Domestic Homicide Review Report into the death of:

'Kathleen'
Died August 2020

Author: Tony Blockley
Report completed: March 2022

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Acronyms

DHR	…………………….	Domestic Homicide Review
IMR	…………………….	Individual Management Report
MAPPA	…………………….	Multi-Agency Public Protection Arrangements
MARAC	…………………….	Multi-Agency Risk Assessment Conference
IDVA	…………………….	Independent Domestic Violence Advisor
MASH	…………………….	Multi-Agency Safeguarding Hub
DAU	…………………….	Domestic Abuse Unit
DAIPS	…………………….	Domestic Abuse Intervention and Prevention
DVPN	…………………….	Domestic Violence Protection Notice
DASH RIC	…………………….	Domestic Abuse Stalking and Harassment Risk Indicator Checklist
DWP	…………………….	The Department of Work and Pensions
PVPU	…………………….	Protection of Vulnerable Person Unit
PCMHT	…………………….	Cheshire and Wirral Partnership NHS Foundation Trust Primary Care Mental Health Team
IAPT	…………………….	Improving Access to Psychological Therapies
ADHD	…………………….	Attention deficit hyperactivity disorder
VPA	…………………….	Vulnerable Persons Assessment
CWP	…………………….	Cheshire and Wirral Partnership NHS Foundation Trust
HIT	…………………….	High-Intensity Therapy
CBT	…………………….	Cognitive behavioural therapy
IRIS	…………………….	Identification and Referral to Improve Safety

DHR overview report into the death of Kathleen, August 2020

Preface

Cheshire West and Chester Domestic Homicide Review Panel would like to express its profound condolences and sympathy for Kathleen's[1] family.

At all times, the panel has tried to view what happened through Kathleen's eyes. We would like to assure them all that in undertaking this review, we are seeking to learn lessons to improve the response of organisations in cases of domestic abuse.

The independent chair and author of the review would also like to express his appreciation for the time, commitment, and valuable contributions of the review panel members and contributing report authors.

[1] Kathleen is not her true name. It is a pseudonym requested by her family.

Kathleen – a personal tribute on behalf of the family

A pen portrait

She should have been an only child and an actress, so said Kathleen's grandmother whilst she had barely reached her teens.

Whilst that little insight probably raises more questions than it answers it does provide a useful starting point to talk about Kathleen.

In all the 37 years we had the delight of being Kathleen's parents there were many ups and downs. And more downs than many would wish for over the last 10 years she was with us.

All her life Kathleen fizzed with energy and her mind would always be operating at the speed of light.

Whilst some folk lack any self-awareness, this was something Kathleen was overburdened with and it was this more than anything which contributed to her lack of confidence and constantly beating herself up about the smallest things,

Even at rest, she'd be thinking, analysing, and running scores of thoughts and ideas through her head so much so that it was hard to keep up sometimes.

We may never know what or when the tipping point came but I'm sure her hyperactive mind and self-criticism greatly contributed to her inability to face the demons which crowded in on her.

As a child Kathleen loved home life but as she grew older was itching to make her own way in life and move away.

Paradoxically, when she did move away, we could tell that she was deeply unhappy – however hard she tried to hide it. Taken in isolation this might have seemed like normal teenage behaviour, but it was just one of many examples of her pushing away so many things which made her happy.

Kathleen was a wonderful carer and the people she looked after whilst as a nurse and afterwards, absolutely adored her.

She was a wonderful observer and would spot things missed by most of us, but she did have a blind spot when it came to people taking advantage of her.

She was an inherently trusting individual and mostly thought the best of others, but her lack of confidence and self-worth never allowed her to question others' motives more deeply.

Kathleen's character was one of intensity. A tremendous force in everything that she did, her emotions and highs and lows which reached levels many of us would never experience. But allowed some to take advantage her for their own ends and whilst she recognised this, she never allowed the closest members of her family to protect her in the way that she needed to be.

Kathleen's creative side

Kathleen was nothing if not supremely creative.

And while she would push back at any praise her ability to turn a house into a home, random flowers into a beautiful arrangement and haphazard objects into something you could only stop to admire was without equal.

She could cook wonderful meals and sew and make beautiful things to wear and for around the house.

Last summer Kathleen made a beautiful apron out of cream fabric with ducks on it.

The Tuesday before she died, Kathleen made a lovely supper, and she and her mum had a wonderful evening together.

After the meal, she showed [her mum] all her pot plants and told her how proud she was of her little collection, and I really thought she was embracing the future.

She did a little twirl in her apron and asked me if I liked the pockets and the lining, and I told her it was beautiful.

Kathleen did the same supper for her sister and [sister's] fiancé, the next day.

[They both] had a wonderful time and were so hopeful about Kathleen's attitude towards the future.

Kathleen wanted [her sister] to have the duck apron, but [she] wouldn't take it.

I realise now that this was Kathleen's goodbye to us, and [her sister] has the apron and wears it with great fondness and love.

Her caring side

Kathleen had a deeply caring nature and loved to help people and bonded effortlessly with young children or the elderly with equal ease.

But she found it incredibly hard to respond when that kindness was reciprocated.

She particularly loved her little black cocker spaniel and she so enjoyed helping with the animals at home and they were completely at ease and trusting in return.

Hobbies

Kathleen's favourite hobby was being busy, but cleaning and tidying were her forte.

We christened her Mary Poppins because her ability to disappear into the most fearful jumble of clutter and chaos and transform it in the blink of an eye was truly amazing and had to be seen to be believed.

But the epithet she loved most was Mrs Tittlemouse after Beatrix Potter's wonderful character whose cleanliness and tidiness was legendary.

On one occasion, Kathleen had helped an elderly lady with her laundry and had ironed and folded her pyjamas so beautifully that she couldn't bear to wear them because they looked just like new.

At home, she would fold freshly washed towels so exactly and neatly that they looked like they'd come straight from the factory.

These are just two tiny examples of how neat and precise she was. Not just the visual evidence like this but her thoughts and actions too.

Everything she did was so detailed and precise and thought through to the very last detail. But this never spilled over into being obsessive.

Sense of Humour

Kathleen had an impish sense of humour and loved to tease but would burst into a fit of giggles and laughter before the subject of her leg-pulling had time to work out whether it was genuine or not.

As a child of perhaps 7 or 8 years old, she took her youngest brother aside, looked him in the eye and told him that she was his fairy godmother, and he must do everything she said.

On another occasion as a very young teenager, she decided to have some fun with my penchant for the mint chocolate treat, Twilights.

Kathleen sat down and composed a letter purportedly from Twilight Headquarters which arrived in the post telling me that I had set a new world record for Twilight consumption and that I would be rewarded with a 20-year supply.

What made the letter so remarkable was the incredible detail she went to in composing almost two sides of A4 detailing some publicity the manufacturers would like me to participate in, information about the Twilight Olympics and some of the rather unpleasant side-effects of eating too many of their minty treats which illustrated what an amazingly vivid imagination she had.

Yes, as a child, she was mischievous, but this never spilled over into anything sinister and provides a tiny insight into how she found so much fun in everything she did.

Thoughts from Kathleen's friends and just a tiny glimpse into what she meant to them.

[We] remember Kathleen as a fun-loving giggler in school. She was always on the brink of laughter, and we will cherish that memory.

She was a golden girl. She was a beautiful person and a kind soul, and she had a heart of gold.

The memories I have of the mischief Kathleen used to get up to will always bring a smile to my face – what a tragic waste of a beautiful life.

Kathleen was such a wonderful person.

Kathleen was a beautiful person, a kind, caring and thoughtful friend. Whenever we caught up it was like no time had passed at all and we would have such a giggle together. Such precious memories.

I don't have the words, but I want to find some to tell you how I can't think of growing up without thinking of Kathleen. Her laughter, mischief, she made everything so much fun.

I remember her as a lovely young girl looking every bit a Kathleen, fit to have stories written about her.

Kathleen was a beautiful, clever, talented, and extremely kind young woman who was surrounded by love from those who mattered most.

I'll always remember that vibrant and beautiful young woman who was so kind and funny.

Kathleen truly was one of a kind, a unique and caring person that I will never forget. To be Kathleen's friend for what was such a special part of our lives – all the fun and mischief that we got up to together!!

You could always guarantee that Kathleen's "plans" would get us into trouble, but the fun and laughter always made it so worth it!

1 Introduction

1.1 The key purpose of undertaking a Domestic Homicide Review is to enable lessons to be learnt from homicides where a person is killed because of domestic abuse. For these lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change to reduce the risk of such tragedies happening again. Kathleen's death met the criteria for conducting a Domestic Homicide Review under Section 9 (3)(a) of the Domestic Violence, Crime, and Victims Act 2004.

Domestic Homicide Reviews (DHRs) were established on a statutory basis under the Domestic Violence, Crime and Victims Act 2004 and were enacted in 2011.

The Act states:

(1) In this section "domestic homicide review" means 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 term domestic abuse will be used throughout this review where possible, as it reflects the range of behaviour encapsulated within these definitions and avoids the inclination to view domestic abuse in terms of physical assault only.*

The term domestic abuse is referenced in the cross-government definition issued under the Home Office Circular: 003/2013, which was implemented on 31st March 2013.

1.2 Domestic Violence and Abuse definition

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
- 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.

1.3 The purpose of a DHR is to:

a) establish what lessons are to be learned from the domestic homicide 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 inform national and local policies and procedures as appropriate;

d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e) contribute to a better understanding of the nature of domestic violence and abuse; and

f) highlight good practice.

1.4 The domestic homicide review (DHR) examines the circumstances leading up to the death of Kathleen, who took her own life in August 2020. An inquest was held on 12th August 2021, the coroner's verdict was suicide.

1.5 Timescales

1.6 Following Kathleen's death in August 2020, the Cheshire Constabulary notified the Cheshire West and Chester Community Safety Partnership of the circumstances and requested consideration be given to convening a multi-agency discussion to establish whether a domestic homicide review is appropriate.

1.7 Following the request Cheshire West and Chester Community Safety Partnership met In November 2020, discussed the information, and concluded a Domestic Homicide Review would be completed.

1.8 The Home Office was formally notified In December 2020 of the Community Safety Partnerships' decision to commission a DHR. An independent chair was appointed in December 2020 and the panel met for the first time later that month where Individual Management Reviews (IMRs) were commissioned, and agencies were advised to implement any learning without delay.

1.9 There was consideration of the circumstances and that although there was no criminal trial, there would be a Coroner's inquest. Consultation and discussions were held with the Coroner and the Coroners officer was kept up to date with the progress of the review throughout.

1.10 During the initial discussions, the background circumstances of Kathleen's death and information obtained during the police investigation identified several key issues, including a suicide note left by Kathleen. Also included in the information was a note on her phone that read as follows:

You have abused me in every single way. You have never cared about me at all and have just used me for the last 3 years. You are a bully [Phillip][2]. You've hit me, spat at me, thrown water at me, broken so many things including 3 of my phones, damaged this property, kicked me, hurt me emotionally. The list goes on. I cared for you so much and did so much for you. But all you did was treat me like dirt. You have a huge sense of self entitlement, it's never your fault is it? You just roam the pubs charming people. Picking up 'friends' then dumping them when you have new people to play with. You say I lie but I know for a fact you do. People have told me all sorts and I know you have been picking up young girls. Your aggression is getting worse and worse. Adam even told me you pushed him off a bar stool when he said something you didn't like in clubbies. And you only have to look at how you thrash coco if she has been a bit naughty. The sad thing is [Phillip] I hate you but I still love the old [Phillip] and I miss you. You have no emotional capacity so I know this message will mean nothing to you only that you will do anything possible to make my life hell. You need to pay your half of water and gas. You also need to pay me back the £13.50 I put in your account for August EE. I have worked out that

[2] Phillip is a pseudonym and has been selected by the chair of the DHR panel for anonymity.

you have defrauded the council at least £14,000 in rent. You would go to prison for that alone.

1.11 Confidentiality

1.12 The findings of this DHR report are restricted. Until the report is published it is marked: Official Sensitive Government Security Classifications April 2014. Information is available only to panel members and Community Safety Partnership until the review has been submitted and approved for publication by the Home Office Quality Assurance Panel. Following publication, the Cheshire West and Chester Community Safety Partnership will widely disseminate the report to all linked partnership boards and forums.

1.13 The key themes and lessons learnt will be shared through multi-agency targeted learning events and a short briefing paper disseminated to front-line practitioners across the partnership. The multi-agency Domestic Abuse training delivered through the Local Authority Learning and Development Department will be reviewed to ensure learning and key messages are incorporated.

1.14 As recommended within the 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' to protect the identities of those involved, pseudonyms have been used where appropriate and precise dates obscured. Family members were not consulted about the use of pseudonyms as they did not engage. At the time of the fatal incident, Kathleen was 36 years old, and Phillip was 31.

1.15 The Executive Summary of this report has also been anonymised where appropriate.

1.16 Any media will be managed through the Cheshire West and Chester Community Safety Partnership, which will be encouraged to adopt the best practice guidance about the reporting of domestic abuse deaths published by Level Up[3]. All agencies are aware of this and agree. If there is a need for any statement a jointly agreed statement between the partnership and agencies will be issued.

[3] Dignity of Dead Women: Media guidelines for reporting domestic violence deaths (2018)

2 Terms of Reference

2.1 For effective learning, the scope of the review identified critical dates from 1st January 2015 through to the date of Kathleen's death in August 2020. This date enabled the capture of information relevant to the relationship and agency involvement. Agencies were asked to search their records between those dates for involvement with Kathleen and/ or Phillip.

2.2 Agencies were also asked to search for any information before those dates and include any information in summary form.

2.3 The full terms of reference can be found in **Appendix A**, the terms of reference identified the following:

2.4 Understanding of needs and assessment:

- Whether the incident in which Kathleen died was an isolated one or whether there were any warning signs and whether more could be done to raise awareness of services available to victims of domestic abuse.

2.5 Access to services:

- Whether there were any barriers experienced by Kathleen or her family and friends in reporting any abuse in Cheshire or elsewhere, including whether they knew how to report domestic abuse should they have wanted to.
- Whether there were opportunities for professionals to 'enquire' as to any domestic abuse experienced by Kathleen that was missed.
- Whether there were opportunities for agency intervention in relation to domestic abuse regarding Kathleen, Phillip or other family members that were missed.
- The review should identify any training or awareness-raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services in the area covered by the Cheshire West and Chester Community Partnership.

2.6 Diversity issues:

- The review will also consider any equality and diversity issues that appear pertinent to Kathleen or Phillip e.g., age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

2.7 Effective practice:

- How should friends, family members and other support networks and, where appropriate, the perpetrator, contribute to the review and who should be responsible for facilitating their involvement?
- How should matters concerning family and friends, the public and media be managed before, during and after the review and who should take responsibility for it?
- How will the review take account of a coroner's inquiry, and (if relevant) any criminal investigation related to the homicide, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process or compromise to the judicial process?
- Does the review panel need to obtain independent legal advice about any aspect of the proposed review?
- How should the review process take account of previous lessons learned from research and previous DHRs?
- Whether Kathleen or Phillip was 'in need of care' within the auspices of the Care Act 2014.
- Whether there were any issues in communication, information sharing or service delivery between services.

2.8 Case-Specific Issues:

- Was the impact of **Kathleen's** alcohol abuse considered in the context of domestic abuse and how did this manifest itself in agency responses?
- Was **Kathleen's** mental health recognised and how was it considered in the context of domestic abuse?

- Was the impact of **Kathleen's** substance misuse considered in the context of domestic abuse and how did this manifest itself in agency responses?
- Was the impact of domestic abuse considered across all services and was there a holistic view of engagement and interagency response?
- What was the involvement of family and friends? How was information received managed and acted upon in support of **Kathleen**?
- Were there any considerations of domestic abuse, including coercive and controlling behaviours?
- The extent of the abuse appears unrecognised by agencies – what more could be done to ensure similar cases do not occur and/or cases are able to be identified?
- Given the nature of this DHR, how will agencies ensure there is no similar repetition with vulnerable persons?

The Review will exclude consideration of how **Kathleen** died or who was culpable which is a matter for the Coroner and Criminal Courts respectively to determine.

3 Methodology

3.1 Research into this type of incident focuses on domestic abuse and its impact on victims in terms of suicide.

3.2 The review considered the purpose of Individual Management Reports (IMRs). The Home office guidance in considering the purpose and the content of an IMR provides the following:

3.3 Any agency or employer that is approached to provide an IMR must provide the review panel with a comprehensive chronology of its involvement with the victim and others that may be the subject of the review. This will allow the review panel and chair to fully analyse events leading up to the homicide.

3.4 It was determined that the following agencies were required to produce a full IMR,

- Cheshire Constabulary
- Cheshire & Wirral Partnership NHS Foundation Trust
- NHS Cheshire Clinical Commissioning Group

- The Countess of Chester Hospital NHS Foundation Trust
- Domestic Abuse Intervention and Prevention Service, Early Help and Prevention, Cheshire West and Chester Council
- Cheshire West and Chester Adult Social Care
- Multi-Agency Risk Assessment Conference (MARAC)

3.5 Due to their limited involvement, it was determined that the following agencies would produce a factual summary report for the review.

- North West Ambulance Service (NWAS)
- National Probation Service
- Aqua House[4]

3.6 Agencies completing factual summary reports were asked to provide chronological accounts of their contact with Kathleen and/or Phillip before Kathleen's death. Where there was no involvement or insignificant involvement, agencies advised accordingly. The recommendations to address lessons learnt are listed in section 14 of this report and action plans to implement those recommendations are included in **Appendix C.**

3.7 Each report was scrutinised by the Panel and discussed in depth to ensure that any learning could be identified and used.

3.8 The Panel has checked that the key agencies taking part in this review have domestic violence policies and is satisfied that where these exist, they are fit for purpose. Where they do not exist, recommendations have been made.

3.9 The Panel and Individual Management Review (IMR) authors have been committed, within the spirit of the Equalities Act 2010, to an ethos of fairness, equality, openness, and transparency, and have ensured that the Review has been conducted in line with the terms of reference.

3.10 This report is an anthology of information and facts gathered from:

[4] Aqua House is part of the Westminster Drugs Project, a commissioned service that provides a range of health and wellbeing services to adults and young people across the UK around drug and alcohol use.

- The factual summary reports.
- The Cheshire Constabulary
- The initial coroners' investigation (including witness statements) and associated press articles.
- DHR panel discussions
- Information from friends and family members.

3.11 Cheshire West and Chester Community Safety Partnership are responsible for monitoring the implementation of the action plans.

3.12 **Persons involved in this DHR.**

Name	Gender	Age at the time of the death	Relationship with the victim	Ethnicity
Kathleen	Female	36	Victim	White British
Phillip	Male	31	Housemate/partner	White British

3.13 Summary of the incident

3.14 This Domestic Homicide Review overview report is about Kathleen, a 36-year-old woman who died in Chester, in August 2020 after taking her own life. An inquest was held on 12th August 2021, the coroner's verdict was suicide.

3.15 Kathleen had lived with Phillip for several years and they had been in an intermittent intimate relationship. Phillip had been violent towards Kathleen on several occasions that were reported to Cheshire Constabulary and although Phillip was arrested, there were no prosecutions. On each occasion that violence towards Kathleen, by Phillip, was reported to Cheshire Police, there was insufficient evidence to proceed with a prosecution, including evidence led prosecution. Following one incident he was cautioned for criminal damage to a wardrobe door.

3.16 On other occasions, Phillip displayed coercive and controlling behaviours that impacted Kathleen.

4 Involvement of family, friends, work colleagues, neighbours, and wider community

4.1 Kathleen’s family

4.2 Kathleen’s family have engaged with the review and has been able to share information about Kathleen and her relationship with Phillip and others. Their contribution is significant and as a result, the review can examine any issues through the lens of Kathleen.

4.3 Kathleen’s family have been engaged with the review from the commencement of the process, including discussions relating to the terms of reference and the process of the review. After a discussion with the chair, they did not want to take part in the panel meetings but were satisfied to be provided with updates following the panel meetings. During the initial contact, Kathleen’s family were also made aware of the support available to them through the various advocacy services but did not feel the need to utilise their services.

4.4 On completion of the review, the chair met with Kathleen’s family and discussed the report, going through the various details with them and answering any questions they had. They were left with the report for them to consider in their own time and suggest any amendments or changes they felt appropriate; however, they did not have any.

4.5 The review panel thank Kathleen’s family for their support of this review.

4.6 Interview with Phillip

4.7 The following information is a summary of the discussions with Phillip, the review has not sought to clarify or add to the comments.

4.8 Phillip was contacted by the chair and subsequently engaged in a telephone call with the chair of the review. During the call, the chair explained the process of the review, its purpose and its intentions. Following this explanation, Phillip went on to provide

some background information and raised some concerns. It should be noted that the interview was cut short at the request of Phillip.

4.9 As the interview was terminated the chair was unable to discuss the contents of Kathleen's messages or the suicide note she had left.

4.10 Interview with Chris[5] (included here as the person has been identified and adds context to the narrative provided by Phillip. This is not appropriate to include within the chronology as it is not contained within IMRs.)

4.11 Chris was a worker with the commissioned drug and alcohol service and Kathleen was a client with whom he worked. He was relatively new to the role and during the assessment he had with Kathleen, she disclosed that both she and Phillip argued and fought. Kathleen told him they were both aggressive towards each other.

4.12 As a result of the disclosure Chris discussed it with his line manager who agreed to take over the case, however after a further 14 weeks, Kathleen contacted Chris, saying no one had been in touch. Subsequently, a worker did contact Kathleen, and during the discussions, Kathleen discussed suicide. As a result, Kathleen was discussed within a Multidisciplinary Team Meeting including her suicide risk, however, nothing was recorded in the minutes of the meeting. No information was shared and after a further few weeks, Kathleen's worker left, and Kathleen's case was closed.

Following discussions with the commissioned drug and alcohol service, Kathleen did contact them and spoke to the caseworker, although the content of the case file notes is different to the above. There is a comment in the notes by Chris that Kathleen had *'split from partner'* and that she had *'no suicidal thoughts.'*

There is no specific mention of current domestic abuse within the notes, nor the suicide risk as suggested. Kathleen's case was not closed at the time of her death and was only closed because of her death. As standard practice within the service, any

[5] This is not his real name; Chris is a pseudonym selected by the author of this report.

report of domestic abuse should initiate a referral to MARAC, irrespective of the level of risk.

Following Kathleen's death, the service undertook an internal review of her case and identified several actions to improve their administration of services, these included reviewing all cases managed by Chris as it was noted that records were not kept correctly and that internal procedures were not followed. Additional training was provided to staff and a safeguarding review of all cases undertaken. Safeguarding has been highlighted to all staff, with additional support and training. In the event of a client's death, those cases will as a standard be reviewed. Discussions and findings from the review have been discussed with the Commissioners of the service.

5 Contributors to the review and review panel members

The DHR panel was comprised of the following.

Tony Blockley	Independent Chair and Author
Michelle Nicholson	Senior Manager, Community Safety Partnership, Early Help Prevention Service, Cheshire West and Chester Council (CWaC)
Zara Woodcock	Domestic Abuse Intervention & Prevention Service (DAIPS) Senior Manager
Fiona Roberts	National Probation Service
Jackie Goodall	Designated Nurse Adults (NHS CCG)
Nicky Brown	Review Officer, Cheshire Constabulary
Karen Owen	Senior Manager, Adult Safeguarding, Adult Social Care, CWaC
Viki Mannion	DAIPS Team Manager (Observer)

Lowri Owen	Wales Community Rehabilitation Company
David Targett	Operation Manager and CQC Registered Manager (Westminster Drug Project – Aqua House)
Jane Murphy	Service Manager (Westminster Drug Project – Aqua House)

None of the panel members had any involvement with Kathleen, Phillip or the family and are independent for this review.

6 Independent Chair and Author of the Overview Report

6.1 Author

Professor Tony Blockley is a highly experienced consultant within the field of homicide reviews. Throughout his 30-year extensive policing career, he has both investigated and been responsible for homicide reviews, including domestic homicides. As Chief Superintendent and Head of Crime for Derbyshire Constabulary, he was chair of Multi-Agency Public Protection Arrangements (MAPPA) and was responsible for the management and operation of public protection units including all forms of abuse, child and adults.

Professor Blockley has undertaken the following types of reviews: Child Serious Case Reviews; Safeguarding Adult Reviews; multi-agency public protection arrangements (MAPPA) serious case reviews; Domestic Homicide Reviews; and has completed training for undertaking DHRs.

Having been involved in around 60 Domestic Homicide Reviews he has a wealth of knowledge and experience managing and reporting reviews, engaging and supporting families and presenting findings. He is a special advisor to a 3rd sector organisation and Head of Criminology at Leeds Trinity University.

Tony chaired the independent panel responsible for the introduction of Clare's Law and the Domestic Violence Protection Notice and Orders within Derbyshire. He was also responsible for the implementation of the 1st perpetrator programme within

Derbyshire and a member of the board at a Domestic Violence and Abuse charity, SALCARE.

*Further information is included in **Appendix B**

6.2 All panel members and Individual Management Reports (IMR) authors were independent of any direct contact with the subjects of this DHR, nor were they the immediate line managers of anyone who had direct contact with the persons within this review.

7 Parallel reviews

There was no criminal investigation due to the circumstances of Kathleen's death. There was a Coroner's enquiry that was managed by Cheshire Constabulary in parallel to the DHR process. It was not felt that the completion of the DHR or the Coroner's inquest would impact each other.

8 Equality and Diversity

8.1 The Panel and Individual Management Review (IMR) Authors have been committed, within the spirit of the Equalities Act 2010, to an ethos of fairness, equality, openness, and transparency, and have ensured that the Review has been conducted in line with the terms of reference.

Further detail is included in 10.10.

9 Chronology and Overview

9.1 8th September 2015 – Road Traffic Collision with Kathleen, she was arrested, taken into custody and admitted to drinking two or three bottles of wine.

9.2 During her time in custody, Kathleen went on to disclose that she was an alcoholic and suffering from depression. She was seen by the Health Care Professional and reported that she had self-referred to CAIS (drug & alcohol rehabilitation) and had a key worker whom she saw from there.

9.3 Kathleen was bailed to appear at Prestatyn Magistrates Court on 29th September 2015. She pleaded guilty and was disqualified from driving for 3 years.

9.4 The “Advice to Persons Released from Police Custody” leaflet has been provided to the detainee and the following pathways have been explored and signposted where required.

- Accommodation - No
- Attitudes, Thinking and Behaviour - yes
- Children and Families - No
- Drugs and Alcohol - Yes
- Education, Training and Employment-Yes
- Finance, Benefit and Debt - Yes
- Health - Yes

9.5 29th July 2016 The Department of Work and Pensions, (DWP) rang North Wales Police reporting that Kathleen had been informed over the telephone that her benefits were going to be stopped and Kathleen had stated that she was going to hang herself and then terminated the call. The DWP had attempted to call her back but got no response and were requesting Police carry out a welfare check.

9.6 Officers attended her address and spoke to Kathleen who was intoxicated and upset as DWP were going to stop her benefits, as she was considered fit for work. She stated that she did not intend to harm herself and was angry at the time she said this. The attending officer reported having no immediate concerns. Kathleen was said to live at the address with her parents and auntie and had good support in place.

9.7 A Protection of Vulnerable Person Unit (PVPU) referral was completed which states, *‘Kathleen was talking to an alcohol worker on the telephone, she was clearly very upset because she had been told that she was capable of working and she does not see herself as being able to do so at this time. She informed me that she was an alcoholic and struggling to cope, she felt that she may as well be dead. Kathleen stated that she did not have any intention of killing herself there and then but stated that she might do so in the future but she wouldn't tell anyone if she was going to do so. She was offered the opportunity to voluntarily attend hospital but she could see*

little merit in doing so. Kathleen lives at the address with her mother and father who are supportive. She was arrested approx. 1 year ago for drink driving and clearly has a drink problem. Kathleen feels as though no-one is helping her although it would appear that she is using many different agencies at this time, she mentioned using (Alcoholics Anonymous) AA[6], CAIS[7] and has a keyworker in Rhyl.'

9.8 3rd March 2017 an ambulance attended Chester Railway Station, following a call from the British Transport police stating that Phillip had a lot to drink and was being sick, they reported that he was having mental health issues and felt suicidal, Phillip was conveyed to The Countess of Chester hospital. Whilst at the hospital Phillip was under the influence of alcohol demanding to see a psychiatrist due to the *'voices in his head.'*

9.9 He was arrested for a public order offence after making threats towards reception staff and acting in a manner that could be seen as intimidating. Following his arrest, Phillip was taken to Chester Police Station where following enquiries he was issued with an Adult Caution.

Whilst at the hospital staff contacted a residential unit with Phillip's permission to discuss the support available and the circumstances surrounding his arrest and assessment.

It was agreed that a letter should be sent to his GP for an assessment for attention deficit hyperactivity disorder (ADHD) should they feel it appropriate.

9.10 In August 2017, a referral was made to Cheshire and Wirral Partnership NHS Foundation Trust Primary Care Mental Health Team (PCMHT) by Kathleen's GP. Kathleen had presented to her GP as low in mood and suffering from anxiety. It is recorded that she had been in rehab recently (June) for alcohol abuse but had relapsed, although she had stopped drinking again and was going back to Alcohol Anonymous.

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[6] Alcoholics anonymous

[7] CAIS is a registered charity and leading voluntary sector provider of personal support services in Wales.

9.11 Kathleen reported that her future was not great and had previously been on sertraline (an antidepressant) but had stopped it. She stated that she had thought about suicide but had no plans. Within her disclosure, Kathleen said she had considered hanging herself with a skipping rope, but these thoughts had subsided.

9.12 14th September 2017, the Improving Access to Psychological Therapies (IAPT) team received a referral from Chester Work Zone where Kathleen had presented with low mood and bipolar.

9.13 16th September 2017 Kathleen attended a nurse screening appointment with the Primary Care Mental Health team following a referral from her GP.

Kathleen reported that she struggled with low self-esteem, low mood, and poor self-confidence. She disclosed that she had completed a 6-month rehabilitation programme for alcohol misuse in February 2017. It was reported that she had been engaging with the commissioned drug and alcohol service, however, it is documented that she was continuing to relapse and was binge drinking regularly.

The risk assessment at the time indicated that Kathleen reported not *"wanting this life for herself"*, however, there was no indication of any thoughts, plans or intent to harm herself and it is recorded that she was motivated to engage with therapy.

9.14 A plan was agreed for Kathleen to engage with specialist alcohol services and was directed to the commissioned drug and alcohol service. A letter was sent to her GP detailing the assessment and outcome. Kathleen was discharged from PCMHT.

9.15 In October 2017, IAPT wrote to Phillip inviting him to contact the team to arrange an appointment. In November 2017, Phillip contacted IAPT for a telephone appointment and requested an ADHD assessment. He was told this was not appropriate over the telephone and that he would need a GP referral. During the appointment, no risks were identified. Phillip described historical thoughts of suicide, but there were no plans or intent evident. It is recorded that Phillip had a history of misusing substances but that he reported being abstinent.

9.16 Following the telephone appointment, PCMHT attempted to contact Phillip, but they did not receive any reply, consequently, Phillip was discharged from the service.

9.17 Phillip called the North West Ambulance Service to admit himself to the Accident and Emergency Department at Countess of Chester Hospital. At the hospital, he explained he was at home and admitted to using alcohol and cocaine.

Phillip described a four-week time scale of feeling that his situation had deteriorated and stated that he had contacted the Crisis Resolution and Home Treatment Team (CRHTT) via telephone to request help and was advised to attend A&E.

Phillip said that he had lived in Chester for a year since he was placed there for a residential rehabilitation placement. He stated that he shared a house with his friend Kathleen whom he gets on well with. Kathleen had accompanied Phillip to the hospital.

It was suggested that Phillip had been diagnosed with ADHD and continued to misuse cocaine and alcohol regularly. Phillip also said that he had noticed a decline in his mood and sleep and felt that he required a medication review to address these difficulties. Phillip also explained that he had been experiencing suicidal thoughts and an increase in his feelings of anger.

Phillip was encouraged to engage with Narcotics Anonymous and the commissioned drug and alcohol service, however, he was reluctant to do this as he did not find their support beneficial. Phillip agreed to see his GP to discuss his low mood.

9.18 On 24th August 2018, Phillip attended the Cheshire and Wirral Partnership NHS Foundation Trust ADHD Team for an initial ADHD assessment. He disclosed that he continued to struggle with addiction and stated that relapse can have an impact on his mental health. He discussed previous suicidal thoughts but had no current thoughts.

Phillip also discussed his poor sleep but had a good appetite and no recent weight loss. He associated his sleep problems with the use of stimulants but currently, he attributed the problem to symptoms of undiagnosed ADHD. Phillip did present with some symptoms of ADHD in his restlessness, racing thoughts, spontaneous actions and problems with sleep, however, this was difficult to assess due to the contributing factors of substance and alcohol use.

He reported experiencing voices that he described as racing thoughts, which he sometimes miss-attributes to thoughts that are not his own when under the influence of alcohol, drugs, or extreme stress. There was no evidence at that time of an underlying psychotic disorder or of an underlying depressive episode.

9.19 2nd November 2018, Cheshire Constabulary were called to Kathleen's home address following a call from a concerned neighbour. Kathleen had called at the neighbour's House asking for a bottle of wine and appeared distressed. The neighbour, feeling concerned for Kathleen went to Kathleen's address and was unable to find her, the neighbour then reported the incident to Cheshire Constabulary as she was concerned.

9.20 Cheshire Constabulary attended and found Kathleen, describing her as intoxicated, but safe and well. The officer went on to say that Kathleen lived with her flatmate (Phillip) who was an alcoholic, and that Kathleen was frightened he might hit her. Phillip was described as extremely intoxicated, and the officers were trying to get him to stay elsewhere for the night.

9.21 It was also reported that Kathleen and Phillip had no *'romantic attachment'* and that they are just friends. Kathleen alleged that Phillip had been *'forceful'* in the past when he had been drinking but had not been this evening. The officer explored this further, and Kathleen advised that he had hit her in the past, but she did not wish to make a complaint. The officer tried to obtain further details regarding this, but Kathleen did not want to make a complaint to the Police.

Despite this limited information and Kathleen not wishing to support action, the officer submitted a Vulnerable Person Assessment (VPA), and the crime was recorded.

9.22 Kathleen left the address in a taxi to spend the night at her mother's address.

9.23 This incident was not recorded as a domestic-related incident as it did not fit the definition applied by Cheshire Constabulary, which is.

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
Emotional
(Family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or stepfamily).

9.24 Following a risk assessment after the VPA submission, it was concluded that the root cause was alcohol misuse and Kathleen was already receiving treatment. Kathleen's details were not shared with alcohol services and consideration has not been given to support services for the perpetrator, who was also said to be an alcoholic and had warnings for mental health and possible ADHD.

9.25 On 14th January 2019, Sainsbury's Chester reported that Kathleen had stolen two bottles of wine. The supermarket had been informed of the theft by Phillip stating that he was '*very concerned about Kathleen and her drinking.'* Kathleen was described as *'heavily intoxicated'* having drunk all the wine. Phillip requested that police attend and arrest Kathleen, but not disclose it was he who reported her. Phillip added that he did not want anyone to call that day, explaining that Kathleen was *'too drunk to be dealt with anyway.'*

9.26 Following the report, Sainsbury's asked for Kathleen to be dealt with by community resolution and to pay for the goods, she would also be banned from the store. Following a visit by Cheshire Constabulary, Kathleen's family paid for the wine. It is recorded on the incident that Kathleen *"has an alcohol addiction which is recorded over the last 8 years, for which she is being treated. She is a binge drinker and functioning alcoholic, previously been in Aqua House. She has tried therapy, hypnosis, medications bought privately and self-help groups and considered surgery to beat her addiction. Currently, she is under a doctor with an ongoing review."* It is also recorded on the incident that Phillip was Kathleen's boyfriend.

9.27 It is also recorded on the incident that the officer did not feel any *'worth in a referral to Aqua House as the suspect is already embedded with medical interventions.'* This would appear to be an assumption and a missed opportunity to ensure Kathleen was receiving treatment.

9.28 On 30th January 2019, a referral was made for Kathleen to PCMHT by her GP. Her GP had requested that Kathleen be assessed following the presentation of significant anxiety. The referral advised that Kathleen suffered from chronic low self-esteem which she felt stemmed from a sense of being overlooked in childhood. She described her parents as loving and kind, but the household was busy as she was one of four siblings.

The referral said that every six weeks or so she would find her anxiety build overwhelmingly and so used alcohol to manage her extreme anxiety. At these times she would drink to dangerous excess over several days and has exhibited risk-taking behaviours on several occasions.

The referral also advised that Kathleen has sought help from commissioned drug and alcohol services both in the past and recently but had been disappointed at the lack of response to two recent requests for help.

She also reported that she had self-funded private counselling which was helpful but did not address the coping behaviour she has developed with alcohol. Kathleen's GP had stated that Kathleen required help to address her coping mechanisms and felt she may benefit from Cognitive Behaviour Therapy.

During February and April, attempts were made to contact Kathleen to arrange an appointment, but she had not answered the calls or responded to messages left.

9.29 On 8th February following an outpatient ADHD appointment, Phillip failed to attend, saying he had broken his hand. Phillip finally attended the ADHD Appointment on 12th March 2019 and said that he had not had his prescription since the last time he was seen.

9.30 Other issues were discussed including his overall well-being and lifestyle. Phillip reported that he was not sleeping very well, and his appetite was poor. He also disclosed that he was drinking too much alcohol.

9.31 On 15th April 2019, Kathleen attended Cheshire and Wirral Partnership NHS Foundation Trust (CWP) for an initial assessment. She identified her low mood and anxiety as impacting her ability to function and cope. Kathleen demonstrated insight into how her past experiences had led to her using more negative coping behaviours and ultimately developing alcohol dependence.

Kathleen also explained that she was in recovery from alcohol dependence. Kathleen denied any current thoughts, plans or intent to self-harm and cited close friends and family as protective factors. In the appointment, safety planning was discussed, and she was aware of where she could seek support if required. Kathleen was referred for step 3 counselling.

Step three counselling is a high-intensity counselling intervention that is led by the client. Counsellors will build a supportive, non-judgemental and in-depth relationship with you the client, based on empathy and honesty.

Step three counselling aims to help the client access and express underlying feelings, make sense of them, and draw on the new meanings which emerge to make positive changes in their life. Session by session there is a requirement for the client to feedback to the counsellor to inform them of where they'd like to focus. During the time between sessions, the client will be asked to reflect on what has been explored.

Step three counselling is offered up to 12 sessions, in which the client and the counsellor work collaboratively to establish and work towards a therapeutic aim. Through exploration of experiences and emotions, the counsellor will support the client to develop emotional awareness, gain a greater understanding of themselves and their responses to others, as well as finding different ways to manage feelings.

9.32 On 2nd May 2019, Kathleen contacted Cheshire Constabulary and stated that Phillip was assaulting her. She stated that *'He has been violent in the past. Male is [Phillip].'* The line was briefly dead until Kathleen could be heard to say *'no, no'* before coming back onto the line and saying that Phillip had taken the phone off her and she could not get away from him.

9.33 On the arrival of the Cheshire Constabulary, it was reported that both Phillip and Kathleen were intoxicated, and Phillip had said that the argument had stemmed from Kathleen having *'relapsed (alcohol).'*Kathleen told the officers that Phillip had caused damage to her wardrobe door and slapped her over the head. She wanted him arrested and at that time was happy to make a complaint, but reluctant to provide a statement, indicating she would do it later that day.

9.34 Phillip was arrested and taken into police custody. Officers returned to the address on several occasions later that day to see Kathleen and obtain a statement but there was no answer. Cheshire Constabulary had determined that if they were unable to raise Kathleen, they would force entry to the house to ensure her safety. On the next visit by the police, she did answer the door but refused to speak to the officer or to provide a statement or any further information. The officer did take photographs of the damage to a wardrobe door. A VPA was submitted following this incident.

A vulnerability marker was added to the home address, the purpose of which is to provide a warning or information to attending officers or to indicate that priority attendance should be considered.

The criteria are that there is either.

- Life/property at risk (threats made, domestic violence etc.).

- For officer safety (dogs present, access to weapons, violence, threats, specialist knowledge).

9.35 During the interview, Phillip told the interviewing officers that on the previous night, they were both at home. He was downstairs watching the football and had consumed two bottles of San Miguel Lager. Kathleen was upstairs in bed drinking. Phillip stated that Kathleen had started secretly drinking again recently, which she was hiding from him. He also alleged that she was stealing from him. Phillip said that this made him angry and because she was drinking the previous night, he lost his temper and smashed Kathleen's wardrobe by punching and head-butting it. He admitted to damaging the wardrobe but denied assaulting Kathleen stating that he would never hit a woman. Phillip had injuries to his left hand and knuckles, which he said, were from punching the wardrobe.

9.36 The attending officers recorded that a DASH risk assessment was not completed as Kathleen gave very scant detail to police at the initial attendance and when they re-attended later Kathleen would not speak with police. They did submit a VPA. This was an opportunity to complete a DASH risk assessment to understand the extent of the risk and the behaviours by Phillip and was a missed opportunity to engage with Kathleen and assess her risk.

9.37 Several days later, on the 5th of May 2019, a member of the public called Cheshire Constabulary reporting that they were with a female (Kathleen) and that she was partially clothed, missing her top, walking around with her jacket open and her chest on show. Kathleen was reported as being very confused, she did not have a phone and did not know where her friends were. It was also reported that Kathleen did not know where she was staying, but that she had wine with her and looked very upset.

9.38 The ambulance was also called by Cheshire Constabulary who arrived at the incident first and updated the police, saying that [Kathleen] had told the member of the public that *'her boyfriend has thrown her against the wardrobe and hit her.'*

9.39 Following the arrival of the officers, they took Kathleen home and updated the incident, stating *'[Kathleen] is stating that she has been assaulted last night by her*

boyfriend [Phillip]. I have taken a non-complaint statement; will submit a high VPA - photos taken of injuries.'

9.40 Kathleen explained that Phillip had come into her room and challenged her about her drinking. He had then '*battered'* her causing bruising to her left arm and chest. Kathleen was *'adamant she didn't want police involvement and she loves Phillip.'* Kathleen was tearful when speaking about Phillip and appeared in *'fear of him.'* Kathleen agreed that something needed to change but did not want police involvement, although she was *'open to non-police support.'*

9.41 Following the incident, a DASH risk assessment was completed, alcohol was documented as the root cause, and it was noted that Kathleen had no safe number as she had lost her mobile phone and an email address was provided instead. It was also requested for a *'Referral to IDVA and believe Kathleen requires signposting to drugs and alcohol services.'*

9.42 Later that day Kathleen contacted Cheshire Constabulary stating she wanted to retract her statement, and that she had lied. In her statement, she said that *'the bruises were sustained during the incident on 2nd May but that she had told Paramedics that she had been assaulted as she was ashamed of being found intoxicated and partially clothed.'* Kathleen went on to say that if police took further action, Phillip would be wrongly punished for something he did not do, which would affect their relationship and cause a wide range of further issues.

9.43 Kathleen said that she and Phillip were still living together but that she could not see the relationship lasting. Kathleen went on to say that she was receiving support from alcohol services and that she was making that statement of her own free will and had not been *'asked or controlled'* to retract her statement. A VPA was submitted.

9.44 On 7th May 2019, the Domestic Abuse Intervention and Prevention Service (DAIPS) received the VPA from Cheshire Constabulary. On the 8th and 9th May the DAIPS Independent Domestic Violence Advisor (IDVA) attempted to contact Kathleen, unsuccessfully.

9.45 Two further unsuccessful attempts were made on the 10th and 13th May. On the 21st of May, a further referral was received by DIAPS from the North West Ambulance Service.

9.46 Following the North West Ambulance referral and the ongoing police referral, contact was attempted again on 22nd May but to no avail. On the 28th of May, the IDVA contacted Cheshire Constabulary to establish any further contact options.

9.47 On 23rd May, Kathleen contacted CWP regarding her appointment wanting to know when it was likely to be. She was told that the appointment was soon and that she would be contacted within the next week.

Kathleen was upset during the call and said that she had taken an overdose and had to attend A&E.

9.48 Kathleen had her first counselling appointment with West Step 3 Counselling. During this appointment she denied any thoughts, plans or intent to harm herself, however, she did disclose that she had experienced thoughts of self-harm in the past and had taken an overdose in April 2019.

Kathleen denied any ongoing thoughts of harm to herself, and the safety plan was revisited and agreed upon. Kathleen went on to disclose that she sabotaged relationships by pushing people away until they went. Kathleen said she lived with a housemate whom she met in rehab. She was not happy with the arrangement but said that he was her best friend. There does not appear to have been any further exploration of the relationship and as such, this is a missed opportunity to enquire about any domestic abuse.

9.49 During her next appointment with West Step 3 Counselling on 6th June, Kathleen said she was having a good week. That she had taken away her options to choose not to repeat old patterns of behaviour. She had worked on her family dynamics and felt that she was the 'problem' and that the family watched and waited for her to slip up. She had also worked on trying to identify triggers when she behaved differently which leads to remorse and more self-doubt.

9.50 On 6th June 2019, Kathleen was discussed at the MARAC meeting following the VPA submission by Cheshire Constabulary for the incident on 2nd May 2019. During the meeting, details of her driving offence in 2015 and the theft of the wine from Sainsbury's in 2019 were disclosed. During the meeting, Phillip was described as her boyfriend and that they lived in the same house.

It should be noted that the house was rented by Kathleen from her aunt, as such Phillip was allowed to stay by Kathleen.

9.51 The incidents involving the allegations of the assault and damage to the wardrobe were also discussed although it was noted that there was no substantive evidence in support for the assault and there was no concern for Kathleen's safety identified by any of the officers who attended the incidents.

9.52 During the MARAC meeting, it was recorded that the IDVA had multiple failed contacts with Kathleen and although it appeared that Kathleen wanted support, she did not respond when called. Information given from the Countess of Chester hospital identified that Kathleen had attended the Accident and Emergency Department on 19th May following a collapse.

9.53 The Information from the Countess of Chester hospital also identified that Kathleen had attended the Accident and Emergency department on 20th May having consumed two bottles of wine and taken 7 x 10mg Propranolol following an argument with her aunt. During her attendance, Kathleen told staff that she regretted her actions and did not want to die. She had seen her GP and was awaiting counselling through primary care. It is recorded that she was not under anyone for alcohol treatment at this time.

9.54 It was also recorded that Kathleen had disclosed domestic abuse on 21st May to the North West Ambulance Service, although this information was not known to the police.

9.55 Following the MARAC an action was raised for Cheshire Constabulary to visit Kathleen with the IDVA. The IDVA has made contact by telephone with the Cheshire Constabulary asking for this to be arranged. Cheshire Constabulary explained they

did not receive this action and that there was no officer assigned to Kathleen's case and Kathleen was being treated as a suspect. No further explanation was given by Cheshire Constabulary. This was a missed opportunity. The MARAC representative from Cheshire Constabulary should have ensured the action was passed on. The IDVA should have sought more clarity in exploring why Kathleen was considered a suspect.

9.56 Kathleen attended a further appointment with West Step 3 Counselling on 13th June 2019 but did not attend the next one on 27th June. Kathleen later called to request a further appointment.

9.57 On 18th July and 1st August, further contact was attempted to speak with Kathleen by the IDVA, but again this was unsuccessful.

9.58 On 23rd July 2019, Phillip attended an appointment with ADHD Team for his review. He disclosed that he was taking his prescribed medication and that the ADHD symptoms were better.

9.59 On 25th July 2019, at a further appointment with West Step 3 Counselling, she told the counsellor that she had not been in a good place and was thinking *'what is the point'*. She said she was still feeling confused and did not understand herself.

Kathleen talked about her history and how she looked back at it constantly. Kathleen also discussed taking responsibility for her bills and that she had been to the job centre and was hoping to find cleaning or reception work soon. Kathleen said she liked being busy and thought this would help. Kathleen also talked about her lodger and the negatives of living with him. She said that there had been a decision that he should find somewhere else to live.

At this point, Kathleen had been discussed at MARAC with Phillip identified as the perpetrator. It is recognised that separation is a significant risk factor in any domestic abuse relationship, and it appears this was not discussed or considered. This was an opportunity to gather more information and assess risk for Kathleen and the wider agencies involved with her, as such this is a missed opportunity.

9.60 On 1st August 2019, at an appointment with West Step 3 Counselling, Kathleen explained that she was feeling a lot calmer and that she had an interview with a cleaning company and a trial shift the following day.

She also reported that she was dealing with the difficulties of living with her lodger differently and was being a bit more assertive in that situation. This does not appear to have been explored or considered from a risk management perspective and as such is a missed opportunity.

9.61 Later that month, on 15th August 2019, Kathleen attended a further appointment with West Step 3 Counselling, where she discussed work and the benefits. She also disclosed that she was standing up to her housemate more with good effect and enjoying things like walks with the dogs more. Similarly, to her appointment in early August, this was not explored.

9.62 On 19th August, the IDVA closed Kathleen's case. There was a reference to the MARAC action of a joint visit with the police not being completed due to the Police advising that Kathleen was a suspect, and the visit was not appropriate. It is unclear why Kathleen was identified as a suspect. There is nothing to indicate she was.

9.63 On 17th September Phillip contacted Cheshire Constabulary reporting a concern for Kathleen's safety and welfare. He stated that Kathleen had left the house within the last 30 minutes, that she was vulnerable, suffering from bipolar and was potentially suicidal. Phillip also stated that she had been in her bed for the preceding 10 days and *'not been herself'.*

9.64 Officers attending the address were informed of the previous assault and that they should take positive action following the Domestic Violence/Abuse pathway and ensure a VPA is completed.

9.65 Kathleen returned home, just before the police officer arrived. She had been to a shop to buy alcohol and admitted to being an alcoholic stating that she intended to drink the wine herself. No domestic abuse was identified although the details of the MARAC referral were included. A VPA was not completed and as such, this is a missed opportunity.

9.66 On 19th September 2019, Kathleen contacted West Step 3 Counselling in distress. She went on to say that she had another alcohol binge and that she had sabotaged her work by not going in. Kathleen said she did not think it was appropriate for her to come to see a counsellor because she would *'just moan'* and that her mother was *'going on and on at her'* saying that there must be a diagnosis and telling her that she thought she was manic depressive.

Kathleen stated that she thought she was a bad person and would die *'probably from alcohol poisoning'*. Kathleen stated she wanted more help and requested to see a psychiatrist. Kathleen was offered an appointment with West Step 3 for the following week and a possible referral to the Multi-Disciplinary Team, Kathleen stated she would go to A&E if she felt it necessary.

9.67 On 26th September 2019, Kathleen attended an appointment at West Step 3, and it was noted that she was tearful on arrival. During the appointment, possible triggers for her drinking were discussed. Kathleen said that she understood what happened and why. She talked about her guilt and then reported that there was coercive control from the man she lived with [Phillip], whom she did not describe as a boyfriend.

The male [Phillip] rang her repeatedly during the session accusing her of drinking because the appointment was at 5 pm. The counsellor spoke to him at Kathleen's request to confirm that Kathleen was where she said she was. Kathleen talked about him being violent to her in the past, but not at present. Kathleen said that Phillip drinks from 10 am and uses cocaine and other drugs but blames her for everything.

Kathleen said she was fearful of going home that evening and said she would pack and go to her parents. Like other appointments, there does not appear to have been any risk assessment and as such is a missed opportunity.

Kathleen said that Phillip was house hunting, and his parents were buying him a house. The counsellor worked with Kathleen on a safety plan and considered how he (Phillip) could be encouraged to leave soon. Kathleen talked about him putting his

fist to her face and saying, *'I'm not punching you'*. Kathleen stated that she just tried not to disturb him and to keep a low profile. During the appointment, it was noted that Kathleen was calmer as she left and intended to go straight back to her parents.

9.68 On 10th October 2019, Kathleen attended West Step 3 for a further appointment. During the session, Kathleen said that she felt better about spending time with her parents and that she was being more assertive in the situation with her lodger.

Kathleen said that he was still looking for somewhere to move to and was hoping this would be soon.

The counsellor offered two more sessions or suggested a referral for High-Intensity Therapy (HIT therapy). A referral was made to HIT for Cognitive behavioural therapy (CBT) to address lifelong low self-esteem and repetitive pattern of sabotaging jobs, followed by regret and self-criticism. On the 4th and 22nd of November 2019, Phillip failed to attend his ADHD review.

9.69 On 13th November Kathleen's mother contacted Cheshire Constabulary stating that her daughter (Kathleen) required assistance. Kathleen had called her mother stating that Phillip wanted Kathleen out of the house and was *'controlling.'* Phillip had also taken Kathleen's phone and broken it. Kathleen's mother had said that she had offered to give Kathleen the money to get the bus to her mother's address in North Wales, but that Phillip had told Kathleen that he would lock her out if she went out to get the money.

9.70 On the arrival of officers, Kathleen made a complaint of assault against Phillip, who was subsequently arrested.

Following the interview, Phillip was released on police bail to allow further enquiries and evidence to be obtained. The bail period was for seven days and enquiries to be completed were outlined by the Detective Inspector. This included:

1. Ensure IDVA visits the victim
2. Follow-up visit with victim to explore victim wishes for a prosecution
3. MG11 from first disclosure witness – [Mother]

4. House to house to be conducted.

The bail conditions were:

1. Not to contact the victim

2. Not to return to the address they share, less with police to collect necessary belongings

9.71 On 14th November DAIPS received a VPA from Cheshire Constabulary indicating Kathleen was *'high risk'* from domestic abuse. The IDVA attempted to contact Kathleen, unsuccessfully. Following Phillip's arrest, several enquiries were undertaken, including taking statements from Kathleen and her mother.

9.72 In Kathleen's first statement, she states that has lived with Phillip for 3 years but is not in a relationship; however, they do have sex regularly.

She alleged that they started arguing because she was drinking alcohol and that Phillip threw his toothbrush and toothpaste at her. He then threw his phone, clothing, and her phone at her. Kathleen said that her phone was damaged during the incident.

Kathleen described Phillip as an *'absolute bully'* towards her and added that she was intoxicated at the time of making the statement.

9.73 In her second statement, taken later that evening, Kathleen said that she met Phillip when they were both in alcohol rehab. She described the relationship as 'toxic' and said that it started to fall apart due to her drinking and more recently, Phillip had started drinking excessively, as well as taking and selling cocaine.

9.74 Kathleen said she felt Phillip was frustrated with her drinking and threw his phone at her, which hit her on the face, below her eye. He then started to pull clothes and hangers out of the wardrobe and throw those at her, telling her to *'fuck off'* to her mum and dad. He also threw the tv remote control at her.

Kathleen said that Phillip had anger management problems and had attacked her *'many times'* during their relationship. She said that he was a bully, that she was *'scared of him'* and that he told her she was not good enough for him.

9.75 Kathleen then immediately gave a retraction statement saying that she no longer supported Police action and would not attend court. She said that she believed that Phillip was moving out soon and that this would prevent any further issues. It was also recorded that Kathleen would not support a DVPN as she was adamant that no further action should be taken.

The officer recorded the status of the relationship between Kathleen and Phillip *'According to both parties, they are in a 'friends with benefits' situation. Whilst not being together, and sleeping in different rooms of the same house, they do appear to have sex regularly.'*

Kathleen was said to be under the overview of Aqua House with a level 4 counselling referral for alcohol abuse. The officer reported that no visible injuries could be seen, and that Kathleen refused to show any injuries.

9.76 A statement was obtained from Kathleen's mother who stated that Kathleen had called and told her *'[Phillip] wants me out of the house, you've got to come to me now.'* Kathleen's mother stated that she heard Phillip saying, *'Don't worry [mother], me and Kathleen are still friends,'* but that Kathleen told her that he had said that her mum and dad were *'fucking useless'* when she wasn't on the phone.

9.77 Following the incident and the retraction, it was determined that *'no further action'* would be taken against Phillip due to insufficient evidence, including the lack of corroborating evidence from Kathleen's mother or any physical evidence of an assault.

9.78 Following the incident, a further referral was made to the IDVA following a DASH risk assessment, during which Kathleen disclosed that she had bruises and that she was in fear of further violence/injury and Phillip hitting her. Kathleen also answered positively to the following:

- Do you feel isolated from family/friends? i.e., Does (name(s) of abuser(s)___) try to stop you from seeing friends/family/doctor or others?
- Does (___) constantly text, call, contact, follow, stalk or harass you?

- Are you currently pregnant or have you recently had a baby (within 18 months)?
- Does(___) try to control everything you do and/or are they excessively jealous?
- Are there any financial issues? For example, are you dependent on (___) for money/have they recently lost their job/other financial issues?
- Kathleen also said that the abuse was not happening more often but was getting worse.
- Phillip had tried to strangle/choke/suffocate/drown her and did or said things of a sexual nature that makes you feel bad or that physically hurt you or someone else?
- Kathleen has had problems in the past year with drugs (prescription or other), alcohol or mental health leading to problems in leading a normal life? Alcohol and illegal drugs NFD
- Phillip has breached bail/ an injunction and/or any agreement for when they can see you and/or the children.

9.79 On a further VPA following Kathleen's retraction statement, it is recorded that *'she was scared of the suspect, and that she just wanted to be 'The Stepford Wife' and remain quiet to satisfy him.'* Kathleen also stated that she believed it was her fault Phillip was abusing her, due to her alcohol abuse.

9.80 On 27th November Kathleen was again discussed at the MARAC meeting, it is recorded that the IDVA had arranged to call Kathleen back as she had been working with her dad and did not wish to speak at the time of the call.

CWP reported that Kathleen did not wish to share information with MARAC. Action for CWP to query Kathleen's GP information and ask the GP to consider a referral to WDP (drug & alcohol services). There is no update on previous actions.

9.81 On 4th December, the IDVA made another unsuccessful attempt to contact Kathleen. 5th December Kathleen contacted the IDVA requesting contact be made with her on 9th December, saying she was working for her father and did not wish to speak about her circumstances in his presence.

9.82 On the 9th of December, the IDVA contacted Kathleen. During the call, Kathleen agreed to contact DV assist (legal support company for obtaining orders) and request a non-molestation order but in her own time, Kathleen agreed to speak with the IDVA after Christmas.

9.83 On 10th December, a further MARAC meeting was held. The same day Kathleen and the IDVA had a telephone call during which Kathleen advised she was living on her own and Phillip had stayed with his parents. His parents are to going buy him his own property.

9.84 Kathleen acknowledged that she still had *'blips'* with alcohol but was feeling much better. She discussed being isolated from her friend during her relationship with Phillip. Kathleen was provided advice regarding peer support groups and the domestic abuse recovery programme Gateway.

9.85 Kathleen told the IDVA that she felt safe and there had been no further incidents. Safety planning was completed, and Kathleen agreed with the IDVA for the closure of the intervention.

9.86 On 20th February 2020, Kathleen's mother rang Cheshire Constabulary stating, *'My daughter is undiagnosed bipolar, and her neighbours have rung to tell me she is walking around naked.'* Phillip was contacted by the control room staff and stated *'Kathleen is an alcoholic, I'm trying to stay away from her because I can't keep her at the property any longer. A neighbour rang me to say I had to bring Kathleen back into the house as she was leaving the house completely naked.'*

9.87 Police officers attended and found Kathleen in the house fully clothed. Kathleen stated that she had argued with Phillip over the phone and then left the house naked to get alcohol. She stated that Phillip would not be returning to the house that night. Kathleen appeared upset but went to bed and would not say anything further. The officer offered to get an ambulance for Kathleen, but she refused. When they left the house, the officers ensured it was secure.

9.88 Kathleen's mother was contacted and updated over the telephone. She stated that this is a regular occurrence, (every 6 weeks) for Kathleen.

The officer pointed out that Kathleen was on her own and intoxicated. Kathleen's mother stated she may get a taxi to the location later this evening as she was unable to drive. Kathleen's mother was happy with the police's actions and grateful for police attendance.

9.89 A referral was made to the mental health team to raise awareness of the incident and for further assessment.

9.90 On 18th May 2020, following a call from a taxi company, police officers attended an incident where Kathleen approached PCSOs in Chester and reported that Phillip had called her a *'c***'* and told her to *'fuck off'*. There was no disclosure of physical assault and no visible injuries.

9.91 Kathleen disclosed that Phillip gets very jealous and does not allow her to see certain people. She disclosed he has been physically violent once which occurred two years ago, this was not reported to the police. Further to this, Kathleen disclosed that he had previously thrown water over her. She stated that the arguments stem from alcohol when she drinks; she admitted that she had had a few drinks today.

9.92 Kathleen stated that she wished to end the relationship and would be asking Phillip to leave her property. Kathleen said that she did not want any police action regarding the incident. A DASH risk assessment was completed, and Kathleen was directed towards domestic abuse support services. Kathleen appeared to want to engage with these services.

9.93 Kathleen wished to return home to get some sleep. She assured officers that she did not feel in danger and had not been threatened with violence. A VPA was submitted although on review it was not felt to meet the criteria for a *'referral to IDVA.'*

9.94 On 23rd May, Phillip reported a domestic incident to Cheshire Constabulary, saying that *'My housemate [Kathleen] is an alcoholic, she has become verbally abusive towards me, so I've left the house and currently in proceedings to move out for good.'* Phillip confirmed that no assault or any offences have taken place. He went on to explain that *'there was an incident a few months back where Kathleen made up a*

false allegation about him, so he just wished for this to be logged.' Phillip did not want any contact from the police regarding this. Phillip explained that this happened due to Kathleen being continuously drunk for the last 10 days.

This would appear to be Phillip victim-blaming, using the information to divert actions away from his behaviours to create the impression that Kathleen was the perpetrator and he the victim. Minimising the assault on Kathleen and that because she had retracted, she had made it up. The tactic of minimisation and apportioning responsibility towards Kathleen is a clear tactic to deflect responsibility.

9.95 On 15th July, a neighbour of Kathleen's reported that they were concerned for Kathleen saying *'she [Kathleen] has just got home and is paralytic drunk, she is outside her house trying to get into her property and her face is badly swollen and possibly bruised as well.'*

9.96 Officers attended the address, and an ambulance was also called for by the police. On their arrival, Kathleen was found to have *'a lot of swelling to her forehead and left eye and a cut lip.'* It was also reported that there was *'blood on the floor in front of the stairs.'*

9.97 Kathleen was described as *'heavily intoxicated'* but said that she had been *'pushed down the stairs by her partner.'* There was a fresh pool of blood at the bottom of the stairs. The officer requested that a Crime Scene Investigator attend to photograph Kathleen's injuries *'as she is often pressured into retracting her statement.'* This is evidence of good practice by the officer, being aware of Kathleen's situation and ensuring all available evidence is collected and recorded in the event Kathleen withdraws the complaint. Phillip was arrested for the assault and taken into police custody.

9.98 Kathleen provided a statement to say that on 15th July 2020, she and Phillip were at home drinking. Kathleen went downstairs to the living room where she argued with Phillip. She tried to back out of the room, but he came towards her shouting that he hated her and began to punch her in the face repeatedly at the foot of the stairs. She tried to run up the stairs, but he pulled her back. She broke free and ran upstairs to her bedroom and could not remember what happened until the police arrived.

9.99 Kathleen also gave details of a historical assault that is alleged to have occurred around 12 months after they moved into the address when she stated Phillip assaulted her after she let his dog out. She said that he would regularly lock her in the house while he went out drinking all day and would say this was for her own good, as he did not trust her to go out when she had been drinking. She said he would throw water at her and belittle her.

9.100 During an interview, Phillip said that he had never assaulted Kathleen. He vehemently denied being in a domestic relationship with her, saying they met each other at rehab in December 2017 and he moved into the address in April 2018. He says they do not have a conventional relationship; they sleep in separate bedrooms and very occasionally have sex. He goes on to say that any relationship they could have had, has been affected by Kathleen's drinking which is out of control. He planned to move out of the property after this incident.

9.101 Phillip said that Kathleen had been drinking for seven days up to 15th July and that she gets so drunk that she soils herself. Phillip said that when he woke on the morning of 15th July, after having very little sleep due to Kathleen banging about with bottles, he found Kathleen in the armchair with her dressing gown raised and red wine spilling down her mouth. He returned to bed and left the house later that morning.

9.102 Before leaving, he told Kathleen that she was a *'scruffy bastard'* and that she was *'disgusting.'* When he left, she had no obvious injuries. He denies that he and Kathleen argued that day. Phillip said that whilst out with friends he received a text message from a neighbour stating that Kathleen was knocking on one of the neighbour's doors.

9.103 Phillip said that he was quite close with Kathleen's parents as they were all trying to keep her sober and safe. They regularly text each other about Kathleen's welfare but more recently they have become distanced. He said they had raised concerns that he was a bit controlling with Kathleen.

9.104 Phillip denied financial control and denied control over whom she sees (friends and family). He said that he regularly locks the front door as Kathleen has been known to get drunk and leave the front door open, letting his dog out. He says that he always leaves the back door unlocked and does not lock her in the house. He sometimes locks the side gate but there is a key in the house to unlock it.

9.105 Phillip denied domestic abuse and said they both say things to each other, he said he does not go out of his way to belittle her - Kathleen has issues that stem from childhood, and he thinks she may have bipolar. Phillip did not think that Kathleen would maliciously accuse him of assault, but it was more likely that she was so drunk and confused/embarrassed that she accused him of assault.

9.106 Following his interview, Phillip was bailed from the police station, with the condition not to contact Kathleen or enter the address where she lived.

9.107 DASH was not completed as Kathleen was said to be intoxicated and struggled to comprehend questions. She reported that Phillip was in the process of moving out and that she wanted this to happen. The officer notes that the relationship appears to be toxic, and that Kathleen is vulnerable due to her alcohol abuse. A referral was made to IDVA. This was an opportunity to engage Kathleen and conduct an appropriate risk assessment, given the intended separation this was a missed opportunity.

9.108 On 16th July, A VPA was received for Kathleen, indicating '*High risk'* domestic abuse from Cheshire Constabulary and the North West Ambulance Service. Following the referrals, contact was attempted with Kathleen but was unsuccessful.

9.109 On the 18th of July Kathleen was contacted by DAIPS on the phone. Kathleen advised she was safe to speak and informed that she did not wish to discuss the recent incident. Kathleen was described as sounding emotional and a further contact date of 22nd July was agreed upon. Kathleen advised she may return to the Yorkshire area to be near family and that she was aware Phillip was subject to bail conditions until 10th August 2020.

9.110 On 22nd July there was another failed contact with Kathleen. Due to the level of risk, the information should have progressed to MARAC, and this is deemed to be a missed opportunity for a multi-agency plan.

9.111 Kathleen was spoken to over the telephone on 23rd July, in the company of her sister by the investigating officer. In the information, it is recorded that Kathleen's sister was staying with Kathleen and said that Kathleen had continued to drink to excess and had been permanently intoxicated since the incident on 15th July.

9.112 During this call, Kathleen said that at around 7.30 pm on 14th July Phillip phoned her mum and after getting off the phone he was very cross. Kathleen went to go upstairs, and she was about three stairs up when she felt Phillip grab the back of her dressing gown and pull her down the stairs. She stumbled but did not fall. He then repeatedly shouted at her *'I fucking hate you.'*

9.113 He then used an open palm to slap her twice to the side of the face, causing an injury to her left eye. She went upstairs and Phillip left the house. She went to sleep without ringing anyone and woke up the next morning (she is unclear what time it was) and felt dried blood on her face from her nose. She wiped it clean. She could not remember any further details.

9.114 Kathleen was asked why she had stated that the assault had happened on 15th July, and she said she had been repeatedly punched. She was also asked to explain the injury to her forehead. Kathleen said she could not remember and felt like she was being interrogated. Then she said, he [Phillip] hit me against the wall. She was asked if she wanted to make a complaint and attend court to give her account and she said no and terminated the call.

9.115 On 23rd July, Kathleen's sister contacted the officer in the case to ask if Kathleen had a social worker and whether she could be sectioned. She was told that Kathleen is deemed to have the capacity to make her own decisions and probably due to her alcoholism, does not want to engage with Police or medics. Kathleen's sister was very concerned about her sister but did not know whether Kathleen was telling the truth about being assaulted by Phillip. She was advised regarding the IDVA.

9.116 During the investigation, it was reported that Kathleen disclosed several different accounts of the incident. Kathleen told the attending paramedic that she *'had fell down the stairs'* and then *'I was pushed down the stairs and kicked in the head.'* Kathleen also said that *'I want him out of the house'* and *'he's locked me out my house.'*

9.117 Following a review by the Crown Prosecution Service, a decision was made that no further action would be taken due to there being no realistic prospect of conviction. Their rationale was that *'The only person who could give evidence as to the assault is the victim. She was admittedly very drunk at the time of the assault and subsequently gave many different accounts of both the nature and date of the assault. Her evidence would not be credible.'*

There appears to be a lack of understanding of the impact of domestic abuse and in particular the linkage between domestic abuse and alcohol consumption.

9.118 On the 27th of July, Kathleen's sister contacted DIAPS requesting to speak with Kathleen's IDVA. A call was arranged for the following day. During this call on 28th July, the IDVA and Kathleen's sister discussed their shared concerns for Kathleen. The concerns were Kathleen's alcohol use and how at times her sister has had to offer personal care when Kathleen is intoxicated.

9.119 Kathleen's sister discussed Kathleen's past when Kathleen was a nurse in London, that she stole drugs from her employment and how she was concerned regarding the relationship with Phillip.

9.120 Kathleen's sister disclosed that Kathleen demonises people and lies a lot and that she is concerned that Kathleen has a mental health issue and that when assessed by practitioners she is not truthful regarding her symptoms. Kathleen was reported as negative and isolated from her family and friends. Kathleen's family had paid for therapy over the past 15 years, but no interventions were successful.

9.121 Kathleen's sister also told the IDVA that Kathleen had told her Phillip had previously raped her [Kathleen], but this was confidential. Kathleen's sister also believed that Kathleen would rekindle the relationship with Phillip.

9.122 Kathleen’s sister agreed to facilitate contact between Kathleen and the IDVA, to contact Adult Social Care to request a care act assessment and she was given safety planning advice to undertake with Kathleen. On 29th July, a further attempt was made to contact Kathleen by the IDVA but was unsuccessful.

9.123 On 7th August the IDVA contacted the customer relations officer from Adult Social Care who advised of Kathleen’s sisters' request for a Care Act assessment, Adult Social Care agreed to contact Kathleen’s sister. On the same day, Kathleen’s sister was contacted in respect of the Care Act Assessment even though Kathleen had not given permission, in the circumstances, this should be seen as good practice.

9.124 On 13th August Cheshire Constabulary was called by the ambulance service to assist Phillip, who was in a bus stop, intoxicated with a head injury and *‘lacked capacity.’* They also said that the male was becoming aggressive, and they were unable to attend to him. Update from the officer at the scene *‘Male is struggling to answer ambulance questions and can't even comply with simple tasks like pricking of finger, so they are saying he needs to go to hospital under the Capacity Act.’*

10 Analysis against the Terms of Reference

10.1 The Individual Management Reviews have been carefully considered through the viewpoint of Kathleen, to ascertain if each of the agencies’ contacts was appropriate and whether they acted by their set procedures and guidelines. Where they have not done so, the Panel has deliberated if all the lessons have been identified and are being properly addressed.

10.2 The Review Panel is satisfied that all agencies have engaged fully and openly with the Review and that lessons learned and recommendations to address them are appropriate.

10.3 The authors of the IMRs and Reports have followed the Review’s Terms of Reference carefully and addressed the points within it that were relevant to their organisations.

They have each been honest, thorough and transparent in completing their reviews and reports.

10.4 Terms of reference

The following key areas have been considered throughout the review. Each point has been identified and where appropriate, commented on within the key findings and lessons learned.

10.5
- Whether the incident in which Kathleen died was an isolated one or whether there were any warning signs and whether more could be done to raise awareness of services available to victims of domestic abuse.

10.6
- Whether there were any barriers experienced by Kathleen or her family and friends in reporting any abuse in Cheshire or elsewhere, including whether they knew how to report domestic abuse should they have wanted to.

10.7
- Whether there were opportunities for professionals to 'enquire' as to any domestic abuse experienced by Kathleen that were missed.

10.8
- Whether there were opportunities for agency intervention in relation to domestic abuse regarding Kathleen or Phillip that were missed.

10.9
- The review should identify any training or awareness-raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services in the area covered by the Cheshire West and Chester Community Safety Partnership.

10.10
- The review will also give appropriate consideration to any equality and diversity issues that appear pertinent to Kathleen and/or Phillip e.g., age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

All nine protected characteristics in the 2010 Equality Act were considered by the DHR panel. The protected characteristics considered relevant to this DHR, are race, religion and belief. Within the review specific considerations were given to the age of both Kathleen and Phillip and whether there was any impact on the services offered, support available or their treatment within agency responses. The panel also

considered the status of the relationship between Kathleen and Phillip, their race, sexual orientation and religion. Specifically examining the characteristics and any link to discriminatory or preferential treatment as a result. The panel did not find any evidence of such discrimination or preference. The panel recognised that domestic abuse is a gendered crime and women are more likely to experience it.[8]

10.11

- How should friends, family members and other support networks and, where appropriate, the perpetrator, contribute to the review and who should be responsible for facilitating their involvement?

Kathleen's parents have engaged with the review. The panel thanks them for their involvement and the provision of a better understanding of Kathleen. Their thoughts have been included throughout the review.

10.12

- How should matters concerning family and friends, the public and media be managed before, during and after the review and who should take responsibility for it.

Any media will be managed through the Cheshire West and Chester Community Safety Partnership. All agencies are aware of this and agree. If there is a need for any statement a jointly agreed statement between the partnership and agencies will be issued.

10.13

- How will the review take account of a coroner's inquiry, and (if relevant) any criminal investigation related to the homicide, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process or compromise to the judicial process?

10.14

- Does the review panel need to obtain independent legal advice about any aspect of the proposed review?

[8] Domestic abuse is a gendered crime - Women's Aid (womensaid.org.uk)

10.15 • How should the review process take account of previous lessons learned from research and previous DHRs?

The review has considered several DHRs and other academic learning to identify any learning points.

10.16 • Whether Kathleen or Phillip was 'in need of care' within the auspices of the Care Act 2014

Sec 42 of the Care Act 2014 places a statutory responsibility on local authorities regarding individuals who require care.

This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)—

(a) has needs for care and support (whether or not the authority is meeting any of those needs),

(b) is experiencing, or is at risk of, abuse or neglect, and

(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

10.17 A Care Act Assessment was offered via Kathleen's sister, but this was not progressed before Kathleen died.

10.18 Kathleen was vulnerable and could be considered an adult at risk while intoxicated and consuming large amounts of alcohol were likely to affect her capacity for decision-making, however, there is no documented evidence to support her being under the influence of alcohol while in consultations with her GP's. It is apparent from consultations that she was articulate in her conversations, understanding the risks she took for example when obtaining and taking the medication Antabuse.

10.19 • Whether there were any issues in communication, information sharing or service delivery between services.

Following an analysis of all the information and the circumstances and events leading up to Kathleen's death, the review did not find any issues in communication, information sharing or service delivery between services.

10.20 Case-specific issues

10.21

- **Was the impact of Kathleen's alcohol abuse considered in the context of domestic abuse and how did this manifest itself in agency responses?**

10.22 There is frequent reference within the agency records of Kathleen's alcohol abuse, and whilst she had accessed alcohol treatment services there was never a greater level of understanding of the triggers.

10.23 There does not appear to have been a link drawn between her alcohol use and domestic abuse, nor an understanding of whether the alcohol abuse created a vulnerability that was exploited by her partners, or whether it was a coping mechanism. Victimisation may elevate an individual's risk of substance misuse[9].

10.24 High levels of negative effects caused by assault can lead individuals to engage in behaviours that reduce negative emotions[10]. The use of alcohol minimises the effects of trauma. This was described by her family who explained that Kathleen's alcohol abuse was cyclical. She was functioning perfectly normally for a time and then as pressure mounted, she resorted to alcohol and binged excessively. A referral from her GP to PCMHT explained that every six weeks or so Kathleen would find her anxiety build overwhelmingly and so used alcohol to manage her extreme anxiety. At these times she drank to dangerous excess over several days and exhibited risk-taking behaviours on several occasions.

10.25 On another occasion, Kathleen was described as having *'relapsed'* and Phillip had damaged her wardrobe door and assaulted Kathleen. On this occasion, Phillip was

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[9] Schaefer, J.D., Moffitt, T.E., Arseneault, L., Danese, A., Fisher, H.L., Houts, R., Sheridan, M.A., Wertz, J. and Caspi, A., 2018. Adolescent victimization and early-adult psychopathology: approaching causal inference using a longitudinal twin study to rule out noncausal explanations. *Clinical Psychological Science*, *6*(3), pp.352-371

[10] Bhuptani, P.H. and Messman-Moore, T.L., 2019. Blame and shame in sexual assault. In *Handbook of sexual assault and sexual assault prevention* (pp. 309-322). Springer, Cham.

arrested. Several days later Kathleen was again intoxicated wandering in the street with no top on.

10.26 Kathleen also disclosed to her West Step 3 counsellor her alcohol abuse describing herself as a '*bad person'* and would die '*probably from alcohol poisoning*.'

10.27 Research suggests that the rates of lifetime physical and/or sexual assaults are much higher among women experiencing substance use/abuse/dependence. This correlation between alcohol and increased vulnerability is often unrecognised and rather than substance use highlighting the greater potential for exposure to abusive behaviours can be seen to minimise the behaviours and apportion blame to the victim. On one occasion Phillip explained he had found Kathleen asleep in the chair after consuming red wine, he said to Kathleen that she was a *'scruffy bastard'* and that she was '*disgusting.'*

10.28 It is also suggested that the use of alcohol and drugs is often used to medicate the pain involved in situations of domestic violence and trauma by women.[11] It has also been shown that women victims are more likely to use alcohol and drugs to alleviate the impact of the abuse[12] and women in treatment for alcohol and other drugs report elevated rates of victimisation[13].

10.29 There is research that suggests strong associations between abusing alcohol, having a partner that abuses alcohol and experiencing domestic abuse.[14] This was the case for Kathleen. On many occasions, both Kathleen and Phillip were intoxicated, either at the same time or not. On several occasions, this resulted in physical violence and abuse.

10.30 Agencies responded to incidents when Kathleen was reported as being intoxicated or attending medical facilities and positive and supportive actions were taken.

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[11] Lutwak, N., 2018. The psychology of health and illness: The mental health and physiological effects of intimate partner violence on women. *The Journal of Psychology*, *152*(6), pp.373-387.

[12] Zilberman, M.L. and Blume, S.B., 2005. Domestic violence, alcohol and substance abuse. *Brazilian Journal of Psychiatry*, *27*, pp.s51-s55.

[13] Miller BA, Wilsnack SC, Cunradi CB. Family violence and victimization: treatment issues for women with alcohol problems. Alcohol Clin Exp Res. 2000;24(8):1287-97.

[14] Buller, A.M., Devries, K.M., Howard, L.M. and Bacchus, L.J., 2014. Associations between intimate partner violence and health among men who have sex with men: a systematic review and meta-analysis. *PLoS Med*, *11*(3), p.e1001609.

Cheshire Constabulary attended one incident and looked after Kathleen, ensuring she was safe in the house and bed before checking the house and locking the door.

10.31 The individual agency responses followed their procedures and support for Kathleen; however, a holistic review of her alcohol abuse may have provided a greater understanding of the abuse she was receiving from Phillip.

10.32
- **Was Kathleen's mental health recognised and how was it considered in the context of domestic abuse?**

10.33 It is clear from agency records that Kathleen's mental health was recognised and discussed, often her mental health and alcohol consumption were linked.

10.34 It is documented within the clinical records that Kathleen suffered from low mood and anxiety that impacted her coping ability and functioning. Within the records, there is no evidence of any serious and enduring mental illness and therefore no care needs identified from a secondary mental health service perspective.

10.35 However, following an initial screening through the Primary Care Mental Health Trust Kathleen was referred for step 3 counselling with a request for consideration of further high-intensity therapy.

10.36 Within GP records, it is recorded that Kathleen has discussed struggles with alcohol consumption, high anxiety, self-esteem, and termination of pregnancy, as well as family issues. The GP had referred Kathleen to the Primary Care Mental Health Team.

10.37 There are documented discussions about Kathleen's mental health, but there does not appear to be an exploration of the impact of domestic abuse in this regard. In this context, there are associations between the choice of partners with tendencies to select or stay with those with a greater risk of abuse[15]

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[15] Tsai, A.C., Weiser, S.D., Dilworth, S.E., Shumway, M. and Riley, E.D., 2015. Violent victimization, mental health, and service utilization outcomes in a cohort of homeless and unstably housed women living with or at risk of becoming infected with HIV. *American journal of epidemiology*, *181*(10), pp.817-826.

10.38 On another occasion, Phillip also disclosed mental health issues and his addiction. It is recorded within the MARAC minutes that Kathleen suffered mental health issues, and this was also raised by Kathleen's sister to DAIPS shortly before Kathleen died.

10.39 There is recognition that domestic abuse is associated with a high rate of depression, substance abuse and anxiety disorders.[16] The longer-term impact of sustained abuse creates greater mental health issues for the victims.[17]

10.40 Agencies were aware of Kathleen's mental health issues, and she was undergoing support and treatment through mental health services. However similarly to Kathleen's alcohol abuse, the information and treatment remained within individual agencies. There was information shared within MARAC, however, there does not appear to have been a direct connection between Kathleen's mental health, her alcohol consumption and the domestic abuse, creating a holistic picture for agencies. This is a point of learning.

10.41 It is recognised that intimate partner violence is a significant risk factor for attempting suicide. It is suggested that the link between suicidality and domestic abuse stems in part from feelings of powerlessness, depression, loss of control, social isolation and financial issues.[18] These issues are unfortunately prevalent in many relationships, however, there does not appear to have been a direct link between the abusive history and the psychological impact on Kathleen. The correlation between accessing psychological services combined with adult physical abuse increases the rates of suicidal attempts.[19]

10.42 There have been recent developments in respect of the classification and criminalisation of coercive and controlling behaviour together with understanding the outcomes. This provides an opportunity to assist agencies to understand and correlate the actions of the abuser with the actions and behaviours of victims. However, an abuser's liability for suicide will continue to depend upon an

[16] Campbell J: Health consequences of intimate partner violence. Lancet 2002; 359:1331–1336

[17] Taris TW, Kompier MAJ (2014) Cause and effect: optimizing the designs of longitudinal studies in occupational health psychology. Work Stress 28(1):1–8

[18] Almış, B.H., Gümüştaş, F. and Kütük, E.K., 2020. Effects of domestic violence against women on mental health of women and children. *Psikiyatride Guncel Yaklasimlar*, *12*(2), pp.232-242.

[19] Kaplan, M. L., Asnis, G. M., Lipschitz, D. S., & Chorney, R (1995). Suicidal behavior and abuse in psychiatric outpatients. *Comprehensive Psychiatry, 36,* 229-235.

assessment of whether a chain of causation between the abusive behaviour and the suicide can be established and remain intact.

10.43 The review found no concrete evidence that there was a link between the abusive behaviour Kathleen was suffering and suicidal ideation. However, evidence suggests that this remains a lesson for agencies to consider in the context of complex relationships.

10.44

- **Was the impact of Kathleen's substance misuse considered in the context of domestic abuse and how did this manifest itself in agency responses?**

10.45 There is information that Phillip used cocaine and alcohol, which together with his mental health issues created unstable and sometimes violent actions towards Kathleen.

10.46 During Kathleen's discussion with the IDVA and the completion of the DASH risk assessment, Kathleen disclosed the use of alcohol and drugs but there is no further exploration or explanation.

10.47 There is no other information concerning Kathleen using illegal drugs and as such agencies do not appear to be aware of whether she was or not. It is unclear whether she was asked or did not disclose, however, given her alcohol addiction, Phillip using cocaine and Kathleen's mental health her drug use should have been explored.

10.48 It is also recognised that not all agencies were aware of Phillips' cocaine use, Kathleen had disclosed the information to West Step 3 IDVA service and Cheshire Police during a statement she made relating to an incident of domestic assault.

10.49 Phillip had provided information about his use of cocaine to the Accident and Emergency Department at Countess of Chester Hospital in October 2017.

10.50 Similar, to Kathleen's alcohol use and her mental health, some agencies were aware, but not all. Importantly some agencies were aware of some of the information, but not all. This created the individual agency response without a holistic overview. This is included within the point of learning.

10.51 • **Was the impact of domestic abuse considered across all services and was there a holistic view of engagement and interagency response?**

10.52 It is recognised that experiencing more than one type of abuse (physical, sexual, and/or emotional/psychological) increases the probability of having depressive symptoms.[20]

10.53 Treatment of the holistic impact of Domestic abuse is important. Isolated treatments may have a short-term impact, but longer-term results require a joint holistic approach between agencies.

10.54 There are instances when the impact of domestic abuse was recognised and considered including Cheshire Constabulary, GP services, hospital and the IDVA service. All agencies responded appropriately considering the information they had.

10.55 Information was shared at MARAC and as such the knowledge of Kathleen's abuse was promulgated further. However, there does not appear to have been any broader holistic view of the interagency response or engagement.

10.56 Kathleen had challenges, and alcohol and her mental health were dominant in her life. On several occasions, she did not attend appointments or support police investigations surrounding her being assaulted. This is by no means victim-blaming, Kathleen's life was complex, and her relationship with Phillip was complex. He was abusive and violent, and Kathleen's sister alleges that he also raped Kathleen.

10.57 His language towards her was aggressive, undermining and exhibited his controlling and coercive behaviour.

10.58 Phillip's controlling behaviour was also exampled when he reported Kathleen as having stolen two bottles of wine and asked for her to be arrested, not to mention it was he who reported her. This is also at a time when Phillip himself was engaged in

[20] Stylianou, A. (2018). Economic Abuse Experiences and Depressive Symptoms among Victims of Intimate Partner Violence. Journal of Family Violence.

using Class A controlled drugs. Also, when Phillip rang the West Step 3 counselling service repeatedly during Kathleen's appointment to check where she was.

10.59 Further examples are when Phillip regularly locked Kathleen in the house while he went out drinking all day and would say this was for her own good, as he did not trust her to go out when she had been drinking. She said he would throw water on her and belittle her.

10.60 Agencies often supported Kathleen within their relevant roles. Other than the MARAC meetings there was no wider consideration of Kathleen's complexities and as such there was no holistic view undertaken. This is a point of learning for this review.

10.61

- **What was the involvement of family and friends? How was information received managed and acted upon in support of Kathleen?**

10.62 Family and friends are an important network for victims of domestic abuse, it is recognised that victims are likely to confide in someone close to them[21].

10.63 The reasons are many and varied, including that family and friends are more trusted, with greater accessibility, and able to offer practical assistance and emotional support[22]. However, it is also acknowledged that family and friends are unsure how to respond for fear of upsetting the individual or not wanting to get involved themselves. There is little research available that can identify what victims feel about the support they are offered, but that which is available suggests victims feel the most helpful response as having someone either convey understanding or assurance that they were not to blame, receiving assistance with decision making, or having someone to listen to them.[23]

10.64 On several occasions, both Kathleen's mother and her sister attempted to support her. They either attended appointments with Kathleen to provide background

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[21] Boethius, S. and Åkerström, M., 2020. Revealing hidden realities: disclosing domestic abuse to informal others. *Nordic journal of criminology*, *21*(2), pp.186-202.
[22] Johnson, I.D. and Belenko, S., 2021. Female intimate partner violence survivors' experiences with disclosure to informal network members. *Journal of interpersonal violence*, *36*(15-16), pp.NP8082-NP8100.
[23] Beeble, M.L., Post, L.A., Bybee, D. and Sullivan, C.M., 2008. Factors related to willingness to help survivors of intimate partner violence. *Journal of Interpersonal Violence*, *23*(12), pp.1713-1729

information or reported incidents to agencies. They both explained to agencies about Kathleen's behaviours when she was using alcohol and that they had concerns over her capacity to make decisions when she was intoxicated.

10.65 Kathleen's sister was also able to provide further background information to the IDVA service and requested that Kathleen be given a 'Care Act' assessment. Unfortunately, this occurred only days before Kathleen died.

10.66 She was also able to provide more detailed information about Kathleen and her relationship with Phillip, and that he had previously raped Kathleen.

10.67 It is difficult to analyse the behaviours of family and friends; they are placed in a difficult situation and no doubt following the death of Kathleen they reflected on what they could have done. A challenge for authorities is to be able to provide the relevant information; support and guidance to family and friends who may have had domestic abuse disclosed to them or that they have suspicions that domestic abuse is occurring, that they feel confident and able to report such matters, without compromising their relationships.

10.68

- **Were there any considerations of domestic abuse, including coercive and controlling behaviours?**

10.69 There is no doubt that some agencies were aware of the domestic abuse Kathleen was suffering. Cheshire Police, Adult Social Care, health professionals and domestic abuse services were aware of the behaviours, but from the agency records and the notes made by Kathleen, which became known after her death, they were not fully aware of the behaviours she was being subjected to.

10.70 Kathleen's mother had contacted Cheshire Police to explain that Phillip was 'controlling' towards Kathleen, and they had acted on the information, resulting in Phillip being arrested for assault on Kathleen. She also explained that if Kathleen left the house, he would lock her out and so she was afraid to leave and held as a captive in her own home.

10.71 Phillip used abusive and demeaning language towards Kathleen, he used abusive language to describe Kathleen's parents. A picture of his behaviours is found in Kathleen's notebook, where she describes that he would hide his collection of 50p pieces and accuse Kathleen of stealing them. That he would make her wait outside before letting her in the house. He would not pay for food or his share of the electricity. Phillip did not believe he was doing anything wrong 'spitting at her, kicking her and doing nasty, petty things to hurt her."

10.72 Much of this information has become known since Kathleen's death, although there are no records that suggest coercive and controlling behaviours have been explored outside of any reported behaviours to those agencies.

10.73 It is noted within the behaviours that Phillip was not paying for his food or his share of the electricity and this is recognised as a feature of economic abuse. The information has become known during the review from Kathleen's diary. There was further information on Kathleen's phone indicating that Phillip was withholding monies owed to Kathleen, and although the panel are unable to determine any impact on her, due to this behaviour, the panel recognises that as this is recorded in her diary and her phone, this behaviour has had some impact.

10.74

- **The extent of the abuse appears unrecognised by agencies – what more could be done to ensure similar cases do not occur and/or cases are able to be identified?**

10.75 Engagement with victims is essential to providing services. Agencies should be aware of the impact of their communications and contact should be direct with the individuals concerned and not through 3rd parties. Where alcohol, drugs and/or mental health are involved, agencies should look at all the circumstances holistically to ensure suitable and appropriate responses are provided, thereby ensuring services meet the needs of the individuals. This links to greater awareness of the implications of alcohol use and domestic abuse, their interconnectedness and reliance, but allows interventions and support to be tailored to the individual. Similarly, the link between mental health and domestic abuse to be understood and recognised, ensuring individuals have the bespoke interventions required.

10.76 Information sharing is important within the context of domestic abuse and whilst there are some positive examples of effective information sharing, there are opportunities to ensure greater awareness, for example, Adult Social Care going outside of standard practices to ensure suitable and appropriate information sharing takes place.

10.77 There is a need to ensure agencies are aware of the complexity of relationships, for example, individuals living within the same household are linked and the behaviours of their housemates can be equally damaging in terms of coercive and controlling behaviours and domestic abuse.

10.78

- **Given the nature of this DHR, how will agencies ensure there is no similar repetition with vulnerable persons?**

10.79 The development of learning emanates from this review regarding the circumstances of the relationship and the agency responses. Lessons from the review will be cascaded through agencies to ensure staff are aware. This will also involve a review of processes to ensure any lessons learned are implemented to avoid repetition. For example, the development of the MARAC action monitoring to ensure actions are finalised and completed within appropriate time frames.

10.80 The emphasis on joint learning and expectations is equally important to ensure agencies can understand and operate in a multi-agency fashion, being aware of their individual and collective responsibilities to ensure the safety of individuals who are harmed by domestic abuse.

11 Areas of good practice

11.1 In February 2020, officers from Cheshire Constabulary attended Kathleen's address following a report that she was naked in the street. On their arrival, Kathleen was fully dressed and declined to discuss anything with the officers and went to bed. The officer offered to call an ambulance for Kathleen, but she declined, on their way out of the address the officers ensured the property was safe and secure, this should be seen as good practice.

11.2 In August 2020, a Care Act Assessment was declined by Adult Social Care, due to limited information provided by Kathleen's sister. The IDVA had a discussion with Adult Social Care who agreed to re-contact Kathleen's sister, even though Kathleen had not given permission, in the circumstances, this should be seen as good practice.

12 Lessons to be learnt and conclusions.

12.1 This was a tragic case and although information is now available to the review, much of this information was not available to agencies at the time.

12.2 Kathleen had significant alcohol and substance misuse issues. Agencies should consider why a person is abusing substances and whether there are any underlying circumstances leading to such behaviours.

12.3 In this instance, there was evidence of domestic abuse, and the consequence was alcohol and substance abuse. The wider understanding of the impact of domestic abuse on the behaviours of victims is recognised by all agencies.

12.4 Information sharing across agencies is paramount. Agencies must not presume information is known and that they should share it on all occasions. Through this process a better picture is presented and so agencies are not operating in silos.

13 Recommendations

13.1 All agencies

- Within 6 months, in light of this review conduct a review of policies and procedures relating to domestic abuse and ensure the lessons are implemented.

13.2 Multi-Agency recommendations

- Within 6 months, review all internal domestic abuse training and education programmes to incorporate the learning from this DHR, specifically highlighting the impact of alcohol and mental health within domestic abuse relationships.

- Within 1 month, agencies to work in partnership with each other and be aware of the need to take a holistic approach to domestic abuse.
- Within 1 month, services share information and communicate effectively within the guidelines available.

13.3 Specific agency recommendations

13.4 **Cheshire & Wirral Partnership NHS Foundation Trust**

13.5

- Within 6 months, develop a bespoke domestic abuse training package to be delivered to the Improving Access to Psychological Therapies (IAPT) service by Cheshire West Domestic Abuse Intervention and Prevention Service.

- Currently, domestic violence and abuse training form part of the level three safeguarding training. Within 3 months consider whether a stand-alone domestic abuse training programme is required for all clinical staff across the trust.

- With immediate effect, the CWP staff will take appropriate action when a disclosure is made.

- Within 6 months, ensure a process whereby MARAC alerts are added to PCMIS systems if service users are heard at MARAC.

13.6 NHS Cheshire Clinical Commissioning Group

13.7

- Within 3 months, ensure practitioners in GP practices are trained to approach domestic abuse with professional curiosity.

- Within 3 months, where high-risk domestic abuse is identified, General Practitioners are aware of the need to complete a referral, regardless of other agencies involved. They must inform the client when a MARAC referral is made. For lower risk, referrals with consent can be made to support services.

- Within 3 months, General Practitioners are to be made aware of the need for information sharing with other services e.g., Alcohol and Mental Health Services.

13.8 Adult Social Care

13.9
- With immediate effect, ensure that staff are aware that where possible contact is made with victims directly and not through a 3rd party.

13.10 The Countess of Chester Hospital NHS Foundation Trust

13.11
- Within 6 months, training needs analysis for domestic abuse is to be completed.
- Within 6 months, learning from this review is shared with Countess of Chester Hospital Staff.

13.12 Cheshire Constabulary

13.13
- Within 6 months Police to ensure a robust response to non-intimate domestic abuse that reduces risk.

- Within 6 months, review and consider any referral pathways for perpetrators, cascading the information to front-line officers.

- With immediate effect, it is critical that MARAC information is available on police systems to inform safeguarding.

13.14 Domestic Abuse Intervention and Prevention Service, Early Help and Prevention, Cheshire West and Chester Council

13.15
- None

Appendix A

Domestic Homicide Review

Terms of Reference

Overarching aim

The over-arching intent of this review is to learn lessons from the homicide to change future practice that leads to increased safety for potential and actual victims. It will be conducted in an open and consultative fashion bearing in mind the need to retain confidentiality and not to apportion blame. Agencies will seek to discover what they could do differently in the future and how they can work more effectively with other partners.

Principles of the Review

1. Objective, independent & evidence-based
2. Guided by humanity, compassion, and empathy with the victim's voice at the heart of the process.
3. Asking questions, to prevent future harm, learn lessons and not blame individuals or organisations.
4. Respecting equality and diversity
5. Openness and transparency whilst safeguarding confidential information where possible.

Terms of reference

Following a review of the guidance and factors for consideration, the following were felt to be applicable.

- Whether the incident in which Kathleen died was an isolated one or whether there were any warning signs and whether more could be done to raise awareness of services available to victims of domestic abuse.

- Whether there were any barriers experienced by Kathleen or her family and friends in reporting any abuse in Cheshire or elsewhere, including whether they knew how to report domestic abuse should they have wanted to.

- Whether there were opportunities for professionals to 'enquire' as to any domestic abuse experienced by Kathleen that were missed.

- Whether there were opportunities for agency intervention in relation to domestic abuse regarding Kathleen, Phillip or other family members that were missed.

- The review should identify any training or awareness-raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services in the area covered by the Cheshire West and Chester Community Partnership.

- The review will also consider any equality and diversity issues that appear pertinent to Kathleen or Phillip e.g., age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

Under the management of the review, the panel also considered the following factors:

- How should friends, family members and other support networks and, where appropriate, the perpetrator, contribute to the review and who should be responsible for facilitating their involvement?

- How should matters concerning family and friends, the public and media be managed before, during and after the review and who should take responsibility for it.

- How will the review take account of a coroner's inquiry, and (if relevant) any criminal investigation related to the homicide, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process or compromise to the judicial process?

- Does the review panel need to obtain independent legal advice about any aspect of the proposed review?

- How should the review process take account of previous lessons learned from research and previous DHRs?

- Whether Kathleen or Phillip was ‘in need of care’ within the auspices of the Care Act 2014

- Whether there were any issues in communication, information sharing or service delivery between services.

Key lines of enquiry

The Review Panel (and by extension, IMR authors) will consider the following:

- Was the impact of **Kathleen’s** alcohol abuse considered in the context of domestic abuse and how did this manifest itself in agency responses?

- Was **Kathleen’s** mental health recognised and how was it considered in the context of domestic abuse?

- Was the impact of **Kathleen’s** substance misuse considered in the context of domestic abuse and how did this manifest itself in agency responses?

- Was the impact of domestic abuse considered across all services and was there a holistic view of engagement and interagency response?

- What was the involvement of family and friends? How was information received managed and acted upon in support of **Kathleen**?

- Were there any considerations of domestic abuse, including coercive and controlling behaviours?

- The extent of the abuse appears unrecognised by agencies – what more could be done to ensure similar cases do not occur and/or cases can be identified?

- Given the nature of this DHR, how will agencies ensure there is no similar repetition with vulnerable persons?

- The Review will exclude consideration of how **Kathleen** died or who was culpable - that is a matter for the Coroner and Criminal Courts respectively to determine.

Family involvement and Confidentiality

The review will seek to involve the family of both the victim and the perpetrator in the review process, taking into account whom the family wish to have involved as lead members and identifying other people they think are relevant to the review process.

We will seek to agree on a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

We will identify the timescale and process and ensure that the family can respond to this review endeavouring to avoid duplication of effort and without undue pressure.

Disclosure & Confidentiality

- Confidentiality should be maintained by organisations whilst undertaking their IMR. However, the achievement of confidentiality and transparency must be balanced against the legal requirements surrounding disclosure.

- The independent chair, on receipt of an IMR, may wish to review an organisation's case records and internal reports personally or meet with review participants.

- Individuals will be granted anonymity within the Overview Report and Executive Summary and will be referred to by pseudonyms.

- Where consent to share information is not forthcoming, agencies should consider whether the information can be disclosed in the public interest.

Timescales

Guidance for Domestic Homicide Reviews states they should be submitted to the Home Office within 6 months of notification. Any delays to this deadline will be communicated to the Home Office.

Media strategy

Any media enquiries during and post-publication should be referred to the Cheshire West and Chester Community Safety Partnership who with the Chair will agree on a media strategy.

Chairing & Governance

An independent chair has been appointed to lead all aspects of the review and will report to the chair of the Cheshire West and Chester Community Safety Partnership.

A Panel has been convened specifically to overlook the review process. This is a mix of statutory and voluntary sector agencies and includes specialist domestic violence services.

The Cheshire West and Chester Community Safety Partnership will sign off the final report and submit it to the Home Office Quality Assurance process.

Additionally, representatives from the Cheshire area will be invited to participate in the review process and, where appropriate, the findings from the Domestic Homicide Review will be shared with the relevant agencies and/or partnerships in that area,

Agency roles and responsibilities

- Delegate a senior officer to lead the review on behalf of their organisation.
- Senior officers will attend all Panel meetings.
- Complete Individual Management Reviews within agreed time frames
- Contribute to the Review Report

Information Sharing & Confidentiality

The principles outlined in Cheshire West and Chester Community Safety Partnership Information Sharing Guidance will be always applied. In addition to this, further reference will be made to the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews.

Appendix B

Domestic Homicide Review

Further Information about the Chair and Report Author

Professor Tony Blockley is a highly experienced consultant within the field of homicide reviews. Throughout his extensive career, he has both investigated and been responsible for homicide reviews, including domestic homicides. As Chief Superintendent and Head of Crime for Derbyshire Constabulary, he was chair of Multi-Agency Public Protection Arrangements (MAPPA) and was responsible for the management and operation of public protection units including all forms of abuse, child and adults.

Since completing over 30 years of policing practice he was a consultant in Northern Ireland supporting and engaging with families bereaved because of 'The Troubles'. This involved reviewing historic and significant incidents involving the death of a person in the military or by the military. This was a particularly sensitive role, politicised throughout the province. He has been involved in numerous other homicide reviews throughout the UK and abroad.

Tony chaired the independent panel responsible for the introduction of Clare's Law and the Domestic Violence Protection Notice and Orders within Derbyshire. He was also responsible for the implementation of the 1st perpetrator programme within Derbyshire and a member of the board at a Domestic Violence and Abuse charity, SALCARE.

Having been involved in around 60 Domestic Homicide Reviews he has a wealth of knowledge and experience managing and reporting reviews, engaging and supporting families and presenting findings. He is a special advisor to a 3rd sector organisation that provides domestic abuse services (not in the area covered by the Cheshire West and Chester Community Safety Partnership).

He is the Head of School for Criminology, Investigation and Policing at Leeds Trinity University.

Appendix C

Domestic Homicide Review

Action plan

Ref	Recommendations	Scope of recommendation i.e., local, or regional	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome
	In light of this review conduct a review of policies and procedures relating to domestic abuse and ensure the lessons are implemented	Local	Conduct a review of policies and procedures relating to domestic abuse	**All agencies**		November 22	November 22 Completed
	Review all internal domestic abuse training and education programmes to incorporate the learning from this DHR, specifically highlighting the impact of alcohol and mental health within domestic abuse relationships	Local	Conduct a review of all internal domestic abuse training and education programmes	**All agencies**		November 22	November 22 Completed
	Agencies to work in partnership with each other and be aware of the need to take a holistic approach to domestic abuse.	Local	conduct a holistic review of cases involving domestic abuse	**All agencies**		June 22	June 22 Completed
	Services share information and communicate effectively within the guidelines available	Local	Share information and communicate effectively	**All Agencies**		June 22	
	Develop a bespoke domestic abuse training package to be delivered to the Improving Access to Psychological Therapies (IAPT) service by Cheshire	Local	Improving Access to Psychological Therapies (IAPT) to access training bespoke to their needs	**Cheshire & Wirral Partnership NHS**		November 22	November 22 Completed

Ref	Recommendations	Scope of recommendation i.e., local, or regional	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome
	West Domestic Abuse Intervention and Prevention Service			**Foundation Trust**			
	Consider whether a stand-alone domestic abuse training programme is required for all clinical staff across the trust.	Local	CWP clinical lead to review training offer for clinical staff	**Cheshire & Wirral Partnership NHS Foundation Trust**		August 22	August 22 Completed
	The CWP staff will take appropriate action when a disclosure is made.	Local	Provide within the CWP Safeguarding Practitioner Leads (SPL) meetings, an overview of what to consider following disclosure of domestic abuse and disseminate this to teams	**Cheshire & Wirral Partnership NHS Foundation Trust**		May 22	May 22 Completed
	Ensure a process whereby MARAC alerts are added to PCMIS systems if service users are heard at MARAC.	Local	Devise and implement a process for alerts to be added to PCMIS systems if service users are heard at MARAC.	**Cheshire & Wirral Partnership NHS Foundation Trust**		November 22	November 22 Completed
	Ensure practitioners in GP practices are trained to approach domestic abuse with professional curiosity.	Local	Provide support through the IRIS programme to ensure that GP Practices are appropriately trained and supported about DA	**NHS Cheshire Clinical Commissioning Group (Now**		August 22	August 22 Completed

Ref	Recommendations	Scope of recommendation i.e., local, or regional	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome
				integrated care board)			
	Where high-risk domestic abuse is identified, General Practitioners are aware of the need to complete a referral, regardless of other agencies involved. They must inform the client when a MARAC referral is made. For lower risk, referrals with consent can be made to support services.	Local	GP practices to have access to appropriate support to enable them to make referrals	**NHS Cheshire Clinical Commissioning Group (Now integrated care board)**		August 22	August 22 Completed
	General Practitioners are to be made aware of the need for information sharing with other services e.g., Alcohol and Mental Health Services.	Local	Specific learning from this review about information sharing to be shared with GP practices	**NHS Cheshire Clinical Commissioning Group (Now integrated care board)**		August 22	August 22 Completed
	Ensure that staff are aware that where possible contact is made with victims directly and not through a 3rd party.	Local	Specific learning from this review about direct contact shared with Adult Social Care	**Adult Social Care**		May 22	May 22 Completed
	Training needs analysis for domestic abuse is to be completed	Local	Where there are training needs identified a specific training package to be developed	**The Countess of Chester Hospital NHS Foundation Trust**		May 22	May 22 Completed

Ref	Recommendations	Scope of recommendation i.e., local, or regional	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome
	Learning from this review is shared with Countess of Chester Hospital Staff	Local	High-level learning from this DHR should be incorporated into a 7-minute briefing for staff and the wider partnership	**The Countess of Chester Hospital NHS Foundation Trust**		November 22	Lunch and learn
	Police to ensure a robust response to non-intimate domestic abuse that reduces risk.	Local	To ensure that all officers are appropriately trained in recognising non-intimate domestic abuse.	**Cheshire Constabulary**		November 22	November 22 completed
	Review and consider any referral pathways for perpetrators, cascading the information to front-line officers.	Local	Explore what services are available for domestic abuse perpetrators and share information with officers.	**Cheshire Constabulary**		November 22	November 22 completed
	MARAC information must be available on police systems to inform safeguarding	Local	Ensure that the minutes from MARAC meetings are held on the relevant police information systems for staff	**Cheshire Constabulary**		May 22	May 22 completed