
Improve system to ensure an increase in safeguarding adults' referrals to Adult Service and involvement of HHFT Safeguarding Adults team.	Local	Regular meetings between HHFT safeguarding team and Adult Services Increase awareness of care and support needs of patients relating to domestic abuse, alcohol dependency and self-neglect, and support for veterans.	HHFT	Fortnightly meetings between HHFT Safeguarding Adults team and Adult Services in Basingstoke Hospital to talk through ongoing referrals and discuss any upcoming concerns. Bespoke training for ED to focus on self-neglect, domestic abuse, and support needs of veterans (provided by commissioned domestic abuse service).	July 2024 Ongoing	Completed

Improve and monitor effectiveness of referral pathways to STOP Domestic Abuse hospital teams.	Local	Domestic Abuse pathway updated. Online training developed.	HHFT	Pathway promoted across teams. Training delivered. Reports on effectiveness reviewed quarterly.	July 2024	Completed The domestic abuse service at HHFT is a commissioned service required to report to HHFT quarterly on the effectiveness of domestic abuse referrals
Implement routine enquiry for domestic abuse, in accordance with statutory guidance and in partnership with the commissioned domestic abuse service.	Local	Routine enquiry forms part of the domestic abuse training, Ensure it forms part of the ED clerking assessment, where there are possible indicators of domestic abuse.	HHFT	Embed routine enquiry into HHFT's development of an all-digital service	October 2024	Awaiting full implementation of digital service
Ensure domestic violence training is mandatory across Levels 1-3, and completion to be monitored.	Local	Make domestic abuse training mandatory across all levels of safeguarding adults and children training System in place to monitor completions.	HHFT	Training compliance is monitored by the local training platform - training compliance is monitored by the safeguarding assurance group and reported to the ICB on a quarterly basis		Completed
Inclusion Hampshire (Midlands Partnership Foundation Trust)						
Improve earlier information sharing with consent to ascertain agencies involved in supporting a person.	Local	System to gain an individual's consent early on to share information between agencies, and regularly re-visiting this consent to share. System to gain consent from an individual to advise a partner agency should they drop out of	Inclusion	Process review on going within local teams.	October 2024	Completed This has been reviewed Hampshire Inclusion and 'new to service' assessment has been reviewed to obtain consent to share appropriate and proportionate information with the

		treatment/disengage with one service.				referrer and other agencies to protect person accessing service from harm and abuse.
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.	Local supported by MPFT safeguarding service	Complete audit of clinical records regarding domestic abuse enquiry and actions taken for disclosures from victims and perpetrators. Ensure Inclusion staff undertake domestic abuse training relating to identifying and responding to victims and perpetrators of abuse.	Inclusion	Audit by dip-sampling clinical records where. domestic abuse has been identified, for action taken, and address any improvements required. Inclusion services have access to - domestic abuse training Level 2 awareness of domestic abuse and level 3 that includes enquiry, making a referral to MARAC and safeguarding. - designated domestic abuse lead for advice and support - intra-net page for information regarding domestic abuse.	June 2025 October 2024	Strengthened integrated pathways between Inclusion and Hampshire domestic abuse services. Completed
Police: HIOW Constabulary						
Ensure that the decisions of priority and repeat victims are clearly	Local	Communication to all investigators to remind them	HIOWC	- Putting victims first is one of the force priorities.	February 2024	**March 2024**

recorded, including their reasons for not wishing to support a police investigation or later withdrawing their support.		to place victims at the centre of all police contact.		-Investigation briefing packs have been developed to outline what a good investigation looks like for officers and supervisors. This includes placing victims first, relentlessly pursuing suspects, policy compliance, appropriate risk assessments, thorough investigation plans, accurate crime recording and identifying all reasonable lines of enquiry. - Launch of a two way messaging service for victims to allow them to send their OIC a direct message using the portal and the OIC can respond using the Niche OEL. - As part of the Police and Crime Commissioner's police and crime plan to improve outcomes for victims, the OPCC has introduced victim's hubs in local police stations. These includes drop in sessions and become an additional provision of service. -HIOWC to launch a 24/7 Support Line for victims of rape. This is a government-funded service operated by Rape Crisis England &		-OPCC victims hubs launched in February 2024 -Two way messaging service for victims launched in February 2024 -24/7 support line for victims launched at the beginning of 2024. - Guidance on protective orders circulated and available on the force intranet placing the emphasis on the perpetrator and not the victim. -The Power and Control wheel is also available on the force intranet to highlight the different stages of CCB and how these can be seen in the daily life of a victim. This includes how a victim of CCB may be perceived as 'non-engaging'. - College of Policing 'myth busts' on the force intranet for why victims may appear unwilling to engage to prompt officers/staff to think of alternative ways to capture evidence.

				Wales with specialist operators available on the phone or webchat providing information and emotion support and signposting to longer term services such as ISVAs. -Victim Contact Management module to be completed for every victim of crime.		-Investigation briefing packs completed -Assistant Chief Constable for Crime and Criminal Justice circulated a message in February 2024 reminding all officers and staff to use the Victim Contact Management module to manage and document victim's wishes and record changes such as a new OIC and review risk to the victim. -A final victim based working sheet is now on RMS to record victim's decisions and reasons for withdrawing 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	Local	DA Champions to complete a dip sample of outcome 16 high risk domestic abuse cases.	HIOWC	-Changes in crime allocation policy: medium risk domestic abuse cases that can't be dealt with by timely voluntary attendance and out of court disposal will now sit with PIP1 in the Custody Investigation Team (CIT)/Criminal Investigations Department (CID). -Review deployment to ensure all key lines of enquiry are identified quickly and followed up	June 2024	**June 2024** -QUATT dip sampling underway. -CIT/CID teams have a Detective Inspector leading who has experience with managing PACE custody time limits. -PIP2 staff receiving training on custody time limits.

				- A knowledge hub to be developed for investigation best practice for all crime types. -Expand Investigation Advisors across all force areas. Investigation Advisors can support DPT and NET officers, sergeants and inspectors by reviewing crimes and assisting with lines of enquiry, case-file building and interviewing. -Investigation briefing packs to be developed to outline what a good investigation looks like for officers and supervisors. This includes placing victims first, relentlessly pursuing suspects, policy compliance, appropriate risk assessments, thorough investigation plans, accurate crime recording and identifying all reasonable lines of enquiry. -QUATT dip sampling to commence in June 2024. Inspectors will review 3 crimes a month to ensure that reasonable lines of enquiry are being followed, aligning the crimes with the investigation briefing pack. The results will be tracked and fed back in area performance meetings and		-PIP2 management has seen an increase in charged cases, DVPNs and Right To Know applications since August 2023. This remains the case as of March 2024. - All grade 2 domestic abuse incidents and any incidents involving children are now prioritised for deployment over other grade 2 incidents to ensure officers are on scene within 60 minutes. -Movement of high risk domestic abuse cases to the highest trained officers (PIP2) will ensure all lines of enquiry are completed with oversight from PIP2 supervisors. -Investigation briefing packs completed -Assistant Chief Constable for Crime and Criminal Justice circulated a message in February 2024 reminding all officers and staff to use the Victim Contact Management module to manage and document

				raised at an investigation oversight board chaired by ACC of Crime and Criminal Justice.		victim's wishes and record changes such as a new OIC and review risk to the victim. - Operation Soteria is exploring products (subcodes) to provide the Constabulary with an auditable record of victims' decisions and their reasons when they withdraw support, and that it documents whether it has considered evidence-led prosecutions in all such cases.
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.	Local	Officers and staff to be reminded of factors that can increase vulnerability to harm and exploitation.	HIOWC	-Specialist Trauma Informed Practitioners (TIPs) to patrol with officers and help embed trauma informed policing through training. -Drug related harm to sit under the Priority Crime Team (PCTs) including drug related violence, cuckooing, habitual knife carriers, the use and supply of controlled drugs and County Lines. PCTs to have ownership of all red (highest risk) Operation Fortress addresses with the assistance of Neighbourhood Enforcement Teams (NETs) to patrol and attend as required.	March 2024	**March 2024** -TIPs established in force, commissioned by the Violence Reduction Unit for a proposed period of two years. -Officers and staff now receive trauma informed training through 'Rock Pool'. -In-force IDVA from Stop Domestic Abuse in place who can provide further advice and support. -New area model now embedded and designed to tackle district hotspots and priority offenders.

				-Officers from the High Harm Team (HHT) to be reallocated to PCTs and NETs so there is retained knowledge. PCTs to attend MARAC for their district and manage repeat, high risk domestic perpetrators. The new model allows for a holistic knowledge of individuals in the local area and a better informed picture of wider issues impacting on individuals. -Designated Neighbourhood Officers (DNOs) to be introduced. -PCSOs on NET to be specially trained in problem orientated policing approach to tackle the underlying issue and develop tailored responses to victims of crime.		-DA Learning Panel to assist in identifying district areas of concern. -PCT/NET officers being prioritised for DA matters training if not already completed. -PCT attendance at MARAC so actions can be assigned and completed quicker. - PCT officers/staff all trained as Domestic Abuse Champions. -DNOs assigned, specially trained in problem-orientated policing to identify district issues and tailor responses -Training packages for domestic abuse include impact of substance misuse and mental health on the victim and perpetrator.
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 health and social care agencies.	Local	Training to be rolled out to MASH coordinators regarding multiple care and support needs, vulnerability and sharing thresholds for ASC.	HIOWC	-Meeting with police MASH and ASC arranged for April 2024 to discuss PPN sharing thresholds -Mandatory training to be rolled out to all MASH coordinators on adults at risk. Emphasis will be placed on the need to share	April 2024	**April 2024** -Agreement with ASC that PPNs evidencing multiple care and support needs and to be shared with ASC MASH. -Training underway, this is rolling training to ensure all MASH

				PPNs with multiple agencies and not just consider the main presenting need. Training to include that some concerns routinely shared with the GP (mental health, substance misuse, medication concerns) may result from care and support needs and that these should also be shared with ASC		coordinators are trained, including new recruits and agency staff so there is no end date.
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.	Local	Resources highlighting how domestic abuse impacts on older adults to be added to the Domestic Abuse Hub resource page on the force intranet.	HIOWC	-Training to be updated to include specific risks to older adults -Consider amendment to 'officer observation' box on the PPN/DASH for age-specific risk questions -DA Champions to dip sample domestic abuse occurrences for older adults to identify areas for improvement and good practice via the Domestic Abuse Learning Panel.	March 2024	**March 2024** -The Constabulary now promote 'Hourglass' services to safeguard older adults. Hourglass run a webinar on older male victims of abuse that officers/staff can access -Domestic Abuse Lead to capture learning from this DHR to use as a case study in future domestic abuse training -Domestic Abuse Hub resources for officer and staff updated with links to support and resources for older adults
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	Local	Raise awareness of support and resources for male victims of domestic abuse to officers and staff.	HIOWC	-Amendments to be made to training -Learning from this DHR and the other three DHRs involving male victims in Hampshire and IOW to be shared at the PCC Homicide and Serious Violence Board	May 2024	**May 2024** -DA Champions have received training on male victims of domestic abuse. This included a visit from a male with lived experience.

increase officer and staff awareness of support for male victims of domestic abuse.				and the four local Safeguarding Adult Boards to promote wider agency awareness and understanding. -Update force intranet with current resources and support services for male victims of domestic abuse. -DA Champions to dip sample domestic abuse occurrences for male victims via the Domestic Abuse Learning panel to identify any additional learning in this area.		-Up2U delivered training to officers/staff on female perpetrators of domestic abuse in heterosexual relationships. -Training recorded and made available on the force intranet for all officers/staff to access -Domestic Abuse Lead to capture learning from this DHR and other DHRs with male victims to use as case studies in future domestic abuse training -Respect toolkit, helpline and national male victim's standards added to the DA Hub for officers/staff to access. -Domestic Abuse Champions made aware of new resources in May 2024 for male victims for immediate action
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	Local	Ensure all victims (male and female) receive the same level of support and response when reporting a serious sexual offence.	HIOWC	-SOIT officers (Sexual Offences Investigation Trained) make contact with all victims of rape and sexual offences by penetration within the forensic window.	June 2024	**June 2024** -Op Soteria knowledge hub in July 2023 for officers/staff to access best practice examples/guidance/force policy and procedure

SOITs in the Constabulary is sufficient in meeting demand.				-SOITs are solely based in Amberstone teams and so it is rare that one is not available to see a victim as they are protected from being pulled in another operational direction. -There are 29 SOITs in the Constabulary, 26 of these are female and 3 are male. North (this covers Test Valley): 8 SOITs, 7 female and 1 male East: 11 SOITs, 10 female and 1 male West: 10 SOITs, 9 female and 1 male -Victims are asked if they would prefer to see a male or female SOIT. All victims are referred to ISVA if the victim gives consent. -Op Soteria national operating model launched in July 2023 following Home Office funded research in to rape and serious sexual offences and the subsequent police investigation and response to victims. Hampshire and IOW Constabulary were an early adopter of the operating model in 2022		-In January 2024, the Constabulary launched a commitment to all victims of rape and serious sexual offences that their mobile phones would not be retained for more than 24 hours to aid victim's accessing their support network, personal information and ongoing support services -In March 2024, mandatory training was launched for all frontline officers in responding to rape and serious sexual offences. -55% increase in investigation outcomes in the last 12 months (January 2023-2024) compared to data from 2022-2023. -Amberstone investigation toolkit regularly updated with Op Soteria developments -OPCC victims hubs launched in February 2024 -Two way messaging service for victims

				(one of 14 forces), aligning the force priorities with the national operating model and the code of ethics. Op Soteria uses products to analyse the Constabulary response and generates a Constabulary specific improvement plan. -HIOWC to launch a 24/7 Support Line for victims of rape. This is a government-funded service operated by Rape Crisis England & Wales with specialist operators available on the phone or webchat providing information and emotion support and signposting to longer term services such as ISVAs. -Mandatory training on first response to rape and serious sexual offences being rolled out in March 2024. Phase 1 is intended for officers and staff and phase 2 will focus on district and neighbourhood policing teams.		launched in February 2024 -24/7 support line for victims of rape launched early 2024. -Assistant Chief Constable for Crime and Criminal Justice circulated a message in February 2024 reminding all officers and staff to use the Victim Contact Management module to manage and document victim's wishes and record changes such as a new OIC and review risk to the victim. -A final victim based working sheet is now on RMS to record victim's decisions and reasons for withdrawing support.
HIOW NHS Healthcare FT						

All staff from the involved CMHT, including long term agency staff, complete safeguarding adults level 3 training.	Local	Deliver Level 3 Adult Safeguarding training that includes domestic abuse relevant practice guidance.	HIOW NHS Healthcare FT	Ensure training includes - Identifying indicators of harm, abuse and neglect, - Law and policy requirements - Importance of 'Making Safeguarding person' - Information sharing, record keeping and other response - S42 requirements and MARM responses	March 2024	Completed Training learning outcomes cover required areas.
Improve practitioner responses to domestic abuse and safeguarding enquiries.	Local	Ensure meetings include focus on historic and current risk, safeguarding concerns, and domestic abuse, and document rationale behind decisions and who is responsible for actions. Improve awareness of responsibilities under care Act s42 enquiries. Embed DA position in frontline teams Increase awareness of routine enquiry responsibilities	HIOW NHS Healthcare FT	Review and improve meetings format and embed SBAR Tool into multi disciplinary meetings. Disseminate a communication briefing to promote awareness of Section 42 enquiries and responses required when they are received Scope possibility of embedding link role, and allocate resources to deliver.	February 2024 January 2025 April 2025	February 2024 meetings follow the SBAR framework. Covered in mandatory Level 3 Safeguarding Training for Adults and Children for the Trust. And covered in Local Trust Newsletter. Ongoing work in relation to embedding, sexual safety and DA champions in Trust teams.

				Embed DA questions into electronic patient records.	April 2025	Risk formulation training is ongoing around professional curiosity for example questions around socio-economics and family dynamics. **There is to be a pilot to be undertaken with Perinatal mental health team regarding routine enquiry, which is supported by public health Hampshire. This will inform System wide work with NHSE and led by the ICB, to embed routine enquiry into health contacts. HIOWH Trust are part of the task and finish and implementation group. The safeguarding support team is working closely with our mental health leads to support this workflow.**
		Deliver Level 3 Adult Safeguarding training		Deliver training	Ongoing	This training is now mandatory relevant to banding and being rolled out in phased stage

Test Valley Borough Council						
Improve housing engagement with domestic abuse MARACs to focus on actions that reduce risk and harm.	Local – Test Valley Borough Council specific	Routinely check the MARAC agendas and cross reference for names of people known to the Housing Service Ensure that an Officer attends the MARAC meetings in order to fully participate in multi-agency working and information sharing. Ensure Social Housing Providers are informed if a case comes to MARAC that is within their responsibility.	Test Valley Borough Council - Housing Service	Appointment of a Housing Options Domestic Abuse Officer. Their role will include responsibility for ensuring MARACs are attended and any actions are undertaken that reduce risk and harm. A requirement for this role is that the Officer is an IDVA.	July 2024	Completed Housing Options DA officer in post and attending the MARACs
Clarify the links between domestic abuse and community (anti-social behaviour) multi-agency partnerships to avoid confusion between both.	Local – Test Valley Borough Council specific	The TVBC Community Safety multi -agency meeting is currently referred to as the C-MARAC (Community MARAC) Work is underway to review this group which will involve a change of name and refresh of Terms of Reference. The Community Safety Team and Housing Options DA officer will ensure communication of cases known to overlap both groups to ensure joint working takes place.	Test Valley Borough Council Community & Leisure Service Community & Leisure Service	Change of name/terms of reference for the CMARAC Appointment of Housing Options Domestic Abuse Officer.	Sept 2024 July 2024	Completed Completed: Housing Options DA Officer in post and liaising with the Community Safety officers over CMARAC cases.

		The Housing Options Domestic Abuse Officer will be on the CMARAC distribution list.	Housing Service			
Improve information and awareness about domestic abuse amongst TVBC customers.	Local	Review what routine information about domestic abuse could be provided for customers. Update domestic abuse pages on the website to reflect support for male and female victims.	TVBC	Provide information for customers in various formats, for example, on receipts, leaflets, or bills. Update website content.	July 2025 April 2025	July 2025 Leaflets made available. Information will not be added to receipts or bills, at this time due to formatting issues Completed April 2025 (subject to annual review)
Ensure compliance with the Hampshire County Council Domestic Abuse Strategy and relevant housing specific domestic abuse policy and procedural guidelines.	Local – Test Valley Borough Council specific	Part of the role of the Housing Options Domestic Abuse Officer post will be to ensure that we adhere to the Hampshire County Council Domestic Abuse Strategy. Development of TVBC Domestic Abuse Housing Policy which will outline the procedures that staff must undertake when dealing with any case where domestic abuse is a factor.	Housing Service	Appointment of Housing Options Domestic Abuse Officer. Adoption of the TVBC Domestic Abuse Policy	July 2024 March 2025	Completed. Housing Options DA Officer in post. Completed March 2025: Working guidance on DA for officers produced and implemented.
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.	Local – Test Valley Borough Council specific	Housing staff to send information to the TVBC Safeguarding inbox when they have made a referral into either Children or Adult Services. The Safeguarding team will then check and cross	Housing Service Community & Leisure Service	Work undertaken by Housing Manager and Safeguarding lead to remind all Housing staff of the requirement to copy Safeguarding into any referrals for cross reference purposes.	January 2024	Completed Housing staff now ensure the safeguarding team are copied into referrals made.

		reference details for any other known concerns.				
Ensure staff are aware of the process for making safeguarding referrals, recording of safeguarding referral information and outcomes.	Local – Test Valley Borough Council specific	Clarify format for safeguarding referrals with AHC Whenever a referral for a safeguarding concern is made into Adult or Children's Services, the officer must record the referral number and any outcomes. Members of the Safeguarding team will ensure that this is made clear when supporting staff to make a safeguarding referral.	Community & Leisure Service Housing Service	Ensure referrals made to AHC are clearly designated as safeguarding referrals. Safeguarding team to ensure records made of safeguarding referral numbers. Safeguarding training to be updated to include targeted training for frontline staff and emphasis on the importance of record keeping for all referrals to HCC or others. Housing Manager to ensure all staff are aware that they must follow formal reporting procedures for safeguarding concerns into both AHC and Children's Services and record details. Bespoke safeguarding awareness delivered to Housing team focusing on the importance of following formal reporting procedures for safeguarding concerns.	May 2025	Completed July 2025 and subject to regular review Completed Safeguarding team brief 16/07/24 Completed Safeguarding training pack revised and included in staff induction for all housing staff. Completed Housing Team Refresher Training September 2024 Completed: Housing Team Refresher Training September 2024

Improve information sharing between TVBC Revenues & Welfare team and Housing Service with regards residents identified as vulnerable	Local – Test Valley Borough Council specific	A review of information sharing protocols will be undertaken and the provision of access to relevant IT systems to enable cross reference of cases.	Housing Service Revenues & Welfare Team	Assess the best practice method to share information and establish a mechanism to ensure this takes place	July 2025	Investigation on options underway.
Review training package, and incorporate additional or bespoke content, where needed, in relation to safeguarding, domestic abuse and multiple and complex needs.	Local – Test Valley Borough Council specific	The Housing Options Domestic Abuse Officer and Housing Manager will review existing staff training to ensure that there is a focus on safeguarding, domestic abuse and responding to multiple and complex needs. This will include training to undertake a DASSH risk assessment with the requirement for all cases where domestic abuse is identified to undertake this assessment.	Housing Service	Appointment of Housing Options Domestic Abuse Officer. Complete the review of required training. Act on the outcome of that review as appropriate.	July 2024 March 2025	Completed: Housing Options DA Officer in post. Completed: All officers offered training through HDAP plus bespoke internal training as required.
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.	Local – Test Valley Borough Council specific	Make improvements in line with DA statutory guidance including consideration to achieving DAHA accreditation for TVBC and partnership housing providers. (This should make use of the County's grant scheme for DAGA accreditation).	Housing Service	Appointment of Housing Options Domestic Abuse Officer. Consider DAHA accreditation. Implement new Consumer Standards in relation to domestic abuse and enable tenants to access appropriate support.	July 2024 December 2025	Completed: Housing Options DA Officer in post. Completed March 2025: Not pursuing DAHA accreditation at this time. Key principles have been applied to the working guidance on DA for officers.
Multi-agency recommendations ***Informed by Review learning, analysis, or discussion by Panel***						

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	Hampshire – regional	Agencies to audit their own delivery against Statutory Guidance. HDAP requests annual reporting to the Board against the standards, to be incorporated into the annual report around delivery of the Act.	Hampshire Domestic Abuse Partnership	Establish reporting system for relevant agencies. DA Board to review agency annual audit reports. Actions identified and implemented on organisational change improvements. Monitor training attendance and review impact of training on practice through organisational change / supervision processes. Ensure alignment between training and domestic abuse procedures/ protocols.	2025/26 annual reporting schedule	Partially completed. HDAP has completed an annual report around the delivery of the DA Act 2021 with named partner organisations. This report is shared with HDAP members and presented to the HDAP Board. The Hampshire VAWG Strategic Board no longer exists.
Strategic review of MARAC and HRDA 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.	Hampshire - regional	HCC Public Health facilitate meetings to progress MARAC review, with approach coordinated by Police. All relevant agencies contribute to strategic review. Improve agencies' contributions to MARAC, Ensure HRDA and MARAC processes effectively integrate with safeguarding	Public Health	Strategic review commenced, led by Public Health and Police Review actions are agreed and implemented.	September 2025	Completed and ongoing quarterly strategic Hampshire MARAC meetings chaired by Hampshire and Isle of Wight Constabulary with other statutory and commissioned organisation representatives attending. Also, Strategic MARAC update received by HDAP quarterly.

		enquiries, risks and issues being raised.				
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	Hampshire - regional	Increase awareness of and confidence in initiating a MARM by agencies responding to domestic abuse. Improve involvement of victim and family, where safe to do so, in the MARM process.	Hampshire Safeguarding Adults Board	Agencies in this review to embed MARM into policies. Undertake an audit of domestic abuse cases referred to the Adult Safeguarding Team to ensure that the MARM framework is considered for cases which do not meet the criteria for a S42 enquiry. Discuss with 4 LSABs the need to prioritise developing domestic abuse multi-agency safeguarding adults guidance, to accompany guidance for FGM, forced marriage and trafficking.	March 2026	Complete. June 26: MARM self-audit underway. Results will be considered via the Quality Assurance Subgroup with ongoing workstreams identified forming part of the subgroups workplan. Monitored via quarterly board reports. Audit of DA/MARM to be included in ongoing work following the audit providing a baseline position. 4LSAB-Multi-Agency-Domestic-Abuse-Guidance-January-2025.pdf now in place.
Review how services can better meet the circumstances of older men, including ensuring that policies and procedures do not dissuade or prevent older men from accessing help.	Hampshire - regional	Support providers should be supported to develop (where non exists) specific services and approaches for older men, including therapeutic and peer support. Ensure organisations supporting female and male domestic abuse victims are accredited to do so in accordance with the national Male Victims' Standard.	Public Health / Hampshire Domestic Abuse Partnership	Building on learning from existing domestic abuse therapeutic services for male victims, include targeted support for male victims, and pathways to Men's Advice Line and use of Male Victims Toolkit and Standards in future commissioning of domestic abuse services.	From next commissioning cycle 2025/26 onwards.	Completed. Commissioned Domestic Abuse Support Provider has a dedicated webpage for male victims and resources. Also dedicated resources for elder victims of domestic abuse. There is specialist support for male victims including

		All agencies using DASH risk assessment do so in parallel with Male Victims Toolkit, where relevant.				group work and access to safe accommodation. HDAP webpages include images of men and women of different ages and ethnicities. I need help for myself or someone else includes the Men's Advice Line, ManKind Initiative, Andy Man's Club. Men's Shed's and Mangang. Also Aurora New Dawn's Armed Forces Helpline number. Public Health webpages for mental wellbeing also have the 'Men's Mental Wellbeing Toolkit' and mental health support and specialist support information including Op Courage the NHS veterans mental health service and allied organisations supporting veterans. Male Victims Toolkit and Standards utilized by Stop Domestic Abuse.

Clarify and raise awareness of pathways to support between specialist veterans' services, domestic abuse and safeguarding responses.	Regional	HCC mapping of veterans services across Hampshire to include review of effectiveness of pathways to domestic abuse services and actions to improve effective joint working.	Hampshire Domestic Abuse Partnership and Public Health (HCC)	Map existing provision. Make recommendations for improvements in pathways to support for veterans. Raise awareness of Aurora New Dawn specialist domestic abuse services for veterans of the Armed Forces (national response, based in Hampshire).	March 2026	Partially completed. Veterans services have been mapped and domestic abuse services included in related online materials. Aurora New Dawn has presented to the HDAP Board and featured in the HDAP Bulletin and webpages around their specialist domestic abuse services. HDAP have also ensured that Aurora New Dawn's information is available on Connect to Support Hampshire and the Social Care Practice Manual. Stop Domestic Abuse is now also collating referral data into their services for veterans
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	Regional	Review training packages on domestic abuse and include economic abuse and links with suicide, if this is a gap. Develop training content to include economic abuse identification and response and improving skills and competency to identify and reduce risks of suicide or	Hampshire Domestic Abuse Partnership and Hampshire Safeguarding Adults Board	Map existing training provision. Make recommendations for improvements in training content. Promote trainig amongst agencies involved in this review, and monitor take-up.	March 2026	Complete: HDAP and HSAB are coordinating a range of multiagency training sessions as part of the annual HSAB training calendar. Signs and risks included in the 4LSAB-Multi-Agency-

amongst people impacted by domestic abuse.		self harm amongst people impacted by domestic abuse.				Domestic-Abuse-Guidance-January-2025.pdf Suicide, self-harm and financial abuse linked to DA is learning shared in HSAB led lunch and learn sessions and with the suicide prevention forum June 2026. New safeguarding concerns tool for practitioners recognises self harm and non-fatal suicide attempts as potential safeguarding risk: Safeguarding-Concerns-Multi-Agency-Tools-July-2025-FINAL.pdf
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.	Local	The quality and sign off of crime scene cleaning be reviewed by police in person, ensuring that the scene/ property will not be released back to family until evidence of the death has been cleaned. Police and housing providers visit to check no evidence of the murder	HIOW Police / Aster and TVBC	Review crime scene completion policies to maximise trauma informed practice after cleaning the scene and to support family to re-enter.	March 2026	Complete April 2025

		remains at scene before families re-enter. An accompanied visit is offered to family members for support, and referral to debrief support from a recognised agency is made for family, to minimize emotional distress from being at the scene. The cost of crime scene cleaning is not pursued from the family of the victim, by the landlord.		Referrals are made to recognised agencies that support family of victims of domestic abuse related deaths (e.g. AAFDA, SAMM) Review housing provider policies to exempt families of victims of domestic homicide being pursued for rental or other charges associated with the death.		Complete April 2025 Complete
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.	National	Chair write to the Ministry of Defence and Home Office highlighting the changes the family call for, alongside this review.	Chair / Secretariat	Liaise with TVBC and HSAB manager to draft letter. Send letter to UK Government (MOD / HO).	June 2025	Completed: Sent September 2026

Panel 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.	National	Chair write to DAHA and Home Office highlighting the changes the family call for, alongside this review.	Chair / Secretariat	Liaise with TVBC and HSAB manager to draft letter. Send letter to DAHA.	June 2025	Completed: Sent September 2026
Panel 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.	National	Chair write to CoP, NPCC, DAHA and Home Office highlighting the changes the family call for, alongside this review.	Chair / Secretariat	Liaise with TVBC and HSAB manager to draft letter. Send letter.	June 2025	Completed: Sent September 2026

Home Office

Interpersonal Abuse Unit 2
Marsham Street London

SW1P 4DF

Tel: 020 7035 4848

www.homeoffice.gov.uk

Dave Growcott
Community Manager
Test Valley Borough Council
Beech Hurst
Weyhill Road
Andover
SP10 3AJ

24th February 2026

Dear Dave,

Thank you for submitting the Domestic Homicide Review (DHR) report (Max) for Test Valley Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Board. The report was considered at the QA Board meeting on 14th January 2026. I apologise for the delay in responding to you.

Please find the QA Board's feedback in the form below. On completion of the changes suggested the DHR may be published.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter and the feedback form is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Board letter and feedback form should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Board, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Board

DHR QA Board Feedback for the Community Safety Partnership

TITLE OF DHR	Max
COMMUNITY SAFETY PARTNERSHIP	Test Valley
DATE REVIEWED BY QA BOARD	14th January 2026
DECISION	Publish with amendments
GOOD PRACTICE COMMENDED	• The review shows a strong and effective use of expert input throughout. • There is a powerful pen portrait from Max's children and his wife, from whom he had been separated. Their tributes are highly impactful, offering a rich and personal insight into Max as a father, husband, grandfather and individual. • Condolences were offered to Max's family and friends, along with thanks for their contribution to the DHR process. • The dissemination plan is clearly set out, including specific publication details. • The terms of reference are well developed. • Equality and diversity considerations have been addressed thoroughly and appropriately. • The jointly commissioned DHR/SAR represents a positive and well-judged approach. • In addition, the appendices include a helpful summary table outlining agency training and policies. • The action plan is very detailed, with many actions already completed. • There is good reference to previous DHRs with similar circumstances.
FEEDBACK FOR FUTURE DHRs	

	DHR SECTION	**DHR QA BOARD FEEDBACK (improvements required before publication)**
1	Title Page	No amendments necessary.
2	Contents Page	No amendments necessary.
3	Pen Portrait	No amendments necessary.
4	Condolences	No amendments necessary.

5	Confidentiality and Anonymity	No amendments necessary.
6	Terms of Reference	No amendments necessary.
7	Equality and Diversity	No amendments necessary.
8	Background Information	No amendments necessary.
9	Combined Chronology	No amendments necessary.
10	Overview	No amendments necessary.
11	Analysis	No amendments necessary.
12	Conclusions	No amendments necessary.
13	Lessons learnt and recommendations	No amendments necessary.
14	Timescales	No amendments necessary.
15	Involvement of family / friends / community	No amendments necessary.
16	DHR contributors	No amendments necessary.
17	DHR Panel	No amendments necessary.
18	DHR Author	There is no reference to training the author has undertaken in relation to completing DHRs, which would be helpful to reference.
19	Parallel Reviews	No amendments necessary.
20	Dissemination	Please confirm whether Max's family has been consulted regarding key dates to avoid around publication, and whether any support will be required for them during this period.

21	Action Plan	No amendments necessary.
22	Has there been a request to withhold publication? *If Yes, include the reason for the request. Is it proportionate and appropriate?*	No request to withhold publication.
23	Any other comments	• Introduction: please clarify that Section 8 of the Victims and Prisoners Act 2024 has not yet come into force. • Please proofread the report prior to publication to correct minor typos.