CHELTENHAM BOROUGH COUNCIL

DOMESTIC ABUSE RELATED DEATH REVIEW (DARDR)

Under s9 of the Domestic Violence Crime and Victims Act 2004

In respect of the death of Kelly, June 2019

Draft report produced by Independent Chair
Professor Jane Monckton Smith

Final Draft
June 2022

Restricted / Official Sensitive
Please do not circulate

KELLY

I remember the day Kelly was born - a beautiful daughter born on a lovely spring morning in 1978.

Kelly was perfect in every way as she grew from baby and toddler to infancy.

Unfortunately, in time, my marriage to Kelly's mother didn't survive and they eventually moved to her family home in the North East. There Kelly's mother remarried and had two children; a brother and sister for Kelly.

Despite the distance between us I still had as much contact as possible which was mostly during school holidays. Without exaggeration this became my world and Kelly lit it up.

As the years passed, I met and married my second wife, and we had our own children – 3 sisters for Kelly. I tried to integrate Kelly into our family. Being from a broken home myself this was very important to me; I hope we succeeded - we certainly have many happy memories.

As Kelly grew up she had another change to cope with when her mother moved with her to London, leaving her siblings behind.

Possibly the upheaval wasn't helpful in her final years at school, and she left education a little sooner than I would have liked. However, what Kelly had in abundance was intelligence, personality, and an excellent work ethic; she put this to good use at her first job at a food import / export company based at Heathrow. She dealt with and no doubt charmed many of their Middle Eastern customers. Kelly's career over the next 10 years looked good, whilst also proving to me that you don't need a degree to do well.

It was towards the end of her time at the food import/export company that I realised that Kelly's life was not as perfect as I had hoped. I received a phone call from the director of the company telling me that Kelly was taking time off and that he was concerned about her well-being and if she might be drinking too much.

Trips and phone calls to and from London followed. Kelly's relationship with her mother broke down irretrievably to the extent where they never spoke again.

Kelly wanted a fresh start and in 2003 she moved to Cyprus, working as a hotel receptionist. Kelly found a lovely flat, she was so house proud, she loved the country and the climate. Whilst there she met and married a man from Pakistan.

They moved back to London, but Kelly struggled with culture differences. Her drinking increased and their marriage crumbled.

Not long after, Kelly went into 12 step rehab in Luton. The rehabilitation calls on faith to help people struggling with their addiction.

I have read all of Kelly's essays and projects from Luton and she certainly found the strength to confront many of her demons. However, the most poignant section was the good luck messages she received from everyone as she left. At Kelly's funeral I met two people from Luton, and they explained how grateful they were for the inspiration and guidance Kelly had given them to help them give up alcohol and rebuild their lives. Unfortunately, Kelly just couldn't do that for herself.

Kelly settled in Luton finding a flat and making it a home whilst working at an hotel where she progressed to duty manager.

The eventual crash was hard to take with Kelly's health deteriorating resulting in many periods of hospitalisation. She then entered The Nelson Trust rehabilitation in Stroud in 2013, again she worked so hard to turn her life around.

Kelly left The Nelson Trust for Cheltenham and with the help and support of services joined AA meetings, even taking a class in Aromatherapy.

In 2015 Kelly met and married Mark

In the final years of Kelly's life, it became apparent that she was reluctant for me to visit her, it wasn't that she didn't want to see me as much as she didn't want me to see her decline.

Looking back Kelly didn't want me to worry though in reality we spoke every day on the phone and I knew all was not well, unfortunately I didn't understand the full extent of Mark's physical abuse of Kelly until after her death.

Kelly never complained or blamed anyone for her illness, she would always do her best to find the funny side. Although laughter became a rare commodity, but it was what she wanted more than anything.

Kelly was the kindest of souls facing insurmountable difficulties, as a family we love and miss her so much.

Kelly's Father, Stepmother and Step-Sisters

Glossary

AAFDA - Advocacy After Fatal Domestic Abuse

CSP - Community Safety Partnership

DARDR – Domestic Abuse Related Death Review

DHR - Domestic Homicide Review

DASH - Domestic Abuse, Stalking and 'Honour'-Based Violence Risk Identification Checklist

DVPP - Domestic Violence Perpetrator Programme

FLO - Family Liaison Officer

GMPS - Government Protective Marking Scheme

IDVA - Independent Domestic Violence Adviser

IMR - Individual Management Reviews

IOPC – Independent Office for Police Conduct

MAPPA - Multi-Agency Public Protection Arrangements

MARAC - Multi-Agency Risk Assessment Conference

SIO - Senior Investigating Officer

TOR - Terms of Reference

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Preface

I would like to begin this report by expressing my sincere sympathies, and that of the Panel, to the family and friends of Kelly who is remembered universally as a kind and gentle person, and who is keenly loved and missed.

Kelly was found dead by Probation professionals and the exact cause of her death has not been established. It is known that Kelly suffered domestic abuse before her death at the hands of her husband. It was agreed by Cheltenham Borough Council that the circumstances surrounding Kelly's death fitted the criteria for holding a formal review. As no cause for her death was found this review will be referred to as a Domestic Abuse Related Death Review (DARDR).

The DARDR followed the Home Office guidance for a Domestic Homicide Review (DHR) with the purpose of identifying improvements which could be made to community and organisational responses to victims of domestic abuse, with the objective of preventing future tragedies such as this from happening again.

I would like to thank the panel, and those who provided chronologies and information, for their time, patience, and co-operation.

It is important in this review to mention issues of confidentiality. The family have suffered terribly because of this tragedy and further suffering must be avoided wherever possible. For this reason, I have excluded some information which may identify individuals, like specific dates and detail of certain incidents. We have however, used Kelly's real name throughout this report as her family have requested this. Mark is a pseudonym chosen by the independent chair.

Jane Monckton Smith

Independent Chair

1.0 Summary

1.1 Kelly's body was discovered at her home address in June 2019 by two probation officers. Her husband was also at the address but had not reported her death for some 4 or 5 days. He had recently been released from prison for offences relating to domestic abuse against Kelly and had post sentence conditions not to be at her home. Kelly was classified as being at high risk of serious harm or homicide from him by police and IDVA services.

Subsequent post-mortem and toxicology results indicated that Kelly had been deceased for some days prior to the discovery of her body but the cause of death was inconclusive. The police report received by Cheltenham CSP states that Kelly's husband may have been present at the time of her death, even though he should not have been present at her home due to an active restraining order.

1.2 This report is a Domestic Abuse Related Death Review (DARDR) and examines agency responses and support given to Kelly, prior to the point of her death in June 2019.

1.3 The DARDR follows the Home Office Multi-Agency Guidance for the Conduct of Domestic Homicide Reviews

1.4 In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before her death, whether support was accessed within the community, and whether there were any barriers to accessing support.

1.5 By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer. The report summarises the circumstances that led to a DARDR being undertaken in this case.

1.6 The review considers agencies' contact and involvement with Kelly from January 2014 to June 2019 but additional information, specific to a history of domestic violence in her and her partner's lives provided by some agencies, has also been considered.

1.7 The key purpose for undertaking the DARDR was to enable lessons to be learned from Kelly's death particularly as there was the potential that domestic abuse was a relevant factor in her death.

1.8 For these lessons to be learned as widely and thoroughly as possible, professionals need to understand fully what happened and most importantly what needs to change to reduce the risk of such tragedies happening in the future.

2.0 Timescales

2.1 Cheltenham Borough Council was notified of the death of Kelly on the 10th October 2019.

2.2 Kelly's body had been discovered at her home in June 2019.

2.3 Kelly's husband was found at the property, but he had not reported her death.

2.4 Kelly was a high-risk victim of domestic abuse from her husband. He had just been released from prison; he was the subject of a restraining order and should not have been at the property.

2.5 Cheltenham Borough Council made the decision to hold a Domestic Abuse Related Death Review (DARDR) to investigate the events leading up to Kelly's death.

2.6 Cheltenham Borough Council appointed an Independent Chair in November 2019 and notified the relevant agencies for the Panel.

2.7 The Panel met 6 times. The first meeting of the Panel was held on February 26th 2020; the second meeting was held on the 21st September 2020; the third meeting was held on the 28th September 2020; the fourth meeting was held on the 29th January 2021, the fifth meeting on the 14th May 2021, the sixth and final meeting was held with the family meeting the panel.

2.8 The review was unavoidably delayed due to the Covid-19 restrictions, including the unforeseen illness of some of those involved, and urgent organisational responsibilities around the restrictions. In addition, Mark had been charged with preventing a decent and lawful burial. He was found guilty in August 2020 and sentenced to fifteen months imprisonment. The panel waited for the outcome of the trial before collecting information.

3.0 Confidentiality

3.1 The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers prior to publication.

3.2 It was decided to use Kelly's real name as the family have requested this. Mark is a pseudonym chosen by the independent chair.

3.3 Kelly was found deceased in June 2019, but the post-mortem report revealed that she had probably died a few days earlier.

3.3 Kelly was born in May 1978 and was 41 years of age when she died.

3.4 Kelly's husband, Mark, was born in October 1960 and was 59 when Kelly died.

3.5 Kelly and Mark were both white British.

4.0 Terms of Reference

Background

4.1. On 10 October 2019, Cheltenham Borough Council (CBC) was notified about a death which required consideration as to whether a Domestic Homicide Review (DHR) should be undertaken.

4.2. The victim's body was discovered at her home address in June 2019 by two probation officers; she was classified as being at high risk of domestic abuse from her husband who was also at the address but had not reported her death. He had recently been released from prison where he had served a sentence for offences relating to domestic abuse against her and he had post sentence conditions not to be at her home.

4.3. In terms of whether the circumstances surrounding the victim's death gives rise to a DHR, CBC considered the national guidance for DHRs which has two key parts:

1. A DHR should be carried out after the death of a person aged 16 or over which has or appears to have resulted from violence abuse or neglect.
2. A DHR is a review of the circumstances held with a view to identifying the lessons to be learnt from the death.

4.4. In terms of the first element, although the evidence of cause of death has not been proven, it is CBC's opinion that the victim's death would appear to have resulted from neglect and would therefore meet the first element of the definition.

4.5. Secondly, in terms of identifying the lessons to be learnt from the death, the victim was a high-risk victim of domestic abuse from her partner and had multiple touch points to the safeguarding system, being well known to several agencies.

4.6. CBC is therefore interested to review the role of agencies in the run up to the victim's death with the aim of learning lessons about how other vulnerable high-risk victims of domestic abuse can be kept safe in the future.

4.7. As the cause of death was inconclusive CBC took the decision to call the review a Domestic Abuse Related Death Review (DARDR) rather than a Domestic Homicide Review (DHR).

Purpose of the Panel

4.8. To establish the facts about events leading up to and following the death of the victim in June 2019.

4.9. To establish the roles of the agencies involved in her case; the extent to which she had involvement, with those agencies and the appropriateness of single agency and partnership responses to her case.

4.10. To establish whether there are lessons to be learnt from this case about the way in which organisations and partnerships carried out their responsibilities to safeguard her wellbeing.

4.11. To identify clearly what those lessons are how they will be acted upon and what is expected to change as a result.

4.12. To identify whether as a result there is a need for changes in organisational and/or partnership policy, procedures, or practice in Gloucestershire to improve our work to better safeguard victims of domestic abuse.

The scope of the panel review

4.13. To produce a chronology of events and actions in relation to the case of the victim from the period January 2014, which is when Kelly moved to Gloucestershire, until her death in June 2019. Agencies can go outside of these dates if they have information that is relevant to the review. January 2014 is when Kelly first sought accommodation in Cheltenham after being in residential care.

4.14. To review current roles, responsibilities, policies, and practices in relation to victims and perpetrators of domestic abuse with complex needs – to build a picture of what lessons can be learnt.

4.15. To review this against what happened, and to draw out the strengths and weaknesses.

4.16. To review national best practice in respect of protecting adults from domestic abuse.

4.17. To draw out conclusions about how organisations and partnerships can improve their working in the future to support victims of domestic abuse with complex needs.

Panel Membership

4.18. The panel will be made up of representatives of the agencies that had some involvement in the victim's life, those that have duties to care for adults at risk of domestic abuse and that will have local knowledge and insight. See 8.0 for names and roles of panel members.

5.0 Methodology

5.1 The decision to hold a review was taken by Cheltenham Borough Council in October 2019

5.2 The Multi-Agency Statutory Guidance for Conducting a Domestic Homicide Review was followed.

5.3 Professor Jane Monckton Smith was appointed as Independent Chair in December 2019.

5.4 The first panel meeting was held in February 2020.

5.5 All agencies were asked to search their records for any contact with Kelly and her husband either as a couple or individually.

5.6 Due to the circumstances of the case Gloucestershire Constabulary referred themselves for an IOPC investigation. The final report from the IOPC has been shared with the family and the independent chair.

5.7 The agencies identified as having significant contact with Kelly were asked to provide an IMR detailing the contact and analysing the way the contact was handled.

5.8 Agencies who provided IMRs were Gloucestershire Adult Social Care (GASC), Gloucestershire Clinical Commissioning Group (GCCG), Gloucestershire Domestic Abuse Support Services (GDASS), Gloucestershire Health & Care NHS Foundation Trust (GHCNHSFT), Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT), Gloucestershire Police (GP), Home Group (HG), National Probation Service (NPS) and South Western Ambulance Service NHS Foundation Trust(SWASNHSFT)

5.9 Each IMR author presented their report in person to the review panel.

5.10 The IMR authors were then available to answer questions from the panel about the contact they had.

5.11 All the information and data was circulated to the panel, and was discussed at panel meetings.

5.12 All panel members were asked to comment on the information and feed their comments to the Chair prior to the first draft of the Overview Report.

5.13

6.0 Involvement of Family, Friends, Work Colleagues, Neighbours and Wider Community

6.1 The Independent Chair wrote to Kelly's husband and her father inviting them to be part of the review.

6.2 The letter to Kelly's husband was hand delivered to him by the police, but he did not respond.

6.3 A second attempt to contact Kelly's husband was made by contacting his solicitor but no response was received.

6.2 Kelly's father responded and said that he and Kelly's stepmother and stepsisters wished to be part of the review.

6.3 The Independent Chair spoke to Kelly's father and gave him information on the charity Advocacy After Fatal Domestic Abuse (AAFDA) who would be able to support him through the review process.

6.4 The Independent Chair held a virtual meeting with Kelly's father and sisters in October 2020 and an AAFDA advocate attended to support the family.

6.5 The family were invited to meet with the Panel to feedback their comments on the draft report.

6.6 The family wrote a pen picture about Kelly which is included in the report.

6.7 The family met with the DARDR Panel to discuss the report.

6.8 The family's comments will be incorporated into the report by the Independent Chair before publication.

7.0 Contributors to the Review

Change Grow Live (CGL)
Cheltenham Borough Homes (CBH)
Gloucestershire County Council Adult Social Care (GASC)
Gloucestershire Clinical Commissioning Group (GCCG)
Gloucestershire Constabulary (GC)
Gloucestershire Domestic Abuse Support Service (GDASS)
Gloucestershire Health and Care NHS Trust (GHCNHSFT)
Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT)
Home Group (HG)
Kelly's Family
National Probation Service (NPS)
Southwestern Ambulance Service NHS Foundation Trust (SWASNHSFT)
Turning Point

8.0 The Review Panel Members

Name	Agency
Professor Jane Monckton Smith Independent Chair	
Sue Haile PA to Independent Chair	
Andrew Moore Manager	Change, Grow, Live
Richard Gibson Strategy and Engagement Manager	Cheltenham Borough Council
Caroline Walker Head of Community Services	Cheltenham Borough Homes
Moira Wood Principal Social Worker (Adults)	Gloucestershire Adult Social Care
GPs via Katy Mcintosh Named GP for Safeguarding Adults and Children	Gloucestershire Clinical Commissioning Group
Wayne Usher Detective Chief Inspector	Gloucestershire Constabulary
Sophie Jarrett County Domestic Abuse and Sexual Violence (DASV) Strategic Coordinator	Gloucestershire Constabulary and Gloucestershire County Council
Heather Downer Service Manager	Gloucestershire Domestic Abuse Support Service (GDASS)
Alison Feher Head of Safeguarding	Gloucestershire Health and Care NHS Trust
Jeanette Welsh Lead for Safeguarding Adults	Gloucestershire Hospitals NHS Foundation Trust
Kate Windsor Manager	Home Group
Mark Scully Head of Gloucestershire and Wiltshire Local Delivery Unit	National Probation Service
Amanda Robinson Safeguarding Lead	South Western Ambulance Service NHS Foundation Trust

9.0 Author of the Overview Report

Professor Jane Monckton-Smith was appointed by Cheltenham Borough Council as Independent Chair and Author of the Overview Report in November 2019. She has a substantive position as Professor of Public Protection at the University of Gloucestershire. She is a specialist in domestic homicide, coercive control and stalking. In addition to academic research and lecturing she maintains a wide portfolio of professional work training professionals in threat and risk, coercive control and stalking, as well as working with bereaved families and developing practical assessment tools.

Professor Monckton Smith has previously conducted a Domestic Homicide Review for Cheltenham CSP but has no involvement with any of the agencies involved in the DARDR into the death of Kelly.

10.0 Parallel Reviews

10.1 An inquest into the death of Kelly was held in June 2019 by HM Coroner for Gloucestershire.

10.2 Gloucestershire Police referred themselves to the IOPC for enquiry into the conduct of their officers in relation to Kelly's death. No recommendations were made, and no evidence was identified that indicated that the police may have caused or contributed to Kelly's death.

10.3 A criminal investigation into the prevention of a lawful and decent burial was conducted which resulted in Mark being charged with the offence of 'Preventing a decent and lawful burial'. He was found guilty in August 2020 and sentenced to 15 months imprisonment.

11.0 Equality and Diversity

The relevant protected characteristics identified in this case are: Sex, Age and Disability.

11.1 **Sex:** Sex is always relevant when considering domestic abuse, domestic abuse related deaths and domestic homicides because of the significance of the statistical breakdown

between offenders and victims. Men predominate more generally as both perpetrators and victims of homicide globally (90% and 80% respectively) except in the intimate partner homicide category where women predominate as victims (82%) (UNODC 2019) and men make up around 95% of perpetrators. Between 2009 and 2015 in the UK 936 women were killed, and of those 598 were killed by an intimate partner (Brennan 2016).

11.2 Mark's violence was directed at Kelly and there were allegations of many high-risk behaviours and characteristics, notably: violence, sexual violence, strangulation, financial abuse, gaslighting, psychological abuse and coercive control.

11.3 The links between intimate partner homicide (IPH) and domestic abuse are powerful, and a history of perpetrating domestic abuse is a key risk marker in those who are IPH killers (Bourget *et al* 2010). This indicates that those men who are perpetrators of domestic abuse are more likely to kill their partners, so it is important then to be able to identify it if risk is to be managed. Controlling behaviours, rather than violence alone, are important in identifying the highest risk domestic abuse, and where there is control, violence, and a separation after living together there is a 900% increase in the potential for homicide (Stark 2009). The often hidden and complex nature of coercive and controlling patterns of behaviour mean they are not always recognised or identified, though recent legislative changes which have criminalised these patterns in the UK (s.76 Serious Crimes Act 2015) reflect their importance and value in predicting serious harm and homicide. Stark (2009) notes that coercive and controlling behaviours are predominantly employed by men in an intimate relationship. Women in relationships with men are more likely to suffer prolonged and serious abuse with higher risk of serious injury and harm. When assessing risk of harm to women this should be considered along with the structural, physical and cultural elements that make women more vulnerable.

11.4 Age: Mark was significantly older than Kelly. There has been research to suggest that the risk of serious harm, control or homicide to a victim may increase where there is a significant age gap (Monckton Smith 2012). Kelly was 41 when she died, and Mark was 59.

11.5 Disability: Kelly and Mark were both alcohol addicted. Kelly 's condition was in an advanced state, and she was very ill. When she was hospitalised, she was nearly always very malnourished and required specialist input from dieticians to re-introduce food. In addition, her treatment needed specialist advice from microbiology, from dietetics, from occupational therapy, from podiatry, from liver specialist nurses, alcohol liaision nurses and referral to social workers and HIDVAs.

11.6. Disabled women are significantly more likely to experience domestic abuse and can experience more frequent and more severe domestic abuse. People with disabilities

may also experience domestic abuse in wider contexts and more often from significant others, including intimate partners, family members, personal care assistants and health care professionals. Disabled people encounter differing dynamics of domestic abuse, which may include more severe coercion, control, or abuse from carers. Abuse can also happen when someone withholds, destroys, or manipulates medical equipment, access to communication, medication, personal care, meals and transportation.

11.7. It must also be considered that disabled people may have their disability used to abuse them. For example, through psychological bullying, withdrawing medication and support or items they need for movement and calling for support.

Bourget, D., Gagne, P., & Whitehurst, L. (2010). Domestic Homicide and Homicide-Suicide: The Older Offender. *Journal of the American Academy of Psychiatry and the Law Online, 38*, (3), 305-311.

Brennan, D. (2016). *Femicide Census.* Retrieved March 30, 2018, from http://www.northwales-pcc.gov.uk/Document-Library/Advice/Femicide-Census-Report-2016.pdf

Monckton Smith, J. (2012). *Murder, Gender and the Media: Narratives of dangerous love.* Hampshire: Palgrave Macmillan

UNODC (2013). Global Study on Homicide. *United Nations Office on Drugs and Crime.* Retrieved March 30, 2018

Stark, E. (2009), *Coercive Control: How men entrap women in personal life.* Oxford: Oxford University Press

12.0 Dissemination

Gloucestershire Police and Crime Commissioner

Cheltenham Borough Council

Cheltenham Borough Homes

Change Grow Live

Gloucestershire Clinical Commissioning Group

Gloucestershire Constabulary

Gloucestershire Domestic Abuse Support Services (GDASS)

Gloucestershire Health and Care NHS Foundation Trust

Gloucestershire Hospitals NHS Foundation Trust

National Probation Service

South-West Ambulance Service NHS Foundation Trust

Gloucestershire County Council Adult Social Care (GASC)

Kelly's Family

13.0 Background Information (The Facts)

13.1. There is a significant amount of information in the chronology in this case, largely due to the health problems suffered by both Kelly and Mark. We accept that both were suffering the problems of alcohol misuse, and both had health conditions in addition. We think there is no need to document the various health appointments if these facts are accepted. We have therefore reduced the chronological information to that which we feel is relevant to establishing the events surrounding Kelly's death and identifying potential learning.

13.2. Kelly's body was discovered at her home address in June 2019 by two probation officers. Her husband was also at the address but had not reported her death. He had recently been released from prison for offences relating to domestic abuse against Kelly and had post sentence conditions not to be at her home. Kelly was classified as being at high risk of domestic abuse from him by the police and IDVA service. It was noted that Mark had facial injuries that he claimed were caused by Kelly prior to her death. This suggests there may have been a physical altercation involving them before she died.

13.3. Subsequent post-mortem and toxicology results indicated that Kelly had been deceased for a few days prior to the discovery of her body but the cause of death was inconclusive. The police report received by Cheltenham CSP states that Kelly's husband may have been present at the time of her death even though he should not have been present at her home.

13.4. Kelly was alcohol addicted and tried many times to give up alcohol; she was a very vulnerable and fragile woman. Kelly's degree of alcoholic liver disease is described consistently as 'decompensated', meaning it was serious and there was a fine balance to maintain her in a healthy condition; she had encephalopathy, meaning that her brain had been adversely affected by alcohol and she could become confused. She had oesphageal varices banded in 2013, meaning there was an ever-present risk that those would re-develop and she would exsanguinate to death if they burst open.

13.5. Decompensated liver disease is a medical emergency with a high mortality. It is defined as a patient with cirrhosis who presents with an acute deterioration in liver function that can manifest with the following symptoms:

- Jaundice (yellowing of the skin and whites of the eyes due to the liver not breaking down old blodd cells fully)
- Increasing ascites (fluid accumulation around the abdomen)

- Hepatic encephalopathy (gradual deterioration in the function of the brain due to 'poisoning' by accumulated waste products which the liver usually removes – this manifests predominantly as confusion)
- Renal impairment (failure of the kidneys)
- Gastrointestinal bleeding (bleeding from the gut, either in vomit or faeces)
- Signs of sepsis/hypovolaemia (difficult to distinguish from each other initially but consistently low blood pressures due to low circulating volumes of blood)

There is frequently something that precipitates decompensation of cirrhosis. Common causes are:

- Gastrointestinal bleeding
- Infection/sepsis (often spontaneous rather than 'caught')
- Alcoholic hepatitis (inflammation of the liver due to excess alcohol)
- Acute portal vein thrombosis (a blood clot blocking the blood input to the liver)
- Development of liver cancer
- Taking drugs or starting to drink alcohol again
- Dehydration
- Constipation

13.6. Mark was also alcohol addicted and experienced a brain injury in 2012 that resulted in him suffering from epilepsy that was extremely difficult to control because he did not take his medication. It is not known whether the medication would have controlled the seizures. Following his brain injury Mark was assaulted and suffered a head injury. Thereafter his epilepsy became more difficult to control and he started having non-epileptic attacks. Mark led a chaotic life, drinking and smoking heavily; his mobility was impaired and the frequent seizures he experienced meant that he frequently attended hospital for both inpatient and outpatient services.

13.7. Alcoholism is a severe form of alcohol misuse and involves the inability to manage drinking habits. People who are alcohol addicted may feel they cannot function without alcohol.

13.8. Both Kelly and Mark were suffering serious health conditions as a result. There was likely some bonding over their alcoholism, and potentially an inter-dependence. However, Mark was also highly abusive and violent towards Kelly and there are serious assaults recorded against her, there was also evidence of controlling patterns and psychological abuse. Kelly was made to believe (through a process known as 'gaslighting') that she was suffering with a brain tumour. Mark shaved her head and convinced her she was suffering with cancer. Kelly's GP said in her statement to police that it was her belief that Mark's gaslighting and psychological abuse, coupled with the effects of prolonged alcohol abuse on her cognition, meant that Kelly's grasp on reality

was severely affected and may have prevented her from making decisions that were in her own best interets.

13.9. Kelly had contact with many agencies locally, including various health services, housing services, domestic abuse services, social care services, police and ambulance visits and contact with probabtion services as a result of Mark's offending and licence conditions. There is no evidence to suggest that any agency failed badly in their contacts with Kelly, she received a good service from all agencies. There are however, learning opportunities when the broader picture is considered.

14. Chronology

14.1 There is a significant amount of information in the chronology in this case, largely due to the health problems suffered by both Kelly and Mark. We accept that both were suffering the problems of alcohol misuse, and both had health conditions in addition. We think there is no need to document the various health appointments if these facts are accepted. We have therefore reduced the chronological information to that which we feel is relevant to establishing the events surrounding Kelly's death and identifying potential learning.

14.2 Kelly had a difficult upbringing with her mother. It appears that her mother was not particularly warm and caring towards Kelly and removed her from the home when she was sixteen years old. Kelly's mother did not attend her funeral and they had been estranged most of her adult life. Her father, who did not live with her mother, was someone Kelly was close to, and she was a welcome part of her father's life and her step- mother's and her stepsisters' lives.

14.3 Kelly moved to Gloucestershire in 2014 to attend a residential drug and alcohol rehabilitation centre. She is described at this time by her GP as a recovering alcoholic but in between lapses she was high functioning and employed in a theatre.

14.4 Kelly told of domestic and sexual abuse in the home when she was living with her mother as a child, she disclosed this during her stay at the rehabilitation centre. Unfortunately, she had agreed to undergo therapy to deal with past trauma caused by physical and sexual abuse, and this seemed to destabilise her; it is reported that this brought back painful memories and she relapsed into alcohol misuse. It was not possible to corroborate the information on Kelly's experiences of physical and sexual abuse as a child with her family as her mother did not wish to be involved with the review and Kelly had not disclosed this information to her father. Kelly was noted to have anxiety and depression, alcoholic cirrhosis of the liver, hypertensive gastropathy and oesophageal varies banding (alcohol related). She had experienced an episode of psychotic depression in 2008 and had made two attempts to take her own life in 2010 and 2012.

14.5 After leaving the residential unit Kelly lived in supported accommodation in Cheltenham until 2015.

14.6 She was allocated a keyworker and made great efforts to reduce her alcohol consumption by reducing what and how much she drank.

2014

February Kelly's GP tried to refer her to the mental health recovery service, but this was refused due to Kelly's alcohol consumption which the service believed would have a detrimental effect on her mental wellbeing. Kelly was signposted to Turning Point as an alternative. Turning Point were the agency contracted by Gloucestershire to provide support to people with drug and alcohol abuse, mental health, offending behaviour, and unemployment issues. The contract for this work was taken over by Change Grow Live in January 2017.

April Kelly was hospitalized due to jaundice and liver disease. On release she visited her GP for blood tests.

June Kelly was described by her GP as 'not in a good way at all'. She reported that her support worker was leaving, and she said she would have no support from anyone. The hospital doctor had recommended that she have further blood tests, and these were taken. Kelly said that she was willing to engage with Turning Point.

July Kelly visited her GP with her support worker as she was desperate to detox. She reported that her boyfriend had moved to Cheltenham but was terminally ill. Kelly was advised to contact Turning Point.

A friend of Kelly's phoned Gloucestershire Adult Social Care Helpdesk as they were concerned about Kelly's mental health.

The police contacted Gloucestershire Adult Social Care Helpdesk concerned about Kelly's mental health.

Kelly was admitted to hospital with acute liver failure.

August Kelly contacted Turning Point as she wanted support for her alcohol issues. She was given a SPOC (Single Point of Contact). She was also given the contact of Cruse bereavement service.

Kelly reported that her boyfriend had recently died from alcohol related disease. We have little information about this boyfriend, except that they met in rehabilitation and spent six months together before he died. His death distressed Kelly and may have impacted on her alcohol misuse. Plans were made for Kelly to attend Turning Point, AA, and a counselling service.

September Kelly attended a key worker session and reported that she was not taking alcohol at this time. Kelly visited her GP for a follow up appointment following

discharge from hospital. Kelly was aware that if she drank again, she would have little chance of surviving. At a further visit she reported being extremely tired and unwell. She was booked to have an endoscopy in early October.

October Kelly attended a key worker appointment with Stoneham (housing service). She was well and cheerful, she reported not drinking for ten weeks. She said she had attended AA which she found helpful she was also using an online help service called 'breaking free'.

Kelly visited GP for a minor operation to remove a wart, but this could not be carried out as her blood platelets were too low.

Kelly did not attend an appointment with Turning Point. She said she had fallen asleep.

Kelly attended key worker session with Turning Point. She was positive and still abstinent. Her specialist said her health was improving and improved blood tests. She said she was collecting her partner's ashes this day and was worried that it may have a negative effect but wanted to use it to stay sober.

November Kelly attended a keyworker appointment. It is reported that she was on time and looked well. She was attending AA twice a week.

GP noted that Kelly was doing very well and still abstaining from alcohol.

December Kelly informed her GP that she was moving to independent accommodation and although she would lose her support worker, she intended to continue with her Turning Point worker. She was also continuing to see the hospital liver team every month. She agreed to a review of everything in January.

Turning Point attempted to contact Kelly by phone, but she did not answer

2015 Kelly started a relationship with Mark in 2015 but it is not known exactly when they met. Her sudden disengagement with services and starting to drink again suggest that this was possibly around December 2014 or January 2015.

January 5th January Kelly cancelled a key-working appointment due to moving accommodation.

12th January Turning Point called Kelly to make appointment but there was no answer.

13th January. Turning Point called Kelly to check on welfare there was no answer.

22nd January Kelly cancelled a Turning Point appointment – she said she was not in the area.

27th January Tuning Point called Kelly for welfare check, she said she was in her new flat which is fully furnished but was feeling down and needing to adjust. She reported that she was expecting a visit that night from Stoneham and an appointment was made with Turning Point for 5th February.

30th January information was received by Turning Point from a third party that Kelly had relapsed heavily and was drinking. There was no answer to calls.

Kelly's GP recorded that Kelly was stable. Kelly's tenancy at the supported accommodation was terminated.

February Further attempts to call Kelly by Turning Point were made on 2nd Feb; 5th Feb; 9th Feb; 10th Feb.

10th February text message received by Turning Point from Stoneham that Kelly was threatening suicide. Police were informed.

11th Feb Stoneham gave Turning Point Kelly's new address. Letter sent to Kelly for an appointment on 13th February but she did not attend.

16th Feb phone call received from Kelly's father. The recovery worker told him that they would have to discharge Kelly if she could not be contacted. Her father said he would contact her and try to get her to re-engage.

26th February Turning Point sent a seven-day re-engagement letter to Kelly.

Kelly attended the emergency department at her local hospital and was admitted to the acute care unit for further investigation but she self-discharged against medical advice. She was readmitted a few days later due to vomiting blood, she was given a blood transfusion and further investigation was planned.

March 5th March Turning Point could not contact Kelly, a letter to offer treatment was sent. She contacted them this day saying she had been in hospital and needed help. They made an appointment for the next day, but she did not turn up – she sent them a message saying she was on the way to hospital A&E. They tried contact again on – 16th March; 21st March; 25th March but there was no answer on all occasions. Treatment for Kelly was closed by Turning Point.

Mark contacted Kelly's GP to report that Kelly was vomiting and passing blood but was too weak to get to the surgery. GP advised that he should call 999 but when the ambulance arrived Kelly refused to go to hospital. Paramedics determined that she had capacity and she agreed to contact her GP. A few days later Mark contacted Kelly's GP to report that she was drinking 4 cans of beer each day, that the bleeding had settled but that she had developed

spontaneous bruising and nosebleeds. She was still refusing to go to hospital, but he agreed to take her to the surgery the following day. She did not attend the appointment as it was said that she refused to leave her flat; she had not left it for several weeks. GP checked that Kelly was aware of the options – that she needed urgent investigations and treatment – and that should she collapse Mark should call an ambulance.

April Kelly self-referred to Turning Point. She said she has relapsed and was drinking 5-6 cans of lager a day. She said she didn't want to die and wanted help. She said she was suicidal, poor health and liver deterioration. She says she has a partner living with her.

Mark called Adult Social Care Helpdesk as Kelly was refusing to attend hospital for treatment, was not engaging with Turning Point and would not visit her GP. A safeguarding referral was raised but closed as it did not reach the threshold for Section 42(Care Act 2015). Kelly was referred to her GP and Turning Point. The GP (not Kelly's regular GP) spoke to Kelly about going to the surgery for blood tests. Kelly said that she did not want to die and did want to engage with services but that she knew that there was a possibility that the blood test results would mean that she would have to go into hospital which she didn't want to do. She agreed to an appointment but did not attend so the GP did a home visit and found Kelly pale and unwell sitting on her sofa. Kelly admitted to drinking 8 cans of lager a day but that when she stopped drinking, she was experiencing fits. GP took blood samples and Kelly agreed to go into hospital if the blood results warranted it. The blood tests were abnormal and the out of hours team tried to admit Kelly to hospital, but she refused.

May Message received from Mark on Kelly's phone – he said they were in A&E seeing if Kelly could be de-toxed and asked if Turning Point could start a de-tox.

14t May Turning Point phone Kelly – no answer.

GP spoke to Kelly who said that she was afraid that if she went into hospital, she wouldn't come out. GP told her that she was more likely to die if she did not go into hospital so it was agreed that Mark would take her into hospital in a taxi. Kelly was admitted to the Acute Care Unit. Mark was noted as her next of kin. Kelly told the hospital that she was drinking up to 28 units per day and that this increase had slowly built up following the death of her boyfriend in 2014. Kelly agreed whilst in hospital to self-refer to Turning Point

June Kelly attended triage appointment with Turing Point with Mark and appeared slightly intoxicated, but she was coherent. She was dressed well and spoke clearly. She wanted to be referred for a de-tox process. She was told she needed to engage with structured treatment. A risk assessment was carried out and her

health was assessed to be at risk. She had recently been treated for organ failure because of alcohol dependency. She was de-toxed during the hospital stay but had relapsed.

Kelly attended a GP appointment and reported that she had reduced her drinking to 3 cans of lager per day but following a home detox when she had experienced a fit she had increased to 4 cans of lager per day. GP wrote a letter to support Kelly's application for PIP.

24th June Kelly was sent a text by Turning point but there was no response so a letter for an appointment was sent.

July

2nd July Turning Point worker called Kelly's GP to discuss de-tox. Also to tell GP that they were unable to contact Kelly.

9th July Kelly did not attend an appointment with Turning Point.

Kelly made an appointment with Turning Point but did not attend.

August

27th August – Turning Point called Kelly but no response. They sent a 7-day engagement letter to Kelly.

Kelly made an appointment with NHS Dentists for treatment for an abscess, but she did not attend. GP notes that she was attending her monthly appointments with the hospital liver team.

September

18th September no contact from Kelly with Turning Point so the contact was closed. There was no further contact with Kelly.

GP noted that Kelly's blood test results were abnormal and contacted the specialist liver nurse for an update but was told that she was waiting for the consultant to contact her.

October

Kelly and Mark married but Kelly retained her surname. When Kelly saw her GP after she had married Mark, she reported that she was having psychotherapy which was going well. She said that the liver specialist team were pleased with her and her blood was improving. She did have poor balance that was related to alcohol induced peripheral neuropathy. She said that she was hoping to conceive in 2016 and the GP referred her to the family planning clinic and suggested that she make another appointment for an internal examination. Kelly also advised her GP that her partner had been told that he had Hepatitis B. GP agreed to re-check her blood.

November

Kelly's blood tests were negative for Hepatitis B. GP informed the hospital liver team. Kelly advised that she was considering a private detox.

December

Kelly was reminded to make an appointment for an internal examination.

2016

February — Kelly told her GP that she was not taking her medication regularly as it made her drowsy. She was encouraged to keep taking it and to attend her monthly hospital liver team appointments.

March — GP noted two bruises on Kelly's back and thigh. Suggested that Kelly discuss her alcohol consumption with the hospital team. Kelly's prescription for citalopram was adjusted as Kelly felt better while taking it than not taking it.

May — Kelly admitted to still drinking. She was concerned about Hepatitis B but the GP assured her that her result for this had not been positive. She told the GP that she would be moving to London. She did not keep her next appointment.

June — GP rang Kelly. Kelly reported that the hospital liver team had discharged her as she did not keep two appointments. GP agreed to speak to the team to get treatment reinstated. The GP also booked Kelly an appointment for July to check her bloods.

July — Kelly's blood results showed that she was anaemic. Further blood tests were needed before a transfusion could be given but Kelly did not attend the appointment. Her partner advised that she had collapsed on the way to the surgery. GP said to take her to the hospital.

August — Kelly reported feeling very unwell – said that she was only drinking one can of lager per day. GP took blood tests.

September — Kelly was concerned about the Hepatitis B test – she was telling people that she had it.

2017

January — Kelly's notes were transferred to Change Grow Live as service provision was changed from Turning Point.

Kelly reported to her GP that she had had contact with rats, but there is nothing to say that they were in her home, it appears she fell outside and that's when she could have been bitten. The GP recommended blood tests. Later in the month she called an ambulance for Mark as he was having seizures, had loss of speech and was unable to walk. Both Kelly and Mark denied that they had been drinking.

February — Kelly reported to her GP that she had hit her head. GP had information from the out of hours service that Mark had thrown a can of lager at her, but Kelly

dismissed this. She was reminded to make an appointment for blood tests and to discuss what had happened to her head in more detail. The blood tests showed that Kelly had Wells Disease. GP tried to contact her twice to let her know that repeat tests would need to be done but she was unable to contact her.

March — Mark phoned the police to report that Kelly had hit him with a hammer. They were both intoxicated and Mark was removed from the premises. At 1830 Kelly phoned the police to say he had returned and when police arrived, she made a complaint of assault. He was arrested despite no statement from Kelly. He was later released with No Further Action as there was no evidence.

GP texted Kelly about further blood tests and with an appointment for the following day. Kelly did not respond and did not keep the appointment. Police believe that Kelly and Mark had separated after the previous assault, but Mark had returned to the flat after the police removed him and assaulted Kelly again. He was arrested and interviewed but Kelly did not press charges and the case was dropped although a medium risk referral was made to Gloucestershire Domestic Abuse Support Services (GDASS). GDASS were unable to contact Kelly, although they did make three attempts as per their procedures. It is possible that the police could have pursued a prosecution without Kelly's support.

April — Kelly's GP tried to contact her about her head injury without success.

May — Kelly dialled 999 to report she had been hit in the face by Mark. When police arrived, she disclosed that historically he had hit her on the head with a hammer four times and tried to strangle her. She also reported that Mark had anally raped her on many occasions although she later retracted this, and Mark denied the charge. He was arrested and a DVPN was issued. He breached the DVPN the following day and was arrested. He was sentenced to three weeks in prison. Kelly did not provide a statement. a medium risk referral was made to Gloucestershire Domestic Abuse Support Services (GDASS). GDASS were unable to contact Kelly, although they did make three attempts as per their procedures.

The MARAC process commenced. When contacted, Kelly reported that she had decided to end the relationship with Mark. He was in hospital following a seizure. Kelly had a broken jaw and other injuries to her face. She reported that she wanted to move to the Isle of Wight where her father lives.

When the IDVA called Kelly, she discovered that Mark was back in the flat as he had apologised and said he had nowhere to go. Kelly was not aware of the bail conditions on Mark or the court date. She denied that Mark had raped her but said that he had a fascination with anal sex, and sometimes would do it after she had said no; the IDVA advised her that this constituted rape but Kelly did

not agree with this. When the case went to court Mark presented as Kelly's carer but this was denied by GDASS on Kelly's behalf as Mark had only helped Kelly when she was suffering from anxiety; he would run errands for her when she was covered with bruises after he had assaulted her.

A DVPO was issued against Mark. GDASS chased for a MARAC meeting. Kelly challenged the need for the DVPO as she thought everything had been blown out of proportion. In a telephone call Kelly advised GDASS that Mark was in hospital due to a seizure and that she did not want to resume the relationship and would speak to Mark about this. The IDVA warned her of the risks involved with this.

June — Kelly was taken to her local hospital by ambulance due to collapsing in the street. She refused a full examination and blood tests and reported that she only came to the hospital to collect her keys from her husband who was in the Resus Room. On her way home she collapsed again and was taken back to the hospital by ambulance.

July — MARAC meeting was arranged but Kelly disengaged from GDASS as she decided that she did not want support from them anymore. Kelly reported that she was friends with Mark and that he stayed with her sometimes. She explained the injuries that had been seen by the police and were as a result of her falling down the stairs. A warrant without bail was issued against Mark.

August — A housing worker and Kelly's GP made a home visit as they had been unable to contact Kelly. She said that Mark was living with her again although she didn't want him there – she was considering moving to Kent to get away from him. She was offered the opportunity to be admitted to hospital, but she was reluctant to accept. She reported that she was not taking her medication and was continuing to drink. She also reported that her father was unwell, and she wanted to visit him. GP advised Kelly that if she did not go into hospital she would most probably collapse.

Kelly called for an ambulance from her flat and a man screaming abuse at her could be heard in the background. Kelly was admitted to hospital – she told staff that she was detoxing but she refused to see the alcohol liaison team and also said that she wanted to see her partner. Hospital staff raised a safeguarding concern because Kelly had extensive bruising on her body especially around her groin – the bruising had the appearance of fingerprints.

Kelly was visited in hospital by Gloucestershire Adult Social Care (GASC) and GDASS. She denied any abuse was taking place and said she was not concerned about returning home; she said that she didn't want sheltered accommodation. MARAC was updated. A Deprivation of Liberty Safeguarding (DOLs) request was

made by hospital staff as Kelly wanted to leave the ward but an MRI scan showed brain damage which suggested that capacity may be impacted. Over the course of four days Kelly made improvements to her capacity and self-discharged. It was considered that Kelly was aware of the decisions she was making and their impact, and therefore had capacity. GDASS closed the case as Kelly would not engage with them. Kelly declined assistance from GASC and returned to live with Mark. Once at home Kelly reported feeling unwell and was having difficulties with shopping. GASC offered community meals, and these were accepted, but support from GDASS was declined.

September — GASC contacted Kelly to discuss arranging a package of care for her at home. Kelly agreed to accept this but not until she received the financial package that went with it. She denied any physical harm from Mark but said that he was snappy with her. She was advised that he should turn himself into the police. ASC also contacted Kelly's landlord who reported that she had paid her rent but that she was struggling to walk, her hair was matted, and her gums were bleeding. She reported that Mark was 'vile and abusive'. She refused a visit from a social worker and said that she did not want to re-engage with GDASS. Kelly did say that she would be contacting her dad and may go to stay with him for a while.

Kelly was concerned that Mark had been arrested; she said that she wanted to go back to her simple life without any agencies involved with her. ASC, Mental Health Services and Kelly's GP all attempted to work with Kelly – they were concerned about her mental health and her relationship with Mark. The GP and a housing officer made a home visit to Kelly, and they found her home unclean and very untidy. They managed to speak to Kelly alone for about 40mins and they noted that Mark was controlling her mind and her finances. Kelly agreed to continued visits by the housing worker.

October — GASC visited Kelly to do a mobility and outdoor mobility assessment, but Kelly was asleep and declined the assessment. Mark was present during the visit. Physio issued Kelly with a pair of crutches to help with her mobility. GP attempted to call Kelly several times but was unable to contact her.

November — Kelly's GP made several attempts to contact Kelly without success.

December — No recorded contact with Kelly although there are several recorded incidents of Mark being treated in hospital for injuries sustained whilst drunk.

2018

January — Kelly phoned 999 to report Mark was outside and wouldn't leave. Police were delayed in attending but called her back. Officers attended five hours after the initial call but there was no one in and no male outside.

Officers re-attended but could not speak to Kelly, they went back later, and she told them she had been assaulted causing a black eye. Mark was arrested but Kelly did not want to make a complaint, so he was released without charge. A DVPN was issued. Police housed Mark in a hotel overnight and he was provided with information to access Turning Point the following day to assist with housing.

Kelly phoned police to report that she wanted Mark removed from her home. She said she had been assaulted, police attended, and she said she only wanted him removed and not to make a complaint. The DVPN was served, and he was removed from the property. Kelly called police again later questioning his whereabouts. She said she was scared of Mark and was injured through him. She said she wanted to make a complaint of assault. Less than 2 hours later and before police attendance Kelly called again to say he was at her front door. Police attended, located him, and he was arrested for breach of the DVPN. The court warned him about his behaviour, and he was released.

Less than 12 hours after his release Mark was outside Kelly's house and she called the police. He was arrested for breach of the DVPN. Owing to logistical issues with the courts Mark was not able to be put before the court within time and so he was further arrested for public order and the CPS authorised a charge of S4 Public Order instead rather than release him with no charge. Kelly provided a statement regarding the public order and Mark was remanded in custody then sentenced to 8 weeks in custody which was suspended for 12 months.

GDASS contacted police to report concerns for Kelly as Mark was due in court and historically the court have released him and he has gone straight to her house. GDASS worker was unable to contact Kelly and was worried that Mark was with her. Police attempted to call Kelly but there was no reply, so a text message was sent. This was followed up with a visit in which Mark was found curled up on the kitchen floor he was arrested for breach of the DVPN and upon entering custody it became apparent that he had been issued with a restraining order at court. He was remanded and placed before the court he was sentenced to 12 weeks in prison which added to the suspended 8 weeks meant he was given 20 weeks in prison.

Kelly informed her GP that she had split with Mark because he had given her a black eye and that he was not allowed to enter her flat. She was worried that she had a brain tumour as Mark had convinced her that she had.

GDASS stayed in touch with Kelly and liaised with probation over Mark. GP visited Kelly with housing officer and found Kelly to be barely functioning. GP made an urgent referral to Change Grow Live.

February A joint visit of GASC and GDASS went ahead with only GASC attending as the GDASS worker was unwell. Kelly was found to be very fragile and walking with a stick. She said that she wanted to address her alcohol issues but didn't want to go into hospital. Kelly had a shaven head which she said was due to her having tests for a brain tumour which were negative. It was later discovered that Mark had convinced her that she had a brain tumour and encouraged her to shave her head. Kelly cancelled several appointments with her GP. Cheltenham Borough Homes (CBH) received an electronic application for housing from Kelly – the medical form stated that she had cirrhosis of the liver, is alcohol dependent and has mobility issues at her current home. She stated that she was open to occupational therapy. GASC closed their case on Kelly until her housing situation sorted.

March Mark was released from prison and was instructed to go straight to the bail hostel. He did not report there and was reported as missing. Officers attended Kelly's address to find Mark hiding behind the sofa. He was arrested and recalled to prison. He was also arrested for the breach of the order, he was charged and received two weeks in prison.

Kelly informed her GP that she wished to re-engage with the hospital liver team. GDASS appointed Kelly a Floating Support Worker (FSW). Kelly met with the FSW and explained that she wanted the restraining order against Mark to be removed but she did not want him to return to the flat. She said she had felt better since he had been in prison as he had emotionally destroyed her.

Kelly received notice from her landlord, but it isn't known why. She attended court to try and get the restraining order on Mark removed but was unsuccessful. GDASS worker telephoned Kelly following court case and she was very angry that the restraining order had not been removed and that subsequently she would not be able to speak to Mark for two years. She felt that GDASS had not done their best to support her as they were 'stirrers' – she was very aggressive to the GDASS worker.

April Police conducted a safeguarding check on Kelly and whilst there Kelly disclosed that she had been receiving letters from Mark in prison in breach of the restraining order and she was scared of him. Details of the breach were raised with West Mercia Police, and he was sentenced to a further 8 weeks in prison.

May Kelly was found naked from the waist down sitting on a wall near to her home. She was very unsteady on her feet, confused with obvious jaundice; she was very unkempt and covered in old bruises and scratches. She was taken to hospital. When visited by GASC she did not know why she was in hospital. GDASS contacted Kelly in hospital and were advised that she did not want to be kept away from Mark when he is released from prison, and she maintained that

he had never been abusive towards her. She self-discharged and was collected by her parents.

Kelly signed a tenancy agreement with CBH although the lettings officer had concerns around her mobility, alcohol use, lack of understanding around managing a home and that Mark may move into the property when released from prison.

June GASC contacted police to inform that Kelly and Mark were having phone contact and were arranging to meet on the 12th June. No further action was taken as it was a report from a third party. On the same day the police conducted a safeguarding check on Kelly and found Mark on the balcony of the flat. He was arrested again for breach of the order for which is he is sentenced for a further 8 weeks but to run concurrently with the previous sentence.

CBH were notified by a neighbour that Kelly had moved into the property but had no electric and was feeling unwell. A few days later Kelly was treated at hospital for injuries sustained to her head when she fell backwards out of a taxi. She refused admission and said that she felt safe as Mark was in prison. There was a multi-agency meeting at Kelly's home and CBH queried her suitability for general needs housing; it was agreed that GASC would work with Kelly to enable her to do shopping, set up her home and settle into the community. Kelly informed her GP about her head injury and that she had moved. Mark contacted Kelly from prison in breach of the restraining order and asked her to meet up with him. Kelly refused. Mark was released from prison on the 8th June 2018 he was subject of a Post Sentence Supervision Licence issued by the probation service.

July Information was received that Mark was at Gloucestershire Royal Hospital where he said he had had a seizure and that this had been witnessed by Kelly.

An ambulance was called for Kelly when she collapsed in the street. She refused to be taken to hospital but said she would contact her GP in the morning. GP contacted Kelly in response to the ambulance report and Kelly reported feeling much better and would keep the appointment that had been made for blood tests. Kelly cancelled appointments with GASC.

Mark went to Kelly's flat on release from prison. He had a seizure and was taken to hospital. Kelly reported to GASC that £3000 had been taken out of her bank account but she had not reported this to the police but had notified her bank. Kelly admitted that Mark had been staying with her since his release from prison, but he was now in hospital. Police informed GASC that Mark was not being recalled to prison as he had missed his probation appointment due to being in hospital.

August

Ambulance Service attended to Mark, and he requested he was taken to Kelly. As a result of this the police attended Kelly's home and found him there. He was arrested for three breaches of the order and was remanded; he was sentenced to 5 months in prison.

GASC visited Kelly and she reported that she 'had given up' since Mark had been taken back into custody. She also reported feeling lost and isolated as she had no phone. She said that she and Mark had spoken to a solicitor about getting the restraining order removed.

GASC raised a Safeguarding Alert because of the domestic abuse that Kelly experienced, and she did not see the need for the restraining order. GASC contacted Kelly's GP as they were concerned about her health and the fact that she was not taking her medication. They were also concerned as she felt hopeless now that Mark had returned to prison. Kelly told her GP that she was worried about his health, but she was taking her medication and had reduced her drinking to one can of lager per day.

Later in the month an ambulance was called for Kelly when she fell over in town. She told the ambulance crew that she did not know how she had fallen. She admitted to being an alcoholic but said she hadn't drunk anything that day, but she did smell of alcohol. The crew were concerned for Kelly as it appeared she was self-neglecting as she had not eaten for days and was extremely cold. She was taken to hospital but discharged herself a short time later.

September

Kelly requested to meet ASC in town and not at home. She was very unsteady on her feet and very intoxicated. ASC helped her get some food from a supermarket as she had not eaten for days. Kelly cancelled the support that ASC had put in place and said that she would contact AA herself. ASC made a welfare call when they learned that Kelly had not attended the AA Meeting.

Mark wrote letters to Kelly asking for money and wanting to meet. These breaches of the restraining order were sent to the Crown Prosecution Service to be added to previous charges. Kelly did not support the prosecution. MARAC was informed.

A pre-release MARAC meeting was held. Probation said that they would try to ensure that Mark was housed in a neighbouring city but due to available spaces in approved premises this might not be possible. Probation approached GASC for care for Mark as he had care and support needs. GDASS received a high-risk referral for Kelly.

Kelly did not keep numerous appointments with GASC, the hospital liver team and her GP. Kelly provided a victim impact statement for the court and said that she wanted Mark to be discharged and to keep away from her for six

months; he was detained for another two months. She wanted Mark to sort his benefits out, get his own bank account and his own accommodation. She said that she was feeling strong, she was able to see through the lies that Mark told her and she no longer wished to be controlled by him. She had however written to him in prison and sent him her mobile number. The Restraining Order was amended so that Mark could not go within 100m of Kelly's home.

ASC made a home visit to Kelly and were concerned that she had no food in the house, and it was not clear if she was taking her medication. They were also concerned by Kelly's lack of awareness of security as she was leaving her front door unlocked and had no concern for the safety of her personal possessions.

A live restraining order was issued, which would expire on the 9th April 2019. The RO stated he was not to go within a hundred metres of Kelly's home address. Breaching this would allow for his arrest and detention.

November Mark was released from prison and did not visit Kelly but contacted her by telephone; his son also contacted her. Kelly agreed to inform the police if Mark came to the house. GASC visited Kelly at home and found her looking well; there was no evidence of alcohol in her flat. She confirmed that she had had no contact with Mark. Kelly reported that things were much better for her now and she didn't need a needs assessment as she could now move around her home easily.

December Ambulance service contacted police to advise they had been contacted by Mark who was concerned for Kelly's welfare. He was unable to get an answer from her home. Kelly was spoken with. She said she hadn't heard him banging. It was deemed there was no breach of the restraining order so not further action taken. Kelly advised that when the restraining order expired, she was planning to get back with Mark.

CBH visited Kelly at home and found her immobile on the floor outside her property; she was unsteady on her feet. CBH telephoned GASC to highlight their concerns. GASC called Kelly and she told them that she had fallen over twice the previous week and was in considerable pain because of this and unable to walk. ASC advised her to call 999 for an ambulance if necessary. Kelly spoke to her GP about her pain, but she did not tell her about the falls. GP advised Kelly to rest and call again the following day if needed. GP also advised Kelly that she needed a scan of her liver and that recent blood tests indicated that she was suffering from malnutrition.

A few days later Kelly called GASC to complain about the police calling on her to check if Mark was with her. She wanted to move on with her life and was unable to do so with the police constantly checking to see if Mark was at her home.

GASC called Kelly and found her to be in good spirits and looking forward to Christmas. A few days before Christmas the Fire and Rescue Service were called by Mark to make entry into Kelly's home as she was not answering the door. She was found collapsed on the floor suffering from the effects of alcohol. Kelly reported to GASC that she has been drinking more due to the stress of Mark being released from prison.

2019

January — CBH called GASC who told them that they were no longer working with Kelly as she had refused consent for them to do so. Kelly reported maintenance issues to CBH, but the engineer could not gain access to the property. GASC called Kelly for a welfare check as part of their deallocation process; Kelly reported that she had been ill over Christmas and currently had swollen feet. She had a hospital appointment booked for the following day which she kept. Kelly said that Mark's family had left Christmas presents for her outside her door, but they had been stolen. She had not reported this to the police as she did not want the police calling or knocking on her door. Kelly understood that the restraining order and licensing agreement against Mark had expired and GASC agreed to ask the police to confirm.

February — Kelly reported that Mark had been in her home, but she had not reported this to the police as he had left when she asked him to. GASC made several welfare calls to Kelly but did not manage to speak to her.

March — Agencies were aware that Mark may be staying with Kelly, and this was confirmed when a physiotherapist visited. Kelly was found to have facial bruising which Mark said she had sustained through a fall. This incident was reported to the police who visited the flat and arrested Mark for breaching the restraining order. He was sentenced to eight weeks imprisonment. A MARAC referral was made. GDASS received a high-risk referral for Kelly, but she refused to engage. ASC attempted a home visit, but Kelly did not answer the door.

April — Kelly reported that Mark has been in touch with her from prison to tell her that he is to be released shortly; he also asked her to transfer some money into his account. Kelly was annoyed that the police had not kept her informed about what was happening with Mark. MARAC Coordinator advised CBH and GASC that the case would not go to MARAC as Kelly refused to engage. GASC were unable to contact Kelly by telephone or home visit. Kelly did not attend her appointment with the hospital liver team.

May — An email from probation service requesting a welfare check on Kelly was received by the police, as they were concerned about the risk that Mark posed to her as he was not complying with his post sentence supervision licence.

Probation Service advise they couldn't conduct the meeting for another week. Police attended her address but got no reply. They knocked on neighbouring properties but didn't get any answers. A further attempt was tried the following day, but no reply. Enquiries with neighbours revealed they had not seen her for a couple of days nor heard any movement from the property. Incident was closed as it was deemed suitable for Probation Service to progress.

Mark contacted the mental health team to report that Kelly was schizophrenic, bipolar, drinking twenty-five cans of strong lager every day, has brain damage and liver and kidney problems. Mark said he wanted help for Kelly but did not want to contact her GP. He sounded intoxicated and was advised to contact the GP.

ASC made a welfare call to Kelly, and she reported that she was ok but had had a few falls and her leg hurt. She was advised to contact the drop-in service should she require assistance. Kelly did not attend her appointment with the hospital liver team.

June Kelly was found dead in her home with Mark present. Mark was arrested. It was noted that Mark had facial injuries that he said were inflicted by Kelly. This suggests there may have been a physical altercation prior to Kelly's death.

15. Overview

15.1. Kelly was a woman with complex needs. It is clear that there were a lot of agencies involved in her care and that they all recognised her vulnerabilities. The police addressed the behaviours of her abuser by arresting and charging him with offences. Her GP kept a close relationship with her most of the time. She was given support through the local domestic abuse service GDASS and offers of help from alcohol services and mental health services, as well as Adult Social Care and housing services. Kelly case had been heard at MARAC several times but the process itself was limited in any measures it could take to safeguard Kelly due to the issues with her not engaging with GDASS. The MARAC process support agencies in sharing information and working jointly to safeguard victims. This does not suggest that any individual agency failed significantly in their duty to Kelly.

15.2. However, learning may be identified more generally around Kelly's complex needs and how agencies together, responded to them. People with complex needs can present challenges to agencies offering and delivering support. This case is not unique.

15.3. There are also lessons identified around the comprehensive nature of the abuses suffered by Kelly at the hands of Mark. Domestic abuse was rightly identified and classified as high risk. In cases such as this, where the abuses were numerous a more holistic view of the effects of those abuses on someone with identified complex needs may be helpful.

15.4. Therefore, the analysis will focus on the difficulties presented for the victim and agencies in responding to complex needs, and the complexities in responding to high-risk domestic abuse.

15.5. Ten IMRs were completed and the following documents the learning identified for individual agencies by themselves.

1. <u>IMR Gloucestershire Hospitals NHS Foundation Trust</u>

The GHNHSFT identified some areas where practice may benefit from learning:

i) A consideration of the role of epilepsy in domestic abuse homicides and whether epilepsy should be considered a risk factor.

ii) A consideration for including an individual's history of domestic abuse on their medical records if they present a danger to a named victim

iii) A review of three DHRs where epilepsy was a characteristic in the abuser is being undertaken

iv) The need to stress professional curiosity at all levels of safeguarding

2. Gloucestershire Adult Social Care (GASC)

GASC made the following recommendations for learning in their IMR

i) When working with people at risk of domestic abuse, practitioners regularly review the input of informal support to ensure appropriate support remains available.

ii) Customer Service Officers ensure that all suitable referrals are passed to the Locality team for assessment.

iii) Customer Service Officers inform professionals when they have not been able to complete an agreed action, and that action remains outstanding and not closed unless the professional advises to do so.

iv) Where individuals are reluctant to engage with Registered Social Workers specifically, alternative social care practitioners may provide support to the individual under the direction of an appropriately qualified lead worker.

v) ASC workers to clearly record the purpose and anticipated content of ongoing welfare telephone calls and/or visits and where for any reason the welfare check is not undertaken, this is immediately escalated to the line manager for discussion and agreement on next steps. ASC workers may wish to agree in advance relevant "code words" to be used by the individual to alert the worker to perceived risk/threat and agreed actions that will follow in these circumstances; this will be clearly recorded on the person's record.

vi) When working with individuals who may be at risk of abuse or neglect, practitioners remain professional curious ensuring all appropriate methods of communication are utilized.

vii) Multi-agency reviews to be requested by ASC if situation escalates/changes.

viii) ASC practitioners remain aware of the principles of Making Safeguarding Personal in conjunction with the statutory requirements of s11 Care Act 2014 "Refusal of Assessment" and document where this has been considered

ix) For ASC practitioners to clearly document that they have considered the im-pact of domestic abuse on the person's ability to make decisions with capacity free of coercion or controlling behaviours.

3. MAPPA NPS

The following are observations made by the National Probation service around learning opportunities:

i) The NPS Court team staff will revisit guidance in relation to sentencing recommendations for offenders assessed as suitable for an Accredited Programme Requirement.

ii) All NPS OM staff will familarise themselves with enforcement procedures for Community Orders and Post Sentence Supervision cases by reviewing the processes on EQUIP – NPS process and guidance tool and supporting documents.

iii) All NPS OM staff to familiarise themselves with the Home Visits policy and to ensure consideration of unannouced home visits.

iv) NPS LDU head to explore a process for receiving information relating to police domestic abuse callouts.

4. South Western Ambulance Service NHS Foundation Trust (SWASNHSFT)

The ambulance service made the following observations on learning:

i) All agencies: Information sharing between agencies, in particular knowledge of the restraining order – this is a systems challenge as SWASNHSFT can only attach information to addresses, not individuals. If there is a call to a public place, this information would not be able to be seen.

ii) SWASNHSFT: Recognising the care and support needs of those addicted to alcohol and the likely self-neglect as a consequence of this. There were a number of missed opportunities for SWASNHSFT crews to raise Safeguarding alerts for self-neglect to Adult Social Care. This has been addressed by inclusion on Development Days for frontline staff 2019 –

Recognition of chronic alcohol abuse as Self-Neglect. 2020 Assessment of the intoxicated patient and its effect on Capacity. This also prompted national discussions within Ambulance Services , resulting in new JRCalc guidelines.

5. Cheltenham Borough Homes (CBH)

The following is the learning identified by CBH

i) For CBH staff in key supportive roles to receive training in relation to mental Capacity, the Mental Capacity Act and how assessments are carried out. In order to increase their understanding and allow them to fully engage in professional discussion with partner agencies, and also to confidently challenge a decision if the need to do so arises.

6. Gloucestershire Domestic Abuse Support Service (GDASS)

The following are observations made by the domestic abuse service

i) The occasion where KD felt that GDASS supported the court to refuse a removal of her Restraining Order.This was not KDs allocated worker. The decision was made due to perceived risks to KD by DV. The GDASS Court IDVA did not explicitly provide a report in Court. KD felt the Court IDVA did not make it clear that KD wished for it to be removed despite these risks in open court. This perhaps could have been made clearer although was unlikely to have effected the outcome of this decision. It is not clear what information was discussed with CPS during this hearing, the worker no longer works for GDASS. However it is possible that they did make it explicit to CPS and this was not shared with the court. This occasion impacted on KDs willingness to engage with GDASS. However KDs engagement had already been sporadic, it is unclear whether this would have changed had she felt hat GDASS represented her more explicitly in court.

7. Gloucestershire Constabulary

i) IOPC have advised that there was no learning to come from this death as Gloucestershire Police had acted approriately and had not failed in their efforts to protect KD.

Developments since the death

ii) All Officers and Supervisors within Gloucestershire Constabulary are aware they should consider so-called 'victimless' or Evidence Led Prosecutions (ELP) in cases of domestic abuse, where there is other supporting evidence. It is also best practice, and part of new recruits training, that officers are encouraged to activate their body worn cameras on arrival at calls for assistance in domestic abuse related incidents. A Joint webinar was delivered with Crown Prosecution Service highlighting the specific requirements and considerations of an Evidence Led Prosecution (ELP). In addition, pilot work is being carried out in relation to the custody management software, to ensure that ELP has been considered in all DA cases prior to the release of person arrested.

8. MARAC

The following are observations on learning from MARAC:

i) Safety Planning to consider options for support of offender if this will support safety planning of the victim, e.g., signposting to housing related to support in the case of DV. This is also something for police to consider when DVPOs are issued and ensuring links are made with district housing teams.
ii) Ensure pre-release MARAC meetings are held to allow enough time for agencies to implement their actions before offender release.
iii) The MARAC Steering Group to continue to consider looking into options to reduce the MARAC backlog.
iv) MARAC decision maker to be mindful of language used when deciding not to hold formal MARAC meetings, avoiding language that could be seen as victim blaming.

Developments since the death

i) The Gloucestershire MARAC has seen an increase in staff resources since the start of 2021 with 2 new permanent MARAC decision makers. These new decision makers are very experienced domestic abuse professionals, once of which is a qualified IDVA and has been actively working as an IDVA up until the point of taking on the role. This increases the capacity of MARAC to now include 2 MARAC Coordinators and 2 Decisions Makers/Chairs. There is now no MARAC backlog, and the process can respond more dynamically to high-risk cases because of this increased capacity. These new MARAC decision makers are aware of the need to ensure actions that are perpetrator focused are considered as part of victim safety planning. The Police DVPO policy has also recently been updated and this includes the details for the district housing teams to address perpetrator housing when a DVPO is issued.

ii) The Pre-release MARAC process is an area of best practice for Gloucestershire and is now in place to ensure an appropriate safety plan can be implemented prior to a perpetrator's release from prison.

iii) The MARAC Steering Group has agreed to conduct a dip-sample audit of MARAC cases to continually develop the process. This will be conducted annually with a development plan for the MARAC.

9. Gloucestershire Clinical Commissioning Group (GCCG)

i) The author believes that the GP practice and uGP demonstrated excellent continuity of care, showed a good understanding of the risks and raised concerns appropriately, engaging with other agencies widely when required.

ii) From a GP/Primary Care point of view, we can recommend that GPs try to ensure continuity of care with one "usual" GP for each vulnerable person and families, however we can not make this a SMART recommendation as it can not be contractual, nor audited under the current Primary Care GP contract. Patients should also have the opportunity to see different GPs according to accessibility and convenience.

10. Gloucestershire Health and Care NHS Trust

The following points were identified as learning and recommendations.

I) Make every contact count - using opportunity for conversations about domestic abuse and exploring options and choice. Make efforts to seek consent to liaise with and involve family members if considered safe and potentially helpful to do so.

II) Development of a 'notice, ask, refer' reminder card for staff is being progressed by the Domestic Abuse Lead in the Trust.

III) GHCNHST level 2 manadatory safeguarding training now includes a family used throuhout the day where domestic abuse impacts on each family member. This extends from an older person with care and support needs, adults – one of whom has alcohol misuse problems; a 16 year old child and a 3 month old baby. All new clinical staff will have this training and those staff who have to repeat level 2 every 3 years will now do so.

16. Analysis

16.1. There are two key issues that frame this analysis and any recommendations that result, and they are:

i) Kelly had complex needs.
ii) Kelly was subjected to wide ranging high-risk domestic abuse.

16.2. Both these issues create challenges, but together the challenges are significant for both Kelly, and the agencies involved.

16.3. Complex Needs

16.4. Kelly was a person with serious complex needs. She suffered with alcoholism, and was also suffering severe health implications because of that, she was in fact, considered to be terminally ill. She knew the seriousness of her situation and that continued alcohol misuse may result in her imminent death. This has implications for service delivery, for decision making, and potential responses to professionals by Kelly.

16.5. One of the impacts of Kelly's alcoholism and its effects on her body were that it impacted on her cognition and her perceptions of reality on occasion. She was as a result, especially vulnerable to psychological abuse and gaslighting, as much as the physical assaults on her body. This is important when thinking about her capacity and when she might be capable of making decisions in her own best interests. There is also the potential for a building co-dependency with Mark through their shared reliance on alcohol, to be able to function as they saw it. All these things present challenges for professionals who may or must assume competency and capacity.

16.6. A further consideration when responding to someone with complex needs is that they will likely be accessing support from numerous agencies. There is no doubt in this case that agencies were providing support to Kelly and there are many examples of good practice. What may be more at issue is the number of agencies involved. There are going to be challenges of information sharing and cross agency communication. It is also quite possible that the sheer number of different agencies could have created problems for someone like Kelly. It may have been difficult to keep track of different appointments, and coordinate in her mind what she needed, what she was required to do, when, and with whom.

16.7. Just her health care involved many different specialisms and medical interventions or supports, without adding in the social care needs she had, housing, domestic abuse etc. The CCG report states that Kelly had 149 contacts over the review period, and this represents ten times the average number of appointments, not including those she did not turn up for. This is significant and is in addition to other appointments with other agencies for her various needs. The ambulance service recorded 39 call outs, 30 for Mark and 9 for Kelly.

16.8. This of course also adds extra pressure on resources for her GP and health services, and similar pressures for other agencies.

16.9. There is also the issue for the victim of being overwhelmed by the numbers of appointments and actions and communications they must try to organize. Missed appointments are common in complex needs cases. If agencies do not know how many appointments, forms, phone calls, actions and travelling that the victim needs to do, they may not see how their agency fits into a wider and complex picture. Kelly could barely look after herself, so it is fair to imagine that she would not be able to manage a diary, recognize and evaluate her competing needs, and fulfil all the admin required by different agencies. The attention may become too difficult. When she was feeling unwell, and sometimes very unwell, the thought of appointments and admin may have overwhelmed her. It may even be that she could start to feel antagonistic towards those trying to help her.

16.10. A growing co-dependency between her and Mark may have at times, been easier to cope with than engaging with agencies. It is a part of chronic alcoholism that individuals sometimes feel that drinking makes it easier to function. This would have been a shared problem with Mark.

16.11. This is a difficult challenge for agencies, and for someone like Kelly, and there are no easy answers, but recognising complex needs as a particular status may give opportunities for formulating a more focused response. It may be considered, for example, that in those cases where there are complex needs, that a Single Point of Contact (SPOC) may be beneficial, or more importantly someone to act as an advocate for people suffering domestic abuse, especially with complex needs. This need not be someone from GDASS and other professionals can take this role in the context of their business, as has been found in recent research (Monckton Smith et al 2022).

16.12 Coercive Control

16.12. A public consultation completed by the Home Office in 2012 found that *Coercive Control* was the best framework for understanding and responding to Intimate Partner Abuse (IPA). Thus, Coercive Control as a pattern of behaviour was deemed to be a criminal offence under s.76 of the Serious Crimes Act of 2015 in England and Wales, and the offence carries up to 5 years imprisonment upon conviction. Coercive control is the most common form of IPA for which victims seek help or assistance. The law states it is:

16.13. *'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'. Coercion encompasses psychological, physical, sexual, financial and emotional abuse. Controlling behaviour is defined as 'making 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 lives'.*

16.14. Coercive Control perpetrators use a broad range of non-consensual tactics over an extended period to subjugate or dominate a partner, rather than merely to hurt them physically in isolated violent incidents (Stark 2009). Compliance is sought and achieved by making victims afraid and by denying basic rights, resources, choices and liberties without which they are unable to effectively refuse, resist or escape demands that are against their interests. This aspect to Coercive Control is relevant when thinking about Kelly's ability to make decisions in her own best interests. The *predicament of entrapment* in which victims of Coercive Control are often caught usually develops 'behind closed doors,' and its dynamics and consequences are rarely well documented or known in detail by outsiders. The major elements of coercive control include physical and/or sexual violence or coercion; threats, stalking, intimidation, gaslighting, isolation, degradation, and control. Many of the effects of Coercive Control make it difficult or near impossible to escape the entrapment.

16.15. There is ample evidence to establish that Kelly was subject to coercive control. There is evidence to suggest, violence, gaslighting, financial abuse, psychological abuse, persistent attention and harassment, isolation and sexual abuse.

16.16. The domestic abuse service, and health services have recorded injuries to Kelly, some of them serious and life threatening. For example, serious facial injuries, strangulation to the point of unconsciousness, and head injuries caused by a hammer.

16.17. She had been convinced by Mark that she was suffering with a brain tumour, and he apparently shaved off all her hair – this could be interpreted as gaslighting tactics. Hair shaving has been noted in other cases to humiliate victims and keep them from leaving the home. Kelly's GP considered that the gaslighting was severe and coupled with the effects of her alcohol misuse meant that her capacity to make decisions in her own best interests, and her perceptions of reality were affected.

16.18. Kelly also disclosed that she was having sexual relations with Mark when she did not want to, and there was significant bruising noted to her groin by health professionals. However, Kelly did not consider she had been raped when talking with the IDVA but had made allegations of anal rape to the police and health services.

16.19. Kelly told the police that she was frightened of Mark. This is one of the key high-risk markers for serious harm. Kelly would have known what Mark was capable of, she had experienced it. This was fuelling her fear of him.

16.20. There were allegations from Kelly that Mark took money from her, demanded money, and had an expectation that she would pay for things for him. This creates another form of abuse that can have wide ranging consequences for a victim. This is financial abuse, a sub-category of economic abuse that can take many forms. It is a legally recognised form of abuse and is defined in the Domestic Abuse Act (2021). It seems that Mark pressured Kelly to give him her money, and even threatened her. It is not known whether this was a co-ordinated pattern to make her more dependent on him or was simply that he wanted money and abused her to get it. He certainly used her accommodation and resources as if they were his own.

16.21. The financial abuse continued after Kelly's death and her family have contacted an MP to challenge the way perpetrators of abuse can exploit a victim's finances after their death.

16.22. He had his own accommodation but kept turning up to her accommodation, he would hang around outside and made it very difficult for Kelly to resist his company.

16.23. When Mark was around, it is also the case that Kelly became more isolated. She would withdraw from agencies, and neighbours would report times when they wouldn't see

her at all. This kind of isolation creates distance from help and Mark would become the only influence in her life. There are clear repercussions from this as there would be no witnesses to injuries, and alcohol consumption would likely increase.

16.24. Mark was known to use various tactics to make Kelly feel sorry for him and to make her feel guilty if she did not support him or if she called the police or asked him to leave her home. As noted, Mark had his own accommodation but persistently harassed Kelly even when there were no-contact orders.

16.25. The evidence therefore establishes that Kelly was suffering from serious and high-risk abuse, and this was also the assessment of all agencies involved. When this is coupled with Kelly's pre-existing difficulties with alcohol and the impact of her alcoholism the risk to Kelly escalated exponentially. It does seem as if her pre-existing issues were compounded with the abuse, and she found it very difficult to address those issues whilst Mark was around. Her GP also believed that the abuse coupled with her health and addiction issues affected her grasp on reality and her ability to make decisions in her own best interests.

16.26. The ambulance service recorded burn injuries to Mark's back that had not been attended to. There is no explanation available to this review around how this injury occurred. Mark did not make any allegations against Kelly but reported that he had laid on some tealights that were lit and on the floor.

16.27. Domestic Violence Prevention Orders (DVPO) were issued which Mark constantly breached, leading to multiple arrests and remands in custody and consequently a restraining order which was issued in October 2018. It was a breach of this restraining order which resulted in Mark being arrested again and being imprisoned. Mark could have been offered an accredited programme to address his abuse of Kelly such as Building Better Relationships (BBR) whilst he was in prison, but this may have been difficult to introduce due to the numerous short sentences he received and the length of time required to complete a programme. When not in prison, it is unlikely that Mark would have engaged with a voluntary programme held in the community as he would have been preoccupied with his fixation on Kelly and his alcoholism. Although he may have agreed initially to undertake a programme it is unlikely that he would have completed it as he was known to regularly miss appointments

16.28. He was also given sentences for breaching orders whilst in prison by contacting Kelly by letter. She said she wanted him to stop.

16.29. Mark had no intention of staying away from Kelly, and if court orders were not working, it seems likely that Kelly would have had little chance of deterring him.

16.30. The police did act when Kelly called, and Mark was prosecuted without her support. In the early arrests Mark was not incarcerated after conviction. Police even worked to change a charge so that Mark could be kept away from Kelly.

16.31. Kelly did engage with domestic abuse services, but she was not consistent and there was a point where she became angry with the domestic abuse service and her GP over a restraining order that she wanted lifted. The domestic abuse service, the GP and police acted in a way consistent with good practice. However, Kelly disengaged from the domestic abuse service because of this disagreement, though her engagement was always sporadic. Her GP kept contact even though it was difficult.

16.32. Kelly expressed on many occasions her desire to escape Mark, especially when he wasn't around or was incarcerated. When he was around Kelly would sometimes say she wanted to be with him. It is possible that coercive control was driving Kelly's changing opinion, her growing cognitive difficulties, and her increased alcohol consumption.

16.33. At a few points, Kelly expressed a desire to leave Cheltenham and live elsewhere, most notably to move to be close to her family and their support. There is no clear indication from the available documents that she was specifically helped with this request. Her family included her father, stepsisters and stepmother, all of whom were supportive of Kelly and were willing to help her. There was almost daily contact on the telephone between her and her father. A move would potentially have been difficult for Kelly to achieve on her own, and possibly a frightening and difficult move given her complex needs and need for ongoing health support. Not only would she need to arrange housing and benefits, but she would have to transfer her health care to a new area. It could be that whilst Mark was in prison that these things could have been furthered, and Kelly helped to move out of the area.

16.34. Given the framework discussed above, learning opportunities are identified in the context of the two key issues. A trawl through the chronology would not be the most effective way to draw out learning.

16.35. The following learning identified focuses on how we might respond to complex needs and domestic abuse together.

16.36. It appears that agencies did engage with Kelly and Mark. Kelly was in receipt of support for her varying needs. It does not seem there was any significant failure by any agency involved the problems arise from the context of dual complex issues.

16.37. The circumstances of Kelly's death remain unexplained. It is known however, that Mark knew she was deceased, and had lived with her dead body for around four days. No help was sought, and Kelly's body was not treated with dignity after her death.

16.38. She was naked when found and lying on the floor beneath rubbish.

16.39. Mark had some facial injuries which he claims were caused by Kelly, so it is possible there was an altercation before her death.

16.40. Kelly was found when two probation officers attended the address looking for him. He was not supposed to be there. The police had also attended twice during that week but had not managed to get an answer. It is not known whether Kelly was dead or alive at the time of the police calls.

16.41. Mark answered the door to the probation officers naked from the waist down. He asked the officers if they would like to see a dead body.

16.42. This is clearly a strange response, and it is likely that Mark was suffering the effects of alcoholism. He said he could not remember what happened.

16.43. Due to the lack of evidence and the length of time between the discovery of Kelly's body and examination of it, her advanced illness and precarious state of health, it is unlikely the circumstances of her death will ever be known.

17. Conclusions

17.1. An overall view of Kelly's situation reveals that her problems were most likely overwhelming for her. She was very unwell, she was suffering domestic abuse, and she was misusing alcohol. Her GP considered that her health problems coupled with the domestic abuse had affected her perceptions of reality and her ability to make decisions in her own best interests. Her husband was a determined and violent man who ignored court orders and was misusing alcohol himself. The records also show that Mark was suffering with epilepsy and often failed to take his medication leading to seizures. Mark was resistant to change, resistant to taking his medication, and resistant to following court orders or licence conditions.

17.2. The analysis has not focused on individual events from the chronology, and this was purposeful because the complex challenges created by the dual impacts of complex needs and domestic abuse render micro level focus almost irrelevant. I say this because the overriding impacts of the meso and macro level challenges are more likely to identify relevant learning. Overall, Kelly and Mark were receiving the services they needed, they were having above average levels of contact with some agencies, even if they did not always engage fully with them. Kelly's health was being monitored and her GP understood her competing problems; the police responded to calls for help and arrested Mark, prosecuting him. The problems arise from the complex needs and domestic abuse together.

17.3. This creates problems for Kelly.

17.4. This also creates problems for all agencies involved.

17.5. It does seem that Kelly's status as a high-risk victim of domestic abuse was sometimes in conflict with her status as an individual with complex needs. The extra resources and time needed for agencies to respond must also be considered.

17.6. Therefore, I conclude that the best way forward from all the information collected, is that we consider the recommendations made by agencies in their IMRs and place them in the context of complex needs and high-risk domestic abuse to identify relevant learning.

18. Learning Opportunities and Recommendations

Learning Opportunity 1: Responding to Complex Needs and SPOC

When considering complex needs it must be recognized that there are a lot of agencies involved: the scale of contact with Kelly was above average. Agencies should be aware of the hierarchy of need to support engagement of those with complex needs in particular recognising that for some victims of domestic abuse it can be difficult for them to act in relation to domestic abuse when other needs are a priority - housing, food, clothing etc. These issues need to be addressed first, building trust, and supporting the victim to meaningfully engage in wider domestic abuse safeguarding activities. This presents challenges for agencies and for the victims of abuse. There are the challenges of information sharing and cross agency communication. There is also the issue for victims such as Kelly of being overwhelmed by the numbers of appointments and actions and communications they must try to organize. Missed appointments are common in complex needs cases. If agencies do not know the number of appointments, forms, phone calls, actions and travelling that the victim needs to do, they may not see how their agency fits into a wider and complex picture. Kelly could barely look after herself so it is fair to imagine that she would not be able to manage a diary, recognize and evaluate her competing needs and fulfil all the admin required by different agencies. The attention may become too difficult. When she was feeling unwell, and sometimes very unwell the thought of appointments and admin may have overwhelmed her. It may even be that she started to feel antagonistic. It may be of potential use for specified complex needs victims to have a Single Point of Contact (SPOC).

As noted above the challenges for domestic abuse victims with complex needs are numerous, and this means they are different in many ways. There should be a way of creating a marker for 'complex needs domestic abuse victim' so that a particular route to support can be considered that takes account of the issues for victims and agencies.

Gloucestershire County Council (GCC) are currently carrying out transformational work with respect to complex needs and individuals who are experiencing multiple disadvantages. GCC will be commissioning a consultant to carry out a piece of engagement work over the Summer of 2021 with senior colleagues across the system to gain insight into their views on this subject. It is hoped to secure engagement at senior level and use the insight gained from the work to inform workshops in the Autumn that will help drive this agenda forward

RECOMMENDATION 1a

Ensure the review into Gloucestershire's collective response to individuals experiencing multiple disadvantages considers the findings from this review. This will ensure that the countywide response to 'complex needs' considers the specific needs of victims of domestic abuse and supports future victim engagement in services/increased safety

RECOMMENDATION 1b

Ensure agencies are aware of the need to address immediate physical (shelter, food, clothing, emergency health care, sleep etc) needs (that may be caused by DA) first in complex cases to support victim engagement

Learning Opportunity 2: Complex needs, domestic abuse and capacity

Kelly had sporadic contact with multiple agencies, often several agencies at the same time, though these agencies were not always aware of each other's involvement unless disclosed by Kelly or otherwise identified by agencies themselves. Kelly's GP said that she thought that Kelly's cognition was affected by Mark's abuse and coercive control, and by the effects of prolonged alcohol misuse and that subsequently Kelly was not making good decisions about her safety. This observation has been made by other agencies too at differing points of their contacts with Kelly, however there was an absence of opportunity for this opinion to be shared and acknowledged as a multi-agency group and in turn inform agency's "time and decision-specific" Mental Capacity Assessments. Consequently the approach taken by those undertaking these MCA Assessments, particularly in the hospital setting where full knowledge of the existence of these multiple factors or of their potential impact on Kelly's decision-making capacity may not have been known by those undertaking MCA assessments at the time in question, may have differed and this may also be a reflection of the tiered approach taken by agencies in delivering MCA training to their respective workforce with some staff having more advanced knowledge and skills than others. It may be good practice where the perpetrator is next of kin, to have an alternative name. Victims could be asked this when it is known they are victims, or they disclose.

RECOMMENDATION 2a

A small working group drawn from multi-agency partners, in conjunction with the Safeguarding Adults Board Workforce Development sub-group, be formed to review both the content and delivery of existing Mental Capacity Act Training, and Domestic Abuse training ensuring sufficient emphasis is given to the impact on decision-making capacity of long-term substance misuse, domestic abuse, and/or coercion and control.

RECOMMENDATION 2b

Multi-agency partners to review the Mandatory, or other status of such training to respective areas of the workforce involved in assessing and supporting people's decision-making.

Learning Opportunity 3: Complex needs and domestic abuse – acting fast on requests

Kelly was inconsistent in whether she wanted Mark around, and this made things challenging for agencies, notably the GP, the police and GDASS. Given this challenge, there may be some benefit in complex needs cases with domestic abuse that rapid action or focused action could be taken when a victim is in a position of asking for specific help.

RECOMMENDATION 3a

Ensure agencies are aware of the immediate safety measures that should be considered when responding to victims of domestic abuse to ensure safety planning is not delayed or linked to ongoing victim engagement

RECOMMENDATION 3b

For the Safeguarding adults board to ensure the findings from this review are considered alongside the 5 women SAR to ensure a joined up approach to the learning around 'ensuring agencies can respond effectively at the point when someone is ready to accept support' and the need to act fast in these situations to safeguard vulnerable people.

Learning Opportunity 4: Complex needs and domestic abuse - safe and well checks

A safe and well check by the police could have been more persistent given the complex needs and the serious violence and control recognising the restrictions placed on them by current legislation. It is possible that Kelly was dead when the calls were made. When Probation called they were more persistent and got an answer.

RECOMMENDATION 4

When agencies contact the police regarding safe and well checks, where possible, the information should be relayed directly (phone/face to face) in order to convey the risk associated with the individuals it concerns. This will support police in ensuring Safe and well checks are conducted appropriately, and victims are safeguarded.

Learning Opportunity 5: Complex needs and domestic abuse – self-care help

Kelly's ability to care for herself fluctuated, as did her engagement with support in this area when it was offered. At times Kelly said she needed help with self-care, at points Mark being identified as able and willing to provide this care (though this was accepted by professionals without them having any knowledge of any domestic abuse in the relationship at the time). At other points it was identified Kelly did not need help with self-care. Where there are such fluctuations in both the person's ability to self-care and remain engaged with external support, and in the known presence of domestic abuse, the absence of external support holds the potential to isolate the person further potentially increasing their vulnerability.

RECOMMENDATION 5 a

Domestic abuse training should explore the impact of domestic abuse on the person's ability to maintain self-care independently and how this area of a person's life may be used as a means to isolate them from an otherwise supportive network.

RECOMMENDATION 5b

When engaging with people who have complex needs and where domestic abuse may be known or suspected, all professionals should exercise professional curiosity when exploring with the person their ability to self-care and/or the appropriateness of their support network in relation to any arising needs for care and support.

Learning Opportunity 6: high risk domestic abuse and prison communications

It is known that there was contact between Mark and Kelly whilst Mark was in prison – letters and phone calls – and whilst an order was in place barring contact. Mark had two sentences imposed for this. Is there opportunity for Mark to be prevented from contacting the primary victim of his abuse? Monitoring of contact? This would be an opportunity for the prison service.

RECOMMENDATION 6 (NATIONAL)

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HM Prison Service to review its policies and practice around communications from prison in cases of domestic abuse to ensure the ongoing safeguarding of victims.

Learning Opportunity 7: High risk domestic abuse grading and incarceration

There was an assumption that because Mark was in prison that the threat to Kelly was reduced significantly. This may be exactly the time to put in place safeguarding that separates the two permanently, particularly if that is what the victim wants. Also, there was communication between them so risk should be considered even when perpetrators are in prison. Control can be exerted from a distance.

RECOMMENDATION 7

All agencies to ensure DA training is clear on how professional should respond to immediate and long term risk; recognising the opportunity of perpetrator incarceration in engaging and safeguarding victims in the long term.

Learning Opportunity 8: domestic abuse perpetrators and noting a history in health records

There is a lack of consistent approach across health services currently around recording perpetrator information on records. Health providers are currently undertaking a project to integrate all the health-related safeguarding within the Integrated Care System (ICS). There is an opportunity both locally and nationally for consideration to be given to the Should a perpetrator of domestic abuse have this recorded somewhere on health records? There may be a relationship between control issues and abuse.

RECOMMENDATION 8a (NATIONAL)

All NHS Safeguarding integration projects provide a solution for how risks presented to and by a patient are documented within clinical records, so that NHS staff do not inadvertently increase their patient's risk of harm from or to others

RECOMMENDATION 8b (LOCAL)

Gloucestershire Safeguarding Integration Project to look to a solution for how risks presented to and by a patient are documented within clinical records in line with National practice and the National recommendation from this DARDR.

Learning Opportunity 9: awareness of domestic abuse and identifying perpetrators

Professionals should take every opportunity to raise their skills in identifying and assessing domestic abuse and recognising offenders. Ongoing commitment to training in all agencies should remain or become a priority.

RECOMMENDATION 9

The domestic abuse partnership board to review DA training and to consider opportunities to commission countywide training via Lot 5 of the DA Framework to ensure a consistent approach to DA Training for the county that is sustainable in upskilling all professionals in identifying and responding to DA

Training should ensure the inclusion of a specific DA perpetrators module to ensure all professionals understand how to identify perpetrators of DA and respond effectively to manage their behaviour and hold them to account.

KD DARDR ACTION PLAN							
Recommendation	**Scope i.e. local or regional**	**Action to take**	**Lead Agency**	**Key milestones in enacting the recommendation**	**Target Date**	**Date of Completion and Outcome**	**RAG Rating**
OVERVIEW REPORT RECOMMENDATIONS							
Learning Opportunity 1: Responding to Complex Needs							
Ensure the review into Gloucestershire's collective response to individuals experiencing multiple disadvantage considers the findings from this review. This will ensure that the countywide response to 'complex needs' considers the specific needs of victims of domestic abuse and supports future victim engagement in services/increased safety **Outcomes**: To ensure that the long term work of the county council to improve the collective response to complex needs considers the needs of victim of DA. This is a long term action and the DA LPB will maintain input and oversight.	Local	-Commission consultant to conduct review. -Develop and run countywide workshops with a range of key stakeholders. -Develop and agree strategic approach for the county response to individuals experiencing multiple disadvantage	GCC: Head of Commissioning (Complex Needs)		October 2022 and ongoing	Gloucestershire County Council are leading. The DA LPB has requested to maintain some oversight of this work, with regular updates. The public health commissioning lead for DA will also take on the oversight of the county response to complex needs. This is a long term piece of work. The findings from this review were fed in to the initial work conducted by The Kings Fund for the county.	

Ensure agencies are aware of the need to address immediate physical (shelter, food, clothing, emergency health care, sleep etc) needs (that may be caused by DA) first in complex cases in order to support victim engagement to then address safety in domestic abuse. Outcome: To ensure agencies are aware of approaches to supporting victims of DA who present with complex needs.	Local	-Develop multi-agency guidance to raise awareness of Maslow's Hierarchy of need and responding to domestic abuse and complex needs. -Provide guidance to support agencies in identifying complex needs (questions to ask, national definition etc). -GDASS website to be updated with guidance and advice -Raise awareness and promote the 'once chance rule' approach for domestic abuse.	DASV strategic Coordinator and GDASS	-Guidance produced and published -Updated DA training -Professionals awareness campaign	July 2022	Guidance Revised and circulated to the partnership. DA training pathway reviewed and commissioning considerations underway. Follow up action to take place for the DA LPB to assure itself that partner agencies are utilising this guidance and the approaches can be embedded in policy work (current action of the DA LPB delivery plan)	
Learning Opportunity 2: Complex needs, domestic abuse and capacity							

A small working group drawn from multi-agency partners, in conjunction with the Safeguarding Adults Board Workforce Development sub-group, be formed to review both the content and delivery of existing Mental Capacity Act Training, and Domestic Abuse training ensuring sufficient emphasis is given to the impact on decision-making capacity of long-term substance misuse, domestic abuse, and/or coercion and control.	Local	Meeting arranged with Workforce Development Lead and MCA lead to take this forward. External specialist input will be needed to achieve this LO	Simon Thomason, MCA Governance Manager	GSAB Workforce Development Sub Group Chair and Simon Thomason, MCA Governance Manager met and agreed Simon should lead on this. A discussion has taken place in the MCAGG (Mental Capacity Act Governance Group), all agreed that they did not have the specialist skills to produce the additional content required for the training. Simon Thomason is looking for additional content from external providers.	March 2024		

Multi-agency partners to review the Mandatory, or other status of such training to respective areas of the workforce involved in assessing and supporting people's decision-making. **Outcome**: To ensure DA training is available across the county and that agencies ensure their staff are accessing training.	Local	-To ensure training on DA includes detail on capacity -To ensure mapping of training develops an understanding of levels of training currently available and if mandatory training needs to be extended or explored. -To develop a plan for future DA training commissioning	DA LPB Training task and finish group	-Training mapping conducted -Review of Training pathway -Develop recommendations for commissioners -Commissioning of training pathway	June 2022-August 2022	Training pathway reviewed and signed off by the DA LPB. Commissioning considerations underway. (this is a long term action to fully fund the roll out of all elements of the training pathway, paper on funding options going to the DA LPB in October 2023)	
Learning Opportunity 3: Complex needs and DA-Acting fast on requests							
Ensure agencies are aware of the immediate safety measures that should be considered when responding to victims of domestic abuse to ensure safety planning is not delayed or linked to ongoing victim engagement **Outcome**: that all agencies ensure their response to victims of DA prioritises immediate safety to improve victim safety and engagement.	Local	-Update guidance on identifying and responding to DA to include further detail on immediate safety measures as well as promoting the need to telephone immediate concerns for welfare instead of email. -Raise awareness and promote the 'once chance rule' approach for domestic abuse. -Raise awareness of	DASV strategic Coordinator and GDASS	-Update existing guidance, re-circulate and publish. -Update DA training -Professionals awareness campaign	July 2022	Guidance Revised and circulated to the partnership. DA training pathway reviewed and commissioning considerations underway. Follow up action to take place for the DA LPB to assure itself that partner agencies	

		the role of the IDVA and ensure agencies refer high risk DA to an IDVA prior to making a referral to MARAC.				are utilising this guidance and the approaches can be embedded in policy work (current action of the DA LPB delivery plan)	
For the Safeguarding adults board to ensure the findings from this review are considered alongside the 5 women SAR to ensure a joined up approach to the learning around 'ensuring agencies can respond effectively at the point when someone is ready to accept support' and the need to act fast in these situations to safeguard vulnerable people.	Local	The recommendation from the 5 Women SAR has been incorporated into the GSAB Multi Agency Risk Management Framework, currently in draft. This will be shared widely across the multi agency partnership. This learning will also be incorporated into the Gloucestershire Adult Safeguarding Multi Agency Policy and Procedures, currently under review.	Safeguarding Adults Board	The recommendations from this review have been considered alongside the Five Women SAR. A GSAB Multi-Agency Risk Management (MARM) Framework has been produced, this has been shared widely and discussed with multi-agency partners. A MARM Co-Ordinator post is currently being created, who will lead on all MARM work including chairing, minuting and	October 2023		

		Partner agencies' own policies should then be amended to reflect the changes in the main policy and procedures.		following up on actions from the meetings.			
Learning Point 4: Safe and well checks							
When Police are contacted by other partner agencies regarding safe and well checks, where possible, the information should be relayed directly (phone/face to face) in order to convey the risk associated with the individuals it concerns. This will support police in ensuring Safe and well checks are conducted appropriately and victims are safeguarded.	Local	-All agencies to ensure their DA policy reflects this recommendations and this is communicated to staff. -The DA partnership to assure itself that all agencies have completed this action. -Local DA guidance is updated to ensure awareness of this recommendation.	All Domestic Abuse Partnership Board (DASV strategic Coordinator)	-Policies updated -Reporting back to DA partnership -Guidance updated and re-circulated -Police to monitor and update DA partnership if changes are being seen in the control room.	TBC	*Guidance Revised and circulated to the partnership.* *DA training pathway reviewed and commissioning considerations underway.* *DA LPB to monitor this wider recommendation via policy leads.*	
Learning Opportunity 5: Complex needs and domestic abuse – self-care help							

Domestic abuse training should explore the impact of domestic abuse on the person's ability to maintain self-care independently and how this area of a person's life may be used as a means to isolate them from an otherwise supportive network. **Outcome**: Ensuring that all professionals who come in to contact with victims of DA have access to training that supports them in understanding the impact of capacity and self care on victims of DA so that they can fully consider this in their risk assessment and action plans.	Local	-To ensure training on DA includes detail on capacity -To ensure mapping of training develops an understanding of levels of training currently available and if mandatory training needs to be extended or explored. -To develop a plan for future DA training commissioning	DA LPB Training task and finish group	-Training mapping conducted -Review of Training pathway -Develop recommendations for commissioners -Commissioning of training pathway	June 2022-August 2022	DA training pathway reviewed and commissioning considerations underway. Follow up action to take place for the DA LPB to assure itself that partner agencies are utilising this guidance and the approaches can be embedded in policy work (current action of the DA LPB delivery plan)	
When engaging with people who have complex needs and where domestic abuse may be known or suspected, all professionals should exercise professional curiosity when exploring with the person their ability to self-care and/or the appropriateness of their support network in relation to any arising needs for care and support.	Local	-To ensure all professionals are made aware of the learning from this DHR -To ensure revised domestic abuse guidance is circulated to all and agencies raise awareness of the guidance. -To ensure DA training covers the learning	Safer Gloucestershire DASV Strategic Coordinator DA LPB Training task and finish group	-DHR learning event to be rolled out -Updated guidance circulated. -T&F group to ensure the revised training pathway considers all learning from this	TBC following publication June 2022-August 2022 June 2022-August 2022	Guidance Revised and circulated to the partnership. DA training pathway reviewed and commissioning considerations underway. DHR learning event to be	

Outcome: To ensure all professionals who have contact with victims of DA understand the importance of making enquiries about a victims support network to ensure it is appropriate and safety planning considers all possible needs.		from this review		review		arranged.	
Learning Opportunity 6: high risk domestic abuse and prison communications							
HM Prison Service to review its policies and practice around communications from prison in cases of domestic abuse to ensure the ongoing safeguarding of victims.	National		HM Prison Service				
Learning Opportunity 7: High risk domestic abuse grading and incarceration							
All agencies to ensure DA training is clear on how professional should respond to immediate and long term risk; recognising the opportunity of perpetrator incarceration in engaging and safeguarding victims in the long term. **Outcome**: ensuring all professionals who come in to contact with victims of DA can access	Local	-DASV Strategic Coordinator and GDASS to develop a training aid for all agencies. -All agencies to ensure the inclusion of this in their DA training and raise awareness within their agency. -DA Partnership Board to monitor the	All Domestic Abuse Partnership Board (DASV strategic Coordinator)	As per Actions.	June 2022-August 2022	*DA training pathway reviewed and commissioning considerations underway.* *Training under Lot 5 commissioned and rolled out during 2023.*	

training that supports them in understanding risk full, enabling them to better support a DA victim and ensure they have access to the right support/safety plan		implementation of this action. -DA partnership board to ensure this is considered in the need for services to be commissioned under Lot 5 of the DA commissioning Framework re: workforce development				*As per above update on DA LPB taking assurances that this work is underway.*	
Learning Opportunity 8: Domestic abuse perpetrators and noting a history in health records							
All NHS Integrated Care Boards to provide a solution for how domestic abuse risks presented to and by a patient are documented within clinical records, so that NHS staff do not inadvertently increase their patient's risk of harm from or to others	National	DHR author to take this issue to Home Office for action					
NHS Gloucestershire Safeguarding teams to look to a solution for how risks relating to domestic abuse are consistently recorded across health partners.	Local	NHS Gloucestershire SG teams will review current local practice in line with future national guidance when the national guidance is updated and establish alerting procedures with NHS Digital colleagues.	NHS Gloucestershire	Dependant on national guidance	August 2023 : this is dependent on digital system development and national guidance beyond local control	This has been raised at South West Named GP forum and others are having similar issues – this is being taken to the National Network of Named GPs.	
Learning Opportunity 9: Awareness of domestic abuse and identifying perpetrators							

The domestic abuse partnership board to review DA training and consider opportunities to commission countywide training via Lot 5 of the DA framework to ensure a consistent approach to DA training for the county that is sustainable in upskilling all professionals in identifying and responding to DA. Training should ensure the inclusion of a specific DA perpetrators module to ensure all professionals understand how to identify perpetrators of DA and respond effectively to manage their behaviour and hold them to account. Outcome: All front line professionals are able to identify perpetrator behaviour, challenge appropriately and refer to specialist services where necessary.	Local	-Task and finish group to be established to review DA training pathway -Recommendations to DA LPB re: commissioning county wide training - DA LPB to agree approach to commissioning long term countywide training.	DA Partnership Board	As per actions	June 2022-August 2022	DA training pathway reviewed and commissioning considerations underway. Training under Lot 5 commissioned and rolled out during 2023. Update Sept 2023: DA perpetrator training currently being commissioned by the OPCC As per above update on DA LPB taking assurances that this work is underway.	

INDIVIDUAL AGENCY RECOMMENDATIONS							
Gloucestershire Adult Social Care (GASC)							
When working with people at risk of domestic abuse, practitioners regularly review the input of informal support to ensure appropriate support remains available.	Local	Learning from this DARDR is shared with Senior Management of Operational teams for cascading to frontline practitioners. Review of Care Act Training content, together with review of Make the Difference paperwork and guidance Line Managers ensure Frontline practitioners are compliant with completion of Domestic Abuse training relevant to their role ASC Newsletter promotes good practice guidance in working with people at risk of Domestic Abuse (CCInform resources)	GCC ASC		September 2022 October 2021 May 2022 December 2022 September 2022	ISCM meeting October 2021 Care Act Refresh Training delivered to all ASC Assessing staff May 2022 Make the Difference practice model and paperwork now includes prompts re: suitability and needs of informal carers Managers are able to check training compliance via Learnpro system Oct 2022 ASC Ops Newsletter article	

Customer Service Officers ensure that all suitable referrals are passed to the Locality team for assessment.	Local	Learning and recommendations shared with Snr Management ASC Support Services. Review of training, audit and quality assurance processes within the Customer Contact Centre Review of referral pathways	GCC ASC		August 2022 August 2022 August 2022	 August 2022 Review completed and audit and assurance processes updated August 2022 The Council has undertaken a review of its current pathway for safeguarding concerns received by the Adult Helpdesk. This review included clarification of roles, accountability and decision making, and consideration of the risks of the current pathway and alternative approaches. As part of this review and	

						the Adults Transformation Work, we are introducing a Single Point of Access team for all safeguarding concerns raised by professionals; this will be located in the safeguarding team and will be introduced in early 2023	
Customer Service Officers inform professionals when they have not been able to complete an agreed action, and that action remains outstanding and not closed unless the professional advises to do so.	Local	Learning from this DARDR is shared with Senior Management of Operational teams and Snr Management ASC Support Services giving consideration to decision-making responsibilities and mechanisms in support of CSO's and Operational Locality teams.	GCC ASC		August 2022 August 2022	 August 2022 As part of Adult Social Care Transformation work, a review has been undertaken at the Customer Contact Centre (Adult Helpdesk). This review included clarification of roles, accountability and decision making, and consideration of the risks of the current pathway and alternative	

		Review of training, audit and quality assurance processes within the Customer Contact Centre (Adult Helpdesk)			August 2022	approaches. August 2022 Review completed and audit and assurance processes updated	
Where individuals are reluctant to engage with Registered Social Workers specifically, alternative social care practitioners may provide support to the individual under the direction of an appropriately qualified lead worker.	Local	Learning from this DARDR is shared with Senior Management of Operational teams for cascading to frontline practitioners and Leads/supervisors.	GCC ASC		September 2022	ISCM's meeting Also guidance on roles/responsibilities considers where joint work may be undertaken between ASCP/SW	
ASC workers to clearly record the purpose and anticipated content of ongoing welfare telephone calls and/or visits and where for any reason the welfare check is not undertaken, this is immediately escalated to the line manager for discussion and agreement on next steps.	Local	Learning from this DARDR is shared with Senior Management of Operational teams including Enablement Services for cascading to frontline practitioners, Leads/supervisors.	GCC ASC		September 2022	ISCM's meeting	

ASC workers may wish to agree in advance relevant "code words" to be used by the individual to alert the worker to perceived risk/threat and agreed actions that will follow in these circumstances; this will be clearly recorded on the person's record.							
When working with individuals who may be at risk of abuse or neglect, practitioners remain professionally curious ensuring all appropriate methods of communication are utilized.	Local	Learning from this DARDR is shared with Senior Management of Operational teams including Enablement Services for cascading to frontline practitioners, Leads/supervisors. ASC Newsletter promotes good practice guidance using CCInform resources	GCC ASC	Topic of professional curiosity to be emphasised in new UoG Social Work Post Graduate module currently in development between GCC PD Team and UoG	September 2022 First cohort expected September 2022	ISCMs meeting Newsletter item Oct 2022 New PQ modules course commenced Sept 2023; 9 Experienced Social Workers on first cohort	
Multi-agency reviews to be requested by ASC if situation escalates/changes.	Local	Learning from this DARDR is shared with Senior Management of Operational teams including Enablement Services for cascading	GCC ASC	In addition to existing mechanisms for convening multi-agency discussions/meetings, new Multi-Agency	September 2022		

		to frontline practitioners, Leads/supervisors.		Risk Management protocol in development.			
ASC practitioners remain aware of the principles of Making Safeguarding Personal in conjunction with the statutory requirements of s11 Care Act 2014 "Refusal of Assessment" and document where this has been considered	Local	Learning from this DARDR is shared with Senior Management of Operational teams including Enablement Services for cascading to frontline practitioners, Leads/supervisors. Review of Assessment paperwork	GCC ASC		September 2022	June 2022 Assessment paperwork now provides prompts to consider s11 Care Act 2014 requirements.	
For ASC practitioners to clearly document that they have considered the impact of domestic abuse on the person's ability to make decisions with capacity free of coercion or controlling behaviours.	Local	Learning from this DARDR is shared with Senior Management of Operational teams including Enablement Services for cascading to frontline practitioners, Leads/supervisors. Review of MCA planning tool	GCC ASC		September 2022	January 2021 MCA Assessment planning tool now provides prompts to this effect	
Probation Service							

The Gloucestershire Probation Delivery Unit *Quality Improvement Plan* is revised to include learning from this DHR. The Probation Service aim is to deliver excellent services. We are working to improve the quality of work in domestic abuse cases: sentence management; assessments and reports.	Local	The *Quality Improvement Plan* will be reviewed by the Head of Service, Quality Development Officer and Managers to ensure the plan will support staff to be aware, confident, trained and so they deliver good practice regarding: • Assessment for accredited Programmes • Compliance and Enforcement Home Visits	Probation	A revised Quality Improvement Plan and audit activity.	September 2022 and then quarterly to September 2023		
Improve access to information about domestic abuse call outs to inform assessment.	Regional/local	Nationally additional funding has been made available to recruit dedicated staff to obtain information relating to domestic abuse call outs. Locally in Gloucestershire we will support the implementation of the	Probation	Staff, IT, protocols in place and operational	Review progress by April 2023		

		new model (likely to be a regional hub) and ensure local multi-agency working relationships are maintained and developed to support information sharing.					
South Western Ambulance Service NHS Foundation Trust (SWASNHSFT)							
Recognising the care and support needs of those addicted to alcohol and the likely self-neglect as a consequence of this. There were a number of missed opportunities for SWASFT crews to raise safeguarding alerts for self-neglect to Adult Social Care.	*Local*	This has been addressed by inclusion on Development Days for frontline staff. 2019 – Recognition of chronic alcohol abuse and self-neglect. 2020 – Assessment of the intoxicated patient and its effect on capacity. This also prompted national discussions within ambulance services, resulting in new JRCalc guidelines.	SWASNHSFT Safeguarding Team	As per actions		*Complete 2020*	
Cheltenham Borough Homes (CBH)							
For CBH staff in key supportive roles to receive training in relation to mental Capacity, the Mental Capacity Act and how assessments are carried out. In order to increase their understanding and allow them to fully	*Local*	Training to be delivered to colleagues in key roles	CBH/GCC	As per action	Target date December 2021	Complete - Training delivered 8th December 2021 – colleagues have benefited from enhanced knowledge and are	

engage in professional discussion with partner agencies, and also to confidently challenge a decision if the need to do so arises.						using this to benefit current cases	
Gloucestershire Clinical Commissioning Group (GCCG)							
Make efforts to ensure continuity of care with a "usual GP" for patients who are known to be vulnerable.	Local	From a GP/Primary Care point of view, we can recommend that GPs try to ensure continuity of care with one "usual" GP for each vulnerable person and families, however we cannot make this a SMART recommendation as it cannot be contractual, nor audited under the current Primary Care GP contract. Patients should also have the opportunity to see different GPs according to accessibility and convenience.	CCG SG team	Presentation to SG Lead GPs at next GP SG Adult forum	November 2022		
Gloucestershire Health and Care NHS Trust							
Make every contact count - using opportunity for conversations about domestic abuse and	local	Deliver through safeguarding supervision sessions, training sessions and advice line contacts.	GHC Safeguarding Team		Safeguarding group July 2022. Delivery will be ongoing.		

exploring options and choice. Make efforts to seek consent to liaise with and involve family members if considered safe and potentially helpful to do so.		Discuss at GHC July 2022 safeguarding group and circulate Trustwide as a highlight.					
Development of a 'notice, ask, refer' reminder card for staff is being progressed by the Domestic Abuse Lead in the Trust.	local	Develop based on Pathfinder toolkit, promote through GHC safeguarding group and send out as a highlight. Upload on to intranet.	GHC Domestic Abuse Lead	-produce 5 min guide -take to SG group for approval -Upload on intranet and promote across GHC		*17/12/20*	
GHCNHST level 2 manadatory safeguarding training has been based around a family where domestic abuse impacts on each family member from a baby to an older adult with care and suport needs. Includes reference to alcohol misuse and MAPPA.	local		GHC Safeguarding Team/Learning and Development team			Implemented.	