DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

Into the death of

Kelly in February 2015

Report Author

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CONTENTS

Preface

The Norfolk County Community Safety Partnership Review Panel would like to express their sincere condolences to the family members and friends of Kelly whose unexpected death has brought about this Review. She is greatly missed by her family.

The independent chair and author would like to thank those who have made contributions to this Review, for the assistance of the Norfolk Coroner's office, and to express her appreciation for the time and thoughtful contributions made by members of the Review Panel.

The key purpose for undertaking a Domestic Homicide Review (DHR) is to enable lessons to be learnt where there may be links with domestic abuse. In order for these lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. The victim's death met the criteria for conducting a Domestic Homicide Review according to Statutory Guidance[1] under Section 9 (3) (1) of the Domestic Violence, Crime, and Victims Act 2004, states that there should be a "review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

> (a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
> (b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death".

The Home Office defines domestic violence as:

> *Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial, and emotional.*
>
> *Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim*

This definition, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

The term domestic abuse will be used throughout this Review as it reflects the range of behaviours encapsulated within the above definition, and avoids the inclination to view domestic abuse in terms of physical assault only.

[1] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Revised August 2013) Section 2(5)(1)

THE REVIEW OVERVIEW REPORT

1. Introduction

1.1 This report of an unexpected death examines agency responses and support given to a resident of Norfolk prior to the point of her death in February 2015. It is important to note that Kelly's death was not due to homicide. However as there had been contact with the Police in relation to domestic abuse in the months before her death, in line with legislation; it has been decided to examine agency contact and involvement with Kelly. The scope of the Review is from 2010 when the first notification of domestic abuse was made to the Police up to her death.

1.2 The incident leading up to this Review began early one morning in February 2015 when Kelly telephoned the Police on 999 threatening to take her own life. Officers were despatched immediately. On arrival officers had to break into the property where they found Kelly. Attempts were made at the scene by officers and paramedics to save her life and she was transferred to hospital where she died 3 days later.

Timescales

1.3 The Chair of the Norfolk County Community Safety Partnership received notification from the Police concerning the unexpected death on 5 June 2015. There was a delay in referring to the Partnership as the circumstances were not immediately linked with domestic abuse. Following discussion between the Police and the local authority area in which Kelly lived a reassessment of the circumstances surrounding the fatal event identified that Kelly had previously been in contact with the Police in connection with incidents of domestic abuse as a consequence the death was referred to the Partnership as possibly meeting the circumstances which may require a Domestic Homicide Review. The Chair and Partnership members met on 25 June 2015 when the decision was taken that the circumstances did meet the requirements to undertake a Review. The Home Office was informed on 28 July 2015. The Review commenced with a first Panel meeting on 17 September and was concluded on 22 April 2016. It was not possible to complete the Review as required within 6 months due to difficulties in obtaining key agency information.

Confidentiality

1.4 The findings of this Review are confidential. Information is available only to participating officers/professionals and their line managers until the Review has been approved by the Home Office Quality Assurance Panel for publication.

1.5 To protect the identity of Kelly, her partner, and their families the following pseudonyms have been used throughout this report:

1.6 The deceased: Kelly aged 31 years at the time of her death. Kelly was of white British ethnicity.

1.7 Her former fiancé: Paul aged 32 years at the time of Kelly's death. Paul is of white British ethnicity.

Dissemination

1.8 Chair and Members of Norfolk's Community Safety Partnership
Chief Constable, Norfolk Constabulary
Norfolk Police & Crime Commissioner
Chief Officer of the relevant Local Authority Area
Chief Officer, Norfolk and Suffolk NHS Foundation Trust
Community Services Manager, Leeway Domestic Violence & Abuse Service
Chief Officer of the relevant Clinical Commissioning Group
Chair of the Norfolk Health & Wellbeing Board
Norfolk Domestic Abuse & Sexual Violence Board
Independent Chair, Norfolk Safeguarding Adults Board
Chief Officer, Norfolk Victim Support
GP Practice for Kelly
Chief Officer, Norfolk Recovery Partnership
NHS England

Summary

1.9 It is believed that Kelly's relationship with Paul began approximately 8 years ago. The first report of domestic abuse was made to the Police in 2010, and between September 2013 and December 2014 there were 4 domestic abuse incidents involving the couple. Their relationship was volatile and there was mutual violence often involving alcohol or illegal substances.

1.10 In January 2015 an incident took place in the street between Kelly and Paul which was reported to the Police by a neighbour. As on previous occasions Kelly did not support any Police action; she also refused the option of moving to a refuge or having an alarm installed at the address, although she did allow officers to make welfare visits and accepted a referral to the Independent Domestic Violence Advocacy (IDVA) Service.

1.11 Kelly's case was referred and heard at the Multi-Agency Risk Assessment Conference (MARAC) in January 2015 and the Police gained a Domestic Violence Prevention Order at the Magistrates Court on 15 January 2015. This ordered Paul not to contact Kelly for 21 days. The Independent Domestic Violence Advocacy Service made contact with Kelly on one occasion, but this was unable to be sustained as Kelly did not answer her phone.

1.12 Kelly saw GP practice nurses on 3 occasions in January the first of which was 4 days after the last domestic abuse incident. She reported being unable to cope. Kelly reported longstanding problems with alcohol which she thought exacerbated feelings of anger towards her partner, and also with recreational drugs. She was prescribed anti-depressants and referred to the mental health Wellbeing Service and signposted to a drug and alcohol agency. The Wellbeing Service was unable to make telephone contact with Kelly. Kelly denied being suicidal at these medical appointments.

1.13 Kelly contacted the Police via a 999 call in the very early morning at the beginning of February 2015. She was threatening to take her own life. Officers rushed to her property and on breaking in found Kelly with a ligature around her neck. Medical services were called and officers made efforts to save her life until they arrived. Kelly was taken to hospital where she died 3 days later. Enquiries revealed that Paul had been seen in the company of Kelly the day before the fatal incident. This was in breach of the Domestic Violence Prevention Order.

1.14 **Terms of Reference for the Review**
Statutory Guidance (Section 2) states the purpose of the Review is to:

- Establish what lessons are to be learned from the unexpected death 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; and
- Prevent deaths linked to domestic abuse and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.

This Review is not an inquiry into how the victim died or who is culpable. That is a matter for the coroner.

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

1) To examine the events occurring during Kelly's relationship with her former partner from 2010 when the first notification of domestic abuse was made to the Police, and her death in February 2015. Agencies with information relevant to Kelly before 2010 are to provide a chronology and summary of that information.

2) To determine as far as is possible if there is evidence to suggest that Kelly's unexpected death was in any way connected to her being a victim of domestic abuse.

3) To establish what contact agencies had with Kelly and;

a. what assessments had been undertaken
b. what treatment plans or support services were provided
c. whether plans or services were appropriate and in line with procedures and best practice.

4) Were appropriate risk assessments undertaken and acted upon both in respect of Kelly's mental ill-health, as a victim of domestic abuse, or in respect of any other vulnerabilities?

5) Was communication and information sharing between agencies or within agencies adequate and timely and in line with policies and procedures?

6) Did agencies in contact with Kelly have knowledge that she was a victim of domestic abuse, ask about domestic abuse as part of assessments, and how did this impact on the support she received?

7) What training had those practitioners in contact with Kelly received on domestic abuse, risk assessment and referral to MARAC and specialist support services, and do their agencies have appropriate domestic abuse policies and pathways in place to support their practitioners?

8) Are there any systems or ways of operating that can be improved to prevent such loss of life in future, and were there any resource issues which affected agencies ability to provide services in line with best practice?

9) Over the period of time covered by this Review two criteria applied for assessing an adults' vulnerability. Up to March 2015 a 'vulnerable adult' was defined by the Department of Health 'No Secrets' guidance as:

> *"An adult (a person aged 18 years or over) who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or serious exploitation." No Secrets, Department of Health 2000*

Under the Care Act 2014 which was enacted in April 2015 the term 'an adult at risk' was adopted. An 'adult at risk' is considered in need of safeguarding services if she/he:

> *(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.*

Was Kelly assessed or could she have been assessed as a 'vulnerable adult' pre 31 March 2015 or an 'adult at risk' post 1 April 2015? If not were the circumstances such that consideration should have been given to this risk assessment?

10) To examine whether there were any barriers which prevented Kelly from seeking or accepting help in respect of experiencing domestic abuse, her health needs, or any other relevant support services. Are there lessons to be learnt from the identification of any barriers which could assist agencies in adapting their procedures and processes which could alleviate or break down these barriers in future?

11) The chair will aim to make contact with family members and to keep them informed of the Review and its outcome.

Methodology

1.16 Following the decision to hold this Review 13 agencies were contacted to establish whether they had knowledge of Kelly. A total of 6 agencies confirmed contact and were asked to secure their files and to provide a chronology of their contact in the first instance. From individual chronologies a combined narrative chronology was written. Individual Management Reviews (IMRs) were requested from 5 agencies and additional information was supplied by the Housing Department of the relevant Local Authority via their Panel member. A check was made of a neighbouring Local Authority Housing Department to see if Kelly had made an application for housing, but this was negative. The GP practice provided copies of information provided to the Coroner and answered a number of questions via email, but declined to do an IMR as there was no one independent to undertake this task. Given the practice's contact with Kelly shortly before her death an interview was requested with her doctor. The chair and a Health representative on the Panel were subsequently offered an appointment to see her GP at the practice at the end of February 2016. This interview provided helpful context which addressed a number of issues arising from the submitted chronology and information, and also informed recommendations arising from the Review.

1.17 The Panel found the IMRs submitted were generally of a good quality, although some needed follow-up for additional information. The Panel conducted its deliberations openly and thoughtfully; there was helpful inter-agency debate around Domestic Violence Prevention Orders and the role of Housing in particular which resulted in early learning during the Review.

1.18 The chair wrote to Kelly's family members including the Home Office leaflet explaining the Review process and the reason why a Domestic Homicide Review was being undertaking although no homicide had taken place. Kelly's parents felt unable to contribute, but nominated one of Kelly's siblings to be the point of contact for the family. The terms of reference were shared and helpful additional information was provided for the Review by Kelly's sibling. The Review is grateful for their comments on the final draft of the report which resulted in further amendments. A copy of the report is to be provided to Kelly's family member once the report has been passed by the Home Office, but before publication.

1.19 A letter and Home Office leaflet was sent to Kelly's former fiancé inviting his contribution to the Review. No response was received to this invitation. In acknowledgement of data protection legislation this Review has only included information about Paul which is already in the public domain i.e. from the Coroner's Inquest or court proceedings. Information from the Police in regard to domestic abuse incidents involving Kelly and Paul are from Kelly's data.

1.20 Telephone contact was made with one of Kelly's friends and an appointment made for a telephone interview. However, at the arranged time the contributor could not be contacted, and subsequent texts received no reply.

Contributors to the Review

1.21 The following agencies who have contributed to this Review and the nature of their contribution is shown below:

- Norfolk & Suffolk NHS Foundation Trust including Mental Health Liaison Team and Improved Access to Psychological Therapies - chronology & Individual Management Review (IMR)
- Norfolk & Suffolk Recovery Partnership - chronology & IMR
- Norfolk Police - chronology & IMR
- Norfolk & Norwich University Hospital Trust - chronology & IMR
- Local Authority Housing Department - chronology & information
- GP Practice - chronology and information

Review Panel Members

1.22 The following were members of the Review Panel:

Ian Sturgess, Domestic Abuse & Sexual Violence Coordinator, Office of the Police & Crime Commissioner Norfolk
Margaret Hill, Community Services Manager, Leeway
Michael Lozano, Patient Safety Lead, NSFT
Det. Supt. Julie Wvendth, Norfolk Constabulary
Sandra Flanagan, Norwich MIND (first Panel meeting only)
Howard Stanley, Adult Safeguarding Nurse, Norfolk & Waveney Clinical Commissioning Groups

Jodie Cunnington-Brock, Housing Manager, Circle Housing
John Morrison, NHS England
Walter Lloyd-Smith, Adult Safeguarding Board Manager, Norfolk County Council
Helen Frayer, Senior Service Delivery Manager, Victim Support
Steph Butcher, Public Health, Norfolk County Council (first Panel meeting only)
Emma McKay, Director of Nursing, Norfolk & Norwich University Hospital Trust
Jon Shalom, Community Safety Coordinator, Norfolk County Council
Dawn Jessett, Community Safety Administration & Panel minutes
Gaynor Mears, Independent Chair and Report Writer

Author of the DHR Overview Report:

1.23 The author of this DHR Overview Report is independent DHR chair and consultant Gaynor Mears OBE. The author holds a Masters Degree in Professional Child Care Practice (Child Protection) and an Advanced Award in Social Work in addition to a Diploma in Social Work qualification. The author has extensive experience of working in the domestic abuse field both in practice and strategically, including roles at county and regional levels. Gaynor Mears has undertaken a number of Domestic Homicide Reviews, and research and evaluations into domestic violence services and best practice. She has experience of working in crime reduction with Community Safety Partnerships, and across a wide variety of agencies and partnerships. Gaynor Mears is independent of, and has no connection with, any agencies in the county of Norfolk.

Parallel Reviews

1.24 A Coroner's Inquest was held in the summer of 2015 where an open verdict was recorded. The Coroner said that there was no doubt that Kelly took her own life, but that he could not be certain that she intended to do so. It was the Coroner's view that it was likely that, having called the Police, Kelly had been intending to be found and was using the call as a cry for help. The Coroner found that she had been trying to get help from her GP to be rehoused away from her partner, but she had not wished to move back with her parents. However, enquiries for this Review found neither Kelly's Local Authority area nor a neighbouring Authority has any record of her enquiring about housing.

The cause of Kelly's death was given as (a) Hypostic brain injury and (b) Hanging.

2. The Facts

2.1 Kelly lived in a village in Norfolk where she shared a rented property with her fiancé Paul. They had been in a relationship for approximately 8 years. Paul held the tenancy for the property from a local Housing Association and they were the only occupants. It was in this property that Kelly took actions which led to her unexpected death.

2.2 The events leading up to Kelly's death which have resulted in this Review are that at 05:59 hrs in February 2015 she telephoned the Police saying that she had a knife, but she was going to hang herself. Kelly's details were already on the system due to contacts with the Police regarding a number of calls related to domestic abuse the last of which had resulted in a referral to MARAC and the 'flagging' of her address. Officers were despatched to her address and arrived at 06:16 hrs; they had to use force to enter the property where they found Kelly with a ligature around her neck. Officers immediately released her from the ligature

and commenced CPR. This was continued by paramedics when they arrived at the scene. Kelly was taken to the Norfolk and Norwich Hospital, but she did not regain consciousness and sadly she died 3 days later.

3. Chronology

Background Information:

3. 1 In his statement for the Coroner's Inquest Kelly's father reported that she was born in Norfolk and she left school aged 15 years without academic qualifications. Kelly was the youngest child in the family. She had several jobs in the following years, before working for approximately 4 years at a branch of a national supermarket chain until sometime in 2014.

3. 2 In his statement for the Inquest Kelly's partner Paul recalled first meeting her 13 years ago when they were introduced by a friend, but their relationship did not start until 8 years ago when Paul contacted her when he came out of prison. It is understood that they separated a few times, but always returned to their relationship. Kelly's father reported that the relationship had always been 'rocky' and they had a number of difficulties although this did seem to have been worse in recent years. This information had been passed to him by others; he had not witnessed any difficulties himself.

3. 3 Kelly had a troubled time in her teenage years. A family member reports that she 'got in with the wrong crowd' at school. She was known to the Police from 1999 and had a number of convictions between 2000 and 2008 including theft, public order offences, and 5 violent offences 2 of which were assaults on Police and 2 offences where she offended with weapons against strangers; one was an assault using a broom, in the other she was a co-accused in a knife point robbery. Kelly had involvement with the Youth Offending Service, and she served custodial sentences the longest of which was 10 months in 2003 for a series of accumulative offending. There are no records of Kelly offending after 2008 and indeed a close relative stated that she seemed to turn her life around.

3. 4 It is reported in Kelly's father's statement to the Coroner that she had visited her parents a number of times clearly upset. She had also expressed a wish to leave Paul and return to live with her parents. Paul appeared to rely on Kelly for money in addition to his benefits and it was reported that he would exert pressure on her and demand money whenever he thought she had some. Her father believed this was because Paul used illicit drugs and he thought Kelly was also being both mentally and physically abused, but she rarely openly criticised Paul.

3. 5 Kelly disclosed to Health professionals that she had been using illicit drugs since the age of 14, but she denied having ever injected drugs. Kelly is known to have previously taken a deliberate overdose of Paracetamol and Codeine tablets in 2001.

3. 6 As the Review author has not received a response to correspondence inviting Paul to contribute to the Panel's enquiries we are mindful that due to data protection legislation we can only cite background information relevant to Paul which is already in the public domain i.e. from court proceedings which are open to the public. As a result his background is limited. Paul has a criminal history of 14 convictions from 30 offences committed over a 15 year period. Nearly half of his offending is made up of dishonesty offences i.e. theft and fraud, 4 against

property, and one offence which showed a propensity towards violence. This was for Actual Bodily Harm in 2002 against another male which was committed whilst he was on bail which resulted in an 18 month custodial sentence. Paul accrued just over 5 years in custody predominantly from burglary offences in 2003. The Panel is unable to confirm Police involvement for previous domestic abuse or other offences as no further prosecutions have taken place, thus nothing further is in the public domain.

3. 7 In his statement to the Coroner's Inquest Paul confirmed that he and Kelly had lived in the village where they shared a rented property for approximately 18 months. Paul described Kelly as his 'rock' when 7 years ago he suffered a significant bereavement. He also reported that around this time Kelly self-harmed; he said she had used a butter knife, the wound was not deep and it was not serious enough to go to hospital. Paul confirmed that they both enjoyed a drink and smoking cannabis, but maintained that they were not addicted. This situation is alleged by Paul to have changed when they moved to the village in which they lived and they started socialising with others who used a range of illicit substances and they were drinking more heavily. From Kelly's medical notes her registration at a local GP practice indicates that the couple moved to the village in 2013.

Chronology from 2010:

Police Callout No 1:

3. 8 The first contact by the Police with Kelly and Paul in relation to a domestic abuse related incident was a callout involving a heated argument between the two on 3 December 2010. Both had been drinking and Paul had called the Police fearing violence from Kelly. On arrival officers found the situation had calmed down. Kelly is recorded as saying "*He is more afraid of me than I am of him*". The incident was assessed as standard risk.

Police Callout No 2:

3. 9 The next Police involvement was on 22 September 2013 at 23:42 hrs when a non-crime domestic abuse incident was recorded. Paul had returned home drunk with a friend and a very loud argument between the couple prompted a neighbour to call the Police. All was calm on the officer's arrival and Kelly confirmed that no crime had taken place. A standard risk assessment was recorded.

Police Callout No 3:

3. 10 A further Police call out took place three months later following a call from Kelly at 03:03 hrs on 2 December 2013. During the call the signal repeatly droppped out, however contact was regained and the call handler noted that Kelly sounded very upset. When officers arrived at the scene they found that both parties were under the influence of alcohol. A friend of the couple was also present in the house. Kelly reported that Paul had stormed out of the flat following an argument and she was concerned for his welfare. It is recorded that all parties stated that there had not been any violence; Paul had told Kelly to leave, but she refused, and Paul left instead to calm down. Kelly was seen to have a slight nose bleed, but she told officers that she suffered from nose bleeds. There was no sign of a disturbance and both parties were calm. The incident was recorded as medium risk. This risk assessment was confirmed when reassessed by an officer in the

MASH[2] due to both parties having drug and alcohol issues and it being highlighted on the system that Kelly had a chronic personality disorder and mental health issues. These mental health matters are recorded on the Police system and arise from questioning when Kelly had a previous occasion of being detained in custody; they are self reported by Kelly and are not due to any official diagnosis. There was no further follow up as it appeared that the couple were separating. However, a marker was placed on the address to alert the Control Room and attending officers of the concern should another incident be reported.

Police Callout No 4:

3. 11 Four days later on 6 December 2013 Kelly called the Police at 06:17 hrs stating she had "*Just beat up her boyfriend*". During the call she stated that she had thrown a glass at him, that he was not bleeding and no ambulance was required; he had now gone to bed. Kelly went on to say that they had both been drinking, and she had taken two blue tablets that had been given to her by a friend, but she did not know what they were just that they calmed her down. Records show that Kelly stated that she had made the call as she had "*Gone off her head and smash him and wanted to call us to tell us"*. The call taker called for an ambulance for Kelly due to the tablet consumption and officers were despatched. When officers arrived Kelly was unresponsive. Paul confirmed that Kelly had been drinking all night and when he went to bed she had 'flipped out' and started throwing items around. He said he had not been assaulted in any way by Kelly. In addition to alcohol she had taken unknown tablets to calm herself down. Kelly was taken to the Norfolk & Norwich Univeristy Hospital and treated for a possible overdose of tablets and for an excess of alcohol. The exact tablets Kelly had taken were not identified, however the hospital IMR notes the admission being for an overdose of benzodiazepines[3] and alcohol. Kelly admitted to staff that she was binge drinking too much. She was seen in the hospital by the Mental Health Liaison Team, but did not appear to have any active suicidal or self harm thoughts and it was decided that no further Mental Health support was required at that time. There was no reference to domestic abuse or relationship issues noted during the assessment. Information on Kelly's admission was sent to her GP by the Mental Health Liaison Team.

3. 12 On 3 January 2014 Kelly missed an appointment with a nurse at her surgery for an asthma review, but she saw a GP for prescriptions on 28 February for an unremarkable ongoing condition. She missed a GP appointment on 17 March 2014, but attended a routine prescription review on 23 May 2014.

3. 13 In June 2014 Kelly and Paul went on holiday with her parents. In his statement Kelly's father reported that Paul had spent any spending money he was alleged to have saved for the holiday before they left. Kelly's father stated that he looked after the spending money she had saved for the holiday, but Paul is reported to have managed to get this money from Kelly before the holiday ended. Her father also reported hearing sounds of Paul shouting in an angry voice coming from

[2] The Multi Agency Safeguarding Hub (MASH) physically and virtually co-locates key professionals including Children's Services, Health and Independent Domestic Violence Advocates (IDVAs) to facilitate early information sharing, analysis and decision making in relation to children, young people, and adults.

[3] Benzodiazepines are medicines that help relieve nervousness, tension, and other symptoms by slowing the central nervous system. Information provided by the GP practice indicates that no prescription for benzodiazepine was issued to Kelly. Side effects may cause behaviour changes in some people, similar to those seen in people who act differently when they drink alcohol. More extreme changes, such as confusion, agitation, and hallucinations also are possible. http://medical-dictionary.thefreedictionary.com/Benzodiazepines Accessed 09.01.16

Kelly's apartment during the holiday. On returning from the holiday Kelly saw a GP on 8 July 2014 with a history of a cough and upper abdominal pain. She was prescribed medication, but due to her recent travelling she was sent to the Norfolk & Norwich Hospital for a check up. This was negative.

3. 14 On 30 July 2014 Kelly missed an appointment with one of the GPs in her surgery. She next attended on 3 September 2014 for a recurrence of a previous condition and a repeat prescription. When leaving it was noted by the GP that Kelly wanted to discuss anxiety issues, but wanted a longer appointment for this. A follow up longer appointment was given for a week's time. Kelly did not keep the appointment. The GP telephoned her and Kelly said she had been running late so decided not to come. She was advised to rebook the appointment if she still wanted to discuss her anxiety. However, between September 2014 and Janaury 2015 Kelly did not attend to see a GP.

Police Callout No 5:

3. 15 On the 29 November 2014 at 04:59 hrs the Police received a call from a female and the call taker could hear screaming and then a male voice before the call was terminated. The number was identified as Kelly and Paul's home number and the call taker attempted to call the number back, but was unable to connect. Officers attended and found Kelly and Paul who were intoxicated and arguing along with two other males. Kelly refused to engage with the Police or make a complaint. She had visible injuries to her right shoulder and arm, scratches and grazing as well as reddening. Kelly would not divulge how the injuries occurred, but they appeared fresh. She reported that an argument started because they had all been out celebrating a special event and Kelly had refused to go home when Paul and his friends left. When she returned home this had resulted in an argument. Officers were concerned that Kelly had been assaulted by Paul and compiled supporting evidence to progress a victimless prosecution. Statements were particularly detailed about the aggressive demeanour of Paul and the correct use of Section 17 PACE[4] powers to obtain entry despite a refusal by Paul upon their arrival to let the officers in. Officers noted damage to the premises and the injuries to Kelly. Although she refused to engage fully offficers managed to obtain three photographs of her injuries before she disengaged and noted her comments to Paul "*Look at the holes in the doors. Look at this*" as she presented her scratched and bruised arms to him. Paul was arrested on suspicion of Actual Bodily Harm; the two male witnesses present refused to engage with the Police. Officers were unable to complete a DASH risk assessment as Kelly made the Police leave. Due to Kelly's non-engagment and Paul stating in interview that her injuries were caused by falling and being intoxicated no further action was taken against Paul on the advice of the Crown Prosecution Service.

3. 16 Victim Support provide support to standard and medium risk victims within the county and they received an automated referral from the Police on 29 November 2014, and in line with the agreed process with Norfolk Constabulary, they waited for a secondary risk assessment to be performed by the Police before initiating contact with Kelly. Telephone contact was attempted on 9 and 10 December 2014, but Kelly did not answer the calls. In line with protocol the case was closed.

3. 17 Around this time Kelly gave up her job at the national supermarket. A close family member reports that since moving to the village Kelly found it increasingly difficult

[44] Police And Criminal Evidence (PACE) Act1984, Section 17 sets out the criteria under which an officer may enter premises without the permission of the occupant.

to afford the cost of driving to work. She worked for a short time at a local care home for older people, however she told her relative that this was difficult as she found it hard when residents died.

Police Callout No 6:

3. 18 Two further callouts to Kelly and Paul's address took place in the following month: On 24 December 2014 at 03:48 hrs Kelly called reporting that she had had an argument with Paul and she was concerned for his whereabouts as he had threatened to throw himself from a bridge. During the call Kelly disclosed that Paul had assaulted her, but she was reluctant to talk about it. When officers attended Kelly reported that several hours earlier Paul had assaulted her by grabbing her around the throat and head-butting her in the face causing reddening to her cheek and marks around her neck. Photographs were taken of Kelly's injuries, and house to house enquires were made to try and gain supporting evidence; this proved negative. Kelly also reported that they had argued in the street and both threatened to the other that they were going to kill themselves by jumping from a building. Kelly had returned home instead of carrying out the threat and Paul had not returned which prompted her to call. Attempts were made to locate Paul, however during a welfare check on Kelly later that day he was found to be at home with her. He was duly arrested for the assault, interviewed, denied the offence, and the CPS made the decision to take no further action on several grounds including Kelly's non-engagement and lack of supporting evidence.

3. 19 Victim Support received an automated referral from the Police on 24 December and awaited the second risk assessment. However, on 5 January 2016 they received notification that Kelly's case was high risk and had been referred to MARAC and the IDVA Service, therefore in line with protocol they closed their involvement.

Police Callout No 7:

3. 20 The second call of the month was received by the Police on 31 December 2014 from Paul; the call taker heard arguing. Paul stated that he had had an argument with Kelly who was intoxicated and he wanted her removed. This changed during the phone call as Kelly had allegedly left with a friend. Police officers were despatched to speak to Paul and to locate Kelly to ensure she was safe and well. Paul said he regretted calling the Police and did not want to talk to them. Kelly made her own call to the Police, but she did not disclose any offences and she refused to tell officers where she was. Numerous attempts were made to contact Kelly during 1 January 2015 and into 2 January without success.

Police Callout No 8:

3. 21 A further domestic abuse incident was reported to Police at 01:27 hrs on the 3 January 2015 when a member of the public reported an incident in the street between a male and female. The call taker's record shows that the caller reported that they believed the male had hit the female as the female had been heard to scream "*You just punched me in the face*". Officers attended and intelligence suggested that it may have been Kelly and Paul involved in the incident. On arrival officers found a tearful Kelly, but Paul was not present. Kelly would not make a written complaint, but she told officers that she had wanted to leave the house, but Paul would not let her. She had managed to climb out of the lounge window into the garden, but Paul caught up with her and pushed her through the garden fence. Kelly had punched Paul to get him off her and they continued to

argue in the street. Kelly reported that this resulted in Paul pushing her to the ground, sitting astride her and then putting his hands around her throat and he had bit her lip. Officers noted very faint reddening to her neck, but no other injuries or signs of a disturbance in the house. Officers noted signs of cannabis use on the table in the lounge. Kelly kept telling the officers that she had not called the Police and she did not want them there.

3. 22 The male and female officers tried to engage with Kelly and to help her understand the level of risk that was present. During their assessment Kelly said she wanted to leave, but she had nowhere to go. She was offered refuge, but declined, and offers to take her to friends or family were also declined, as was the installation of an alarm at the address, although she did agree to local officers making welfare visits and accepted to be contacted by the Independent Domestic Violence Advocacy Service. Kelly would not provide a statement or support any form of Police action. Officers followed up their concerns by generating a victimless prosecution file. It is recorded that after 2 assaults in the last month and with alcohol as a contributory factor, Kelly was tired of the abuse and wanted to end the relationship. In the officer's statement regarding this incident she had noted that Kelly gave no indication that she was suicidal, but she did appear depressed and detached from the situation. Within the notes it is recorded that Kelly stated that the relationship would probably end by either Paul killing her or her killing him. The officer challenged this statement saying that this would not be an acceptable conclusion and there were things they could do to help her. Kelly is noted as saying she did not care any more though. She stated that when she and Paul were arguing earlier in the night she wished she would have stabbed him so that "*at least it would be over*". When asked what she meant by this she would not elaborate, she simply repeated "*I didn't even want the Police involved".*

3. 23 The officers submitted a domestic crime report and emailed the MASH with their concerns. Within the email the officer documented that Kelly spoke of having low mood and that she had phoned her GP to ask for help. Kelly was assessed as high risk and a referral was made to MARAC. The DASH risk assessment which was undertaken gained 14 positive answers, and the referral to MARAC was made with Kelly's agreement.

3. 24 For 6 days following the assault Paul remained at large and officers were tasked at Daily Management Meetings with locating him. During this period Kelly was contacted by a detective constable from the MASH to discuss her options and an unsuccessful attempt was made to gain her cooperation by making a statement to support a prosecution. Kelly disclosed that she had been in touch with Paul. The officer felt Kelly was of sound mind and did not appear to present with any mental health concerns, but the risk to her remained whilst she stayed with Paul and refused to engage with support. The officer continued to explore other safeguarding options and Kelly's case was due to be heard at the MARAC on 22 January and an IDVA was allocated to provide support.

3. 25 Paul eventually handed himself in at a Police station in the county on the 13 January 2015. The incident was put before the Crown Prosecution Service who made the decision to take no further action due to lack of evidence. There were no reasonable lines of enquiry open to officers from neighbours or other witnesses. The person who reported the incident to the Police had well-grounded reasons for not wishing to assist having been the target of threats when making a previous unrelated domestic abuse incident report. In addition although the incident reporter heard shouting and screaming this could not be specifically linked to the suspect and complainant.

3. 26 Therefore following the incident on the 3 January 2015 no further action was taken against Paul in terms of a prosecution. However, a Domestic Violence Prevention Notice was authorised by a Police Superintendent, which was subsequently converted into a Domestic Violence Prevention Order at Norwich Magistrates Court on the 15 January 2015. This ordered Paul to have no contact with Kelly or go within half a mile of her address for a period of 21 days. He was also prohibited from molesting her or evicting her from the property.

3. 27 An advocate from the Leeway Domestic Violence Advocacy Service made telephone contact with Kelly on Monday 5 January 2105. The MARAC process was explained to her and what it meant. Kelly said she was '*okay*' with this. The help that could be offered was explained. Kelly was noted to have been scared by the most recent incident and so she said she would like support. However, when further telephone contact with Kelly was attempted on 6, 9, 13, and 15 January, there was no answer and there was no voicemail facility on her phone to leave a message. On some of these occasions more than one call a day was made. On 20 January the Domestic Violence Prevention Order notification was received by the IDVA Service; this was 3 working days after the order was granted. Further unsuccessful telephone contact attempts were made on 21, 23, 26, 28 January and 2 February 2015.

3. 28 On 7 January 2015, 3 days after the domestic abuse incident, Kelly attended her GP practice and saw a nurse practitioner. She complained that she felt she was no longer able to cope. Kelly reported to the nurse long standing problems with excessive alcohol and recreational drugs, and she admitted to using cocaine and having previously used acid. Kelly reported that alcohol triggered anger and as a result she would 'get cross' with her partner. She felt the alcohol caused her to be paranoid about her partner and friends as if they were talking about her. Kelly said that it had most recently come to a head at the weekend when her partner of eight years had left as he was unable to cope with her anger and mood swings. She reported to the nurse that she had little contact with her family since leaving home age 15 years old, and she had attended anger management classes when she was 20 years old which had helped. Kelly informed the nurse that she had been working in a care home, but left before Christmas as she felt unable to cope when residents passed away. She went on to report that she had had thoughts of self harm that weekend, but now realised that this was not the way to make things better. It was noted during the consultation that Kelly had good eye contact, was well presented and was wearing make-up. She was tearful, but was able to smile and laugh by the end of the appointment. In addition to a clinical assessment a Generalised Anxiety Disorder Seven Item Score (Appendix A) was completed with Kelly producing a score of 19[5] (over 15 indicates severe anxiety) and a Patient Health Questionniare (Appendix B) with a score of 18[6] (within the scale indicating moderately severe). The nurse practioner discussed a plan with a GP following which a prescription for Escitalopram 5 mg was given. 14 tablets only were given and side effects explained. A referral was also made to the

[5] The GAD-7 originates from Spitzer RL, Kroenke K, Williams JB, et al; A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006 May 22;166(10):1092-7. Scores of 5, 10, and 15 are taken as the cut off points for mild, moderate, and severe anxiety, respectively. When used as a screening tool, further evaluation is recommended when the score is 10 or greater. http://patient.info/doctor/generalised-anxiety-disorder-assessment-gad-7 accessed 08.01.16.

[6]The Patient Health Questionnaire is not a screening tool for depression but it is used to monitor the severity of depression and response to treatment. However, it can be used to make a tentative diagnosis of depression in at-risk populations. Depression Severity: 0-4 none, 5-9 mild, 10-14 moderate, 15-19 moderately severe, 20-27 severe. http://patient.info/doctor/patient-health-questionnaire-phq-9 accessed 08.01.16

Wellbeing Service based at the Hellesdon Hospital by the nurse practitioner and Kelly was signposted for self referral to the drug and alcohol service the Matthew Project. Blood tests were arranged to rule out any underlying conditions.

3. 29 On 8 January 2015 the mental health referral was faxed and received by the Norfolk & Suffolk NHS Foundation Trust Access and Assessment Team which is the single point of access for GP referrals. The Team confirmed its receipt. Kelly's difficulties appeared to be linked to low mood and/or anxiety; following triage her referral was passed to the Improved Access to Psychological Therapies (IAPT) service. In line with normal procedures Kelly was contacted by phone on 15 January to be invited to attend a taster session of a psycho-educational class which teaches about stress, low mood and anxiety, and to explain what the service has to offer. Alternatively, an initial telephone assessment was offered. Kelly declined to attend the taster session and a telephone assessment was booked for a month's time on 9 February 2015. Sadly, this call came after Kelly's death.

3. 30 Kelly missed a follow-up appointment with the nurse practitioner on 14 January 2015. The following day, 15 January the practice received a letter from the Wellbeing Service advising that after triage, they thought Kelly would benefit from psychological therapies.

3. 31 On 16 January 2015 Kelly was seen by another nurse practitioner at her surgery. It was noted that she had missed the follow-up appointment. Kelly said her friend had made her come that day. Kelly was not sleeping and she again admitted her history of illicit drug use to the second nurse. It was noted that she did not have suicidal or self harm intentions, but she had poor eye contact, otherwise she was well presented. A second assessment was undertaken using the Generalised Anxiety Disorder 7 Item Score which gave a score of 15 (this score comes into the 'severe' anxiety scale. Kelly's score for the Patient Health Questionnaire was 21 (this comes into the severity scale of 'severe'). After discussion with a GP the nurse issued a sick note for anxiety reasons. Kelly was given a leaflet about the Norfolk Recovery Partnership[7] and strongly advised to contact them. The Escitalopram prescription was increased to 10mg and Kelly was advised to avoid alcohol, and to have a review as soon as possible if there were any problems. Information provided by the GP practice states that there was no reason to consider that Kelly was not taking the medication as planned. At this time it was noted that Kelly was drinking 38 units of alcohol per week (the recommended weekly consumption level is no more than 14 units per week[8]) .

3. 32 Kelly is known to have made a self referral to the Norfolk Recovery Partnership via their website on 19 January 2015. A referral is not necessary for their service as they operate a drop in service and website self referral system. In her self referral Kelly wrote that she needed help "*with drugs and alcohol*"; she was "*drinking a lot*" and taking "*methadrone[9], tcb[10], and MDMA (Ecstasy)*", something

[7] Norfolk Recovery Partnership provides advice and treatment for adults with drug and alcohol problems across Norfolk.

[8] http://www.nhs.uk/Livewell/alcohol/Pages/alcohol-units.aspx

[9] Methadrone (also known as Mephedrone, methedrone, and methylone see http://www.drugwise.org.uk/mephedrone-methedrone-methadrone-and-methylone/) is a powerful stimulant and is part of a group of drugs that are closely related to the amphetamines, like speed or Ecstasy. The main effects and risks include: Euphoria, alertness and feelings of affection towards people. Feelings of anxiety and paranoia. Methadrone, can also over stimulate the heart and circulation; and can over stimulate the nervous system with risk of fits. http://www.talktofrank.com/drug/mephedrone Accessed 09.01.16.

she reported she had been doing for the past 15 years. She reported that she wanted "*help before she got into trouble*" and she had been to see her GP who encouraged her to refer herself. There was no other information about her mental wellbeing. A section on the website referral asking about risk and safety issues was not completed. A letter was sent to Kelly on 22 January 2015 inviting her to attend the Norfolk Recovery Partnership assessment clinic and stating the times and days this was available. Kelly's referral was passed to the team which covered her area.

3. 33 Kelly's case was heard at the MARAC meeting held on 22 January 2015. The referral noted that whilst Kelly would accept assistance from agencies, and rehousing would be beneficial as Paul held the sole tenancy of the property she shared with him, Kelly refused to consider staying with her parents or friends, although there was no evidence from the DASH assessment that she was isolated from them. She also refused the installation of an alarm. It was hoped that she would accept IDVA support. The DASH indicates that Kelly reported that she had tried to separate from Paul in the past year; that he constantly wanted to know where she was and what she was doing; the abuse was getting worse and more frequent, there were also money worries as both were unemployed. Other positive answers in the assessment are related to Paul, but as the DASH is not in the public domain this information is not included in the Review. (See paragraph 3.6). It was noted that Kelly had recently referred herself to a drug and alcohol service, and the repeated difficulty in making IDVA contact was noted. The Housing representative advised that changing locks on the property was not an option as Kelly did not hold the tenancy, and there was an injunction in place because of noise and other tenancy breaches. Actions from the MARAC were for the IDVA Service to update the MARAC when contact was made with Kelly, and to request that the relevant drug and alcohol service liaise with the IDVA. The MARAC referral states under 'Disability' Chronic Personality Disorder (this is from the Police system and is a condition self reported by Kelly see paragraph 3.10).

3. 34 Following the MARAC the Safeguarding Team at Norfolk & Suffolk Foundation Trust (for mental health services) sent an email on Thursday 22 January 2015 to the Norfolk Recovery Partnership regarding Kelly to highlight the risk of domestic abuse (from MARAC information). The service was advised to treat Kelly as a priority and information regarding other agencies involved was passed to Norfolk Recovery Partnership. The service attempted telephone contact with Kelly twice on Monday 26 January, but there was no response. A phone call was made and a letter was sent to the GP practice informing them of this outcome on 29 January.

3. 35 On 23 January 2015 the detective constable who had contacted Kelly previously managed to contact her on her mobile phone. It was confirmed that she was aware of the Domestic Violence Prevention Order conditions. She was still at the couple's address, but she told the detective that she had been to her local council housing department and been told that she needed to go onto benefits before she could apply. The detective offered his support with this matter, but Kelly declined saying she wanted to do it by herself. The officer gained the impression that Kelly intended to stay in the property indefinitely and will re-engage with Paul when the Prevention Order expires. It was explained to Kelly that when it does

[10] Tcb is among a family of drugs which have both psychedelic/hallucinogenic and stimulant effects. The effects are a cross between Ecstasy and LSD. As hallucinogens or psychedelics the substance can make the person taking the substance see objects and reality in a distorted way and may cause hallucinations (seeing and hearing things that are not there). As stimulants they can make the taker feel awake and alert and may cause changes in emotions. http://www.talktofrank.com/drug/2c . Accessed 09.01.16

expire Paul will have no conditions imposed upon him. She understood this and Kelly was urged to speak to her IDVA, which she agreed to do. However, her IDVA did not have a call from Kelly nor were her calls to Kelly answered. The Local Authority confirm that they have no records of Kelly visiting or telephoning them for housing advice and she would not have been told that she needed to be on benefits before applying.

3. 36 On the 29 January 2015 Kelly's surgery received a letter and phone call from the Norfolk Recovery Partnership with a message for the nurse practitioner who had advised Kelly to refer herself to that service advising that they had tried to call Kelly several times, but had not been able to contact her. On the following day 30 January, Kelly attended the surgery for a blood test previously arranged by a nurse practitioner, but she was seen by a phlebotimist for this appointment who would not have accessed her notes for the appointment, therefore the fact that the Norfolk Recovery Partnership was trying to contact Kelly was not raised with her.

3. 37 A detective sergeant completed a supervisor's review of Kelly's case on 1 February 2015. The officer was happy with the current safety measures and the case was to remain high risk. It was to be reviewed on expiry of the Prevention Order. Welfare checks on Kelly continued, but these were unsuccessful; no answer was obtained from a knock on the door check. On 3 February officers made enquiries of a neighbour, but they confirmed that they rarely saw or heard Kelly anymore and had not really spoken in months. They had not seen Paul for a long time. The Police system was updated asking late shift officers to visit outside working hours.

3. 38 A 999 call was received by the Police at 05.59hrs on 4 February 2015, but the call was discontinued; the communications officer asked for the call content to be played which was *"It's not an emergency, it's not an emergency. I just wanted to ring you to tell you that I've got the biggest kitchen knife and I aint walked out the door with it. What I want to do is hang myself, do you know what I mean? so I don't have to do that and I..."*. The officer checked and recognised the number as Kelly's mobile and made the connection to previous domestic abuse incidents. She then phoned the number and spoke to Kelly at 06:03hrs. When asked if everything was alright Kelly said "*Yeah I'm fine, just acting a little bit crazy that's all"*. The officer asked several times for Kelly to give her name and eventually she confirmed that she was Kelly and said "*I'm just aaagh, I'm, I'm just acting crazy. I tried hanging myself twice today, and I just, I don't know I just rang 999 that's all"*. The officer asked where Kelly was and said it sounded as though she needed some help and support, to which Kelly replied *"I don't need that erm apparently Police, I've had help and support since Christmas, I've had f*** all!"* The officer tried again to find out where Kelly was, but at 06:05hrs Kelly hung up. Officers were despatched and arrived at Kelly's address at 06:16hrs. The officers had to break into the house where they found Kelly hanging in the hallway. Officers started CPR and an ambulance was called. Kelly was taken to hospital, but she did not regain consciousness. She died 3 days later. No note from Kelly was found in the house.

3. 39 Information from members of the public obtained by the Police following Kelly's death identified that Paul had been seen at the address in the days leading up to her death. Mobile phone records also showed that Kelly and Paul had been in frequent touch with each other in breach of the Domestic Violence Prevention Order. Paul confirmed in his statement to the Inquest that he had been in the company of Kelly following the issuing of the Order. He was arrested on 5

February 2015 for a breach of the Domestic Violence Prevention Order and fined £25 at the Magistrates Court.

3. 40 In his statement for the Coroner Kelly's father said *"It is my firm belief that the effects of Paul's behaviour over the years have had a major impact on Kelly and have contributed significantly to her decision to end her own life. I am not aware of any other factors which may have led her to these actions".*

4. Overview

4.1. In summarising the information known to agencies it appears that up to the holding of the MARAC in January 2015 when information was shared with a selection of partner agencies, the only agency to be aware of the incidents of domestic abuse within Kelly and Paul's relationship was the Police. The is no GP representation on the MARAC therefore GPs are out of the 'information loop' as far as domestic abuse cases are concerned.

4.2. From the information provided by the GP surgery it would appear that the practice nurse Kelly saw on 7 January 2015 recorded notes about her anger issues and relationship problems, but there is no indication that she was asked about domestic abuse, any controlling behaviour she may have been experiencing, or that Kelly disclosed that there was abuse in her relationship nor that the Police were involved.

4.3. Kelly's mental health assessment when she was seen in hospital after an excess of alcohol and taking tablets, did not identify any issues around domestic abuse; the root cause of her admission on that occasion was due to symptoms caused by intoxication.

4.4. The Norfolk Recovery Partnership did not have direct contact with Kelly, but they were informed about the outcome of MARAC and made aware that she was judged to be at high risk of domestic abuse. The IAPT Service was due to undertake a telephone assessment with Kelly at a date which came after her death. They were not informed of the outcome of MARAC and therefore they had no knowledge of her relationship or domestic abuse.

4.5. Other Relevant Information:

4.6. Kelly appears to have been significantly affected by a 15 year use of illicit drugs and her use of alcohol which she disclosed to nurses in her GP practice with considerable candour in January 2015. She acknowledged with some insight that these substances, particularly the alcohol, exacerbated her propensity to anger and violence and sadly she seemed to be on the verge of starting the journey to seek help to address these issues just before her untimely death.

4.7. A close family member acknowledged that Kelly had become involved with the wrong crowd when she was a teenager at school and she had gone down a path which was alien to the rest of the family. When she was growing up Kelly is described as someone who always stood up for the underdog, but not for herself. She had a 'bubbly' personality and was 'cheery' with others, and would give her last pound if someone needed it. Her relative was aware that Kelly used substances recreationally for example at parties, but the extent of that use was not known.

4.8. Kelly's relative reports that Kelly had turned her life around from her troubled teenage years. They were aware that Kelly found it very difficult when she moved from privately rented accommodation in 2013 to the village Housing Association property in which she lived; she felt isolated and the distance made it more expensive to drive to her work and eventually she could not afford to keep her car and continue in her job. She had worked in this job for 4 years and was also a union representative.

4.9. According to Kelly's relative she would sometimes express how fed up she was with Paul, but she always stuck up for him. Other relatives who sometimes visited Kelly at her home reported that Paul treated her badly; he would often put Kelly down verbally; telling her she was useless and calling her names such as 'slag'. Derogatory names and verbal abuse also contributes to emotional abuse, as it can have a very undermining effect on self esteem and feelings of self worth. In her risk assessment for MARAC Kelly indicated that Paul would check up on her, and the fifth incident to which the Police were called in November 2014 was said to be the result of an argument because Kelly had refused to go home from a night out when Paul wanted her to. Kelly was once asked to babysit by her relative, but she said she would have to ask Paul first. These examples are suggestive of a pattern of controlling behaviour taking place. Her relative was aware that Kelly paid for holidays and other expenses and that Paul made Kelly buy her own food whereas he would go out with friends and stay in the town at a hotel on occasions. It was also reported that Kelly told her relative that after the Domestic Violence Prevention Order was put in place Paul and one of his relatives came and removed the television from her.

4.10. Just before Christmas 2014 Kelly is reported to have looked on Paul's phone and realised that he was having an affair with another woman. Her relative said this made Kelly very upset. This may be around the time of the call to the Police on 31 December 2014 when Kelly left the property she shared with Paul and refused to say where she was.

4.11. From the chronology of events the verbal and physical abuse within the relationship appears to have been on both sides at times especially when Kelly had been drinking. In his statement to the Coroner's Inquest Paul stated that they always liked to have a drink and use cannabis, but when Kelly drank she became a different person; she would be angry and aggressive. Kelly herself reported her propensity to anger and aggression to a nurse practitioner, and also mentioned similar behaviour to the Police; on one occasion she stated that Paul was more afraid of her than she was of him (see paragraph 3.8). At the Inquest Paul admitted 'cheating on' Kelly and she would bring this up in their arguments. He also alleged that the situation became worse when they moved to the village and both started using other drugs which were widely available in the area. This is counter to Kelly's admission that she had been using illicit substances for many years, although there could have been an escalation in use which prompted her to seek help.

4.12. In his Inquest statement Paul stated that they were both 'fiery' when they had a drink; Kelly would call the Police and say he had beaten her up, but 'that was the alcohol talking'. He admitted things 'got physical' sometimes, but denied it was to the extent that was reported. This is counter to Kelly's reports and injuries seen by Police officers, and in two of the incidents involving injuries there was no Police report that Kelly was intoxicated.

4.13. The history of events and other information known to the author, suggests that Kelly's sense of isolation, loss of independent transport, and the psychological,

emotional, and financial abuse may have had a more damaging affect on Kelly than was realised. Since leaving her job at the care home she had no employment to give her day structure or contact with others. The added stress of housing and money worries and the additional adverse side effects of alcohol and some of the substances she admitted she was using, may have exacerbated her depression and anxiety and ability to cope.

4.14. Paul's statement alleged that Kelly had self harmed for years, but he said they were like 'cat scratches' and not deep enough to need hospital treatment. The Review is unable to substantiate this claim. He also stated that 2 to 3 months before she died he had come home and found a piece of 'string stuff' hanging from the loft hatch. Kelly had said she was just being silly and said it was due to drink. Paul reported that it was so thin Kelly would not have been able to do anything and she had no marks around her neck.

4.15. The Inquest also learnt from Paul via his statement to the Inquest that there were difficulties with his tenancy. The Housing Association had received complaints about noise and hearing the couple shouting and arguing. He reported that there was a repossession order on the house and this added to their stress. He stated that since leaving her job in the care home Kelly had no money as she was having difficulty obtaining benefits. They were short of money, and he alleged that Kelly was spending all her money on drink which she did not used to do. He stated that it was the drink and drugs that ruined them in the end, and he admitted his disloyalty and untruthfulness had not helped.

4.16. According to his statement to the Inquest Paul last saw Kelly the evening before she phoned the Police the final time. She had been sober and there was no sign of alcohol or drugs. She had not wanted him to leave; she did not want to be on her own, but he stated that as she had not been opening the door to the Police when they visited he did not think it would be long before they would break in to make sure she was alright. He left to see a friend in a nearby town. When he returned next morning he saw a Police car outside and left. He later learnt from friends that Kelly had been taken to hospital.

4.17. In concluding his statement to the Coroner Paul said it made him sad that the Police only saw the tough side of Kelly; he admitted they had their ups and downs, but stated that she was the biggest, softest, loveable person who cared for other people more than she cared for herself, which he thought did her no favours; she was a troubled, fragile beautiful person.

4.18. Kelly's relative who contributed to the Review cannot imagine how and why she did what she did. She loved her family.

5. Analysis

5.1 The following analysis considers the events known to agencies and the findings within the IMRs and information provided to the Review. The analysis will be structure around the terms of reference for the DHR.

Term of Reference 1:

To examine the events occurring during Kelly's relationship with her former partner from 2010 when the first notification of domestic abuse was made to the

Police, and her death in February 2015. Agencies with information relevant to Kelly before 2010 are to provide a chronology and summary of that information.

5.2 The events of which agencies had knowledge has been provided within the chronology of the Review. This has been constrained by data protection considerations with regard to Kelly's former fiancé.

Term of Reference 2:

To determine as far as is possible if there is evidence to suggest that Kelly's unexpected death was in any way connected to her being a victim of domestic abuse.

5.3 From the chronology it is evident that the number of calls to the Police was growing in frequency during 2014. It is interesting to note that of the 8 incidents resulting in Police attendance 5 are in the month of December, with 1 in September, 1 in November, and finally at the beginning of January; all within autumn/winter months. There is no information to suggest a rationale for this.

5.4 There is a sense of growing tension between the couple during the latter part of 2014. In contrast to earlier incidents only one of the incidents during this period (24 December 2014) was confirmed as involving alcohol. Paul alleged that Kelly was intoxicated when he called the Police on 31 December, but she was not seen by officers to confirm this. All previous incidents, whether Kelly or Paul called the Police were exacerbated by the couple's use of alcohol. A further difference to earlier incidents is the fact that the calls on 29 November, 24 December 2014, and 3 January 2015 demonstrate an escalation in abuse as Kelly was found to have experienced physical assault.

5.5 Information provided by Kelly's close relative reveals that Kelly had discovered that Paul was being unfaithful to her before Christmas 2014. The convergence of escalating abuse and this discovery may have contributed to Kelly's depression and anxiety with which she was diagnosed by nurse practitioners in January 2015 shortly after the final domestic abuse incident. The substances she confirmed she was using also had side effects which may have increased her sense of anxiety and depression. Kelly was also out of work at the time having found her job in the care home difficult to cope with; having no job to go to may also have heightened her sense of isolation in the village, and shortage of money would have been an additional source of anxiety.

5.6 By her own admission Kelly's use of illicit drugs predated her relationship with Paul; we do not know when her binge drinking started. We do know however, that abused women may use alcohol as a coping mechanism, particularly in cases of psychological and emotional abuse which can lead to low self esteem, depression and anxiety, self harming behaviours, and drug and alcohol abuse[11]. Information provided within this Review suggests that Kelly experienced these effects. The DASH risk assessment undertaken after the final incident to which the Police were called found Kelly to be at high risk. It contained positive answers to questions indicating controlling behaviours i.e. being texted, and being called wanting to know where she was, and controlling what she did. Paul appears to have had no respect for the Domestic Violence Prevention Order for he continued to see and phone Kelly from the start of the order being imposed.

[11] Shipway L (2004) *Domestic Violence A handbook for health professionals*, Routledge, London

5.7 Kelly acknowledged to a nurse practitioner that her alcohol use triggered anger and she would become 'cross' with Paul. There is also evidence of mutual violence between the couple; Kelly told a Police officer that Paul was more afraid of her than she was of him, and in December 2013 she had phoned the Police herself to report that they had both been drinking and she had beaten Paul up, although evidence of physical assault was not found. A number of longitudinal studies of between 20 to 30 years duration which followed large cohorts of children into adulthood in the United States and New Zealand examined violence in relationships, and although elements of the research concerning the propensity of women to violence in relationships are deemed contentious due to the recording of types of abuse[12], the research identified key characteristics associated with those who went on to be violent.[13] Adolescent Conduct Disorders was found to be the strongest predictor in both genders, and where Conduct Disorders failed to diminish in some individuals there was a tendency to develop personality disorders; this in turn predicted intimate violence in both sexes[14]. Women with a juvenile history of anti-social behaviour and conduct problems were more likely to be with an abusive man at age 21years old and they were more likely to commit violence against their partners. Frequent violence was most common in relationships where 'bidirectional abuse' took place.[15] The life trajectory suggested by these studies resonates with Kelly's life path.

5.8 Research also suggests that victims of abuse who have problematic alcohol use as Kelly did are also vulnerable to domestic abuse[16] and they are less likely to be able to protect themselves when incapacitated by drink or drugs. Abused women have also been found to be 5 times more likely to attempt suicide than non-abused women[17]. These findings highlight how vulnerable Kelly was and how important it is for these factors to be taken into consideration when assessing risk.

5.9 Kelly made a salient and poignant remark which was noted by one of the officers attending the final domestic abuse incident. She said she did not care anymore, and she wished she had stabbed Paul so "at least it would be over". This suggests a woman who has had enough; who had been worn down. She also told the nurse practitioner that she felt she was no longer able to cope. Although she did maintain at the time that she did not feel suicidal.

5.10 Kelly and Paul appear to have had a turbulent and volatile relationship which was chaotic and violent at times. According to relatives they had split up in the past, but always came back together. It is not possible to emphatically state that domestic abuse caused Kelly to take the action she did; there was a complexity of issues possibly affecting her state of mind for which she had recently begun to seek help. However, there is a strong possibility that had she been in a non-abusive, healthy and supportive relationship the effect of the other problems in her life would have been mitigated.

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[12] Common Couple Violence: What's in a name? [Respect Newsletter Winter 07/08] Thangam Debbonaire

[13] Dutton D (2006) *Rethinking Domestic Violence,* Vancouver, UBC Press.

[14] Ibid

[15] Ibid. p141

[16] Weisheimer RL et al. *Severe intimate partner violence and alcohol use among female trauma patient. Journal of Trauma 2005*in World Health Organisation Intimate Partner Violence & Alcohol Factsheet.

[17] Stark E, Flitcraft AH. Spouse abuse, in Rosenberg M, Mersy J eds. *Violence in America:a public health approach*. cited in Domestic violence: a health care issue? British Medical Association

Term of Reference 3, 4 and 6 will be addressed together:

To establish what contact agencies had with Kelly and;

a. *what assessments had been undertaken*
b. *what treatment plans or support services were provided*
c. *whether plans or services were appropriate and in line with procedures and best practice.*

Were appropriate risk assessments undertaken and acted upon both in respect of Kelly's mental ill-health, as a victim of domestic abuse, or in respect of any other vulnerabilities?

Did agencies in contact with Kelly have knowledge that she was a victim of domestic abuse, ask about domestic abuse as part of assessments, and how did this impact on the support she received?

5.11 The Police attendances at incidents were all subject to risk assessment using the DASH[18] risk checklist. Secondary risk assessment was undertaken by specialist staff in the MASH. Following the first incident a 'marker' was placed against the address on Police systems to enable attending officers to be aware of the domestic abuse history. The risk assessment tool did not identify mental health concerns for Kelly, but following the final incident the officer involved did highlight to the MASH her concerns about Kelly's low mood that day, but did not identify this as a suicide risk. The IMR found that both Kelly and Paul's lack of engagement with officers hampered more in depth risk assessment which in turn prevented the appropriate provision of support and intervention.

5.12 On two occasions officers attempted to gather additional information to pursue a victimless prosecution. On 24 November 2014 despite Kelly's lack of engagement they managed to obtain 3 photographs of injuries, plus statements from 3 individuals who were at the house. Damage to the property was recorded, but not photographed. On the 24 December 2014 officers photographed Kelly's injuries and tried to obtain supporting evidence via house to house enquiries, but this was unsuccessful. Officers also generated a victimless prosecution file following the 3 January 2015 incident, however, whilst the incident is comprehensively recorded, there is no record in the IMR to indicate that photographs were taken of Kelly's injury on this occasion.

5.13 The assessment and referral to MARAC following the final incident was both timely and appropriate, and safeguarding measures were taken without waiting for the MARAC to take place. This included welfare checks by patrol officers and referral to the IDVA Service as Kelly was assessed as at high risk. Unfortunately, despite repeated calls only the first call on 5 January 2015 before MARAC was answered by Kelly, thus there were no further opportunities to encourage her to accept the range of support they could offer, including help with alternative accommodation. This does raise the question as to whether telephone contact only is the best method of contacting high risk victims who may be reluctant to accept outside support, although undoubtedly there are resource issues arising from this especially for a service with covers the whole of a geographically very large county.

[18] DASH - Domestic Abuse, Stalking and Harassment risk assessment checklist is a list of 27 questions which assist in assessing the risk faced by a victim. Risk is judged Standard, Medium or High. 14 positive answers and above is judged High Risk and results in a referral to the Multi-Agency Risk Assessment Conference (MARAC) for additional safety planning to protect the victim.

5.14 Of particular good practice was the obtaining of a Domestic Violence Prevention Order to try and provide extra safety for Kelly. The Prevention Order was due to expire on 5 February 2015, 2 days after Kelly was found by officers at her home. However, it appears that the order was breached from the beginning. From Paul's statement at the Coroner's Inquest he admitted that he was in contact with Kelly and he continued to stay at the property. He stated that he was there when officers were knocking on the door to check on Kelly's welfare, which explains why officers did not manage to see her when they called. Paul was arrested for the breach of the Prevention Order. Breaches of these orders are a civil not a criminal matter; Paul received a £25 fine for the breach. The Panel felt this was an inadequate deterrent for the breach of an order which is intended to protect someone from potentially serious harm, and in effect undermines the order in the eyes of the perpetrator and the victim. This was a view held by some participants in the evaluation of Prevention Orders[19].

5.15 The MARAC plan was appropriate considering Kelly's non-engagement. The IDVA was to continue to try and contact Kelly, and drug and alcohol services who had just received a self referral from Kelly were asked to liaise with the IDVA to ensure coordinated support was provided. The MARAC highlighted the difficulties that Housing faced in relation to changing the locks on the property as Paul was the sole tenant, and although there were problems with the tenancy which Housing was in the process of addressing, they could not change the locks to keep the legal tenant out. Housing was not aware of the previous medium risk domestic abuse incidents.

5.16 Kelly first mentioned she wanted to discuss anxiety with her GP in September 2014, but she failed to attend the appointment booked to discuss this. To ensure that the anxiety had not become worse her GP followed this up by telephoning Kelly, but she said she missed the appointment because she was running late. She was advised to rebook if she still wanted to discuss her anxiety. The action taken by the GP was good practice and showed concern for their patient.

5.17 Kelly did not contact the surgery again however until January 2015 when she saw two different nurse practitioners. This was due to her missing a second follow up appointment booked with the nurse who saw and assessed her first on 7 January. For consistency it would have been preferable if Kelly had seen the same nurse, but 2 days after she failed to attend the appointment she saw a second nurse practitioner and it may be that this was the only appointment the surgery could offer; it was helpful that she was fitted in. Kelly is described by her GP as having a good rapport with the nurse practitioner who first carried out the assessment of her depression and anxiety. The level of candour shown by Kelly in her disclosure of alcohol and substance misuse to the nurse is evidence of this good rapport. Appropriate assessments were undertaken for her presenting problems of low mood and anxiety. Oversight and advice was given by GPs regarding treatment and medication on both occasions, and to reduce risk of overdose only a small number of tablets were prescribed.

5.18 From information supplied by the practice the assessment tools used are informed by a combination of history, observation, and any relevant examination. The practice confirm that the nurse practitioner who saw Kelly on 7 January would have had access to her computerised medical records from September 2013 and any scanned documents attached to these records. From the notes of the

[19] London Metropolitan & Middlesex University (November 2013) *Evaluation of the Pilot of Domestic Violence Prevention Orders,* Research Report 76, Home Office

consultation it appears that the nurse did access her records and was aware of Kelly's admission in December 2013; the discharge letter from this admission states "Reviewed by mental health team - no evidence of low mood or suicidal ideation. Denies ongoing problems with alcohol use".

5.19 Although Kelly alluded to getting angry and cross with her partner when she drank, and she is recorded as saying that things had "come to a head that weekend" indicating that all was not well in her relationship, she does not appear to have mentioned during her assessments that she was experiencing any abuse, nor that the Police had been called and were still involved. However, there is no record of any questions or discussion with her about her relationship. Kelly may not have raised the issue because she did not recognise herself as a victim of domestic abuse especially as there were occasions when she was the aggressor; there had been at least 5 years of volatility within the relationship, probably more, as it is known that early incidents of abuse rarely result in a call to the Police. Kelly may not have recognised that the verbal and financial abuse by Paul reported by her relatives (paragraph 4.9) was in fact domestic abuse.

5.20 A meta-analysis of mental health disorders and domestic violence has identified a strong correlation between these two issues; finding that there is a higher risk of experiencing adult lifetime partner violence among women with depressive disorders, anxiety disorders, and PTSD compared to women without mental disorders[20]. Yet the assessment tools used by Health, the GAD-7 (see Appendix A) and PHQ-9 (see Appendix B) do not suggest asking about experiences of abuse. The last question on the GAD-7 asks whether the patient is 'Feeling afraid as if something awful might happen', however, this wording is not conducive to drawing out experiences of domestic abuse. Similarly there are no questions in the PHQ-9 questionnaire which would ask about abuse. This begs the question; should there be routine enquiry about experiences of domestic abuse when a patient is screened for mental health disorders? Given the research and the facts from this Review it would be helpful if assessment tools were revised to include such screening questions.

5.21 The absence of questioning about domestic abuse meant that no specific risk assessment was undertaken in this regard with Kelly. Her GP pointed out that if they had information that a patient had been referred to MARAC this would greatly assist them to recognise when a patient was at risk. The practice already has a flagging system for Safeguarding and adding a further flag onto notes would be easily achieved and in her GP's opinion this could provide valuable context when assessing patients.

5.22 Kelly was appropriately urged by a nurse practitioner to self refer to the Norfolk Recovery Partnership and it has been confirmed by the Partnership that she did so on 16 January 2015. The service sent Kelly a letter on Thursday 22 January with information about their open access service. It was good and timely practice that on the same day as the MARAC was held the Partnership was informed that Kelly's case was heard at MARAC and they were asked to treat her as a priority. On Monday 26 January two phone calls were made to Kelly, but there was no response, thus there was no opportunity to risk assess or put in place a treatment plan. The Partnership service is voluntary unless part of a court order, therefore pursuing Kelly further would not have been appropriate, and she had been sent a letter about the service to access if she wished. However, it would have been

[20] Trevillion K, Oram S, Feder G, Howard LM (2012) Experiences of Domestic Violence and Mental Disorders: A Systematic Review and Meta-Analysis. PLoS ONE 7(12): e51740. doi:10.1371/journal.pone.0051740

preferable to phone her again on a different day and time in case there was a particular reason why she may not have answered her phone on the one day she was called. A letter was sent to her GP practice and a phone call made on 29 January to let them know of the difficulty in contacting Kelly. This was a good example of inter-agency liaison by the Partnership. It is not clear whether this was recorded on Kelly's notes, but when she was seen next day by the phlebotomist for a blood test she was not told of the Partnership's efforts to contact as the phlebotomist would not have had cause to access her notes. Another means of alerting Kelly to the Partnerships efforts to contact her might have useful as she appeared to have a good relationship with the practice staff.

5.23 The referral by the nurse practitioner to the mental health Access and Assessment Team was sent in a timely manner and received on 8 January the day after Kelly saw the first nurse practitioner. It was ticked as a routine referral. The appropriateness of this level given the level of severity of her depression and anxiety scores was discussed with Kelly's GP who pointed out that the fax referral form had on 2 options; routine or contact the patient within 4 hours. As Kelly said she was not suicidal she did not need to be seen within 4 hours, but it was her GPs view that an additional choice needed to be added, preferably offering contact within 24 to 72 hours. Kelly's GP reported that they had raised this with service commissioners. The Norfolk and Suffolk NHS Foundation Trust website does show a choice of three referral levels: Emergency - within 4 hours of referral; Urgent - within 72 hours of referral, and Routine - within 28 days of referral[21]. The Trust's Review Panel member confirms that this was changed after consultation with referrers and the change was publicised widely by the Trust. It appears that the referral form used for Kelly was an out of date form which did not show the revised three levels of referral.

5.24 The referral was assessed and passed to the Improving Access to Psychological Therapies (IAPT) team. The referral contained no reference to high level risk or urgency (Kelly had denied feeling suicidal) and Kelly was contacted by phone by the Wellbeing Team on 15 January 2015, a week after the referral was received, this was within the timeframe for the level of referral given the form which was used[22]. Kelly was offered the opportunity to attend a 'taster session' on 2 February, but she declined, and instead chose a telephone assessment which was booked for 9 February 2015 at 10am. The service had no information to indicate that Kelly's referral would need to be escalated. The predominant concerns that they were aware of concerned substance misuse and anxiety due to relationship breakdown.

5.25 The IAPT team had not had the opportunity to undertake a risk assessment and in their initial telephone conversation with Kelly there was no disclosure of domestic abuse as this was not a clinical screening, triage or assessment telephone call, it was to assist Kelly to decide which type of appointment she wished to pursue. Their response was in line with protocols. However, the Panel and Kelly's GP expressed concerns regarding the use of telephone assessments for a patient who is suffering from depression and anxiety, since the patient cannot be seen visually to assess their appearance and demeanour, or to have eye contact, factors which can be essential in the assessment process. Since the Review new flexible methods of engagement have been added to the services available including Skype calls, and open access services in different locations.

[21] http://www.nsft.nhs.uk/Our-services/Pages/Access-and-Assessment-Service-Suffolk.aspx

[22] At the time of the referral the target for initial session (either face to face or phone) was 28 days. It is now 15 working days.

5.26 Kelly's missed appointments were discussed with her GP and it was explained that it was not uncommon for patients with chronic conditions such as asthma to miss appointments. Missing appointments can sometimes be an indicator of domestic abuse either due to injuries which a patient may wish to conceal, or due to constraints on their movements. Kelly's GP had no information to indicate that she was experiencing domestic abuse or that she had been referred to MARAC. Her GP was of the view that such information would be of significant value and enable them to better support their patients, for example by informing the referral process to other services to ensure timely appointments.

5.27 As a mental health or drug and alcohol assessment of need had yet to take place there was no plan in place at the time of Kelly's death.

Term of Reference 5:

Was communication and information sharing between agencies or within agencies adequate and timely and in line with policies and procedures?

5.28 It was not until the incident in January 2015 which was assessed as high risk and the case was referred to MARAC that the domestic abuse incidents became known outside of the Police structures, which includes the MASH and Victim Support. Internal communication when dealing with the previous incidents and the high risk incident were timely and effective.

5.29 There was efficient communication between Mental Health Services and the GP practice. The communication by letter and follow up phone call from the practitioner in the Norfolk Recovery Partnership is an example of good practice. There is no indication that Kelly was told of the Partnership's efforts to contact her to encourage her to follow up the referral.

5.30 The fact that someone in the Norfolk & Suffolk Foundation Trust emailed the Norfolk Recovery Partnership on the day of the MARAC to alert them of Kelly's high risk status as a victim of domestic abuse was good practice, and represented timely communication and coordination between services. This is an example of how a MARAC can work to improve services to victims.

5.31 Whilst the Foundation Trust alerted the Norfolk Recovery Partnership however, there is no mention in the IMR that the Access and Assessment Team and IAPT were informed of the MARAC information. This is due to the Trust Safeguarding Team not having access to the IAPT electronic health record; hence they were unaware that Kelly had made contact with IAPT. The IMR suggests that had they known of Kelly's high risk status they may have proactively tried to contact her again and bring forward the appointment booked for the 9 February. The IMR recommends that the Safeguarding Team remedy this gap in access to improve information sharing about high risk victims.

5.32 GP practices do not have representation on the MARAC and they had no information concerning the Police attendance at incidents or the nature of those events. It is of note however, that the MARAC referral form contains a reminder and wording in the 'Consent' section of the document to be read to a client/victim concerning the obtaining of and sharing of information which has to be ticked when this has been completed. The wording concludes with "*To make sure it is the most appropriate and effective service for you, it may mean that we will be sharing this information or obtaining information about you, from other agencies such as your GP, Health worker, Housing. (Tick when completed)" The* box was ticked on Kelly's referral. Had the GP practice had notification or there was some

form of GP representation on the MARAC to identify a victim's GP with whom to share information, Kelly's assessments and referrals by the practice staff may have been different in content and urgency.

5.33 Information from the Housing Department involved with the parties to this Review which has been withheld for data protection reasons highlighted a gap in information sharing in the operation of Domestic Violence Protection Orders. There appears to be no formal information sharing protocol in place between the Police and local authority Housing Departments concerning the implementation of the orders. Housing Departments have the potential to provide assistance in the operation of these orders, and the behaviour which brings about these orders may be in contravention of tenancy agreements which requires enforcement action. One of the lessons from the evaluation of Domestic Violence Prevention Orders identified the need to establish good inter-agency communication and referral processes[23].

Term of Reference 7:

What training had those practitioners in contact with Kelly received on domestic abuse, risk assessment and referral to MARAC and specialist support services, and do their agencies have appropriate domestic abuse policies and pathways in place to support their practitioners?

5.34 All staff within the Norfolk & Suffolk Foundation Trust receive domestic abuse awareness training and have access to the safeguarding team for advice. Within the Trust's safeguarding processes there is a current policy, and a website which includes information relating to MARAC and risk assessment.

5.35 Norfolk Recovery Partnership is a service commissioned by Public Health which is hosted within Norfolk & Suffolk Foundation Trust. As such staff in the Partnership receive domestic abuse awareness training and have access to the Foundation Trust's safeguarding team for advice via a duty system operating in office hours. The Partnership also comes under the Foundation Trust's safeguarding processes and domestic abuse policy, plus staff have access to the same website and information related to MARACs and risk assessment as the Foundation Trust's staff. The staff within the Trust and the Norfolk Recovery Partnership did not have the opportunity to put their training into practice as Kelly had yet to be contacted or have an assessment. However, the MARAC representative recognised the significance of the information for assessments and passed this to the Recovery Partnership, although not to IAPT.

5.36 Norfolk Police officers are trained on domestic abuse and DASH risk assessment. There are also regular announcements to officers on updates to legislation and policy changes. Further advice and guidance is available via the Constabulary's intranet which provides a comprehensive library on domestic abuse, Domestic Violence Prevention Notices, Domestic Violence Protection Orders and the services available through the MASH to support officers in the investigation and risk reduction of abuse. All officers across the Constabulary have been provided with a Vulnerability Guide which details safeguarding activity around abuse. The Safeguarding and Investigation Command have also created a series of podcasts as part of the vulnerability learning schedule to compliment the vulnerability online eLearning modules. The podcasts are designed to help officers to

[23] London Metropolitan & Middlesex University (November 2013) *Evaluation of the Pilot of Domestic Violence Prevention Orders*, Research Report 76, Home Office

understand their role in identifying vulnerable victims, understanding the principles of safeguarding and showing the different types of abuse vulnerable victims can experience. Included within this series is a specific podcast relating to domestic abuse. The actions of the officers in this case were consistent with the training they receive and the policies in operation.

5.37 The GP practice with whom Kelly was registered has confirmed that their staff have received training in domestic abuse and safeguarding adults, including the different categories of domestic abuse. They received a short training session by the Leeway Domestic Violence & Abuse Service on 23 September 2014 which the practice confirm covered identification, categories under which domestic abuse can occur, and written and verbal advice on who staff should contact if abuse is identified. The practice confirms that the training was to enable clinicians to enquire about domestic abuse and guide patients appropriately. Staff are aware of the DASH risk assessment tool, but have not had training in its completion. Similarly, they have not had training in the referral pathway for MARAC, but have been provided with contact details for the domestic abuse helpline and Leeway. The Panel is aware that Leeway was commissioned to provide training to GPs following previous Reviews. However, the training is very condensed as it is designed to fit around surgery times. Research shows that many women choose to disclose abuse to their GP if they feel safe to do so, and women living in rural areas in particular have been found to emphasise the role of health professionals in providing a safe and confidential service[24]. There was no inclusion of questions about domestic abuse in Kelly's assessments at the practice indicating that further training and support for staff would be beneficial to help them identify high risk patient groups, and to develop their skills around sensitively asking questions to identify when abuse is taking place. Kelly's GP has stated that they would welcome further training on asking about domestic abuse and having training on the content of the DASH risk assessment.

5.38 Domestic abuse is core work for Leeway and as would be expected their staff are trained and policies support their practice. Similarly, Victim Support staff are trained in domestic abuse and there are policies in place for the client group they support and referral on for the high risk clients to the IDVA Service run by Leeway.

Term of Reference 8:

Are there any systems or ways of operating that can be improved to prevent such loss of life in future, and were there any resource issues which affected agencies ability to provide services in line with best practice?

5.39 The system of telephone contact used for assessments and engaging with service users has its pitfalls when applied to those who may be apprehensive or unsure of engagement, resistant, or suspicious. Accessing drug and alcohol, and mental health services can be daunting and surrounded by stigma which can present significant barriers. The Panel discussed this issue in light of the many attempts and failures which services experienced in trying to contact Kelly. Home visit contacts to service users have been impacted upon by resource constraints, and those in rural areas are especially affected by this; it is not practical or an efficient use of practitioner time to undertake home visits before contact is achieved and an appointment is made.

[24] McCarry, M. and Williamson, E. (2009) *Violence Against Women in Rural and Urban Areas.* Bristol: University of Bristol.

5.40 The Panel member for Victim Support reported that their service users have reported that they do not answer calls from withheld numbers, and such numbers are frequently used by services. Also a service user may be anxious about answering a call from an unknown number if they have money difficulties in case it is someone calling about an unpaid bill. These may be possible explanations for why Kelly did not answer calls. It was suggested that sending a text message may be a more successful approach as service users can be asked how they wish to be contacted and a text gives them time to consider the message and respond when convenient or safe to do so.

5.41 The MARAC system works well in Norfolk, however there is a gap in terms of GP representation and sharing of information. Given how crucial GPs are in assessing the needs of their patients and being the gateway to other more specific healthcare services, the gap in information sharing about their patient's experiences of abuse and the risk they face is significant. As mentioned in the information sharing terms of reference section, if a victim has consented to information sharing at the start of the MARAC referral, which includes their GP, the barriers to this information sharing, even if only from MARAC to a GP, should not exist. Whilst appreciating the acute pressures GPs are under, Kelly's GP recognised the value of such information and how it would only serve to increase the accuracy and effectiveness of assessments, and the potential this brings to save time and to direct patients to appropriate resources. The practice already has a 'flagging' system for safeguarding, and Kelly's GP helpfully suggested that a similar system would be straightforward to introduce to highlight the support needs of patients who were at high risk from domestic abuse. If a suitable representative GP liaison person could be found to attend MARAC and feedback to a victim's GP this could have increased benefits for a patient's treatment plan and wellbeing, as well as increasing their personal safety.

5.42 It is sad to think that Kelly had taken steps to seek help for her mental health problems and her substance abuse, but agencies had such difficulty in contacting her by phone for whatever reason. Agencies need to have a clear policy for how to deal with non-attendance or failed contact which includes a process for escalation where this gives, or should give, cause for concern.

Term of Reference 9:

Was Kelly assessed or could she have been assessed as a 'vulnerable adult' pre 31 March 2015 or an 'adult at risk' post 1 April 2015? If not were the circumstances such that consideration should have been given to this risk assessment?

5.43 The Panel and information from IMRs found that Kelly did not meet the criteria to be considered as a vulnerable adult or the more recent term of an adult at risk under all the criteria for these terms. It is arguable that she was in need of 'care and support', however she was capable of taking steps to protect herself, and she had begun to take some of those steps by seeking support from her GP practice.

Term of Reference 10:

To examine whether there were any barriers which prevented Kelly from seeking or accepting help in respect of experiencing domestic abuse, her health needs, or any other relevant support services. Are there lessons to be learnt from the identification of any barriers which could assist agencies in adapting their procedures and processes which could alleviate or break down these barriers in future?

5.44 Women who experience domestic violence are 15 times more likely to use alcohol and 9 times more likely to use drugs than women that have not been abused[25]. Research consistently shows that women's use of alcohol in abusive relationships is as a consequence of the abuse, with alcohol often used to self-medicate to dull the effects of physical abuse and/or emotional pain[26]. The co-existence of these issues presents additional barriers for service users and challenges for services.

5.45 Barriers can be internal or external[27]. Among the internal barriers are perceptions of the stigma attached to all three problems of domestic abuse, mental ill-health, and substance misuse which can present obstacles to seeking help. In his statement for the Inquest Kelly's father said he was aware that there were sometimes difficulties in the relationship, but he was unaware of what those were; he learnt of them from others. There is an indication that Kelly shielded her family from what was going on. In his statement for the Inquest Paul maintained that he had urged Kelly to talk to her parents, but that she had said "they don't need to worry about me".

5.46 Survivors of domestic abuse have often been subjected to years of emotional abuse which depletes their self-esteem and self confidence to the extent that they become disgusted and ashamed of themselves for their drug and alcohol misuse.[28] Coupled with depression this can make seeking and finding help seem like too much effort, or the survivor may convince themselves they are not worth the effort or cannot succeed in changing. Kelly also appears to be enmeshed in her relationship with Paul which again may indicate that she felt she could not manage on her own. It is telling that she turned down an offer of support with housing by a Police officer because she wanted to do it for herself; one action perhaps she felt at the time she did have the power to achieve, but the additional requirement she mistakenly thought of needing to access benefits first may have proved another effort she could not cope with at the time, for there is no evidence that she did contact any local Housing Department. Perhaps she could not overcome her feelings for Paul and decided to stay with him instead.

5.47 Women may blame themselves for the abuse and this can form a psychological barrier to seeking help. Kelly appears to have done this to an extent when she admitted that she became aggressive and angry with her partner when she was drunk; she told the nurse that this was why her partner had left, but not about his assault. Whilst this may be true by her own admission, she appears to take the sole blame for the difficulties in the relationship; there was no recognition that Paul's behaviour and infidelity contributed to her drinking and its consequences.

5.48 Among the external barriers are access to services, the timing of services, and particularly for those living in rural areas, there are barriers in terms of fewer sources of information and services, and transport costs to access services. Women living in rural areas may also be concerned about confidentiality in a

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[25] Barron J (2004) *Struggle to Survive*. Bristol, Women's Aid Publications

[26] Humphreys C, Thiara R, Regan L. (2005) *Domestic Violence & Substance Misuse, Overlapping issues in separate services. London, Stella Project*

[27] Adi Jaffe, Ph.D., *Can't Get In: Barriers to Addiction Treatment Entry*. *https://www.psychologytoday.com/blog/all-about-addiction/201203/cant-get-in-barriers-addiction-treatment-entry* . *Accessed 09.01.16*

[28] Druglink January/February 2007. http://www.ccrm.org.uk/images/docs/7.3bdoubleedgedswordarticle.pdf . Accessed 10.01.16

small community[29]. Having to go on a waiting list has also been found to be a deterrent and to affect engagement[30]. How services are delivered may impact on a service user's engagement; Kelly declined to attend a taster session group and as this was her first attempt at accessing drug and alcohol services it is understandable that she might find a group very daunting. The alternative telephone assessment in a month's time proved too late for Kelly.

5.49 From a practical point of view agencies found that Kelly did not have a voicemail facility on her phone; therefore they were unable to leave messages. It is reported that she was short of money, and her family member reported that sometimes she did not have credit on her phone, and so even if she had picked up messages she may not have had credit to phone back. Coupled with her other problems this practical barrier possibly impacted on her ability to engage with services and the resultant delays meant "striking while the iron was hot" when she was showing an interest in addressing her drug and alcohol problems, was lost. A further problem highlighted by our Victim Support Panel member is that their research revealed that service users are reluctance to answer 'withheld' numbers; 'withheld' telephone numbers are frequently used by services. An added difficulty for Kelly was the fact that Paul was later found to have been at the property in breach of the Prevention Order, therefore she may not have answered calls due to his presence.

Term of Reference 11:

5.50 *The chair will aim to make contact with family members and to keep them informed of the Review and its outcome.*

5.51 The chair has fulfilled this duty which is described in the Methodology section of this Review.

6. Conclusions

6.1 From the information known to agencies, particularly from the beginning of contact with Kelly in January 2015, her death was indeed unexpected and was therefore not considered predictable. She herself told Police officers and health professionals that she did not feel suicidal even though her anxiety and depression scores appear to be high from the assessments used. Key health professionals such as her GP, nurse practitioners, and IAPT did not know she was considered a high risk domestic abuse victim, had they done so the urgency of referral and speed with which she was seen might have been different.

6.2 Sadly, Kelly died unexpectedly just as she appeared to begin seeking help for some of her problems. There is no definitive evidence to support an hypothesis that faster access to mental health support may have prevented her actions. Therefore it is speculation as to whether face to face contact with a mental health professional soon after the initial phone call might have made a difference instead of having to wait for a telephone assessment in a month's time. However, something clearly changed for Kelly which drove her to take the action she did, what that was we do not know.

[29] McCarry, M. and Williamson, E. (2009) Violence Against Women in Rural and Urban Areas. Bristol: University of Bristol.
[30] ibid - see footnote 21

6.3 Kelly's family members do feel that her experiences within her relationship with Paul had an effect on her. In one family member's statement for the Coroner they stated that they believed his behaviour contributed significantly to her decision to end her own life.

6.4 The Police acted as fast as they could on receiving the call from Kelly in February 2015, but were unable to save her. The Review is unable to find with any certainty that her death was preventable.

Lessons Learnt

Information Sharing:

6.5 This Review has identified that the Police were the primary agency with information about the domestic abuse within the relationship until the last incident when the MARAC referral meant information was shared more widely, but this information did not reach the GP practice with whom she had close contact or the section of the Mental Health Trust to which Kelly had been referred. This meant that key information about the risk and difficulties Kelly faced in her life were not known to her GP practice and the mental health service to which she had been referred. This affected both her assessments and the level of priority she was given. A way needs to be found to include information sharing with GPs and to ensure that all services to which a victim has been referred are fully appraised of their needs and the risks they face to enable safe coordination of services to take place.

6.6 The local housing provider had no knowledge of the Domestic Violence Prevention Order, and this information would have assisted them in managing the tenancy and the problems which were arising from it. It was the view of the Panel representatives for the housing provider and the Local Authority Housing Department that had they known they could have assisted the Police with the management of the order. A lesson learnt from the evaluation of these orders highlighted the value of multi-agency coordination and processes. It would be helpful if formal agreements could be put in place to assist in what is a relatively new tool in the box for protecting those affected by domestic abuse. This was a point of early learning in the Review and the Police commenced work to address information sharing with housing providers.

6.7 Kelly's GP practice had information from the Norfolk Recovery Partnership informing them of their inability to contact her. This was not passed on to Kelly when she next came into the surgery the day after. Given her good relationship with practice staff and a practice nurse's recommendation that she self refer to this service, it would have been positive reinforcement if she had been contacted by a practitioner to let her know of the missed contact.

Assessments:

6.8 Whilst assessments undertaken for assessing depression and anxiety were in line with the purpose for which they were intended, namely looking for evidence of mental disorder rather than the cause, the PHG-9 and the GAD-7 used by Health do not include trigger questions or guidance to ask about domestic abuse despite the proven links between mental health disorders and domestic abuse. It is important that services ensure that health professionals are fully aware of this evidential link and steps are taken to amend or augment assessment tools to include questions about domestic abuse.

Access to Services and Lack of Engagement

6.9 Professionals had great difficulty in engaging and contacting Kelly. It is likely that there were a multitude of reasons for this compounded by what has become known as the toxic trio of domestic abuse, mental ill-health, and the misuse of substances such as drugs and alcohol. Services need to understand the additional internal and external barriers that victims face, which sometimes appear as barriers they themselves are putting up against engaging with those trying to support them. Learning from this Review should generate a review and discussion concerning the coordination and delivery of the relevant services, taking into account that those affected by the three issues may feel stigmatised and nervous about engaging with services. Therefore extra effort may be required to encourage and support engagement with services and this needs to be informed by service users themselves.

6.10 There were practical barriers in accessing Kelly. Her phone had no voicemail facility, and her family member reported that she often ran out of credit on her phone making it impossible for her to make phone calls. We also know that Paul was in the property with Kelly in breach of the Prevention Order, and his presence may also have prevented her from answering her phone. A Panel member also advised that some service users do not like to answer phone calls from 'withheld' numbers which are often used by services. These situations provide a significant barrier when service's systems of operating are reliant on a set number of attempts at telephone contact and then closing the case when this is not successful. The system does not take into account these difficulties. There needs to be more flexibility in services' procedures in recognition of the barriers identified in this Review, especially were domestic abuse brings added risk and vulnerability

6.11 Whilst recognising that there needs to be a degree of motivation to change and engage with services, there is a tendency for too much onus to be put on the patient or service user to take responsibility for this. When an individual is suffering from a depressive illness the effort to respond to letters and phone calls, and find the means to travel to appointments can seem too much. The Review has heard that patients referred to mental health services now have one phone call and if this is missed then a letter is sent giving 7 days to respond after which the case is passed back to the referrer for further risk assessment.

Victim as Both Victim and Perpetrator

6.12 Judging a victim who is also a perpetrator of violence is not always straightforward and care is needed to assess underlying factors. Kelly's troubled teenage years appear to have set her on a life course different from her family members. It led her into a peer group seen as 'the wrong crowd' and into a relationship which was abusive as well as inconsistent in the degree of loyalty shown to her. Whilst she appeared to settle and have steady employment for a number of years the move to the small community in which she lived seems to have changed her life in a negative way; she left her job due to transport difficulties which in turn left her short of money and lacking structure to her day. She and her partner also socialised with a group of people who were engaged in drinking and the use of illicit substances which exacerbated her problems.

6.13 Although Kelly admitted to using various substances for many years previously the Police callouts to incidents involving alcohol in particular appeared to be increasing. This was a problem for Kelly as she herself admitted that she became angry and aggressive when she was drunk and on some of the Police callouts she

was the aggressor. It is hard to judge from the facts known whether Kelly's drinking was in response to the abuse she was experiencing, especially the psychological and verbal abuse, but alcohol and drugs are frequently used to self-medicate to block out thoughts and to cope with feelings arising from abuse. So although at times the violence in the relationship seemed to be mutual, in the context of domestic abuse Kelly's violence appears to have arisen from her alcohol use when she felt less inhibited and less aware of the risks attached to her actions.

6.14 It is noteworthy that at the time of the last assault involving Police intervention in January 2015 Kelly was not intoxicated and she had appeared genuinely frightened by the assault she had sustained. She told a Police officer that the relationship would end by Paul killing her or her killing him, and that she wished she had stabbed him so that "at least it would be over". These comments give a strong sense that she had been worn down over time by the relationship and her depression was increasing. Recognising the victim underneath the aggression is sometimes difficult, but Kelly had complex needs for care and safety which required a multi-agency approach which she may have been finding difficult to navigate.

Early Intervention

6.15 Looking back to her teenage years and into her 20's could more have been done to address the damage of her chaotic and risky lifestyle? The Review has not researched the interventions by agencies at that time, however, it is known from Kelly's comments that she found an anger management course useful in her 20's. She clearly recognised she had difficulties in her personal life and her behaviour at that point. What was behind her anger we do not know, but early psychological and therapeutic interventions may have been helpful at that stage of her life.

Recommendations

6.16 The following recommendations arise from agency's IMRs and from the lessons learnt from this Overview Report. A SMART action plan containing the recommendations and the method of their implementation has been developed.

National:

1) The Home Office Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Section 2 subsection 4 should be amended to specifically include GP practices as having a duty to participate in a Domestic Homicide Review and to have regard to any guidance issued by the Secretary of State

2) A clause should be added to the NHS GP contract to stipulate their active participation in Domestic Homicide Reviews and Safeguarding Adult Reviews

3) That Intercollegiate Guidance for adult safeguarding which informs national training should include specific focus on domestic abuse including the Home Office definition of domestic abuse[31], recognition of risk, and a process to escalate those risks and concerns.

[31] https://www.gov.uk/government/news/new-definition-of-domestic-violence

County:

4) The MARAC process should be reviewed to ensure that information concerning risk relevant to the service user is passed safely and promptly to any services to which they have been referred, as well as their GP practice.

5) A multi-agency protocol should be put in place to set out a process for sharing information with partner agencies when a Domestic Violence Prevention Notice or Prevention Order is being considered and/or put in place to support effective implementation and monitoring of the Order.

6) Mental ill health, depression or anxiety presentations to GPs, other health and social care practitioners and wider partners should ensure that the known links between these conditions and domestic abuse are recognised and that:

- assessments include sensitive routine enquiry about domestic abuse
- appropriate action is taken if abuse is identified

7) The Domestic Abuse & Sexual Violence Board to form a working and consultation group to examine the most practical and effective method of supporting GPs and their clinical staff to:

- implement a system of identification and risk assessment for patients who disclose, or who may be experiencing domestic abuse
- ensure a process for referring to specialist support and safety planning
- explore feasibility of providing in-house counselling services

8) Learning from this Review should be disseminated and generate a review of service delivery to those with the coexisting issues of domestic abuse, mental ill-health, and/or substance misuse, and be informed by service users themselves.

The aims of this review should include:

- coordinating service provision to improve access and engagement
- ways and means of maintaining active engagement of the service user through the most appropriate agency and means of contact
- developing a clear policy for how to deal with non-attendance or failed contact, with a process for escalation where this gives cause for concern
- Consideration of referral to Adult Safeguarding.

(The review may wish to consider the whole system and holistic approach advocated by Alcohol Concern's Blue Light Project).

9) The Norfolk & Suffolk Foundation Trust to ensure that the Safeguarding Team have access to all patient record systems to effectively identify when a patient has been referred to any branch of their service and to MARAC, and to alert the service of the MARAC referral and outcome quickly to ensure appropriate and timely services to high risk victims of domestic abuse

10) The Trust should work together with CCGs to review the referral timescale choices to provide appropriate and timely options for referrers and their patients and to ensure that this is communicated to front line practices.

Top of Form

Generalised Anxiety Disorder Questionnaire (GAD-7)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. Feeling nervous, anxious or on edge?	Not at all Several days More than half the days Nearly every day
2. Not being able to stop or control worrying?	Not at all Several days More than half the days Nearly every day
3. Worrying too much about different things?	Not at all Several days More than half the days Nearly every day
4. Trouble relaxing?	Not at all Several days More than half the days Nearly every day
5. Being so restless that it is hard to sit still?	Not at all Several days More than half the days Nearly every day
6. Becoming easily annoyed or irritable?	Not at all Several days More than half the days Nearly every day
7. Feeling afraid as if something awful might happen?	Not at all Several days More than half the days Nearly every day

TOTAL: /21

The GAD-7 originates from Spitzer RL, Kroenke K, Williams JB, et al; A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006 May 22;166(10):1092-7.

The GAD-7 score is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all," "several days," "more than half the days," and "nearly every day," respectively, and adding together the scores for the seven questions. Scores of 5, 10, and 15 are taken as the cut off points for mild, moderate, and severe anxiety, respectively. When used as a screening tool, further evaluation is recommended when the score is 10 or greater.

Source: http://patient.info/doctor/generalised-anxiety-disorder-assessment-gad-7 Accessed 9.01.16

Patient Health Questionnaire (PHQ-9)

Over the last two weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things?	Not at all Several days More than half the days Nearly every day
2. Feeling down, depressed, or hopeless?	Not at all Several days More than half the days Nearly every day
3. Trouble falling or staying asleep, or sleeping too much?	Not at all Several days More than half the days Nearly every day
4. Feeling tired or having little energy?	Not at all Several days More than half the days Nearly every day
5. Poor appetite or overeating?	Not at all Several days More than half the days Nearly every day
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down?	Not at all Several days More than half the days Nearly every day
7. Trouble concentrating on things, such as reading the newspaper or watching television?	Not at all Several days More than half the days Nearly every day
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual?	Not at all Several days More than half the days Nearly every day
9. Thoughts that you would be better off dead, or of hurting yourself in some way?	Not at all Several days More than half the days Nearly every day
	TOTAL: /29

Depression Severity: 0-4 none, 5-9 mild, 10-14 moderate, 15-19 moderately severe, 20-27 severe.

Kroenke K, Spitzer RL, Williams JB; The PHQ-9: validity of a brief depression severity measure. J Gen Intern Med. 2001 Sep;16(9):606-13.

Source: http://patient.info/doctor/patient-health-questionnaire-phq-9 Accessed: 09.01.16

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21 October 2016

Dear Ms Jessett,

Thank you for submitting the Domestic Homicide Review (DHR) report for Norfolk in relation to the death of 'Kelly' to the Home Office Quality Assurance (QA) Panel.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel found this to be an excellent report with good probing of agency reports and which sensitively represented the information obtained. The Panel commended the liaison with the Coroner and the involvement of the GP. The Panel found the footnotes particularly helpful.

The Panel made the following observation which you may wish to consider before you publish the report:

- Paragraph 6.16 makes reference to an action plan containing the recommendations but this was not submitted with the overview report and executive summary.

The Panel does not need to see another version of the report, but I would be grateful if you could include our letter as an appendix to the report.

I would also be grateful if you could email us at DHREnquiries@homeoffice.gsi.gov.uk and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners (PCC) on DHRs in their local area. I am, accordingly, copying this letter to the PCC for Norfolk for information.

Yours sincerely

Christian Papaleontiou
Chair of the Home Office DHR Quality Assurance Panel