DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Into the death of
Claire in October 2023

Independent Chair and Author
Michelle Baird MBA, BA

Report Completed: 27 August 2024

CONTENTS

1. THE REVIEW PROCESS

1.1 This summary outlines the process undertaken by the Safer Stronger North Somerset and Safer Somerset Partnerships, in reviewing the death of Claire who was a resident in an area in North Somerset.

1.2 To protect the identity of the deceased, perpetrator, family and friends, pseudonyms have been used throughout this report.

- Claire - (Deceased)
- James - (Perpetrator)
- Sam - (Claire's first child)
- Robin - (Claire's second child)
- Jordan - (Claire's third child)
- Drew - Claire's fourth child)
- Pat - (Claire's best friend and work colleague)
- Alex - (Claire and James' friend)
- Dale - (Claire and James' friend)
- Riley - (Claire's Manager)

1.3 Claire aged 61 years of age at the time of her death, lived with her adult child Jordan and died at James' home address in an area in Somerset. James at the time of Claire's death (now deceased) was 70 years of age. Both Claire and James were white British nationals.

1.4 The process began with an initial meeting of the Community Safety Partnerships on 02 April 2024, that the homicide would be the subject of a Domestic Homicide Review held jointly between North Somerset and Somerset Councils due to the cross-border element of this case.

1.5 Five of the fourteen agencies contacted confirmed contact with Claire and James and were asked to secure their files.

2. CONTRIBUTORS TO THE REVIEW

2.1 Whilst there is a statutory duty on bodies including the Police, Local Authority, Probation, and health bodies to engage in a Domestic Homicide Review, other organisations can voluntarily participate; in this case the following agencies were contacted by the Review:

- **Avon and Somerset Police:** This Police Force had relevant contact with James, and an Individual Management Review (IMR) was completed. A Senior Member of this Force is a Panel Member.

- **Next Link Domestic Abuse Support Service (North Somerset):** This domestic abuse support service had no relevant contacts relating to Claire or James. However, a recommendation has been put forward by a Senior Member of this Charity who is a Panel Member.

- **NHS Bristol (North Somerset & South Gloucestershire ICB on behalf of GPs):** This organisation had minimal contact with Claire. A Senior Member of this organisation is a Panel Member and an IMR was completed.

- **NHS Somerset Integrated Care Board (ICB) on behalf of GPs:** This organisation had minimal contact with James. A report has been provided to the Review.

- **North Somerset Public Health:** Although this organisation had no contact with Claire or James, a recommendation has been made by the Panel Member.

- **Probation Service (Taunton):** This Service had relevant contact with James, no contact was had with Claire. A Senior Member of this Service is a Panel Member and an IMR was completed.

- **South Western Ambulance Service NHS Foundation Trust (SWAST):** This service had contact with Claire on one occasion, this was on the day of Claire's death. A summary of their attendance was provided for the Review.

- **University Hospitals Bristol & Weston NHS Foundation Trust (UHBW):** This organisation had no contact with Claire or James. A Senior Member of organisation is a Panel Member.

- **With You:** This service had no previous involvement Claire or James. A Senior Member of the Trust is a Panel Member.

2.2 The following agencies were contacted and reported having no contact with Claire or James:

Alliance Homes, AWP Mental Health, Curo Housing, Mankind and Somerset and Avon Rape and Sexual Abuse Support.

3. REVIEW PANEL

3.1 The Domestic Homicide Review Panel consists of Senior Officers from statutory and non-statutory agencies who are able to identify lessons learned and to commit their agencies to setting and implementing action plans to address those lessons. All Panel Members were independent of any direct involvement with or supervision of services involved in this case. Membership of the Panel:

Michelle Baird	Independent Chair
Hannah Gray	Domestic Abuse & VAWG Lead - North Somerset Council
Suzanne Harris	Senior Commissioning Officer Interpersonal Violence - Somerset Council
Kate Blakley	Sexual Health Commissioning Manager /Mental Wellbeing and Community Development Manager - North Somerset Public Health

Louise Catlin	Detective Chief Inspector - Avon and Somerset Police
Leena Analyse	Safeguarding Adults Operational Lead Nurse - University Hospitals Bristol and Weston NHS Foundation Trust.
Lally Mergler	North Somerset Service Manager - Next Link Domestic Abuse Support Service (North Somerset)
Gill Flanaghan	Head of Service - With You North Somerset
Lucy Austin	Deputy Designated Nurse for all Age Safeguarding - NHS Bristol, North Somerset & South Gloucestershire ICB
Ashley Fussell	Head of Somerset Probation Delivery Unit (PDU)

3.2 After an initial pre-meeting on 15 April 2024, the DHR Panel met formally four times via 'Teams'.

- 04 June 2024
- 16 July 2024
- 30 July 2024
- 27 August 2024

4. CHAIR AND AUTHOR OF THE REVIEW

4.1 The Independent Chair and Author of this Domestic Homicide Review is a legally qualified Independent Chair of Statutory Reviews. She has no connection with the Safer Stronger North Somerset/Safer Somerset Partnerships and is independent of all the agencies involved in the Review. She has had no previous dealings with Claire or James.

4.2 Her qualifications include 3 Degrees - Business Management, Labour Law and Mental Health and Wellbeing. She has held positions of Directorship within companies and trained a number of Managers, Supervisors and Employees within charitable and corporate environments on Domestic Abuse, Coercive Control, Self-Harm, Suicide Risk, Strangulation and Suffocation, Mental Health and Bereavement. She has a diploma in Criminology, Cognitive Behavioural Therapy and Emotional Freedom Techniques (EFT).

4.3 She has completed the Homicide Timeline Training (five modules) run by Professor Jane Monckton-Smith of the University of Gloucestershire.

4.4 In June 2022, she attended a 2 day training course on the Introduction to the new offence, Strangulation and Suffocation for England and Wales with the Training Institute on Strangulation Prevention. She has also attended a number of online courses provided by the Institute for Addressing Strangulation (IFAS).

5. TERMS OF REFERENCE (As set out at commencement of the Review)

5.1 This Domestic Homicide Review, which is committed within the spirit of the Equality Act 2010, to an ethos of fairness, equality, openness, and transparency will be conducted in a thorough, accurate and meticulous

manner in accordance with the relevant statutory guidance for the conduct of Domestic Homicide Reviews.

5.2 **Statutory Guidance states the purpose of the Review is to:**

- Establish what lessons are to be learned from the Domestic Homicide Review regarding the way in which local professionals and organisations work individually and together to safeguard victims.

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

- Apply these lessons to service responses including changes to policies and procedures as appropriate.

- Prevent domestic violence and homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.

- To seek to establish whether the events leading to the homicide could have been predicted or prevented.

5.3 **Specific Terms of Reference for this Review:**

- Consider the period from September 2022 and the date of Claire's death in October 2023, subject to any significant information emerging that prompts a review of any earlier or subsequent incidents or events relating to domestic abuse, violence, substance abuse or mental health.

- Seek the involvement of the family, employers, neighbours and friends to provide a robust analysis of the events, taking account of the criminal justice proceedings in terms of timing and contact with the family.

- Aim to produce a report within 6 months of the Domestic Homicide Review being commissioned which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and make any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

- Consider how (and if knowledge of) all forms of domestic abuse (including whether familial abuse) are understood by the local community at large – including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.

- To discover if all relevant civil or criminal interventions were considered and/or used.

- Determine if there were any barriers Claire or her family/friends faced in both reporting domestic abuse and accessing services. This should also be explored Against the Equality Act 2010's protected characteristics.

- Examine the events leading up to the incident, including a chronology of the events in question.

- Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults.

- Identify how interventions designed to manage perpetrators were implemented (including registered sex offenders), and the impact this had on Claire.

- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.

- Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.

- Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of the family in decision making and how this was done and if thresholds for intervention were appropriately set and correctly applied in this case.

- Whether practices by all agencies were sensitive to the gender, age, disability, ethnic, cultural, linguistic and religious identity of both the individuals who are subjects of the review and whether any additional needs on the part of either were explored, shared appropriately and recorded.

- Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively (including the COVID pandemic).

6. SUMMARY CHRONOLOGY

6.1 The synopsis of the case has been informed by information provided by family, friends, a work colleague and chronologies of the contact agencies had with Claire and James.

6.2 Claire was born and grew up in an area in Somerset. She had been in two previous relationships prior to meeting James and has four children from these relationships, two children from each.

6.3 During the timeframe of the Review, contact with statutory agencies and Lisa was minimal, the only contact arising from her GP practice which was on seven occasions. There were no records of domestic abuse recorded,

therefore the Review relied on information provided by family, friends and work colleagues.

6.4 James, a Registered Sex Offender was well known to Police and Probation Service. He was convicted in 2000, of offences that took place between 1986 and 1999. He drugged and sexually assaulted 4 victims over this period, all of them being adult females who he was in a relationship with. His relationships seemed to overlap, whereby he had already met the next victim as his current relationship was ending. James received a life sentence and was released from prison in 2013 on life licence. On release, he moved into approved premises in the Cheshire area.

6.5 James moved to the Somerset area in September 2020 and was managed jointly by Avon and Somerset Police and the local Probation Service. He was assessed as posing a medium risk of harm towards intimate female partners.

6.7 In September 2020, James met Alex and Dale at a local pub. As James was new to the area, they invited James to a Christmas dinner (December 2020), during which he spoke openly about his relationships with women on dating sites. Alex and Dale witnessed James trawling through his two phones that he used for dating sites.

6.8 During Police and Probation visits, James constantly denied being in intimate relationships and accessing dating sites. Officers reported that there were never any signs of anyone living with James or evidence of female belongings at the property.

6.9 In March 2021, James was issued with a Senior Probation Officer final warning for not disclosing that he had met a female via a dating site and a second final warning was issued to him in September 2021 for deleting internet history on his phone.

6.10 In April 2022, a MOSOVO (Management of Sexual or Violent Offenders) Officer installed ESAFE, (software that monitors internet usage and highlights sexualised text messages) on James' phone. James informed the Officer that he had no further devices. The Officer was unable to search James' property as Police remain subject to s.17 powers of entry and have no general powers to search a property.

6.11 During visits by Probation and MOSOVO Officers, James' phone was checked and there were no signs of history being deleted, or James accessing pornography. The Officers stated that it appeared that James' phone was often dormant, and this lack of phone use was considered to be possibly generational.

6.12 Claire and James met on a dating site, they chatted online a few times before meeting each other in person on 02 September 2022. Initially friends, their relationship began in April 2023. They were in a relationship for 6 months prior to Claire's death.

6.13 On 05 January 2023, Claire attended a nurse appointment for blood pressure and lifestyle review, Claire reported problems sleeping linked to shift work. Her alcohol consumption was reported to be 32 units/week (national guidance is no more than 14 units per week maximum). Claire's compliance with blood pressure medication was suboptimal. The following was documented: *'Working long shifts. Eating pattern all over the place. Also, drinking Vodka to help sleep when coming off night shifts. We discussed needing to change jobs as not sustainable. Feels tired all the time, eating junk food, drinking alcohol to help sleeping pattern".*

6.14 Towards the end of April 2023, James introduced Claire to Alex and Dale. According to Alex and Dale, James was seeing a number of women whilst in a relationship with Claire, two of whom he introduced to Alex and Dale at the pub.

6.15 On 15 May 2023, Claire requested a medical review for a leg injury, as she was concerned about the excessive bruising. She was seen the same day by a GP who diagnosed cellulitis (skin infection) and prescribed antibiotics. The mechanism of injury was reported by Claire and documented by the GP: *Fell off a kerb forward and her left knee bumped the ground, has a graze on her knee. Bruising developed over left anterior lower leg. Moving knee okay, taking over the counter co-codamol as needed for bruising but feels bruising has increased rather than improving".*

6.16 On 12 September 2023, during a nurse appointment for a diabetes review, Claire requested a supporting letter to assist in changing her shift patterns to reduce cycling between days and nights. It was felt her current shift pattern was detrimental to her health, her diet and sleep. A supporting letter was written by the nurse which Claire collected from reception the following day.

6.17 In October 2023 (5 days prior to Claire's death), Claire disclosed to Pat that she was going to end her relationship with James as she had met someone else. Pat had advised Claire to do this via text message, but Claire insisted breaking it off in person. Claire went further to say that her and Pat had a lot of catching up to do, but sadly this did not happen.

6.18 On an evening in October 2023, Claire and James went out to a pub to watch the rugby, they had some drinks and then returned to James' flat. In the early hours of the next morning, James got out of bed, Claire was asleep on the living room floor and could be heard snoring loudly. Some 3 hours later, James got out of bed again to go to the bathroom, this time, Claire had stopped snoring which prompted James to rouse her but was unable to get a response from her. James called 999 at 03:17 for the Ambulance Service to attend. During the call, James was instructed by the call handler to perform CPR on Claire.

The Ambulance Service arrived at James' address at 03:27, Paramedics continued CPR with drug therapy. Police were called as they were attending to Claire who was unresponsive. Upon Police Officers arriving at the scene, Claire was laying on the floor in the living room and James was sat on

a chair. On Police Officers speaking to the Paramedics, there was indication that Claire had taken 10 NYTOL sleeping tablets and had been drinking, there were also Viagra tablets at the scene. Claire was pronounced deceased at the scene at 04:05 hours.

Officers spoke to James to get his account of what had taken place, (recorded in para. 6.21).

Officers observed James' behaviour to be very anxious and he seemed on edge, pacing the lounge floor. James explained they had popped the blister pack of the NYTOL tablets and placed them in a container prior to going out for the rugby, and when they got home Claire took them. An Officer asked James if he had taken any and he said, *"No but it's something we do because I like watching Claire sleep".*

An Officer ran a Police National Computer (PNC) check and found that it was of particular concern that James has a conviction history for administering drugs to obtain intercourse with females.

Rationale for Arrest

6.19 James now a suspect, is believed to have administered an illicit substance to Claire to allow him to carry out voyeuristic acts on her whilst she was stupefied. He had a history of this type of behaviour and the circumstances surrounding the discovery, appeared upon further investigative review to be suspicious.

6.20 James had also breached his notification requirements, by not informing Probation and his Police Offender Manager about his new relationship with Claire as he is a registered sex offender (RSO).

6.21 The following day, when an attempt to arrest James on suspicion of murder was made, it was discovered that he had fled to a location yet to be identified and had left his mobile phone behind at his address. A prison recall was issued for the breach and a manhunt was underway for the arrest of James on suspicion of Claire's murder. In April 2024, six months after Claire's death, James was found deceased by a member of the public who informed Avon and Somerset Police.

6.22 As part of the DHR, the Review Chair was able to make contact with Claire's family and friends, who were able to give an insight into the abuse perpetrated against Claire by James. Below is a brief summary as to what was disclosed, further information can be found in paragraph 16 of the Overview Report.

6.23 Sam and Jordan informed the Review that Claire had never discussed her relationship with James, or the abuse she endured. Jordan did however, witness bruising on Claire on one occasion, this was after Claire had stayed overnight at James' flat. Information known to the family came to their attention post Claire's death from friends, work colleagues and information found on Claire's mobile phone.

6.24 Claire confided to Pat about her relationship with James and the abuse she endured. She spoke to Pat about James' interest into bondage, discipline/dominance and sadomasochism (BDSM), and how he liked to tie Claire up, handcuff her and would perform sex with Claire which she was always extremely uncomfortable with.

6.25 Alex and Dale described the relationship between Claire and James as controlling. They had witnessed James' behaviour towards Claire, his relationships with other women whilst in a relationship with Claire and described James as a narcissist and sexual predator.

6.26 Riley had witnessed bruising on Claire on returning to work after calling in sick. Initially informing Riley that the bruising was caused by a fall, Claire subsequently disclosed the abuse she endured.

7. KEY ISSUES AND CONCLUSIONS

7.1 The Review Panel has formed the following key issues and conclusions after considering all of the evidence presented in the reports from those agencies that had contact with Claire and James.

7.2 A key issue in this DHR is that Claire's contact with agencies was found to be minimal. There was no contact with any agencies relating to domestic abuse prior to her death, and as a result the Review Panel has not been able to look at the specific issue of how local professionals and organisation worked individually and together to safeguard Claire in this case. It has focused instead on identifying the lessons to be learned more broadly, and has applied these lessons to service responses, including considering any changes to policies and procedures where that may be appropriate. This is in keeping with the purposes of DHRs, which include: preventing domestic violence and homicide and improving service responses by developing a coordinated multi-agency approach to ensure earlier identification and improved response, as well as contributing to a better understanding of the nature of this issue. Where relevant, the Review Panel has also sought to identify good practice.

7.3 Conversations with family, friends and colleagues revealed a pattern of behaviour by James towards Claire of coercion and control. This was characterised by his interest in bondage, discipline/dominance and sadomasochism (BDSM), the monitoring of her movements, the changes made to Claire's appearance and James drugging and physically/sexually assaulting her.

7.4 It was acknowledged by the Review Panel that this Review highlights the importance of professional curiosity. Enquiries should have been conducted relating to Claire's mental health, alcohol and drug use given her history of depression and alcohol dependency.

7.5 The Review acknowledged that James displayed disguised compliance. James was in possession of a second mobile phone which he had hidden from Police and Probation Service. This would explain the mobile phone

known to Police and Probation being dormant at times when checked by his MOSOVO Officer. It has however, been noted by the Review, that Police working with a managed offender remain subject to s.17 powers of entry and had no general powers to search their property.

7.6 Whilst there are lessons to be learnt and recommendations regarding the management of this case, the Police and Probation managed James' licence conditions in line with policy and agency guidelines. It was not possible for a coordinated response to be made by agencies regarding Claire, as it was not known that she was in a relationship with James who purposely concealed it. Had the relationship been known, this would have led to enforcement action being taken, which might have included recall.

7.7 It was acknowledged by the Review, the vital role that friends and associates can play in providing information and insights about relationships being reviewed. This is especially so in circumstances when agency involvement is limited, as it was in this case.

7.8 Claire's death was tragic, and James' death has meant that the criminal justice process was unable to run its course, and those affected by Claire's death have been denied the opportunity to obtain justice.

8. LESSONS LEARNED

8.1 The following summarises the lessons agencies have drawn from this Review. The recommendations made to address these lessons are set out in the Action Plan template in Annexure A of this report.

Avon and Somerset Police

8.2 When MOSOVO Officers checked James' mobile phone, it was often found to be dormant, and the lack of phone use was considered by the Officers to be possibly generational. Unconscious bias was displayed due to James' age.

8.3 Disguised compliance was displayed by James by not disclosing to MOSOVO Officers that he was in possession of a second mobile phone which he used to access dating website.

8.4 There were no specific actions for Police within James' Risk Management Plan. MOSOVO and Probation to review the viability of joint training in risk assessment.

NHS Bristol, North Somerset & South Gloucestershire ICB

8.5 There was no record of domestic abuse at the time Claire registered with the GP practice, or directed questioning relating to domestic abuse ever undertaken.

8.6 There were missed opportunities to explore Claire's alcohol intake further when she reported excessive alcohol intake and stress/sleep disturbance in

January 2023, and in May 2023 when she reported falling from a curb and injuring her leg.

8.7 There was no evidence of Claire's mental health or drug use/misuse being discussed, despite a previous history of depression and alcohol dependence.

North Somerset Community Safety Partnership / Safer Somerset Community Safety Partnership

8.8 Information and advice on domestic abuse should be widely available and easily accessed online for all residents in the area.

8.9 Local awareness-raising re online dating in later life/internet safety.

8.10 DBS checks should be carried out on individuals who are voted, elected or volunteer as representatives on housing association and property management board limited companies within privately owned/rented accommodation.

North Somerset Public Health

8.11 Domestic Abuse toolkit for workplaces to be included in the North Somerset Healthy Workplaces Accreditation Scheme.

Probation Services - Taunton

8.12 Whilst Probation had an awareness that James' visible compliance may have been false, management of the case would have benefitted from more formal conversations/reflections about James' compliance (in conjunction with Police). This may have led to the relationship with Claire being discovered.

9. RECOMMENDATIONS

9.1 The Domestic Homicide Review Panel's recommendations and up to date action plan at the time of concluding the Review is set out in Appendix A.

ANNEXURE A - ACTION PLAN

Avon and Somerset Police

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome
MOSOVO to review requirement for regular refresher training in the MOSOVO National Policing Curriculum, in particular training focused on disguised compliance and manipulation by offenders.	Force Wide	MOSOVO National Policing Curriculum Refresher training requirement to be reviewed and frequency of refresher training to be determined Review refresher training materials/modules to ensure a focus on disguised compliance and manipulation by managed offenders Deliver refresher trained delivered according to agreed schedule	ASP		December 2024 December 2024 In line with training cycle	
Force to review the provision for regular training in unconscious bias for MOSOVO.	Force Wide	Offender Manager training plans to be reviewed for inclusion of cyclical intentional training in unconscious bias. Training content to be developed if required. Frequency of training within training plan to be agreed. Deliver training as required by training schedule.	ASP		December 2024 In line with training cycle	

MOSOVO and Probation to review the viability of joint training in risk assessment.	Force Wide	MOSOVO and Probation to review viability of initiating joint training. Training plan and materials to be agreed if appropriate Training to be delivered	ASP / Probation		End October 2024 In line with training plan	

National Recommendation

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome
Home Office to put forward a recommendation to the Ministry of Housing Communities and Local Government for owner/tenant boards within private/rented accommodation to conduct appropriate checks on members who are voted, elected or volunteer as representatives on housing boards.	National	DBS checks should be carried out on individuals who are voted, elected or volunteer as representatives on housing association and property management board limited companies within privately owned/rented accommodation.				

Next Link Domestic Abuse Support Service (North Somerset)

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome
All partner agencies who are made aware of domestic abuse should have the information to offer to Next Link.	Across BNSSG	Consider reaching out to agencies with referral pathways.	Next Link		December 2024	

NHS Bristol, North Somerset & South Gloucestershire ICB

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome
Review of new registration process / forms used to consider inclusion of safeguarding screening questions.	Across BNSSG	Consider meeting with GPCB about this, to influence rewriting of registration forms	BNSSG / GPCB	Including safeguarding screening question in GP registration form.	December 2024	
Further training of primary care staff on risk factors for victims of domestic abuse, and indicators of abuse.	Across BNSSG	Training session delivery via Lunch+Learn session, Level 3 training session, Link GP meetings.	BNSSG	Promoting use of ‘routine inquiry’ so all staff (incl. nurses) feel able to ask direct question about domestic abuse during medical appointments where relevant.	December 2024	

North Somerset Community Safety Partnership / Safer Somerset Community Safety Partnership

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome
Information and advice on domestic abuse should be widely available and easily accessed online for all residents in the area.	Local	Refresh of the NS Friends & Family DA Guide for the Safer Stronger North Somerset website. Updated area on Safer Stronger North Somerset and Somerset Domestic Abuse websites to include section for friends and family and information on Clare's Law disclosure scheme.	North Somerset & Safer Somerset CSPs	SSNS and Somerset Domestic Abuse websites has been updated to include the new content, currently being finalised by the web development team for re-launch end of July 2024. Review	October 2024	
Local awareness-raising re online dating in later life/internet safety.	Local I	Comms & social media campaign highlighting online dating safety targeting those aged 40+.	North Somerset & Safer Somerset CSPs	SSNS and Safer Somerset Partnership to plan joint awareness raising plan Both CSPs to launch awareness raising campaign across both North Somerset and Somerset areas.	TBC	We would like this to coincide with publication of the DHR should the family be in agreement.

North Somerset Public Health

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome
Domestic Abuse toolkit for workplaces to be included in the North Somerset Healthy Workplaces Accreditation Scheme.	Local	Inclusion of the toolkit to the co-ordinator of the healthy workplaces scheme.	NSC Public Health	Suggestion has been made to the lead on this programme of work and agreement been made to look at including during the review of criteria in July 2024.	July 2024	

Probation Service - Taunton

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome
Head of Services for Somerset Probation to ensure that Probation Practitioners within Somerset undertake relevant training/briefings relating to ‘disguised compliance’.	Local	Set up training days to ensure Practitioners have sufficient knowledge and awareness of disguised compliance.	Probation		December 2024	