Norfolk County Community Safety Partnership

DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

Into the death of

Emily in May 2015

Report Author

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Preface

The Norfolk County Community Safety Partnership Review Panel would like to express their sincere condolences to the family and friends of Emily whose unexpected death has brought about this Review. She is greatly missed by her family, her close friends and many members of her local community who have been very distressed by her sudden death.

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 are or 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. In this case Emily's death was not due to homicide, but met the criteria for conducting a Review under statutory guidance[1] issued under Section 9(3) of the Domestic Violence, Crime, and Victims Act 2004, which 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*

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)

DOMESTIC HOMICIDE REVIEW

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 May 2015. Although this Review is called a Domestic Homicide Review it should be noted that the death is not due to a homicide, and no one is or has been under investigation in respect of Emily's untimely death. However, as there had been recent contact with the Police in relation to domestic abuse, in line with legislation, it has been decided to conduct a review to consider agency contact and involvement with Emily and to establish if there are lessons to be learnt. The scope of the review is from 2013 when Emily's relationship with her husband is alleged to have changed up to the date of her death.

Timescales

1.2 The Chair of the Norfolk County Community Safety Partnership received notification from the Police concerning the unexpected death of Emily in May 2015. The Chair and Gold Partnership members met on 25 June 2015 when the decision was taken that the circumstances met the requirements to undertake a Domestic Homicide Review. The Home Office was informed on 28 July 2015. This was just inside the required notification period of 1 month (taking into account working days). The review commenced with a first Panel meeting on 17 September 2015 and was concluded on 31 March 2016.

Confidentiality

1.3 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.

1.4 To protect the identity of Emily, and her family the following pseudonyms have been used throughout this report.

The deceased: Emily aged 69 years at the time of her death. Emily was of white British ethnicity.

Her husband: Peter aged 82 years at the time of the death. Peter is of white British ethnicity.

Dissemination

1.5 The following agencies will receive copies of this report:

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
GP Practice for Emily
NHS England
Chief Officer Age UK Norwich
Chief Executive Officer & the Safeguarding Policy Lead National Age UK
Chief Officer, Norfolk Branch of MIND

Summary

1.6 In May 2015 an incident took place on a railway line in Norfolk in which a woman suffered fatal injuries after standing in front of a train. The woman was later identified as Emily. Norfolk Police had had contact with Emily on four occasions prior to her unexpected death; twice in the previous month, and twice in May. The first and second contacts were in response to a phone call from Emily reporting threatening behaviour by her husband which resulted in his arrest and caution for common assault; this was followed-up by a call to check her welfare and to provide advice. The third contact was due to concerns raised for Emily's wellbeing by a third party, and in the final contact Emily visited the Police station in person.

1.7 During contact with the Police Emily described behaviours which suggested verbal and psychological abuse and various actions by her husband which were controlling. She maintained that her husband's behaviour had changed in the last 2 years, and she thought he may have dementia, but he would not go to the GP. From the information available to the Review there is no indication that Emily’s husband was diagnosed as suffering from dementia.

1.8 Emily had no history of mental ill-health in that she had never been referred to Mental Health Services. However, she had shared her worries about her relationship and her thoughts that her husband's change in behaviour in the last few years may be due to the onset of dementia with her GP. At her last GP appointment she had been prescribed medication used for the treatment of severe anxiety and tension. Emily had also sought the advice of Age UK.

1.9 Among the information and support offered to Emily by the Police, Victim Support and Age UK was to contact Leeway, a specialist domestic abuse support agency. However, checks reveal that she did not make contact.

Terms of reference of the review

1.10 **Statutory Guidance (Section 2) states the purpose of the Review is to:**

a) 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;
b) 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;
c) Apply these lessons to service responses including changes to policies and procedures as appropriate; and
d) 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.

DHRs are not inquiries into how the person died or into who is culpable; that is a matter for the coroners and criminal courts, respectively, to determine as appropriate. Nor are they specifically part of any disciplinary inquiry or process.

Specific Terms of Reference for this Review:

1) To examine agency contact and events occurring from 2013 when the Emily's relationship with her husband is alleged to have changed up to her death in May 2015. Agencies with information relevant to Emily before 2013 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 the unexpected death of Emily was in any way connected to her being a victim of domestic abuse.

3) To establish what contact agencies had with the Emily 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 Emily's physical and mental 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 the Emily 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 the Emily 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?

9) Were there any resource issues which affected agencies ability to provide services in line with best practice?

10) 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 Emily 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?

11) To examine whether there were any barriers which prevented Emily 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?

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

Methodology

1.11 The first Panel meeting took place on 17 September 2015 at which the terms of reference were drafted. There was a delay in convening the first Panel due to the availability of Panel members, however, this did not delay information being gathered from agencies who were asked to confirm whether they had contact with Emily, and if so to provide brief information of that contact and to secure their files.

1.12 Of the 13 agencies contacted 6 confirmed knowledge of the parties involved, of which 4 had direct contact with Emily and information supplied by them was written into a combined narrative chronology. From this the Panel agreed that the Police and GP would be required to submit an Individual Management Review (IMR) and Age UK Norwich would provide information proportionate to their involvement. Victim Support provided a chronology of their brief contact.

1.13 The chair wrote to family members to inform them of the Review, and following telephone contact with one of Emily's close relatives the terms of reference were sent to them and they were invited to add any questions they might wish to have answered. No further extra questions were requested. It was agreed that the chair would make contact after the coroner's inquest to share the draft report and to gain contributions from family members. The chair shared a final draft of the report with a member of the family who was acting as the main point of contact and a number of amendments were made and extra information was added as a result. A copy of the report will be provided to the family member once agreed by the Quality Assurance Panel and before it is published.

1.14 Prior to the Coroner's inquest the chair had a number of phone conversations with Emily's husband, and information provided by him is included in this report.

1.15 The chair conducted interviews with two contributors who had known Emily for many years, and copies of statements and a copy of a note written by Emily have been provided by British Transport Police whose jurisdiction covers the rail network. They were the lead agency for the investigation of Emily’s death.

1.16 The IMR provided by the Police was thorough and met the terms of reference. The IMR author is part of the Professional Standards Department, and is independent of the line management of the officers who had contact with Emily or her husband. In undertaking the IMR in addition to reviewing the Force domestic abuse policy, the author reviewed

both electronic and paper files, including pocket note books of officers involved. Three officers involved were interviewed and the training they had received reviewed.

1.17 Information concerning Emily's appointment with Age UK was provided by the agency and this was followed by further information arising from questions by the chair in light of contributions by others.

1.18 The GP practice IMR was requested via NHS England. However, no IMR was received. The Panel received a chronology of Emily's GP appointments for the period under review including scans of letters to her GP. This chronology raised questions which the Panel felt needed answers. A member of the Panel agreed to contact the practice to arrange an interview with Emily's GP. The Panel member's request for an appointment was unsuccessful. The practice maintained that the report provided to the Coroner for the inquest contained all necessary information. The chair was provided with a copy of this report and the Panel disagreed with this view. The chair liaised with the Coroner's office and the Coroner requested sight of an early draft or the DHR Overview report for her information. This was agreed by Panel and the draft report which detailed agency involvement and up to the analysis section was provided prior to the inquest being held. The chair provided the Coroner's officer with the additional information the Panel was seeking from the GP practice, and the GP and practice manager were called to give evidence to the inquest. Significantly more information came to light in the inquest which had direct relevance for the Review, and recommendations have arisen as a direct result of this. The coordination and collaboration between the DHR chair and Panel members and the Coroner's office proved particularly effective in achieving crucial facts to inform both the inquest and the DHR. The chair is grateful for the support of the Coroner and her officer in this case.

Contributors to the Review

1.19 The following agencies and the nature of their contribution to this review are:

- Norfolk Police - chronology and Individual Management Review
- GP Practice - chronology
- Age UK - chronology and information
- Victim Support – chronology
- British Transport Police

Members of the Review Panel:

1.20 The members of the Review Panel for this DHR were:

- Gaynor Mears, Independent Chair and Report Writer
- Det. Insp. Bruce Clark, Professional Standards Dept., Norfolk Constabulary
- Helen Frayer, Senior Service Delivery Manager, Norfolk & Suffolk Victim Support
- Meadhbh Hall, Deputy Head of Safeguarding Adults, Norfolk Community Health and Care.
- Margaret Hill, Community Services Manager, Leeway Domestic Violence & Abuse Services
- Michael Lozano, Lead for Patient Safety, Norfolk & Suffolk NHS Foundation Trust (Mental Health Services)
- Emma McKay, Director of Nursing, Norfolk & Norwich University NHS Hospital
- John Morrison, Quality & Safety Manager, NHS England East
- Walter Lloyd-Smith, Safeguarding Adults Board Manager, Norfolk County Council
- Jon Shalom, Community Safety Coordinator, Norfolk County Council
- Howard Stanley, Adult Safeguarding Nurse, Gt Yarmouth and Waveney Clinical Commissioning Group

- Sandra Flanagan, Deputy Chief Executive Officer, Norwich MIND (attended 1st Panel)
- Ian Sturgess, Domestic Abuse & Sexual Violence Coordinator, Office for the Police & Crime Commissioner for Norfolk
- Jo Willingham, Information & Advice Manager, Age UK Norwich
- Det. Supt. Julie Wvendth, Safeguarding & Harm Reduction, Norfolk Constabulary
- Dawn Jessett, Community Safety Assistant, Norfolk County Council, (DHR Administration)

Author of the Review:

1.21 The author of this DHR Overview Report is independent 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 violence field both in practice and strategically, including roles at county and regional levels. Gaynor Mears has undertaken previous 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 Norfolk in the past or currently.

2. The Facts

2.1. Emily and her husband lived in Norfolk on the outskirts of one of the county's towns; they had lived in the same home for many years, and were active members of their local community. Emily and her husband had been married for 42 years and had grown up children and grandchildren. They lived alone, their family having left home to live independently.

2.2. It is known from a statement made by a contributor and confirmed by the services concerned that on the morning of her death Emily phoned her GP practice to speak to her GP who was not there and she visited the local Police station. When Emily visited the local Police station early in the afternoon she asked to see a named officer, but he was not on duty. She had had two visits to her home by the Police previously in relation to a common assault by her husband, and following a third party raising concerns for her welfare. When Emily visited the Police station that afternoon she was seen by a Police Community Support Officer; she was seeking advice. She was expressing concern that her husband's behaviour was due to the onset of dementia. Emily explained that she had sought help from her GP, but had been told that without evidence they were unable to do anything. She asked the officer she saw for advice about whether she could put up a camera to record evidence of her husband’s behaviour and what he says to her.

2.3. Emily told the officer about the previous Police involvement and her husband's behaviour which she said had been going on for years, but that it was just ‘insulting words and things like that’. The officer checked with Emily if she felt at risk of harm and she said she did not, she just wanted advice about recording and for her husband to go to the doctor. The officer advised that it was his understanding that she could do what she liked in her own home, but was not 100% sure and recommended she speak with a solicitor. The officer checked with their superior that the advice given was correct. The officer reminded Emily to call 999 if she felt in danger, and discussed further what she could do. Emily reiterated that she just wanted advice and thanked the officer.

2.4. Emily was due to have her 70th birthday the day after her death, and it is understood that it was the family custom to celebrate by going out to lunch together. However, when her

family members contacted her about arrangements Emily was evasive and would not make a firm commitment to meet. She said she would contact them later.

2.5. At approximately 19:15hrs that day a woman later identified as Emily was killed in a collision with a train.

Parallel Reviews:

2.6. A Coroner's inquest was held in December 2015. A verdict of suicide was recorded. The Coroner issued a Regulation 28: Report to Prevent Future Deaths raising matters of concern which was sent to Emily's GP practice. The concerns raised covered the flowchart used by the practice for responding to domestic abuse which was vague and used an assessment of risk pertaining to depression and not the risk of abuse. The practice had no questionnaire specific to domestic abuse to assist in recognising signs of abuse and standardising the surgery's GPs' response to concerns raised. There was no method available to members of staff to recognise when a patient's call should be escalated and dealt with immediately.

2.7. British Transport Police conducted the enquiry into the fatality and submitted a report to the Norfolk Coroner.

2.8. Following Independent Police Complaints Commission (IPCC) guidelines on incidents of death or serious injury following contact with the Police, Norfolk Police made a voluntary referral to the IPCC. The IPCC decided the matter should be subject to local investigation by the Norfolk Constabulary Professional Standards Department. The following is the rationale for their decision:

> *In making this recommendation we have considered the information and evidence which has been made available to us as well as the potential for further evidence which may be available. Although concerns have been identified regarding the manner in which (Emily) was dealt with prior to her suicide, we are satisfied that this matter can be investigated by the PSD. We recognise that a domestic homicide review is being recommended and this should aide in further ascertaining whether all the risk assessments that were applied to the circumstances were appropriate, and, whether all the appropriate steps were taken by relevant agencies in ensuring safeguarding was in place in respect of (Emily's) ongoing welfare.*

3. Chronology:

3. 1 Information given to the Police by Emily indicates that the relationship between the couple changed after her husband had an illness in 2013 and he reached 80 years of age. This is corroborated by other contributions to the review. Her husband's illness was not life threatening, and he was treated with medication. Before this time they were seen to be a happy couple.

3. 2 Emily consulted her doctor predominantly due to physical health problems. She suffered from a small number of common ailments for which she received medication. In January 2012 she had a fall after which she consulted her GP about chronic hip, neck and back pain for which she was prescribed Naproxen, a non-steroidal anti-inflammatory drug (NSAIDs) which is widely used for pain relief and to reduce inflammation. When this proved insufficient she was prescribed Amitriptyline[2] 25mg, and later a short course of

[2] Amitriptyline: a group of drugs called tricyclic antidepressants, although they are still used to treat anxiety and depression, they are also now widely used at lower doses to help block the chronic (long-term) pain of some rheumatic conditions. The main aim of lower-dose amitriptyline is to relieve pain, relax muscles and improve

Tramadol. In the coming years she had a repeat prescription for co-codamol for pain relief. An x-ray revealed mild to moderate osteoarthritis. However, this does not appear to have prevented Emily from pursuing her keen interest in gardening.

3. 3 Emily also suffered from tinnitus which caused her problems sleeping. She was referred privately to a consultant in December 2012, after which she was fitted with hearing aids to help address a diagnosed hearing loss. The consultant commented that Emily appeared to be 'a rather anxious lady', although this is contrary to descriptions of Emily by close friends.

3. 4 The first time problems in Emily's relationship with her husband appear to be disclosed was to her GP. As she was leaving an appointment on 19 January 2015 she asked where she could get advice; her husband was being critical of everything she did and of her appearance. The GP suggested relationship counselling, but Emily had replied that she did not think her husband would agree. It was suggested that they both come together for an appointment, but again Emily thought that her husband Peter would not agree. Emily was given details about Age UK and Relate.

3. 5 Emily saw an Age UK advisor at their Information and Advice drop-in service on 13 February 2015. The adviser was informed by Emily that she had been married for over 40 years, but her husband's behaviour over the past year had become very controlling; he did not like her going out with friends, questioned her every movement, and often locked her out of the house. A contributor reports that Emily would sometimes be locked out when she was outside gardening. When this happened she had to phone her daughter on her mobile phone to call him and try to reason with him. Emily stated that he had not been physically violent towards her, but she was finding his behaviour very distressing, she was a sociable person who liked to go out with her friends but was unable to do this as she was worried about what she faced when she returned home. The adviser had the impression that Emily needed to talk through the options that may be available to her rather than pursuing a specific solution.

3. 6 The Age UK advisor listed in their notes made on the day of the appointment the actions they had taken; this included contacting Leeway[3] and explaining how they could help with practical and emotional support, and giving Emily leaflets with telephone numbers. However, the family member who accompanied Emily to this appointment has stated that they have no recollection of a discussion about Leeway's services and the leaflets they were given were about pension entitlement, and housing options. One leaflet had a short mention of Leeway in small print. The possibility of leaving her husband and finding alternative accommodation was discussed, including possibly staying with her daughter until this could be found, and Emily was given details of housing associations in the area she could contact for sheltered housing. The advisor reassured Emily that Age UK could arrange for any benefits that she might be entitled to claim to help with rent, council tax, pension credit etc. Emily was unable to make any decisions at that time and said she would discuss options with her daughter. She was advised to call the police if she felt threatened at any time. Emily was happy to talk and she was advised to come back at any time if she wanted to speak further.

3. 7 Emily had booked an appointment at Age UK for 25 February 2015 to see a solicitor at one of the advice sessions offered by the service. She wanted advice about 'problems with her husband'. However, the solicitors who volunteer their services to Age UK are mainly experts in areas such as Power of Attorney and wills, hence Emily was advised that they would be unable to help, therefore she did not pursue this further. In case Emily

sleep, but it may also help reduce any anxiety or depression resulting from the pain. Low-dose amitriptyline alone is not sufficient to treat severe depression. Amitriptyline comes in 10mg, 25mg and 50mg tablets

[3] Specialist domestic violence and abuse service which provides refuge, outreach and IDVA Services across Norfolk.

consulted another legal advice centre contact was made with the Norfolk Community Law Service, but she was not known to them.

3. 8 On 23 February 2015 Emily's GP received a letter from her in which she wrote:

> *"Dear Dr .....*
>
> *On your advice I went to Age UK, seems like after a long talk and offers of being able to see a solicitor (who are not actually qualified to help) apart from various leaflets did not help my situation which is getting much worse.*
>
> *Can you in your medical capacity help with situation or put me in touch with anyone who can.*
>
> *Regards (Emily)"*

3. 9 Emily visited her GP on 12 March 2015 and her notes record that she had a long chat with her doctor about what is recorded on her notes as her 'ongoing problem at home', and that she had been to Age UK, but their solicitor was not qualified to deal with her problem. The GP prescribed 2.5mg Pericyazine an antipsychotic medication use of which includes for the short-term treatment of severe anxiety or tension.

3. 10 The next agency to have contact with Emily involved the first call to the Police on 2 April 2015 when Emily called to report that her husband had been threatening towards her and whipped her round the face with some clothes from a charity bag she had left out for collection which they were arguing over. According to other contributors' statements Emily had put the charity bag of clothes out ready to be collected the next day and Peter had objected and ordered her to bring the bag in. She refused and said to him "If you want this in, you go and get it" he picked it up and threw the clothes all over the lounge. Emily said Peter was aggressive towards her saying "now pick them up", Emily is reported to have replied "if you want them picked up you pick them up!" She said Peter had knocked her glasses off her face with some of the clothing. Emily reported to a contributor that later when she went to her bedroom, as they slept in separate rooms, she saw the charity clothing had been arranged in the shape of a body on her bed.

3. 11 In conversation with the DHR chair Emily's husband Peter confirmed this incident, but said they had argued over the clothes which were spread over the floor and he had picked up a jumper and thrown it at Emily and this had knocked her glasses off. He was very annoyed and went upstairs to her bedroom and 'trashed her bed'. Some hours later Emily had gone to her room seen the state of her bed, confronted him and dialled the Police on her phone. He reports that officers attended and he was interviewed upstairs and Emily interviewed downstairs.

3. 12 Peter was arrested and received a caution for common assault. The incident was assessed as standard risk using the DASH[4] risk assessment checklist. Emily gave positive answers to the following questions:

- Are you feeling frightened - yes
- Afraid of further injury to self - yes
- Are you feeling depressed or having suicidal thoughts - yes
- Is the abuse happening more often - yes

[4] 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 judge High Risk and results in a referral to the Multi-Agency Risk Assessment Conference (MARAC) for additional safety planning to protect the victim.

- Is the abuse getting worse - yes
- Is the abuse controlling - Answers given - locks in house, controlling over car and cancelled mobile phone

No injuries were documented and Emily said she had none. She did not wish to support a prosecution, although she assisted the officers with the investigation. There is clear documentation in the risk assessment completed that Emily believed that the assault was due to her challenging the behaviour of Peter when he ripped the clothing from the charity bag and threw them about the house. She was worried about Peter's behaviour and she felt it was due to his mental state.

The Police IMR chronology concerning this incident records that whilst in custody Peter had a health care assessment and risk assessment which included questions about his mental health. He answered 'no' when asked if he had any mental health problems. It was not deemed necessary to appoint an Appropriate Adult to assist Peter with communication.

Emily was contacted and advised that Peter had received a caution and would be returning home. It is recorded that Emily was happy with this course of action.

3. 13 The Multi-Agency Safeguarding Hub (MASH)[5] reviews and undertakes a secondary risk assessment for victims initially assessed as medium or high risk. It is unable to do this for standard risk due to the high numbers involved. However at the time of the incidents involved in this Review standard risk crimes received a secondary risk assessment and standard risk non-crime offences were dip sampled and about 10% of these cases were able to be given a secondary risk assessment. Emily's risk assessment was one of this 10% and her risk assessment was increased to medium. This was in recognition of the fact that Peter had returned home, therefore the couple would be remaining living together.

3. 14 A Police officer attempted contact with Emily on the 8 April 2015, but Peter picked up the phone and said that everything had calmed down. Peter asked that Emily be called back the following day. The officer called again on 9 April and spoke to Emily who also said that everything had calmed down; however she felt that the situation would probably escalate again at some point. She stated that she lived in a shared house and was not prepared to lose everything and leave. She stated that the marriage had broken down but she would not leave as she will not go into a hostel. The officer discussed Leeway with Emily and she stated that she would call them. The officer gave Emily his details and phone number. Checks with Leeway's systems for the review revealed no record of any contact by Emily. Peter reported to the review author that when he saw Emily the following morning after his arrest and caution she said she did not expect it to go so far; she only wanted him to have a 'slap on the wrist'.

3. 15 On 4 April 2015 Victim Support received an automated referral from the Police. The agreed process with the Police is to wait for a secondary risk assessment to be performed by the Police before contacting the victim. On 14 April the secondary risk assessment having been completed, a Victim Support caseworker telephoned Emily who reported that there had been no further issues since the incident, but she said she expected more abuse in future. The caseworker discussed safety measure, especially around leaving the house in a hurry, having a packed bag, alerting a neighbour, and having a mobile phone charged and switched on. The caseworker also advised about contacting the Police and Leeway, and family and friend support. Emily said she would call Victim Support if she required further support. The case was closed following this call.

[5] 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. 16 On 20 April Emily's GP received a letter from her which is quoted below:

> *"Dear Dr.......*
>
> *Thank you for your time and the advice that you could give me, unfortunately the situation has got quite bad over Easter and I had to call the Police out.*
>
> *(Peter) was arrested for assault, but let off with a caution as he didn't actually hit me. Our number and address are now flagged up, which is reassuring should anything happen again.*
>
> *I think we will have a quiet spell as my eldest daughter had a long talk with him and got him to see reason over his behaviour, but we are under no illusion that it won't happen again as his temper seems to be escalating. Thought it best to inform you of the situation.*
>
> *Regards ....(Emily)"*

3. 17 At 15:26hrs on a day in May 2015 one of Emily's neighbours made contact with the police to express concerns about her safety. Emily had put a note through her door which contained the following words:

> *"Sorry I won't be able to support the plant sale afraid (Peter) is prowling from room to room, slinging papers everywhere banging doors etc. He's threatening to come down the Hall and cause trouble, have now had to cancel trip out with friend later as I don't want to involve her in it. He's now gone roaring off in car, wonder if he's safe to be on roads!!"*

Her neighbour reported a history of Emily's husband being verbally abusive and he would be a bully at times.

3. 18 A uniformed officer attended the address at 15:51hrs and spoke with the Emily; she was weeding in her front garden at the time and it was recorded that she was very shocked to see the officer. He explained the reason he was there to which she replied she could not speak to him because she could not be sure that her husband would not be looking and listening to every word. The officer asked if she would like to attend the station to discuss any issues, but she declined stating that she could not leave the house. Emily stated that her husband had never been violent towards her, he was just making himself known and making her feel small. He did not want her to go out of the house for reasons unknown. He will lock her out of the house if she goes out; he has blocked all unknown numbers from the telephone so that outside companies cannot contact her. Emily reported that her husband was unaware that she had a mobile phone however. She added that if he knew the reason why the officer was there then it would make things incredibly hard at home. She thought that her husband may be suffering with dementia, but no further detail was provided other than that her husband will not go to the GP so this had not been diagnosed. Peter has reported to the review author that he was aware that Emily had a mobile phone.

3. 19 When her husband Peter appeared and asked why the officer was there the officer explained he was there in relation to a parking issue in the area. The officer thought Emily appeared afraid of him; she did not speak when he was in the room. During the visit Emily re-assured the officer that she was safe where she was and that the abuse was psychological.

3. 20 The officer resumed patrol at 16:27hrs. After leaving the address a non-crime domestic report was completed and a standard risk assessment made. The Police IMR contains the following details of Emily's answers to the following questions:

- Is the victim afraid of the suspect killing - 'other' is recorded
- is the victim afraid of something else happening - 'to self' is recorded
- Is the abuse happening more often - 'yes' is recorded
- Is the abuse getting worse - 'yes' is recorded
- Does the suspect try to control everything the victim does and/or are they excessively jealous - 'yes' is recorded
- Does the victim know if the suspect has ever been in trouble with the Police or has a criminal history - 'yes' (for domestic violence is recorded)

3. 21 The officer recorded that the atmosphere within the house was uncomfortable; he felt there was more to the issue than was said, and that Emily had not been given the time or space to be able to speak to the Police properly. The officer recorded that he would request that an advocacy worker try to make contact with Emily to give her an opportunity to discuss what may be going on. A request for this appears not to have been received at the MASH or by Independent Domestic Violence Advocacy (IDVA) services, but as IDVAs are commissioned to support high risk victims Emily would not have met the risk level for their support. Leeway provides other support services, but these were not accessed, nor was a referral made to Victim Support.

3. 22 In conversation with the review author Peter discussed this Police visit. He reported that after the officer left Emily said to him "you're pretty gullible, he came to see me". Peter reported that he was aware that his wife had been in contact with the Police as she had received a number of calls some from Police officers and others which she refused to discuss, but she had told him that some were calls from the Police. He reported that he was aware that someone had called the Police, he thought this was on Saturday 16 May, and said that his wife was depressed and in tears.

3. 23 After the visit the officer spoke with a detective sergeant. The officer said he felt there were no immediate risks and he did not believe Emily would come to any harm; long term she needed to have a point of contact and the male (her husband) may also require support. The officer was asked to ensure that everything was in place to safeguard Emily. It was suggested that an email be sent to the MASH for them to risk assess and find a positive outcome. This email was sent at 18:49hrs on 16 May to the MASH safeguarding inbox making them aware of the non-crime incident which the officer believed required an input from them or the domestic violence team.

3. 24 A reply was sent from a detective sergeant in the MASH the following day at 08:49hrs explaining that the current processes within the MASH did not include the secondary risk assessment of all standard risk non-crime incidents as they did not have the capacity to do so. The officer who had visited Emily was advised that it was his responsibility to make sure everything was in place. If he needed any advice he could just email or call into MASH domestic team who could assist.

3. 25 A day later at approximately 09:30hrs Emily visited a contributor to the review who made a statement to the British Transport Police in which they state Emily talked about the incident 2 days previously when the Police officer had visited. She had said Peter had thought the Police had come regarding the parking. They discussed the possibility of Peter having dementia, the contributor offered to take her to the doctors or police, but she declined as she was going to see a friend. Arrangements were made in relation to attending an open day about dementia in Sheringham on 1 June 2015 which they agreed would also make a day out. This was the last time the contributor saw Emily.

3. 26 At around 10:00hrs the same morning a second contributor's statement to British Transport Police described how Emily called round to their house, she stated she was cross with Peter as they had both bought IPad and Peter was insisting that Emily had paid more for hers and so she had hidden her IPad. She then told the contributor that Peter had come up behind her and put his hands around her throat and said "I can tighten". No marks were visible. Emily said she had made her mind up to go to the doctor's and the police station. At the end of her visit she said she now felt better and she would go to the surgery. Emily left on foot. The contributor told the review author that when Emily was leaving they gave each other a hug and Emily said "All I want is to be loved". This was the last time the contributor saw her.

3. 27 Information provided to the Coroner's inquest confirmed that Emily phoned her GP practice around mid-day asking to speak to her doctor, but her GP had left for the day. It was reported that the receptionist phoned the GP who asked that a message be given to Emily that they would phone her the following morning. The receptionist called Emily and passed this on and during the call Emily mentioned that her GP had said they would 'intervene when the time arrives' and she added that 'the time has now come'.

3. 28 At approximately 13:49hrs that afternoon Emily attended her local Police Station asking to speak with a named officer regarding her husband and ongoing problems, however the officer was not on duty. A Police community support officer (PCSO) offered to speak to her. Emily explained that she wanted advice about her husband as she had been to the doctor to ask them about her belief that he was suffering from dementia, but was told that without evidence they were unable to do anything. She wanted to know if she could record what her husband does and says as she wants to capture his erratic behaviour to show the doctor, who she stated does not believe her.

3. 29 The officer told Emily that his understanding was that she could do what she liked in her own home, but was not 100% sure and advised that she talk to a solicitor regarding the civil matters of the breakdown of her marriage. They discussed her situation and Emily told the officer about the Police visit and the arrest of her husband. She mentioned the name of the detective constable who had spoken to her from the safeguarding hub and she had his telephone number. Emily spoke of her husband's behaviour and described how over several years he had been calling her names like 'fat cow' and making derogatory personal remarks about her appearance, but that it was just insulting words and things like that she said. When asked whether she was worried or felt at risk of harm Emily said she did not, she just wanted her husband to go to the doctor.

3. 30 The officer asked whether anything she had spoken of was new to the Police, but she said she had already spoken about everything. In interview for the IMR the PCSO reported that Emily was calm and spoke about the support she had received from the Police. She did not appear unduly concerned about returning home and was clearly planning for the future in as much as she was looking to record her husband's behaviour in order to get him assessed and help through the doctor. At no time did the officer get the impression that Emily was making enquiries about recording equipment to capture evidence of domestic abuse. The officer specifically asked Emily if she felt at risk by her husband's behaviour and she said the she was more fed up with it really. She said she had put off seeing a solicitor as she did not want to pay for a solicitor to sort things out between them. When asked if Emily would like him to refer her to any agency she declined, saying that she had the Police officer's number from before if she needed and she had spoken to Age UK.

3. 31 Following Emily's visit the PCSO sent an email to the named officer she had come to see informing him of her visit, the issues discussed, and asking the officer to contact Emily on her mobile rather than a home visit as her husband is likely to be there. No DASH risk assessment was completed or submitted by the PCSO after this visit.

3. 32 Emily's death occurred later that day at approximately 19:15hrs on a railway line in the county.

3. 33 Following receipt of the Domestic Incident Report arising from the visit to Emily on the Saturday 16 May a detective sergeant in the MASH undertook a secondary risk assessment on 19 May 2015. It was risk assessed as medium on the grounds of :

- Even though there appeared to be no violence in regard to the incident there had been violence in the past (2 April).
- Emily had disclosed no suicidal tendencies on the latest risk assessment, but the attending officer had shown concern in relation to the psychological effect that her husband has on her.
- There appeared to be an on-going pattern of psychological abuse against Emily and due to Emily being unable to speak to officers or agencies independently without her husband being present there were several concerns highlighted that require further attention and support.
- Adult services were liaised with, but they are not aware of Emily or her husband.
- The Independent Domestic Violence Advocacy (IDVA) service was spoken to, but they have no information in relation to the couple as it was risk assessed as standard therefore they would not have been made aware.
- Due to these unknown factors as well as concerns raised by the officer the reviewing detective sergeant raised the risk to medium.

3. 34 Police enquiries of the couple's GP practice established neither was known to Mental Health Services and neither had been referred. The practice confirmed that Emily had seen the GP and had discussed mental health referrals but that none were deemed necessary (believed to relate to the dementia concerns referred to).

4. Overview

4.1. In summarising the information known to the 4 agencies and the professionals involved with Emily the most consistent issues are her concern that her husband was suffering from the onset of dementia, and the increasing strain his behaviour was having on her. However, it must be reiterated that there is no evidence that her husband was suffering from dementia.

4.2. The first agency to be aware of her growing worries about her husband's behaviour and mental health was her GP who advised Emily to seek advice from Age UK which she did. When this could not meet her needs she sought help again from her GP, following up one appointment with a letter on 23 February 2015 asking for medical help or to be put in contact with anyone who could assist. From the medical records Emily last saw her GP on the afternoon of 12 March 2015. Her GP notes record a "long chat about her ongoing problem at home, been to Age UK but their solicitor is not qualified to deal with her problem". What her GP meant by 'ongoing problem at home' is not clear; further clarification has not been provided by the practice. Following the first call out of the Police Emily wrote to inform her GP and included that her husband had been arrested; therefore her GP knew of the Police involvement and the outcome. Emily's letter did not receive a response; there are no actions recorded on the notes. Contributors to this review report that Emily felt very unsupported by her GP. She told them that the GP had said to her if you get Social Services involved it will get very messy. This comment had also been confirmed to them by one of Emily's daughters.

4.3. Age UK was next to be contacted by Emily and they too were informed about her concerns about her husband's actions and her belief that his change in behaviour might be due to the onset of dementia. The advice they gave about alternative accommodation, benefits,

and Leeway, suggest that they were aware that Emily's marriage had broken down and there were forms of domestic abuse taking place. Unfortunately, the Age UK volunteer solicitors appeared not to have been able to help Emily, but it is not clear from Age UK records exactly what legal advice Emily was seeking.

4.4. The Police held detailed information about the incidents they were called to, and the level of risk Emily was judged to be facing. The address had been flagged on Police systems and their two visits were recorded on Police databases. They knew that Emily was reluctant to leave her home, and they knew of the range of behaviours that Emily described being subjected to. A third party had corroborated to the Police that Emily was experiencing verbal abuse and that her husband 'could be a bully at times'. The Police understood from Emily that she thought her husband's behaviour could be due to the onset of dementia and she reported that her GP said they needed proof. This appears to have been the catalyst for her visit to the Police station in May when she sought advice about whether she could use cameras in the home to capture her husband's behaviour to show the doctor.

4.5. Victim Support had just one telephone exchange with Emily following the receipt of information via a referral and risk assessment from the Police in follow up to the 2 April incident. Although Emily said she would contact them again if she needed to, there is no record that she did so. Nor did she follow up information given by Age UK, Police and Victim Support about contacting the specialist domestic abuse service Leeway.

Other Relevant Information:

4.6. Emily and Peter are described as well liked members of the community, and Peter would do voluntary work locally; he is seen as a pillar of the community. The fact that Emily and Peter's relationship began to deteriorate approximately 2 years ago is confirmed by what Emily told Police and others, and what Peter himself has reported to the review author. Perhaps not unexpectedly, there are different perceptions about the circumstances and cause of this change.

4.7. From Emily's perspective she expressed concern that Peter's changing behaviour and demeanour might be due to the early onset of dementia. Whatever the basis for the change in behaviour it would appear that Emily was turning to a range of sources for support. At various times she described Peter's behaviour as controlling and psychologically abusive, but not violent, although on the day of her death a statement by one contributor recalled Emily had reported that Peter had come up behind her, put his hands around her throat and said "I can tighten".

4.8. Emily also reported to a contributor that her husband controlled when she could use the car. On occasions she would have to cancel outings with friends because he refused to let her use it. When Emily was out with friends he would phone to see where she was; Emily thought he was trying to control her, and yet if anyone came to the house he would be sociable and convivial. Although on one occasion a contributor recalled witnessing Peter go into the downstairs cloakroom, he came out and said "that cloakroom is really filthy, go in and clean it"; Emily whispered "I have just cleaned the bathroom and the cloakroom". She had also related to one contributor that Peter had thrown coffee and egg shells over the carpets and then stood on them. Emily confided that when he began to change Peter told her that nothing belonged to her; that she had contributed nothing. Contributors report that when they married Peter did not want Emily to work. She was very house proud and their home was spotless. She loved gardening and contributed to the home in her own way.

4.9. Information provided to the review author also confirms that Peter had access via computer to Emily's bank account, her mobile account, and her System1 GP medical

system. He knew the amount she had in her bank account and where she spent money, who she called on her mobile phone, and what GP appointments she had. A family member had told him that he should not have this access and asked him to stop. However, he did not. On the day Emily went missing he checked her bank account to see where she might have spent money as a means of seeing where she might be.

4.10. After Peter's behaviour was perceived to change Emily reported that he would follow her around the house; he also became more money conscious and she reported that she had a purse with shopping money in it and she had to list everything she spent. Emily reached a stage where she told Peter that she would do the shopping, cleaning and washing, but he would have to do his own cooking. She would buy ready meals for him, or he would go out for lunch on his own. There were also occasions when Peter would lock Emily out of the house even when she was in the garden and he would leave the keys in the door making it impossible for her to use her keys to get in. Emily would sometimes travel into the nearest town by bus and spend all day in the centre and at the library rather than spend time in the house. She also disclosed that Peter had shredded all her papers, and although he had a computer which he used, he had decided that he wanted her tablet computer, but Emily hid it. On one occasion a friend invited Emily to stay to give her a break, but she said she would not leave her home.

4.11. A contributor to this review related how they suggested to Emily that she have a family round table discussion about Peter's behaviour, but they do not think this took place, although they felt that both of Emily and Peter's children knew what was going on. The contributor was aware that Emily went to Age UK with one of her adult children, but she had said no one seemed to be able to help her. She wanted someone to liaise with Peter. She wanted the surgery to help to see why his behaviour had changed.

4.12. Emily died the day before her birthday. It was a family tradition to go out for a family meal on her birthday. As her birthday approached Emily told contributors to this review that she did not want to go out and celebrate. Her children had taken the day off work, but Emily told the contributor she did not want to. It is believed Emily's decision caused 'words' between her and her children.

4.13. Emily has been described by friends as a very strong women, who was strong minded; "you didn't try to change her mind once made up". She was very helpful and had numerous friends. She was also a doting grandmother who would regularly drive quite a distance at 6am to look after one of her grandchildren. In the view of some contributors the fact that Emily was a strong person and had expressed disapproval of suicide in the past, for her to take her own life was seen as out of character.

4.14. Emily and Peter's marriage was described by one contributor as like two parallel lines running along together but separate, although they had once appeared happy and travelled extensively together. None of the friends knew Emily was Peter's second wife until quite recently.

4.15. Peter has informed the review author that he and Emily had been married for 42 years and had lived in their home all that time. He reports that he had heart trouble 2 years ago after which Emily cared for him very well. However, as he recovered he said she told him that he was now senile and her attitude to him changed. Peter said he was very upset and angry by her accusation that he was senile. He reported that he had cognitive tests in hospital during his treatment and had been able to answer all questions put to him correctly. The doctor doing the test had concluded it before the end as he said there was clearly nothing wrong with Peter's mind. However, Peter said Emily continued with her opinion that he was senile and from this point they traded insults, name calling, and verbal abuse. Peter recalled Emily saying to him that at one point she wished he was dead. The couple had separate bedrooms and Peter said on one occasion his wife told

him that when his bedroom door opened each morning her heart sank because it meant he was still alive. A family member has confirmed that Emily and Peter did trade insults.

4.16. Peter reported that Emily would tell her friends about their rows and then tell him that she had done this; he said he did not like her doing this and he said she had responded that this was why she did it. He added that Emily would not go out in the car with him or go out for meals with him. Peter added that he would never have a bad word to say about his wife; she was a good mother and a good housekeeper. He had no explanation for Emily's actions; she had always said she would never leave her grandchildren.

4.17. Peter maintained he did not appreciate the impact their verbal confrontations were having on Emily, and that he should have realised that it was having more effect on her than it was on him. Up to 2 years ago they had enjoyed a good life together, and had travelled to over 20 countries together. Peter said he had not appreciated that by responding to his wife by being verbally abusive the impact this might have on her. Peter reported that their relationship deteriorated 2 years ago. Emily wanted him to sell the family home and buy two apartments and live separately. Peter was adamant that this was not an option; he had lived in the house for 47 years and did not wish to leave it.

4.18. Peter said he was aware that his wife had had angry conversations with their children in the days before her death as they wanted to take her out to celebrate her 70th birthday. However, Emily had refused and Peter reported that Emily had told her children that she was just going to go into town, have a coffee and a scone and they had to accept that. He added that Emily had apparently then returned home and went out in the car. By 7pm when she had not returned home her children became alarmed and they contacted the Police.

5. Analysis

5.1 This analysis will address the terms of reference and is informed by the IMR and information provided to the review.

5.2 It is important to repeat that this review is not into the cause of Emily's unexpected death, but in answer to the terms of reference 2 we are asked to examine whether the domestic abuse could have been a contributory factor. The purpose of the review is to examine the contact Emily had with services and to analyse whether those services were appropriate and whether there are lessons to learn from her tragic death.

Term of Reference 1:
To examine agency contact and events occurring from 2013 when the Emily's relationship with her husband is alleged to have changed up to her death in May 2015. Agencies with information relevant to Emily before 2013 are to provide a chronology and summary of that information.

5.3 The chronology and additional information within this report has addressed this term of reference.

Term of Reference 2:
To determine as far as is possible if there is evidence to suggest that the unexpected death of Emily was in any way connected to her being a victim of domestic abuse.

5.4 It is evident from the information provided to this review that Emily experienced actions and behaviours which are consistent with the definition of domestic abuse and of coercive control. There is a sense that she did not see herself as a victim of domestic abuse however, as she appears to have persisted in her hypothesis that Peter's change in behaviour and the abusive and controlling acts she was experiencing was possibly due to the onset of dementia.

5.5 There is a hint that verbal abuse was taking place longer than the 2 year time span of this review, for Emily told the Police Community Support Officer that her husband had been calling her derogatory names for several years (paragraph 3.27). She said she suffered belittling comments from her husband. On their own many of the acts Emily was subjected to may appear trivial and insubstantial. However, abuse is a course of conduct which can include methods of control and humiliation the cumulative impact of which can be increasing fear and a victim in a constant state of dread.[6] Emily told Police officers that she was not in fear at home, possibly thinking purely in physical safety terms. But was Emily's propensity for taking herself into town to spend time in the centre and the library an indication of the dread she felt of spending time in the home with Peter?

5.6 Peter admitted that he underestimated the impact on Emily of the verbal insults they exchanged. The derogatory names used aimed at physical appearance can be very degrading, undermining to a woman's self esteem, and can 'disable a woman's capacity to affirm her femininity' which significantly amplifies the effect of the insult.[7] Emily mentioned that she was 'fed up' with Peter's behaviour towards her, which suggests a cumulative effect over time.

5.7 A further challenge to Emily's identity as a house proud and efficient housekeeper is suggested by the fact that Peter was critical of the cleanliness of the house (paragraph 4.8) and it is reported that he deliberately soiled a carpet on one occasion. Emily was noted as having a spotless home and this may have undermined another element of her self esteem.

5.8 It is noteworthy that Emily had been prescribed 2.5mg Pericyazine for the first time on 12 March 2015, a medication whose use includes the short-term treatment of severe anxiety or tension. At the Coroner's inquest her GP reported that they did not think Emily was anxious at the time the medication was prescribed, it was for her to take as needed.

5.9 As previously mentioned Emily's birthday was to be the day after her death. Information provided to the review suggests that she did not want to celebrate her birthday by way of a family meal, and this caused some disagreement between her and her family. Understandably her family members wanted to mark her special day and had arranged time off for the purpose. However, from comments made by Emily to a contributor to this review, she could not face the usual family meal with Peter present. How Emily felt about this family disagreement we cannot know.

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[6] Monkton Smith J, Williams A, Mullane F (2014) *Domestic Abuse, Homicide and Gender, Strategies for Policy and Practice.* Hampshire, Palgrave Macmillan

[7] Stark E (2007) *Coercive Control How Men Entrap Women in Personal Life.* p257 New York, Oxford University Press

5.10 The risk assessment undertaken at the first visit by the Police included a 'yes' answer to the question 'Are you feeling depressed or having suicidal thoughts'. Unfortunately it is not clear whether she was answering 'yes' to feeling depressed, or 'yes' to having suicidal thoughts. There is an argument for separating this one question into two, or for officer to specifically note to which issue the answer applies. The two states of mind in this question represent different levels of risk to the person concerned, for example a person who was suicidal would require prompt medical attention. The officer who saw Emily as part of the incident on 16 May observed that she did not appear to be really upset and did not appear to be suffering, but she was not a happy person. The officer felt that something was not quite right, but could not put their finger on why. However, this was a surprise visit and her husband was present, therefore gaining an accurate assessment of her mood would have been difficult. On her visit to the Police station on 18 May Emily was said to be calm and she did not appear unduly concerned about returning home.

5.11 Emily did not leave a note or letter before her death; therefore it is not possible to speculate with any certainty what drove her actions. Pieces of paper found at the scene contained the contact numbers for Vulnerable Adults, and a Police officer. She had visited two close friends that morning, telling one of them that all she wanted was to be loved. According to the information given to the Coroner's inquest Emily then called her GP surgery around mid-day to speak to her GP, but they had left for the day. She was told that her doctor would phone next morning; Emily had replied that her GP would intervene when the time arrives, and that "the time has now come". What she meant by this is unclear. Emily then visited the local Police station in the early afternoon to enquire about using cameras in the home as she said she needed to obtain proof of Peter's changed behaviour to show her GP. This indicates some element of planning ahead to try and achieve the support she was looking for.

5.12 Whether the fact that Emily had been prescribed medication which is used in the treatment of severe anxiety and tension was related to the effects of abuse and may be salient to understanding how Emily was feeling that day, we cannot say. It is known however, that the psychological effects of abuse can include depression, anxiety, and suicide; the impact upon mental health, self esteem and feelings of self worth[8] cannot be ignored. Research in the United States has found a significant link between an increased likelihood of suicide and a history of domestic abuse in women of 55 years and over[9]. A family member explained to the review author that their mother had always thought committing suicide by the method she used was a selfish act as it affected others; this is what made her death all the more shocking. It also suggests that the level of distress Emily may have been experiencing was such that she was not thinking of the after effects for others at the time and may indicate that she was reaching the end of her tether.

5.13 The following terms of reference will be addressed together:

Term of Reference 3:
To establish what contact agencies had with the Emily and;
a. what assessments had been undertaken;

[8] British Medical Association (1998) *Domestic Violence a Health Care Issue.*
[9] Odgood N & Manetta N (2001) *Abuse and suicide issues in older women*. Omega G1 p71-81 in South East Wales Women's Aid Consortium (2011) *Domestic Abuse & Equality: Older Women*
https://www.equalityhumanrights.com/en/file/6241

b. *what treatment plans or support services were provided;*
c. *whether plans or services were appropriate and in line with procedures and best practice.*

Term of Reference 4:
Were appropriate risk assessments undertaken and acted upon both in respect of the Emily's physical and mental health, as a victim of domestic abuse, or in respect of any other vulnerabilities?

GP Services:

5.14 Emily saw her GP 8 times in the last year of her life, and had regular repeat prescriptions for pain relief and some common ailments. From the medical notes chronology Emily had assessments in connection with tinnitus from which she was suffering and joint pain problems. There is nothing in the chronology notes recording an assessment in connection with the prescription prescribed on 12 March 2015 for Pericyazine, however at the Coroner's inquest her GP stated that Emily did not seem anxious at the time, but the prescription was given to be taken as needed. It is not known if Emily had a treatment plan. She had been prescribed pain relief and other medication for some considerable time. There is no reference in the GP chronology of a depression and anxiety risk assessment taking place.

5.15 There is no information in the notes to indicate whether the GP recognised that Emily was a victim of domestic abuse, nor that a risk assessment was undertaken in this regard. The Coroner's inquest was informed that the practice uses a depression risk assessment tool, it does not have such a system for domestic abuse. In such cases risk assessment is based on clinicians identifying 'symptoms' of domestic abuse and judging whether a patient is at imminent danger. It may be that Emily did not recognise herself as a victim of domestic abuse, and therefore she did not frame Peter's behaviour in those terms or the impact it had on her. However, she wrote to her GP on 20 April to inform them that the Police had been called and that Peter was arrested for assault, thus providing evidence that she was a victim of domestic abuse. Despite her letter stating that "his temper seems to be escalating" (paragraph 3.15), her letter appears not to have triggered a response. At the Coroner's inquest her GP stated that Emily was a strong lady and they had thought that she did not want things to escalate to the Police. However, following the 20 April letter her GP had felt 'reassured' that the Police had been involved and they were aware that Emily had been given leaflets for Leeway and Social Services. The GP did not contact Emily following the receipt of the letter as they thought if she wanted more she would have made an appointment to be seen.

5.16 At the inquest it became known that Emily first disclosed the controlling and verbally abusive behaviour she was experiencing to a GP at an appointment on 19 January 2015; hence a GP was the first practitioner to have this information. This appointment was not in the GP chronology provided to the review. There were also consultations or letter contact with her GP during February, March, and April 2015 seeking help with Peter's behaviour which she thought might be due to the onset of dementia. Emily was advised to contact Age UK, but they were unable to help. She was advised that proof was needed of Peter's behaviour. Her letter in April seeking medical help or alternative support does not appear to have had a reply. The sticking point seems to have been that Peter would

not go and see the GP himself, and Emily did not think he would attend a joint appointment. The frequency of the appointments and the content of her letters do not appear to be recognised as an escalation in risk to Emily and an increase in her levels of anxiety and mental wellbeing brought on by her experiences at home.

5.17 From Emily's contacts with others it is plain that the only rationale she could think of for Peter's change in behaviour was that he was affected by a health condition that would explain his actions. There is a strong sense that a diagnosis was becoming an imperative to explaining what she was experiencing in her home. Peter himself is of the firm belief that he does not have a health condition such as dementia. Patient confidentiality prevented the GP sharing knowledge of Peter's health with his wife. The dementia toolkit for Primary Care[10] states:

"...that diagnosis need not be linked to any particular stage of dementia, and that people and families can be enabled to access the support that helps them when they start to need it. We should respect the decision of patients and families to present themselves at the time that is right for them"

and a Key Point in the toolkit states:

'Timely' diagnosis is when the patient wants it. In some cases it may be when the carers need it" (page 10)

This suggests that a family member can when they need it, call on a GP for access to support including with diagnosis.

Police:

5.18 During the Police contacts with Emily and Peter the appropriate assessments were undertaken with the use of the DASH risk assessment checklist. Attending officers risk assessed the incidents as standard risk. On submission to the MASH the risk assessments were part of a dip sample which were given a secondary risk assessment by officers experienced in identifying risk factors in domestic abuse and the risk was raised to medium. On the first occasion an officer from the MASH made a follow up call to Emily, on the second occasion further support was unable to be offered by the MASH, but the officer who attended in May 2015 was advised that they could contact the MASH for advice. Emily also had the number of the MASH officer from the first Police attendance. The process of secondary assessment clearly has value, however, the levels of incidents make this difficult to sustain. For example in August 2015 there were 1607 incidents requiring risk assessment of which 524 were crimes. In September 2015 there were 1430 incidents requiring risk assessment, of which 475 were crimes. Current resources preclude routine reassessment of standard risk crimes and non-crime incidents; they are therefore now part of the 10% dip sample as referred to in paragraph 3.12.

5.19 The Police took positive action when they attended the first call to Emily's address when they arrested and cautioned Peter. They were cognisant of the risk for Emily when he was returned home after his caution, and this influenced the decision to increase the risk

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[10] https://www.england.nhs.uk/wp-content/uploads/2014/09/dementia-revealed-toolkit.pdf
Royal College of General Practitioners, Dementia Revealed: What Primary Care Needs to Know Version 2: November 2014

assessment to medium. Her other home contact with the Police following the third party referral was handled sensitively and the officer took steps to try and conceal why he was there to avoid any ramifications for Emily once he had left. The officer felt that being in uniform hampered him from being able to engage in a lengthier discussion with Emily as she appeared to be concerned about her husband seeing her speaking to a Police officer. The Police IMR author could find no indication that by attending her address the second time the situation had been made significantly worse for Emily. This finding is based on the fact that during her visit to the Police station 2 days later she did not mention that the visit had created any difficulty. Emily also spoke positively of the support she had received, and she had been impressed by how quickly the Police had responded.

5.20 As none of the incidents were assessed as high risk they did not qualify for referral to the Multi-Agency Risk Assessment Conference[11] (MARAC) therefore there was no formal plan in place for Emily. However, the IMR found that an intervention plan was in place in line with procedures via her address being flagged on the Police data base, she had been given the telephone number of the officer at the MASH and she knew she could call him if required. Emily had also been given the details of Leeway, and she had a follow-up support call from Victim Support. These were appropriate actions.

5.21 The Police Community Support Officer (PCSO) was used to dealing with cases of domestic abuse as part of his duties. He reported that there was no indication that Emily attended the Police station to report a crime or a domestic incident. For this reason no risk assessment was completed with Emily at this visit. She was clear that she wanted advice about placing recording equipment in her address to capture what was described as her husband's erratic behaviour to show the doctor, who she said did not believe her. The PCSO gave advice on the assistance provided by Age Concern and asked if Emily had been to Citizen's Advice. Emily told the PCSO that she was putting off going to a solicitor as she did not want to pay a solicitor to sort things out between them. This would have been an ideal opportunity to signpost Emily to the Norfolk Community Law Service where she could have accessed some free legal advice, or Rights of Women[12] who provide a free legal advice helpline for women. Women in Emily's position can often have limited access to funds to finance solicitors; therefore it is important that sources of free advice are provided to help them take what can be a daunting step.

Age UK

5.22 Emily visited the Age UK Norwich Advice Centre once. The advice worker gained the impression that she wanted to explore options rather than solutions to her problem. She was given a range of options to consider from alternative living arrangements to pensions advice. Her family member who accompanied her reports that no details about Leeway services were provided which contrasts with the advisors notes made on the day. It appears that a great deal of information was imparted during the appointment; and it may be that not all was taken in; her family member stated that Emily felt overwhelmed by the information given, and felt there was an emphasis on leaving, and all the housing options were outside her area and in areas she would not wish to live in. When someone's life is in turmoil it is often difficult to process information which is outside their

[11] Multi-Agency Risk Assessment Conference (MARAC) is a meeting of agency representatives to share information on high risk cases and to draw up a plan to support and increase the safety of high risk victims.
[12] http://rightsofwomen.org.uk/get-advice/

normal experience, and perceptions can differ regarding what is said or offered. The legal advice through the service proved not to be able to meet Emily's needs and she was described as very disheartened on receiving this news as she felt unable to afford a solicitor. No risk assessment was completed. Given that Emily was discussing problems in her relationship with her husband and issues such as separation and alternative accommodation were being discussed, it would have been appropriate to introduce the DASH risk assessment checklist and go through it with her. Physically going through the DASH in person can help to 'open the eyes' of the person completing it that what they are experiencing is abuse and does carry risk. This can be the catalyst for accessing expert help from a specialist domestic abuse service.

5.23 The Panel discussed the advantages and disadvantages connected with the voluntary sector being expected to adopt the use of the DASH risk assessment by all staff, particularly small organisations who rely on volunteers some of whom may be volunteering for limited amounts of time. Issues such as who would be responsible for acting on the assessment if a volunteer was 'off duty' for some days or weeks; training time taking up valuable volunteer client support work, and lack of regular contact with those affected by domestic abuse could result in a loss of skill over time. The Panel agreed that agencies such as Age UK would greatly benefit from training in domestic abuse and coercive control especially its impact on older people. They should have knowledge of the DASH risk assessment and MARAC enough to enable them to recognise risk to enable them to safely deal with such situations, to refer on appropriately, and to actively support and encourage clients to access specialist services locally.

5.24 Emily clearly did not feel able to make any decisions on the day of her visit; she said she would discuss it with one of her children. This is not surprising, and the advice worker was probably correct in assuming that she wanted to know what her options were as this was the first advice she had sought from an agency apart from her GP. The advice worker took the correct approach. It is good practice to enable a client in Emily's position to have control over the steps she wants to take, at the pace she feels right for her. As with the Police however, it would have been helpful to direct Emily to other sources of free legal advice once it was clear that the Age UK solicitor could not help. Perhaps offering to speak to Leeway on her behalf, to see if they could provide the advice she was seeking, may have 'broken the ice' and helped her access the breadth of services and experience they can offer to women in her position.

Victim Support

5.25 Victim Support's contact with Emily consisted of one phone call and thus there was no opportunity to develop a support plan. She was given information about Leeway, but Emily declined support from them at that time. Their service was appropriately offered but declined.

Term of Reference 5;
Was communication and information sharing between agencies or within agencies adequate and timely and in line with policies and procedures?

5.26 It is not practice for the Police to notify a GP when a patient has been a victim or perpetrator of domestic abuse. However, Emily herself wrote to her GP and informed

them that the Police had been called and that Peter had been arrested and cautioned as a consequence. This is unusual, but perhaps demonstrates Emily's attempts to drive home the serious effects of Peter's behaviour for which she was trying to gain support. No information available to the review or given to the Coroner's inquest indicates that Emily's GP liaised with or referred to any other agencies on her behalf. The GP indicated at the inquest that they felt a referral to a statutory agency would 'complicate' matters. They also viewed Leeway, the local voluntary sector specialist domestic abuse service, as being part of the Police and therefore did not consider an onward referral to them. Such a perception of services and the reluctance to make contact with statutory or specialist services is of concern and warrants further exploration with the practice.

5.27 Following Emily's letter to her GP in February outlining her difficulties in obtaining the information she felt she needed, there was internal communication via a GP practice meeting when options to help Emily were discussed. The practice manager researched services and gave the GP an 8 page list of support organisations. Whether this list was given to Emily is not known, but such a large list would probably have been overwhelming to her.

5.28 A further form of internal communication came under scrutiny during the Coroner's inquest when it was reported that Emily had phoned the surgery around mid-day on the day of her death asking to speak to her GP. A receptionist took the call and told Emily that her GP had left for the day. The receptionist called the GP and was asked to tell Emily that she would be called by her doctor the following morning. When this message was relayed by the receptionist the inquest was told that Emily said that her 'GP had said they would intervene when the time arrives; the time has now come'. The call was recorded on the system showing as pink; action required. The Coroner made a recommendation that the practice put in place an escalation process for call takers to follow to refer such calls to another GP in such cases in future.

5.29 The Police shared information concerning the callout on 2 April with Victim Support in line with usual practice, and shared the reassessed copy of the risk assessment with them. Internal communication was good concerning Police attendance, with the relevant databases updated, risk assessments shared with the MASH, and officers sought additional guidance when necessary from their supervisors. The IMR author identified one occasion when further information was warranted. This concerns the officer's email to the MASH following the visit in May when a detailed report within the domestic non-crime risk assessment was provided, but the officer had not expanded on their concerns. Nor was a request made to discuss the incident with a supervisor from the MASH at a convenient time when they were next on duty. The officer believed that by raising the awareness of the MASH further action could be taken in respect of contacting Emily. The PCSO who saw Emily the day she died emailed the officer Emily had come to see to inform them of her visit.

5.30 In discussions with the IMR author the officer stated that there was something about his interaction with Emily and with Emily and Peter together that raised a 'gut feeling' that something was not quite right rather than fitting a higher risk assessment; there was something different about the situation that they could not put their finger on. After the visit the officer could not shake his view that something was not right. The officer appears to be demonstrating the use of professional judgement by expressing what is

often called 'gut feeling' or 'gut instinct'. Page 1 of guidance on the completion of the DASH risk assessment clearly states:

"Please pay particular attention to a practitioner's professional judgement in all cases. The results from a checklist are not a definitive assessment of risk. They should provide you with a structure to inform your judgement and act as prompts to further questioning, analysis and risk management whether via a MARAC or in another way"[13].

It is important that officers have confidence in their judgement and are able to reflect this in risk assessments. The officer identified that Emily was experiencing psychological abuse, but was not in immediate danger. However, the impact of psychological abuse is insidious and produces harmful effects, although from the officer's brief interaction with Emily that day it would not have been possible to assess the depth of such harm.

5.31 The Police IMR identified that timely communication between a front line officer and the MASH can be affected by shift patterns and the officer having a full understanding of how the MASH works. The MASH working hours are 07:00 - 15:00hrs at weekends, and 07:00 - 19:00hrs weekdays. The home visit to Emily was at a weekend and the officer emailed the MASH at 18:49hrs to make them aware of the non-crime domestic incident report which the officer believed needed input from the MASH or domestic violence team. The response the next day at 08:49hrs (also the weekend) from the MASH was to clarify that they did not have the capacity to secondarily risk assess standard non-crime incidents, that it was the officer's responsibility to make sure everything was in place, but they could call the MASH for advice or assistance. The officer was on a late shift that day, which started after the MASH had closed and so it was not possible to call, but the officer spoke to his supervisor and further options for supporting Emily and ways to see her away from the house were discussed. On the day Emily died the officer came on duty at 14:40hrs, but did not make attempts to contact the MASH.

5.32 It is doubtful that had the officer contacted the MASH that afternoon for advice that it would have had an impact on the outcome of this case. Emily visited the local Police station at 13:40hrs to obtain advice about cameras in her home to record her husband's behaviour. Because this was not in relation to a domestic abuse incident no domestic incident report was completed on the system, hence information would not be visible to other officers that she had attended. With hindsight the PCSO told the IMR author that they now wish they had done so, but recognise that it may not have made a difference. Nevertheless, if her visit was recorded and the information visible on the system, and the officer who visited her 2 days earlier had checked and seen it, the officer may have been prompted to call Emily in follow up. However, whether such actions would have been possible in the time between Emily leaving the Police station and her death is pure speculation. The IMR author rightly suggests that as the MASH help desk was open at the time of Emily's visit to the station, this would have been a good opportunity to call the MASH to enable Emily to speak to them directly away from her home.

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[13] http://www.safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL.pdf

5.33 Emily's visit to Age UK and phone call from Victim Support did not result in any information sharing, and this would have needed Emily's consent before taking place. Given that Age UK's volunteer solicitor could not meet Emily's needs it would have been helpful to signpost her to the Norfolk Community Law Service who have a broader range of legal advice on offer.

Term of Reference 6:
Did agencies in contact with the Emily 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?

5.34 The Police, Age UK and Victim Support all knew that Emily was a victim of domestic abuse. In the case of the Police and Victim Support this was as a direct result of Emily's contact with the Police about a domestic abuse incident and she received a risk assessment and information about agencies who could offer support and telephone numbers to call. With Age UK Emily had discussed her husband's behaviours as part of finding out what her options were, and as a result she was given a range of options covering housing, benefits and specialist domestic abuse services.

5.35 There is no reference or indication in her GP notes that she was recognised as a victim of domestic abuse apart from scanned copies of her letters to the GP the content of which make it clear that domestic abuse has taken place. Her letter to the GP informing them of Police involvement was received on 20 April, but she had been seeking support before that time. It is noted that during an appointment on 12 March that her "problems at home" were discussed, but no domestic abuse context is given to this in the notes and no referral was made to specialist domestic abuse services. In the absence of a GP IMR it is not possible to state that Emily's GP did not realise she was a victim of domestic abuse. However, given Emily's letter informing her GP of the Police visit and the arrest of her husband, it is difficult to accept that her GP did not recognise this fact. Nevertheless, this did not result in any referral to specialist support, and Emily's level of anxiety appears not to have been seen in the context of her experiences of domestic abuse.

Term of Reference 7:
What training had those practitioners in contact with the Emily 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.

5.36 Both the Police officers and the PCSO had received training in domestic abuse and the completion of the DASH risk assessment. In the judgement of the IMR author both officers' dealings with Emily were in line with the standards of professional behaviour. They were also aware of the constabulary 'One Chance' poster campaign which was displayed in the station. This promotes the message that staff have 'one chance' to assist and provide support for vulnerable people including those experiencing domestic abuse.

5.37 The Police do have clear policies and procedures in place to guide officers, and the IMR author's analysis of the officers actions in this case found that current force policy had been followed. Whilst the Police officer did have some understanding of the MASH

process of secondary risk assessment they did not have an in depth understanding of when an IDVA would normally be involved in supporting a victim. The IMR drew a lesson and recommendation from this gap in knowledge. The IMR author felt that the officer may have considered re-attending Emily's address to explore what further support could be offered. However, the officer demonstrated an understanding of the potential risks this may pose, and alternative methods of contacting Emily away from home were being considered.

5.38 Age UK Norwich confirm that their advisors receive domestic abuse training, and the fact that the advisor provided information to Emily about Leeway's support services indicates that they were knowledgeable about the appropriate pathways to domestic abuse services. Age UK Norwich has a Safeguarding policy which incorporates domestic abuse. However our review Panel member for the organisation has made a recommendation that they have a separate additional domestic abuse policy including a copy of the DASH risk identification form to make staff and volunteers aware of its content. As far as our Panel member is aware advisers have not had specific DASH training. For clarification each Age UK branch is a separate entity, however, as there is a possibility that other branches nationally may be providing services to those affected by domestic abuse, the chair of the review has contacted national Age UK to suggest that a separate domestic abuse policy is recommended to branches with an example of best practice provided to support branches nationally.

5.39 Victim Support staff are trained in domestic abuse and the organisation has domestic abuse policies. Victim support staff are clear about referral pathways and refer high risk victims to the IDVA service. They had provided Emily with information about Leeway services as had the Police and Age UK Norwich.

5.40 At the Coroner's inquest the practice manager for the GP surgery reported that the practice had received domestic abuse training from Leeway in April 2015. Leeway confirmed to the Panel the date of the training; it was delivered the day after Emily's last letter was received by her GP in which she asked for further help. Leeway was unable to confirm which staff at the practice were present for the training session. Leeway has confirmed that no one at the practice raised any queries with them about Emily or a patient following this training session. It is recommended to Leeway that attendees at their training sign an attendance register to enable the practice and Leeway see which staff received the training and which still need to attend.

5.41 As mentioned in paragraph 2.6, the Coroner judged the GP practice domestic abuse policies and procedures to be of concern and in need of amendments. In response to the Coroner's Regulation 28 report raising these concerns the practice accepted that their identification, procedures, protocol and action flowchart could be improved. The practice has confirmed to the Coroner that they have now introduced a more robust system. The DHR Panel welcomes the steps taken by the practice. The policy and protocol include the use of the DASH risk assessment and an action flowchart which includes steps to take for each risk level, information sharing and record keeping guidance. The Review author noted that the definition of domestic abuse used in the policy was confined to sexual violence, emotional and psychological abuse, and financial abuse. Coercive control and other forms of abuse which feature in the Home Office definition were absent. The fuller

definition version has been provided to the practice with the suggestion that this is included in their policy.

The following terms of reference will be addressed together.

Term of Reference 8:
Are there any systems or ways of operating that can be improved to prevent such loss of life in future?

Term of Reference 9:
Were there any resource issues which affected agencies ability to provide services in line with best practice?

5.42 Realistically, it is unlikely that any system operating on its own can prevent loss of life in similar circumstances to those faced by Emily. Domestic abuse requires a multi-agency response. One agency working in isolation cannot be expected to address the complexity of issues which arise. For high risk cases the MARAC provides the multi-agency coordination needed to protect victims within a framework of information sharing protocols and trusting relationships between partner agencies. This is not so easily achieved for the many standard and medium risk cases due to the volume of cases, and the time and resources needed. However, individual practitioners can, and should, take responsibility for acting within a multi-agency support system which exists in their area. Informal enquires of specialist agencies on a 'what if' basis can be a valuable first step to gaining the right support for a patient or service user. With the consent of the victim of abuse referrals can be made, and where the safety and wellbeing of an individual is at risk, a referral must be made.

5.43 The Police IMR sets out the challenges faced by the MASH in terms of their capacity to undertake secondary risk assessments for all standard risk incidents. In the first half of 2015 they were reassessing all standard crimes and approximately 10% of standard risk non-crimes. The first risk assessment for Emily was changed from standard to medium. The second was reassessed the day after her death, and again raised from standard to medium risk. In the face of an average of over 1,500 incidents per month there is little doubt that providing a risk assessment for all incidents would have a significant impact on staff time and their ability to provide the support needed to higher risk victims. And yet sadly deaths do happen to those assessed as standard risk.

5.44 Nevertheless, from the reassessment of Emily's risk assessments it would seem that the more experienced 'expert eye' in the MASH does make a difference to how cases are risk assessed. It is arguable that Emily's second contact with the Police did warrant a review of the risk assessment as this was the second incident in just over a month with signs of escalation. The Panel is aware that the Police and other agencies are facing considerable reductions in funding currently. However, agencies are also seeing a significant number of reports of domestic abuse and demands for service. A review of the capacity of the MASH to risk assess all incidents would be valuable both in terms of harm reduction to victims, and medium to long term savings from a reduction in repeat incidents and perhaps deaths. A review of the MASH was also identified by the Police IMR.

5.45 Emily's visit to the Police station for advice on the day she died did not meet the need for a domestic incident report to be completed. The PCSO did pass on information about her visit by email, however, a system of updating a file with information on the Police database would prove helpful and be visible for any future contacts or incidents officer were involved in. However, it is highly unlikely that such a system would have made any difference in Emily's case due to the short time between her visit to the Police station and the fatal incident.

5.46 It is clear that Emily was trying a number of ways to obtain support to deal with Peter's behaviour towards her. Her GP was important in her endeavours and was someone she turned to repeatedly. However, although the practice reported to the Coroner that they had a domestic abuse policy and a flowchart to guide them for the referral process for the MASH and Safeguarding, there was no system in place to assess when a patient was at risk from domestic abuse and there appeared to be little understanding of the impact this was having on their patient. It was reported that clinicians look out for symptoms of domestic abuse and then use their judgement as to whether a patient was in imminent danger. It is difficult to assess the efficacy of such an approach without understanding how 'imminent danger' is defined, in conjunction with what level of knowledge and skill a clinician has in identifying symptoms and assessing risk in relation to domestic abuse. Emily's GP practice reported their risk assessment was an assessment for depression and anxiety. In Emily's case this resulted in prescription for medication, although the chronology notes do not mention any such assessment tool being completed. Thus the symptoms of Emily's distress were being treated, but not the cause. No onward referral to a specialist domestic abuse service was made where an holistic approach to Emily's needs could have been available. This suggests that the skills and systems necessary for identifying and assessing risk in cases of domestic abuse within the practice were not sufficient.

5.47 Whilst acknowledging that the medical profession works within a system of patient confidentiality, there are suggestions that Emily's welfare was being increasingly affected by Peter's actions; yet the root cause of her problem as she saw it, Peter's behaviour and her belief that he was suffering from dementia was not addressed. Emily and Peter shared the same doctor and the GP reported to the Coroner that Peter had mental capacity and did not have dementia, but due to patient confidentiality the GP was unable to say this to Emily. It must be acknowledged that Emily's GP offered a joint appointment to Emily with her husband with the assurance that this would be done without divulging her information, however, Emily said that Peter would never agree to such an appointment, therefore her belief that dementia was an explanation for his behaviour remained.

5.48 GP practices are known to be very busy, but in the absence of an IMR from the GP practice it is unknown whether there were any specific resource issues which may have affected the practitioner's ability to act on Emily's disclosure of domestic abuse effectively. From the information available to the review what appears more likely is that Emily's experiences were not sufficiently recognised as domestic abuse and treated appropriately.

5.49 There is no suggestion that Age UK's interaction with Emily could have had an impact on her death. She visited them 3 months before her death. However, as previously mentioned, an improvement in the service's system for supporting those disclosing domestic abuse would be for advisors to have knowledge of the DASH risk assessment so that they are better informed about risk factors, confident in supporting clients, and able to work together with specialist services with clients or refer on their behalf.

5.50 Due to Victim Support's brief contact with Emily no relevant issues were identified.

Term of Reference 10:

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 the Emily 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?

5.51 Abuse is the violation of an individual's human and civil rights by another person or persons, (No Secrets, Department of Health 2000), and abuse can be intentional or unintentional, active or passive and it may be part of a pattern of behaviour or a single incident[14]. The information within this review suggests that this definition of abuse would apply to Emily. However, the Panel felt that she could not be considered to be 'vulnerable adult' as defined by the Department of Health 'No Secrets' guidance, nor was she considered an 'adult at risk' the term which has replace 'vulnerable adult' under Section 42 of the Care Act 2014 as before her death there is evidence to suggest that she was taking appropriate steps to protect herself by going independently to the Police, her GP, and Age UK Norwich for support. Had an assessment taken place late on the day of her death a different judgement might have been made.

5.52 The Panel considered the meaning of the term 'care and support' and what this might mean in practice. The Care Act 2014 introduces a number of important principles in particular that of wellbeing[15]. The Act's guidance notes at 1.1 and 1.2 the following:

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[14] Norfolk Multi-Agency Safeguarding Adults Policy July 2015. http://www.norfolksafeguardingadultsboard.info/assets/NSAB-Policy/NSAB-Multi-Agency-POLICY-SEPT2015-FINAL1.pdf

[15] Section 1 of the Care Act 2014.

1.1. The core purpose of adult care and support is to help people to achieve the outcomes that matter to them in their life. Throughout the guidance document, the different chapters set out how a local authority should go about performing its care and support responsibilities. Underpinning all of these individual "care and support functions" (that is, any process, activity or broader responsibility that the local authority performs) is the need to ensure that doing so focuses on the needs and goals of the person concerned.

1.2. Local authorities must promote wellbeing when carrying out any of their care and support functions in respect of a person. This may sometimes be referred to as "the wellbeing principle" because it is a guiding principle that puts wellbeing at the heart of care and support. 'Wellbeing' is a broad concept. It is described as relating to number of areas. Those listed which are relevant to Emily include; physical and mental health and emotional wellbeing; protection from abuse and neglect, and control by the individual over their day-to-day life (including over care and support provided and the way they are provided).

These wellbeing principles are pertinent to Emily. Her health was being affected by the psychological and emotional abuse she was experiencing, and she was in need of protection from that abuse. She did not have complete control over her day-to-day life as the control she was subjected to were impinging on her ability to meet friends when she chose, use the car when she needed, and she was locked out of the house on occasions. Under these circumstances Emily could be judged to be in need of care and support.

Term of Reference 11:
To examine whether there were any barriers which prevented the Emily 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?

5.53 One barrier which appears to have prevented Emily from accessing specialist domestic abuse services was that she was of the view that her husband may be suffering from the onset of dementia and this was the cause of his behaviour; this seems to have affected her ability to see his behaviour as domestic abuse or accept that this was the case. However, she did say that the abuse was psychological not physical, and in common with many people the absence of physical violence may also have been a barrier to seeing herself as a victim of domestic abuse.

5.54 Emily also expressed a reluctance to leave her home; it is documented by the officer from the MASH who spoke to her that she was not prepared to lose everything and leave. The thought of leaving her home for a refuge was anathema to her, and she even turned down a friend's invitation to stay for a while to have a break because she did not wish to leave her home. Leaving a home of many years is a recognised barrier especially for older women, and it can involve leaving not just a house, but a community and support

networks[16]. She also said that she did not want to pay for a solicitor suggesting that she may have had limited financial resources. A family member confirms that Emily did not have a great deal of money herself.

5.55 Research[17] indicates that older women do face additional barriers to younger women which may have been relevant to Emily's situation. This can include:

- Even less awareness of services than younger women;
- Brought up in an era where domestic abuse was a private matter;
- Protecting family brings complexity; the wish not to disrupt family life, worry about children's reaction, and the fear they will not be believed or even blamed;
- Financially dependent on the abuser and no independent financial income can discourage women from leaving.

Term of reference 12:
The chair will aim to make contact with family members and to keep them informed of the Review and its outcome.

5.56 The actions to fulfil this term of reference have been outlined in the Methodology section of this Review.

Examples of good practice

5.57 On call-out to the first domestic incident the Police took positive action and arrested and cautioned Emily's husband. This is in line with best practice and reinforces the message that the Police take domestic abuse seriously.

6. Conclusions

6.1 It is not the place of this review to determine the cause of Emily's death; that is the role of the Coroner. However, term of reference 2 asked that the Review 'determine as far as is possible if there is evidence to suggest that Emily's unexpected death was in any way connected to her being a victim of domestic abuse'. In her summing up the Coroner began by acknowledging that there was a background of Emily having relationship difficulties and she had spoken of psychological abuse which had greatly played on her mind, and although this in itself was not enough to confirm why she took the actions she did, her actions do lead to the conclusion of suicide. The information provided to the review by contributors who knew Emily well, plus her interactions with her GP and the Police, suggests that she was affected by the psychological and verbal abuse she was experiencing, but in the absence of any explanatory note by Emily it is not possible to speculate whether it was the sole reason for taking her life, but it would appear to have been a significant contribution.

6.2 The Coroner commented that Emily was seeking help, but she was unable to get across how much it was playing on her mind. It was the Coroner's opinion that it is important that professionals recognise this. The review author would also wish to reinforce that

[16] South East Wales Women's Aid Consortium (2011) *Domestic Abuse & Equality: Older Women* https://www.equalityhumanrights.com/en/file/6241

[17] ibid

domestic abuse is not solely a matter of physical violence; it is important to recognise the harmful impact of control and psychological abuse on a victim's mental wellbeing.

6.3 The GP practice had a flowchart to guide referrals to the MASH, but the Coroner was not convinced that this was effective. The practice risk assessed for depression, but not for domestic abuse and the Coroner felt the DASH could be used by GPs and more robust procedures needed to be in place. There was also concern that there was no method available to members of practice staff to recognise when a patient's call should be escalated and dealt with immediately. The Coroner sent a Regulation 28: Report to Prevent Future Deaths report to the GP practice setting out these concerns and that action should be taken to prevent future deaths. The practice confirmed back to the Coroner within the specified timescale that they have amended their domestic abuse policy and procedures and were implementing the use of the DASH risk assessment to guide practitioners in cases of domestic abuse.

6.4 The fact that Emily was not referred to a specialist domestic abuse agency where she could have received the type of legal advice and support she was seeking for her particular situation formed a barrier to resolving her problem. She did not want to leave her home, and she did not appear to have the information she needed about her rights.

6.5 Emily's death was a shock to those who knew her. Her friends are of the view that she was a strong woman who disapproved of suicide; the thought that she might take her own life was very much out of character. Peter also commented that Emily said she would never leave her grandchildren, and contributors describe her as a doting grandmother who thought the world of her grandchildren. No note or letter was found to indicate what she was thinking or feeling on the day of her death.

6.6 Evidence to the review suggests that Emily felt her husband's behaviour had changed in the past 2 years. Peter himself acknowledges their relationship changed, but he has stated that he took exception to Emily saying he was senile. He reports that the couple exchanged verbal insults, but he did not realise that this was having such an impact on Emily. Other descriptions of his actions such as locking Emily out of the house, making it difficult for her to use the car or to go out with friends are a different matter. Along with verbal abuse they are behaviours which fit the definition of domestic abuse, particularly psychological and emotional abuse, and coercive control.

6.7 The Police dealt with one domestic abuse incident and had two interactions which could be called symptoms of the abuse. They handled the incidents with sensitivity, but with limited success for two reasons: Firstly Emily was looking for a medical solution to the problem believing that the onset of dementia was the catalyst for Peter's behaviour. Secondly she would not contemplate leaving her home with all that entailed to remove herself from the situation. Emily may not have followed up the advice from Age UK for the same reason.

6.8 The effects of psychological and emotional abuse can be very damaging to a victim's self esteem and undermine their resilience to cope. Every day almost 30 women attempt suicide as a result of experiencing domestic abuse and every week three women succeed in taking their own lives[18]. We cannot know if Emily's struggle to achieve a medical assessment of her husband and help with his behaviour proved too much. We do know she was 'fed up' with his behaviour and felt it was becoming worse. The fact that she was prescribed medication for anxiety suggests her coping mechanism was possibly weakening. However, it is arguable that the support Emily needed was not pills, but tangible practical support which was not available from a clinician.

[18]Walby, S. and Allen, J. (2004), Domestic violence, sexual assault and stalking: Findings from the British Crime Survey. London: Home Office

6.9 It is not unusual for victims of domestic abuse to seek help from a number of sources sometimes with limited success, and this in itself can be very disheartening and confusing. However, when an area has well established domestic abuse services as Norfolk does, the pathway to support should not be strewn with barriers, some of which are put in place due to other agencies lack of knowledge. Emily felt things were escalating and shared this with her GP and with the Police, but the incidents attended by the Police did not meet the high risk criteria, and therefore fell outside of the process for inter-agency information sharing such as exists via the MARAC. And yet this case cries out for a coordinated response between GP, Police and preferably the advocacy of a specialist domestic abuse service. It is disappointing that Emily's GP did not make a referral to Leeway because they thought they were part of the Police. They also stated at the inquest that they though a referral to Police or Social Care would 'complicate' matters. This negative view of such agencies is of concern.

6.10 The Care Act 2014 actively encourages coordination and cooperation between partner agencies. The Act's Guidance sets out 5 aims of co-operation between partners which are relevant to care and support[19], but points out that co-operation is not limited to these matters:

1. promoting the wellbeing of adults needing care and support and of carers
2. improving the quality of care and support for adults and support for carers (including the outcomes from such provision)
3. smoothing the transition from children's to adults' services
4. protecting adults with care and support needs who are currently experiencing or at risk of abuse or neglect;
5. identifying lessons to be learned from cases where adults with needs for care and support have experienced serious abuse or neglect

With the exception of point 3, these categories justify the need for cooperation between partners in Emily's case to achieve the care and support she needed as mentioned in the previous paragraph. The Guidance states that "The local authority must co-operate with each of its relevant partners, and the partners must also co-operate with the local authority".[20] The Act specifies the 'relevant partners' who have a reciprocal responsibility to co-operate and this includes the Police, NHS bodies including primary care, CCGs, hospital trusts and NHS England. Thus the Act supports the very coordination of care and support required for Emily.

Lessons Learnt

6.11 Domestic abuse can affect anyone, can start at any stage of life, and may not involve physical violence. Older victims in particular face additional barriers to seeking and accepting support. Such barriers as the wish not to leave ones home and community of many years cannot be underestimated. Limited financial resources for women who have not worked outside the home and the prospect of living on benefits is also a huge issue for many older women. It is important that all practitioners and agencies recognise these additional barriers faced by older victims which have been highlighted in this review.

6.12 Emily was prescribed medication used to treat anxiety, and research shows there can be devastating affects to self esteem and mental health from psychological abuse and control. This was not recognised in Emily's case. However, the impact of psychological abuse is difficult for a practitioner such as a Police officer or advice worker to assess in a short interaction with a victim; it requires clinical knowledge. Nevertheless, training in this aspect of domestic abuse would be valuable for frontline practitioners who come into

[19] https://www.gov.uk/guidance/care-and-support-statutory-guidance/integration-and-partnership-working
[20] ibid paragraph 15.21 and 15.22

contact with victims as part of their work. This is especially important given the inclusion of coercive control in the definition of domestic abuse, and the introduction of a new offence identifying a course of coercive and controlling behaviour as a criminal offence from the 29 December 2015. The accurate recording of incidents or reports involving coercive control by all practitioners whether Police, GPs or advice workers will be essential to support evidence of a course of such behaviour.

6.13 Emily was trying all means she knew of to get help. She especially wanted medical help as she thought Peter's change of behaviour was a health issue. However, she had reached an impasse; Peter would not go to the GP, and Emily said the GP told her they were unable to help without proof, yet the GP knew that Peter did not have dementia. A way needs to be found to address this situation so that the welfare and safety of the patient with concerns about their partner's health which is impacting on their health can be met, as well as addressing professional ethics in relation to patient confidentiality in relation to the patient about their partner has concerns.

6.14 Although the DASH risk assessment is not a definitive guide to risk it does provide a framework to help practitioners form their judgements, and victims to identify which of their experiences have the potential to increase the risk they face. In some cases the DASH can enable the person being assessed to view themselves as a victim of domestic abuse for the first time. Hence it is useful for agencies to have knowledge of the contents of this tool and to understand the relevance of those contents; it is not just a tool for the Police. Practitioners also need to have confidence in their professional judgement; if they instinctively feel something is not right they should follow this up.

6.15 The Police IMR found that there were gaps in the knowledge of officers about the MASH process, notably about their capacity to provide secondary risk assessment and follow up support to victims. The role of IDVAs was not fully understood, nor the range of services the Leeway Domestic Abuse Service can provide. It was also felt beneficial to reinforce the message that officers and staff can contact the experienced staff at the MASH who can provide them with advice and support to use and pass on to victims. This lack of understanding of these services was also apparent in the GP practice.

6.16 The Police IMR also identified the need for officers to understand the 'One Chance' ethos when dealing with domestic issues. This includes that if required they take responsibility to maximise any opportunity to provide support or give advice to victims. Taking responsibility for the incident they attend is key. The IMR learning considered that officers should recognise that they needed to continue to deal with all aspects of the case until responsibility is handed over to another department or different agency.

6.17 Both the IMR and the review author believe that recognition is needed by the constabulary of the expertise provided by MASH staff, particularly in respect of their skills in providing secondary risk assessments to standard risk crimes and non-crime incidents. Repeat standard risk incidents particularly should necessitate a MASH reassessment. If Emily's visit to the Police station had been recorded as a domestic incident related enquiry this would have been the third contact with her for this issue. Viewing incidents in isolation which in themselves look minor often masks an escalating and worrying trend. Whilst conscious of resource pressures, investment in the MASH could actually prove an investment which will save lives, and put plainly, reduce the costs involved in investigations.

6.18 Emily was given a range of advice most of which she chose not to follow. The barriers to leaving undoubtedly played a part in that decision, but also when someone is under stress they may not always hear all that is said to them. Apart from her need for a medical assessment for Peter, Emily appeared to be trying to seek legal advice, but she said she did not want to pay for it, or perhaps she did not have the independent funds to pay for it. There was a missed opportunity to direct her to the free advice of the Norfolk

Community Law Service or the Rights of Women helpline when she said this to the PCSO, and when Age UK could not meet her needs through their legal services. Whilst Emily was given a range of good advice this demonstrates how important listening is, as identifying one small thing which might engage a victim can lead them to accepting further support.

Recommendations

6.19 These recommendations are drawn from those arising from the IMR provided for this review and the deliberations of the Panel.

6.20 National

Recommendation 1:

That Home Office Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews S2(4) be amended to specifically include GP practices as having a duty to actively participate in DHRs including attendance at panel meetings, and have regard to any guidance issued by the Secretary of State.

Recommendation 2:

It is recommended that a clause is added to the NHS GP contract to mandate their active participation in Domestic Homicide Reviews (DHRs) and Safeguarding Adult Reviews (SARs).

Recommendation 3:

That Intercollegiate Guidance for adult safeguarding which informs national training should include specific focus on domestic abuse & coercive control including recognition of risk, applying the link between domestic abuse and mental health to assessments, and a process to escalate those risks and concerns. This should link with NICE Quality Standards 116 - Domestic Violence, Quality Standards 1, 2, 3 and 4 published 29 February 2016.

Recommendation 4:

In recognition of Coroner's Inquest findings NHS England should write into the contracts of all GPs that all GP practices ensure that:

a) they have a stand-alone policy & referral pathway for patients experiencing physical, psychological, financial or emotional domestic abuse and/or coercive and controlling behaviours from a partner, former partner or family member.

b) the referral pathway clearly advises practitioners how to refer to specialist domestic abuse services who can provide the appropriate practical advice, legal options, safety planning and emotional support.

c) they identify a domestic abuse lead, who has specialist domestic abuse training, and who then leads on the practice's response to concerns on domestic abuse for individual patients.

d) they have in place clear guidance and a method of recognising and escalating when a patient's request to speak to their GP (where domestic abuse is expected/anticipated) requires an immediate response, or in their GPs absence an appropriate escalation process is activated.

6.21 **Local Level: Multi-Agency**

Recommendation 5:

The County's Domestic Abuse Change Programme and the Domestic Abuse Champions initiative to ensure that all appropriate services and advice agencies have processes in place by September 2016 to identify those experiencing domestic abuse with a particular focus on those experiencing coercive and controlling behaviours and that agencies have a clear pathway to domestic abuse support services.

Recommendation 6:

All agencies to whom the Review is disseminated ensure staff are briefed on the findings, recommendations and learning, and to confirm this has been completed to the County Community Safety Partnership by July 2016.

Recommendation 7:

All domestic abuse training content should be reviewed by June 2016 to ensure that:

(a) Older victims of domestic abuse and the additional barriers they face form part of the training.

(b) The content of training covering psychological abuse and coercive and controlling behaviour is covered in sufficient depth and takes into account the Home Office 'Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework, December 2015', to enable practitioners to identify its effects and support victims appropriately.

(c) Training should include reinforcing the importance of record keeping, particularly the use of a chronology to record information about all abusive and controlling behaviours experienced by a victim to identify and evidence any pattern of abuse.

(d) Completion of risk assessment should include clarity of the mental well-being of the person being assessed, e.g. depressed and/or suicidal.

6.22 **Police**

Recommendation 8:

A review of the MASH's current capacity and capability is recommended by end May 2016 to identify what extra resources or funding streams would be required to enable experienced staff within the MASH to assess all domestic crimes and incidents recorded by officers.

Recommendation 9:

A process of continued training and message dissemination should be put in place by the end of April 2016 describing the role of the MASH, its key roles and responsibilities, and including details of the support and advice that officers can expect and the process for obtaining that advice.

6.23 **GP Practice:**

Recommendation 10:

The GP practice to have a stand-alone domestic abuse policy & referral pathway to guide staff seeing patients experiencing physical, psychological, financial or emotional domestic abuse and/or coercive and controlling behaviours, risk assessment, & how to refer to specialist domestic abuse services by March 2016.

6.24 **Leeway Domestic Violence & Abuse Services**

Recommendation 11:

Leeway to provide an aide memoire for front line officers and agency staff by April 2016 to inform agencies of the range of services Leeway provides and how to access them.

Recommendation 12:

When delivering training Leeway is recommended to keep a register of attendees to show the name of the person and their role within the agency receiving the training.

6.25 **Age UK Norwich**

Recommendation 13:

It is recommended that by July 2016 Age UK Norwich put in place a stand-alone domestic abuse policy and referral pathway for their staff and volunteers separate to their safeguarding policy.

Recommendation 14:

The content of Age UK Norwich domestic abuse training for staff and volunteers who are engaged in the role of advising service users should include awareness of the DASH risk assessment checklist and how to refer on to local specialist domestic abuse agencies according to identified risk. The agency to confirm the inclusion of this content by July 2016.

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Mr Jon Shalom
Community Safety Coordinator
Norfolk County Council

15 August 2016

Dear Mr Shalom,

Thank you for submitting the Domestic Homicide Review (DHR) report for Norfolk in relation to the death of ‘Emily’ 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 a thorough, sensitive and balanced report with a good use of pseudonyms. The Panel particularly commended the breadth and expertise of the review panel. The Panel also noted that the review includes good practice.

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 (PCCs) on DHRs in their local area. I am, accordingly, copying this letter to the PCC for information.

Yours sincerely
Christian Papaleontiou
Chair of the Home Office DHR Quality Assurance Panel