Content warning: over 18s only

The following document contains material of a highly sensitive nature (including references to death, violence, and abuse) and may be upsetting for some individuals.

Reigate & Banstead
Borough Council
Banstead | Horley | Redhill | Reigate

Reigate & Banstead
Community Safety Partnership

Domestic Homicide Review
Executive Summary

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

Review into the death of Oliver
in Autumn 2019

Report Author: Christine Graham
September 2022

Preface

Reigate & Banstead Community Safety Partnership and the Review Panel wish at the outset to express their deepest sympathy to Oliver's family and friends. This review has been undertaken in order that lessons can be learned.

This review has been undertaken in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of Oliver's death in a meaningful way and address, with candour, the issues that it has raised.

The review was commissioned by Reigate & Banstead Community Safety Partnership on receiving notification of the death of Oliver in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

Contents

Preface	2
The Review Process	4
Contributors to the Review	5
The Review Panel Members	5
The Independent Chair and Overview Author	6
Terms of Reference	7
Summary Chronology	7
Key issues and lessons identified	11
Conclusions	13
Recommendations	14

1. The Review process

1.1 This summary outlines the process undertaken by the Reigate & Banstead Community Safety Partnership ('the CSP') domestic homicide review panel in reviewing the death of Oliver who was a resident within their area prior to his death in the autumn of 2019.

1.2 The following pseudonym's have been used in this review for the victim, perpetrator and others as set out below, to protect their identity and those of their families:

- The deceased in this case will be known as 'Oliver'. He was a white British man who was only 31 years old at the time of his death.
- His partner of the time will be known as 'Louise'.
- The couple had been in a relationship since January 2018 and lived together in the Surrey area.

1.3 At just before 2am on an autumn night in 2019, the police were called to a local town centre after a member of the public had found aman, Oliver, hanging from a nearby structure. He was recovered with the assistance of the fire brigade but was deceased at the scene. Oliver did not leave a note or provide any indication as to what led him to end his life. The day before had been his birthday and he had spent it at a relative's christening, without Louise.

1.4 Having viewed the CCTV available, the police concluded that there were no suspicious circumstances, and a file was prepared for the coroner. Subsequently, following an approach from Oliver's mother and sister, a police investigation was launched into an allegation that Oliver may have been a victim of controlling and coercive behaviour. Louise was interviewed as part of this investigation, but the police were unable to find sufficient evidence that they felt reached the evidential standard of proof for criminal proceedings, and no charges were brought.

1.5 An inquest followed in the summer of 2021. HM Coroner recorded a finding, on the balance of probability, that Oliver died by way of suicide. Oliver's sister and mother feel that the coroner dismissed available evidence to show that Oliver was a subject of abuse.

1.6 It is within this context that this review is set.

1.7 The process of this review began in December 2019 when Surrey Police were contacted by AAFDA[1], who were supporting Oliver's mother and sister. They requested that the circumstances of his death be considered for a Domestic Homicide Review. In response to this contact, Surrey Police informed Reigate & Banstead Community Safety Partnership: a meeting to discuss the case was held on 6th February 2020. A Preliminary DHR Steering Group was held on 3rd March 2020 and partners were updated on the police investigation. Following this meeting, the Chair agreed that a full Domestic Homicide Review would be held and that an Independent Chair and Report Author would be appointed.

1.8 All local agencies were scoped for prior contact with the victim. Only three agencies were found to have had relevant prior contact. Those agencies secured what files were available to them.

[1] Advocacy After Fatal Domestic Abuse

2. Contributors to the Review

2.1 Three agencies contributed to the Review by way of IMR. They were:

- The Metropolitan Police (previous call-outs to the couple)
- Surrey Police (previous call-out)
- Oliver's GP

2.2 The independence of the IMR authors was confirmed through the review process.

2.3 The Chair and Author were made aware that Oliver had self-referred to substance misuse services, provided by Catalyst. Their involvement was limited, but information was provided by them.

2.4 The Review also learned Oliver and Louise attended relationship counselling. The counsellor was contacted but review was unable to use any information that the counsellor held, due to her insurers saying a court order would be required.

2.5 Specialist support to the review was provided by:

- ESDAS – local domestic abuse service who provided independent advice to the panel
- Mankind Initiative – national charity supporting male victims of domestic abuse, who provided specialist support to the panel

2.6 The Review was assisted by Oliver's sister and mother who were supported by AAFDA and engaged throughout the process.

2.7 A number of Oliver's friends, including an ex-partner, assisted the review by way of interview by the Chair and Author.

2.8 Approaches were made to engage Louise with the Review, but she declined to assist. The Review respects that position.

3. The Review Panel Members

3.1 The members of the original Review Panel were:

- Gary Goose, Independent Chair
- Christine Graham, Independent Report Author
- Andrew Pope, Statutory Review Lead (Surrey Police)
- Ross Spanton, Community Safety Officer (Reigate & Banstead Borough Council)
- Marilyn Selwood, Service Associate (Mankind Initiative)
- Marino Labour, Designated Safeguarding Adults Professional (South West London Clinical Commissioning Group)
- Helen Rendell, Specialist Crime Review Group (Metropolitan Police Service)
- Name not provided to maintain confidentiality, Business Manager (Oliver's GP practice)
- Michelle Blunsom, Chief Executive Officer (ESDAS)

3.2 All members of the panel and IMR authors were independent of direct involvement with either Oliver or Louise.

3.3 Oliver's sister and mother were offered, at their first meeting with the Chair and Report Author, the opportunity to meet the review panel. At this point, they did not feel the need to do this as they felt that a meeting would be more meaningful once they had had time to consider the contents of the draft report. However, later in the process, they requested the opportunity to do this. This process, and resulting discussion with them, resulted in appropriate amendments to the report.

4. Domestic Homicide Review Chair and Overview Report Author

4.1 Gary Goose served with Cambridgeshire Constabulary rising to the rank of Detective Chief Inspector: his policing career concluded in 2011. During this time, as well as leading high-profile investigations, Gary led the police response to the families of the Soham murder victims. From 2011, Gary was employed by Peterborough City Council as Head of Community Safety and latterly as Assistant Director for Community Services. The city's domestic abuse support services were amongst the area of Gary's responsibility, as well as substance misuse and housing services. Gary concluded his employment with the local authority in October 2016. Thereafter he has been self-employed as a safeguarding review independent chair.

4.2 Christine Graham worked for the Safer Peterborough Partnership for 13 years, managing all aspects of community safety, including domestic abuse services. During this time, Christine's specific area of expertise was partnership working – facilitating the partnership work within Peterborough. Since setting up her own company, Christine has worked with a number of organisations and partnerships to review their practices and policies in relation to community safety and anti-social behaviour. As well as delivering training in relation to tackling anti-social behaviour, Christine has worked with a number of organisations to review their approach to community safety. Christine served for seven years as a Lay Advisor to Cambridgeshire and Peterborough MAPPA, which involved her in observing and auditing Level 2 and 3 meetings as well as engagement in Serious Case Reviews. Christine chairs her local Safer off the Streets Partnership.

4.3 Gary and Christine have completed, or are currently engaged upon, a number of Domestic Homicide Reviews across the country in the capacity of Chair and Overview Author. Previous Domestic Homicide Reviews have included a variety of different scenarios: male victims; suicide; murder/suicide; familial domestic homicide; a number which involve mental ill health on the part of the offender and/or victim; and reviews involving foreign nationals. In several reviews, they have developed good working relationships with parallel investigations/inquiries, such as those undertaken by the IOPC, NHS England, and Adult Care Reviews.

4.4 Neither Gary Goose nor Christine Graham are associated with any of the agencies involved in the review nor have, at any point in the past, been associated with any of the agencies.[2]

[2] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (para 36), Home Office, Dec 2016

4.5 Both Christine and Gary have completed the Home Office online training on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing overview reports, as well as DHR Chair Training (Two days), provided by AAFDA (Advocacy After Fatal Domestic Abuse). Details of ongoing professional development are available in Appendix Two.

5. Terms of reference

5.1 The full terms of reference are set out within the overview report, however, specifically, this review sets out to:

5.2 Explore the specific nature of suicide, and what can be learned from this case to protect others in the future

5.3 Explore any specific barriers for male victims of coercion and control that may prevent them from seeking support.

6. Summary chronology

6.1 This section summarises the information known. Full details are contained within the overview report.

6.2 Oliver was only 31 years old when he died. He had spent several years abroad after meeting a woman, who was to go on to be his fiancé, whilst they were travelling on gap years. They travelled through Europe and North America for almost a year before settling in Australia, where her family was living.

6.3 Oliver and his fiancé began building a life together in Australia. After initially living in Queensland, they then moved to Sydney. Oliver had embarked upon business enterprises whilst in Australia.

6.4 Unfortunately, in 2017 the relationship ended. In the December of that year, Oliver returned to the UK to visit his family for Christmas. He intended to return to Australia, back to his life and business, in the New Year. In January 2018, Oliver met Louise in a bar. They very quickly decided, within days of meeting, that Oliver would stay in England: living in her flat rent-free, as the relationship progressed. The couple initially lived in London.

6.5 By the March of that year, there were problems within the relationship that are known to the review: the police first became involved in April 2018 when Louise called the MPS stating that during an argument, Oliver had smashed her mobile phone. The police attended and spoke to both Oliver and Louise. The couple had been drinking with friends and both agreed that they had argued about Louise sending photographs of herself to other men. Louise told the police that Oliver had grabbed her phone and threw it across the room, smashing it. He then apologised and asked to repair the phone. Oliver agreed to leave and stay with a friend for the night. Neither had any injuries nor wished to substantiate any allegations. A DASH risk assessment was completed with Louise, and the risk was assessed as standard. As Louise did not wish to engage with officers, she was not given details of any support services: the case was closed with no further action taken.

6.6 It is clear that from that time on the relationship was in difficulty. The review has revealed that Oliver was saying to friends that Louise was 'crazy' and that he did not want to be in the relationship. Louise equally was saying that Oliver had a drink problem and didn't know how to deal with it. Despite this, the couple stayed together.

6.7 The toxicology undertaken after Oliver's death, suggested that he had consumed some alcohol and cocaine prior to this death. The Forensic Toxicologist noted that, whilst the use of substances has been linked to instances of self-harm, it was not possible to provide specific comments on the exact effects that alcohol or cocaine, either alone or in combination, may have had on Oliver (or his state of mind) at the time of death.

6.8 Louise called MPS again in July to report Oliver as missing. She reported that they had exchanged text messages that morning and she had told Oliver that she wanted to end the relationship. Oliver told her that he wasn't going home and would be sleeping in the park. Louise said that he had done this previously when she had asked him to leave. She stated that he had been drinking and that she was worried about him.

6.9 The MPS updated their records the following day to show that Oliver returned home on 24th July.

6.10 In August, Oliver messaged a friend, saying: 'in (London) with [Louise], working things through nicely'. The friend said that things seemed fine from August through to March 2019 but that this was an assumption gathered from their text conversations.

6.11 At the Christmas of 2018, Oliver told a friend, that he was unhappy with the financial arrangement about the house and felt pressured into purchasing a house with Louise. He also spoke to his brother-in-law about an occasion when he had held Louise at arm's length because she was trying to attack him and that she had smashed his laptop.

6.12 In January 2019, Oliver messaged another friend, and told him: 'Not trying to worry you but if I end up dead, it's Louise'. His friend replied with a 'shock' emoji.

6.13 Around the same time, Oliver's ex-fiancée says she noticed a change in Oliver's personality. She said that he started apologising in emails and suggested that he had ruined their relationship. He made comments like, 'sorry for what I put you through', which she found confusing – given there was nothing untoward that he had done while they were dating.

6.14 Louise called MPS again in January 2019 stating that she and Oliver were arguing. Police attended and spoke to both. Officers noted that the couple had consumed alcohol. Louise told officers that her father owned the flat but that they were planning to buy a house together. Neither had any injuries nor wished to substantiate any allegations. Oliver agreed to leave and stay with a friend overnight. A DASH risk assessment was completed with Louise, and the risk was assessed as standard. A subsequent letter was sent to Louise with details of Victim Support, but they were unable to contact her. The case was closed with no further action.

6.15 In her police interview after his death, when the police were investigating the allegation of coercive and controlling behaviour, Louise said that Oliver had been physically violent towards her on 27th January.

6.16 Louise called MPS again, two days later, stating that Oliver was drunk and trying to gain access to the flat. The police attended and spoke to both Oliver and Louise. Louise told officers that the couple had been out during the afternoon, and they had argued about the amount of alcohol that he had consumed. Oliver told the police that he just wanted to go into the flat to collect his belongings. The officers returned his belongings and he agreed to leave and stay with a friend. Neither had any injuries nor wished to substantiate allegations. A DASH risk assessment was completed with Louise and was assessed as medium – based on it being the third reported incident during the previous 12 months.[3]

6.17 On 1st February, it was planned that the case should be referred to the local MARAC. The case was not heard. This will be commented upon later within the report.

6.18 On 2nd February, Oliver called Surrey Police to report that Louise had walked off from her parents' home, where they were staying, after being abusive to him. He said that she was very drunk and was not responding to his calls to her. He said that she had tried to assault him by grabbing his arm (digging her nails in) when he tried to prevent her from leaving. He said that this had caused no injury and he did not want to make anything of it. He said that he had called the police as he was concerned about her. Louise was found by police at a nearby public house. She was very intoxicated. At the same time, the police arrived at the parents' address. It was established that Oliver had an address in London, and he agreed to return there so Louise could be brought home and the situation would not escalate. He was taken by the police to the station where he caught a train to London. A DASH risk assessment was completed with Oliver and recorded as standard. A crime report was generated in respect of the allegation of common assault: this was immediately filed as Oliver was not supportive of any further police action.

6.19 On 9th March, Oliver messaged a friend to say that he had left Louise. This was followed by other messages during March to friends indicating that he was 'trying to leave'. Oliver also asked to borrow money from one of his close friends, a move that unusual for him.

6.20 Despite the above, in April, Louise and Oliver completed the purchase of the house they were to live in together. Oliver sent a photo of himself and Louise to a friend, telling him about the house.

6.21 In her police interview after his death, Louise told the police that alcohol made Oliver aggressive. She said that in July, he had slammed a door into her hand after she came home and found him intoxicated and the house covered in beer cans. She said that she could no longer trust him and that he had trashed the previous flat. He spent that night with a friend and then went to stay with his family. Louise considered that the relationship was over and told him as much. She left possessions for him to collect. She said that she then gave him another chance but that his drinking continued, despite having therapy sessions.

6.22 Oliver had told his ex-fiancée (in an email on 20th June) that he was going to Spain in July. He said that he thought it would be clear, by the time they came back, if the relationship was going to work. This review is unable to establish whether in fact they went to Spain.

6.23 In July, Oliver contacted Reach Out Counselling, provided by Catalyst. He had an assessment when he said that he would like to get support in identifying the triggers that he felt made him drink, so that he could get to the point that he would only drink socially. Following this assessment, Catalyst was not able to contact Oliver and so he was not seen by a counsellor.

[3] The review notes that if the report to the police, in July, of Oliver being missing after an argument was counted, this was the fourth call.

6.24 Also in July, Oliver cancelled a meeting with a work partner, as he was heading back to Wales (to see family). Amongst the text exchange Oliver said "I know it's been shit from me I just need to get out that horrible, fucking abusive situation. Everything will speed up now. I can't even put it into words how it's been".

6.25 Later in July, Oliver was staying with his sister and told her that he had separated from Louise and was very upset. He was focused on the fact that the relationship was over. He was planning to go back to Surrey and collect his property and then return to an area known to the review.

6.26 The next day Oliver was in London and messaged his sister. He told her about physical abuse. He sent her photos of injuries that he said had been caused at the beginning of the relationship. He said: 'abuse from when I met her. Whipped me with a phone cord'. His sister asked how often she did this and he said: 'enough but always my fault. That's what I've been told. I've had to share. There has been so much for so long'. He then spoke to his sister on the phone and was very upset. He said that there had been multiple occasions when her aggression had turned to physical violence. When his sister asked what prompted this, he said that it could be anything, including if her cup of tea was too cold. He said that he had bought her a kettle for the bedroom, to encourage her to make her own tea. He said that she was volatile and would react to anything. He said that he would leave if she had not already thrown him out – he was scared and knew it would always turn physical. He often stayed with friends, in hotels or slept outside. He said that he had to leave suddenly one night as he had knocked her with his arm whilst they were sleeping. She reacted violently and he said that he had to get up and leave the situation.

6.27 In August, Oliver messaged a friend saying: 'all of this is coming to a point and today/last night has been horrendous. 1pm tomorrow I am getting my things tomorrow to draw a line. Sorry but my brain cannot focus on any work right now. I am really sorry, but it will be done by Saturday. Struggling a bit so just need a day or so to sort all this mentally'. Later, Oliver told a friend that he had attended SMART[4] meetings. At a later date, he said that he was staying with Louise again.

6.28 A few days before his death, Oliver asked another friend, to lend him money: he said that he was in need of £40,000-£50,000. He said that he had to pay a loan back to someone but did not say to whom – this is, however, the balance of the money he owed to Louise's father, in relation to the house.

6.29 In August, Oliver and Louise celebrated his birthday with her family.

6.30 1st September was Oliver's birthday and his nephew's christening in another part of the country. He travelled by train. Oliver attended the christening. He and his family were expecting him to stay longer than the day as he had taken clothes for a few days and had purchased an open-ended ticket. During the day, after an ongoing argument between Oliver and Louise over text, he changed his plans and returned home because Louise had indicated that she had planned a special meal. Oliver's sister said that Louise was unhappy about Oliver's plans to attend the Christening.

6.31 Oliver is known to have got off the train at Reading to go for a drink with a man he met on the train. He then continued his journey, getting off the train in a town in Surrey. Louise is

[4] SMART meetings are support groups facilitated by Catalyst Substance Misuse Services.

alleged to have told people that there were text conversations between them during this journey: this review has been unable to confirm that assertion, despite interviews with numerous friends of Oliver. Louise has not engaged with the review and Oliver's mobile phone has not been accessed to provide evidence of what these conversations might have added.

6.32 Oliver's final movements were captured on CCTV. He was seen to walk to the riverfront where he took his life. During those last few minutes, he was seen to be actively interacting with his mobile phone. The context of that activity remains unknown.

7. Key issues arising from this Review and lessons identified

7.1 This Review has identified a number of key issues that it has sought to explore, identify lessons that can be learned and make recommendations that will help keep others safer in the future.

7.2 From a process perspective, this Review only began when the circumstances were brought to the attention of the police by an advocate supporting the family. Prior to that referral, the police had not considered that this case met the criteria for a DHR. Local learning has been put in place to ensure that the CSP are made aware of all cases that may meet the criteria as set out within the statutory guidance, including cases of suspected suicide.

7.3 The Review has sought to identify any trail of abuse that existed within the relationship between Oliver and Louise. It seems apparent that Oliver realised that he was being subjected to abuse. His conversations with friends and some members of his family make this abundantly clear. The fact that he was planning to leave the relationship, and had made attempts to do so previously is further evidence that he knew he needed to get away. Above all else, the fact that he photographed what he described as his injuries and sent them to his sister is a significant indicator of his need to let others know.

7.4 What we also know is that Oliver did not report the abuse to anyone outside of his family, albeit he did call the police when the couple were arguing, as did Louise. Neither, however, would provide any evidence or information of substance once that initial call was responded to.

7.5 We have sought to understand why Oliver felt unable to report the abuse, and if fact, exit the relationship for good. To that end, this review has sought specialist advice about male victims of abuse and sadly, Oliver seems to fall within the stereotype for men when it comes to abuse of perhaps feeling ashamed of being a victim, conflicting emotions of 'love' for his partner and perhaps feelings of failing in the relationship. All of these notions need to be dispelled and this review can help dispel those myths. The review thus makes a number of recommendations relating to support for male victims and awareness amongst professionals that anyone can be a victim of domestic abuse, irrespective of gender, size, age or status.

7.6 The Review examined the role that services played when they were called by the couple. The Metropolitan Police were called three times within a year and whilst on each occasion they were met largely with a couple who had been verbally arguing, and who declined to take the matter further, they did recognise that the repeat calls should have led to a MARAC referral. Whilst all their records show that this was intended, there is an unexplained failure for the case ever to be heard. Despite all of their research and that of this review the

reasons for that cannot be ascertained. The MARAC system has changed since that time and the Review is assured that the checks and balances now in place indicate that a repeat is extremely unlikely.

7.7 The Review has then looked at Surrey police's response to a call made only four days after the last call to the MPS. Whilst the response to the call by the attending officers was appropriate, the fact is that they knew nothing about the previous calls to the MPS. The fact that officers still work in isolation and ignorance of such relevant information from a neighbouring police area shows just how lacking the police's information systems are. The Police National Database, brought in after the Soham murders, is now nearly 20 years old and this review asks the Home Office to assess whether it is still fit for purpose.

7.8 Oliver's sister and mother challenged the standard of the police investigation following their complaints of abusive behaviour by Louise towards Oliver that they made after his death. Their 'victims right to review' was examined and the police accepted that they could have investigated other areas to support the case, however they were sure that even if those areas had been examined it would have been unlikely to have resulted in a prosecution.

7.9 This Review has had the opportunity to examine that investigation through the lens of the specialist domestic homicide review panel. The panel was concerned that there did appear to be a lack of recognition that Oliver could have been a victim and an attitude that 'coercive and controlling behaviour has to have consequences to prove evidence'. This review would suggest that there was evidence that show that Oliver's state of mind was affected by abuse before he took his life.

7.10 Oliver's sister and mother argued that the inquest into this case await the outcome of the DHR. HM Coroner declined that request and declined to include evidence of abuse on that basis that she felt 'the relationship contributed, not more than minimally, to Oliver's death'.

7.11 The evidence that this review has been able to attain and the specialist lens through which it is viewed would suggest that the relationship may well have contributed more than minimally to Oliver's state of mind at the time he took his life. There continues to be a lack of clear guidance to HM Coroners and DHR Chairs/CSP's about the interconnection between the processes of inquest and DHR's. This leads to an inconsistent approach across the country which is not helpful to anyone. This review makes recommendations to the Home Office seeking clear guidance be published for everyone's benefit.

8. Conclusions

8.1 This review has looked to see what lessons can be learned from the tragic death of a much-loved son, brother, and friend to many.

8.2 There is unequivocable evidence that Oliver took his own life, on his birthday. An inquest into his death recorded a finding of suicide. What drove him to that decision has been the focus of this review.

8.3 Oliver was a man with his life stretching ahead of him. On the face of it, he enjoyed life. However, it has become clear that he was involved in a difficult relationship with his girlfriend of the time. There had been several calls to the police by both parties in the months leading up to his death. No prosecutions arose from those calls: each of which, amounted to arguments fuelled by drink.

8.4 What has emerged since Oliver's death is evidence of injuries that he recorded on his own mobile phone, including facial injuries and marks across his back. These had not been previously reported and the fact that Oliver went to the trouble of recording the injuries, is evidence itself of the fact that he knew what was happening to him was wrong.

8.5 The police have since investigated these, alongside allegations of controlling and coercive behaviour (made by some members of Oliver's family) against his girlfriend of the time. Those investigations have not resulted in prosecutions.

8.6 There are indications that there remains an inequality in the way in which male victims are treated by staff who encounter them. We believe that more positive action may have been taken by attending police, had the allegations been made by his girlfriend.

8.7 It is clear that Oliver was using his mobile telephone in the minutes prior to his death but the police have been unable to interrogate it for messages that may have illuminated us to his thinking at the time.

8.8 Whilst this review may not be able to shine a full light on Oliver's thinking that day, we are confident that the recommendations we have made will help secure a safer future for others who may be suffering in a similar way.

Recommendations

Home Office

That the Home Office should provide clear guidance on the interaction between inquests and safeguarding reviews to ensure that the interaction and communication is clear, consistent, and fully informed.

That the Home Office assesses whether the PND is still fit for purpose – 20 years after it was conceived.

That the Home Office revisits the positioning of domestic abuse and coercive control experienced by men, in order that it is understood in its own context and not in conflict with abuse experienced by women.

Surrey Police

That male victims of domestic abuse are provided with the details of specific services tailored for male victims or their local commissioned integrated services that support males.

That all officers are reminded that a proactive response to domestic abuse should be taken, regardless of whether the victim is male or female.

Reigate & Banstead Borough Council

That awareness is raised with the officers from Reigate & Banstead Borough Council about the suicide prevention work in Surrey so that they can champion this.

Reigate & Banstead Community Safety Partnership

That Reigate & Banstead Community Safety Partnership writes to the British Association of Counselling and Psychotherapy, of whom the counsellor was an accredited member, and asks them to review their competency framework and training in order to assure themselves that accredited counsellors raise the awareness and possibility, with clients, that domestic abuse may be prevalent in why they are seeking counselling, and to have a solid understanding of domestic abuse, particularly coercion and control.

That this report is shared with the office of the Mayor of London in order that this learning can be considered.

That agencies within the local area review their messaging to male victims of domestic abuse, considering these observations.

That the Community Safety Partnership provides guidance for friends and family of those men experiencing domestic abuse and initiates a publicity campaign to give the message that ‘men can be victims too’.

East Surrey Domestic Abuse Service

That East Surrey Domestic Abuse Service (ESDAS) includes on its website, information for family and friends of those experiencing domestic abuse, both men and women.

Public Health England

That domestic abuse is included as a specific priority within the sixth annual progress report of the National Suicide Prevention Strategy[5] (due in 2022).

GP surgery

That the GP surgery provides information in the surgery, specifically targeted at male victims of domestic abuse.

Commissioners in Surrey

That commissioners in Surrey encourage the providers of substance misuse services to review their training, with a view to including sessions on recognising domestic abuse, particularly coercion and control, and how victims may use alcohol to cope.

[5] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf