North Northamptonshire Community Safety Parntership

DOMESTIC HOMICIDE REVIEW

Into the circumstances of the
death of Jane aged 62 years
in August 2019

Case DHR 01

Independent Author:

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TESTIMONY TO JANE FROM HER CHILDREN

Jane

Our mum before 2010 was a happy bubbly woman, she had an amazing sense of humour and would easily spark a conversation with anyone.

It was like people gravitated towards her. She was very fussy about her appearance everything had to match, down to the jewellery and of course her makeup!

She loved a trip to the charity shops and ASDA George, she had far too many clothes which she often handed down to me and my sister.

Jane loved cooking for her family, me, my brother and sister particularly enjoyed her famous sausage casserole!

When mum would visit we'd take for hours putting the world to rights and having a laugh these are the times we miss.

She was a creative person, helping the grandkids with school projects or fancy dress, of course they'd always win!

She enjoyed many after work classes, like dancing, reiki, Indian head massage, aerobics, pottery these are just a few she took part in.

She was a hard worker, working as a carer and HCA most her life, she just loved taking care of others.

Everyone in the workplace loved being around mum, she had many friends.

She often hosted games night, nibbles a glass of wine and playing the Nintendo Wii!

We just miss her and the way she was, we miss her smile, her laugh just everything about her that was taken away from us slowly over time.

Jane was a very spiritual person, we hope she's found peace and we hope she knew in her heart we tried.

We have to live with the guilt everyday that maybe we could have done more.

The what if's then maybe she'd still be here.

This is our life now, all we can try to do Is remember the mum we had before 2010 before all our lives as a happy family changed forever.

Regards

Mum's (Jane's) children

List of Abbreviations

AAFDA	Advocacy After Fatal Domestic Abuse
A&E	Accident and Emergency Dept. (Hospital)
ADL	Activities of Daily Living
ARM`	Adult Risk Management System
ASC	Adult Social Care
ASML	Acute Substance Misuse Liaison - nurse
AUDIT	Alcohol Use Disorders Identification
CCG	Clinical Commissioning Group
CCSP	Cory Community Safety Partnership
CCTV	Close Circuit Television
CGL	Change Grow Live
CIWA	Clinical Initial Withdrawal Assessment
CPR	Cardiac Pulmonary Resuscitation
CSC	Customer Service Centre Northamptonshire County Council
DASH	Domestic Abuse, Stalking, Harassment
DHR	Domestic Homicide Review
EMAS	East Midlands Ambulance Service
FLO	Family Liaison Officer (Police)
GRACE	GP Risk Assessment Control and Escalation Assessment Tool
GP	General Practitioner
HIDVA	Hospital Independent Domestic Violence Advisor
ISA	Investment Savings Account
KGH	Kettering General Hospital
IMR	Individual Management Report
MADRA	Multi Agency Daily Risk Assessment
MARAC	Multi Agency Risk Assessment Conference
NCC	Northamptonshire County Council
NDAS	Northamptonshire Domestic Abuse Service
NGH	Northamptonshire General Hospital
NHS	National Health Service
NNCSP	North Northamptonshire Community Safety Partnership
PPN	Public Protection Notice
SARA	Scan – Analyse – Respond - Assess - Problem solving model
SIO	Senior Investigating Officer (Police)
SPOC	Single Point of Contact
SOVA	Safeguarding of Vulnerable Adults

S2S Substance to Solutions

NORTH NORTHAMPTONSHIRE COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Into the circumstances of the death of

'Jane' aged 62 years in August 2019

The Domestic Homicide Review Panel express their sincere condolences to the family of Jane who died in August 2019.

The family have chosen the pseudonym Jane for the victim.

Her Partner will be known as "Partner".

1 Introduction

1.1.1 This Domestic Homicide Review concerns the death of a 62 year old woman, Jane, who died of natural causes in hospital in August 2019. However, subsequent to her death information was obtained indicating that she had been subjected to coercive and controlling behaviour by her partner for several years and it was suspected by her family members that her Partner's behaviour contributed to her illnesses that eventually caused her death. Jane was a white British citizen. Her Partner is also a white British citizen.

1.1.2 Following Jane's death, Northamptonshire Police opened an investigation and in later 2020, interviewed her Partner who stated that he had acted towards Jane in the manner he had in her own best interests.

1.1.3 The police investigation was restricted by the guidance to the Serious Crimes Act of 2015, ('the 2015 Act) which deals with coercive and controlling behaviour, as the law does not allow evidence of such behaviour prior to the implementation of the act, (2015), to be considered when determining the threshold for prosecution. Much of the evidence of such behaviour by her Partner towards Jane was before 2015.

1.1.4 At the end of 2020, Northamptonshire Police determined that there was insufficient evidence to prosecute her Partner for any offence in connection with Jane's death and no further action was taken against him. None the less, the evidence obtained does fit the criteria within the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews[1] (DHR) (the statutory Guidance)and accordingly a DHR was commissioned.

[1] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2016

1.2 Process of the Review - Methodology

1.2.1 In late 2019, the circumstances of the death of Jane was initially considered by the Northamptonshire Safeguarding Adult's Board regarding the possibility of a Safeguarding Adult's Review. However, when information was obtained from a number of agencies about the alleged coercive and controlling behaviour of her partner, the case was referred to the then Corby Community Safety Partnership, now re-named, North Northamptonshire Community Safety Partnership (NNCSP).

1.2.2 The Home Office was notified of the intention to conduct a DHR on 11th June 2020, an Independent Chair and Author was commissioned and appointed and a DHR Panel was appointed. At the first review panel meeting on 23rd July 2020, terms of reference were drafted. On ******, the NNCSP approved the final version of the Overview Report and its recommendations.

1.2.3 Statutory Guidance[2] recommends that reviews should be completed within 6 months of the date of the decision to proceed with the review. The Home Office has been notified of the reasons for any delays in the process. The delay was as a result of the police investigation and the decision making regarding her Partner's involvement with the death of Jane.

1.3 Purpose of the Review

1.3.1 The Domestic Violence, Crimes and Victims Act 2004, establishes at Section 9(3), a statutory basis for a Domestic Homicide Review, which was implemented with accompanying statutory guidance[3] on 13th April 2011 and reviewed in December 2016[4]. Under this section, a domestic homicide review means a review "*of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—*

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

1.3.2 Where the definition set out in this paragraph has been met, then a DHR must be undertaken.

1.3.3 It should be noted that an intimate personal relationship includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

1.3.4 In March 2013, the Government introduced a new cross-government definition of domestic violence and abuse[5], which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that domestic violence and abuse is:

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[2] Home Office Guidance 2016 pages 16 and 35
[3] Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*
[4] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2016
[5] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office now revised again by 2016 guidance.

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

Controlling behaviour is: a range of acts designed to make a person dinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their Victim."

In December 2015, a new domestic abuse offence to tackle coercive and controlling behaviour was commenced in legislation, the Serious Crimes Act 2015, Section 76."

1.3.5 In December 2016, the Government again issued updated guidance on Domestic Homicide Reviews especially with regard to deaths resulting from suicide. The guidance[6] states:

'Where a Victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted.'

1.3.6 The circumstances of Jane's death met the criteria for a DHR as set out in the Statutory Guidance in that the deceased had complained on numerous occasions to various agencies that her relationship with her partner that was coercive and controlling.

1.3.7 Domestic Homicide Reviews are not inquiries into how a Victim died or who is to blame. These are matters for Coroners and Criminal Courts. Neither are they part of any disciplinary process. The purpose of a review is to:

- Establish what lessons are to be learned from the homicide regarding the way in which local professionals and organisations work individually and together to safeguard Victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to the policies and procedures as appropriate; and

[6] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office revised again by 2016 guidance paragraph 18 page 8

- Prevent domestic homicide and improve service responses for all Victims and their children through improved intra and inter-agency working.

- Contribute to a better understanding of the nature of domestic violence and abuse : and

- Highlight good practice

1.4 Timescales

1.4.1 The period of this review will be from 31st May 2010, the date that her Partner's neighbour reported an assault allegation to the police until the date of Jane's death in August 2019.

1.5 Scope of the Review

1.5.1 Following the death of Jane, the Safeguarding Adults Board received a referral from Jane's GP. More information was obtained about possible domestic abuse. The circumstances were then reviewed by the Community Safety Partnership of Corby Borough Council (now Northamptonshire Community Safety Partnership) on 8th January 2020, and it was decided that the case met the criteria of controlling and coercive behaviour under the definition determined for a DHR, as per the Statutory Guidance. The Home Office were informed of the intention to commence a DHR on 11th June 2020**.** The Home Office have been kept informed of the progress of this review and on 17th November 2020, the Home Office were informed of the decision taken by Northamptonshire Police not to take the investigation further.

1.6 Confidentiality

1.6.1 Information regarding this review is confidential and all panel members and Individual Management Reviews (IMR) authors have agreed to adhere to that principle.

1.7 Involvement of family, friends and her Partner

1.7.1 Jane's family were written to at a very early stage of this review process and have been engaged throughout. They have been provided with the relevant Home Office Leaflet as well as an information leaflet from the charity AAFDA (Advocacy After Fatal Domestic Abuse). To date, the family have not yet engaged with AAFDA or another support services. The Terms of reference were shared with the family members.

1.7.2 Statutory Guidance[7] requires that

> 'Consideration should be given at an early stage to working with Family Liaison Officers and Senior Investigation Officers involved in any related Police Investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide.'

1.7.3 The Home Office Guidance[8] illustrates the benefits of involving family members, friends and other support network as:

[7] Home Office Guidance 2016 page 18
[8] Home Office Guidance 2016 Pages 17 - 18

a) assisting the family with the healing process which links in with Ministry of Justice objectives of supporting Victims of crime to cope and recover for as long as they need after the homicide;

b) giving family members the opportunity to meet the review panel if they wish and be given the opportunity to influence the scope, content and impact of the review. Their contributions, whenever given in the review journey, must be afforded the same status as other contributions. Participation by the family also humanises the deceased helping the process to focus on Victims and Perpetrator's perspectives rather than just agency views.

c) helping families satisfy the often expressed need to contribute to the prevention of other domestic homicides.

d) enabling families to inform the review constructively, by allowing the review panel to get a more complete view of the lives of Jane and/or Perpetrator in order to see the homicide through the eyes of Jane and/or Perpetrator. This approach can help the panel understand the decisions and choices of Jane and/or Perpetrator made.

e) obtaining relevant information held by family members, friends and colleagues which is not recorded in official records. Although witness statements and evidence given in court can be useful sources of information for the review, separate and substantive interaction with families and friends may reveal different information to that set out in official documents. Families should be able to provide factual information as well as testimony to the emotional effect of the homicide. The review panel should also be aware of the risk of ascribing a 'hierarchy of testimony' regarding the weight they give to statutory sector, voluntary sector and family and friends contributions.

f) revealing different perspectives of the case, enabling agencies to improve service design and processes.

g) enabling families to choose, if they wish, a suitable pseudonym for Jane to be used in the report. Choosing a name rather than the common practice of using initials, letters and numbers, nouns or symbols, humanises the review and allows the reader to more easily follow the narrative. It would be helpful if reports could outline where families have declined the use of a pseudonym.

1.7.4 The Overview Author made contact with one of Jane's two daughters and explained the DHR process. It was also explained that seeing family members while the Police investigation was ongoing would not be possible. The daughter stated that she, her sister and her brother wished to engage with the review process and she understood about the delay. Arrangements were made to meet the family through a virtual process at a later date once the Police investigation had concluded.

1.7.5 On 4th December 2020, members of the family met with the report author and the Safer Corby Manager via zoom meeting facilities. The family attended a later panel meeting on 29th July 2021.

1.7.6 Family members have been afforded the opportunity to have sight of the draft report, being provided with a copy for them to examine in private and have been invited to make comment accordingly.

1.8 Contributors to the Review - Individual Management Reports

1.8.1 Thirteen agencies were contacted and requested to examine their records. An Individual Management Report and comprehensive chronology was requested from the following organisations:

- Northamptonshire Clinical Commissioning Group to include GPs
- Kettering General Hospital NHS Foundation Trust
- Kettering General Hospital NHS Foundation Trust (Employment Services)
- Northamptonshire Police
- Northamptonshire Sunflower Centre
- East Midlands Ambulance Service
- S2S (Substance to Solutions)
- Northamptonshire County Council
- Corby Borough Council
- Northampton Adult Social Services
- Northampton Domestic Abuse Service

1.8.2 Reports of information provided by:

- Northampton Health Foundation Trust
- Adult Social Care

1.8.3 The Statutory Guidance[9] was provided to IMR Authors through a Report Author's briefing. Statutory Guidance determines that the aim of an IMR:

- Allow agencies to look openly and critically at individual and organisational practice and the context within which professionals were working (culture, leadership, supervision, training, etc.) to see whether the homicide indicates that practice needs to be changed or improved to support professionals to carry out their work to the highest standard
- To identify how those changes will be brought about.
- To identify examples of good practice within agencies.

1.8.4 IMR Authors were encouraged to make recommendations within their IMR's and these were accepted and adopted by the agencies that commissioned the reports. The recommendations were supported by the Overview's Author and the Panel.

1.8.5 The IMR reports were of a high standard providing a full and comprehensive review of the agencies involvement and the lessons learned. The IMR authors confirmed their independence and impartiality.

1.9 Review Panel[10]

1.9.1 In accordance with the statutory guidance, a Panel was established to oversee the process of the review. Mr Ross chaired the Panel and also attended as the author of the Overview Report. Other members of the panel's professional responsibilities were:

- Representative from Corby Borough Council Housing
- Representative from Kettering General Hospital
- Representative from Northampton General Hospital

[9] Home Office Guidance 2016 Page 20
[10] Names and responsibilities of the Panel members have been omitted from the Overview Report and the Executive Summary for the reasons set out in the letter to the Home Office that accompanied these reports.

- Representative from Northamptonshire Healthcare Foundation Trust
- Detective Chief Inspector Northamptonshire Police
- Representative from Office of Police and Fire Crime Commissioner
- Representative from Northamptonshire Domestic Abuse Service
- Representative from East Midlands Ambulance Service
- Representative from NHS Northamptonshire Clinical Commissioning Group
- Representative from Northamptonshire Adult Social Services
- Representative from Corby Borough Council

1.9.2 All but one panel member confirmed they had no direct involvement in the case, nor had line management responsibility for any of those involved. The Detective Chief Inspector of Northamptonshire Police who was a panel members had involvement at the beginning of the police investigation. The Panel was supported by the DHR Administration Officer. The business of the Panel was conducted in an open and thorough manner. The meetings lacked defensiveness and sought to identify lessons and recommended appropriate actions to ensure that better outcomes for vulnerable people in these circumstances are more likely to occur as a result of this review having been undertaken. The DHR panel met on the following occasions:

23rd July 2020 (held virtually due to Covid-19), 9th September 2020 (held virtually – IMR authors presentations) 10th September 2020 (virtually – IMR authors presentations), 25th February 2021, (virtual) 24th March 2021 (virtual), 29th July 2021 with family member,

1.10 Independent Chair and Author

1.10.1 Statutory Guidance[11] requires that;

> *"The Review Panel should appoint an independent Chair of the Panel who is responsible for managing and coordinating the review process and for producing the final Overview Report based on IMRS and any other evidence the Review Panel decides is relevant", and "…The Review Panel Chair should, where possible, be an experienced individual who is not directly associated with any of the agencies involved in the review."*

1.10.2 Mr Ross was appointed at an early stage. He is a former Senior Detective Officer with West Midlands Police and was a Senior Investigating Officer on many murder investigations often involving domestic abuse/homicides. Since retiring in 1999, he has 23 years' experience in writing over 80 Serious Case and Child Practice Reviews and chairing those processes. Since 2011 he has performed both functions in relation to over 60 Domestic Homicide Reviews. Prior to this review process he was not involved either directly or indirectly with the members of the family concerned or the delivery or management of services by any of the agencies. He has attended the meetings of the panel, the members of which have contributed to the process of the preparation of the Report and have helpfully commented upon it.

1.11 Parallel proceedings

1.11.1 Northampton Police conducted an investigation into the relationship Jane had with her partner. Information was obtained that suggested that her Partner was a coercive and controlling man throughout almost the entirety of their relationship. An in depth investigation was conducted and whilst it was accepted by the police that there was

[11] Home Office Guidance 2016 page 12

coercive and controlling behaviour on the part of her Partner, the threshold for prosecution was not reached. In November 2020, it was decided by Northamptonshire Police that no further action would be taken against her Partner. Her Partner and Jane's family were duly notified of the decision.

1.11.2 The Office of H.M. Coroner for Northamptonshire was informed of Jane's death which was recorded as a natural death.

1.12 Equality and Diversity

1.12.1 Statutory Guidance[12] requires consideration of individual needs and specifically:

> 'Address the nine protected characteristics under the Equality Act 2010 if relevant to the review. Include examining barriers to accessing services in addition to wider consideration as to whether service delivery was impacted'

1.12.2 Section 149 of the Equality Act 2010 introduced a public sector duty which is incumbent upon all organisations participating in this review, namely to:

- eliminate discrimination, harassment, Victimisation and any other conduct that is prohibited by or under this Act;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

1.12.3 The review gave due consideration to all of the Protected Characteristics under the Equality Act 2010.

1.12.4 The Protected Characteristics are: age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation

1.12.5 There was nothing to indicate that there was any discrimination in this case that was contrary to the Equality Act 2010.

1.13 Terms of Reference

1.13.1 The Terms of Reference for this review can be found at Appendix No. 1 to this report.

1.14 Dissemination

1.14.1 A copy of the report has been supplied to Jane's adult children. In addition panel members have access to copies of the report as well as NNCSP Board members.

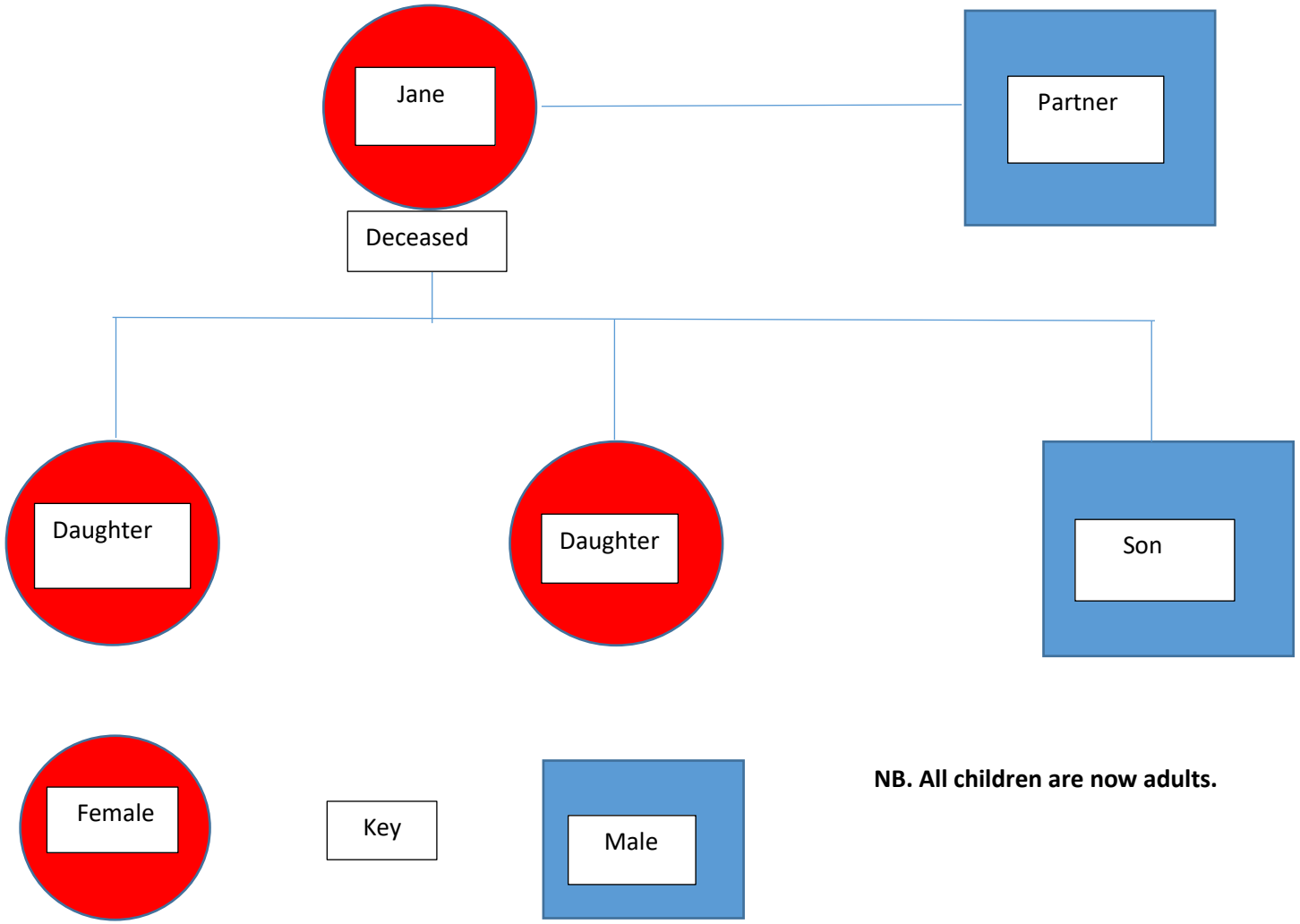
1.15 Subjects of the Review

1.15.1 The following genogram identifies the individuals in this case, as represented by the following key:

Victim	**Jane**
Perpetrator	**Partner**

[12] Home Office Guidance 2016 page 36

GENOGRAM



NB. All children are now adults.

2. Summary

2.1 This DHR concerns the death of 'Jane' a 62 year old woman in August 2019 who died in hospital of natural causes. She had for many years lived with her male partner in his house in Northamptonshire. She worked as a Health Care Assistant at a local hospital and for over 20 years and had the same manager for the majority of that time and who got to know Jane extremely well.

2.2 GP records indicate that Jane had significant contact with her GP. Jane had mentioned to her GP and to her manager over a period of time that her partner's behaviour towards her was controlling. She mentioned he would control what she ate, controlled her finances, and controlled who she saw and where she went. It appears that his control was such that he separated her from her three adult children and her grandchildren although on occasions she sought respite by going to stay with her daughter in Oxfordshire.

2.3 Following her death, considerable debate took place between the Safeguarding Adults Sub Group and the Community Safety Partnership as to whether this review should be a Safeguarding Adults Review (SAR) or a DHR. More information was requested from agencies which highlighted previous incidents of domestic abuse and in May 2020, the CSP agreed to undertake a DHR. A full explanation of this process is outline at para. 3.119 of this report.

2.4 Whilst consideration was being given to a Safeguarding Adult Review, information was sought from various agencies and that information revealed a long history of Jane complaining about her Partner's controlling and coercive behaviour towards her. It was subsequently decided in January 2020 that the circumstances warranted a review under the Domestic Homicide Review Process.

2.5 Northamptonshire Police conducted an investigation into the allegations of coercive and controlling behaviour by her Partner but there was insufficient evidence to meet the threshold for prosecution. No one has been charged with any offences relating to Jane's death.

3. Chronology

3.1 The sequence of events in relation to the death of Jane started in May 2010, when her Partner was interviewed by the Police in relation to his allegedly dangerous driving in a cul-de-sac where children were cycling. It appears that a neighbour grabbed her Partner around the head and assaulted him. The neighbour denied the assault and made a counter claim against her Partner which resulted in no further action being taken by the Police. The neighbour was to become an important feature in the domestic situation between Jane and her Partner.

3.2 The neighbourly disputes between her Partner and the neighbour continued for many years with constant allegations made by her Partner that the neighbour was responsible for scratching Jane's car. Police were called on numerous occasions by her Partner regarding alleged damage to Jane's car but often there was no evidence of damage whatsoever. Her Partner was often aggressive towards officers and he would threaten to make a complaint about the lack of action by officers about the alleged damage. These constant complaints had two affects. Firstly, it had a detrimental effect on Jane's health and secondly it gave her Partner justification in his mind for installing CCTV around his house and also within Jane's car. On one occasion her Partner is reported to have aggressively complained to the security at the local hospital where Jane parked her car. He demanded that the security pay attention to her car to prevent it from being scratched. The installation of his CCTV system eventually extended to him installing a camera within Jane's bedroom.

3.3 In June 2010, a Borough Council Community Safety Warden was tasked by the police to visit her Partner at his home address regarding reports of crime being committed in the local area. Her Partner complained of children damaging grass and the relatives of the children had been intimidating him. He said he had been assaulted on two occasions by unknown people. Damage had also been caused to Jane's new car. The police were looking into the assault allegations. The Partner was offered the free installation of CCTV by the Council, but he declined saying he had his own system.

3.4 In July 2010, details of her Partner's complaints were sent to the police and a Police Sergeant visited and requested that Corby Borough Council send diary sheets which were delivered by hand by a Warden. A few days later a meeting took place with the police and the Warden to discuss the incidents her Partner was complaining of using the SARA model of problem solving, (SCAN – ANALYSE – RESPOND – ASSESS). The outcome of the meeting was that it was decided that any visits to her Partner should be done in pairs, Wardens were to visit at least once per week and give her Partner email notice of the arrangements and formal offers of mediation to be made to her Partner. (Visitors were informed by the Wardens that her Partner records visits on audio equipment). Follow up visits by the Warden in August showed that all was quiet around the area and the problems seemed to have been resolved.

3.5 On the 21st October 2010, both the Police and East Midlands Ambulance Service (EMAS) were called to Jane's address following a report of a domestic incident between Jane and her Partner. John told the police that the situation between them had flared up as a result of perceived constant aggravation with the neighbour. Jane decided not to receive any medical attention. There is limited information available from the police but records indicate that no further action was taken by the Police and no one was injured.

3.6 Jane worked at a local hospital and on 14th December 2010, her manager conducted a Welfare Review as Jane had been off work. According to the manager, Jane disclosed there was abuse at home from her violent partner and the reason she was off work was because she had bruising to her face. The Manager had said she would make an email referral to Occupational Health but there is no record of either the email or if Jane attended Occupational Health.

3.7 Police were again called to the house on the 10th April 2011, where it is reported that a verbal argument had developed between Jane and her Partner, which according to police records, stemmed from alleged criminal damage to her car by the neighbour. It is recorded that by her own admission, Jane had been drinking that day and it was recognised that Jane had a dependency on alcohol. On this occasion she stated that she was not fearful of any threat of violence from her Partner. She declined to engage with the Police in the completion of a DASH form[13]. Her Partner however, is understood to have been sober and perplexed as to why Jane had called the police in the first instance.

3.8 Eight days later the neighbour called the Police complaining that her Partner was hiding in bushes watching him. On the 26th May 2011, her Partner again called the Police complaining about the neighbour's behaviour and told the officer that he was going to complain to the Independent Police Complaints Commission as he thought the Police were not taking his complaints seriously. Police Officers did not record the incident as a crime. They were of the opinion that her Partner had become obsessed about the criminal damage to Jane's car.

3.9 The dispute with the neighbour escalated in July 2011, where both made allegations of harassment against each other. Both were interviewed and denied any offences.

[13] DASH – Domestic Abuse Stalking Harassment Risk assessment process.

The Crown Prosecution Service reviewed the case and said there were no case to answer by either the partner or neighbour. This incident had involved Jane in supporting her Partner's version of events around the damage to her vehicle. Officers attending formed the opinion that she felt some compulsion to do so because of his dominance to involve her and report harassment from the neighbour. Her Partner produced CCTV of the incident.

3.10 In August 2011, Jane attended the police station alone and made a written statement about the harassment incident. Later, when the CCTV footage was examined it showed that Jane's account of events did not accord with the CCTV recording. She was called back to the Police station but walked out when presented with the footage. However, whilst talking to an officer alone, for the first time she reported that she was unhappy in her relationship as her Partner was overpowering, controlling and influencing her. She stressed there was no physical violence, but her partner constantly overpowered her, and she was of the opinion that her Partner used the dispute with the neighbour as a way of controlling her. The officer spoke to her about her alcohol issues and referred her to the Sunflower Centre[14]. She disclosed that she was already in contact with them.

3.11 On the 5th October 2011, the Police intelligence report indicated that Jane had been seen in her car overnight (which was on her drive) with bedding indicating that she was probably sleeping in her car rather than in her house.

3.12 Five days later on the 10th October 2011, Police and EMAS were called to Jane's address following her reporting that she had been assaulted by her Partner causing an injury to her fingers during an argument when she tried to leave. Her Partner said that she was attempting to drive her car whilst under the influence of alcohol and he had grabbed the keys from her, cutting her finger in the process. She was taken to A&E at KGH where she stated that she had been assaulted by her partner the previous day. No particular medical treatment was required at hospital. Jane did not pursue the complaint. She made a statement saying that the injury was accidental. Her Partner was also interviewed, and he confirmed her version of events. A Safeguarding Adult referral was made by the EMAS to Northamptonshire County Council but it was decided that it did not meet the criteria to consider Jane as a vulnerable adult. The Police were involved and Jane appeared to have taken practical steps to minimise the reoccurrence of further incidents. Two days later, on 12th October 2011, Jane reported to the Sunflower Centre that after a recent incident with her partner, she had fled to her daughter's house in Oxfordshire.

3.13 On the 22nd February 2012, Police received a report from the facilities manager at a local hospital, which confirmed the occasion when her Partner had complained to the Security at the hospital about the damage being caused to Jane's car. Although her Partner had remained calm during this conversation, there were veiled threats that if nothing was done about the damage being caused to Jane's car, he would arrange for a group to attend and take the law into their own hands. He made a reference to Raul Moat, a person convicted of shooting dead one person and wounding two others in Cumbria. This behaviour demonstrated that her Partner wanted to know the business of Jane without her authority and also that he was willing to exert some authority over the security staff at the hospital where Jane worked. It also indicated that Jane had returned to live with her Partner after she had left him in October 2011.

3.14 Police were again called to Jane's house on the 21st April 2012, to a domestic argument between Jane and her Partner over a microwave oven. They found Jane had locked her Partner outside the house and as a result of what they were told by the Partner,

[14] Northamptonshire Sunflower Centre supports High Risk victims of domestic abuse through risk assessment and safety planning.

the Police suspected that Jane would be inside the house self-harming. They forced entry when they heard chocking sounds from inside the house and found her safe albeit she appeared to have been drinking alcohol. There were no visible injuries, but she became obstructive and argumentative and refusing to accept help from the officers. She was arrested to prevent a breach of the peace. A DASH form was completed for her Partner, which scored a low risk.

3.15 On 12th June 2012, acting on information police executed a section 46 Firearms Warrant at her Partner's house looking for gas canisters. It became apparent to officers that her Partner was controlling Jane's lifestyle. She stated that her Partner no longer allows her to drive her car on the pretence that the vehicle was constantly being scratched. She had no keys to the address, she wasn't allowed to use the landline to call her family and she had no access to her own money which she alleges was tied up in an ISA (Investment Savings Account). She stated she was not allowed to know the passwords to her own financial accounts. Jane complained of being constantly belittled by her Partner.

3.16 Her Partner had apparently arranged for a counselling session at the GP for her as he believed that she had a problem. She disclosed that she was secretly drinking alcohol to cope with her partner's behaviour and that she hid the alcohol around the house. She described how she used to attend social events, Tai Chi and dancing classes but he had stopped her doing these. Police made a referral to the Domestic Violence Unit.

3.17 On the 16th June 2012, plain clothes officers met Jane who said that she was feeling better and she was attending counselling sessions at her GP's surgery, however, she was aware that her self-esteem was being affected. She mentioned to the officers that things had been slightly better for the last week but the previous day for no reason her partner had called her something that she described as 'horrible'. She also mentioned that her children do not visit her as this would cause her problems with her partner. Another DASH form was completed which was graded as a medium risk. Information was left with her regarding Women's Aid support[15].

3.18 On the 13th August 2012, following two anonymous calls, Police officers attended to a road near her Partner's home address. On arrival they found Jane in her car, in tears arguing with her partner. Members of the public had called the Police. Jane wouldn't tell the officers what was happening but indicated that this was common practise when she separated from her Partner. A risk assessment form was completed but neither Jane nor her Partner would answer questions for the DASH form.

3.19 On the 14th August 2012, her Partner reported to the Police that he had been threatened by Jane. She had apparently left the house being in possession of a knife. She was quickly traced but she did not have a knife or any injuries. Officers persuaded her Partner to leave the address for a day to allow things to settle down. This gave the officer an opportunity to speak to Jane on her own during which she said that she did not have house keys, or car keys, and wasn't allowed to freely go about her house or use things such as the computer. After speaking to Jane's daughter who indicated her worries for her mother's safety, the officer advised Jane to collect her belongings and move out on a temporary basis as soon as possible. She was also advised to seek help from the Sunflower Centre and Women's Aid. Another risk assessment form was submitted.

3.20 On the same day there is another Police report of an argument between Jane and her Partner and her Partner had called for an ambulance as he had reported Jane having a knife and was self-harming. Police officers found Jane in nearby fields but there was

[15] Women's Aid is one of a group of charities that provide support to victims of domestic abuse across the United Kingdom. Its aim is to end domestic violence against women and children.

no sign of a knife. It was clear that Jane was scared of her partner who she reported to be controlling and possessive. The Police Domestic Abuse unit spoke to Jane who did not mention if there was any violence in the relationship.

3.21 In September 2012, a Medical Ward Manager at the hospital where Jane worked made a referral to Occupational Health as Jane had been off work on sick leave with stress and anxiety. Jane's partner had been prosecuted in court for behaviour connected to neighbourly disputes. Jane had disclosed that her Partner was constantly watching her and had installed CCTV in the house and in her car. She was receiving counselling. She was due to return to work on 15th November 2012 but Jane's mother was taken ill. She returned to work in January 2013.

3.22 On the 16th December 2012, Police again responded to another domestic incident between her Partner and Jane. They found her Partner outside the house and Jane in a bedroom, the door of which had been removed by her Partner. When questioned about that he said it was his house and he had caused no damage. He said that Jane had swung a Christmas tree at him. There was no injury and no offences disclosed. Her Partner refused to complete a DASH form but Jane cooperated in the completion of one. She mentioned her Partner bullying her, mental abuse, controlling and manipulative behaviour towards her. She also mentioned that sometime during the previous year, he had tried to strangle her. The DASH form was assessed by medium risk.

3.23 Within eight hours of this incident, her Partner told Jane to leave the house but she refused so her Partner called the Police again. Officers attended and ascertained that this was a verbal disagreement and there was no evidence of violence or any threats. Another DASH form was completed but both Jane and her Partner refused to participate.

3.24 On the 20th December 2012, Police records show that her Partner stated that Jane was acting in a suicidal way at times due to the stress of the neighbour's dispute. The officer began to give her Partner advice regarding support but he cut the officer off by saying that he was giving her all the support and help she needed. He then made two comments that the Police officer considered strange, the first was regarding recent shootings at a school in the USA and how many people acted in this way, and the second he mentioned an SAS officer who had been sent to prison for having a gun. He then made a further comment complaining of Police action, alleging that the Police were corrupt and stated he would sort the situation out and wouldn't stop until he died.

3.25 The officer made a referral to the Professional Standards Department for Northamptonshire Police. Within eight hours of this incident, her Partner told Jane to leave the house but she refused so her Partner called the Police again. Officers attended and ascertained that this was a verbal disagreement and there was no evidence of violence or any threats. Another DASH form was completed but both Jane and her Partner refused to participate.

3.26 On 28th January 2013, Jane saw the Occupational Health Advisor at work. She stated that the problems at home were continuing and she felt that she could not leave her partner, although he controlled all aspects of her life. She had no access to money or the computer. The police and ambulance had been recently following calls for assistance. She was given details of the Sunflower Centre, but said that her partner controls her phone. It was suggested that she used the phone at work if she needed to.

3.27 In February 2013, Jane again saw the Occupational Health at work. Her mother had died the previous week. She had not contacted the Sunflower Centre but she had decided that if her Partner should become aggressive, she was going to shut herself

in her bedroom. She did acknowledge that her Partner was unlikely to change. She was advised to keep in contact with the Occupational Health Unit.

3.28 On the 15th August 2013, another domestic incident was recorded by the Police. This concerned a verbal argument between Jane and her Partner around the use of the telephone and computer. Officers attended and found her Partner waiting outside. The attending officer, who had been to numerous domestic incidents at this address before, commented that this was the usual pattern of behaviour by her Partner and considered that this was her Partner's way of getting the 'first word in' before Jane was seen. Jane was spoken to separately from her Partner. She described again her Partner's controlling behaviour in relation to everything she did including not allowing her to use the phone. She said she felt trapped with nowhere else to go. Her Partner was spoken to and agreed that she could stay at the house so long as she stayed in another bedroom away from him, which was another example of his controlling behaviour. Both Jane and her Partner refused to assist with a DASH risk assessment form.

3.29 On the 21st August 2013, ambulance and Police were called to a domestic dispute. They found Jane emotionally upset. She declined any treatment or being conveyed to hospital. The argument had been about the use of telephones and computers. No offences were disclosed but Jane did say that her partner controls everything she does. He was happy for her to stay in the house providing she kept herself in another bedroom away from him. She said she had nowhere else to go. Officers submitted a report to the Domestic Abuse Unit and to request contact by an IDVA, (Independent Domestic Violence Advisor) from the Sunflower Centre.

3.30 Officers attended again on the 4th October 2013, regarding an argument over Jane's dependency over alcohol. She had been throwing things on the floor but caused no damage. No offences were disclosed. Her Partner was treated as a victim on this occasion but it appears that Jane had been woken by the attendance of the Police checking on her welfare. She was confused as to why Police were there when there were no issues. A risk assessment form was completed where her Partner claimed that Jane was abusive and manipulative towards him. He stated he had tried on several occasions to end their relationship, but she wouldn't accept it. He refused to complete a DASH form.

3.31 On 14th December 2013, officers responded to a domestic argument where her Partner was alleging that Jane had mental health problems. She was moved to her daughter's address in Oxfordshire. No offences were disclosed, and her Partner refused to complete a DASH form.

3.32 Sometime over Christmas 2013, Jane returned to live with her Partner. An argument occurred on the 29th December. The Police attended and her Partner described an argument over the use of television and Facebook. He had asked Jane to leave the house but she had refused. Officers asked her to leave which she did on the understanding that she would not return. However, there is little information recorded to say where she went or how she travelled. Her Partner refused to answer questions for a DASH form. On the same day, EMAS records indicate that they received a 999 call saying that Jane was struggling with her mental health and she was in dispute with her partner. She refused to have her medical observations taken. She refused to go to hospital and indicated that her GP was aware of the situation.

3.33 In response to another call regarding a domestic incident on 13th January 2014 made by her Partner, officers found there had been an argument about a doctors' appointment for Jane. Her Partner was given advice by the Police. A safety plan for Jane was created and it was agreed that she could contact friends in the local area if needed. Legal advice was given in respect of restraining orders. The following day the Northamptonshire County Council's Safeguarding Adult team received a referral from

NHS Complaints Advocacy Service to the effect that her Partner was making a complaint about Jane's GP as the GP had advised him to 'lock her out of the house and get rid of her', which her Partner did and was now alleging that Jane suffered hypothermia as a result. The referral was sent to the Northamptonshire County Council's Safeguarding Team and it conducted an initial assessment which did not suggest physical abuse but that the letter from her Partner was a cry for help.

3.34 On 9th March 2014, Police were again called to a domestic incident and found Jane intoxicated. Little information is recorded but records show the completion of a DASH form was declined by both Jane and her Partner.

3.35 As Jane was intoxicated at the time she was removed for her own welfare and to prevent a breach of the peace but her detention at the Police station was refused by the custody Sergeant. She was released and agreed to leave her car keys at the Police station for her to collect when she was sober. It was thought she may have attempted to drive whilst over the legal limit to do so. A DASH risk assessment was completed which scored high and a referral was made for a MARAC.[16]

3.36 Having been released from the Police station Jane returned to the house around 8am the following morning. Her Partner again called the Police. Officers attended and asked her again to leave the premises which she did. However, a short time later she again returned and the argument continued. Officers were called yet again and she was arrested for a breach of the peace.

3.37 Another domestic incident occurred on 21st April 2014, when her Partner called the Police saying Jane was violent, abusive and drunk. Her Partner met the police on the doorstep. Officers spoke to Jane on her own about how she was in a controlling relationship. She alleged that during the argument her Partner had shut her arm in a door causing reddening but no significant injury. She was removed for her own welfare and prevention of a breach of the peace. She reiterated the controlling element of their relationship as she had done before in terms of money, internet banking passwords, him removing light bulbs from her room, the installation of CCTV around the house, recording all of her conversations with a Dictaphone, following her to work and waiting outside her work, removing batteries from her mobile phone preventing her from using it, hiding the house phone for the same reason, and isolating her from her friends and family.

3.38 Her Partner was questioned about recording the conversations but was unable to playback the recent alleged outburst by Jane. Jane was also uncooperative and refused an offer to remove her to her family. Northamptonshire Count Council's Adult Social Care, (Adult Social Care) were contacted to assist with alternative housing but stated it was not within their remit to help. Officers tracked down a friend of Jane's but she refused to go there. The police contacted the Council Out of Hours Housing who considered this to be a housing issue and signposted Jane to the relevant agency.

3.39 Whilst in police custody after being detained to prevent a breach of the peace, Jane was referred to Change Grow Live[17] (CGL) and assessed. She disclosed that she was in an abusive relationship but was unable to leave due to financial constraints. She said that although her Partner did not drink alcohol, he was physically, verbally and emotionally abusive towards her. She felt at risk whilst in the relationship and she used alcohol as a coping mechanism. During the assessment an AUDIT[18] test was conducted, in order to pick up early signs of increasing risk and harmful drinking. The

[16] MARAC – Mulit-Agency Risk Assessment Conference.
[17] Change, Grow, Live offer a free and confidential service to help people with challenges including drugs or alcohol, trouble with housing, domestic abuse, or your mental and physical wellbeing.
[18] AUDIT test – Alcohol Use Disorder Identification test

score, 13, was an indication that Jane's use of alcohol was of increasing risk to her health. The recommended outcome was for Jane to be referred to CGL for a brief intervention with a Criminal Justice Worker. There is nothing to indicate that she was referred to any domestic violence support agencies.

3.40 Jane attended an appointment with a Criminal Justice Worker three days later. She advised that she was not a habitual drinker but drank now and again. She explained that she was having issues with her partner and with work but neither of those issues were explored further. A brief intervention was completed as far as the assessment pathway was concerned and Jane was discharged from CGL.

3.41 Two weeks later, another domestic argument during the morning of 3rd May 2014 occurred. Jane had returned home from shopping and had gone into the loft of the house to get a garden chair. An argument had ensued with her Partner becoming annoyed and alleging that she had previously damaged a bedroom door whilst doing the same thing. He asked her to leave the house, she refused, and he called the Police. By the time the Police arrived both Jane and her Partner had calmed down and each were spoken to separately. Her Partner expressed his concern about Jane's drinking and he admitted installing CCTV in her bedroom in order to catch her hiding alcohol. The officers challenged him on this matter, and he admitted that he was wrong to do so and became defensive when inconsistencies in his account were questioned. He had stated that Jane was drunk but officers assessed her as being completely coherent and not smelling of alcohol. She was, however, very upset and stated she planned to leave within weeks to move to her daughter's. After some negotiation with the officers, she left the house of her own accord albeit she was reluctant to do so.

3.42 On the 16th June 2014, another argument occurred over Jane's excessive drinking. She had left the house before the arrival of the Police, no offences were disclosed and a DASH risk assessment concluded medium risk.

3.43 On the 6th August 2014, hospital staff placed a Medway alert[19] on record at Kettering General Hospital (KGH) which is where Jane worked. The entry reads'

> 'should (Victim) attend with injuries/conditions that are believed to have been resulted from domestic abuse, please contact Police if required. Give information to (Victim) regarding the Sunflower Centre'.

This entry was a clear example of Jane's management at KGH being proactive in relation to Jane's records.

3.44 On the 29th August 2014, Jane attended a drop in attendance session with her partner at CGL, S2S (Substance 2 Solutions). The session was for those who wish to self-refer for support in relation to substance abuse and the assessment is completed with the individual with a Recovery Champion. It is designed to capture all demographics, past medical history and the history of substance misuse including the use of the AUDIT to determine how hazardous the individual's use of alcohol is. From that an appropriate support or treatment package can be determined.

3.45 As stated, she attended with her partner and there is nothing recorded to suggest that she was given the opportunity to be seen alone. Jane stated that she drank alcohol 3 or 4 days a week, up to 2 bottles of wine. Her Partner suggested she drank more. Jane scored 27 on the AUDIT which indicated possible alcohol dependency and the need for specialist support to assist her to detox safely from alcohol. She was required to undergo an assessment with the alcohol nurse to determine the most appropriate treatment. Following the assessment, she was provided with an appointment to attend

[19] Medway Alert - Hospital computer system alert, A & E, can be for any issue- makes staff aware of particular issues of note regarding a patient.

an induction group on the 4th September 2014 where she would be given more information about the support that CGL would provide. On that day she attended alone. She appeared a little introverted but became more confident as the meeting progressed. She was given a further appointment for 11th September 2014. Again there is no indication of any exploration of domestic violence.

3.46 On the 11th September 2014, Jane attended her CGL appointment. She reported she had reduced her alcohol to 4 days a week and her consumption was one small glass of wine on each occasion. She agreed to attend a mutual aid support group in the community and an appointment was made for her to attend an assessment with a Non-Medical Prescriber on the 18th September 2014. She also reported that she was working 5 days a week at the local hospital and because she was having issues with her partner she was a living for a time being in nurse's accommodation.

3.47 During the afternoon of the 21st September 2014, her Partner discovered Jane discreetly consuming alcohol in her bedroom and an argument ensued. Her Partner called the Police to stop the argument from escalating. It appears that a safety plan was already in place with a current risk showing as high. Little more is known about how this incident was finalised.

3.48 On the 23rd October 2014, Jane attended for her alcohol assessment with the Non-Medical Prescriber. She attended alone and during the assessment described her history of alcohol use and that she had been using alcohol excessively (binge drinking) since moving from Oxfordshire to live with her partner, although she reported a reduced intake of alcohol over the last few weeks. She did however admit that she had consumed four small bottles of wine over the weekend. Further, she said she was managing not to drink during the week but was struggling not to drink at weekends. She said her drinking had caused problems with her relationship with her Partner. She said she wanted to reduce and control her drinking as opposed to abstaining.

3.49 Jane reported that she had been to see her GP recently for various tests which were all in order. She reported she was a victim of domestic violence in the form of emotional abuse from her partner, she felt isolated in her house and that her Partner had turned the neighbours against her. She had little contact with her family in Banbury and she found it financially difficult to consider changing her housing situation and she felt this is one of the reasons why she stayed with her partner. She wished to explore the option of a relapse prevention medication to help her with her craving for alcohol. Following the assessment the medication was provided and because domestic violence had been disclosed a MARAC referral was made. It may have been beneficial for her to have been signposted to domestic violence support services as well.

3.50 On the 5th November 2014, Jane attended a planned appointment with her recovery Worker. She appeared well with no physical or mental health concerns. She reported she had not used alcohol for two weeks and the medication was helping her not to drink. She was given the telephone number for an (Independent Domestic Violence Advisor) IDVA but reported she was already in contact with them. There is nothing recorded about the MARAC referral made on 23rd October.

3.51 On the 21st November 2014, Jane attended her appointment with her Non-Medical Prescriber. She was still alcohol free and was feeling positive and up-beat. She did however express her intention to drink alcohol over the forthcoming Christmas period. The pros and cons of this were discussed with her Non-Medical Prescriber. She reported she was working full time and keeping busy. Another appointment was made for the 27th November 2014.

3.52 On this date she appeared well but stated that her partner was still controlling and had only just given her the key back to the house after six months. She reported that her

Partner was upset over something and she feared he would take it out on her but she did not want to leave the relationship. She also stated that she wanted to remain at home and did not want to go into a refuge. She was given advice about protecting herself and about refuges should she change her mind about leaving. An exit plan was discussed should the need arrive. A care plan and a risk plan were also completed. Jane maintained that she was still alcohol free but she had bought two bottles of alcohol in preparation for Christmas. Respite hotel accommodation was suggested and she was advised to contact the IDVA who worked at the hospital. She stated that her adult children no longer visited because of her Partner.

3.53 On the 7th January 2015, Jane did not attend her appointment with her recovery worker and the following day attempts were made to contact her. A voicemail was left for her to contact the office. The S2S IMR comments that it may have been beneficial to raise this with her manager given her previous disclosure of domestic violence.

3.54 Three weeks later on the 29th January 2015, Jane 'dropped into' S2S and saw the Non-Medical Prescriber. She had stopped taking her Acamprosate[20] medication. She reported two lapses with regards to alcohol, one before and one after Christmas. She reported no change in her physical or mental health since the last time she was seen two months previously. She said that she and her partner were getting on better albeit he was still controlling. She was unsure if she was going to stay or to move out of the relationship. It was at this meeting that the frequency of her appointments were reduced to monthly by S2S, but the S2S IMR suggests that they should have remained at one appointment every two weeks. Her medication was recommenced.

3.55 On the 3rd March 2015, another argument broke out over the cooking of a meal. The argument lasted well into the evening and most of the night. Her Partner reported to the Police that at one stage Jane had slapped him across his face but he did admit that he had been following her around the house. He refused to make a complaint and it appears that no risk assessment or DASH was completed. Jane was not arrested for an assault. Neither was the incident recorded as an assault.

3.56 Just after 10am on the 4th March 2015, the recovery worker received a text from Jane stating that she had a bad night at home and when she returned in the morning she found the locks on the house had been changed. There is no indication where she had been but apparently an argument had started over cooking the evening meal. Her Partner had spat in her face and accused her of drinking alcohol. He kept following her around the house and she admitted slapping him in the face. She advised the worker that she would not be able to attend for her appointment but she did in fact attend later that day and was seen by the recovery worker. She said she needed to find alternative accommodation as the situation at home had become too much for her. She indicated that she was going to her daughter's the following week. The S2S IMR indicates that this may have been an opportunity to signpost her towards domestic violence support and housing options. A further appointment was made for her to see the recovery worker on the 18th March 2015.

3.57 The following day, 5th March 2015, her Partner again called the Police alleging that Jane had attacked him. He stated that she wanted her to leave and as she tried to do so he had hidden her car keys because she was intoxicated. Jane was in her bedroom wearing her pyjamas and refusing to get dressed. She was eventually persuaded to leave and was taken to a Premier Inn and told to collect her car the following day, and not to return to inside the house. Within an hour of being taken to the hotel, she had consumed a bottle of wine and she contacted her Partner saying she'd lost her car keys and then she returned to the address. She was arrested for a breach of the peace

[20] Acamprosate, is a medication used along with counselling to treat alcohol use disorder. Acamprosate is thought to stabilize chemical signaling in the brain that would otherwise be disrupted by alcohol withdrawal

and whilst in the custody suite at the Police station, it was noticed she had scratches to her upper chest and ribs which had not been there when the officers first attended the address earlier that day. Officers did not think that her Partner had caused these injuries as there was no opportunity for him to do so.

3.58 Police again attended on the 13th March 2015, to a similar complaint from her Partner in that Jane was drunk and attempting to leave in her car. On the arrival of the Police she indicated that she wanted to leave and go to her family. Her Partner said she was no longer welcome and again she became hostile and obstructive but did agree to leave. Her family declined to have her and she was taken to a local hotel.

3.59 On 18th March 2015, Jane missed her appointment with her Recovery Worker and no contact was made with her. The S2S chronology suggests that it may have been beneficial to attempt to contact her given her recent disclosures of domestic abuse. A text was sent to her on 25th March 2015, but again no response was received. Again a comment is made in the S2S chronology that enquiries could have been made with Jane's GP with whom consent to share information had already been given following a previous domestic abuse incident.

3.60 On the 16th April 2015, she attended for her appointment at S2S with her recovery worker. She expressed regret about consuming the wine the month earlier but indicated that she planned to attend a party in the near future but was worried in case she couldn't resist the alcohol. She was advised not to attend the party if there was a risk that she couldn't resist the alcohol. She reported that she had moved into her own apartment because her Partner had locked her out of the house and a discussion took place about how safe she would be if she chose to allow her partner to visit her at her new apartment.

3.61 A further appointment was arranged for the 22nd April 2015 which was cancelled and moved to the 29th April by S2S. On the 29th April the recovery worker received a text from Jane saying she was unable to attend the appointment. There was no reason given. There is no evidence to suggest that she was contacted until the 2nd June 2015, when the recovery worker text her asking her to make contact to which Jane replied that she was ok and getting on well.

3.62 A week later on the 9th June 2015, the recovery worker attempted to telephone Jane but the call went to voicemail. A text message was sent to her asking her to make contact. The usual practice would have been for a letter to have been sent inviting Jane to contact the service within seven days if she still required support but the service did not have her new address so no letter was sent. Because there was no contact, Jane was discharged from the service. Jane had last collected her four week prescription on the 16th April 2015 and had not attended for her next prescription.

3.63 Nothing more was heard of Jane by local agencies until 2017 when medical records indicate that she had significant treatment for cancer and bouts of depression.

3.64 In March 2017, Jane's Manager at work recorded that she was frequently going to work upset, crying, depressed and unable to work properly. She stated that she still wanted to come to work as this got her out of the house and away from her Partner.

3.65 On 19th August 2017, there is an entry in the Kettering General Hospital chronology to the effect that a letter had been sent to her GP starting that whilst in hospital being seen by a Nurse Specialist, it had been noted that Jane had bruises to her abdomen despite being on the correct dose of the injected medication enoxaparin. Injection techniques were discussed as well as the use of ice. The note states that the bruising was attributed to 'anti-coagulant self-injection sites'. There is no mention of domestic

abuse being discussed or about any conversation with Jane about how the bruising had occurred.

3.66 On 30th August 2017, a note in the hospital records indicate that Jane had been off work sick again with stress related issues.

3.67 On 7th October 2017, following a referral from her GP, Jane was seen at the hospital regarding her struggling with the bruising to her abdomen. Hospital notes state that the referral mentions that she was at high risk of domestic violence as well as having a history of alcohol use.

3.68 In May 2018, Jane's Manager at work recorded that she often goes to work crying and upset and unable to control her emotions. The Manager had concerns about her mental health and the situation at home with her Partner is the cause of Jane's problems. Later in August 2018, the Occupational Health Specialist Practitioner at the hospital recorded that Jane had been off sick with anxiety again. Jane had said that she did not have much social life as her partner does not like to see her go out. She had a HADS[21] test which showed she had mild anxiety.

3.69 On 6th March 2019 Jane's GP practice received a letter from her Partner advising the practice that Jane was an alcoholic and her Partner was requesting the GP to do something about it. The letter was acknowledged by the practice but on the following day the GP called Jane to talk about his receipt of the letter from her Partner. Jane was told about the content of the letter and she denied that they were true. She described how once she's home from work she sits in her room to avoid her Partner and she claimed that it was him that needed help. She denied any thoughts of self-harm and stated that she intended to move in with her daughter to get away from her Partner.

3.70 Later that day Jane's manager from work called the GP to talk about her Partner's accusations. Jane was present with her manager. The manager explained how Jane was emotionally unwell and had lost a lot of weight and had been sent home. There was concern about her home situation but it should improve when she moves in with her daughter. The GP explained that he was unable to share any information but he did listen to the managers concerns.

3.71 The following day on the 8th March 2019, the surgery received another letter from her Partner raising concerns about the discussion the GP had with Jane's manager. The letter also warned the practice in a threatening and intimidating way that they must act on his request. That letter was acknowledged by the practice on the 13th March 2019 by letter.

3.72 On the 15th March 2019, the GP practice sent a letter to her Partner which advised him they had no consent to share medical information on Jane so they were unable to comment any further. On the same day the GP tried several times over a three hour period to call Jane and finally managed to speak to her at 5.15pm. She explained that she was currently locked in her room at home and that her Partner was being very verbally abusive, scaring her at times and making things up about her so that people would think badly of her. She denied any physical abuse and said she felt safe locked in her room. She stated that the Police had been no help but she'd sought assistance from charities for domestic violence but had been told there was no help available. She said she intends to see her daughter in the near future and was happy to attend the surgery to see the GP on the 18th March 2019, to talk more freely. She was advised to ring 999 for the Police if things got worse and explicitly dissented to the GP sharing

[21] HADS – Hospital Anxiety Depression Score test.

any information with any other party but she agreed with the letter that had been sent to her Partner saying that information could not be shared with him.

3.73 On 18th March 2019, Jane saw her GP face to face and disclosed that she was in an abusive relationship with her partner. She described how he controlled her, watched her all of the time and verbally abused her although she denied any physical abuse. She only felt safe when she was locked in her bedroom. She had lost confidence in the Police for not taking any action. She stated that she had not taken alcohol heavily for over a year, but she was aware that she was not looking after her health in the way that she should. She had stopped seeing her Consultant regarding one of her illnesses. Her GP confirmed that in his opinion the way she was being treated was abuse and gave her contact details for Northampton Domestic Abuse Service (NDAS). She expressed concerns about calling NDAS because her Partner examined her phone, so the GP offered her the opportunity to make the calls from the surgery.

3.74 Following her visit to the GP's surgery, Jane went home to find that she was locked out and her Partner would not answer the door. She flagged a passing Police car down and requested that the officer help her recover medicines and possessions from the house. Her Partner was cooperative explaining that he had asked her to leave but she had refused so when she went to see her GP, he sought the opportunity to change the locks on the doors. Her Partner undertook not to destroy, damage or sell any of Jane's possession and for her to make arrangements with him to collect them. The officer gave both Jane and her Partner advice and completed a DASH risk assessment form which was graded as medium risk. The officer also facilitated a telephone call between Jane and the Sunflower Centre and provided information for the National Centre for Domestic Violence (NCDV) and Women's Aid. The DASH risk assessment form was later scrutinised by a Supervisor who agreed with the action taken and the outcome.

3.75 Later that day the GP surgery received another letter from her Partner complaining about Jane's appointment with the GP that day and her attitude once she had arrived home from the surgery. He even questioned whether she had in fact attended at the surgery. The contents of the letter were, once again, threatening and intimidating. The GP called Jane and discussed the letter that her Partner had sent to the surgery. Jane stated that her Partner had become angry and accused her of not seeing anyone that morning. She was worried that her Partner would become angry with the GP surgery staff. The GP re-assured her that the surgery was able to cope with him and that there would be no disclosure of information to him about her whatsoever. She said that she was going to contact NDAS.

3.76 Later that same day, Police attended at the house to an argument between Jane and her Partner. He told officers that she was drunk and wanted to drive her car. He had hidden her car kays at which she became aggressive and hostile. This continued towards the officers and she was again removed to prevent a breach of the peace. This matter was recorded as a Non Crime and a DASH risk assessment form was completed in respect of Jane which showed a medium risk.

3.77 The following day, 19th March 2019, the GP called Jane who reported that she had been 'thrown out of the house' and she was waiting for her daughter to collect her. The GP offered Jane help through KGH but she declined to go there because of the costs involved.

3.78 On 20th March 2019, the GP tried without success to contact Jane. At 8.40am that day a concerned member of the public called the Police to report that an elderly lady was slumped in the foot-well of a car with an empty bottle of wine next to her. Police officers attended, found Jane and persuaded her to go to her Doctors. Her Partner was made aware and went to the surgery seeking an urgent appointment. The Police were with

Jane at the surgery. She was brought into the surgery by the Police and her Partner, but the Police left before the GP was able to speak to them.

3.79 Her Partner waited in the reception of the surgery and refused to leave when asked to do so. Jane spoke with the GP and stated that she had been drinking 2 bottles of wine per week. She was timid and tearful and wanted to move out of the house and away from the relationship with her Partner. She again stated that neither the Police nor the Sunflower Centre had been of any help. The GP sought advice from NDAS who recommended the GP called the Police to remove her Partner whilst they tried to sort out emergency accommodation for Jane. This was arranged and the GP waited for the Police to attend to deal with her Partner.

3.80 The GP also made a verbal referral to Adult Safeguarding and completed a GRACE tool pro-forma[22]. The GP was advised that the Sunflower Centre was the appropriate response to concerns and for the GP to make a referral to ASC "if he was concerned about abuse". The GP responded by saying that the Sunflower Centre had signposted Jane to Victim Support which had been very helpful and that the GP would not be completing a referral, being content that "it was logged".

3.81 The author of the Adult Social Care chronology comments that there is no recorded discussion around the possible eligible needs of Jane under the Care Act 2014 or around the decision making ability under the Mental Capacity Act 2005.

3.82 The GP helpfully, removed the location services from Jane's mobile phone, which revealed that her Partner had been tracking her movements via her mobile telephone. The Police attended at 1600 hours and took Jane to a local Police station where a specialist team took her to a refuge.

3.83 The verbal referral made to Adult Safeguarding by the GP raised concerns that Jane was in an abusive relationship and had recently been locked out of the house and forced to sleep in her car. She was trying to get out of the relationship. The GP was advised that the Sunflower Centre was the most appropriate service to support Jane and arrangements were made for the GP to submit a written referral. He said that he would do that but needed assurance that the facts were being recorded.

3.84 NDAS spoke to Jane whilst she was at the GP surgery. She said that she did not want to go to a refuge and was advised to seek accommodation at a Bed and Breakfast place. The GP was not informed that Jane did not take up the offer of refuge accommodation.

3.85 On the same day the GP sent a 'zero tolerance letter' to her Partner regarding his threatening behaviour towards the surgery and informing him that he had been removed from the patient list at that surgery.

3.86 On 23rd March 2019, NDAS telephoned Jane who said that she no longer wanted a refuge and that they, (herself and her Partner) were going to sort things out. She said that she was with her Partner at that time and he was going to help her with her drinking and maybe some counselling. Her Partner was heard in the background saying 'rehabilitation' and Jane was replying, 'I'm not going to rehab'.

3.87 On 26th March 2019, EMAS received a 999 call to attend at Jane's house where she had been found slumped over the steering wheel of her car. A neighbour had informed her Partner who had helped her into the house. By the time the ambulance arrived, Jane was awake and alert on the sofa, but clearly under the influence of alcohol. She appeared to be very slim and not eating well. Her Partner was given advice about Jane

[22] GRACE - GP Risk Assessment Control and Escalation Assessment Tool

driving whilst under the influence and a Safeguarding Referral was made regarding her drink driving and also her apparent self-neglect. This referral was shared with the GP and Adult Social Care.

3.88 On 28th March 2019, the police sent a PPN[23] to Adult Social Care regarding the incident that had occurred at the GP's surgery 8 days earlier on 20th March 2019. It appears that EMAS also made a referral on the same day, which related to the incident on 26th March 2019. Notes in the Adult Social Services chronology that the PPN was not clear if there was any abuse occurring. It mentioned that Jane would like some assistance in alcohol treatment.

3.89 On 9th April 2019, Jane saw her GP at the surgery regarding on going stress caused by her partner verbally abusing her. She stressed there was no physical abuse. She had been taken to a refuge but had returned home to resolve the issues with her Partner. The GP made contact with Adult Social Care to discuss the situation with Jane and Adult Social Services tried to contact her but there was no reply.

3.90 On 12th April 2019, EMAS received a call to attend her Partner's home address where Jane was found on the floor. It appears she had been drinking alcohol and not eating over the last 3-5 days and her Partner had entered her room and found her lying on the floor. She denied using alcohol that day but her Partner thought that she had been drinking earlier that morning and he said that she had told him she'd been eating well and was feeling her normal self. Jane however disagreed with that statement. The ambulance records notes that her Partner appeared to be very concerned about Jane. She was taken to KGH, by ambulance and admitted to an urgent care ward with suspected sepsis, alcohol detoxification and self-neglect. She weighed 7st 12ib.The following day a Safeguarding of Vulnerable Adults (SOVA) referral was completed and sent to the local authority as Jane disclosed her Partner had been verbally abusive towards her.

3.91 On the 15th April 2019, Jane was transferred to the Digestive Diseases Unit where a nutrition risk assessment was completed and a referral made to a dietician. There was no body map completed which may have given physical evidence of abuse. A referral was made to S2S. A safeguarding referral was made to Adult Social Services by a nurse on a ward at KGH, stating that Jane had requested a referral and her partner is abusive towards her and controlling whilst at home. He calls her names, checks her banking but does not take any of her money. An advisor attempted to contact Jane to establish if she had been engaging with the appropriate agencies, but for some reason the telephone numbers provided were incorrect and did not work. There was no mention of a MARAC and it was unclear if that was because the referral pertained to mainly verbal abuse incidents. On the advice of the Social Care Duty Worker the enquiry was closed as there was no identified social care needs.

3.92 CGL Hospital Liaison Team provide support and education to hospital staff and patients around the management of substance misuse. Jane was seen by an Acute Substance Misuse Liaison (ASML nurse) and an assessment was made in relation to her needs. Jane asked for support to remain abstinent from alcohol and another appointment with the ASML was made for the following day.

3.93 On the 16th April 2019, a registered nurse spoke to Jane about her alcohol and home situation. Jane said her Partner raised his voice at times to her and when asked if she was ever frightened she did not answer. Jane explained that her family were concerned about her home situation and social aspects especially on her discharge but she explained that she thought things were ok at the moment.

[23] PNN - Public Protection Notice

3.94 On the 17th April 2019, whilst still in hospital a body map was completed of Jane which showed marks on her back, spine, arms and bruises to her side. It was considered that these marks could have been caused by the use of Enoxaparin[24] injections. She was seen the same day by the staff from the occupational therapy and the question about her Activities of Daily Living (ADL) she answered by saying her partner helps her with her daily activities like washing and dressing. It had already been noted that the patient has alcohol dependency as a way of dealing with an abusive partner.

3.95 On the 18th April 2019, the occupational therapist contacted her Partner by telephone and explained that he could expect a delivery of equipment to help Jane as she was to be discharged that day. Her Partner expressed his concern about her eating habits whilst she was at home. Jane was discharged later on the 18th April 2019. A referral was made to the NCC Adult Safeguarding Team about the concerns raised, i.e. Jane not eating, her dependence on alcohol and Jane stating that her partner was aggressive towards her.

3.96 On 23rd April 2019, the Safeguarding referral was received by the Customer Service Centre at NCC and attempted to find the contact details for Jane in order to make contact. However after trying several agencies without success and because of the danger of her Partner opening a letter that could have been sent to Jane containing particular details, it was decided, as no contact could be made safely, a signposting letter was to be sent to her.

3.97 On 27th April 2019, her Partner rang 111 and spoke to an Out of Hours GP concerned about Jane's physical and mental health. He explained that she was alcohol dependant, not eating well and refusing help. He was giving her Guinness to drink. The Out of Hours GP spoke with Jane, who said that she did not need help at that time. The call ended. Her Partner rang back several hours later and on realising he was speaking to the same GP as before he said that he didn't want to speak to him and hung up.

3.98 On 2nd May 2019, EMAS received a call from her Partner saying that Jane was unwell. On arrival her Partner expressed his concern regarding her eating habits and two weeks previously she had been admitted into hospital with malnutrition. He said that she had eaten very little since her discharge from hospital and had only had a few mouthfuls of a pie and half a Complan shake. He also told the EMAS crew that she was alcohol dependant but had not had any drink that day. Jane gave her consent for an examination and she was found to have a temperature for which she was given paracetamol. She was conveyed to KGH due to clinical concerns.

3.99 The EMAS crew noted some safeguarding concerns whilst at the house. They noted that her Partner talked over the patient and answered for her. On route to the hospital Jane told the ambulance crew that she felt trapped at home by her partner. She described how he puts her off eating by standing over her and yelling at her to eat. She said he had done that for an hour that morning before the ambulance crew had arrived. She described how he belittled her and kept putting her down. She also said that he tries to handle phone calls about her care and discusses her care out of her hearing range and he doesn't keep her informed. She said he was never physically violent but he had been banned from attending the GP's surgery after he was abusive to staff. She described how he prevented her from going to see her GP. The EMAS crew rightfully completed a safeguarding referral that was shared with the GP and the local authority.

[24] Enoxaparin is used to prevent blood clots in the leg in patients who are on bedrest or who are having hip replacement, knee replacement, or stomach surgery. It is used in combination with aspirin to prevent complications from angina (chest pain) and heart attacks

3.100 Once at hospital Jane was referred to the HIDVA service. A body map was completed where bruises were seen to both arms which may have been the result of her using Enoxaparin. A Safeguarding referral was made to the local authority. The Adult Social Care worker was satisfied that Jane was under the care of the Trust and information was being shared adequately.

3.101 On 8th May 2019, CGL received a referral for Jane from the Digestive Disease Unit at the local hospital. She was seen by the Acute Substance Misuse Liaison (ASML) nurse who completed an assessment of her needs regarding her substance use. She was seen alone and reported a two month history of abstinence from alcohol. She also reported her partner was verbally abusive, controlling and coercive towards her. He would stand over her force feeding her, removing her car keys from her and stalking her whilst she was shopping. The ASML nurse offered Jane a 'helpful number card' for support around domestic abuse but she declined saying that her partner goes through her belongings and would find it. The ASML made a referral to the hospital IDVA. A further ASML review was arranged for 10th May 2019.

3.102 On 10th May 2019, the ASML nurse saw Jane. A Clinical Institute Withdrawal Assessment [25](CIWA) was completed that scored 0 and showed that Jane was not experiencing any symptoms of alcohol withdrawal. Jane did not request any further assistance regarding her substance use and she was discharged from CGL. However, Jane stated that she had been seen by an IDVA and a Safeguarding Vulnerable Adult referral had been completed by hospital staff. She said that she had declined police intervention in the past but was now fearful of going home. The ASML nurse shared this information with the Ward Nurse and recorded that the reason why Jane kept going to hospital was that she did not want to be at home.

3.103 Jane remained in hospital until the 10th May 2019. A note on her discharge management plan indicated that she declined help from S2S and the IDVA. She was declared medically fit for discharge but there was nothing in the discharge letter sent to the GP regarding her home situation around possible domestic abuse.

3.104 On 18th June 2019, the HR department where Jane worked, held a first formal meeting regarding Jane's sickness. It was noted that she was very thin and unable to put weight on. It was discussed that she was in a NHS pension scheme and could not be retired on ill health retirement. It was identified that she was in a violence situation at home and options for support were discussed.

3.105 On the 26th June 2019, Jane's GP contacted her by phone indicating that Jane's workplace were requesting a review as to whether she was fit enough to return to work. Her MED3 certificate needed extending. A face to face review was booked for the 1st July 2019. The GP went onto discuss the complaint that her Partner had made to National Health Service England (NHSE) and Jane stated that she was forced to sign a consent form and doesn't want any information disclosed to her partner. She said that whilst there had not been any violence, the situation at home was worsening. She was advised to contact 101 for the Police and advised about the steps she could take.

3.106 On 1st July 2019, the face to face review took place. It was noted that Jane was starting to put weight on and she was less wobbly on her feet. She was struggling to see a way out of the abusive relationship and she stated that her Partner had taken away possessions from her meaning that she could not go out and he had also removed domestic abuse organisations telephone numbers from her phone. The GP gave her the numbers again.

[25] The Clinical Institute Withdrawal Assessment for Alcohol, commonly abbreviated as CIWA or CIWA-Ar (revised version), is a 10-item scale used in the assessment and management of alcohol withdrawal

3.107 On the 10th July 2019, her Partner again called EMAS via 999 expressing concern about Jane's physical and mental health. He said he had made several attempts to get her help but without success. He also said that the Police had visited on that day but he did not say why (it appears the Police did not attend). On arrival the EMAS crew highlighted four main areas of concern which were;

1) Jane is still using alcohol daily and has been for a number of years which had resulted in liver damage.
2) Jane is not eating and her Partner alleges that he is finding food in her pockets
3) Jane's behaviour is odd and fluctuating. She drives to a nearby supermarket and stays in her car for several hours on her own. Her mood swings from passive to verbally aggressive.
4) Non concordance with medication.

3.108 The EMAS crew examined her and found her to be extremely thin with a distended abdomen and a raised temperature. She said she had been unwell recently with a blood disorder and she admitted consuming alcohol earlier that day. She told the crew that she had not been eating because her partner only provides microwave food. She alluded to meeting a friend at the supermarket but could not remember her friend's name. She said she was being verbally abused by her Partner. All of this information was referred to Northamptonshire County Council and the GP. In addition, the EMAS crew were of the opinion that her behaviour could result in her death in that she drives whilst under the influence of alcohol. Her Partner stated he would lock her out of the house when she leaves as he couldn't tolerate her behaviour anymore.

3.109 Upon receipt of the safeguarding referral an Adult Social Care Customer Service Advisor called Jane on the 23rd July 2019. She said things were fine and she didn't want Adult Social Care help. The referral made by EMAS regarding the alleged abuse by her partner was not considered to be a safeguarding issue and no further action was taken.

3.110 On 2nd August 2019, the hospital held another formal meeting regarding Jane's sickness which was acknowledged to be because of stress and depression. It is recorded that offers of help were made but shortage of staff in Occupational Health Department meant that Jane had not been seen.

3.111 On the 20th August 2019, EMAS received another call from her Partner stating that Jane was unwell and her health had declined. He described that she was lethargic, she had decreased water and food intake, she had diarrhoea followed by constipation and vomiting. On arrival of the crew, they were greeted by her Partner. Jane was in bed. She looked pale but she was alert and consented to an assessment. The crew were concerned she had a bowel obstruction or a colon prolapse. The EMAS crew liaised with her GP who helped to persuade her to go to hospital. The EMAS crew were concerned as she needed clinical intervention for the bowel problem. She was transported to KGH. The EMAS crew completed Safeguarding Adult referral stating that there was concern for Jane's health and self-neglect, that her Partner describes her general decline in health and weight, there was a record of alcohol abuse and there was poor personal hygiene with faecal matter on bedding, clothing and her hands.

3.112 On 22nd August 2019, Adult Social Care received a Safeguarding referral from Jane's GP alleging that her Partner was verbally abusive towards her and that she was withdrawing consent for her medical records to be shared with her Partner. The GP added that her Partner controlled most of Jane's life, what she eats, where she goes etc. The GP also mentioned concerns about her alcohol use and the fact that it appeared that she was not eating.

3.113 A Principle Care Manager of Adult Social Care screened the information and decided that no further enquiries were needed as it had been stated that Jane had not consented to a referral and there was no indication of social care needs. As far as the EMAS referral is concerned, this did not mention domestic abuse but Jane was not meeting her needs. The chronology suggest that the Principle Care Manager should have asked for more information and ascertain Jane's needs under the Care Act 2014.

3.114 During 2019 EMAS were called to incidents involving Jane on 5 occasions. Her Partner called three times out of those 5 calls. On 4 occasions EMAS crew made referrals to Adult Social Care and 2 of those referrals made reference to domestic abuse.

3.115 Once at the hospital she was seen by a Senior House Officer and an Early Warning Observations to Identify Deteriorating Patients was undertaken. She was transferred to the urgent care ward where a body map was completed and she was assessed to be at risk for developing pressure ulcers. She was also assessed to being at risk of falls and consented to bed rails being fitted. Her condition was clearly serious.

3.116 On the following day, a Do Not Attempt Cardio Pulmonary Resuscitation form was completed as there was no realistic possibility of CPR succeeding due to Decompensated Chronic Liver Disease and Peritonitis. Jane did not consent to CPR. Regular nursing and medical reviews were conducted and Jane requested no contact with her Partner or rest of her family.

3.117 On the 22nd August 2019, she was transferred to a different ward. She was assessed as having capacity to making her own decisions about her treatment and care, but was bedbound and required assistance to wash and dress. She was described as being frail and during the night of the 22nd August 2019, she deteriorated but insisted that the hospital staff should only call her partner when she was ready or too unwell to do so, i.e. unresponsive.

3.118 At 0345 hours in the 23rd August 2019, Jane died, the cause of death being determined as primary diagnoses of Peritonitis and secondary diagnoses of Co-Morbidities of alcoholic liver disease, malnutrition, alcohol, mental disorder and chronic pancreatitis.

3.119 The GP practice spoke to the Clinical Commissioning Group (CCG) on 27th October 2019, and a discussion took place regarding the practice making a referral for consideration of a SAR. From there, SAR referral was made by GP practice and considered at SAR subgroup in December 2019, where, in the light of information provided to the panel, the decision was that a referral should be made to Corby Community Safety Partnership for consideration of a Domestic Homicide Review (DHR). The DHR referral was made by Northamptonshire Police in January 2020. The CSP decision at that time was not to proceed as a DHR.

3.120 On February 4th 2020, following CSP decision not to undertake a DHR the referral was reconsidered at SAR Sub Group panel. A decision was taken to request further information from agencies to help inform whether SAR criteria met. Request sent to agencies for information.

3.121 On 15th May 2020, original SAR referral re-considered (via virtual meeting) having obtained additional information from partner agencies. At the meeting there was significant information provided by agencies relating to incidences of domestic abuse, spanning a number of years. The SAR Sub Group panel unanimously agreed that the revised information needed to be shared with the Community Safety Partnership for re-consideration of the concerns as a DHR. Northamptonshire Police agreed to make the DHR referral. Following this the CSP decision was to undertake a DHR.

3.122 On 2nd September 2019, her Partner wrote a letter to the Ward manager at the hospital where Jane worked informing of the death of Jane together with her funeral arrangements. An extract from the letter is contained in the KGH chronology;

> "..she passed away. It was extremely unexpected and I was devastated. Despite what you might have heard, I dedicated myself and most of my time trying to get [Jane] help and get her better. I must admit that [Jane] was very stubborn and did not cooperate which made things considerably hard. Apart from that, it seems an impossible task trying to get help with someone with a serious condition and you know what is going to happen if things continue along the same line. It is devastating to be fobbed of with trivial excuses and I know better when really they don't. I did try some unconventional things out of shear desperation but to my amazement still did not work. In act I would say backfired on me. Yes I contacted [Jane's] family to see if they could influence her and they never spoke to me again! I wrote to the GP Practice Manager and gong to see them produced a dead end. They called the police and removed me from the patient list for no good reason but asking for help. Which I may add has been reversed by NHS England. The only thing that was not pursued was [Jane's] health and well-being by them."

3.123 It was decided that the circumstances fitted the definition of the 2016 Home Office guidance on Domestic Homicide Reviews and a review was commenced.

3.124 During the process of obtaining information from agencies it became clear that there was sufficient evidence from Jane's disclosures of coercive and controlling behaviour by her partner, that Northamptonshire Police commenced an investigation into her Partner's involvement with Jane.

4. Views of the family

4.1 The Report Author arranged to meet (virtually because of the Covid virus) with family members on 4th December 2020. Present was Jane's daughter, son, daughter-in-law and granddaughter.

4.2 They explained that Jane had got married many years ago. They had children and she and her husband divorced.

4.3 In 2009 or 2010, Jane met her Partner in this case on a dating app. Everything seemed fine in the early stages of their relationship and only after a few months Jane left her house where she lived and moved to Corby into her Partner's house.

4.4 Soon after that the children began to suspect that things were not so good between their mother and her Partner. On one occasion during a visit to Jane, something happened that made the daughter-in-law laugh and her Partner told her and her family to leave and never to go back to his house again.

4.5 The son and his wife would visit the house only to see his mother, but they had to make it appear that they enjoyed her Partner's company and pretend that they got on with him in order to be able to visit and see the mother and to keep the peace. Both the son and daughter-in-law knew what was happening with the relationship between Jane and her partner. The mother would phone the son but only from her car. She would tell them that her Partner had locked her in her bedroom and wouldn't let her come out.

4.6 The son said that her Partner would tell tales about Jane constantly put her down and belittle her. He was pushy with Jane, who was timid when the son and daughter-in-law were present making her feel awkward. Jane told them that she tried to sleep in her car and that she would not eat for days on end. Her Partner would not let her use the oven. He would only let her use the microwave and she did not have any properly

cooked food. Her Partner didn't want Jane to dirty the oven. P Jane kept a diary which the daughter-in-law has got.

4.7 Both the son and the daughter-in-law reported that they witnessed her Partner was controlling Jane. She would not sit down when they visited as if she was scared to do so. Jane was always on edge as she was petrified about what the son and daughter-in-law would say in conversation. If ever there was a telephone conversation between Jane and family members, her Partner would insist that the conversation was on loud speaker so he could hear the whole conversation.

4.8 The daughter said that her mother had left and had gone back to her Partner on countless occasions.

4.9 Jane worked at the hospital as a Health Care Assistant for the elderly. She had a good friend there, a Matron who she had known a long time. Jane confided in the Matron. The Matron arranged for Jane to move into nurse's accommodation at one point to get away from her Partner, but her Partner convinced Jane that the cost of staying in hospital accommodation was too expensive and she went back to live with him.

4.10 The family described how Jane had her own bedroom and her Partner removed her bedroom door. He would monitor Jane's movements and restrict her contact with anyone else. He would constantly mock her and sing "Ten Green Bottles" to her, the relevance being that ultimately all of the green bottles fall to the floor! He is reported to have been abusive about and towards Jane's children.

4.11 Regarding physical abuse, the children spoken to are aware that Jane had bruises to her stomach. This was said to have been caused by her having to inject herself. The daughter-in-law said that she has had to have the exact same injections and she did not suffer from bruises. Her Partner did the injections for Jane and the children spoken to think that he pinched her stomach so hard that caused bruising.

4.12 The children spoken to are aware that her Partner would follow Jane to the shops and sit outside watching her. He would follow her to work and wait outside the hospital for her to finish her shifts. He would go out in disguise watching her. He also controlled Jane over social media and after her death, he would be logging onto her social media accounts.

4.13 Regarding the installation of CCTV in the house and in Jane's car, the children spoken to said that her Partner said he did that because of the trouble he had with the neighbours. Jane told her children that the CCTV was in every room of the house apart from the toilet.

4.14 The children spoken to said that Jane's alcohol problem was on and off but she started to drink more after she left her Partner. He caused her to lose her job at the hospital. He sent a letter to her boss saying that in his view she was not fit for the job and she was subsequently dismissed from her job which she loved and had been there for many years.

4.15 The last time that the daughter saw her mother was at her house. Her mother gave the daughter her wedding ring saying 'Have it. I won't need it'.

4.16 As a living her Partner had properties that he rents out and he also does computer work often into the late night time. He would tell the children that he once lived in London and was a gangster with access to guns. He apparently had lots of money. There is no evidence to support this. When the neighbour was allegedly causing damage to Jane's car, her Partner asked the daughter if she could get a gun for him to use on the neighbour. None of the children know much about her Partner's history.

4.17 Jane told her family that her Partner had told her that he had killed his ex-wife, but the children had thought that she had gone to Australia. There is nothing to suggest that this comment is true.

4.18 At the funeral service her Partner attended in his car and revved the engine so much that the sound of the car drowned out the music at the service. Her Partner filmed the funeral and then drove off.

4.19 Her Partner didn't tell the children that Jane was in hospital for 4 days. She died at 0300 hours and he didn't tell the children until 12.10pm the same day using Jane's mobile phone.

4.20 On the day of Jane's death, her Partner took £35,000 from her account and put it into his own account. The Bank made him return the money after the family had complained to the Bank.

4.21 The family asked her Partner for Jane's passport, driving license etc. and he said that they would receive them within 2 days. To date they have not received any of the requested documentation.

4.22 The children state that in 2011, her Partner took out a mortgage in Jane's name to the amount of £35,000. Jane made him repay this. She had to pay him £250 per month for rent. Her Partner renewed Jane's car insurance in her name in September 2020, after her death.

4.23 The family believe that her Partner did not pay off the mortgage on Jane's house, as he had started at some stage, because she and her ex-husband had got £40,000 each from the sale.

5. Partner's account

5.1 Her Partner agreed to speak to the Overview Author by telephone (due to the Covid virus and the fact that he did not have IT equipment suitable for any method of virtual meetings). On 18th March 2021, the Overview Author made contact with her Partner and a summary of his comments are contained herein. It should be noted that her Partner had previously forwarded to the Author a 19 page document of his views which is referred to in the conversation the Author had with her Partner.

5.2 Her Partner said that he had lived in Australia with his wife and family. In 1998, he came back to the UK because of problem with a house they had in England. He stayed in the UK and the marriage ended in divorce.

5.3 When he came to the UK and lived in London. He was employed as a Bus Driver with London Transport. He moved from London to Northamptonshire and in 2008 he registered with a dating agency and met Jane who then lived in Oxfordshire.

5.4 Initially he and Jane travelled back and forth between their two houses and on her days off from work, she would travel to stay with him. It was decided between them that she should move and live with him in his house. Jane's house was in joint names with a previous boyfriend and it needed some work doing on the house and garden in order to make it fit for sale. Her Partner says he did all of the work and the house was sold. The ex-boyfriend of Jane took a case to court over the division of the money from the sale.

5.5. When Jane moved in with him she was working in Oxfordshire and after being paid out from the sale of the house she left her employment and lived for some time off the proceeds of the sale. She enrolled with a keep fit courses which she attended 2-3 times per week. Her Partner was retired at that stage.

5.6 At first things between them were good, but they went to a show in Birmingham and stayed in a hotel. He went to the room after the show but Jane didn't. She stayed in the bar drinking and when she got to the room she was drunk and it 'kicked off'. He packed his bags and tried to leave the room but the door was locked and she wouldn't let him leave. Things calmed down and they eventually overlooked that incident.

5.7 Her Partner said that he knew that Jane drank alcohol but he didn't realise that she was an alcoholic. He said the 'penny didn't drop' until he found that she was drinking behind his back. She would suddenly change her mood and become aggressive.

5.8 Her Partner said that in 2010, he tried to sit down with her to discuss her drinking. He told her to drink if she wanted to but not behind his back. He asked her to be open with her drinking so he could keep an eye on how much she was drinking at any one time. He convinced her that she should see a Doctor. They both attended at the GP surgery. He said, 'I did the talking and telling the Doctor my concerns'. The GP said he wanted to speak to her on her own, but the GP believed Jane not her Partner and nothing was done. After that things got worse. She was out of control when she was drunk and she was violent. Asked what that looked like, he said that he had to lock himself in the garage to get away from her and he had to call the police. He said that she had hit him on a couple of occasions

5.9 Her Partner was asked about the finger injury incident on 10th October 2011. He said she was drunk and throwing stuff out of a cupboard all over the place. She would hide his keys around the house and she had his keys at that time. He grabbed the keys she was holding and both his finger and her finger got trapped inside the small key rings in the bunch of keys and they both pulled away and the ring cut her finger. He said that it also cut his. An ambulance was called but he thinks that she was treated at the time and did not go to hospital.

5.10 Her Partner said that he told Jane that she needed help and treatment for her alcoholism. She had tablets prescribed by the GP for her alcohol problem. He was not sure that she was taking them so he went to the chemist. He tried to get some more tablets but the chemist didn't have any. He complained to the chemist that they ought to have tablets that have been prescribed by the GP.

5.11 Her Partner said that Jane would buy alcohol day and night. She would get up early every day to get to a Supermarket before the crowds to buy a bottle of wine which she would drink that day. He is aware that the Supermarket did an offer on 3 bottles and from that time she would buy 3 bottles per day and drink all of them that day.

5.12 Her Partner said that he has a photograph of Jane slumped half out of bed in a drunken condition. He was asked why he had taken the photo of her like that and he said he felt threatened by her.

5.13 Her Partner was asked why had had installed CCTV around the house. He said that he was threatened by Jane and to cover his own back in case of complaints especially with a police officer living down the road from where he lived. He is convinced the police officer would tell other neighbours about him. He described another neighbour, jumping out onto the bonnet of Jane's car when she was driving herself and him home one night. The neighbour claimed that he had been run over by her. Her Partner examined his own camera system and could see the neighbour hiding behind a wall until the car appeared and then jumping out onto the bonnet. All of the neighbours came out and the police were called. He states that he believes that the neighbour set this up. The police spoke to the neighbour and he received a warning from the police.

5.14 Her Partner denied that there was CCTV installed inside the house only outside.

5.15 Her Partner was asked why he had removed the bedroom door to Jane's bedroom. He initially said that he hadn't done that but changed his mind when confronted with the fact that a police officer had been called to the house by him on one occasion and asked the same question to which he had replied words to the effect that it was his house and he could do what he liked. He then recalled that the door in the house had swollen and would not open properly without dragging and this may have been when he removed the doors to re-fit them so they worked properly. He questioned why he would remove a door to her bedroom without a good reason.

5.16 Her Partner was asked why did he think that Jane told the agencies every time she had contact with them, (Police, S2S, Sunflower Centre, Adult Social Care, hospitals and GP), that he was controlling and coercive in their relationship and that she was not allowed to drive, use her bank account, she didn't know the PIN to her accounts or her passwords, that he was aggressive and he determined what she would eat? He stated she did that to get at him. When asked "Why?" he said he didn't know but he knows that if someone is an alcoholic and another tries to help and prevent them drinking to get better, that person becomes the alcoholic's worst enemy. He said that Jane would not own up to her alcohol problem. He said that she would say, 'I am not allowed to do that – or I am not allowed to do this'. He said, 'I never stopped her doing anything'. She would not sit down and talk about it.

5.17 Her Partner said that when she was not drinking she was lovely and sometimes she would thank him for a nice weekend when she had not had alcohol.

5.18 Her Partner said that Jane would hide bottles of wine. When asked about her eating habits, he said that she was not a big eater. She weighed about 9st when she was well. He did all of the cooking. She did nothing – nothing at all! Her Partner did all of the shopping. He was asked about the use of the microwave he said she would say that is all that she had – microwave food. However he explained that his microwave was a dual functional oven as well. He said that he did his best.

5.19 Her Partner said that Jane had fixations about him controlling her but in reality it was the other way round, she controlled him. She had told him that her ex-husband had been violet towards her and her Partner had thought, 'What a nasty person'.

5.20 He said that Jane had told him that she would get him one day because he wanted to get her better and off the alcohol which he knew was killing her slowly. He told her that one day she will become ill and it will be too late.

5.21 When asked about her family, he said that she had told him that her ex-boyfriend would not let her see her family and when he first met them they all got on well. He told her that the house was open to her family.

5.22 Her Partner recalled a phone call from Jane's son asking that they go and get him. He had fallen out with his girlfriend and had nowhere to stay. He came to live with them for a time but the son would not look at him which he found offensive. One of Jane's daughters had a boyfriend and they came to his house. Jane and the daughter got drunk and they began to 'take the mickey' out of him and laughing at him. He told Jane that he didn't like being treated like that and it would be best if the daughter and boyfriend left. That was the last time he saw them. The other daughter didn't want to know him.

5.23 He says he contacted Alcoholics Anonymous about her drinking and they advised him to separate from Jane and that there was nothing else he should do other than part company from her. He tried the GP and was told to pack her bags and get rid of her.

5.24 Her Partner was asked if the situation was so bad, why he didn't end the relationship. He said that they spoke about breaking up but Jane said that she didn't want to break

up and that she was not leaving. He said that they did separate on one occasion. He had found her accommodation in the nurse's quarters. She moved in there but they kept in touch. She was only there for a short time and they got back together.

5.25 Her Partner was asked why they had got back together. He said that she was working extra hours to cover the cost of the nurse's accommodation. He felt sorry for her. He asked her to his house for a meal. They got on very well and he asked her if she wanted to come back home and she said that she did. He said that when she did not drink she was a really nice person but when she drank she was the opposite. Once she went back home she went back to normal, drinking again.

5.26 The partner has been supplied with a copy of the Overview Report for his consideration and his comments. His reply in a long letter (Appendix No.2) clearly indicates that he does not agree with any of the facts in the report or any of the conclusions.

6. Analysis and Recommendations

6.1 From information received from agency reports and from family members, it is clear that the behaviour from her Partner constituted controlling and coercive behaviour as defined by the Serious Crimes Act of 2015. It is also behaviour that constitutes a form of persistent manipulation, commonly called 'Gaslighting'.

6.2 It has to be appreciated however that during the interview of her Partner by the police, and during his meeting with the report author, her Partner maintained that his actions and behaviour were in the best interests of Jane and he acted that way in order to ensure that she was fed, restrained from drinking alcohol and looked after in the best way that he could. It is not the role of the author or the panel to make any judgements as to which version of events is to be believed, so the facts are represented impartially and equally on the side of Jane's family, from records that exist and also from the version given by her Partner.

6.3 The Serious Crimes Act 2015, defines coercive and controlling behaviour as:

- If person A repeatedly or continuously engages in behaviour towards another person B that is controlling or coercive,
- At the time of the behaviour, A&B are personally connected,
- The behaviour has a serious effect on B, and
- A knows or ought to know that the behaviour will have a serious effect on B, and:
- A's behaviour has a serious effect on B if –
- It causes B to fear, on at least two occasions, that violence will be used against B, or
- It causes B serious alarm or distress which has a substantial adverse effect on B's day to day activities.

A & B must be personally connect ie: in an intimate personal relationship, live together or members of the same household, or, they have previously been in an intimate personal relationship with each other.

6.4 'Gaslighting' is a form of persistent manipulation or brainwashing that causes the victim to doubt themselves and to ultimately lose one's own sense of perception, identity and self-worth. 'Gaslighting' statements and accusations are usually based on blatant lies or exaggeration of the truth.

6.5 'Passive aggressiveness' can be defined as anger or hostility in disguise, expressed in underhanded ways to exercise power, control and deception with the hopes of 'getting away with it'.

6.6 There are seven signs of passive aggressive 'gaslighting' according to Preston[26]:

- Persistent lies about deceptions against the 'gaslightee'
- Many subtle digs and subversive judgements
- Persistent negative humour and sarcasm
- Regular negative gossip
- Regular negative social comparison
- Persistent social exclusion
- Persistent blaming.

6.7 Perhaps the most intrusive behaviour by her Partner towards Jane is the extensive surveillance and monitoring he carried out by the increasing use of CCTV. His excuse for doing so was firstly, to monitor the criminal damage being committed on Jane's car either at home, supposedly by the neighbour, or in the hospital grounds where Jane had parked her car whilst she was at work, and secondly surveillance within the house to monitor and prevent her drinking habits. The children say that their mother told them there was CCTV in every room except the toilet.

6.8 Stark[27] comments about this sort of surveillance:

> Surveillance deprives persons of privacy by monitoring their behaviour, usually to gather information without their knowledge. In coercive control, surveillance falls on a continuum with a range of monitoring tactics and has the additional aims of conveying that the perpetrator is omnipotent and omnipresent and letting the victim know she is being watched or overheard."

6.9 Jane reported to the children that her Partner would follow her to the shops and her place of work and he would sit outside both locations waiting for her to finish. It is alleged that he even went to the trouble to disguise himself whilst he was watching her. He would also control her over social media.

6.10 According to Fontes[28] being monitored closely leads some people to grow anxious and become afraid of situations that previously never frightened them. Being stalked feels like wearing invisible handcuffs, tying a victim to her stalker at all times.

6.11 It is clear from the family's experience that her Partner was in the habit of belittling Jane and making comments that 'put her down'. Regarding belittling, Fontes[29] states;

> 'Many men who use coercive control deliberately degrade or belittle their partners to establish their 'ownership' and moral superiority and to damage a woman's self-respect'.

6.12 An example given by the children was her Partner constantly singing 'ten green bottles' to her which to Jane had threatening connotation when the last bottle would fall.

6.13 Another aspect of her Partner's coercive and controlling behaviour which is common in these circumstances is the deliberate exclusion of Jane's family. According to Jane's children, her Partner went out of his way to make family visits to Jane uncomfortable to such an extent that not only did the family stop visiting but Jane became nervous and frightened in case a family member would say something to upset him. One family member recalls an incident where during a visit something innocently happened which

[26] How To Successfully Handle Passive-Aggressive People Preston. N. 2014
[27] Coercive Control: How Men Entrap Women in Personal Life. Stark. E. 2007
[28] Invisible Chains Overcoming Coercive Control In Your Intimate Relationship Fontes. L. A. 2015
[29] Invisible Chains Overcoming Coercive Control In Your Intimate Relationship Fontes. L. A. 2015

made the family member laugh and for some reason her Partner instructed them to immediately leave and never to return to the house.

6.14 Bancroft[30] asks:

> "Why does an abuser sow division in these ways? One reason is that his power is decreased if the family remains unified.

6.15 Stark[31] puts a different slant on family member's relationship with an abused relative:

> "Victims accommodate a partner's jealousy by cutting off old friendships and curtailing their social activities. To placate their partner and prove their loyalty, they quit school or church, stop seeing friends or family".

6.16 Fontes[32] claims:

> "An abusive man might prohibit his partner from seeing family members. Or he might interfere in ways that make family visits short, tense of infrequent. He might tell her it's time to transition from her role as a daughter to her new role with him, urging her to spend less time with her family. The abuser may listen in on phone calls, embarrass the woman in front of family or intercept emails or social media".

6.17 The monitoring of her phones was another example of her Partner's controlling behaviour. A tracking device on her mobile phone was found by staff at the GP's surgery and removed. The children will say that any phone call to or from their mother had to be on loud speaker so that her Partner could hear every word that was being said. There is also a suspicion that telephone calls and conversations were recorded by her Partner.

6.18 There is also evidence of financial manipulation on behalf of her Partner. Very shortly after her death, her Partner transferred a substantial amount of money from Jane's bank account into his own account. As a result of a complaint by the children, the bank instructed her Partner to return the money to Jane's account. Her Partner's version of events when interviewed by the Police was that a bank card for that account had been lost and he was insuring the safety of the money by putting it into his own account for a short period of time until he returned it of his own volition.

6.19 The children have evidence that since Jane's death her Partner has renewed the car insurance on her car in her name.

6.20 Information from Jane's children indicate that she left her Partner on 'countless occasions' but each time returned to him. She was provided with accommodation at the hospital where she worked but not long after moving in there her Partner persuaded her that she would not be able to afford the rent, so she moved back with him.

6.21 Fontes[33] records:

> "A woman may try to escape from the relationship multiple times, but her partner will not let her go. He tracks her down, threatens her, beats her…. Through his charm and connections, he is often able to manipulate.

6.22 There is extensive published research regarding the barriers that prevent women leaving an abusive relationship and the reasons why they return to her Partner even though little has changed. Her Partner claimed that he found accommodation Jane at

[30] Why Does He Do That? Inside the minds of angry and controlling men. Bancroft. L. 2002
[31] Coercive Control: How Men Entrap Women in Personal Life. Stark. E. 2007
[32] Invisible Chains Overcoming Coercive Control In Your Intimate Relationship, Fontes. L. A. 2015
[33] Invisible Chains Overcoming Coercive Control In Your Intimate Relationship, Fontes. L. A. 2015

the local hospital and that she chose to return to him because she could not afford the rent. The family insist that her accommodation at the hospital was found by her work colleagues and that her Partner contacted her and convinced her to return to his house.

6.23 Describing the abusive partner, Bancroft[34] states:

> 'He experiences the separation as a declaration by his partner that she is capable of surviving without him, that she is the best judge of what is good for her, that her needs shouldn't always take a backseat to his, that her will has force. These messages represent a powerful summary of everything that he does not want in his relationship and he feels driven to move quickly to prove them false'.

6.24 Sanderson[35] describes internal and external barriers to leaving and remaining apart from the abuser. Internal barriers include;

- fear of retaliation - where the victims are most at risk when leaving or just after leaving,
- not being able to contemplate an existence outside the relationship and separate from the abuser,
- the debilitating effects of abuse preventing the victim leaving due to chronic physical, emotional and mental exhaustion

6.25 External barriers to leaving include the lack of knowledge and access to practical resources such as

- social support
- access to adequate protection and safety
- access to housing, economic resources medical and legal advice.

6.26 In this case barriers to Jane leaving and remaining apart from her Partner possibly included;

- financial – her Partner controlled her finances
- no suitable accommodation being available – she had no alternative housing.
- he had separated her from her own family.

6.27 There were about 135 domestic abusive related homicides in the UK during the 'pandemic' year of 2020[36] that were as a result of coercive and controlling behaviour. Nationally here were only 3% of arrests made for coercive and controlling behaviour. During 2021, Northamptonshire Police are embarking on Domestic Abuse Matters training for officers which will focus on coercive and controlling behaviour.

6.28 Many agencies are actively engage with training their staff with regard to domestic abuse, but coercive controlling behaviour is a relatively new phenomena and agencies may wish to review their training especially around coercive and controlling behaviour.

Recommendation No 1.

All agencies review their domestic abuse training to ensure that coercive and controlling behaviour is seen as a major focus of that training.

[34] Why Does He Do That? Inside the minds of angry and controlling men. Bancroft. L 2002
[35] Counselling Survivors of Domestic Abuse Sanderson C 2011
[36] Domestic Abuse & Sexual Violence – Covid 19 Impacts. Collette Eaton-Harris Domestic Abuse and Sexual Violence Lead NHS Devon CCG 2020

6.29 Fugate[37] et al found a similar situation in Chicago and reported:

> "Four kinds of barriers were present across all types of help-seeking examined: hassle, fear, confidentiality, or tangible loss. The findings suggest the need for increased awareness among victims of domestic violence as well as the wider community about available services, a need for ongoing evaluation of existing services in meeting the needs of all victims of domestic violence, and reinforcement of the view that victims' safety should inform all efforts".

6.30 It is clear that agencies in Northamptonshire should work together to ensure that there is greater public awareness for victims of domestic abuse, especially with regard to controlling and coercive behaviour by partners, using a publicity campaign and advertising with posters, leaflets and seminars etc.

Recommendation No. 2

All agencies in Northamptonshire to work together under the lead of NDAS to create a county wide publicity campaign regarding domestic abuse but in particular the signs, symptoms and outcomes of coercive controlling behaviour. The campaign should consist of leaflets, posters and seminars to inform the public of this kind of domestic abuse and how to seek support from agencies.

6.31 The Northamptonshire Safeguarding Adults Annual Report 2019 – 2020[38], sets out the Strategic Aims for 2019 – 2021, as well as the Boards priorities, which are:

- Making Safeguarding personal
- Prevention
- Quality

Second in a list of themes in the Annual Report is Domestic Abuse.

6.32 In accordance with the Prevention priorities, early identification of victims of domestic abuse and intervention is critical. In support of this Northamptonshire Police, the Adult Safeguarding Board and other agencies have introduced a MADRA process, (Multi-Agency Daily Risk Assessment. All high and medium risk Domestic Abuse Notifications where children are present or involved are progressed through the MADRA meeting since end of March 2020. The MADRA meeting will also progress standard risk Domestic Abuse notifications where there have been 3 incidents of Domestic Abuse within a 12-month period and those where professional judgement applied identifies risks to the child/ren. There needs to be an extension of this process to include identified vulnerable adults to ensure that such people are identified at the earliest opportunity and therefore receive the appropriate care and support needed.

Recommendation No. 3

Consideration to be given to extend the MADRA (Multi-Agency Daily Risk Assessment) process to include identified vulnerable adults where early intervention by services and support can be offered and given.

6.33 Another issue that emerges from the examination of the information gathered in respect of Jane's death is the lack of professional curiosity on behalf of professionals. There were occasions when opportunities to consider the possibility of domestic

[37] Barriers to Domestic Violence Help Seeking: Implications for Intervention Michelle Fugate, Leslie Landis, Kim Riordan, Sara Naureckas, Barbara Engel ojp.ocom@usdoj.gov 2005
US Dept of Justice – Office of Justice Programmes

[38] Northamptonshire Safeguarding Adults Board Annual Report 2019 - 2020

abuse, particularly coercive and controlling behaviour by her Partner towards Jane were missed and where a more curious, enquiring approach may have identified risks that she faced in her relationship with him. The installation of CCTV in her car and around the house, (although her Partner refutes the CCTV inside the house) and the removal of Jane's bedroom door as witnessed by police officers, (although her Partner says it was done during a period possibly repairing swollen doors) may have raised suspicion of the existence of controlling behaviour. The constant complaining about neighbours and the allegations of damage being caused to Jane's car and thereby the excuse to install CCTV may have given clues about the relationship between Jane and her Partner.

6.34 There were also occasions when as referral could have been made to MARAC: June 2015 and April 2019.

6.35 All agencies should be encouraged to ensure that their individual training on domestic abuse re-enforces the importance of professional curiosity and lateral thinking.

Recommendation No. 4

All agencies are to ensure that training regarding domestic abuse stresses the importance of professional curiosity and lateral thinking so as to ensure that indicators of abuse are not missed.

6.36 Jane was referred to MARAC first in 2014, but in 2015 there was a missed opportunity by S2S to make a MARAC referral. So too in 2019 when KGH could have made a similar referral. This is supported by the Sunflower Centre making an internal recommendation that training specifically on Coercive and Controlling Behaviour should be included in SFC's training schedule.

6.37 It may have been the case that more frequent referral by agencies to MARAC may have resulted in the fuller picture of what life was like for Jane and thereby a more positive and supportive response given to her.

Recommendation No. 5

All agencies to ensure that Domestic Abuse training is to include an update on the use of MARAC referrals, the process, the outcomes of a referrals and the benefits that may result from the referral process.

Agency Involvement

The Sunflower Centre

6.38 Jane was referred to the Sunflower Centre on nine occasions. She was contacted on five of those occasions. The first referral was in October 2011 after Police intervention.

6.39 She was contacted again in August 2012 but didn't feel the appointment was appropriate. She had another appointment in December 2012 which she cancelled saying her and her partner were trying to make a go of their relationship.

6.40 She was referred again in October 2013 and during an attempted telephone contact, it appears her Partner answered the phone and said, 'this is the second time someone has rang asking for females, you must have the wrong number, don't ring again'.

6.41 Jane asked for an appointment in December 2013 saying she was uncertain what she should do as her partner is very controlling. She had a face to face appointment later that month.

6.42 Jane's case was heard at a MARAC in May 2014 and actions included ensuring she was seen alone at the GP's surgery, ensuring she received safeguarding support, and remained in contact with the IDVA.

6.43 Her Partner was referred to the Sunflower Centre in September 2014 and he was referred to MARAC which was heard in October 2014. At that meeting agencies confirmed Jane as the victim and not her Partner.

6.44 A detective from the Domestic Abuse Unit asked the Sunflower Centre to contact Jane in March 2015. She said she was safe and well and did not require any further support from the Sunflower Centre.

6.45 An examination from the input from the Sunflower Centre indicate that all contacts with Jane were in line with the Sunflower Centre Case Management Policy.

6.46 During the period of contact with Jane, coercive control became a crime and since that date (December 2015) the Sunflower Centre has become more aware of the effects of coercive control can have on victims in terms of lethality including suicide. The Sunflower Centre however identify that their record keeping needs updating to ensure that all notes are kept up to date particularly in relation to support provided to hospitals.

6.47 The Sunflower Centre IMR makes four recommendations:

- Regular coercive control training to be delivered to all Sunflower Centre staff including the MARAC Team.
- Data recording instructions within Case Management Policy to be updated and staff to be reminded of recording responsibilities.
- Source additional Mental Awareness Training
- Identification of primary victims in cases to ensure appropriate support is provided.

Northamptonshire Domestic Abuse Service

6.48 Northamptonshire Domestic Abuse Service (NDAS) had five contacts with Jane during 2019. In March 2019, she was advised to ring NDAS by her GP after a disclosure of abuse by her partner.

6.49 In March 2020, Jane contacted NDAS during the incident at the GP surgery where she had nowhere to go. Jane was unsure of her options to keep herself safe, but she decided she did not want to move into shared accommodation initially, but later changed her mind and was accommodated overnight in a hotel.

6.50 The following day, NDAS called Jane. She had returned home and stated her partner was going to help her with her drinking habits and that she no longer was in refuge.

6.51 An examination of NDAS's actions indicate that all appropriate policies were in place, staff were fully trained, and NDAS's dealings with Jane were in line with usual procedures. There was effective communication between NDAS, the Police and the GP surgery. NDAS make no recommendations.

Kettering General Hospital – Employment

6.52 Jane was employed at Kettering General Hospital as a Health Care Assistant from May 2010 and the occupational health department of the hospital together with her manager had significant dealings with Jane offering support and guidance.

6.53 KGH has guidelines regarding domestic abuse which includes a specific aim relating to staff:

- For professionals to be aware that domestic abuse can affect anybody including those around us, therefore being aware of support available for staff and staff involved who encounter domestic abuse as a victim or following a disclosure from a colleague.

6.54 KGH also have a Safeguarding Adults at Risk Policy which relates to both patients and staff. Jane's manager was aware of her home situation and referred her to occupational health. Occupational health consistently signposted her to appropriate services, e.g., the Sunflower Centre and her GP. The manager offered support outside of her formal supervision and the human resource structures had consistently shown awareness of issues related to domestic violence and abuse and their impact on capacity to work.

6.55 The KGH Employment Report identify the training that staff undertake in relation to safeguarding.

- Occupational Health Advisors – level two Safeguarding Adults and Children Training.
- Human resource staff – level one Safeguarding Adults and Children Training (basic DVA awareness training including in level one and two SAC training)
- Hospital IDVA provides bespoke training for all staff. Training is monitored by Electronic Staff Record.
- Compliance with Safeguarding Training consistently exceeds the 85% minimum standard.

6.56 There were however, three instances which related to a lack of resources.

- No Trust Staff Counselling Service for occupational health staff to refer Jane to in May 2010.
- Lack of occupational health capacity for human resources to refer Jane for advice re returning to work in August 2019.
- A six week delay in sending out the First HR Formal Sickness Meeting Letter which resulted in Jane missing her scheduled two week review meeting in August 2019.

6.57 There was evidence of professional curiosity in the occupational health disclosures of domestic abuse in 2012, 2013 and 2017. In addition, Jane was seen alone in occupational health consultations and she was offered the use of the office phone to contact the Sunflower Centre. There was also evidence of a full mental health assessment of Jane using the appropriate assessment tools and good practise was identified when the HR manager did not include all the issues discussed in the Long Term Sickness Meeting in a letter that was posted to Jane at her home address, clearly recognising the risk should it have been read by her Partner.

6.58 Jane eventually lost her job at the hospital due to her not being able to cope with work and her domestic situation.

6.59 In her research, Collette Eaton-Harris[39] discovered:

> "An estimated 51,000 NHS staff experience domestic abuse each year. NHS Employers reports that;

[39] Domestic Abuse & Sexual Violence – Covid 19 Impacts. Collette Eaton-Harris Domestic Abuse and Sexual Violence Lead NHS Devon CCG 2020

• 75% of people who endure domestic violence are targeted at work from harassing phone calls and abusive partners arriving at the office unannounced to physical assaults.

• 58% of abused women miss at least three days of work a month.

• 56% of abused women arrive late for work at least five times".

Kettering General Hospital

6.60 As stated above, KGH has guidelines for domestic abuse and is based predominantly on the Nice Domestic Violence and Abuse: Multi Agency Working 2014. These guidelines include responsibility of staff to be aware of coercive and controlling behaviour, encourage professional curiosity in the area of domestic abuse, identifying abuse from indicators such as depression, anxiety and substance misuse and the referral process to an IDVA. An examination of the involvement of KGH with Jane indicates that is not clear from her medical notes if there was an input from KGH Safeguarding Team during Jane's hospital admissions. A safeguarding notification was completed at her request while Jane was an inpatient and this related to her Partner being verbally abusive. A copy of the notification was not retained on her notes.

6.61 There is evidence from the chronology of effective team working such as the Registered Nurse, Doctor and Occupational Therapist working together to enable to discharge of Jane in May 2019. It is unsure, however, if Jane consented to the occupational therapist and the doctor talking to her Partner on the phone about delivery of equipment and Jane's eating habits.

6.62 Good practice is identified by the Digestive Diseases Unit giving Jane positive support at referring her to S2S in 2019.

6.63 Regarding the bruising noted to Jane's abdomen, there was no evidence of a body map being completed which should have been done every time Jane visited the emergency department. Neither was there evidence of the fact that there was bruising escalated to senior colleagues. There was a missed opportunity to consider the possibility of the bruising being attributed to domestic violence.

6.64 There were three Medway Alerts relating to Jane, the first of which in August 2014 mentions domestic abuse. The other two alerts related to medical issues. There is no evidence that the alert domestic abuse prompted professional curiosity to ask more questions and consider domestic abuse risks. The fact that her Partner was present or not when she accessed services is not recorded.

6.65 There are, however, examples of good practice where hospital staff addressed Jane's mental health. There is evidence of a nurse suggesting she visited her GP and another nurse recording that Jane was depressed, tearful and concerned about medical procedures, however, there does not seem to have been a link considered between anxiety and depression and potential domestic abuse.

6.66 There is evidence of professional curiosity and adherence to the guidelines on domestic abuse when in April 2019, a nurse used skilful questioning to encourage disclosure by Jane and a referral was made to the Sunflower Centre IDVA. There is nothing however to indicate that there was a discussion with the KGH safeguarding team.

6.67 In May 2019, it is recorded that Jane told doctors about her abusive relationship at home and the fact that she said she could not get help from Social Services. The discharge team noted that Adults Social Services had called to confirm that there was safeguarding in place for Jane and it is also noted that she had chosen to decline Police input. There was no record of any discussion with KGH safeguarding team. She

was discharged three days later into what was considered a potentially unsafe environment and the discharge letter to the GP contained no information about her home situation or the domestic abuse.

6.68 KGH make no formal recommendations other that it states that in-house training for safeguarding will continue and will reflect the implications of the forthcoming Domestic Abuse Bill of 2020.

Northamptonshire Healthcare Foundation Trust

6.69 NHFT only record two dates where Jane came to their notice. A referral letter was sent from Jane's GP for IAPT to increase access to psychological therapies. A letter was sent to Jane but no reply received. The second occasion was in May 2019, when a letter was received by NHFT from IAPT saying that there had been no contact with Jane.

6.70 There is no record on community nursing or secondary metal health records that Jane had been seen by NHFT services.

Northampton Adult Social Care

6.71 The Adult Social Care chronology shows 2 contacts with Jane in 2011, 2 contacts in 2014 and 8 contacts with her in 2019.

6.72 The 2011 entries related to a domestic incident where EMAS were called and the Safeguarding Adults Team were informed in line with procedures.

6.73 The first incident I 2014, on 14th January, concerned letter that her Partner had written to. NHS complaints that had been referred to Adult Safeguarding Team in line with the correct procedures.

6.74 The second 2014 incident was as a result of the police making a referral to the Out of Hours team on behalf of Jane. Regarding housing issues. The referral was passed to Corby Emergency Housing and there was no request made to follow up with other agencies.

6.75 In March 2019 Jane's GP contacted ASC concerned about her being in an abusive relationship with her partner. It was correctly decided that the Sunflower Centre was the most appropriate resource to support Jane's needs

6.76 The details of another EMAS referral in March 2019 were shared with the police and Jane's GP due to concerns about her drink driving and her alcohol abuse.

6.77 On the 9th April 2019, the GP rang ASC regarding concerns he had about Jane especially around the events on 20th March 2019 at the surgery when she had been removed to a refuge but had returned home to her Partner. Attempts were made by ASC to contact her but without success and as there was no contact back from her ASC took no further action. The comments made by the chronology author for ASC include that attempts to include the safeguarding lead at the GP's surgery could have been made and a possible discussion may have been had with the GP surgery about initiating the ARM process

6.78 The next contact with ASC, on 15th April 2019, saw more positive attempts to contact Jane. Checks were made with her to see if she had been accessing appropriate services in terms of domestic violence, which she appeared to have done so. Again on 3rd May 2019, the Social Worker assured themselves that she was receiving the appropriate care and information shared.

6.79 The last entry from ASC was on 23rd August 2019, when EMAS found Jane in her bedroom in a very frail condition. EMAS made a referral to ASC but did not mention domestic abuse, rather than she was not meeting her needs. Comments made in the chronology indicate that a Principle Care Manager who received the referral may have asked more questions to ascertain if this case was eligible under the Care Act 2014.

6.80 Northamptonshire Adult Social Services Team Manager indicates a number of recommendations that Adult Social Services make which include:

- Northamptonshire County Council Customer Service Centre (CSC) to have a better awareness of risk, exercising professional curiosity, safeguarding processes, and assessing cumulative information organised by a lead social worker.
- A monthly auditing of decision making by the Pro-Support Team in CSC.
- Northamptonshire Safeguarding Adult Board Quality and Performance Sub-group to provide additional training for staff around the new Adult Risk Management (ARM) toolkit (Safeguarding Adult Review reference 016 2020 has made similar recommendations)
- NCC ASC Team to be reorganised in line with the move to a Unitary Authority in April 2021.
- To embed into policy Adult Social Care's revised Serious Incident Policy to ensure that IMRs are systematically and routinely actioned in all cases.

GP's practice

6.81 Jane's GP's practice had considerable engagement with her during the scope of this review. The practice involvement has been examined by a registered nurse with responsibilities for leading and safeguarding at the practice. Throughout their dealings with Jane, primary care was available with a registered name practitioner. In 2010, Jane was advised to self-refer to Women's Aid due to her domestic situation. In March 2019, she suggested that there were no GP services to help her, but it is unclear who she attempted to contact. During an episode of crisis, contact was made facilitated by her GP and refuge place was made available. Records show that there were contacts with the Police, the Sunflower Centre and the occupational health department at the hospital where Jane worked. She repeatedly returned to the GP for help and they appeared to have been available or made time to see her as soon as feasible.

6.82 There is evidence in Jane's medical records of exceptional care and attention by one member of staff. In addition, there were examples of disputes experienced by staff from the practice involving her Partner. There were multiple letters with threats to the staff, offensive telephone calls and her Partner attending in person and being aggressive towards surgery staff. The contents of his concerns related to Jane and her self-abuse while her Partner alleges the practice was negligent. The practice staff correctly ascertained sharing of information permission from Jane and maintained her confidentiality despite difficult situations. Due to his aggressive behaviour, the surgery sought to remove her Partner from the patient list. It is clear that the staff maintained professionalism and acted in Jane's best interest.

6.83 It is considered that staff who engaged with her Partner maintained high professional standards, no information was shared without consent and despite complaints and aggression confidentiality was maintained. During periods of crisis, senior clinicians worked together, sharing workloads and patients to allow one particular GP to concentrate achieving optimal care and attention for Jane.

6.84 The GRACE (GP Risk Assessment Control and Escalation) is the CCG's adaptation of the DASH for Primary Care and was implemented in 2018 by the Safeguarding Lead

GP and the Sunflower Centre Manager. This was used effectively in relation to Jane. The author of the GP Practice report is of the opinion that prior to GRACE, the assessment tools in primary care could have been utilised to assist her earlier were not available.

6.85 The report acknowledges that in 2010 control and coercion was not recognised so this was only evident in hindsight. The report quotes a comment from Jane 'she is ok because he doesn't hurt her physically'. Mental health services appear to have been accessed instead of any other action due to her low mood and self-harm. Since the introduction of specific training, there is evidence for awareness of domestic abuse, its affects, and the organisations ability to help.

6.86 The practices policies and protocols have been updated in line with new legislation i.e., Working Together 2018 regarding Children's Safeguarding and staff from the practice have undergone training including the practice manager and the GP safeguarding lead who has attended specific training regarding domestic abuse. Senior GPs have attended GRACE training. Domestic violence awareness is now deeply embedded into the knowledge and training of all staff at the practice.

Northamptonshire Police

6.87 The IMR author for Northamptonshire Police has examined the police response to both Jane and her Partner's requests for attendance to a variety of reported incidents. The IMR states clearly that officers attending to such calls look at evidence of specific offences and to take positive action where appropriate. In many of the calls to Jane. She complained about her Partner's dominance and control over her but did not expand in detail. She was often found to be obstructive and uncooperative and sometimes under the influence of alcohol. She would also appear to go against advice given by the officers. This made their options difficult and they were faced with limited solutions.

6.88 Where possible, officers did take positive actions. Her Partner was arrested in October 2011, when Jane cut her finger during a domestic incident and she was removed from the house to prevent a breach of the peace on more than one occasion. It is of interest to note that in December 2012, (Page 18) reference is made to police attending a domestic incident where her Partner declined to complete a DASH form. Jane did and in doing so made reference to her Partner trying to strangle her at some stage during 2011. This appears to have no bearing on the DASH Risk Assessment outcome when completed in 2012.

6.89 None fatal strangulation is now, (2022) is considered a major indicator of high risk behaviour whereby a MARAC will be convened and all of the circumstances discussed. Non-fatal strangulation or suffocation is now a stand-alone offence within the Domestic Abuse legislation and carries a term of up to 5 years imprisonment. It is hoped that such a comment by a victim of domestic abuse made today would be the trigger for positive and assertive action by any professional from any agency.

6.90 As stated earlier in this report, the legislation regarding coercive and controlling behaviour came into force in March 2015. There can be no evidence drawn from instances before that date when looking at the threshold for prosecution under this particular legislation. It is of interest to note that of the 24 domestic incidents recorded by the police in relation to Jane and her Partner, only two of them occurred after the implementation of the act in March 2015.

6.91 The police IMR author considers that it is quite possible that Jane's alcohol intake had a bearing on the response the police gave to call from both her and her Partner.

6.92 On a more positive note, it is considered that Northamptonshire Police's initiative of forming a Single Point of Contact (SPOC), a particular named officer to her Partner. He was a local officer to where the couple lived and having an extensive knowledge of her Partner proved to be a very effective form of communication. However, eventually her Partner became so demanding of this officer that his supervisor removed the arrangement as the officer was spending a disproportionate amount of time dealing with her Partner. The IMR comments that it may have been better to allocate Jane this officer who may have been able to achieve a coherent complaint from her.

6.93 Northamptonshire Police make one recommendation:

> It is recommended consideration be given by Northamptonshire Police to the use of a Single Point of Contact (SPOC) in cases where there is a high frequency of incident occurrences where controlling or coercive behaviours is suspected. This could prove beneficial in terms of gaining a victims trust thus empowering them with confidence to provide comprehensive and coherent evidence to be gathered effectively.

S2S (Substance to Solutions)

6.94 Substance to Solutions (S2) were engaged with Jane from April 2014 until June 2015. There was a gap in services to her until April 2019 when she re-engaged until May 2019. It is interesting to note that against the entry for 21st April 2014, when she was seen by S2S whilst she was in custody following a domestic dispute, the chronology author comments,

> 'It may have been beneficial to have signposted [Jane] to domestic violence support agencies at this point'

6.95 Six months later in the chronology, (23rd December 2014) when Jane was seen for her planned assessment with a none medical prescriber and when she disclosed continuing emotional abuse and controlling behaviour from her partner, the same words appear in the comments of the chronology.

6.96 In January 2015, when contact could not be established with Jane the chronology states,

> 'It may have been beneficial to discuss the case with a manager given the disclosure of domestic violence and reduce the contact with the service'.

6.97 On 4th March 2015, there is a comment made'

> 'It may have been a good opportunity to offer signposting around domestic violence support and housing options'

6.98 Again on 18th March 2015 it is stated'

> 'It may have been beneficial to attempt to contact [Jane] following her missed appointment given her recent disclosure about domestic violence'

6.99 On 25th March 2015, the comment is made'

> 'It may have been beneficial to have follow up with [Jane's] GP or next of kin with whom she has provided consent to share information as this was following her previous DV disclosure'.

6.100 A similar comment about contacting the GP is made against the 9th June 2015 entry in the chronology and also'

> 'It may have been beneficial at this point to liaise with MARAC with regards to [Jane's] discharge'.

6.101 It appears that during 2014 and 2015 here was a lack of professional curiosity among the staff at S2S but on examination of the later entries in the chronology for 2019 when Jane returns for S2S services, there is a distinct change in comments in the chronology:

> 15th April 2019 – [Jane] Seen by the ASML Nurse on the day of her referral and the liaison assessment pathway was followed.

6.102 On 8th May 2019, an identical comment was made as well as'

> 'The ASML Nurse followed good practice by making a referral to IDVA following [Jane's] disclosure of domestic violence',

and two days later on 10th May 2019, the comment is made,

> 'The ASML Nurse was satisfied that all appropriate referrals with regards to domestic violence had been made by the hospital and [Jane] had seen the hospital IDVA'.

6.103 The S2S report author considered that it would have been beneficial to offer Jane more frequent appointments around April 2015 and when she was discharged from the services in June 2019, the S2S IMR Author considers that good practise would have been to contact her GP to notify them of her discharge and also to liaise with MARAC.

6.104 It appears that S2S have improved the services that Jane Received between 2014 and 2019, where there were clearly some issues around working practices, professional curiosity and perhaps management and supervision.

6.105 S2S make no recommendations in their report.

East Midlands Ambulance Service (EMAS)

6.106 There are 9 entries in the EMAS chronology between October 2010 and August 2019, where they had dealings with Jane. On each occasion the chronology indicates that referrals were made where necessary or Jane's GP was notified in the nature of the incident. Each time EMASS attended there was full compliance with procedures and policies.

7.0 Conclusions

7.1 As mentioned on previous pages of this report, the facts as set out are an illustration of information the DHR Panel has obtained from agencies, from accounts from Jane's family, friends and colleagues and also from the version of events given by her Partner.

7.2 The account from her Partner differs considerably to that given by Jane's family. It is not the position of the DHR Panel to make judgement on which version is factual and correct. The role of the panel in this case is to report accurately what has been recorded and said, to make recommendations based on that information and to present equally all accounts for consideration.

7.3 Overview Report recommendations have been made on the basis that the information gathers identifies areas where services could be improved. That is also the case for those agencies that have made internal recommendations.

7.4 The report recognises that the police investigation was unable to gather evidence that reached the threshold for any criminal offence being identified and no charges have been brought against her Partner.

7.5 The report also recognises that the circumstances, allegations and disclosures made by Jane do satisfy the requirement for a review as set out in the Home Office Guidance of 2016.

List of Recommendations

Recommendation No 1.

All agencies review their domestic abuse training to ensure that coercive and controlling behaviour is seen as a major focus of that training.

Recommendation No. 2

All agencies in Northampton to work together under the lead of NDAS to create a county wide publicity campaign regarding domestic abuse but in particular the signs, symptoms and outcomes of coercive controlling behaviour. The campaign should consist of leaflets, posters and seminars to inform the public of this kind of domestic abuse and how to seek support from agencies.

Recommendation No. 3

Consideration to be given to extend the MADRA (Multi-Agency Daily Risk Assessment) process to include identified vulnerable adults where early intervention by services and support can be offered and given.

Recommendation No. 4

All agencies are to ensure that training regarding domestic abuse stresses the importance of professional curiosity and lateral thinking so as to ensure that indicators of abuse are not missed.

Recommendation No. 5

With the introduction of Northamptonshire Police Prevention and Intervention Command, the Head of that Command should, whilst making progress with plans to embed the process to prioritise the collation of information from Offender Management systems, MAPPA, Probation and risk management systems in order to gather and assess intelligence which results in proactive action, consider specifically including the MARAC risk management process within its scope.

Recommendation No. 6

All agencies to ensure that Domestic Abuse training is to include an update on the use of MARAC referrals, the process, the outcomes of a referrals and the benefits that may result from the referral process.

Agency Recommendations

The Sunflower Centre recommendations:

- Regular coercive control training to be delivered to all Sunflower Centre staff including the MARAC Team.
- Data recording instructions within Case Management Policy to be updated and staff to be reminded of recording responsibilities.
- Source additional Mental Awareness Training

- Identification of primary victims in cases to ensure appropriate support is provided.

Adult Social Care recommendations

- Northamptonshire County Council Customer Service Centre (SCS) to have a better awareness of risk, exercising professional curiosity, safeguarding processes, and assessing cumulative information organised by a lead social worker.
- A monthly auditing of decision making by the Pro-Support Team in CSC.
- Northamptonshire Safeguarding Adult Board Quality and Performance Sub-group to provide additional training for staff around the new Adult Risk Management (ARM) toolkit (Safeguarding Adult Review reference 016 2020 has made similar recommendations)
- NCC ASC Team to be reorganised in line with the move to a Unitary Authority in April 2021.
- To embed into policy Adult Social Care's revised Serious Incident Policy to ensure that IMRs are systematically and routinely actioned in all cases.

Northamptonshire Police recommendation:

It is recommended consideration be given by Northamptonshire Police to the use of a Single Point of Contact (SPOC) in cases where there is a high frequency of incident occurrences where controlling or coercive behaviours is suspected. This could prove beneficial in terms of gaining a victims trust thus empowering them with confidence to provide comprehensive and coherent evidence to be gathered effectively.

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Northamptonshire Safeguarding Adults Board Annual Report 2019 - 2020

Appendix No. 1

Terms of Reference

1. Supporting Framework

1.1. The Domestic Homicide Review (DHR) is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

1.2. In this section "domestic homicide review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by

A person to whom he was related or with whom he was or had been in an intimate relationship; or

A member of the same household as himself,

Held with a view to identifying the lessons to be learnt from the death.

1.3. Where the definition, set out in this paragraph has been met, then a Domestic Homicide Review should be undertaken.

1.4. In March 2013, the Government added to the definition:

> "any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over, who are or who have been intimate partners or family members regardless of gender or sexuality. This can be encompass, but is not limited to, the following types of abuse:
>
> - Psychological
> - Physical
> - Sexual
> - Financial
> - Emotional

Coercive behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance, and escape and regulating their everyday behaviour.

Coercive behaviour is: a continuing act or a pattern of acts of assault, threats humiliation and intimidation or other abuse that is used to harm, punish or frighten their victim.

2. Purpose of the DHR

2.1. Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

2.2. Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

2.3. Apply these lessons to service responses, including changes to inform national and local policies and procedures as appropriate;

2.4. Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

2.5. Contribute to a better understanding of the nature of domestic violence and abuse; and

2.6. Highlight good practice.

3. Methodology

3.1. This DHR will primarily use an investigative, systems focuses and Individual Management Review (IMR) approach. This will ensure a full analysis by the IMR author to show comprehensive overview and alignment of actions.

3.2. This will ensure that practical and meaningful engagement of key frontline staff and managers will be carried out by the IMR author on a more experiential basis than solely being asked to respond to written conclusions or recommendations.

3.3. This is more likely to embed learning into practice and support cultural change where required.

4. Scope of the DHR

4.1. Victim: Jane

4.2. Partner:

Timeframe

4.3 The period of this review will be from 31st May 2010, the date that her Partner's neighbour reported an assault allegation to the police until the date of Jane's death in August 2019.

4.4 In addition agencies are asked to provide a brief background of any significant events and safeguarding issues in respect of these adults and include information around wider practice at the time of the incident as well as the practice in the case.

4.5 If an agency identifies relevant information prior to the commencement date of this review, details should be included in the chronology and the IMR.

4.6 The Terms of Reference will be a standing item on the agenda of every panel meeting in order the we can remain flexible in our approach to identify learning opportunities.

5. Agency Reports

5.1. Agency reports will be commissioned from:

- Northamptonshire Police to include the Sunflower Centre
- Northamptonshire CCG to include GPs
- Adult Social Care NCC
- Kettering General Hospital
- East Midlands Ambulance Service
- S2S

A written report is to be submitted by Northampton General Hospital

5.2. Agencies will be expected to complete a chronology and IMR. Template and guidance attached.

5.3. Any references to the adult, their family or individual members of staff must be in full and later redacted before submission to the Home Office or published.

5.4. Any reasons for non-cooperation must be reported and explained.

5.5. All agency reports must be quality assured and signed off by a senior manager within the agency prior to submission.

5.6. It is requested that any additional information requested from agencies by the DHR Independent Author is submitted on an updated version of the original IMR in red text and dated.

5.7. It is requested that timescales are strictly adhered to and it should be noted that failure to do so may have a direct impact on the content of the DHR and may be referred to in the final Overview Report to the Home Office

5.8. Agencies will be asked to update on any actions identified in the IMR prior to completion of the DHR which will be fed into the final report. Updates will then be requested until all actions are completed.

6. Areas for consideration

Victim:

6.1. Was Jane recognised or considered to be a victim of abuse and did Jane recognise themselves as being an object of abuse?

6.2. Did Jane disclose to anyone and if so, was the response appropriate?

6.3. Was this information recorded and shared where appropriate?

6.4. Were services sensitive to the protected characteristics within the Equality Act 2010 in respect of Jane and her family?

6.5. When, and in what way, were Jane's wishes and feelings ascertained and considered?

6.6. Is it reasonable to assume that the wishes of Jane should have been known?

6.7. Was Jane informed of options/choices to make informed decisions?

6.8. Were they signposted to other agencies?

6.9. Was consideration of vulnerability or disability made by professionals in respect of Jane and partner?

6.10. How accessible were the services for Jane and her Partner?

6.11. Was Jane or partner subject to a Multi-agency Risk Assessment Conference (MARAC) or any other multiagency forum?

6.12. Did Jane have any contact with a domestic abuse organisation, charity or helpline?

Partner:

6.13. Was her Partner recognised or considered to be a victim of abuse and did the perpetrator recognise themselves as being a perpetrator of abuse?

6.14. Did her Partner disclose to anyone, and if so, was the response appropriate?

6.15. Was this information recorded and shared where appropriate?

6.16. Was anything known about her Partner? For example, were they being managed under MAPPA, did they require services, did they have access to services.

6.17. Were services sensitive to the protected characteristics within the Equality Act 2010 in respect of partner?

6.18. Were services accessible for her Partner? And were they signposted to services?

6.19. Was consideration of vulnerability or disability made by professionals in respect of her Partner?

6.20. Did her Partner have contact with any domestic abuse organisation, charity or helpline?

Practitioners:

6.21. Were practitioners sensitive to the needs of Jane and her Partner, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator?

6.22. Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

Policy and Procedure:

6.23. Did the agency have policies and procedures in place for dealing with concerns about safeguarding and domestic abuse?

6.24. Did the agency have policy and procedures for risk assessment and risk management for domestic abuse, victims or perpetrators (e.g. DASH) and were those assessments correctly used in the case of this victim/perpetrator?

6.25. Where these assessment tools, procedures and policies professionals accepted as being effective?

7. Engagement with the individual/family

7.1. While the primary purpose of the DHR is to set out how professionals and agencies worked together, including how learning and accountability can be reinforced both in, and across, agencies and services, it is imperative that the views of the individual/family and details of their involvement with the DHR are included in this.

7.2. Corby Community Safety Partnership, through the Independent Chair, are responsible for informing the family that a DHR has been commissioned and an Independent Chair has been appointed. The DHR process means that agency records will be reviewed and reported upon, this includes medical records of both Jane and partner if consent is agreed by her Partner.

7.3. Firstly, this is in recognition of the impact of the death of Jane giving family members the opportunity to meet the review panel if they wish and be given the opportunity to influence the scope, content and impact of the review. Their contributions, whenever given in the review journey, must be afforded the same status as other contributions. Participation by the family also humanises the deceased helping the process focus on Jane and partner's perspectives rather than just agency views.

7.4. All IMRs are to include details of any family engagement that has taken place, or that is planned. The Independent Reviewer will be the single point of contact with the family in relation to the DHR in addition to the Police Family Liaison Officer, FLO, in respect of criminal proceedings.

8. Media Reporting

8.1. In the event of media interest, all agencies are to use a statement approved and provided by Corby Community Safety Partnership.

9. Publishing

9.1. It should be noted by all agencies that the DHR Overview Report will be published once completed, unless it would adversely impact on the adult or the family. Publication cannot take place without the permission of the DHR Home Office Quality Assurance Panel.

9.2. The media strategy around publishing will be managed by the DHR Panel in consultation with the chair of Corby Community Safety Partnership and communicated to all relevant parties as appropriate.

9.3. Consideration should be given by all agencies involved in regards to the potential impact publishing may have on their staff and ensure that suitable support is offered and that staff are aware, in advance, of the intended publishing date.

10. Administration

10.1. It is essential that all correspondence with identifiable information is sent via secure methods only. This would be via secure email account (GCSX) or through the Local Authority's Secure Communication System (SCS). Failure to do so will result in a data breach and must be reported to the Data Protection Commissioner.

10.2. The Domestic Homicide Review Officer will act as a conduit for all information moving between the Chair, IMR Authors, Panel Members and the DHR Panel.

Appendix No 2

The response from the Partner after having sight of the Overview Report

Dear Mr Ross 14 June 2022

In answer to your email, dated 14 June 2022. Regarding my comments on your report.

I have not read through your report completely yet. However, what I have read demonstrates that this report is not seeking the truth, but is indeed a **Witch Hunt!** You are not looking for the truth, but just to convict me, regardless, (who happens to be a victim not a criminal) for something I have not done.

Firstly, it is very hypocritical, there are many lies and twists, manipulations and it is very biased. To say it is defamatory is really an understatement. I need to seek legal advice regarding this report.

I can go through this line by line and prove beyond reasonable doubt that this is manipulating and distorting the truth. I have lots of proof in the form of CCTV, telephone recordings, letters, covert recordings, emails, photos, witness names and addresses etc, etc.

However, the system for what it is refuses to act or to acknowledge such evidence. I look at this as Perverting the Course of Justice. There have been police officers sent to prison for less than what they have done to us. It is for this reason that I was unable to get the help for [Jane] that she desperately needed. All I got was excuse after excuse no help whatsoever, I could not believe it and still can't.

You state at the end that you don't know who I contacted; I think you would be surprised. I have tried to get the truth looked at by many official organisations, that are supposed to be there for this purpose. However, by manipulation they always have a feeble excuse, why they cannot do anything.

My conscious is clear, I was the only one trying to help [Jane] and knew what the consequences were if we could not get urgent help for her. I put it into a letter to the GP desperately trying to get help for [Jane]. They broke the code of patient confidentiality and escalated the situation making [Jane] even worse and groomed her against me.

This report twists and manipulates the truth accusing me of something I have not done. I even tried to get [Jane's] family involved as a last resort despite my better judgement, I was told they were Busy People and did not have any time for her, [Jane's] daughter's excuse was, she had the kids and did not have any time for [Jane]. Even though I had told them [Jane] was desperately in trouble. They really did not care not acknowledging [Jane's] Birthday, Mother's Day, not even a card. I am totally disgusted with [Jane's] so-called family. I used to buy something for [Jane] on Mother's Day as she looked so sad. Also as stated I did not like [the son] as he would not look at me, he suffered with Selective Mutism caused by a trauma in early life, look it up! Hear is a link Selective mutism - NHS (www.nhs.uk)

The people that are responsible seem to be untouchable and above the law, as I said before Northampton Police have a reputation for distorting the truth at a high level.

It looks as if you are going to take this as far as possible, perhaps this will be the only way I can get the real truth out and make the people responsible and culpable, made accountable for their actions. I feel confident that I have the proof needed to convict the people responsible.

I liked the distortion about the GP and the tracking. I had reported many times that someone was tracking [Jane's] and my phone. At first, I thought someone had put a tracking device on [Jane's] car. After [Jane] died, I found an app on [Jane's] phone it was Northampton Police? You now are suggesting it was me!

I guess the only way to prove that would be to go to the provider and they would be able to identify who was tracking [Jane]. Unfortunately, they will not give me that information, only the Police can get this information. As I do not trust the police, who knows what they would come up with?

Why would I track [Jane's] Phone she only went to Morrison's each day to buy wine and dispose of her empties or work. I knew where she was? Perhaps someone might use this to follow [Jane] and damage her car which happened daily.

I also like the one about me knowing someone who had guns, it was [the daughter's] boyfriend who was a soldier serving in Afghanistan, but I did not know him.

[The daughter] told [Jane] he could get any firearm etc he wanted, nothing to do with me whatsoever. I don't know anyone who has guns. In response to telling [the daughter] to leave and never come back. After blitzing my house, corrupting my PC and getting extremely drunk making fun of me all night. I did ask her to leave, that's all. She raided my fridge steeling bottles of drink and food and threatened me and damage [Jane's] car on the way out. I believe that [the daughter], also being an alcoholic, takes drugs. I don't know what she had consumed that evening.

As far as I am concerned this report is a total distortion of the truth and I am dedicated to get the truth out there some day. I can now see why people go to the media perhaps that's the only way to get recognised and get something done. In the meantime, I must seek legal advice. There is something wrong about this whole charade.

I guess I will see you in court and let's hope I can get the truth to be acknowledged this time.

[The Partner]

Letter from Home Office

Interpersonal Abuse Unit
2 Marsham Street,
London
SW1P 4DF

Antonia Malpas
Safer Corby Manager,
North Northamptonshire Council,
Deene House,
Corby,
Northants
NN17 1GD

www.homeoffice.gov.uk 28 December 2023

Dear Antonia,

Thank you for resubmitting the report (Jane) for North Northamptonshire Community Safety Partnership to the Home Office Quality Assurance (QA) Panel.

The report was reassessed in December 2023.

The QA Panel felt that it was a good report with a clear, easy to read chronology and appreciated the footnote explaining why Panel members are not named. The report also benefitted from the participation and contribution of Jane's family and the sensitive and impactful tribute that they provided to their mother. This helped to provide a powerful picture of Jane as a mother, friend, and work colleague.

The report also provided good analysis and recommendations around controlling and coercive behaviour.

The updated action plan provides a full outcome of the recommendations and is helpful regarding areas for development.

The Home Office noted that most of the issues raised in the previous feedback letter following the first submission have now been addressed.

The view of the Home Office is that the DHR may now be published.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at: DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel

North Northamptonshire Community Safety Partnership

ACTION PLAN FOR DHR 01

(Please note this action plan is a live document and subject to change as outcomes are delivered.

OVERVIEW REPORT RECOMMENDATIONS

ALL AGENCY RECOMMENDATIONS

Name of the AGENCY ALL AGENCIES						
Recommendation	**Scope of recommendation i.e. local or regional**	**Action to take**	**Lead agency and Responsible Officer**	**Key Milestones achieved in enacting recommendation**	**Target date**	**Completion Date and Outcome**
Recommendation No 1 All agencies review their domestic abuse training to ensure that coercive and controlling behaviour is seen as a major focus of that training.	Local	Review internal and external training to ensure updated to cover coercive and controlling behaviour is covered in depth.	All agencies	Discuss action with training coordinator and ensure training is updated.	February 2023	NDAS updated training programme due Sept 2023 NHFT completed August 2023 - All forms/levels of safeguarding training (adult and children) contain domestic abuse information and all the required components of this report. EMAS completed August 2023 - EMAS recognise the complexity and vulnerability of domestic abuse survivors who are experiencing controlling and coercive behaviour.

						This is embedded in all EMAS safeguarding training and policy. EMAS continue to raise awareness with employees in a variety of ways including: • Sharing ENEWs articles to reflect current themes. This is shared on a weekly basis. • Awareness via 'Workplace' – this includes sharing information from the safeguarding team in relation to coercion and control, domestic abuse and encouraging employees to attend training events and read relevant articles and reports. • A supplementary Domestic Abuse training session is also available to all EMAS staff via the in-house online training e-portal which has been designed specifically for ambulance crews in recognising and responding to domestic abuse. Coercion and control always features in this training.

						• A sticker has been developed since 2020 - this sticker goes into all patients' homes on crew equipment and in the ambulance on the walls. It states- 'Domestic Abuse is not OK and it can happen to anyone. EMAS has a zero tolerance for Domestic Abuse, speak to me or contact the helpline on 0808 2000 247.' It is hoped this helps those experiencing domestic abuse to have the confidence to come forward and ask crew for help, identifies EMAS as a service people can access support if they are experiencing domestic abuse and aids the signposting to the National Helpline. • Our Domestic Abuse policy gives an overview of what controlling and coercive behaviour is and the safeguarding team are on hand to support all employees if they have concerns and want to discuss this and appropriate actions to take.

						• Our Safeguarding Brochure is currently being published and will be disseminated to all staff to ensure they are up to date on the Trusts responsibilities in relation to Safeguarding, including domestic abuse/coercion and control. • All training sessions offered by the Training team and Safeguarding Leads covers domestic abuse and coercion and control. • EMAS have a health and wellbeing leaflet available to all staff and this includes the Domestic Abuse helpline number. NNC Adult Social Care completed and in place - NNC Domestic Abuse Awareness Training was redesigned and updated in February 2023 to be a longer training course which includes an in depth understanding and awareness of Control and Coercive Behaviour and is a focus of the session. This is available on the

						Open Programme via iLearn booking system. Voice and Sunflower completed - DA training has CCB as the focus and works from the perspective that all domestic abuse should be viewed through the lens of coercive control. This includes the holistic review of risk and taking an intersectional approach to the understanding of the experience of those impacted by domestic abuse. The training includes the County-wide MARAC and referral processes and outcomes. We offer training across organisations around the understanding of domestic abuse and how to risk assess and manage the risks to those impacted by domestic abuse. Change Grow Live / S2S completed - We understand the significance of focusing on coercive and controlling behaviour in domestic abuse training. Our charity has proactively revised our training materials to ensure

						that this aspect is given prominent attention. This includes incorporating case studies and scenarios that highlight the recognition and addressing of coercive and controlling behaviours. ICB completed September 2022 - Domestic Abuse training was delivered to Primary Care in September 2022 by the Sunflower Centre / VOICE. This training included coercive and controlling behaviour and MARAC. It also included a section on 'ask' to encourage professional curiosity along with signs of domestic abuse to raise awareness and prompt thinking around whether what a person is presenting with is actually a sign that they are experiencing domestic abuse. Northamptonshire Police - Completed – Northamptonshire Police have embedded training which is delivered to new officers/staff and we also continue to deliver DA MATTERS training both are

						refresher courses but also to those officers changing roles. This ensures the learning is consistent and not lost through natural movement of resources.
Recommendation No. 2 All agencies in Northampton to work together under the lead of NDAS to create a county wide publicity campaign regarding domestic abuse but in particular the signs, symptoms and outcomes of coercive controlling behaviour. The campaign should consist of leaflets, posters and seminars to inform the public of this kind of domestic abuse and how to seek support from agencies.	Local	Ensure relevant agencies are a part of the local DA & SV Partnership Board Coordinate a local DA campaign that highlights the signs, symptoms and outcomes of coercive control	All agencies	Discuss and coordinate campaign via the local DA & SV Partnership Board	February 2023	Countywide campaign currently in the planning stages
Recommendation No. 3 All agencies are to ensure that training regarding domestic abuse stresses the importance of professional curiosity and lateral thinking so as to ensure that indicators of abuse are not missed.	Local	Review internal and external training to ensure updated to cover professional curiosity and lateral thinking	All agencies	Discuss action with training coordinator and ensure training is updated.	February 2023	NDAS updated training programme due Sept 2023 NHFT completed August 2023 - All forms/levels of safeguarding training (adult and children) contain domestic abuse information and all the required components of this report EMAS completed August 2023 - Our 2023/2024 Audit plan which includes

						questions around Domestic Abuse- This audit utilises scenarios based on case studies and external reviews where learning has been identified for EMAS. Completing these specialist audits provides the safeguarding team with assurance regarding dissemination of education and learning as well as policy and procedure. If there are any areas of non-compliance at the time of audit there must be immediate action to re-educate staff members and can extend from immediate education and reflection to contact with management for the area. These audits also offer opportunity to inform and educate staff whilst providing access to the safeguarding leads for the trust. We encourage conversations around professional curiosity and the importance of this when obtaining information for a safeguarding concern. These audits are completed with staff across the whole of the organisation.

						• We have recently raised the awareness of professional curiosity on our internal social media platform. • A training session has recently been delivered to our call handlers on spotting the signs, symptoms and outcomes of domestic abuse/coercion and control. This included a 'train the trainer' session and will be run regularly when new employees join EMAS. Professional curiosity is covered throughout these sessions. • All training sessions offered by the Training team and Safeguarding Leads covers domestic abuse and coercion and control. •The safeguarding team produce quarterly posters for ambulance stations. We include information on domestic abuse/coercion and control and how to access support services. We provide top tips on questions to ask and encourage conversations with the safeguarding team.

						NNC Adult Social Care completed and in place - NNC Domestic Abuse Awareness Training supports with using professional curiosity throughout the activities. NNC also provides staff with a dedicated Professional Curiosity Training course which focusses on Domestic Abuse scenarios as part of the session. This is available on the Open Programme via iLearn system Voice and Sunflower completed - DA training has CCB as the focus and works from the perspective that all domestic abuse should be viewed through the lens of coercive control. This includes the holistic review of risk and taking an intersectional approach to the understanding of the experience of those impacted by domestic abuse. The training includes the County-wide MARAC and referral processes and outcomes. We offer training across

						organisations around the understanding of domestic abuse and how to risk assess and manage the risks to those impacted by domestic abuse. Change Grow Live / S2S completed - Recognising the importance of professional curiosity and lateral thinking, we are dedicated to incorporating these principles into our domestic abuse training. Our training modules emphasise the significance of a holistic approach, encouraging practitioners to consider a wider range of indicators and factors when assessing cases of abuse. ICB completed September 2022 - Domestic Abuse training was delivered to Primary Care in September 2022 by the Sunflower Centre / VOICE. This training included coercive and controlling behaviour and MARAC. It also included a section on 'ask' to encourage professional curiosity along with signs of domestic abuse to raise awareness

						and prompt thinking around whether what a person is presenting with is actually a sign that they are experiencing domestic abuse. Northamptonshire Police - Completed – this forms part of the DA MATTERS training delivered to officers. Intrusive Professional Curiosity is a key safeguarding measure that is promoted by senior officers on force intranet and other internal publications. Questioning Professional Curiosity is also now a more embedded expectation of supervisors when reviewing crime investigation and safeguarding process.
Recommendation No. 4 All agencies to ensure that Domestic Abuse training is to include an update on the use of MARAC referrals, the process, the outcomes of a referrals and the benefits that may result from the referral process.	Local	Ensure relevant agencies are aware and part of MARAC arrangements Review internal and external training to ensure updated MARAC	All agencies	Discuss action with training coordinator and ensure that action is implemented.	February 2023	NDAS updated training programme due Sept 2023 – NDAS is a main partner within the MARAC process and have a dedicated practitioner who provides information to MARAC. NHFT completed August 2023 - All forms/levels of

		processes are covered.				safeguarding training (adult and children) contain domestic abuse information and all the required components of this report. NHFT is a main partner within the MARAC process and have a dedicated practitioner who provides information to MARAC. EMAS completed August 2023 - EMAS do not attend MARAC meetings however we do explain in our training the importance of gathering information that highlights what level of risk the person is experiencing. We reiterate the need for consent and as much detail as possible to assist our partner agencies to complete the MARAC referral. NNC Adult Social Care completed and in place - NNC Domestic Abuse Training includes a full section that ensures an understanding of the MARAC process and best practice in terms of completing DASH – outcomes of MARAC and the benefits it serves. This

						is available on the Open Programme via iLearn booking system. Voice and Sunflower completed - DA training has CCB as the focus and works from the perspective that all domestic abuse should be viewed through the lens of coercive control. This includes the holistic review of risk and taking an intersectional approach to the understanding of the experience of those impacted by domestic abuse. The training includes the County-wide MARAC and referral processes and outcomes. We offer training across organisations around the understanding of domestic abuse and how to risk assess and manage the risks to those impacted by domestic abuse. Change Grow Live / S2S completed - We appreciate the relevance of keeping our personnel informed about the MARAC referral process. Our training/induction programmes have been

						updated to provide a comprehensive overview of the MARAC referral procedure, highlighting the potential outcomes and benefits arising from effective referrals. ICB completed September 2022 - Domestic Abuse training was delivered to Primary Care in September 2022 by the Sunflower Centre / VOICE. This training included coercive and controlling behaviour and MARAC. It also included a section on 'ask' to encourage professional curiosity along with signs of domestic abuse to raise awareness and prompt thinking around whether what a person is presenting with is actually a sign that they are experiencing domestic abuse. Northamptonshire Police – Completed - Northamptonshire Police has an extremely strong and embedded partnership with VOICE and our DAIU supervisors are trained as MARAC chairs. The DAIU

						Inspector and Chief Inspector sit on the MARAC steering group. Performance in this area is monitored and improvements are delivered via recommendations from the MARAC Steering Group or DAIU.

INDIVIDUAL AGENCY RECOMMENDATIONS

Name of the AGENCY			**SUNFLOWER CENTRE**			
Recommendation	**Scope of recommendation i.e. local or regional**	**Action to take**	**Lead agency and Responsible Officer**	**Key Milestones achieved in enacting recommendation**	**Target date**	**Completion Date and Outcome**
Recommendation No 1 Regular coercive control training to be delivered to all Sunflower Centre staff including the MARAC Team.	Local	Deliver regular DA training that includes coercive control within it.	Sunflower Centre		February 2023	During the time of our involvement, CCB legislation was not yet in place. Training has been delivered to IDVAs and the MARAC team on an ongoing basis. All Sunflower staff have training records and PDRs that are regularly updated.

Recommendation No 2 Data recording instructions within Case Management Policy to be updated and staff to be reminded of recording responsibilities. **Recommendation No 3** Source additional Mental Awareness Training	Local Local	Update Data recording instructions within the Case Management Policy and remind staff of responsibilities Source additional Mental Health Training	Sunflower Centre Sunflower Centre		February 2023 February 2023	CCB is included in induction training and IDVAs all deliver training around DA, Voice and Sunflower DA training has CCB as the focus and works from the perspective that all domestic abuse should be viewed through the lens of coercive control. The Sunflower Case Management Policy has been updated with clear instruction around responsibilities for the recording of data. Training plans are completed across all Voice services. Staff have completed the following training in 21/22: Suicide and Crisis Calls Skills Workshop with external Trainer Northants Chamber and FCR

						MH First Aider Course, Mental Health England – currently one trained first aider who is SPOC for the organisation Mind - Customer Support and Mental Health Mental Health understanding and awareness is featured on all training plans and will continue to be so.
Recommendation No 4 Identification of primary victims in cases to ensure appropriate support is provided.	Local	Staff to complete a screening tool to identify primary victims in cases and ensure appropriate support is provided	Sunflower Centre		February 2023	All Sunflower staff are trained to complete a screening tool where required to identify primary victims of domestic abuse. Reviews are also completed by the Senior IDVAs, who holistically review all information available to identify the primary victim of abuse and complete a formal written rationale to evidence this.

Name of the AGENCY North Northamptonshire Adult Social Care						
Recommendation	**Scope of recommendation i.e. local or regional**	**Action to take**	**Lead agency and Responsible Officer**	**Key Milestones achieved in enacting recommendation**	**Target date**	**Completion Date and Outcome**
Recommendation No 1 North Northamptonshire County Council Customer Service Centre (SCS) to have a better awareness of risk, exercising professional curiosity, safeguarding processes, and assessing cumulative information organised by a lead social worker.	Local	Staff undertaking triage of Social Care referrals to have awareness of awareness of risk, exercising professional curiosity, safeguarding processes, and assessing cumulative information	North Northamptonshire Adult Social Care	Restructure occurred in October 2020.	February 2023	Completed (Started in Oct 2020) - Following a restructure of Adult Social Care the Pro-Support Team is no longer in place. All referrals for social care support and safeguarding concerns now go to the appropriate community and longer teams to assess risk

						and implement safeguarding procedures where required. Professional curiosity training is available for all adult social care staff.
Recommendation No 2 A monthly auditing of decision making by the Pro-Support Team in CSC. **Recommendation No 3** Northamptonshire Safeguarding Adult Board Quality and Performance Sub-group to provide additional training for staff around the new Adult Risk Management (ARM) toolkit (Safeguarding Adult Review reference 016 2020 has made similar recommendations) **Recommendation No 4**	Local Local Local Local	Establish monthly audits Establish regular ARM training To reorganise the NCC ASC Teams for the Unitary move Embed into policy Adult Social Care's revised Serious Incident Policy to ensure that IMRs are systematically and	North Northamptonshire Adult Social Care Northamptonshire Safeguarding Adult Board Quality and Performance Sub-group Northamptonshire Adult Social Care Northamptonshire Adult Social Care	Restructure occurred in October 2020. Establishment of two new local authorities for Northamptonshire.	February 2023 February 2023 February 2023 February 2023	Completed - Following a restructure of Adult Social Care the Pro-Support Team is no longer in place. Case audits take place of a monthly basis within the community and longer-term teams. Completed – Regular ARM training is in place and can be found on the NSAB website Completed – October 2020. There are dedicated ASC services for both North and West authorities

NCC ASC Team to be reorganised in line with the move to a Unitary Authority in April 2021. **Recommendation No 5** To embed into policy Adult Social Care's revised Serious Incident Policy to ensure that IMRs are systematically and routinely actioned in all cases.		routinely actioned in all cases.				Outstanding - The NHS Serious Incident Framework is changing in the autumn to the Patient Safety Incident Response. Whether an IMR is required as well as a Serious Incident Report will be a matter for discussion at the NSAB Quality & Performance Sub Group once the new PSIR is made available

Name of the AGENCY			**Northamptonshire Police**			
Recommendation	**Scope of recommendation i.e. local or regional**	**Action to take**	**Lead agency and Responsible Officer**	**Key Milestones achieved in enacting recommendation**	**Target date**	**Completion Date and Outcome**
Recommendation No 1 Consideration be given by Northamptonshire Police to the use of a Single Point of Contact (SPOC) in cases where there is a high frequency of incident	Local	Have a Single Point of Contact (SPOC) in cases where there is a high frequency of incident occurrences	Northamptonshire Police		February 2023	Completed - Repeat victims of DA, of all risk levels and crime types are flagged via the Public Protection

occurrences where controlling or coercive behaviours is suspected.		where controlling or coercive behaviours is suspected				Notice submissions and referrals. These are reviewed by supervisors and partner agencies within VOICE to determine hidden risk, including C&CB. Repeat victim occurrences also feature within performance data. The Domestic Abuse Investigation Unit will undertake a SPOC role for any high risk victims, they will also advise on SPOC allocation for medium or standard risk victims.
Recommendation No. 2 Consideration to be given to extend the MADRA (Multi-Agency Daily Risk Assessment) process to include identified vulnerable adults where early intervention by services and support can be offered and given.	Local	Consider extending the MADRA (Multi-Agency Daily Risk Assessment) process to include identified vulnerable adults	Northamptonshire Police		February 2023	Completed - The MADRA is no longer in place in Northamptonshire Police. A restructure within the MASH has been completed and these referrals are now considered and actioned within daily business as part of their core function