Domestic Homicide Review

Diana

2020

Overview Report

Independent Report Writer: Elizabeth Hanlon

Commissioned by:

Kent Community Safety Partnership

Medway Community Safety Partnership

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1 Diana

1.1 Diana is described as being 'popular, loud and loved being the centre of attention'. She had bundles of life and liked to be the life and soul of the party. Diana was rarely happier than when she was on the dance floor with her friends and sister. She was the loving mother of two children and was described by her family as having loved being a mother. Diana was the person that many people turned to if they had problems, she was always there for her family and friends and no matter what people were going through she always put it aside and dealt with the people that needed her. She will be sadly missed. Diana's mum explained that the funeral for Diana was held in a 'Ascot racing' style because Diana had loved to go to ladies' day at Ascot. She said that everyone who attended the funeral had come dressed in bright Ascot clothes and that it was a funeral that celebrated Diana's life and was very 'fitting for her'.

2 Timescales

2.1 This overview report has been commissioned by the Kent Community Safety Partnership (on behalf of the local CSPs including the Medway Community Safety Partnership) concerning the death of Diana which occurred in 2020.

2.2 It is important to understand what happened in this case at the time, to examine the professionals' perspective at that time, although it is likely as a consequence that hindsight will be encountered. This will be rationalised by taking key matters forward in order to broaden professionals' awareness both for the future and to ensure that best and current practice is embedded and that any learning is maximised both locally and nationally.

2.3 Family members were contacted and asked whether they would like to see a copy of the Terms of Reference and invited to contribute to the review and comment. Diana's sister and mother spoke to the report writer about Diana. The family were liaised with at different stages of the review process and updated on the panel meetings. At the conclusion of the review process, Diana's family were contacted regarding reviewing the overview report and its recommendations and speaking to the report writer. The overview report was shared with Diana's sister and mother.

2.4 The panel wish to send their condolences to the family and friends of Diana. Pseudonyms for both Diana and her ex-partner, Nathan, have been used throughout this report to maintain anonymity. These pseudonyms were shared with the family by the Independent Chair and report writer.

2.5 The Home Office were notified by the Community Safety Partnership (CSP) of their intention to carry out a Domestic Homicide Review (DHR). The Coroner was also notified that a Domestic Homicide Review was taking place.

2.6 In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Kent and Medway Domestic Homicide Review (DHR) Core Panel meeting was held on 22nd October 2020. The panel agreed that the death of Diana met the criteria for a DHR, and this review was conducted using the DHR methodology. That agreement was ratified by the Chair of the Kent Community Safety Partnership.

2.7 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/she was related or with whom he/she was or had been in an intimate personal relationship, or

(b) a member of the same household as himself/herself, held with a view to identifying the lessons to be learnt from the death.

2.8 The Kent and Medway Domestic Homicide Core Panel paid due regard to the guidance within the 2016 publication which 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. Reviews are not about who is culpable.

2.9 The DHR was started in December 2020 when the first meeting took place and concluded in August 2022. The panel met on four occasions, where they identified the key learnings, set the terms of reference, examined IMRs and

agency information, and scrutinised the overview report and its recommendations. The review process was delayed due to the pandemic and the additional pressure placed upon agencies. This meant that agencies were given additional time to complete their IMRs and some panel meetings were also put on hold as a consequence. An action plan was developed and populated by panel members prior to Home Office submission.

2.10 The inquest into Diana's death took place with the verdict being recorded as suicide.

3 Confidentiality

3.1 The findings of the Domestic Homicide Review are confidential. At the beginning of the meetings of the review panel, attendees were reminded of the confidentiality agreement. All panel meetings took place over Microsoft Teams due to the COVID-19 Pandemic. The information supplied throughout the review process was only available to those participating in the review and their line managers until after the DHR was approved by the Home Office Quality Assurance Panel and published. Dissemination is addressed in section 12 below.

3.2 The deceased in this case was a white female of British nationality. Diana was in her 30s at the time of her death. Her ex-partner is a white male of British nationality. Nathan was also in his 30s at the time of Diana's death. Diana left behind two children from a previous relationship who were both present at the time of Diana's death.

4 Methodology

4.1 The purpose of this Domestic Homicide Review overview report is to:

4.1.1 Ensure that the review is conducted according to good practice, with effective analysis and conclusions of the information related to the case.

4.1.2 Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic abuse including their dependent children.

4.1.3 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.

4.1.4 Apply these lessons to service responses including changes to policies and procedures as appropriate.

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

4.2 This overview report has been compiled with reference to the comprehensive Independent Management Reviews (IMRs) prepared by authors from the key agencies involved in this case. Each author is independent of the victim and family and of management responsibility for practitioners and professionals involved in this case. IMRs were signed off by a Senior Manager of that organisation before being submitted to the Domestic Homicide Review Panel. Where IMRs have not been required, reports from other agencies or professionals have been received as part of the review process.

4.3 The overview report author has also fulfilled a dual role and has Chaired the panel meetings in respect of this case. This is recognised as good practice and has ensured a continuity of guidance, context for the review. There have been a number of useful professional discussions arising and the panel meetings have been referenced and noted appropriately for transparency.

4.4 The review author has also made several requests to agencies and individuals for clarity of issues arising and is grateful for the participation of individuals and agencies throughout. The professionalism of the panel members and the overall quality of the responses has been of a high standard.

4.5 Some of the information within the report will not be, where possible, personally referenced, and the author has due regard for any confidentiality and sensitivities required. The author has also sought additional information outside of the date parameters and this has assisted in context to examine some background history.

4.6 It is important that this Domestic Homicide Review has due regard to the legislation concerning what constitutes domestic abuse which is defined as:

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

4.7 The Government definition also outlines the following:

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

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependant 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.

4.8 Section 76 of the Serious Crime Act 2015 created a new offence of controlling or coercive behaviour in an intimate or family relationship. Prior to the introduction of this offence, case law indicated the difficulty in proving a pattern of behaviour amounting to harassment within an intimate relationship. The new offence, which does not have retrospective effect, came into force on 29th December 2015.

4.9 One of the purposes of a Domestic Homicide Review is to give an accurate as possible account of what originally transpired in an agency's response to Diana, to evaluate it fairly, and if necessary, to identify any improvements for future practice.

5 Terms of Reference

The critical dates for this review have been designated by the panel as 1st July 2016 to the date of Diana's death; however, the panel Chair has also asked the agencies providing IMRs to be cognisant of any issues of relevance outside of

those parameters which will add context and value to the report. These dates were felt to be the most relevant in the life of Diana as it was during this time that the domestic abuse, her health and wellbeing was most evident. The timescales were again reviewed by the panel meeting and were still felt to be appropriate.

5.1 The Focus of the DHR

5.1.1 In conducting the Domestic Homicide Review into the death of Diana, the Panel had regard to the following:

5.1.1.1 The review will establish whether any agencies have identified possible and/or actual domestic abuse that may have been relevant to the death of Diana.

5.1.1.2 If such abuse took place and was not identified, the review will consider why not, and how such abuse can be identified in future cases.

5.1.1.3 If domestic abuse was identified, this DHR will focus on whether each agency's response to it was in accordance with its own and multi-agency policies, protocols, and procedures in existence at the time.

5.1.1.4 If domestic abuse was identified, the review will examine the method used to identify risk and the action plan put in place to reduce that risk. This review will also consider current legislation and good practice. The review will examine how the pattern of domestic abuse was recorded and what information was shared with other agencies.

5.2 Specific Issues to be Addressed

5.2.1 Specific issues that must be considered, and if relevant, addressed by each agency in their IMR were:

5.2.1.1 Were practitioner's sensitive to the needs of Diana and her children, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them,

given their level of training and knowledge, to fulfil these expectations?

5.2.1.2 Did the agency have policies and procedures for domestic abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic violence and abuse victims or perpetrators and were those assessments correctly used in the case of Diana? Did the agency have policies and procedures in place for dealing with concerns about domestic violence and abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC or other multi-agency forums?

5.2.1.3 Was anything known about Nathan? For example, was he being managed under MAPPA? Were there any injunctions or protection orders that were, or previously had been, in place?

5.2.1.4 Had Diana disclosed any suicidal thoughts to any practitioners or professionals and, if so, was the response appropriate? Was this information recorded and shared, where appropriate?

5.2.1.5 Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

5.2.1.6 Are there lessons to be learned from this case relating to the way in which this agency works to safeguard Diana, her children and promote their welfare, or the way it identifies, assesses and manages the risks posed by Nathan? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources? Was the right level of support offered to Diana surrounding her impending court case and the impact this might have had on her? Were any stress indicators identified or reacted to regarding the impending court case?

5.2.1.7 Were previous decisions not to investigate DA within Diana's and Nathan's relationship the right decision?

5.2.1.8 Were there any mental health considerations surrounding Diana and any previously identified suicidal ideation?

5.2.1.9 Was any good practice identified within agencies to help develop future practice?

6 Involvement of Family Members and Friends

6.1 Unexpected deaths are tragic, not just for the family, but for friends and work colleagues alike. The overwhelming effect that this has on those individuals can endure and their privacy must be respected and any willingness to assist agencies must be of their own volition. It is acknowledged by the review that they are survivors of this tragic episode, not least the family of the deceased, and this review must be seen as a way forward in supporting others who may have similar needs and obtaining individual and sometimes personal views, may identify intervention opportunities for agencies in future cases.

6.2 Family members were contacted on behalf of the panel by a nominated person who was the cousin of Diana. Through this contact the Chair sent emails to Diana's immediate family asking if they wished to be involved in the review. Initial contact with the family included the Home Office DHR information leaflet and the Chair also informed the family of support available from Advocacy After Fatal Domestic Abuse (AAFDA). Diana's mother replied on behalf of herself and Diana's sister saying that they were understandably still too upset and did not feel that they could take part. The Terms of Reference were shared together with information regarding support that was available for families who have been bereaved through suicide. The Chair continued to keep the family updated with the progress of the review and they were advised that contact could be made at any time. Diana's sister later contacted the chair of the review and agreed to speak to her about Diana.

6.3 The Chair of the DHR spoke to Diana's sister over the phone and explained the review process and the panel membership and responsibilities. She was also asked whether she would like to meet the panel members, but this was declined. Diana's sister described Diana as being a very loving and caring

person who had a bubbly personality. She said that Diana was always the life and soul of any party who was loveable and had a big caring heart. She said that she is greatly missed by all the family and was a big part of their lives.

6.4 Diana's relationship with Nathan was spoken about and it was described that Diana met Nathan in a bar and they started seeing each other on and off for about three years. She said that their relationship had been casual to start with but that seemed to change quickly with Nathan becoming more intense. Diana's sister stated that she and family members noticed a change in Diana after her relationship started with Nathan. She stopped going out so often with her family and friends and became withdrawn. The family believed that Diana was becoming isolated and started to lose her spark. The family believed that Diana was being influenced by Nathan and stopped doing the things that she used to enjoy as she was concerned about Nathan's reactions. Diana's sister described them as having a very close relationship, but that Diana changed when she met Nathan and it seemed that they spent all their time together.

6.5 Diana was described as a pole fitness instructor but that when she met Nathan, he did not like her doing it and so she gave it up. She stated that Nathan was very particular about who he liked and did not like and as a result that caused rifts within the family, they would stop getting together and Nathan would just ignore people which made the atmosphere extremely uncomfortable. Diana's sister described Nathan as being manipulative, giving an example of when Diana wanted to go out with her friends on a Saturday night. Nathan did not want her to go and would appear to deliberately get Diana drunk on the Friday night so that she was not in a fit state to go out on the Saturday. Family members spoke to Diana regarding Nathan, but she would not believe that he was controlling her behaviour.

6.6 Diana told her sister that three months into the relationship Nathan had told her that he did not drink a lot as alcohol had a big negative impact on him and his behaviour. He had described to Diana that he had smashed up a previous girlfriend's house whilst drunk once and that he could not remember doing it. This had raised alarm bells in the family, but Diana felt that Nathan was

different around her. Claire's law[1] was discussed with Diana's sister, and she said that they had not been aware of it when Diana was going out with Nathan but that it is something that they would have tried to get Diana to consider.

6.7 Diana's sister described Diana's fear of going to court to give evidence against Nathan following the assault. She said that the longer the delays were the more worried and stressed she became. Diana could not understand that someone who she loved so much could hurt her so badly and it really affected her. She said that Diana would talk about the court case all the time and about giving evidence although she also said that she was determined to go to court.

6.8 Diana was described as very upset when the support she was receiving from the Domestic Abuse service was stopped because she had found it very helpful. She had been told that the support was stopping due to lack of fundings. She was updated regarding Nathan's court appearances and also the fact that he was making a bail application.

6.9 Diana's sister requested that certain points were raised. She stated that the Inquest into Diana's death did not record the fact that Diana had been subjected to domestic abuse although it was identified that Diana had been subjected to domestic abuse at the time of her death. As a family they strongly felt that mention should have been made to the fact that though Diana had died as a result of suicide, domestic abuse and coercive and controlling behaviour was a contributing factor. She also asked that the issue regarding support provided to family members during court cases was raised. She identified that family members received no support during the subsequent trial of Nathan for Diana's assault after her death. The family did not receive any communication and had no one speak to them about what was happening. She also described having to speak to the press after the court case without any support as there was no one there to help and guide them. She stated that the impact of this was felt greatly by family members and something she felt other families in similar circumstances should not have to go through. This was discussed at the panel meeting, and it was identified that additional support is

[1] Clare's Law, officially known as the Domestic Violence Disclosure Scheme, gives anyone a right to ask the police if they believe that they, or a friend or relative, is in a relationship with someone that could be abusive towards them.

now available from Public Health regarding support for families affected by suicide.

6.10 Diana's sister was spoken to regarding involving Nathan in the review process and she stated that the family had very strong views against this and that she felt that this would impact upon them greatly. The decision was therefore made not to contact Nathan.

6.11 The overview report was shared with Diana's sister and mother and Diana's mother was spoken to by the report writer. She explained that Diana was still extremely missed by everyone and that she held a special place in their hearts. Family members were very happy with the overview report and expressed their thanks at the way the panel had worked and the learnings that they had pulled out. Diana's sister and mother were contacted at the end of 2022 by the report writer to arrange a time for the overview report to be shared with them, however, this was ultimately arranged for February 2023.

7 Contributors to the Review

7.1 The Independent Management Reviews (IMRs) were written by a member of staff from the organisation to which it relates. Each of the agency authors is independent of any involvement in the case including management or supervisory responsibility for the practitioners involved. The IMRs were quality assured by supervisors and were signed off by management prior to being presented to the panel.

7.2 Each of the following organisations contributed to the review:

Agency/Contributor	Nature of Contribution
Kent Police	Independent Management Review
Domestic Abuse Service A (Anonymised due to geographical area covered)	Independent Management Review
Clarion Housing Association	Summary Report
Kent County Council, Integrated Children's Services	Independent Management Review

The Education People, Education Safeguarding	Independent Management Review
Borough Council A, Housing (Anonymised due to geographical area covered)	Independent Management Review
Housing Provider A (Anonymised due to geographical area covered)	Summary Report
Kent and Medway Clinical Commissioning Group, representing Primary Care, including Out of Area CCG	Independent Management Review
London Community Rehabilitation Company	Independent Management Review
NHS Trust A (Anonymised due to geographical area covered)	Independent Management Review
Victim Support	Independent Management Review
HM Prison Service	Summary Report
Crown Prosecution Service	Summary Report

8 Review Panel Members

8.1 The Review Panel was made up of an Independent Chair and senior representatives of organisations that had no relevant contact with Diana and/or Nathan. It also included a senior member of the Kent Community Safety Team and an independent advisor from a Kent-based domestic abuse service.

8.2 The members of the panel were:

Name	Organisation	Job Role
Elizabeth Hanlon		Independent Chair and Report Writer
Kathleen Dardry	Kent County Council, Community Safety	Practice Development Officer
Sophie Scott	Kent Police	Domestic Abuse and Stalking Manager
Jackie Hyland	Domestic Abuse Service A	Operations Manager
Leigh Joyce	Clarion Housing Association	Locality Business Manager (Southern Region)

Sophie Baker	Kent County Council, Integrated Children's Services	Practice Development Manager
Claire Ray	The Education People, Education Safeguarding	Head of Service, Education Safeguarding
Toni Carter	Borough Council A, Housing	Housing Solutions and Private Sector Manager
Colin Lydon	Housing Provider A	Head of Community Safety
Zoe Baird	Kent and Medway Clinical Commissioning Group, representing Primary Care, including Out of Area CCG	Designated Nurse for Safeguarding Adults
Lucien Spencer	London Community Rehabilitation Company	Head of Service (PDU) (Job Title prior to probation merge: Area Manager - London South East Area)
Gina Tomlin	NHS Trust A	Safeguarding Adults Lead
Catherine Collins	Kent County Council, Adult Social Care	Strategic Safeguarding Manager
David Naylor	Victim Support	Area Manger
Simone Clarke	HM Prison Service	Custody Senior Probation Officer
Tim Woodhouse	Kent County Council, Suicide Prevention *(Suicide Expert Opinion)*	STP Suicide Prevention Programme Manager
Celia Dunn	Kent and Medway NHS and Social Care Partnership Trust *(Mental Health Expert Opinion)*	Principle Lead Social Worker / Approved Mental Health Professional

9 Chair and Overview Report Writer

9.1 The Independent Chair and report writer for this review is Elizabeth Hanlon, who is independent of the Community Safety Partnership and all agencies associated with this overview report. She is a former (retired) senior police detective from Hertfordshire Constabulary, having retired seven years ago. She has several years' experience of partnership working and involvement with several previous Domestic Homicide Reviews, Partnership Reviews and Serious Case Reviews. She has written several Domestic Homicide Reviews for Hertfordshire, Cambridgeshire, and Essex County Council.

9.2 The Chair has received training in the writing of DHRs and has completed the Home Office online training and online seminars. She also attends the yearly Domestic Abuse conferences held in Hertfordshire and holds regular meetings with the Chair of the Domestic Abuse Partnership Board in Hertfordshire to

share learnings across boards. She is also the current Independent Chair for the Hertfordshire Safeguarding Adults Board.

10 Other Reviews/Investigations

10.1 Following a Coroner Inquest, the Coroner concluded Diana's death as a suicide.

10.2 Nathan appeared at Crown court on 3rd February 2021 where he pleaded guilty to the offence of Grievous Bodily Harm on Diana and criminal damage. He was sentenced to three years and four months' imprisonment.

11 Equality and Diversity

The Panel considered the nine protected Characteristics under the Equality Act 2010, (age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity). They sought to establish if they were applicable to the circumstances of the case and had any relevance in terms of the provision of services by agencies or had in any way acted as a barrier.

11.1 Sex

11.1.1 There is extensive research to support that in the context of domestic violence, females are at a greater risk of being victimised, injured, or killed. In fact, the term "Femicide", which refers to the killing of women by men because they are women, was coined in the 1970s to raise awareness of the violent deaths of women.

11.1.2 Homicide represents the most extreme form of violence against women, a lethal act on a continuum of gender-based discrimination and abuse. As research shows, gender-related killings of women and girls is a problem across the world, in countries rich and poor. Whilst most homicide victims are men, killed by strangers, women are far more likely to die at the hands of someone they know.

11.1.3 Women killed by intimate partners or family members account for 58% of all female homicide victims reported globally last year, and little progress has been made in preventing such murders, with a total of

87,000 women being killed across the world in 2017 alone. More than half of them (58%) were killed by intimate partners or family members, meaning that 137 women across the world are killed by a member of their own family every day. A third of these women were killed by a current or former partner - someone they would normally expect to trust.[2]

11.1.4 Between 2009 and 2018, at least 1,425 women were killed by men in the UK, meaning a man killed a woman every three days on average. The report shows that women are killed by their husbands, partners, and ex-partners, by sons, grandsons, and other male relatives, by acquaintances, colleagues, neighbours, and strangers. Unfortunately, but unsurprisingly, a huge number of women were killed in the context of intimate partner violence.[3] The link between domestic abuse and suicide is also a consideration within this review and is identified later within the report.

11.2 Chronic Pain

11.2.1 Although Chronic pain is not automatically listed as a disability the impact it can have on those affected is significant and should be considered by professionals. In November 2015 Diana suffered a serious neck injury, which she told professionals was due to a fall. She suffered a slipped disk in the neck causing pressure on the spinal cord and a resulting quadriplegia or paralysis of all four limbs. Emergency surgery was carried out and Diana made a good albeit incomplete recovery. Throughout the time frame of the review, the majority of contact with the GP surgery was in relation to chronic pain and pain relief medication. The impact of chronic pain and the service she received from agencies is reviewed within the report. Agencies were not all aware of the extent of Diana's injuries and the level of medication that was being prescribed. Chronic pain is pain that lasts longer than three months. Its severity can vary from mild to excruciating and can be

[2] https://www.unodc.org/documents/data-and-analysis/GSH2018/GSH18_Gender-related_killing_of_women_and_girls.pdf
[3] UK Femicides 2009-2018

continuous or sporadic. It can be caused by another condition such as arthritis, diabetes, or nerve pain, but is often an illness in its own right.[4]

11.3 Substance Misuse

11.3.1 Whilst substance abuse is not a disability, it is relevant to consider as part of this review due to agency awareness of Diana's alcohol usage. It is necessary to be perfectly clear that alcohol and alcoholism are never a sole trigger for, or cause of, domestic abuse. Rather, they are compounding factors that could eventually trigger intimate partner abuse in a violent individual. Whilst there is evidence that alcohol use by perpetrators, and to some lesser extent by victims, increases the frequency of violence and the seriousness of the outcomes, this does not mean that alcohol use causes domestic abuse. It is neither an excuse nor an explanation.[5] A particular concern to be addressed is the frequency with which victims of domestic abuse who use alcohol problematically are viewed negatively because of their alcohol abuse. For example, victims may be seen as causing the abuse that is perpetrated against them due to their own seemingly antisocial behaviour, including their use of violence to defend themselves.

11.3.2 Alcohol use is a common theme in a sample of 39 DHRs examined, with 27 (69%) featuring varying levels of alcohol-related harm. Not all cases involve one or both partners having an ongoing alcohol "problem", however alcohol misuse is commonplace within the sample:

- In 22 reports (56% of the 39) the perpetrator of the homicide is identified as experiencing problems with alcohol
- In 15 (38%) the victim is identified as experiencing problems with alcohol with a possible problem identified in two further reports
- In 15 reports (38%) both the victim and perpetrator are identified as experiencing problems with alcohol. Every case in which the victim has an alcohol problem, the perpetrator also has a problem

[4] .https://www.remploy.co.uk/employers/resources/z-disabilities/chronic-pain
[5] Alcohol-Concern-AVA-guidance-on-DA-and-change-resistant-drinkers.pdf (avaproject.org.uk)

- This data is not a surprise. British Crime Survey data shows that in 2011, 38% of domestic violence incidents involved alcohol. [6]

11.4 Mental Health

11.4.1 During the court process involving Nathan and Diana it was identified by Nathan that he was suffering from Post-Traumatic Stress Disorder (PTSD)[7]. It is understood that this was also the case during his relationship with Diana and therefore at the time of committing the offence. Nathan was reportedly in the army prior to his relationship. The relationship between mental health and DA is complex and its mechanisms are not yet known. However, systematic reviews have shown that men and women who have a mental disorder are at higher risk of experiencing and of perpetrating DA compared to the general populations. (Trevillion te al 2012; Oram 2013). Recent studies in the UK have shown an association between mental disorder and perpetration of domestic homicides.[8]

12 Dissemination/Publication

12.1 The Panel shall, once it has agreed the final report, submit the report to the Kent Community Safety Partnership for its consideration. The Partnership will be requested to consider the content of the report, the recommendations, and the associated Action Plan. If the Partnership is satisfied with the report, it shall be requested to submit the report to the Home Office.

12.2 The overview report will be published on the website of Kent and Medway Community Safety Partnerships.

12.3 Family members will be provided with the website addresses and also offered hard copies of the report.

12.4 Further dissemination will include:

[6] https://avaproject.org.uk/wp-content/uploads/2016/09/Alcohol-Concern-AVA-guidance-on-DA-and-change-resistant-drinkers.pdf

[7] Post-traumatic stress disorder (PTSD) is an anxiety disorder caused by very stressful, frightening or distressing events.

[8] London DHR Case Analysis and Review Launch 2020 — Standing Together

a) The Kent and Medway DHR Steering Group, the membership of which includes Kent Police, Kent and Medway Clinical Commissioning Group and the Office of the Kent Police and Crime Commissioner amongst others.
b) The Kent and Medway Safeguarding Adults Board
c) The Kent Safeguarding Children Multi-Agency Partnership
d) Additional agencies and professionals identified who would benefit from having the learning shared with them.

12.5 In accordance with Home Office guidance all agencies and the family and friends of Diana are aware that the final overview report will be published. IMR reports will not be made publicly available. Although key issues, if identified, will be shared with specific organisations, the overview report will not be disseminated until clearance has been received from the Home Office Quality Assurance Panel.

12.6 The content of the overview report has been suitably anonymised to protect the identity of the female who died and relevant family members and friends. The overview report has been produced in a format that is suitable for publication with any suggested redactions before publication.

13 Background Information (The Facts)

13.1 Diana was born locally and had two children from a previous relationship. The two children lived with Diana the majority of the time but stayed with their father on occasions. On the night of Diana's death, the youngest child, child B, was due to go and stay with their father but this appears not to have happened. Child A had a friend to stay the night at their house. On the night of Diana's death, she had spoken to her father and a male friend earlier on in the evening and there appears to be no indication that Diana was considering taking her own life. Diana's sister received a text from Diana stating, "I never want to see my child's heart break like that again." This appears to relate to the fact that the child B's father had not picked them up for the weekend as arranged.

13.2 Diana had been in a relationship with Nathan for several years, during which time she was a victim of his abuse, there are incidents of recorded assault upon Diana by Nathan. On the 22nd November 2019 Nathan committed a

serious assault on Diana at her home address which resulted in several injuries including a broken nose and broken cheekbone. Nathan was arrested by the Police and charged with an offence of Grievous Bodily Harm, S18. At the time of Diana's death in 2020, Nathan was still on remand in prison having been charged with the serious assault, Grievous Bodily Harm, on Diana.

13.3 In the early hours of the morning Diana was found hanging by child A. The ambulance was called, and Diana was taken to hospital where she was ventilated in the Intensive Treatment Unit. Later that evening Diana was sadly declared life extinct. A police investigation took place into Diana's death and the investigation concluded that there is no indication of any suspicious circumstances, or third party being involved in the sudden death of Diana.

14 Chronology

14.1 Prior to the timeframe for the Terms of Reference of this review it is of relevance that in November 2015 Diana suffered a serious neck injury, which Diana identified to professionals as having occurred following a fall. Diana suffered a "slipped disk" in the neck causing pressure on the spinal cord and a resulting quadriplegia or paralysis of all four limbs. Emergency surgery was carried out and Diana made a good albeit incomplete recovery. Throughout the time frame the majority of the contact with the GP surgery was in relation to chronic pain and pain relief medication. Diana's sister was spoken to regarding the injury to Diana's neck. She said the family were not aware that the injury had been sustained following a fall and that this was contrary to what they had been told by Diana. This raised concerns for the panel members.

14.2 From July 2016 to July 2017 Diana was prescribed the liquid morphine preparation, Oramorph (the combined analgesic), Co-Codamol and often the sleeping tablet, Zopiclone, on a one to two weekly basis without any recorded advice regarding their potential addiction. After this point there are several records where the GPs have started to wean Diana off the pain relief medication however, this does not appear to be consistent and is discussed within the learning points of the review.

14.3 On 17th July 2016 police were called to a verbal altercation between Diana and Nathan reportedly due to the pain killers that Diana was taking. Diana's two children were recorded as not being at the address at the time of the assault.

Diana made no comment to all of the DASH questions (Domestic Abuse, Stalking and Harassment, and Honour-based violence risk identification, assessment and management module – See Glossary). This incident was recognised as there being potential for escalation and was therefore assessed as medium risk. There were no referrals made to Children's Services at this time.

14.4 On 31st August 2016, Children's Services within Kent County Council received a referral from Thames Valley Police following a report of Nathan and Diana arguing in the grounds of Windsor Castle. The argument had led to Nathan smashing both wing mirrors, front and back windows and bending the wiper blades of Diana's car. The children were not present at the time of the incident. The report was noted but no further action was taken, and no referrals were made to other agencies.

14.5 On 3rd July 2018, Diana called the police stating that Nathan had put his hands on her. They were arguing as he had accused her of taking prescription drugs and not looking after the children. Nathan had left the flat prior to the police arriving. Diana told the police that Nathan did not assault her but that she thought that he was going to. A DASH risk assessment was completed and recorded as medium, although Diana did not wish to take the matter any further with the police.

14.6 On 21st December 2018, Nathan assaulted Diana and caused extensive damage to her flat. It does not appear that the children were present at the address at the time of the assault. Nathan was arrested and charged with common assault and criminal damage. He was given conditional bail to try and prevent any further offences taking place. A DASH assessment was completed which was recorded as high risk and a MARAC (Multi Agency Risk Assessment Conference – See Glossary) referral was submitted. Diana moved from her flat into another County and additional safeguarding measures were put into place.

14.7 A referral was made into Kent County Council's Children's Services regarding criminal damage being caused to Diana's property by Nathan. A Child and Family (C&F) assessment was completed, and a Social Worker was allocated to the children. During this time an anonymous referral was also received

identifying that child A and child B were often heard crying and that their mother was often drunk. A Child in Need plan[9] was not considered necessary as Diana had informed the Social Worker that she had separated from Nathan and intended to support a prosecution against him.

14.8 On 21st December 2018, Diana contacted Housing Provider A, advising that her ex-partner, believed to be Nathan, had stolen her keys and had smashed valuables in her home including her windows. The housing provider agreed to replace her locks and attempted to make arrangements to board up her windows.

14.9 On 24th December 2018, Diana was referred to Clarion IDVA Services. Diana disclosed that she had experienced domestic abuse from her ex-partner, Nathan, throughout their relationship. Diana stated that they had been in a relationship for approximately three years.

14.10 A MARAC referral was made by Kent Police.

14.11 Housing Provider A's Anti-Social Behaviour Officer contacted Diana on 27th December 2018 regarding the damage to her property. A DASH was completed which scored 12, which is medium risk. Advice was given in relation to accessing emergency and refuge accommodation. Diana agreed that the officer could make a referral for IDVA support. This referral was made however, they had already received a referral from the police.

14.12 On 28th December 2018, Diana contacted the police stating that Nathan had been constantly contacting her for over an hour and that he was outside her new address. Diana's new address was outside of Kent, within the Metropolitan area and the Metropolitan Police attended the address but there was no trace of Nathan.

14.13 Also, on 28th December 2018, Diana attended the Civic Centre in Borough Council A area. The manager of the Housing Solutions Team noted Diana as

[9] A child in need plan is voluntary for families and gives children failing to thrive extra services, beyond what every child receives, to help them develop safely. A child in need plan operates under Section 17 of The Children Act 1989 and does not have statutory framework for the timescales of the intervention.

looking scared, tearful and unsure of herself. Intensive support was given to Diana in relation to rehousing her and her children following the assault. Diana was offered temporary accommodation and extra security measures were put in place.

14.14 On 2nd January 2019 a follow up call was made to Diana by the IDVA. The Police were going to fit a panic alarm in the new property. The Police also advised the IDVA that they were going to arrest Nathan for harassment following calls to Diana. This took place a few days later. A Solicitor confirmed that an application for a Non-Molestation Order had been started. The IDVA discussed Claire's law with Diana in relation to a new relationship that she had just started, Diana said that she would consider it.

14.15 It is recorded that on 3rd January 2019 Diana attended the school of child A to explain that child A would be moving schools as they were fleeing domestic violence. She was worried that the perpetrator would follow them home from school to their new safe address. Diana informed the school that Nathan had "tried to stab her". Diana also stated that the children had not been at home at the time of the assault but that they knew that Nathan had 'trashed' the house. It is disturbing that this is the only contact the school had regarding the domestic abuse taking place and there does not appear to have been any notification to the school about the assault from any other agency.

14.16 On 8th January 2019 Nathan was arrested by the Police for the assault on Diana. He was charged with the offence and bailed. The IDVA service continued to support Diana.

14.17 On 16th January 2019 a MARAC meeting took place. At this stage Nathan was on conditional bail with conditions that he was not to attend the address or contact Diana on any occasions. The MARAC appeared to have been well attended by the appropriate agencies including children's services. There is very limited information within the MARAC minutes, however Diana's safety including rehousing and welfare, and personal alarms were discussed. The IDVA service attended and identified that Diana had been referred to their

service and that they were speaking to her and offering her support. A referral was also made to the Freedom Programme[10].

14.18 On 19th January 2019 the police received a call from an unknown person stating that Diana was drunk and had her children with her at her home address. The police attended and found the children in the presence of a male cousin. The children appeared to be well and healthy. The children were removed from the address by their biological father. Diana had left the address before the police had attended. There were no identified concerns raised by the police. There is also no record at either of the children's schools that the children were considered Children in Need.

14.19 Child A moved schools and the move is noted in the safeguarding records as "*due to domestic violence and supported by social services".* Limited records were shared when the children moved schools and as such was a missed opportunity for the school to offer support.

14.20 On 6th February 2019 Nathan appeared before the Magistrates' court in relation to the assault on Diana and criminal damage. He was found guilty and given a Restraining Order Protection[11] (until 5th February 2020), a Community Order, a Rehabilitation Order and unpaid work requirement. On the 7th February 2019 the IDVA contacted Diana who stated that she was disappointed with the outcome of the court hearing, especially as her new address had been disclosed in court in front of Nathan. Safety planning for Diana and the children was discussed and agreed. Good contact continued between Diana and the IDVA service until the case was closed in March 2019.

14.21 On 15th February 2019 Nathan failed to attend his initial unpaid work appointment with the Community Rehabilitation Company (CRC) Offender Management Officer. He also failed to make any attempts to contact his

[10] The Freedom Programme is a domestic violence programme providing free courses to help those facing domestic abuse.

[11] When sentencing for any offence the court can make a restraining order for the purpose of protecting a person (the victim or victims of the offence or any other person mentioned in the order) from conduct which amounts to harassment, or which will cause a fear of violence. Restraining orders are therefore likely to be appropriate in cases where the defendant and the victim are known to each other (whatever the charge) and where there is a continuing risk to the victim of harassment or violence after the date of conviction.

Offender Manager in accordance with the Community Order. There appears to have been some confusion regarding returning Nathan back to court for breach of his Order due to the area of jurisdiction being changed when Nathan appeared at Court for the initial breach. There were no attempts to contact Nathan in relation to the breach until March 2019.

14.22 On 25th March 2019 a breach hearing was scheduled in relation to Nathan's non-compliance of his Order, he failed to attend court and a warrant was issued. On 1st April 2019 Nathan surrendered and pleaded guilty to the breach. The court imposed a fine.

14.23 Diana's case was closed by Clarion IDVA Services on 31st March 2019 as Diana had stopped engaging with the service. It was identified within the review that the case regarding Diana was closed due to the fact that Nathan had been arrested and remanded in prison for the assault on Diana.

14.24 Diana later advised the Crown Prosecution Service (CPS) that in June 2019, Nathan contacted her and threatened to kill himself. It is unclear who Diana contacted as this is not recorded in CPS or Police records. He attended her home address and whilst there accessed her online banking, stole money, and left.

14.25 On 21st November 2019 Nathan attended Diana's home address and persuaded her to allow him to sleep on her sofa. Diana agreed although then left and went to stay at a friend's address. When she returned home Nathan was still there and accused Diana of having an affair and proceeded to begin punching her in the face causing her to suffer a broken nose and cheekbone, as well as other injuries. Diana fled her address and went to stay with her sister. An alarm was installed within her address whilst the police traced and arrested Nathan. Nathan was subsequently arrested, charged and remanded for the offence of Grievous Bodily Harm S18, Fraud, Criminal Damage and breach of the Harassment Order.

14.26 Diana attended the Emergency Department (ED) following the assault on her by Nathan. She had sustained ten punches to her head with multiple injuries to her face and head. It is unclear whether appropriate advice and support was given to Diana following her presentation at ED as the notes regarding her

attendance have not been located. It was confirmed that in mid-November 2019 there was a transition in services from the Domestic Abuse Service A's HIDVA (Hospital Independent Domestic Violence Advisor) to Clarion, who contracted Rising Sun to deliver the HIDVA service. At this time of transition, the service was contactable but unable to be present on site. It was confirmed that there was no record of Diana having had any contact with the HIDVA service or any record of a referral being made into the HIDVA service. There is no record of any questions being asked of Diana regarding her family circumstances and no consideration was given regarding notifying Children's Services. It was identified that there was no mention of DA within Diana's GP records, the GP relied solely on receiving information from Diana herself or other services to share information, especially through other Health professionals.

14.27 A referral was made by the Police to Integrated Children's Services (ICS) following the assault on Diana by Nathan. A strategy discussion took place and a Section 47 enquiry[12] was completed whilst Diana's children stayed with their biological father for the week. The children were considered Children in Need. Support was provided to Diana throughout this period and continued throughout the COVID-19 restrictions. Although the children were considered low risk and not a priority for face-to-face visits during the time of restrictions, Diana and the children were visited in person by her Social Worker on the majority of occasions and other contact was made by telephone or e-mail.

14.28 It is noted that there are no records of Diana suffering from domestic abuse or the injuries she sustained within her GP records. Diana's records showed detailed enquiries as to Diana's physical and mental health, along with the safeguarding measures undertaken by the Domestic Abuse Support Services although there had been no communication to the GP from the services themselves and the GP appears to have relied solely upon gleaning information from Diana directly.

14.29 On 22nd November 2019, Diana was referred to Clarion's IDVA Service. A MARAC referral was also made by Kent Police. IDVA contact was made with

[12] A Section 47 Enquiry is initiated to decide whether and what type of action is required to safeguard and promote the welfare of a child who is suspected of, or likely to be, suffering significant harm.

Diana. Diana identified that she was in a considerable amount of pain and that she was traumatised by the attack. A referral was made to Sanctuary[13] for and as a result Diana was referred for counselling.

14.30 On 25th November 2019 the Witness Care Unit contacted Diana to carry out a Witness Needs Assessment. It noted that Diana was pleased that Nathan had been arrested.

14.31 A MARAC took place on 4th December 2019 where Diana's housing needs were discussed and the need to consider all options available and to make Diana's and the children's safety a priority. The MARAC was attended by several agencies including the Named Nurse from Kent Community Healthcare Trust where information was fed back to other services. A new property became available for Diana in December 2019 following the MARAC meeting. A face-to-face meeting took place on 11th December 2019 to review the risk assessment, safety planning and a potential move to an outreach service. Self-help was also discussed, and Diana was signposted to 'getselfhelp.com' for support with her medication and anxiety. A DASH risk assessment was completed with a score of 9, medium risk. Diana agreed to a referral to Loadstar which is a family recovery programme for historical domestic abuse. The IDVA continued to provide good support for Diana throughout December including arranging essential items for the move and Christmas gifts for Diana and the children.

14.32 Diana was referred to Domestic Abuse Service A's Lodestar Family service on 13th December 2019. The referral came from the Clarion IDVA. Clarion are the Commissioned Domestic Abuse service for those victims that are at high risk. The Lodestar Family Service Domestic Violence Abuse Partnership (DVAP) is for those that have experienced domestic abuse and require a whole family service to rebuild relationships with their family and the wider community. Work is undertaken to safeguard the parent and children who are identified as being of standard risk. During their interaction with Diana, it was established that she and the children had settled into temporary accommodation and that they had had a good Christmas. Diana identified her priorities as being furniture and

[13] Support offered by the local authority to enable people to stay in their own homes.

emotional support for herself and her children. She also stated that she had spoken to the children's school about their emotional well-being.

14.33 Throughout January and February 2020 contact was maintained between the Lodestar Family Service and Diana. Diana disclosed to the support worker that she was struggling emotionally and that she was finding it hard to go into busy open spaces. Diana also identified that the children were also struggling emotionally. Contact with the school of child A was made and it was agreed that emotional support work would take place.

14.34 Child A's school have recorded that a visit took place between them and a social worker. It is not recorded why the visit took place. There is a notable lack of detailed information regarding both children within their school safeguarding records. It is not understood how much involvement the school had with social services regarding the concerns raised over the children. The files neither provide a coherent overview of the children's experiences with known issues of domestic abuse and the family dynamics in the home nor an understanding of the level of input from other agencies that were involved with the family, notably social care.

14.35 There are no recorded safeguarding concerns within the school file regarding child B however, when spoken to, the head teacher stated that the school were fully aware of the family situation with regards to the history of DA and that Diana had a good relationship with the school and kept in contact during the pandemic. They were also aware that child B was a Child in Need (CIN). Information was passed from the schools in relation to both the Child and Family assessments completed by ICS and the school were also involved in the CIN meeting which took place in March 2020.

14.36 In March the DVAP worker contacted Diana who stated that she was worrying about the impending court case against Nathan. It was agreed that the DVAP would contact Witness Care and the Police to ensure that all special measures were in place and to establish whether there was anything additional that the Witness Care Officer could put in place to support Diana through the court process. One special measure identified was that Diana had requested screens within the court whilst she gave her evidence.

14.37 The Witness Care Unit (WCU) deals with all court cases where the offender has been charged and has a civilian witness involved or are Not Guilty Anticipated Pleas (NGAP). The WCU's contact with the victim and witnesses will begin once the defendant has been charged and given a court date and will end once the case has reached its conclusion. The main purpose of the WCU is to manage the expectations of the victims and witnesses regarding the court process, updating them through the key stages of the criminal justice process, signposting and referring to appropriate support services where necessary.

14.38 On 9th March 2020 a worker from Domestic Abuse Service A contacted the Witness Care Unit to make sure that everything was ok as she was looking after Diana as witness support.

14.39 Nathan was due to attend court in April 2020 however, due to COVID-19 the trial date was not effective. A new trial date was set for 21st September 2020 and the custody time limits were extended to accommodate this date. Diana was updated regarding the change in court dates by the WCU.

14.40 On 6th May 2020 the WCU contacted Diana to inform her that there would be a court hearing on 20th May 2020 to deal with custody time limits for Nathan.

14.41 On 7th May 2020 Diana contacted her Social Worker stating that her DVAP was no longer able to support her, and the Social Worker agreed to contact other agencies to explore what support there was for Diana.

14.42 On 21st May the WCU sent an email to Diana to inform her that the court hearing on 24th June was to deal with custody time limits for Nathan.

14.43 On 26th May 2020 Children's Services received a referral from Kent Police regarding an allegation that Diana had left her children in the care of a relative and had driven her car whilst intoxicated. Diana told the Social Worker that she was feeling low and was worried about the impending court case. Diana stated that she was not getting any support and a result a referral was made and accepted by Victim Support.

14.44 On 9th June 2020 the WCU contacted Diana by telephone and spoke to her regarding court dates. Diana stated that she was happy to attend court during COVID-19 and that she wanted her day in court.

14.45 On 19th June 2020 a Victim Support case worker contacted Diana to introduce herself and the service. They agreed a time and date for a follow up call. This call took place on 25th June 2020 however, Diana was not able to talk when contacted so the call was rearranged. Several follow up calls were made; however, no response was received so voice messages were left to contact the service if Diana felt that she needed additional support from them.

14.46 A virtual home visit was completed by the Social Worker on 11th June 2020, Diana stated that her car had broken down and she was happy there was no school at the moment as she didn't have to go anywhere. Speaking to Diana's sister she identified that Diana struggled to access services remotely due to COVID-19 restrictions and she felt that COVID-19 had impacted on the level of support that Diana received.

14.47 On 24th June 2020, Diana was warned for court.

14.48 On 25th June 2020 Diana was contacted by Victim Support and asked if Diana could confirm what support she was receiving from the Domestic Abuse Service A and asked if Diana would consent to them contacting Domestic Abuse Service A on her behalf. Diana asked if this could be reviewed at the next contact meeting as she would then have the correct details of her caseworker with her.

14.49 On 2nd July Nathan submitted an application for bail.

14.50 Diana sadly took her own life in July 2020.

14.51 The bail application took place on 9th July 2020. Nathan was not granted bail.

14.52 It was identified from the Prison IMR that they had received information that Nathan was making contact with Diana whilst he was in prison. There is no further clarifying information available as to how Nathan was making contact or whether Diana was spoken to about it.

15 Analysis

15.1 Kent Police

15.1.1 July 2016 was the first instance of recorded domestic abuse between Diana and Nathan where services were notified. A second referral was also received regarding an argument that took place between Diana and Nathan in August of that year. There is very limited information from agencies regarding these two incidents and it appears that although the first argument was recorded as a domestic incident, referrals were not made by the police to additional agencies for support. Integrated Children's Services were made aware of the second incident where Nathan had damaged Diana's car within a different County however, this referral was not shared with the police in Kent and was not recorded as a domestic abuse incident within their files.

15.1.2 Following the first assault on Diana by Nathan in June 2018 a DASH risk assessment was completed and although recorded as a domestic abuse incident the police did not take any further action as Diana would not support a prosecution. Police no not always need the victim to support a prosecution in relation to certain offences and domestic abuse is one of them. It is unsure whether this was considered in this case. This appears to have been repeated in relation to the domestic abuse incident in July 2018. Nathan is identified as having sent Diana malicious emails and messages and is believed to have 'slashed' Diana's car previously. Nathan had also threatened someone that he believed Diana was seeing. A DASH risk assessment was again completed; however, it is recorded that Diana did not wish to support a prosecution. There were no referrals made to Kent's children's services although the children were identified within the DASH. There is an identified escalation of risk from the initial reported argument to a report of Nathan 'slashing' Diana's tyres and sending threatening emails and messages.

15.1.3 It is good practice for referrals to be made to children's services where incidents of domestic abuse take place even when children living at the same address are not recorded as being present at the time of the

domestic abuse incident. This allows other agencies to gain a full picture of any concerns identified where children might be involved. There does not appear to have been any additional referrals made regarding Diana or the children and no additional support offered. The IDVA and other additional local domestic abuse support services should be offered even though the victim does not always support a police prosecution. There are previously highlighted organisational complexities surrounding police referrals into Social Services relating to their Police intelligence system, Athena. It was identified that the police are the only agency who do not complete a 'request to support' form.

15.1.4 There are numerous statutory and voluntary organisations within Kent and Medway who would be able to provide additional support and advice regarding domestic abuse and Diana should have been signposted towards these.

15.1.5 It is identified good practice that schools, where the children of adults who are subjected to domestic abuse, are notified when a domestic abuse incident takes place. This enables schools to monitor the children and to also put in place additional safety measures if required.

15.1.6 Operation Encompass is a process by which key adults in schools and academies (in most cases the Designated Safeguarding Leads and their deputies) are informed that a child attending school in that area may be affected by domestic abuse. This will usually mean that a child has been in the household where an incident of domestic abuse has taken place or has been exposed to domestic abuse. The initiative in Kent was initially trialled in the Deal area and has been rolled out to other areas covered by Kent Police. This is identified as good practice and although not in place at the time of these domestic abuse incidents is now being used within the area.

15.1.7 A further serious domestic abuse incident took place between Diana and Nathan in December 2018. This is the third incident within seven months. On this occasion Nathan assaulted Diana and caused extensive damage to her flat. The children were not present at the time, but Diana later told the school so that they were aware of what had

taken place and the damage caused. The school only became aware of the incidents of domestic abuse when these were identified to them by Diana. However, the IMR author identified that this information sharing should now happen under Operation Encompass.

15.1.8 Following the assault Diana informed the Police that Nathan had contacted her on several occasions and that she had received a number of calls from Nathan. Diana also identified that Nathan had turned up at her previous address demanding to know where she was.

15.1.9 Following the domestic abuse incident in December 2018 Nathan was arrested and charged with the offence of common assault and criminal damage. A DASH risk assessment took place which was recoded as high. A MARAC referral was made which took place in January 2019. There is no evidence that either children's services or Diana's GP attended the MARAC. The MARAC is a conference where professionals participate as active partners in meaningful joint working and as such it is of great importance that the appropriate agencies are invited and share all relevant information.

15.1.10 There have been two DHRs, Connie 2018 and Jean 2018, which have taken place in Kent and Medway where recommendations have highlighted the importance of agencies, particularly GPs being invited to and attending MARACs. It is noted that a person's GP can often be a great source of information. Work is currently ongoing by the MARAC supervisor to work closely with CCGs to make improvements. One of the recommendations from the previous DHR is for the Kent and Medway Domestic Abuse and Sexual Violence Executive Group to consider how best to ensure that a high-risk domestic abuse victim's GP is invited to attend or contribute to a MARAC meeting at which one of their patients will be discussed. This recommendation is reinforced within this review.

15.1.11 Prior to Nathan's arrest for the assault, Diana contacted Kent Police in December 2018 stating that Nathan had been contacting her constantly for over an hour and that he was outside her home address. As Diana's new address was in the Metropolitan Area the Metropolitan Police

attended but he was not there. It is unknown or unestablished how Nathan became aware of Diana's new address at this time. There were several recorded instances of identified harassment on Diana by Nathan including stalking however, it does not appear that these incidents were given the right amount of consideration by the police as no additional charges were considered.

15.1.12 Dr Jane Monckton-Smith has carried out research to develop the knowledge of professionals around escalating risk within DA which often leads to homicide. She identified eight stages within the Homicide Timeline. The stages identify an escalation process identifying pre-relationship history and early relationship behaviours. These initial signs are significant within this review as it shows a pattern of behaviour of Nathan towards Diana which ultimately led to Diana's death. Nathan reported to Diana early within their relationship that he had previously smashed up a girlfriend's house whilst under the influence of alcohol. He also showed signs of controlling behaviour as identified by Diana's sister including stopping Diana from continuing to do her pole fitness and manipulating her into not seeing friends and family members.

15.1.13 The development of warning signs includes coercive control, stalking and violent behaviours from Nathan towards Diana. This led to Nathan assaulting Diana and persuading her to let him back into the family home. Diana's sister identified that Nathan had built up a strong relationship with Diana's children and would use that against Diana to make her feel guilty about keeping him out of the family home. There is also an instance where Nathan threatened suicide if their relationship failed and continued to show signs of possessiveness and jealousy. Nathan would often send numerous text messages to Diana begging to come back and continued to contact her even though he was in prison due to seriously assaulting her.

15.1.14 Nathan accused Diana of having an affair which led to a serious assault. Diana had supported the prosecuted against Nathan for the initial assault which had led to them separating however, there is evidence of continued harassment of Diana by Nathan through phone contact and contact through her social media accounts. The police were also aware

of contact being as Diana had reported excessive phone calls to her of a threatening nature. Financial abuse was also reported by Diana against Nathan where it appears that he accessed her bank account and stole her money. Financial abuse is another means of controlling the victim and is often used by perpetrators to manipulate and control.

15.1.15 The escalation of warning behaviours continues to build up ultimately resulting in homicide or suicide.

15.1.16 In February 2019 Nathan appeared before the Magistrates' Court where he was found guilty of common assault and criminal damage. He was given a Restraining Order Protection from Harassment until February 2020, a Community Order, a Rehabilitation Activity Requirement and Unpaid Work Requirement.

15.1.17 Later in November 2019 Nathan seriously assaulted Diana after accusing her of having an affair with someone else. The Police failed to consider coercive controlling behaviour within this incident, and it has been identified that the language used by the Police's report was inappropriate and victim blaming. It is reported that Diana 'allowed' Nathan to sleep on her settee as he had nowhere else to go, in breach of his Harassment Order. There is no consideration of the pressure that was probably placed on Diana by Nathan and the possible level of fear that she might have been in. There also does not appear to have been any recognition of aspects of stalking which resulted in Diana closing her social media accounts or the escalation levels as identified by Dr Jane Monckton-Smith. It was clarified within the panel meetings that all officers receive training in relation to the identification of coercive and controlling behaviour and stalking, however, officers did not recognise Nathan's behaviour as stalking at this time.

15.1.18 Further research has taken place regarding the link between domestic abuse and suicide[14]. Previous research has found that there are notable consistencies in the characteristics of victims who take their own lives

[14] https://eprints.glos.ac.uk/10579/16/10579_Monckton-Smith_%282022%29_Home_Office_Report.pdf

in the context of Intimate Partner Abuse (IPA) related suicide, and these include experiences of control, intimidation, stalking, isolation, threats to themselves or others, threats and assaults with weapons, entrapment, and failure of services (Aitken and Munro 2018). It was also found that 96% of victims of IPA who were identified as suicidal suffered from feelings of hopelessness and despair, and that these feelings are a key determinant for suicidality (Aitken and Munro 2018). Research by Cross et al (2017) suggested that there was benefit in training domestic violence helplines in responding to suicidality and that IPA and suicidality should not be treated as separate issues (2017). Eight stages have been identified that show a potential and incremental escalation in risk towards suicide.

15.1.19 Kent Police have recently invested resources into raising knowledge of stalking behaviour across the force which will hopefully enable officers to recognise behaviour like Nathan's as both coercive, controlling and stalking. This additional awareness training was developed mainly as a response to two recent DHRs within Kent and Medway, Rosemary 2017 and Ann 2018 where it was identified that the Police were not recognising the impact of stalking behaviour. Nathan was subsequently arrested, charged and remanded in custody for the offences of assault, fraud, criminal damage and a breach of Harassment Order.

15.1.20 The police made a referral to children's services and a Child Protection Strategy meeting took place. Security measures were also put in place where Diana had moved to. The Witness Care Unit were notified due to Nathan being arrested and charged with offences.

15.1.21 A further MARAC referral was made by the police. There is nothing within the MARAC minutes which suggest that Nathan had a previous history of coercive controlling behaviour and harassment and that he had previously made numerous attempts to contact Diana. Protecting Diana from further contact by Nathan should have been considered by agencies. It appears that agencies did not consider this as Nathan was in prison on remand. Although the Prison Service did have contingencies in place regarding Nathan using the prison phones to contact Diana, consideration was not given as to other means of contact

and the fact that Nathan could use this contact to continue his coercive behaviour. This gap in agencies' knowledge is further reinforced following the information that Nathan had been contacting Diana whilst on remand in prison.

15.1.22 It appears from the police's IMR that a consistent and good service was given to Diana by the Witness Care Unit during the time that Nathan was remanded in custody. Diana was updated throughout the process; special measures were addressed with her and the request for screens was actioned. Diana was notified regarding the change to court dates and the impact that COVID-19 was having regarding the delay in the case. The Witness Care Unit made appropriate referrals to victim support agencies and in this case a referral was made to Domestic Abuse Service A to support Diana through the court case process. Domestic Abuse Service A were updated by the Witness Care Unit throughout their dealings with Diana.

15.1.23 It was recognised that Diana was experiencing concerns regarding the delay in the court process however, it was recorded that there was no indication of suicidal ideation. It is not identified; however, what questions were asked of Diana regarding any suicidal thoughts or the consideration of the stresses that might impact on suicidal thoughts.

15.1.24 In May, Police were notified of an incident where Diana had left her children with their uncle and had driven from the house whilst under the influence of alcohol. When spoken to, Diana identified to officers that she was stressed about the forthcoming trial which had been delayed due to COVID-19, she stated that she wanted help from domestic abuse advice charities. Within the police's IMR it is noted that a referral was made to the Social Services Department however, there is no record of one having been received which raises concerns regarding the referral process between the Police and Children and Adult Social Services. There is also no record that a referral was made to any support charities regarding Diana or any contact with her GP. There also appears to have been no further consideration by the police regarding the stress on Diana of the court case and the delays due to COVID-19.

15.1.25 More recently a DA Protocol has been developed through the Kent Criminal Justice Board which sets out roles, responsibilities and expectations for all agencies involved in supporting victims of domestic abuse through the Criminal Justice System. This protocol covers from the point of charge to case finalisation.

15.2 Kent County Council, Integrated Children's Services

15.2.1 Diana and her family received social work intervention between January 2019 and February 2019 and also November 2019 and August 2020. During COVID-19 lockdown, guidance set down by the Government was implemented including working from home and limiting face to face contact. The Council Senior Leadership Team members agreed each open case would be subjected to a Red, Amber and Green RAG rated exercise by the local teams to prioritise face to face visiting for the most at-risk children and young people. Diana's children were considered as Green risk which meant that they could be visited virtually. Five out of eight visits from the Social Worker were face to face home visits. The Social Worker's commitment to face to face visiting was noted given the high risk of infection within the area at the time.

15.2.2 Diana was open to Social Services in 2011 following the birth of her second child over concerns regarding Diana's use of drugs. Diana was identified as being open and honest about her drug use and the midwife completed a concern and vulnerability form for the child.

15.2.3 Children's Services initially received an assessment from Thames Valley Police in August 2016 following an argument between Diana and Nathan which took place within the grounds of Windsor Castle. No further action was taken as it was the first incident of reported domestic abuse between the couple and there were no children present at the time of the argument.

15.2.4 A subsequent referral was received by children's services in December 2018 from Kent Police following the assault. A Child and Family (C&F) assessment was completed, and a Social Worker was allocated. The purpose of a C&F assessment is to gather sufficient information about the child and family to understand their needs and make decisions about

the nature and impact of the concerns or needs described in the referral and what intervention and support is necessary; and whether the child meets the criteria for a 'Child in Need' plan. During this time an anonymous referral was also received which shared worries that Diana's two children were often heard crying and that the mother was often drunk. A Child in Need plan was not considered necessary as Diana informed the Social Worker that she had separated from Nathan and intended to support prosecution. Diana was discussed at a MARAC and agreed to a referral to The Freedom Programme. The Freedom Programme examines the roles played by attitudes and beliefs on the actions of abusive men and the responses of victims and survivors. Diana was referred to the Freedom Programme on two occasions.

15.2.5 During the assessment the fact Diana informed the Social Worker that she intended to press charges against Nathan and knew that what he had done was wrong were considered as safety factors. There appears to be an over reliance on Diana's plan to remain separate and to self-report any further abuse. A family safety plan may have helped in advance of the possibility of future contact from Nathan. It also does not appear that coercive control was considered, nor the psychological hold that Nathan might have had on Diana. There is limited consideration of the risk to Diana and the children and there is no evidence of any specific tools being considered to support the understanding of any risk, such as a DASH assessment.

15.2.6 The assessment appeared to lack analysis around the impact of domestic abuse on Diana and the children and there is no evidence of Social Work exploration of the psychological effects of the abuse she had experienced or any trauma that she was experiencing.

15.2.7 Although the children were considered in their own right, this related to concerns regarding the protection that Diana was able to provide for the children and not as victims of domestic abuse. Although the children do not appear to have been present during the assaults there is no information regarding the children's knowledge of the domestic abuse and the impact the domestic abuse would have had on the children. The new Domestic Abuse Act will see children who live in a home where

domestic abuse takes place recognised as victims in their own right rather than witnesses for the first time. The Act will recognise a child who sees, hears, or experiences the effects of, domestic abuse and is related to the person being abused or the perpetrator, to be regarded as a victim of domestic abuse.

15.2.8 Following the further assault in November 2019 a further referral was made to Integrated Children's Services (ICS). ICS identified the use of inappropriate language in relation to why Nathan was staying with Diana at the time of the assault. Recorded within the Section 47 enquiry is the fact that "Mother allowed Nathan to come back and live with them despite a previous volatile and acrimonious relationship between them thereby exposing the children to risk of harm……I am concerned about mother's ability to safeguard the children because of poor decision making". This is identified as victim blaming, and as with the police, it does not appear that coercion and control was considered and the reasons for Nathan staying were placed firmly on Diana's shoulders.

15.2.9 This review has identified issues for development and opportunities to support Social Workers in increasing their knowledge around how to work effectively with the victims of domestic abuse and how the experience of trauma may impact on an individual's ability to cope. Additional training is required surrounding the link between suicide and domestic abuse. The British Association of Social Workers have published guidance which is aimed at social workers within the remit of children's services in England, who carry out the critical work of supporting domestic abuse victims/survivors which includes children[15].

15.2.10 Following the assault in November 2019 a strategy discussion took place with the police and a Section 47 enquiry was completed. During the assessment both of Diana's children were spoken to alone and at this point child A identified that Diana had a new partner. Claire's Law was discussed with Diana which is identified as good practice.

[15]https://new.basw.co.uk/policy-and-practice/resources/basw-england-domestic-abuse-guidance-social-workers-april-2021

15.2.11 Following assessments both children were considered as Children in Need (CiN) and a CiN meeting was held in March 2020. There is some evidence that the Social Worker used a family centred approach[16] with Diana and the children. Although information was requested regarding the children's health for the assessment there does not appear to have been any request for information regarding Diana's physical and mental health. It is not clear why this information was not asked for and it is difficult to see how a full family assessment could have been completed without it.

15.2.12 Neither of the CiN assessments evidenced Diana's family history nor did they explore her wider family dynamics, so her early childhood/adult experiences do not appear to have been taken into account when considering her ability to care for the children. The recorded concerns regarding previous drug abuse were not discussed within either assessment nor were the two recorded incidents alleging Diana's misuse of alcohol. These discussions are vital for a rounded needs assessment and for decision making regarding the appropriate support available. Kent provides Adverse Childhood Experiences training (ACEs) to their staff.

15.2.13 There is no recorded information as to whether Diana was actually asked regarding her physical and mental health which could have impacted on the outcome of the assessment, both assessments lacked analysis around the impact and experience of domestic abuse on Diana and the children. There is also no evidence of any consideration being given to Diana's mental health and any suicidal thoughts.

15.2.14 There is good evidence of multi-agency working with the children's schools who appeared to be informed and involved in the planning for the children. However, there is no evidence that the Social Worker and the IDVA communicated during early 2020 and therefore no clarity as to what the Social Worker believed the IDVA's role or purpose was.

[16] Family centred practice is based upon the belief that the best way to meet a person's needs is within their families and that the most effective way to ensure safety, permanency, and well-being is to provide services that engage, involve, strengthen, and support families.

Diana informed the Social Worker that she was being supported by the DVAP however, this was not explored any further, again reliant on self-reporting.

15.2.15 The CiN meeting following the last assault was attended by the children's school, the Social Worker and Diana. It appears that the DVAP was invited to attend the CiN meeting but declined to attend due to the uncertainty of her job. This shows a lack of consideration to what support should be considered or made available for Diana. There is information that the children's social worker did attend the MARAC meeting which is good practice as they are then able to get a better picture of what happened and what support was being offered.

15.2.16 There are recorded instances where Diana told the Social Worker that she was struggling or needed extra help. The last incident was in May 2020 when Diana told the Social Worker that she was feeling low as she was worried about the impending court hearing and was no longer getting support from the DVAP. She also identified that she was struggling with home schooling. The Social Worker did not feel any of the issues were seriously impacting on Diana's emotional or mental health although it also does not appear that they were examined or discussed with Diana. The Social Worker did not consider it necessary to refer Diana to other support services or her GP.

15.2.17 Kent ICS are developing a 'spotlight on domestic abuse' series which is a mandatory development programme which will look to develop knowledge in many aspects of domestic abuse, including coercive and controlling behaviour. It is recommended that this training programme is extended to include the link between domestic abuse and suicide.

15.3 The Education People, Education Safeguarding

15.3.1 There is very limited information surrounding both of Diana's children whilst they were at school. The information within the children's safeguarding files provides limited information about the family prior to Diana's suicide. This in itself has highlighted the necessity of recording of information. Child B's school identified that they had no recorded

information at all although it is identified within the ICS IMR that the school had attended Child in Need meetings.

15.3.2 There is also no information recorded within the files regarding child A, apart from a record in January 2019 stating that child A was moving schools 'due to domestic violence and supported by social services'. A member of staff within the school remembers Diana attending the school requesting a move due to the fact that the family were fleeing domestic violence and that they had been moved to a refuge. Diana had apparently told staff that Nathan had tried to stab her and that the police were involved but that they had been unable to find him at this point.

15.3.3 There are no records of any information being shared by the police regarding their involvement due to alleged domestic abuse, but it is acknowledged that Operation Encompass was not in place in the area at the time of these incidents, but it is now. There is also no record of any involvement with other services or of any follow up conversation with social care following Diana's attendance at the school in January 2019.

15.3.4 In order for a school's safeguarding to be considered effective by Ofsted they must meet the requirements of Keeping Children safe in Education (KCSIE) including having policies and procedures in place, clear recording mechanisms and an appropriately trained Designated Safeguarding Lead (DSL). All other staff should also receive regular training which should include information on how to respond to possible domestic abuse.

15.3.5 There is a record in November 2019 regarding a strategy meeting taking place concerning child A which the Designated Safeguarding Lead attended. This was as a result of the last serious assault. There are no records of the outcome of the meeting or any actions for the school or what support was required for the children. The safeguarding files for both children do not provide a coherent overview of the children's experiences of domestic abuse, the family dynamics in the home nor an understanding of the level of input from other agencies that were involved with the family. There is a record of a meeting taking place at

the school between child A and a worker from Domestic Abuse Service A although there is limited information regarding this.

15.3.6 It is hard to gain a sense of how involved or knowledgeable the staff from the schools of both child A and child B were of the experiences of the children and Diana prior to Diana's death. It also poses the question of how alert school staff were to the individual needs and experiences of the children in the context of experiencing domestic abuse and how this was acknowledged and dealt with in terms of pastoral care and support.

15.3.7 Issues around record keeping in schools has been highlighted in previous multiagency reviews including Domestic Homicide Reviews and Child Safeguarding Practice Reviews.

15.4 Kent and Medway Clinical Commissioning Group

15.4.1 NICE guidelines state that there is insufficient evidence to recommend screening or routine enquiry regarding domestic abuse in most healthcare settings. Therefore, GPs are recommended to practice clinical enquiry, which sets the threshold for asking low and uses the information from the interaction with the patient to make an assessment.

15.4.2 Some physical and mental health issues, such as anxiety, depression, chronic pain, difficulty sleeping, facial or dental injuries, chronic fatigue and pregnancy and miscarriage have a strong link to being a victim/survivor of domestic abuse. Patients who present with such symptoms should always be asked about abuse[17].

15.4.3 Multi agency work with local specialist services is identified as a priority and General Practices hugely benefit from strengthening their relationships with local specialist domestic abuse services. Such links can lead to:

[17] https://safelives.org.uk/sites/default/files/resources/Pathfinder GP practice briefing.pdf

- Training for primary care staff - specialist domestic abuse workers could provide basic training to staff to increase their understanding of domestic abuse and the signs of abuse
- Develop a referral pathway – general practitioners would have better knowledge of the services available for victims/survivors and perpetrators of domestic abuse as well as how to refer patients to such services.

15.4.4 Although IRIS is recommended by SafeLives, GPs within this area are given training on domestic abuse by Clarion. It has been identified that Clarion do not routinely provide training for GPs but are happy to provide training when requested.

15.4.5 The IRIS model was set up to improve the response of primary care to domestic abuse. It is a domestic abuse training, support and referral programme for GP practices. Core areas of the programme are; ongoing training sessions for both clinical and ancillary staff, clinical enquiry and care pathways for primary health care practitioners and an enhanced referral pathway for all patients with the experience of domestic abuse. The work is completed by a full-time Advocate Educator (AE) working with up to 25 practices. As well as providing training to all staff in the practice AEs will also hold a caseload, offering practical and emotional support to patients who have experienced domestic abuse.

15.4.6 The IRIS model has been shown to be effective in the identification and referral of victims/survivors of domestic abuse. One study found referrals to domestic abuse agencies in the intervention practices being 21 times larger than in the control practices.

15.4.7 Training of GPs is fundamental to providing an effective response to domestic abuse in primary care. The IRIS system was discussed within the panel, and it was identified that this is currently being trialled within an area of Kent and Medway, but this has only just been commissioned. The IRIS system and impact will be monitored.

15.4.8 Within the current GP training, Clarion were asked to provide training which covered; the Domestic Abuse Act 2021, the role of the GP and their support for victims, MARACs and the role of the GP, DHRs, and the correct referral pathways. More than 400 GPs were recently trained. It was identified that this training had started just prior to this DHR taking place and was being rolled out to GPs.

15.4.9 The most significant involvement Diana had with her GP was regarding a very serious neck problem resulting from a fall. The neck injury had caused spinal cord damage from which there was an incomplete recovery, and also a lesser problem with the lumbar spine. The GP surgery were also aware of Diana experiencing domestic abuse however, this was mainly through self-reporting and not through referrals from different agencies.

15.4.10 The CCG's IMR identified that Diana's neck and back problem along with the physical and mental complications arising from the domestic abuse resulted in the prescribing of strong pain controlling drugs. The GP's involvement with Diana mainly revolved around the reviewing and prescribing of medication. It has been highlighted within the CCG's IMR that there appeared to be a long history of GPs trying to wean Diana off of her Oramorph and Co-Codamol due to the addictive nature of these drugs. The weaning process is noted within Diana's GP records throughout 2017, 2018 and 2019 but with a very mixed result. It appears that although it was noted within Diana's records that she was being weaned off of medication, prescriptions were still being drawn up for her by different GPs and out of hours health clinics.

15.4.11 Diana was prescribed the drugs for most of the period and whilst there were several attempts at dose reduction these were not sustained or effective with the prescriptions being issued on a repeat basis for extended periods without a clinician's review. The NICE guidance[18] regarding the assessment of all chronic pain and the management of chronic primary pain does not appear to have been adhered to in this

[18] https://www.nice.org.uk/guidance/ng193/chapter/Recommendations - managing-chronic-primary-pain

case. Chronic pain is identified as pain that persists or recurs for more than 3 months. This includes both chronic primary pain and chronic secondary pain, which can coexist. Other terms used include persistent pain and long-term pain. Recommendations from the guidance on how to support patients identified with chronic pain aim to inform a care and support plan by setting out a comprehensive person-centred assessment of the causes and effects of pain and agreeing possible management strategies, including self-management. Although the guidance identified the psychological long-term effect of chronic pain and the impact that this has on the patient's life it does not identify the link between chronic pain and suicide. This is discussed later within the report.

15.4.12 There are notes within Diana's records regarding her experiencing domestic abuse and the impact of this on her children. There was no record within the GP notes that the GP had considered referring Diana for help and support in relation to the domestic abuse that she was suffering.

15.4.13 There were, however, no records of information being passed to the GP from other agencies regarding this and also no records that a MARAC had been held. It does not appear that the GP had been invited to the MARAC nor is there any information surrounding Diana's children being subject to Child in Need meetings. Diana's consent would need to have been obtained in relation to the passing on of this information however it does not appear that this was requested or even considered. The GP was also not aware of the impending court case surrounding Diana and the fact that she was waiting to give evidence again Nathan.

15.4.14 The panel discussed GP attendance and involvement with MARACs and there appears to be a great deal of anecdotal information that GPs do not always attend MARACs and that information is not consistently shared. It was identified that a great deal of work has taken place in relation to inviting and gaining the attendance of GPs at MARACs and that, although not always consistent, this has improved over the years. The CCG continue to work with GPs to emphasise the importance of

good information sharing and the impact their attendance can have at multi agency meetings.

15.4.15 The prevalence of domestic abuse is much higher among people attending GP practices than the wider population, so GPs are well placed to identify patients at risk and help them access support. Despite this, GPs are often unaware of high-risk cases among their patients or the existence of safety plans and fail to share information that could help safeguard people at high risk of such abuse.

15.4.16 In east London, a nurse-led domestic abuse service for general practice was developed as part of a collaboration between Hackney public health services, City and Hackney Clinical Commissioning Group and Homerton University Hospital NHS Foundation Trust. The service was developed in 2015 in response to concerns that:

- Information from GPs to the MARAC on patients who are victims of domestic abuse was inconsistent and often arrived too late to aid safety planning;

- Information from clinical audits showed GPs were often unaware of cases of domestic abuse among their patients and the existence of safety plans, causing them to work reactively rather than proactively when they became aware of such cases.

15.4.17 To improve information sharing, a MARAC liaison nurse role for general practice was created; this meant information sharing did not rely on an administrator sending data from the GP to the MARAC coordinator. The aim was to allow more informed and effective decision making and safety planning for people at high risk of domestic violence[19].

15.5 NHS Trust A

15.5.1 Diana attended the Emergency Department (ED) of the Trust on thirteen occasions over a period of fourteen years, mainly in relation to

[19] https://www.nursingtimes.net/clinical-archive/patient-safety/development-of-a-nurse-led-domestic-abuse-service-for-general-practice-10-02-2020/

her back pain. Diana appeared to be in a significant amount of pain and as such was reviewed in the pain clinic. Diana was also offered a number of Physiotherapy and Hydrotherapy sessions, but these were not always consistently taken up by Diana.

15.5.2 Diana also attended the ED following the serious assault in November 2019. There is no information recorded that Diana was referred to the Hospital IDVA (HIDVA) service or any additional support agencies regarding the domestic abuse that she had suffered. During November 2019, the HIDVA service was being provided remotely however, it is not known whether the service was contacted.

15.5.3 It does not appear that any questions or referrals were made following Diana's attendance at ED. There also does not appear to have been any referrals made with Diana as to whether there were any children or other vulnerable persons at home where the domestic abuse took place or who might have been impacted by it. The IMR author identified that the safeguarding training to ED staff has been reviewed and that the Level 3 children's safeguarding training has changed to be more Family Focused which includes adult level 3 training. This does not however, identify the reason for the lack of questions being asked of Diana regarding the domestic assault and significantly the lack of any referral to the HIDVA service. The process within the hospital requires an urgent review and where necessary the appropriate training needs to take place.

15.6 **Borough Council A, Housing**

15.6.1 Diana and her children were accommodated after presenting as homeless in December 2018 by the Borough Council A Housing Solutions Team (HST). The address is a property managed by the accommodation team via the Private Leasing Scheme (PLS). This scheme is used for short or medium term occupancy for vulnerable families and individuals who have presented as homeless to the council. During the pandemic, the Government instructed every Local Authority to accommodate rough sleepers, those at risk of rough sleeping and those individuals suffering from COVID-19 who could no longer live with vulnerable, shielding family members. As a result, the HST were

accommodating around 35% more homeless residents by July 2020 than it had in February 2020.

15.6.2 At the time of presenting homeless Diana identified that she had been subjected to a serious assault and extensive damage had been caused at her address by her ex-partner Nathan. At the time of presenting, it was identified that Diana was nervous, scared, anxious and traumatised as a result of the assault. Diana referred to her family unit as being very supportive of her and identified to workers that she had fallen victim of someone who just took over her life. Good practice and compassionate staff intervention was identified during the initial interaction as a staff member had seen Diana outside the Civic Centre looking upset and had intervened to make sure she was alright.

15.6.3 Diana's case was allocated and dealt with by an officer who had previous experience in dealing with victims of domestic abuse. It was identified by the worker that Diana had already been allocated an IDVA. An appointment was also made for Diana regarding financial and debt advice with the team's Housing Inclusion Officer.

15.6.4 In early February 2019 Diana advised the HST that her address had been read out in court during a hearing and that Nathan now knew where she lived. She initially stated that whilst she felt unsafe in the property she wanted to remain in the area. Diana was offered a police alarm, along with extra security measures should she need them. This has been researched by Kent Police and the Crown Prosecution Service (CPS) and the panel received information from the Kent Criminal Justice Team stating that no address was recorded on the documentation and an email stated at the time that "no address was given out in court" as the bail conditions were for Nathan to have no contact directly or indirectly with Diana.

15.6.5 Information was received that Diana had again been assaulted at her address by Nathan in March 2019. As a result, an immediate alternative property was sourced, and arrangements were made for Diana to move. Diana again moved address in December 2019. It was identified within

the review that the Senior Officer communicated with Diana's IDVA regarding securing a house move and also attended the MARAC.

15.6.6 There were identified occasions that although additional services were offered to Diana, she did not always attend these appointments. This has identified a gap in the process which monitors client's wellbeing as they apparently begin to recover from trauma. The HST intends to respond to this issue by creating a written 'officer guide' for dealing with vulnerable applicants who are managed in temporary accommodation, including a monthly complex panel with a focus on promoting client engagement. As a result, complex cases will be discussed monthly at a panel of staff in order to pool ideas of positive engagement with hard to reach clients. This will include, but will not be limited to, clients with a DA background.

15.6.7 It was identified by the IMR writer that although training is provided on how to respond to safeguarding concerns for both adults and children there is not a Housing focussed Domestic Abuse Strategy. This is one of the recommendations identified within their own IMR.

15.7 London Community Rehabilitation Company (CRC)

15.7.1 Nathan was known to the London CRC having been sentenced at Magistrates' Court in February 2019 for an offence of Common Assault and Battery on Diana. He was sentenced to a 12-month Community Order, with 20 hours Rehabilitation Activity Requirement (RAR) days, and 60 hours of unpaid work (UPW). The Order naturally expired on the 5th of February 2020 however, as Nathan failed to complete the 60 hours UPW the case remained open until it was revoked in January 2021 due to Nathan receiving a custodial sentence following the second assault on Diana.

15.7.2 At the time of sentencing for the Community Order Nathan was assessed as posing a low risk of reoffending and a medium risk of serious harm towards intimate partners including Diana. It was recorded that the factors addressed as contributing to Nathan's offence were his thinking and attitudes and his inability to deal with conflict within a relationship. Nathan was deemed to pose a risk of physical harm

towards intimate partners and failed to appropriately handle conflict in his relationships with others, which is considered a concern should this be repeated. Although Nathan admitted guilt to the initial offence and accepted the facts of the case, he attempted to minimise his actions. Nathan was considered for the Building Better Relationships Programme however; he was assessed as not being appropriate due to him presenting with a high level of minimisation and denial. A recommendation was made to the court for a sentencing requirement of a Rehabilitation Activity Requirement and Unpaid Work which was felt more appropriate. The fact that Nathan minimised his offence and was a risk to intimate partners, would have been relevant information to have been shared at the MARAC to enable agencies to reflect this information within their risk assessments.

15.7.3 Records show that Nathan did not fully comply with the Order and failed to attend his initial appointments along with any subsequent appointments. Although Nathan did contact the Service Centre to inform them of his work commitments, he failed to provide evidence of his employment. He also failed to attempt to contact his Offender Manager in accordance with the Community Order. Nathan was not supervised/contacted between April 2019 and August 2019. It is not clear as to how his engagement was missed.

15.7.4 Standard practice was not followed regarding the change in Nathan's address. The Offender Manager should have been informed of the address change and then the case could have been transferred. Due to this not happening the breach was not able to be pursued. A further risk was identified regarding the lack of checks taking place regarding Nathan's change of address. No checks took place regarding the suitability of the address and whether any females were resident there or other vulnerable adults or children. This serious gap in the working of the CRC has showed a significant lack of management of Nathan following his conviction of assault on Diana. There is no evidence that Nathan's Offender Manager attempted to contact the social worker assigned to Diana's family and no contact was made with any external agencies including MARAC. A sense of professional curiosity to have a multi-agency approach would have been beneficial to aid the risk

management. It was also identified that the Spousal Assault Risk Assessment (SARA) form was not completed as part of the risk assessment which could have greatly reduced the level of risk that Nathan posed.

15.7.5 The process should have been that the Offender Manager would have been notified of the change of address and then it is the Offender Manager's responsibility to follow up with other agencies as necessary. A gap was also identified when Nathan stated that he was seeing a named Offender Manager in a different area which later was shown to be a lie. It has been identified that Nathan was not managed in alignment with organisational expectations, especially regarding the frequency of appointments offered. There is also evidence to suggest that Nathan sought to manipulate his engagement with the service by presenting false and/or unsubstantiated information. Two DHRs have taken place within Kent where concerns have been identified within CRC regarding the level of management and challenge. Connie 2018 identified similar learnings; 'The Responsible Officer did not challenge him, nor did she contact Kent Police to see if they had any further information or corroboration. This is a missed opportunity' and the 'Risk management of Ryan's case was passive and overtly reliant on his accounts.' Similar learning points were identified in DHR Ann 2018 where there were gaps identified surrounding challenge and curiosity.

15.7.6 It was identified by the CRC panel member that the unification of the Probation Services would allow Probation to work more effectively. The panel would like to know how the learnings from this and previous DHRs will be disseminated within The Probation Service and assurance that they will be acted upon. The CRC were identified as having a significantly high caseload of domestic abuse cases and that processes were being developed to manage the risk profiles within the MARACs and MAPPAs (see glossary).

15.8 **Victim Support**

15.8.1 Victim Support had two interactions with Diana, both being in June 2020 after the serious assault inflicted on her by Nathan. During the first call the support worker explored with Diana her needs and her pathway to

recovery. Options for counselling were discussed which was agreed would take place after the court case. A further call took place however Diana identified that she was with relatives, so a further time and date were booked. It was confirmed that Diana had support from the Domestic Abuse Service A. Several further calls were made to Diana but with no response. The last contact was a text message sent to Diana stating that if she wanted to restart any support for her to contact the service. No additional contact was received from Diana.

15.8.2 During the interaction with Diana, she identified that she was receiving support from her family and the father of her children. Consent was received from Diana for Victim Support to contact children's services which took place, and a referral was also received from children's services, and the level of risk for Diana and the children was confirmed. A structured needs assessment was completed with Diana and the support required was identified. Diana did discuss the upcoming trial and disclosed that this was a stress point in her life however, she stated that the Officer in the Case (OIC) was very engaged with her and that the Witness Support Service had emailed her with reference to the upcoming trial.

15.8.3 During the conversations with Diana, she identified that her youngest child "idolised" Nathan and her concerns were about how she would manage his absence rather than the impact of domestic abuse on her. Diana was signposted to Project Salus[20] for additional support for her children. Diana disclosed clear stalking behaviour from Nathan during their relationship which when teamed with controlling and coercive behaviour led to her feeling the need to close her social media accounts. Diana also disclosed to the Victim Support worker that Nathan was an abuser of various substances and alcohol. Nathan had spent the night prior to the assault of Diana drinking alcohol and Diana believed that his substance abuse was a contributory factor to the abuse she suffered.

[20] SALUS, previously known as Kent Safe Schools, offers a range of innovative services in Kent to benefit children, young people, their families and schools.

Diana did not disclose any mental health issues and stated that she was not unduly stressed or anxious.

15.9 Clarion IDVA Service

15.9.1 The Clarion IDVA service is contracted by Kent County Council to provide domestic abuse support services in North Kent. Diana received IDVA support twice between July 2016 and July 2020. The IDVAs supporting Diana had previous experience of working with vulnerable adults, children/young people and substance misuse in the community and prisons. All IDVAs receive fortnightly case management support which is also identified within the time of their involvement with Diana. During the management sessions risk assessments and risk management plans were reviewed and, if needed, actions to further reduce the risk and/or increase the support were discussed and agreed. As well as the management support, IDVAs receive monthly one to one supervision from their line managers.

15.9.2 The first referral into the IDVA service was via a MARAC referral from the police in December 2018. Contact was made with Diana and the MARAC process and the support available was explained to her. Diana stated that she understood the MARAC process and consented to her information being shared with other agencies. A full assessment was completed with Diana which included background history, the incident, perpetrator's details, children, housing, e-safety and what Diana's wishes were. Safety planning was also discussed with Diana including the safety of her children. The IDVA became involved in helping Diana find safe alternative accommodation and requested extra security measures for the new address.

15.9.3 It is highlighted that Diana identified that she had received several calls from Nathan in January, and that he had made numerous attempts to contact her. This appears to have been reported to the police for their attention. Diana also disclosed that Nathan had turned up at her old address demanding to know where she was. The IDVA confirmed with Diana's solicitor that an application for a Non-Molestation Order had been started.

15.9.4 The IDVA continued to offer support to Diana throughout January 2019 including offering support regarding school moves and liaising with children's services and housing providers. There appears to have been a good relationship between Diana and the IDVA at this time. Following the court case in February 2019 a safety plan took place as Diana's address had been disclosed in court. Children's services were involved. A panic alarm was fitted to the property and Diana was advised to report any breaches to the police. A house move was discussed with Diana, but she did not wish to move as the only available property was out of the area and she did not want to remove the children from their schools.

15.9.5 A case management discussion took place, and a decision was made for a closing conversation to take place with Diana. Several attempts were made to contact Diana after this point however, no further contact was made. The case was closed at the end of March 2019.

15.9.6 The IDVA service again became involved with Diana following the serious assault in November 2019. It was identified that Diana had moved to temporary accommodation and that Nathan had been remanded in custody following his arrest and charge for the assault. It was identified that children's services were involved. The IDVA explained their role to Diana and identified the support she required. The MARAC had been delayed due to Diana's injuries. Diana identified that she felt traumatised by the attack and that she needed to be in constant company to feel safe. She also stated that she kept reliving the attack and was suffering from flashbacks. She identified that her children were currently staying with their father and that she was worried that they might not be able to cope well at the new house. Diana stated to the IDVA that the police had been outstanding with their support.

15.9.7 It was agreed that the IDVA would make a referral for counselling for when Diana was ready, and a referral was also made to Sanctuary. Support was provided to Diana in relation to her house move and a further risk assessment took place including safety planning and a potential move to outreach support if needed. The IDVA discussed self-help for Diana and a referral to getselfhelp.com was identified. Diana stated that she would like counselling when she was settled and that

she had family that were supporting her. An exit strategy survey was completed. Diana was signposted to different charities regarding support for essential items for the house and children over the Christmas period. The IDVA made a referral for StepChange outreach support[21] as previously agreed by Diana.

15.9.8 Throughout the IDVA's interaction with Diana, Diana had disclosed mental health issues which she believed were caused by domestic abuse from Nathan. Information on support available for Diana was shared both on self-help and a referral through to counselling support. There is, however, no consideration to any discussions taking place regarding the risk of suicide or any questions being asked of Diana as to whether she had considered such options.

15.10 **Domestic Abuse Service A**

15.10.1 Diana was being supported by the Lodestar Family Service within Domestic Abuse Service A at the time. The Lodestar Family Service is for those that have experienced DA and require a whole family service to rebuild relationships with their family and the wider community. Referrals into the service is for those victims of standard risk. The referral into the service came from the IDVA who had been supporting Diana during the last month following the assault. The Domestic Violence Abuse Advisor spoke to Diana regarding her needs and wishes. She and her family had just moved into temporary accommodation fleeing the domestic abuse from Nathan.

15.10.2 Diana described to the service that her family were very supportive of her, and that Nathan's family had condemned Nathan's actions to her. A risk assessment was completed which scored high due to the nature of Nathan's behaviour and the case was highlighted to the manager due to the risk score being high. It is highlighted within the risk assessment that "Diana was feeling depressed and suicidal as a result of Nathan making her scared". This is the only record agencies have regarding the impact that Nathan's behaviour was having on her and the seriousness

[21] StepChange Debt Charity have been helping and supporting families with money worries and problem debt for over 20 years.

of her mental wellbeing. This does not appear to have been discussed with Diana and no additional support mechanisms were put in place or suggested to Diana. Diana identified that Nathan was convinced that she was having an affair and would hound her with texts and countless phone calls, and she reported that she found Nathan intimidating.

15.10.3 The contact the service had with Diana in January 2020 highlighted the level of emotional distress that Diana was experiencing. Diana disclosed that she was using cannabis and alcohol to help her relax and sleep. She stated that she had been given sleeping tablets by her GP and was working to reduce her drug and alcohol intake, she also identified that she was struggling to go into open spaces. Diana also stated that the children were struggling emotionally, and she agreed for a DVAP to contact the school to start to work with the children.

15.10.4 Although the support provided to Diana and her children by Domestic Abuse Service A was good there does not appear to have been any consideration of involving other services. There is no record of a conversation taking place between the DVAP and the IDVA service which is a missed opportunity to discuss the best ways of supporting Diana. The DVAP did have conversations with children's services regarding Diana and her ability to support and care for the children and no risks were identified. Although risk assessments were completed with Diana it has been identified that the workers appear to have relied on the outcome of those risk assessments too much without considering other factors or having professional curiosity. A conversation took place between the IDVA Service Manager and the Operational Manager regarding the risk towards Diana and that the risk had not been sufficiently reduced. Diana was identified as still being high risk and it was requested that support continued which happened. Lodestar continued to provide support. Not all agencies considered the fact that Nathan would be able to contact Diana whilst in prison and therefore still harass and coerce her.

15.10.5 In February 2020 a case management meeting took place whereby it was agreed that the support being offered to Diana would continue. It was noted during this meeting that the DVAP on intake had assessed

Diana as high risk and as such her case should have stayed with the IDVA service. It was identified that as Diana was engaging well with her DVAP and appeared to be settled that the support would continue. The DVAP continued to support Diana and contacted Witness care to arrange for special measures to be put in place for Diana to attend court and give evidence. It was noted that Diana was worrying about the court case.

15.10.6 It is worthy of noting that recorded in the Domestic Abuse Service A's IMR, Diana had commented that the social worker was questioning her as to why she had stayed in the relationship with Nathan and why she went back to the property the day of the incident. Diana stated that she felt that she had to justify her actions to make the social worker understand what she was going through. This has been highlighted by Integrated Children's Services in their own IMR, regarding the perceptions and beliefs of their worker.

15.10.7 Good practice was identified regarding using 'Claire's Law' surrounding checks made on Diana's new boyfriend so that she would be aware if there were any domestic abuse concerns. The DVAP was invited to the Child in Need meetings but was unable to attend due to short notice. The DVAP also made a referral for enhanced support for Diana during the court case. Diana mentioned to her DVAP that she was concerned that Nathan would use his PTSD from his time in the army as a defence as to why he attacked her. This unfortunately does not appear to have been given a great deal of consideration and this was not shared with other agencies. Diana stated on several occasions that she was concerned that the court case would be postponed due to the pandemic.

15.10.8 In April 2020 the DVAP informed Diana that the project funding for her role was coming to an end and as such they would be unable to continue to support her. Diana identified that her relationship with her social worker had improved and in May Diana was signposted to Victim Support. It is unclear why the DVAP felt the need to identify to Diana that her role was coming to an end due to lack of funding. This has been taken on board by the service. Domestic Abuse Service A had

made a commitment to continue with complex needs clients and there were several cases which had been kept open.

15.11 Housing Provider A

15.11.1 Housing Provider A supply properties in Kent and Medway and have identified that they are currently working towards achieving the Domestic Abuse Housing Alliance (DAHA) accreditation. Their domestic abuse co-ordinator has worked extensively across departments, including repairs, to raise awareness of domestic abuse to ensure that all teams respond appropriately.

15.11.2 Housing Provider A have one recorded contact with Diana when she contacted them asking for repairs to be completed at her home address. She advised that her ex-partner had stolen her keys and smashed valuables in her home including her windows. It was identified that Diana needed rehousing. The Anti-Social Behaviour Officer (ASB) contacted Diana who reported that she had split up with her partner which had resulted in her property being damaged. The officer completed a DASH assessment with her. Diana agreed for a referral to be made to the IDVA service but when contacting the police, it was identified that a referral had already been made. The ASB officer liaised with the IDVA who confirmed that Diana's case had been heard at MARAC and that Diana was too fearful to return to her property and had been placed in temporary accommodation.

15.12 The Crown Prosecution Service (CPS)

15.12.1 The case of assault against Diana by Nathan was charged by the Crown Prosecution Service direct on the Threshold Test[22] in November 2019 and transferred to a lawyer who kept the case throughout its lifecycle. The case was reviewed and prepared for a pre-trial plea hearing in December 2019. Nathan was not arraigned at this hearing as an assertion was issued stating that Nathan was suffering from PTSD from his time in the forces.

[22] The Threshold Test ("TT") is applied where a suspect presents a substantial bail risk and not all the evidence is available at the time when he or she must be released from custody until charged.

15.12.2 A trial date was set for April 2020 however this was not effective due to COVID-19. A new trial date was set for September 2020 and the Custody Time Limits were extended to accommodate this date. Nathan submitted a bail application in early July 2020 which took place after Diana's death.

15.12.3 Concerns were raised during panel meetings regarding the fact that Nathan became aware of Diana's home address and was therefore able to attend there. It was believed that her address had been read out at Court by the CPS inappropriately therefore putting Diana in danger. Information was requested from the CPS regarding this, and a phone conversation took place between a CPS representative and the Independent Chair. The CPS representative identified that the address that was read out at court was in relation to Nathan's bail conditions and that he was bailed not to attend Diana's home address. The address that Nathan was bailed to not attend was the same address that he had been arrested at and was therefore not new or a breach of confidentiality. This was corroborated by Diana's sister.

16 Domestic Abuse and Suicide

16.1 On average, two women are killed by a partner or former partner every week in England and Wales. What remains far more hidden, however, is the stark number of women who take their own life as a direct result of experiencing domestic abuse.

16.2 In 2019, the age group with the highest rate of suicide was for those aged 40 to 44 years, at 23 deaths per 100,000. The age group 35 to 39 years, with 17.8 deaths per 100,000 population, had the second highest rate of suicides in the UK[23].

16.3 A 2018 study by the University of Warwick[24], focusing on more than 3,500 women supported by domestic abuse charity Refuge, uncovered that almost a quarter (24%) of women supported by the charity had felt suicidal at one time

[23] https://www.statista.com/
[24] http://wrap.warwick.ac.uk/103609

or another. A staggering 83% reported feelings of hopelessness and despair, key symptoms of suicidal ideation.

16.4 The research also found that nearly a fifth (18%) of participants had actively planned to take their own lives, while data from the charity SafeLives indicated a similar number (17%) had planned or attempted suicide.

16.5 Data from Professor Sylvia Walby's research[25] estimates that approximately one in eight of all female suicides and suicide attempts in the UK are due to domestic violence and abuse. This equates to 200 women taking their own lives and 10,000 attempting to do so due to domestic abuse every year in the UK. That is nearly 30 women attempting to complete suicide every single day[26].

16.6 The link between domestic abuse and suicide has long been overlooked, and as we emerge from a global crisis that has significantly intensified both issues, now is the time for this link to be examined closely and preventative measures put in place.

16.7 The report 'Domestic abuse and Suicide Exploring the Links with Refuge's Client Base and Work Force' by Ruth Aitken and Vanessa E. Munro[27] on behalf of Warwick Law school and Refuge identifies:

'Domestic abuse is a high-risk situation, whether this refers to the immediate risk of serious, physical harm from the perpetrator, or to the longer-term risk to the victim's psychological well-being, to their life chances in terms of lost opportunities and potential, or significant damage to 'the self'. Domestic abuse is also a risk to life, either through homicide or suicide of the victim. Although domestic abuse is mentioned as a risk factor within the national suicide strategy, neither suicide nor suicidality are mentioned within the Government's most recent violence against women and girls (VAWG) or domestic abuse strategy, it seems clear that any meaningful integration of policy or practice across both spheres is lacking.'

[25] Professor Sylvia Walby (University of Leeds) *"The Cost of Domestic Violence September 2004"*
[26] Hesita, Celebration 50 years of life beyond crisis.
[27] Ruth Aitken and Vanessa E. Munro, Domestic abuse and suicide exploring the links with Refuge's client base and work force. © Refuge and Warwick Law School 2018

The new Domestic Abuse Plan 'Tackling Domestic Abuse Plan' strongly links domestic abuse with suicide[28].

16.8 The Vulnerability Knowledge and Practice Programme's (VKPP) 'Domestic Homicides and Suspected Victim Suicides During the COVID-19 Pandemic 2020-2021'[29] report systematically counted suspected victim suicides following known domestic abuse in England and Wales for the first time. There are no reliable estimates of victim suicide rates where there was a known history of domestic abuse, but it has been suggested it might account for more domestic abuse-related deaths than intimate partner homicide, and perhaps even as many as four suicides per week. It is estimated that around 500 women who have experienced domestic violence in the last six months' commit suicide every year. Of those, just under 200 attended hospital for domestic violence on the day that they committed suicide[30].

16.9 VKPP found that coercive and controlling behaviour is a substantial risk factor in both intimate partner homicide and suspected victim suicides where there is a history of domestic abuse. In relation to Nathan, he had a previous conviction of assault against Diana, and it was known to agencies that he was again in contact with her in breach of his Restraining Order. He had made numerous attempts to contact her and had turned up at a previous address trying to find her. There is also information that Nathan had been contacting Diana whilst in prison on remand.

16.10 Findings from VKPP looked at suicide with a known history of domestic abuse victimisation and identified that:

[28] Tackling Domestic Abuse Plan - GOV.UK (www.gov.uk)

[29] Lis Bates, Katharine Hoeger, Melanie-Jane Stoneman, and Angela Whitaker - The NPCC and College of Policing working with the national policing Vulnerability Knowledge and Practice Programme (VKPP), tracking all deaths within a domestic setting to learn any potential lessons rapidly as England and Wales moved through various stages of lockdown. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1013128/Domestic_homicides_and_suspected_victim_suicides_during_the_Covid-19_Pandemic_2020-2021.pdf

[30] Walby, S. (2004) The Cost of Domestic Violence. Women and Equality Unit

- In cases where a victim of domestic abuse was suspected of taking their own life, the victim and suspect characteristics were similar to those in intimate partner homicide cases. However, (female) suspected suicide victims were even more likely than female intimate partner homicide victims to be previously known as victims of high-risk domestic abuse involving coercive control:
    - The previous domestic abuse in these suspected suicide cases was highly gendered. Nearly all suspects were male (91%, where known) and victims were female (90%)
    - Nearly three quarters (72%) of suspected victim suicides were aged under 45 years old
    - There were fewer BAME victims – possibly indicating under-identification of suspected victim suicides amongst minoritised ethnic groups
    - Previous non-fatal strangulation by the suspect of this or a previous victim was more present amongst this type of case
    - As with intimate partner homicide, (attempted or actual) separation was also present in a sizeable number of cases.

16.11 On 21st December 2018, Nathan assaulted Diana and caused extensive damage to her flat. Seven days later Diana contacted the police stating that Nathan had been constantly contacting her for over an hour and that he was outside her new address. Although this is recorded by the police, as it was a different area, it does not appear to have been given the right level of consideration. This was prior to Nathan's arrest for the assault on Diana and therefore was not in violation of bail conditions or any Orders.

16.12 It is recorded that on 3rd January 2019 Diana attended the school of child A to explain that child A would be moving schools as they were fleeing domestic violence and that she was worried that the perpetrator would follow them home from school to their new safe address.

16.13 On the 8th of January 2019 Nathan was arrested by the police for the assault on Diana. He was charged with the offence and bailed. There is no evidence that the police considered an additional charge of harassment at this point.

16.14 Within a year of Nathan's first arrest and conviction for assault on Diana, Nathan attended Diana's home address on two occasions and persuaded her to allow him into the family home. The first incident resulted in Nathan fraudulently accessing Diana's bank accounts and stealing money from her. On the second occasion, Nathan claimed that he was homeless and had nowhere to sleep and was therefore 'allowed' to sleep on her sofa. Subsequently Nathan carried out a further serious assault on Diana. There is a recorded history of assault on Diana perpetrated by Nathan, harassment, coercive control and ultimately another assault. Although it does appear that all agencies dealt with Diana in a timely and considerate manner regarding the assaults, agencies do not appear to have considered the impact that the assaults, harassment and coercive controlling behaviour might have had on Diana, perhaps apart from her personal safety. There is no indication that Diana was spoken to regarding the contact that Nathan was making from prison and the pressure this must have put on her regarding the court case. There were no discussions regarding her mental health or the impact that the assault and court case was having on her.

16.15 There is no reference to any agencies having considered the link between domestic abuse and possible suicide. While local suicide rates have gone down slightly in recent years, even one death is one too many so there is still much to be done. Kent and Medway still have a higher rate of suicide than the national average.

16.16 The Transforming Health and Social Care in Kent and Medway Partnership (STP) conducted its own research into the link between domestic abuse and suicide, concluding that almost 1 in 5 (19%) of the people who died by suicide in the county in 2020 had been impacted by domestic abuse. This included current victims and those who had historically experienced abuse, perpetrators and young people living in households where abuse was occurring.

16.17 The STP has started work in providing mental health training to specialist domestic abuse practitioners and vice versa, which is vital in raising awareness of the needs of those supported by both sectors. Trauma workshops have also been facilitated for victims and a mental health support text service has been launched. This is good practice; cross training between different partners could be beneficially adopted in other areas.

16.18 The Kent and Medway Suicide and Self-harm Prevention Strategy 2021-2025[31] is an excellent piece of joined up work combining evidence from suicide patterns with national research and policy direction. The strategy has been developed by the Kent and Medway Suicide and Self-Harm Network, which consists of over 130 partners working together to reduce the number of suicides in Kent and Medway. The strategy identifies significant areas of work to be completed and records the link between domestic abuse and suicide. The strategy has just been completed and it is important that all agencies actively promote this. During panel meetings it was identified that all agencies receive suicide prevention training although it could not be established how impactive this training was. It was identified through the panel meetings that there is a lack of training for professionals regarding how to talk about suicide and the impact that domestic abuse had on someone's mental health.

16.19 The suicide prevention strategy identifies that joined up work is required with all relevant partners on specific projects to reduce the risk of suicide and self-harm in high-risk groups including:

- Middle aged men
- People with previous suicide attempts / self-harm
- People known to secondary mental health services
- People who misuse drugs and alcohol
- People who are impacted by domestic abuse
- Children and young people
- New high-risk groups as identified by real time suicide surveillance

16.20 The work of the Kent and Medway Suicide Prevention Network identified a lack of evidence and wider understanding about the relationship between suicide and domestic abuse and sought to address it locally. They submitted evidence to the Inquiry into Domestic Abuse and Mental Health by the All-Party Parliamentary Group on Domestic Violence and Abuse[32]. which included the following data: Real Time Suicide Surveillance highlighted that between 20% and 25% of all deaths by suicide have been impacted by domestic abuse.

[31] Preventing Suicide in Kent and Medway
[32] https://www.womensaid.org.uk/wp-content/uploads/2022/01/Womens-Aid-APPG-Report-Final.pdf

(60 out of 240 in Kent and Medway during 2020 and the first eight months of 2021). Exploration of the levels of suicidality by analysing local domestic abuse providers DASH risk assessments, which found that 63% of victims had felt suicidal and 61% of perpetrators had attempted or threatened suicide (threatening suicide is a known tactic for maintaining power and control in cases of domestic abuse, and a key risk factor of further harm to victim/ survivors). A review of 93 nationally published DHRs found that 26% of DHRs contained a suicide of either the victim or the perpetrator. A Thematic Analysis of recent suicides amongst children and young people (CYP) in Kent showed that some deaths amongst CYP were of those living in a household that was impacted by domestic abuse.

16.21 In 74% of suspected victim suicide cases, the victim and/or suspects were previously known to other agencies. After MARAC (36%) the most common agencies were mental health services (33%) and domestic abuse services (31%), followed by children's social services. The relatively high number of suspected victim suicide cases already known to mental health and/or domestic abuse services suggests that for some of these victims there were, or could have been, opportunities to offer support. Although the MARAC process considers the risk to the victim of possible further assault and murder the panel do not consider or highlight the risk of suicide. This is an identified gap.

16.22 A recommendation from the VKPP report is that "all agencies involved in any MARAC process should consider the risk of victim suicide following domestic abuse alongside the risk of homicide, where risk factors which indicate coercive controlling abuse – including a history of non-fatal strangulation and attempts to separate – are present". This is a very powerful and important recommendation which has also been identified throughout this review.

16.23 Diana was known to several services with high levels of contact throughout the last years of her life following the initial assault on her by Nathan. Suspected victim suicide and intimate partner homicide in many ways have very similar risk profiles. A history of domestic abuse, non-fatal strangulation and attempts to separate are all indicators of coercive and controlling behaviour and they are risk factors for both intimate partner homicide and suspected victim suicide. This suggests that cases of high-risk domestic

abuse, often characterised by coercive control, might equally well end in either a homicide or suspected victim suicide. In this case Nathan appeared to have a significant hold over Diana which resulted in her having contact with him on occasions after the first assault. The impact that Nathan had on Diana and his relationship with her children was not greatly considered by professionals and coping strategies were not put in place.

16.24 There is still likely to be an under-estimate of all victim suicides with a history of domestic abuse, as it will inherently exclude those suicides where a prior history of domestic abuse was not known to police. The persistent, high-risk, high-harm nature of the abuse which preceded many of these suspected suicides shows that domestic abuse can have an extremely significant impact on victims' mental health.

16.25 Suicide is a very difficult topic of conversation for most people which is why professionals must receive the most appropriate training to enable them to hold those difficult conversations and to highlight stressors that might impact on a person and to help them understand how these stressors can impact them.

17 Coercive and Controlling Behaviour

17.1 Coercive control is a wide-reaching form of abuse and, as control is at the heart of all domestic abuse, it overlaps with many other categories, especially sexual abuse and financial abuse. In early research with survivors, they talked about how difficult it was to describe the ways they felt abuse affected them. Evan Stark's 2007 book[33] outlined the ways in which men can 'entrap' women using controlling and threatening behaviour. Controlling behaviour often creeps unnoticed into a relationship, as initially it can appear to be caring and romantic but gradually changes into patterns of increasing control and an unhealthy loss of the woman's freedom. Control is established using threats to harm the woman if she does not comply or making the atmosphere at home unbearable.

[33] Evan Stark, Coercive Control: How men entrap women in personal life.

17.2 Suspects in cases of suspected victim suicide were three times as likely to have engaged in coercive and controlling behaviour than suspects of intimate partner homicide (95%). National suicide statistics show that strangulation/hanging is the most common method of suicide for females in the general population, accounting for 47% of cases.

17.3 Findings within this review identified that even though Nathan was remanded in custody for the serious assault on Diana, contact was made from prison to Diana. This was identified by an agency and the Prison were informed however, although investigated they were unable to find any means of which Nathan was contacting Diana. There does not appear to have been any consideration by agencies that Nathan could be contacting Diana and the likelihood that he would be using this contact to continue controlling her from prison. There is also no indication that Diana was spoken to regarding these calls, or any additional support put in place regarding them. This should have been dealt with in relation to witness intimidated or at least harassment. The panel were unable to find any additional information surrounding the calls or who made the referral to the Prison Service.

17.4 The security team at the prison received intelligence that Nathan had been contacting Diana either via a pin phone or a mobile phone. Action was taken by the security team to conduct an intelligence led search of his cell and for his calls to be monitored and logged. A cell search was completed but nothing was found. Nathan was seen in person by a Prison worker who issued him with harassment paperwork (notifying him that he should not contact Diana either directly or indirectly) which he signed. This information was added to the Prison intelligence system.

17.5 Agencies were aware of the controlling nature of Nathan as following the first recorded and convicted assault Nathan was able to find out where Diana was living and subsequently attended her home address and accessed her online banking, stealing money from her. He further managed to persuade her to allow him to stay on her sofa. This contact ultimately led to a further and more serious assault occurring.

17.6 Some language used by ICS and subsequently the police, within their IMR, has been acknowledged as inappropriate as they appeared to have put the

blame on Diana for allowing Nathan to stay with her. It does not appear to have been considered that perhaps Diana did not have any say in the matter and that she may have felt that she had no choice over letting him stay. Considerable training has taken place within ICS regarding domestic abuse and coercive, controlling behaviour however, it was identified that all agencies could benefit from further training regarding 'victim blaming' to improve the language sometimes used by services.

17.7 The impact that Nathan had on Diana and her children was underestimated. Agencies were aware that Nathan was a physical risk to Diana and considerable effort and joined up working was put in place to help and support Diana and the children. However, the emotional impact was underestimated. The children had formed a strong bond with Nathan as Nathan and Diana had been in a relationship for several years and therefore the children viewed him as a father figure. Agencies do not appear to have considered the guilt that Diana must have felt when ending the relationship, due to the assault, as she could see the impact on the children of Nathan not being present.

17.8 Diana's family were aware of the instances of assault taking place on her by Nathan and the fact that he was controlling her behaviour. It was identified that the family felt helpless regarding the support they could offer Diana and would have benefitted from knowing what support was available and how they could have gained that support or signposted Diana in gaining that support. Advocacy After Fatal Domestic Abuse (AAFDA) and Wearside Women in Need (WWIN) are currently working on a new initiative with the aim of enabling family, friends and communities to better support the people close to them who are subjected to domestic abuse. It will focus on equipping family, friends and the wider community with the skills they need to ensure their voices are heard. The project aims to improve the way services work with families, friends and the wider community, so that the lifesaving information which they often have, can be shared and acted on effectively. There is also the J9 project[34], which is an initiative named in memory of Janine Mundy, who was killed by her estranged husband whilst he was on police bail. It was started by her family and the local police in Cambourne, Cornwall, where she lived and aims to raise

[34] https://www.hertssunflower.org/media/documents/herts-sunflower-j9-resource-and-information-pack.pdf

awareness of domestic abuse and assist victims to access help and support. The project was established with the primary aim to raise awareness of domestic abuse amongst local businesses and services in order to gain timely help, support and access to services in a safe way. This project has been rolled out in Essex and Hertfordshire and is something worthy of consideration within Kent and Medway.

18 Economic Abuse

18.1 Economic abuse is an aspect of 'coercive control'- a pattern of controlling, threatening and degrading behaviour that restricts a victims' freedom. It is important to understand that economic abuse seldom happens in isolation: in most cases perpetrators use other abusive behaviour to threaten and reinforce the financial abuse. Economic abuse involves a perpetrator using or misusing money which limits and controls their partner's current and future actions and their freedom of choice. It can include use of credit cards without permission, putting contractual obligations in their partner's name, and gambling with family assets[35]. It was identified that Nathan accessed Diana's bank accounts when he returned to the home address and stole money from her. This was dealt with by the police and Nathan was arrested for the theft however, it does not appear to have been formally recognised as a build-up of coercive and controlling behaviour. There is also no record of this escalation being discussed at the MARAC.

18.2 Economic abuse has been formally recognised and defined in the new Domestic Abuse Act however, this form of abuse is still not widely understood, and many girls and women do not recognise the early signs of controlling behaviour by an abuser[36].

19 Chronic Pain and Suicide

19.1 Significantly, chronic pain has been associated with higher rates of suicidal ideation, suicide attempts, and completed suicides. The prevalence of suicidal ideation in chronic pain patients is about three times as great as among those who do not suffer from chronic pain. Evidence was found during a review that

[35] Surviving Economic Abuse: Transforming responses to economic abuse
[36] https://survivingeconomicabuse.org/controlling-your-financial-future-new-guide-helps-women-to-recognise-economic-abuse-across-their-life-span/

chronic pain itself, regardless of type, was an important independent risk factor for suicidality[37]. In Racine's research she highlighted that most suicidal risk factors can be modified by targeted chronic pain treatment and that the inclusion of suicide prevention intervention in chronic pain management programs is justified.

19.2 A recent Kent Safeguarding Adults Review (David) was completed which highlighted similar connections between chronic pain and suicide. The male involved had been diagnosed with Somatoform Disorder[38] and although treated for his disorder, professionals did not consider the linkage between chronic pain and suicide.

19.3 Throughout 2017 it is recorded that Diana was seen by her GP on numerous occasions regarding pain relief for her back. Throughout this time Diana was prescribed liquid morphine, Co-Codamol and often the sleeping tablet, Zopiclone. It was not until later in the year that the GP initiated a weaning regime for the Oramorph and Co-Codamol. This appeared to continue over the following months although it is recorded that in March 2018 Diana was still receiving the same amount of medication through repeat prescriptions. There appears to have been some identified issues where the GP surgery was trying to wean Diana off the addictive medication by instigating a weaning regime however the drug continued to be issued on a repeat basis by the ancillary staff noting "weaning regime" next to the identical quantities for extended periods. These periods should have been monitored more closely by the GP.

19.4 There is no recognition by the primary trust regarding the impact Diana's chronic pain was having on her life and her ability to care for herself and her children. The GP identified that they were aware of Diana's domestic abuse situation and the assault inflicted upon her by Nathan, but these were all self-reported to the GP rather than information shared from other agencies. This information was of significant importance in how GPs care and support their patients and are unable to provide the appropriate support if they are unaware of the full history. There is no evidence of any agency making referrals to the

[37] Chronic pain and suicide risk: A comprehensive review, Melanie Racine 2017.
[38] Somatoform disorder is a form of mental illness that causes one or more bodily symptoms, including pain.

GP regarding Diana and the domestic abuse taking place within her relationship.

19.5 The assault that took place in June 2018 is recorded as having taken place as Nathan accused Diana of taking prescription drugs and not looking after her children. Again, the GP was not provided this information which would have been another avenue to speak to Diana regarding the medication that she was being prescribed and any weaning regime that was in place to provide additional support.

19.6 NICE guidance was published in April 2021[39] highlighting best practice for GPs with patients who have chronic pain. It covers assessing all chronic pain (primary, secondary or both) and managing chronic primary pain in people aged 16 years and over. This guidance is relatively new and therefore the impact of the guidance cannot be established at this time. The guidance, however, does not identify the link between chronic pain and suicide.

20 COVID-19

20.1 The police identified the impact of COVID-19 on delays with court cases and the effect this had on witnesses and victims. Kent Police implemented a specific operation to manage delayed court trials however, this operation did not look at the impact on victims' and witness' mental health.

20.2 The VKPP report previously referenced, asked police domestic abuse leads via survey and interviews about any perceived impact of the pandemic on domestic abuse and domestic homicide.

20.3 It was identified that for around 1 in 7 (14%) submissions police identified a specific impact of COVID-19 on the circumstances of the homicide or suicide, either relating to the victim or perpetrator. In addition, for 30% of victims and 33% of suspects this was recorded as 'Not Known'. So, it is possible that COVID-19 had an impact in more than the 14% of cases where it was positively identified, but that the impact was not visible to or reported by police. Suspected victim suicides had the greatest proportion of COVID-19 impact

[39] Overview | Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain | Guidance | NICE

recorded, with submissions recording that nearly a quarter of those victims were affected by lockdown restrictions.

20.4 The report identified that the ongoing situational pressures arising from the COVID-19 pandemic will persist – these may increase perpetrator risk and decrease victim resilience. Stressors which arose from, or were exacerbated by, this pandemic may not immediately ease with lockdown lifting. The pressures identified in the project submissions as impacting homicides and suspected suicides are as follows:

- Unemployment, job losses, or economic hardship – this may be especially relevant to adult family and intimate partner homicides
- Non-acute mental health issues, such as depression and anxiety – this may be especially relevant to suspected victim suicides
- Delays to court cases especially relating to abuse – this may be especially relevant to suspected victim suicides
- Concerns about perpetrators being released from custody, prison, or secure mental health institutions to their partners (intimate partner homicide and suspected victim suicide), or to the care of their family members (adult family homicide).

20.5 The last two identified stressors are of relevance to this review. The court case against Nathan was postponed on three occasions due to COVID-19 and as a result shortly before Diana's death the defence gave notification of their intention of applying for bail for Nathan as he had been in custody for seven months. The review was unable to identify whether Diana had been notified of this bail application.

20.6 In suspected victim suicide cases, COVID-19 may have reduced the victim's zone of safety or freedom and led to them feeling desperate. Increase in victim anxiety and depression was particularly reported in these cases, as was concern that the perpetrator might be released from prison or remand due to COVID-19 or court cases being further delayed.

20.7 Serious concerns have been highlighted by all four of Her Majesty's Justice Chief Inspectors who have united to express "grave concerns" about the

potential long-term impact of COVID-19-related court backlogs on the criminal justice system across England and Wales.

20.8 In a joint report[40], the Chief Inspectors spell out how the COVID-19 pandemic has affected the work of the police, prosecutors, prisons, probation and youth offending teams. They conclude the greatest risk to criminal justice comes from the "unprecedented and very serious" backlogs in courts.

20.9 The number of ongoing cases in Crown Courts was 44% higher in December 2020 compared to February of the same year. Latest figures show more than 53,000 cases are waiting to come before Crown Courts. Some of these cases have been scheduled for 2022. Despite additional funding, the continuing impact of COVID-19 could cause further delays.

21 Conclusion

21.1 This review is different from the expected context of domestic homicide reviews. Diana did not die in an act of murder directly at the hands of her intimate partner, but rather the domestic abuse she suffered appears to have contributed to her taking her own life.

21.2 The decision by the Kent Community Safety Partnership (KCSP) to conduct a domestic homicide review under the circumstances as presented by this case was a mature and robust decision and made in accordance with the 2016 Home Office Guidance. The robust application of the guidance is a particularly positive aspect of the manner with which the KCSP examines the multi-agency statutory roles, responsibilities, and its overall safeguarding principles.

21.3 There were clear examples of domestic abuse, intimidating behaviour, harassment, stalking and coercive and controlling behaviour on Diana by Nathan throughout their relationship. The psychological long-term impact of this was underestimated by agencies. The physical aspects of dealing with the acts of domestic abuse appear to have been dealt with well by agencies however, as identified, the impact of these acts of domestic abuse on Diana's

[40] https://www.justiceinspectorates.gov.uk/hmicfrs/publications/impact-of-the-pandemic-on-the-criminal-justice-system

mental health were either not considered or were not highlighted as a serious concern.

21.4 Professionals were trained in domestic abuse and recognising the signs of this however, they are not trained to look at the psychological impact domestic abuse has on victims. The difficult questions were not asked of Diana even though she identified to several agencies her level of stress and concern regarding the impact the domestic abuse was having on her and her children. Stigma surrounding suicide creates silence, and silence kills. No one should have to struggle alone with suicidal thoughts, talking through the taboo helps break the silence[41].

21.5 Professionals need to be aware of the impact of domestic abuse and suicide and ask the difficult questions. It is a myth that talking about suicide puts the idea in someone's head. Mentioning suicide does not increase the risk. The risk is not mentioning it at all. Being confident and reaching out to someone can make a huge difference. The evidence surrounding the high levels of suicides regarding those women subjected to domestic abuse is frightening and as such professionals must learn to identify this risk and ask the appropriate questions.

21.6 There was clearly coercive controlling behaviour on the part of Nathan. Nathan had a strong hold over Diana which was not always recognised by agencies. In fact, victim blaming was still evident within the review. Protection plans were put in place for Diana and support was provided regarding her and the children's physical welfare however, the impact that Nathan had on Diana was not identified by agencies. Following a previous DHR in Kent and Medway, Mary 2018, Witness Care have received training in suicide prevention and noted within their records that Diana showed no signs of suicide ideation. It is felt this is not strong enough. Professionals must ask the questions directly and signpost to the most appropriate agency for support.

21.7 Identified within the review was the fact that Nathan managed to contact and resume a relationship with Diana even though he was either on bail or in breach of Orders preventing him contacting Diana. These do not appear to

[41] https://www.papyrus-uk.org/talk-about-suicide-safely/

have been dealt with in a robust manner even when there were clear signs of coercive controlling behaviour. Agencies were naïve regarding their thoughts that when remanded to prison, Nathan would not be able to contact Diana. It is well documented in several areas that those in prison are often able to access mobile phones and use them to contact the outside. This needs to be considered in risk assessments that agencies complete.

21.8 It is worth commenting that there are perpetrator support programmes available across Kent and Medway for DA and Stalking perpetrators. This is offered as one to one and group sessions by Interventions Alliance. The programmes are funded by the Home Office and commissioned by the OPCC. The identified issue is that this is a community programme and those offenders who are under Probation management or custody, or have a court case approaching, cannot access it as they will likely have access to mandated national programmes. In line with the Kent and Medway Domestic Abuse Strategy and action plan, work is underway to review services available to those who perpetrate abuse to promote information and referral pathway sharing with all agencies in Kent. This will allow gaps in provision to be identified, inform commissioning decisions and support funding bids to ensure that quality, coordinated responses from the statutory and voluntary sectors are consistently available across Kent to address perpetrators' behaviour effectively. The Domestic Abuse Act 2021 stipulates that a National Perpetrator Strategy is to be developed and it was announced in the 2021 Budget. The lack of perpetrator programmes was identified within the DHR 'Patrick' 2018[42]. Perpetrator programmes are also delivered by Probation as a part of their current contract, these programmes are in place to deliver risk reduction work as part of a sentence. This work includes 121 interventions and group work programmes to address domestic abuse.

21.9 There are only two mentions within the review of Nathan suffering from PTSD. One is where the court case was adjourned citing Nathan's mental health due to PTSD, and the other where Diana spoke to her DVAP believing that Nathan would try and use this as a defence for assaulting her. This is a missed opportunity for agencies to have looked at the mental health of Nathan and the impact this might have had in how he reacted to Diana and any additional

[42] https://www.kent.gov.uk/__data/assets/pdf_file/0018/126081/Patrick-2018-Overview-Report.pdf

support that could have been put in place. This does not appear to have been recorded in any risk assessments and is not identified in any MARAC meetings.

21.10 Diana was discussed at MARAC on two occasions and in neither of the occasions was the link between domestic abuse and suicide identified. Other identified links with suicide including chronic pain were also not taken into consideration. This should be a routine practice and should become an embedded part of the MARAC process. There are also records within the agencies' IMRs of Diana stating that she was abusing drugs (cannabis) and alcohol as a coping mechanism. These were written within her contact reports however, there are no records of agencies highlighting these issues as possible concerns regarding Diana herself and her children. It appears that the usage of alcohol and drugs were accepted as the norm. These self-reported coping mechanisms should have highlighted concerns for agencies working with Diana.

22 Learning Points and Recommendations

22.1 Suicide Prevention

22.1.1 Knowledge of domestic abuse is required in services that work in suicide prevention. This prevention must be owned by all agencies and not just Public Health. Although the Suicide Prevention Strategy highlights the risk of domestic abuse on suicide this requires additional training for professionals in relation to completing risk assessments and asking those difficult questions.

22.1.2 Agencies need to be aware of the significant impact that domestic abuse can have on a person's mental health and the high risk this poses. The heightened risk that there is to the victim at the time of or immediately following separation should be considered. This should also cover the risk of physical harm, from the perpetrator of the DA, but also note the risk of self-harm through suicide as in this case, where the combination of risks for the victim was high.

22.1.3 In June 2022 the then Secretary of State Sajid Javid identified the direct correlation between domestic abuse and suicide in a speech

announcing the Government's Suicide Prevention Plan. The new plan will include a section on domestic abuse for the first time. Highlighted within the speech is the excellent work taking place within Kent which found that 30% of all suspected suicides in a two-year period were linked to domestic abuse.

22.1.4 All agencies highlighted specific recommendations within their own IMRs. The CRC identified within their IMR the changes within their service and the fact that they were being amalgamated into the Probation Service. As such the recommendations require acceptance and ownership by the Probation Service.

	Recommendations Suicide Prevention	**Organisation**
1a.	Public Health Suicide Prevention Programme to develop and distribute briefing materials, in a variety of formats, highlighting the link between domestic abuse and suicide that can be used to raise awareness amongst agencies and professionals. To highlight the usage of the DA website as a means to promote training and signposting for support.	Kent and Medway Suicide Prevention Panel
1b.	All agencies to incorporate the above training within their pre-existing domestic abuse training.	**All agencies,** Kent and Medway Safeguarding Adult's Board and the Kent and Medway Children's Multi agency Partnership. Kent Coroner's service.
2	To write to the National Suicide Prevention team in the Department of Health to make them aware about the growing number of deaths by suicide that are happening very close to court cases relating to domestic abuse.	Domestic Abuse Commissioner's Office
3a.	To highlight to the Government the huge gap regarding the link between suicide and domestic abuse.	Domestic Abuse Commissioner's Office.

3b.	Although domestic abuse is mentioned as a risk factor within the national suicide strategy, neither suicide nor suicidality are mentioned within the Government's most recent violence against women and girls (VAWG) or domestic abuse strategy. It seems clear that any meaningful integration of policy or practice across both spheres is lacking.	Home Office
4	The MARAC process should consider the risk of victim suicide following domestic abuse alongside the risk of homicide, where risk factors which indicate coercive controlling abuse, harassment and attempts to separate are present.	Kent and Medway MARAC steering group
5	Kent Integrated Children's Services is developing a 'spotlight on domestic abuse' series which is a development programme which will look to develop knowledge in many aspects of domestic abuse, including coercive and controlling behaviour. It is recommended that this training programme is extended to include the link between domestic abuse and suicide.	Kent County Council, Integrated Children's Services

22.2 **Multi-Agency Working and Information Sharing**

22.2.1 Although there is some good evidence within the review regarding the sharing of information by agencies there unfortunately are also some examples where this did not happen. Agencies appeared to communicate well where their involvement with Diana was as a result of the children. ICS were contacted on several occasions with referrals made regarding Diana being subjected to domestic abuse. There were also good examples of Diana receiving a good level of care and support regarding the impending court case however, although identified to agencies by Diana on a few occasions that her mental health was suffering because of the case, this did not appear to have been shared with other agencies. There is no indication within Diana's GP records that she was awaiting a court case and that she was feeling depressed and had had suicidal thoughts.

22.2.2 There is no indication that the GP provided information to the MARAC process or in fact the Child in Need process. Consent would have needed to have been obtained from Diana to have informed the GP that her children were subjected to the CiN process however, this does not appear to have been sought and as such relevant information could have been shared between agencies. Several agencies were aware that Diana was using alcohol and drugs as a coping mechanism but

again this was not shared with other professionals, and it also appears that this information was not considered to be overly relevant. The impact on Diana's decision making whilst under the influence of drink and drugs was not considered and how these substances could have altered her thinking. Professionals would also not have been aware of the high level of pain controlling medication Diana was on and what impact these might have had on her taking drink and drugs.

22.2.3 The lack of GP attendance and information sharing at MARACs has already been highlighted in a previous Kent and Medway DHR and as such that recommendation will be reinforced within this review. This review has highlighted the lack of other agencies being invited to, and attending, the MARAC. The Kent CRC and National Probation Service (NPS) were invited to the MARAC and did attend, information from the London CRC who were managing Nathan was also not supplied to the conference.

22.2.4 The information surrounding Nathan's PTSD was not shared with other agencies. This could have changed the way other professionals dealt with Nathan especially the MARAC and CiN processes where this information might well have impacted on the support offered to Diana.

	Recommendations regarding Information sharing	Organisation
6	Kent and Medway CCG to continue to develop the work with GPs surrounding attendance at MARACs and the importance of information sharing. Consideration to be given to the creation of the role of a MARAC liaison nurse's role for general practice to allow for a more informed and effective decision making and safety planning process to take place.	Kent and Medway CCG
7	Upon completion and review/audit of the IRIS project, dependent of the findings, consideration is to be given to the rolling out IRIS within other parts of Kent and Medway.	Kent and Medway CCG
8	The MARAC process needs to consider that hearing current information surrounding the perpetrator, his background and mindset, can be beneficial as it can establish risk and dynamics. Nathan had a restraining order against him; it would have been beneficial to the meeting to understand Nathan's comments surrounding this and whether he is victim blaming. The	Kent Police and the Probation service

	information regarding his mental health and drug misuse would have also been beneficial to the meeting.	
9	The MARAC process requires a review to make sure that it is more meaningful. Evidence has shown that because numerous victims are discussed within the one meeting there are often times when individual agencies who are relevant are not identified and invited. A more robust process needs to take place where a victim is treated as an individual and that the circumstances are looked at on an individual basis. The minute taking and actions review also requires a review to make sure that they are SMART and meaningful.	Kent and Medway MARAC Steering Group

22.3 Coercion and Control

22.3.1 The level of coercion and control exercised by Nathan over Diana was not identified strongly enough by some agencies. This behaviour was not always identified within agencies' risk assessments, nor was Diana's ability to cope with his behaviour. As identified previously, Diana felt frustrated that her social worker was blaming her for letting Nathan back in her house and that the level of control exerted by him was not recognised.

22.3.2 As identified within the review professionals were naive regarding the fact that Nathan was remanded in prison and the belief that Diana was safe because of this. Risk assessments must always consider the whereabouts of the perpetrator and any previous history of harassment and coercion and control. Nathan had a long history of continuing to contact Diana even though he was subject to Restraining Orders. He had also managed to persuade Diana to let him back in the house even though he had assaulted her previously. This appears to have been underplayed by agencies. Diana identified that the children were traumatised and that she felt guilty about that and the removal of Nathan from their lives.

22.3.3 Although it has been identified within this review that Diana's home address does not appear to have been read out during court appearances it has been recognised by the police that there are no current systems in place to stop this from happening in the future and that this is an area for development.

	Recommendations regarding Coercive and Controlling behaviour	Organisation
10	All agencies' domestic abuse training is to be reviewed to ensure that coercive and controlling behaviour is highlighted to enforce the fact that the stretch of a perpetrator is far reaching to include the impact of economic abuse and where the offenders are in prison or subject to orders.	**All agencies**, Kent and Medway Safeguarding Adult's Board and the Kent and Medway Children's Multi agency Partnership.
11	The Probation Service to consider the findings from the three DHRs within Kent and Medway (Ann, Connie and Diana) which have raised significant concerns surrounding the identified lack of challenge by Responsible Officers and a practice of passive risk management and over reliance on the accounts provided by the perpetrator.	The Probation Service
12	The Criminal Justice Team within Kent Police to identify a means of highlighting the fact that the current address for a victim of domestic abuse is not to be placed on the documentation for the CPS and therefore inadvertently read out in court proceedings.	Criminal Justice Team, Kent Police

22.4 **Training**

	Recommendations regarding Training	Organisation
13	All agencies are to provide guidance to staff regarding the use of 'victim blaming' language within their interaction with victims and also within their written documentation.	All agencies
14	Training to take place with Coroners to identify the linkage with domestic abuse and potential suicide cases.	Chief Coroner
15	The DASVEG to review and consider the implementation of the J9 project or to liaise with Advocacy After Fatal Domestic Abuse (AAFDA) and Wearside Women in Need (WWIN) who are currently working on a new initiative with the aim of enabling family, friends and communities to better support the people close to them who are subjected to domestic abuse.	Kent and Medway Domestic Abuse and Sexual Violence Executive Group

22.5 **The Education People, Education Safeguarding**

	Recommendation for Education	
16	The Head of Education Safeguarding to write to the schools within their area identifying the importance of good record keeping and the role of the Safeguarding Lead within their school.	Head of Educational Safeguarding

22.6 Pain Management

	Recommendation for CCGs	
17	The NICE guidance regarding pain management is to be circulated to GPs within Kent and Medway with a request that they review their patients in light of the new guidance. This recommendation links into the Kent and Medway SAR David (2021) which also made a recommendation regarding the new NICE guidance.	Kent & Medway CCG

GLOSSARY

Abbreviations and acronyms are listed alphabetically. The explanation of terms used in the main body of the Overview Report are listed in the order that they first appear.

Abbreviation / Acronym	Expansion
AAFDA	Advocacy After Fatal Domestic Abuse
ACEs	Adverse Childhood Experiences
ASB	Anti-Social Behaviour
C&F Assessment	Child and Family Assessment
CCG	Clinical Commissioning Group
CiN	Children in Need
CRC	Community Rehabilitation Company
CPS	Crown Prosecution Service
CSP	Community Safety Partnership
DA	Domestic Abuse
DASH	Domestic Abuse, Stalking and Harassment (Risk Assessment)
DHR	Domestic Homicide Review
DVAP	Domestic Violence Abuse Partnership (The Lodestar Family Service)
ED	Emergency Department
GP	General Practitioner
HIDVA	Hospital Independent Domestic Violence Advisor
HMP	Her Majesty's Prison
HST	Housing Solutions Team
IDVA	Independent Domestic Violence Advisor
IMR	Independent Management Review
IPA	Intimate Partner Abuse
KCSP	Kent Community Safety Partnership
KMPT	Kent & Medway NHS & Social Care Partnership Trust
KMDASVEG	Kent and Medway Domestic Abuse & Sexual Violence Executive Group
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
NHS	National Health Service

Abbreviation / Acronym	Expansion
PTSD	Post-Traumatic Stress Disorder
UPW	Unpaid Work
VKPP	Vulnerability Knowledge and Practice Programme
WCU	Witness Care Unit

Domestic, Abuse, Stalking & Harassment (DASH) Risk Assessments

The DASH (2009) – Domestic Abuse, Stalking and Harassment and Honour-based Violence model was agreed by the Association of Chief Police Officers (ACPO) as the risk assessment tool for domestic abuse. A list of 29 pre-set questions will be asked of anyone reporting being a victim of domestic abuse, the answers to which are used to assist in determining the level of risk. The risk categories are as follows:

Standard Current evidence does not indicate the likelihood of causing serious harm.

Medium There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances.

High There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious. Risk of serious harm is a risk which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible.

In addition, the DASH includes additional question, asking the victim if the perpetrator constantly texts, calls, contacts, follows, stalks or harasses them. If the answer to this question is yes, further questions are asked about the nature of this.
A copy of the DASH questionnaire can be viewed here.

Domestic Abuse (Definition)

The definition of domestic violence and abuse states:

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

- *psychological*
- *physical*

- *sexual*
- *financial*
- *emotional*

Controlling behaviour is:

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

Coercive behaviour is:

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

Multi-Agency Risk Assessment Conference (MARAC)

A MARAC is a meeting where information is shared between representations of relevant statutory and voluntary sector organisations about victims of domestic abuse who are at the greatest risk. Victims do not attend MARAC meetings; they are represented by their Independent Domestic Violence Advisor (IDVA).

There are thirteen established MARACs across the whole County which are facilitated by MARAC Coordinators employed by Kent Police. Kent Police also employ a MARAC Central Coordinator, who is responsible for ensuring that the MARACs provide a consistent level of support to high-risk domestic abuse victims. The Central Coordinator deputises for absent Administrators at MARAC meetings.

The Central Coordinator is also responsible for ensuring that the Kent and Medway MARAC Operating Protocol and Guidelines (OPG) are updated, and that each MARAC adheres to them. A further responsibility of the Central Coordinator is to provide training for MARAC members and chairpersons.

Appendix A – Action Plan

The action plan is a live document and subject to change as outcomes are delivered.

Recommendation	Action to take	Lead Agency/ Accountable Professional	Target Date	Progress (Milestones, risks, further actions)	RAG	Outcomes / Measures
1a. Public Health Suicide Prevention Programme to develop and distribute briefing materials, in a variety of formats, highlighting the link between domestic abuse and suicide that can be used to raise awareness amongst agencies and professionals. To highlight the usage of the DA website as a means to promote training and signposting for support.	Develop and distribute DA and Suicide briefing materials	**Kent and Medway Suicide Prevention Programme Team (based in KCC's Public Health team)**	1st July 2022	Briefing paper has been produced and was circulated in the Summer 2022. The KCC Suicide Prevention Team continue to share the briefing at a number of events and conferences.	Green	Increased understanding (amongst frontline workers and commissioners) about the links between DA and Suicide, and how to respond to them
1b. All agencies to incorporate the above training within their pre-existing domestic abuse training	The KMSAB business unit will distribute briefing materials, developed by Public Health Suicide Prevention Programme to partner agencies via email, website and newsletter.	**KMSAB**	1 month after materials produced by/received from Public Health	28/7 - email sent out to partner agencies 11/8 update- document will shared via newsletter/website (accessible version) 1/9 - paper shared in KMSAB newsletter	Green	newsletter link - https://mailchi.mp/9d3 resources page link - https://kmsab.org

Recommendation	Action to take	Lead Agency/ Accountable Professional	Target Date	Progress (Milestones, risks, further actions)	RAG	Outcomes / Measures
	Oasis will create a module of training to complement the existing training for in-house staff and also for the KIDAS partnership that all DA staff can access	**Oasis DA Service**	Oct-22	1. Create module (Sept) 2. Disseminate to KIDAS partners 3. In-house staff to access via Staff Development framework	Green	This training will be disseminated through 2023-24 and thereafter as part of the KIDAS training package and under the care of the LPB/Kent Policy Team
	A virtual development programme to be designed and published which considers learnings from this DHR (plus others) using Public Health materials	**Sophie Baker, Practice Development Manager, Kent County Council, Integrated Children's Services Multi agency Partnership.**	Oct-22	DA ICS development programme was launched at a Communities of Practice virtual session on 31/10/22. Tim Woodhouse (K&Medway suicide Lead) led this CoP and shared learnings from local DHRs. This website was advertised as part of the CoP and details are included in the DA development programme.	Green	Improved workforce knowledge and understanding around domestic abuse including coercive and controlling behaviours - this will be measured within our quality assurance framework Assessments and plans reflect an accurate understanding of risk and need for protection - this will be measured within our quality assurance framework
	Briefing materials to be included as handouts to the KSCMP 'Impact of DA on children and young people' course.	**KSCMP**	Feb-23	Course is currently suspended and due to be redeveloped during Autumn 2022. Train the trainer workshops will follow in Winter 2022. Anticipate delivery will commence from January 2023. Owing to capacity challenges, course development has not yet commenced, and is unlikely to begin until Feb 2023.	Red	

Recommendation	Action to take	Lead Agency/ Accountable Professional	Target Date	Progress (Milestones, risks, further actions)	RAG	Outcomes / Measures
	Briefing materials to be included in KSCMP newsletter.	**KSCMP**	Oct-22	Briefing materials were included into the October 2022 KSCMP newsletter.	Green	
	Briefing materials to be added to the KSCMP website.	**KSCMP**	Aug-22	Materials have been published in the news section of the website. A review of the KSCMP website is due in early 2023 and they will be repositioned to an appropriate page at that time. https://www.kscmp.org.uk/news	Green	
	To be shared in staff meetings across the team during September. To sit as part of induction for new starters	**Victim Support - David Naylor**	31.10.23	The briefing material sits as part of induction materials for new Victim Support staff who will be working on DA cases.	Green	
	Incorporate specific information and briefing materials which highlight the link between domestic abuse and suicide into annual mandatory suicide intervention and prevention training attended by all DA staff. Highlight the use of the Kent DA website into training sessions.	**Clarion Housing Association**	End November 2022	Specialist suicide prevention & intervention training delivered to Clarion DA staff annually will highlight this link. The link between domestic abuse and suicide is highlighted in Clarion training packages. The use of the Kent DA website is highlighted Clarion training packages.	Green	All DA staff attend annual Suicide Intervention & Prevention training. Managers assess understanding and competency during 121's, reflective practice sessions and team meetings.

Recommendation	Action to take	Lead Agency/ Accountable Professional	Target Date	Progress (Milestones, risks, further actions)	RAG	Outcomes / Measures
	SSU to publicise briefing around 'James' which highlights suicide prevention to all ASCH staff. The KMSAB briefing around DA & suicide is also to be highlighted to staff. A DA event was held in November 2021 in conjunction with Safeguarding Adult Awareness Week. Megan Abbott attended the event to speak about DA and Suicide. A Communities of Practice (COP) DA event took place on 27th January 2022 where DA & Suicide were discussed. .On the Safeguarding KNet page there is information for staff on AMPARO - support following suicide SSU to highlight Suicide Prevention training to staff which is available via Delta.	**Kent County Council, Adult Social Care**	Dec-22	James' briefing to be uploaded to Safeguarding KNet & Kent Academy pages and shared via team talks and the staff bulletin SSU circulated information on the DHR themed webinar DA & Suicide (15th July 2022) to Business Support and Safeguarding Managers. It was also shared on yammer and our KNet safeguarding page. DA Event to be held in November 2021 for KCC staff The COP DA event was highlighted to staff via email, yammer and the Safeguarding KNet Page. Suicide Prevention training is highlighted on the Safeguarding KNet & Kent Academy pages	Amber	James' briefing - out of 15 feedback responses 73% thought the briefing was a good resource and 80% felt the briefing helped to raise awareness and understanding of SAR/DHRs in their teams. A total of 212 staff attended the DA event and 95 feedback forms were received afterwards via the Delta website. 70% of staff said the training had exceeded their expectations and 94% of staff said they had learnt new skills for their current role. 115 Staff attended the COP/DA event on 27th January 2022 - 40 feedback forms were received after the event

Recommendation	Action to take	Lead Agency/ Accountable Professional	Target Date	Progress (Milestones, risks, further actions)	RAG	Outcomes / Measures
	No DA specific training provided by ESS to schools/settings but is included in DSL and whole school/setting training. Current training presenter notes to incorporate reference to links between DA and suicide. All trainers provided with PH briefing paper to extend their knowledge. DA webinar planned for later in the year will make specific reference to recommendation 1a.	**Education Safeguarding Service**	Academic Year 22/23	Briefing paper already shared. Trainer notes changed to reflect recommendation	Amber	Training Quality Assurance will ensure this is happening
	The link between Domestic Abuse and Suicide has been covered extensively in training in Kent Police over the last year. Professor Jane Monkton Smith has done multiple inputs to officers on this topic. This is also featured heavily on our internal Vulnerability pages, with an entire section dedicated to DA and Suicide. We will present the findings of the Public Health Suicide Prevention Programme during our 16 days of Awareness campaign	**Kent Police**	Dec-22		Amber	Completion of event in November. Internal web pages updated to highlight the DA Services website

Recommendation	Action to take	Lead Agency/ Accountable Professional	Target Date	Progress (Milestones, risks, further actions)	RAG	Outcomes / Measures
	starting at the end of November. The work being done on the DA Knowledge Hub on internal web pages will highlight the DA Services Website for signposting					
	This has been discussed and shared with the Hospital IDVA in order to incorporate the link between domestic abuse and suicide in the family focused training going forward. Links to further help and support are shared during training.	**Dartford & Gravesham NHS Trust**	Dec-22	Information highlighted during the DHR has already been shared during the Family Focused face to face training. Going forward more of the findings will be shared during the training that is provided to Trust staff. Training material will be update and will be used going forward.	Green	Staff will have increased knowledge and skills on how to ask those patients presenting to the hospital following domestic abuse about suicide intentions. They will be able to offer appropriate levels of support and referrals alongside safety planning.
	Incorporate specific information and briefing materials which highlight the link between domestic abuse and suicide into annual mandatory suicide intervention and prevention training attended by all DA staff. Highlight the use of the Kent DA website into training sessions.	**HMP Rochester - Offender Management Unit**	End of January 2023	The above training was shared during a team meeting and will be included in future in-house DV training. We also intend to link in with the Kent Suicide prevention team for future training.	Amber	Majority of staff have attended Suicide Intervention & Prevention training. The plan is to make sure that all new staff participate in this. Managers to assess understanding during team meetings, reflective practice sessions and supervision. Managers to address any gaps in knowledge and practice via L&D. Evidence via observations, QA, etc .

Recommendation	Action to take	Lead Agency/ Accountable Professional	Target Date	Progress (Milestones, risks, further actions)	RAG	Outcomes / Measures
	The specific briefing paper cannot currently be incorporated into the national training programme, given that this is relevant to service delivery across England and Wales. However, other aligned material does exist within training material The briefing paper has been included within a managers meeting scheduled to take place in November 2022 The briefing paper has also been included within the Learning into Practice forum for the Probation Delivery Unit in November 2022. This forum will agree the mechanism within which this information will be disseminated to all staff within the delivery unit and to evaluate the learning through reflective discussion	**London Community Rehabilitation Company**	Dec-22	This action has yet to proceed given some delays in implementation due to a national inspection programme. The outcome of the PDU inspection, allows this practice theme to sit within the overall improvement plan, as a key strategy to improve assessment, outcomes and risk management for those on Probation. Further discussion in the PDU managers meeting next month, the briefing paper will be discussed within a learning forum arranged to consider how specific action points are implemented across the Probation Delivery Unit (PDU). The proposal being to undertake practitioner briefings within a unit meeting, to all staff. This will incorporate a reflective practice session in which key areas and questions are reviewed. It is planned for the broader briefings to take place in December 2022	Red	The formal briefings are yet to take place, and as such formal outcomes are yet to be collated. It is anticipated that outcome measures will relate to improved understanding of the alignment between DA and suicide, and increased understanding of how risk management planning can be used to document key concerns, and liaison required with other agencies.

Recommendation	Action to take	Lead Agency/ Accountable Professional	Target Date	Progress (Milestones, risks, further actions)	RAG	Outcomes / Measures
	GP's have access to the KMSAB multi agency DA training which has incorporated the importance of being aware of the risks of suicide in cases of domestic abuse.	**Kent & Medway Integrated Care Board**	Jan-22	The link for the KMSAB training has been shared via comms and the GP Bulletin across the Kent and Medway Primary Care system. The link has also been shared with the Primary Care Workforce Programme Manager Kent and Medway Training Hub who will continue to promote the training.	Green	Increased attendance at the KMSAB training leading to improved outcomes for people experiencing domestic abuse accessing GP surgeries. KMSAB will continue to share data with the ICB of health attendance at multi agency training on a quarterly basis.
	The DA/Suicide link information that was sent out from Suicide Prevention Team was sent out in the GP bulletin in September 2021	**Kent & Medway Integrated Care Board**	Nov-22	Completed	Green	Improved recognition and support for victims. A 6 monthly rolling electronic audit of GP's using electronic polling via comms across Kent and Medway to determine improvement in knowledge and skills of GP workforce. To start Q3 2022.
	Domestic Abuse Awareness Day highlighting the work within the strategy, the event is for frontline staff and strategic partners. The event will include Typology, Suicide Prevention and awareness.	**Dartford Borough Council, Housing**	November 2022 (to be completed annually)	Completed November 22	Green	Interactive event for staff and partners, highlighting the links between domestic abuse and suicide in survivors. Feedback required at end of each event to measure learning and increased confidence in reporting and support. Event will be added to staff training records.

Recommendation	Action to take	Lead Agency/ Accountable Professional	Target Date	Progress (Milestones, risks, further actions)	RAG	Outcomes / Measures
	Ongoing domestic abuse training to include session on links between domestic abuse and suicide. To be completed by all new frontline staff as part of their induction and for frontline staff to repeat every 3 years as part of their ongoing safeguarding training	**Dartford Borough Council, Housing**	November 2022 (to be completed every 3 years)	Completed November 22.	Green	Domestic abuse training has been updated and delivery of suicide links has started. Staff training records to be updated as achieved.
	Southern Housing (formerly Optivo) will incorporate training on the link between suicide and domestic abuse within their existing domestic abuse training.	**Southern Housing (formerly Optivo)**	Jul-23	Training to be devised by May 23 and delivered by end of July 23.	Green	Completed - training materials have been updated.
2. To write to the National Suicide Prevention team in the Department of Health to make them aware about the growing number of deaths by suicide that are happening very close to court cases relating to domestic abuse.	Overtaken by events - see progress column	**Domestic Abuse Commissioner's Office**		Sajid Javid commits to including DA in future Suicide Prevention Strategy. Link - https://www.gov.uk/government/speeches/health-and-social-care-secretary-of-state-speech-on-suicide-prevention#:~:text=As%20well%20as,the%20previous%20strategy	Green	

Recommendation	Action to take	Lead Agency/ Accountable Professional	Target Date	Progress (Milestones, risks, further actions)	RAG	Outcomes / Measures
3a. To highlight to the Government the huge gap regarding the link between suicide and domestic abuse.	Overtaken by events - see progress column	**Domestic Abuse Commissioner's Office**		Suicidality is now included in the DA Statutory Guidance published recently. Link - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1089015/Domestic_Abuse_Act_2021_Statutory_Guidance.pdf The links between domestic abuse and suicide is on the agenda for the Domestic Abuse Commissioner as there is progress with the development of the Domestic Homicide Oversight Mechanism. The DA Commissioner will also be engaging with the Department of Health on various aspects of work and priorities, suicide and domestic abuse being a feature in conversations going forward. There are references throughout the recently published DA Plan.	Green	

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3b. Although domestic abuse is mentioned as a risk factor within the national suicide strategy, neither suicide nor suicidality are mentioned within the Government's most recent violence against women and girls (VAWG) or domestic abuse strategy. It seems clear that any meaningful integration of policy or practice across both spheres is lacking.'	To be completed by the agency	**Home Office**	To be completed by the agency	To be completed by the agency		To be completed by the agency
4. The MARAC process should consider the risk of victim suicide following domestic abuse alongside the risk of homicide, where risk factors which indicate coercive controlling abuse, harassment and attempts to separate are present.	As part of the MARAC review process, training for MARAC attendees and coordinators/managers will be imbedded into the model which will include Dr Jane Monckton Smith's research around the 8 steps leading to domestic homicides and suicide awareness.	**Kent and Medway MARAC Steering Group**	Apr-23	Draft MARAC model is in process which includes thorough training for MARAC chairs/ coordinators/attendees on the links between DA and suicide, the 8 steps identified in domestic homicide views and key risks identified as part of the DASH RIC. MARAC mobilisation project group has begun its work, and this will include creating the training package for MARAC attendees.	Amber	Professionals involved in the MARAC process receive the relevant training covering key risk factors and suicide. Professionals are confident in identifying these risks.

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	The Suicide Prevention Team's research on the links between suicide and domestic abuse, are shared with professionals across Kent and Medway. Once the Suicide and DA briefing paper has been finalised by the SPT, this is to be shared with DA Forums and presented at the Kent and Medway Local Partnership Boards.	**Kent and Medway MARAC Steering Group**	Aug-22	Presentation delivered at the Data and Evidence Sub Group and presentation circulated to professionals.	Green	Information and briefings shared across partners and presentation delivered at K&M LPB's.
5. Kent Integrated Children's Services is developing a 'spotlight on domestic abuse' series which is a development programme which will look to develop knowledge in many aspects of domestic abuse, including coercive and controlling behaviour. It is recommended that this training programme is extended to include the link between domestic abuse and suicide.	A virtual development programme to be designed and published which considers learnings from this DHR (plus others)	**Sophie Baker, Practice Development Manager, Kent County Council, Integrated Children's Services**	Nov-22	The DA programme is running from Nov 22 - Feb 23 and has elements virtual training and a practitioner handbook. It has been designed to improve practitioner knowledge in many aspects of domestic abuse, including coercive and controlling behaviour and the link between DA and suicide.	Amber	Improved workforce knowledge and understanding around domestic abuse including coercive and controlling behaviours - this will be measured within our quality assurance framework Assessments and plans reflect an accurate understanding of risk and need for protection - this will be measured within our quality assurance framework

Recommendation	Action to take	Lead Agency/ Accountable Professional	Target Date	Progress (Milestones, risks, further actions)	RAG	Outcomes / Measures
6. Kent and Medway CCG to continue to develop the work with GPs surrounding attendance at MARACs and the importance of information sharing.	KMCCG to continue with building business case to MARAC Administrator for primary care to act as a conduit for information sharing between MARAC and GPs	**Kent and Medway Integrated Care Board**	Jun-22	In April 2022 KMCCG secured funding for a 1 year fixed term post to support the information sharing between GPs and MARAC. The post holder started in June and is currently in her induction period. The KMCCG have started the process of working with MARAC coordinators developing the information sharing processes and aim to have this live by July 2022.	Green	The KMCCG will see improved information sharing with GPs and MARAC which will be measured by data gathering and analysis by the Primary care liaison administrator as part of the pilot project with a view to demonstrating the requirement for the role and funding required for this.
	KMCCG to reiterate the importance of sharing information and attending MARAC with GPs	**Kent and Medway Integrated Care Board**	Jun-22	Domestic Abuse Training was delivered to GP's across Kent and Medway in 2021 in the PLT training, and again in 2022 Older people and DA was discussed in the current (2022) PLT where MARAC was also discussed	Green	KMCCG will see an improved attendance and engagement with MARAC and GPs. KMCCG will aim to complete an audit of GP attendance/engagement in 6 months of the new process starting to measure outcomes
7. Upon completion and review/audit of the IRIS project, dependent of the findings, consideration is to be given to the rolling out IRIS within other parts of Kent and Medway.	KMCCG safeguarding Team will review the audit and evaluation completed by IRIS and consider whether there is merit in building a funding proposal based on success indicators to the KMCCG to consider continuation of the project across the Kent & Medway Health system	**IRIS**	Jun-23	Awaiting completion of Pilot project and audit/evaluation due June 2023	Amber	KMCCG will continue to attend the IRIS steering group to monitor progress and success

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8. The MARAC process needs to consider that hearing from the perpetrator can be beneficial as it can establish risk and dynamics. Nathan had a restraining order against him; it would have been beneficial to the meeting to understand Nathan's comments surrounding this and whether he is victim blaming. The information regarding him having PTSD would have also been beneficial to the meeting.	The Probation Service are committed to providing representation within the MARAC forum, which is often via a single point of contact, both at a practitioner and manager grade. The role of the representative is to provide information and assessment to the panel of any perpetrator currently known to the Probation Service. In doing so, the representative may liaise with colleagues from other Probation regions across England and Wales. Where an individual is subject to Court proceedings, the representative will share any information arising from specialist assessments to key partners, which may include anything disclosed regarding medical history or factors impacting on their behaviour.	**The Probation Service**	30/06/2022	Following the unification of Probation Services in June 2021, the Probation Service has ensured full representation at local MARAC meetings is maintained and any significant information shared. As part of unification, all practitioners have also completed core mandatory training related to domestic abuse. Future monitoring to be done by the DHR Steering Group.	Amber	To ensure the appropriate Probation Delivery unit maintains MARAC attendance on a monthly basis and shares all appropriate information. To ensure MARAC representative have communicated the referral process to all practitioners within the PDU

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	Update the MARAC research form to include significant statements from the perpetrator and evidence known of any mental health conditions. MARAC officer training to be updated to include these aspects	**Kent Police**	Autumn 2022	MARAC is currently under review. A new model is being presented to the DA Executive group on 25th July. If successful, this will fundamentally change MARAC. However, we can still work to improve the information Kent Police present to MARAC, as although the format in which we share it will change, the information itself will not. A new research form has been produced which specifically asks officers about significant statements from the perpetrator and any evidence of mental health conditions. This form is now in use. MARAC training has been updated to include these key points. 12/01/23- a dip sample of MARAC minutes was taken with MARAC minutes from Medway, Maidstone and Thanet from the month of December reviewed. There was evidence of good information being shared about perpetrators in all three MARACs- from NPS, who were present at each meeting, from KMPT, and from Police. As an example, cases discussed custody vulnerability screenings, risks to self or others from perpetrators, and thoughts on self-harm and suicide. Evidence shows good information on perpetrators is being shared; this will be further assisted though by the changes in MARAC	Green	Dip sample of MARAC minutes from all three Police Divisions show that pertinent information about perpetrators was shared at MARAC

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				which are coming through in the next few months. Also MATAC is being reintroduced in Kent- this is a perpetrator focused forum in which agencies who are working directly with perpetrators are invited to attend and reasons for their behaviour are explored (mental health, drugs/alcohol/housing etc). This will further strengthen the approach to perpetrators.		
9. The MARAC process requires a review to make sure that it is more meaningful. Evidence has shown that because numerous victims are discussed within the one meeting there are often times when individual agencies who are relevant are not identified and invited. A more robust process needs to take place where a victim is	Immediate plans are put into place to ensure full minute taking and all actions are captured.	**Kent and Medway MARAC Steering Group**	Feb-22	Additional support from Local Authority and attending agencies put in place. Staffing shortages have now been addressed.	Green	Short term support is put into place until longer term solutions are implemented as part of the MARAC review process.

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treated as an individual and that the circumstances are looked at on an individual basis. The minute taking and actions review also requires a review to make sure that they are SMART and meaningful.	The MARAC process is to undergo a full review led by the Kent and Medway MARAC Steering group, which will include ensuring actions are SMART, robust and agencies are held to account for completing any actions assigned to them.	**Kent and Medway MARAC Steering Group**	Apr-23	Case management system is being considered to enable agencies to assign actions to themselves, and to enable for MARAC coordinators/managers to review the actions assigned. Thorough training sessions for MARAC attendees and coordinator/managers has been included as part of the draft proposals. Funding has been secured and MARAC mobilisation project group has begun it's work.	Amber	CMS is in place. Actions are SMART, there is follow up and accountability, and cases receive the appropriate support depending on risk and individual circumstances.
10. All agencies' domestic abuse training is to be reviewed to ensure that coercive and controlling behaviour is highlighted to enforce the fact that the stretch of a perpetrator is far reaching to include the impact of economic abuse and where the offenders are in prison or subject to orders.	KMSAB to share the learning from this review with the training provider to ensure that coercive and controlling behaviour is highlighted to enforce the fact that the stretch of a perpetrator is far reaching to include the impact of economic abuse and where the offenders are in prison or subject to orders.	**KMSAB**	1 month after report publication We are reviewing training materials with the training provider on 28/7.	DHR to be shared with the training provider (can share email/key information for training provider submission, as evidence)	Amber	SAR Jodie (kmsab.org.uk) http https://kmsab.org.uk/assets/1/s 01/12/22 Update - Domestic ab control are included within the s
	KIDAS training modules include CCB and its reach	**Oasis DA Service**	Completed	Completed	Green	Completed

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	A virtual development programme to be designed and published which considers learnings from this DHR (plus others)	**Sophie Baker, Practice Development Manager, Kent County Council, Integrated Children's Services Multi agency Partnership.**	Nov-22	The DA programme is running from Nov 22 - Feb 23 and has elements virtual training and a practitioner handbook. It has been designed to improve practitioner knowledge in many aspects of domestic abuse, including coercive and controlling behaviour and the link between DA and suicide.	Amber	Improved workforce knowledge and understanding around domestic abuse including coercive and controlling behaviours - this will be measured within our quality assurance framework Assessments and plans reflect an accurate understanding of risk and need for protection - this will be measured within our quality assurance framework
	KSCMP 'Impact of DA on children and young people' course will be reviewed. Coercive control and economic abuse will be included as potential types of abuse. The course however focuses on the impact on children, therefore whilst the other points may be referenced, the focus is on the impact for children.	**KSCMP**	Feb-23	Course is currently suspended and due to be redeveloped during Autumn 2022. Train the trainer workshops will follow in Winter 2022. Anticipate delivery will commence from January 2023. Owing to capacity challenges, course development has not yet commenced, and is unlikely to begin until Feb 2023.	Red	
	Sits within core training	**Victim Support**	Complete	Complete	Green	After completing the training and before seeing a service user, staff and volunteer supporters have to be accredited

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	Review Clarion's DA training to ensure coercive control and the impact of economic (and any other) abuse is highlighted; focus to be given to the potential for a perpetrator's influence to be far reaching; including when they are in prison or subject to orders.	**Clarion Housing Association**	End November 2022	Training packages highlight the use of coercive control and other forms of abuse. The potential for a perpetrator's influence to be far reaching including when in prison or subject to legal orders is incorporated into staff training and induction and into the training Clarion deliver externally.	Green	Managers assess understanding and competency during 121's, reflective practice sessions and team meetings.
	Face-to-face online and e-learning offers around links between DA & Coercion and Control to be looked at to ensure inclusion.Work alongside financial services team to raise awareness of financial exploitation within DA to ASC staff. Women's aid report on DA and cost of living circulated within KCC	**Kent County Council, Adult Social Care**	Dec-22	A SAR Coercive Control case study has been highlighted to staff via the Safeguarding Knet & Kent Academy pages and the staff bulletin. Women's Aid doc circulated to safeguarding teams, finance teams, commissioning and internal ASCH DA group. (https://www.womensaid.org.uk/the-cost-of-living/)Surviving Economic Abuse sent to client financial services(https://survivingeconomicabuse.org/what-is-economic-abuse/)	Amber	The SAR coercive control case study was circulated to staff via the ASCH bulletin on 6th July 2022. It was also circulated to the DA ASCH Group on 19 July 2022.
	Coercive and controlling behaviour included in the existing DSL and Whole school/setting training. Power and control wheel used to demonstrate this further. Learning from DHR 39 shared with trainers including in relation to control from prison etc. DA webinar planned for later in the	**Education Safeguarding Service**	Academic Year 22/23	Content already included in ESS training and learning from DHR 39 shared with service and other education colleagues.	Amber	Training Quality Assurance will ensure this is happening

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	year will make specific reference to recommendation 10.					
	C and C has been embedded in all Kent Police DA training since the legislation came in in 2015. The new 5 day specialist Investigators' DA course talks extensively throughout about coercive control, including economic abuse and breach of orders	**Kent Police**	Complete	Training covers this aspect	Green	Training covers this aspect
	Coercive and controlling behaviours is already included in the HIDVA family Focused training that is being delivered. This includes a video that highlights coercive and controlling behaviour. The training will be updated to include offenders/ perpetrators who are in prison or subject to orders.	**Dartford & Gravesham NHS Trust**	Dec-22	Coercive and controlling behaviour is already included in the family focused training. The presentation requires updating to reflect those perpetrators who are in prison or subject to orders.	Green	Staff will have increased awareness of coercive and controlling behaviour and have confidence in exploring this with patients in a sensitive way.
	The current DA training that is on offer includes coercive and controlling behaviour.	**HMP Rochester - Offender Management Unit**	End of January 2023	All OMU staff have already completed DA training. Despite this, case discussion raised in team meeting about the impact of DV even whilst a perpetrator is in custody.	Amber	Managers assess understanding and competency of OMU staff during supervision and team meetings. For all staff to complete any refresher training.

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	To review national policy and guidance as to ensure the areas of coercive and controlling behaviour is included	**London Community Rehabilitation Company**	Nov-22	The HMPPS Domestic Abuse Policy Framework was updated on the week commencing 10 October 2022. This framework includes specific information for all staff, including information relating to definitions of coercive and controlling behaviour. The framework is specific to Probation work, and as such aligns to mandated arrangements such as child safeguarding and electronic monitoring. The framework includes embedded links to relevant guidance documents to support staff in their work with domestic abuse perpetrators, alongside work with victims. A short video was also produced to promote the updated policy framework, alongside a video entitled Domestic Abuse Policy Framework: A practitioners guide. This video forms part of mandated training for all practitioners to be completed on a yearly basis. A copy of the framework, alongside the accompanying information was disseminated to all practitioners on the week ending 15 October 2022. A set of reflective questions, designed to promote discussion within teams was also shared, with an expectation that this is	Amber	The updated Policy Framework provides all practitioners will the necessary information required to inform their practice. This is a national policy update, accompanied by a training programme, so will both inform new practitioners and refresh learning for more experienced staff. The expected outcomes of delivering this information will fulfil the requirements of recommendation 10, by ensuring practitioners are made aware of key concepts in the management of domestic abuse perpetrators

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				completed as part of monthly team briefings. This action will sit outside of action 1b, as is likely to result in more extensive reflection and discussion, which cannot be accommodated within the timeframe of the unit/PDU meeting. It is expected that all practitioners will review and discuss the new Policy Framework within local team meetings by the end of November 2022. Future monitoring to be done by the DHR Steering Group.		
	All GP's across Kent and Medway received Domestic Abuse training in 2021 as part of the practice learning time (PLT) CPD sessions which included training in regard to coercive control and economic abuse	**Kent & Medway Integrated Care Board**	Nov-22	Completed	Green	Improved recognition and support for victims. A 6 monthly rolling electronic audit of GP's using electronic polling via comms across Kent and Medway to determine improvement in knowledge and skills of GP workforce. To start Q3 2022.
	GP's across Kent and Medway have access now to KMSAB multi agency Domestic Abuse training which includes coercive control and economic abuse	**Kent & Medway Integrated Care Board**		Completed	Green	Increased attendance at KMSAB multi agency training leading to improved outcomes for people experiencing domestic abuse. The ICB will continue to promote the training via comms, safeguarding forums and GP Bulletins. KMSAB will continue to share data

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						with the ICB of health attendance at multi agency training on a quarterly basis.
	A 7 minute read regarding coercive control was shared in the Kent and Medway GP bulletin in 2021 regarding coercive control	**Kent & Medway Integrated Care Board**	Jul-21	Completed	Green	Improved recognition and support for victims. A 6 monthly rolling electronic audit of GP's using electronic polling via comms across Kent and Medway to determine improvement in knowledge and skills of GP workforce. To start Q3 2022.
	Ongoing domestic abuse training is to be up to date, relevant and to ensure it includes all recognised forms of abuse including coercive and controlling behaviour. To be completed by all new frontline staff as part of their induction and for frontline staff to repeat every 3 years as part of their ongoing safeguarding training. Commissioned Domestic Abuse Service Clarion facilitiand 3 levels of training for all DBC staff. DA Champions within housing departments. Consider Professional Judgement, professional curiosity. Bystander	**Dartford Borough Council, Housing**	November 2022 (to be completed every 3 years)	Completed November 2022	Green	Domestic abuse training has been updated and includes module on coercive control. Staff training records to be updated as achieved.

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	Training to be incorporated within the training strategies and funding initiatives					
	Southern Housing (formerly Optivo) will review their existing training materials to ensure the reach of perpetrators is emphasised (including economic abuse and when in prison).	**Southern Housing (formerly Optivo)**	May-23	Existing training is currently being reviewed. Economic abuse is already covered in existing training. Training materials to devised to cover the full recommendation by May 23. Training delivered by the end of July 23.	Green	Completed after receiving outcomes of training and renewed training materials received.
11. The Probation Service to consider the findings from the three DHRs within Kent and Medway (Ann, Connie and Diana) which have raised significant concerns surrounding the identified lack of challenge by Responsible Officers and a practice of passive risk management and over reliance on the accounts provided by the perpetrator.	1. The appropriate Probation Delivery Unit (PDU) to share the learning of this DHR to practitioners. 2. For practitioners to engage in appropriate trainings relating to the alignment between domestic abuse and safeguarding. 3. Operational managers to quality assure risk assessments (OASys) as part of the OASys countersigning framework and that practitioners are assigned roles in accordance to their experience, knowledge and capability.	**The Probation Service**	30/10/2022	Practitioners to have been assigned roles in OASys by the end of May 2022. This is being delegated to improve the level of operational oversight. Operational managers to also ensure monthly supervision with practitioners to provide opportunity for regular reflective case discussion. Future monitoring to be done by the DHR Steering Group.	Amber	Improvements in the quality and frequency of management oversight and quality assurance. All practitioners to have completed mandatory training in relation to domestic abuse, or specific local workshops relating to MARAC

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12. The Criminal Justice Team within Kent Police to identify a means of highlighting the fact that a victim of domestic abuses current address is not placed on the documentation for the CPS and therefore inadvertently read out in court proceedings.	Kent Police Victim Justice Team to liaise with Witness Care Unit and Victim Justice Unit and ensure that no current addresses are placed on documentation for the CPS	**Criminal Justice Team, Kent Police**	Oct-22	Victim Justice have met with Witness Care and VJU and it has been decided that in future, when the victims' address is not known to the offender this will be put on the CPS paperwork; We will ask for the following: - Not to contact JANE DOE directly or indirectly (save for the purposes of Restorative Justice if requested) - Not to attend any address JANE DOE is believed to be residing at (this covers if they are sofa surfing or staying with family etc.)	Green	Changes to working practices have been made and communicated. Cases go through a review process before being submitted so any errors should be picked up on.
13. All agencies are to provide guidance to staff regarding the use of 'victim blaming' language within their interaction with victims and also within their written documentation.	Oasis will create a module of training to complement the existing training for in-house staff and also for the KIDAS partnership that all DA staff can access	**Oasis DA Service**	Oct-22	1. Create module (Sept) 2. Disseminate to KIDAS partners 3. In-house staff to access via Staff Development framework	Green	Victim blaming - the VCS LPB sub-group are working on a module and handout re: use of language as part of the above with a target date of Summer 2023 - LPB/Kent Policy team are owners
	A virtual development programme to be designed and published which considers learnings from this DHR (plus others)	**Sophie Baker, Practice Development Manager, Kent County Council, Integrated Children's Services Multi agency Partnership.**	Nov-22	The DA programme is running from Nov 22 - Feb 23 and has elements virtual training and a practitioner handbook. It has been designed to improve practitioner knowledge in many aspects of domestic abuse, including ensuring we use language that cares and not blame victims for their vulnerabilities.	Amber	Improved use of language, workforce knowledge and understanding around domestic abuse including coercive and controlling behaviours - this will be measured within our quality assurance framework

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	Already sits within our Multi-Crime training completed by any paid staff or volunteer before they commence direct work with service users	**Victim Support**	Complete	Complete	Green	After completing the training and before seeing a service user, staff and volunteer supporters have to be accredited
	Clarion's Practice Framework to be updated to include guidance for staff regarding the use of 'victim blaming language'. Managers to routinely discuss 'victim blaming language ' and it's potential impact in team meetings and 121's.	**Clarion Housing Association**	End October 2022	Clarion have updated their Practice Standards to include a section on 'victim blaming' language. Managers routinely discuss 'victim blaming' language in team meetings and during 1:1 supervision. Managers and staff professionally challenge when victim blaming language is used.	Green	Regular discussions with individuals in 121's and with the team evidence any required understanding and change in practice. Audited case files evidence staff are conscious of their use of language and how it may negatively impact a client / their family. Audited case files evidence the use of appropriate language in all interactions with the client, their family and any agency supporting them.

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	The new practice framework launched June 2022 is putting the person at centre of our involvement and is a strength based approach focusing upon positive interactions. The framework (topic 1) has associated training about effective communication highlighting Equality Diversity and Inclusion and in addition a video has been produced this year around communication . A recent Briefing for staff highlights Recording with Care for ASC staff.	**Kent County Council, Adult Social Care**	Dec-22	A briefing for ASC staff covering Recording with Care has been circulated. A video on communication is available to staff via the Kent Academy Course: Communication (delta-learning.com)	Amber	People's case recording will be highlighted within audits as part of the quality assurance framework due to be commenced Autumn/Winter 2022 Practice Framework - awaiting feedback from topic 1 training
	Domestic Abuse policy written for The Education People. Presented to Executive Committee with specific reference to victim blaming language. Policy written in accordance with non-victim blaming language. DA webinar planned for later in the year will make specific reference to recommendation 12	**Education Safeguarding Service**	Academic Year 22/23	DA policy already written and shared across The Education People	Amber	Policy shared across the company.

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	Victim interaction has been highlighted during inputs from Zoe Lodrick and Jane Monkton Smith. This will further be covered through CPD in the 16 days of Awareness.	**Kent Police**	Dec-22		Amber	Training input provided
	This is discussed during domestic abuse session in the Family Focused training. This will be explored further so as to create more empathy and understanding.	**Dartford & Gravesham NHS Trust**	Dec-22	Victim blaming is already part of the training but will be reviewed to create better awareness amounts staff.	Green	Staff will have increased awareness about language that is used by perpetrators and the impact it can have on the victim.
	Managers to routinely discuss 'victim blaming language' and it's potential impact in supervision and team meetings.	**HMP Rochester - Offender Management Unit**	End of January 2023	This has already been discussed within the team. Despite the fact that we do not have direct interactions with victims. We do not have any documentation that we provide to victims from this setting.	Amber	Evidence via observations, QA of work, etc
	Improvements in case audit and oversight, as to ensure improved accountability of assessment and risk management planning Review of staff against the OASys countersignature framework, to ensure there is appropriate assurance in regards to	**London Community Rehabilitation Company**	Dec-22	All staff were reviewed against the OASys countersignature framework in October 2022. This framework ensures that any practitioners demonstrating deficits within their assessments, including the use of non-prescribed language, are subject to ongoing countersignature arrangements of their assessments. The PDU inspection completed by HMIP has made recommendation regarding the implementation of	Amber	Information relating to the complaints process has been fully communicated and visualised across local offices. The HMIP action plan is subject to submission in mid-November, which will outline an approach for improved case audits. The improved level of oversight will provide a more robust conduit by which

Recommendation	Action to take	Lead Agency/ Accountable Professional	Target Date	Progress (Milestones, risks, further actions)	RAG	Outcomes / Measures
	adequacy of risk assessment			more frequent case audit. This action will be reviewed in line with the HMIP action plan, with an expectation that operational managers (Senior Probation Officers) are reviewing new allocations on a monthly basis Information relating to the Probation complaints process is available to all service users at the point of induction. Anyone subject to probation, or those impacted by Probation intervention, are able to utilise the compliant process to highlight concerns in practice or engagement with practitioners Inclusion and diversity officers have now been assigned across the London region. These officers will engage with staff across a number of practice areas, and will include information relating to inappropriate language and assessments, which will touch on concerns relating to victim blaming		language can be challenged and individuals held to account.

Recommendation	Action to take	Lead Agency/ Accountable Professional	Target Date	Progress (Milestones, risks, further actions)	RAG	Outcomes / Measures
	A learning topic on language and victim blaming will be shared across the Kent and Medway GP Bulletin for all GP's	**Kent & Medway Integrated Care Board**	Nov-22	Named GP for Safeguarding for Swale and Primary Care Safeguarding Practitioner completed 7 minute read to be shared across Kent and Medway GPs within the GP Bulletin 01/03/23.	Green	Improved recognition and support for victims. A 6 monthly rolling electronic audit of GP's using electronic polling via comms across Kent and Medway to determine improvement in knowledge and skills of GP workforce. To start Q3 2022.
	Learning from this review regarding use of language in safeguarding will be shared and discussed in the Medway & Swale Safeguarding forum	**Kent & Medway Integrated Care Board**	Nov-22	Named GP for Safeguarding will offer reflective discussion at Medway/Swale safeguarding forum for Medway & Swale Update - Named GP to provide learning and discussion at forum March 2023 and to represent in the Autumn forum for continuum learning	Green	Improved recognition and support for victims. A 6 monthly rolling electronic audit of GP's using electronic polling via comms across Kent and Medway to determine improvement in knowledge and skills of GP workforce. To start Q3 2022.
	Ongoing Domestic Abuse training to be delivered and ensure module on victim blaming language. Provision for specialist trainer to speak to Typology, The effects of ACES and into adulthood. Domestic Abuse Champions within Housing Services	**Dartford Borough Council, Housing**	November 2022 (to be completed every 3 years)	Complete November 2022	Green	Domestic abuse training has been updated and includes module on use of victim blaming language. Staff training records to be updated as achieved.

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	Southern Housing (formerly Optivo) to develop guidance for staff on victim blaming and also review written documentation for this.	**Southern Housing (formerly Optivo)**	Mar-23	Work on guidance and document review to be started in February 23 and completed in March 23.	Amber	Outcomes to be reviewed after completion.
14. Training to take place with Coroners to identify the linkage with domestic abuse and potential suicide cases.	See progress column.	**Chief Coroner**		The Chief Coroner is unable to comment on the decisions made within this case however, appreciates that there is a general need for coroners to be aware of the possible impacts of domestic abuse and to be able to identify any links with a person's death. The Chief Coroner stated this suggestion of a training topic will be passed to the Judicial College.	Green	

Recommendation	Action to take	Lead Agency/ Accountable Professional	Target Date	Progress (Milestones, risks, further actions)	RAG	Outcomes / Measures
	See progress column.	**Kent Coroner's Service**	Oct-22	The Kent and Medway Suicide Prevention Programme Manager gave a presentation to the Kent Coroner Investigation Officer Team on 12th October 2022. He presented the latest local and national research, as well as the implications for practice, relating to deaths by suicide by people impacted by domestic abuse. The presentation helped the Coroners' Team understand the potential impact of domestic abuse (either as a victim or as a perpetrator) as a factor in the build up to the suicide. The presentation also included information about the Amparo service which has been commissioned to support families who have been bereaved by suicide and who are experienced in supporting families where domestic abuse has been present.	Green	

Recommendation	Action to take	Lead Agency/ Accountable Professional	Target Date	Progress (Milestones, risks, further actions)	RAG	Outcomes / Measures
15. The DASVEG to review and consider the implementation of the J9 project or to liaise with Advocacy After Fatal Domestic Abuse (AAFDA) and Wearside Women in Need (WWIN) who are currently working on a new initiative with the aim of enabling family, friends and communities to better support the people close to them who are subjected to domestic abuse.	Take action to the DA Champions Working group to discuss. The Champions working group is a working group of the DA Forum Chairs meeting who are putting together a three-tiered champions program. 1 - Professional Champions training and network, 2 - Business Champions signed up to the EIDA scheme and a local network & 3 - Community Champions.	**Kent and Medway Domestic Abuse and Sexual Violence Executive Group**	Oct-22	OD - Contact organizations running the J9 project to understand how this may fit into the Community Champions proposal Working group to bring together scoping document inclusive of role description, training requirements, support requirements for champions & funding implications for presentation at Tactical/DASVEG	Amber	Champions working group have put together a professional champions and employer champion package. During the 16 Days of action we partnered with Employers Initiative on Domestic Abuse to offer two free one-hour webinars. 66 employers across social sector, health, education, churches, housing, charity, football clubs, councils, universities have signed up to being a Kent & Medway End Abuse Employer Champion. Poster packs will be sent to each Champion. A scoping document has been put together to explore the implications for the Community Champion programme which has an increased anticipated cost and potential risks to mitigate. This will be presented at the Tactical/Exec in the Spring.

Recommendation	Action to take	Lead Agency/ Accountable Professional	Target Date	Progress (Milestones, risks, further actions)	RAG	Outcomes / Measures
16. The Head of Education Safeguarding to write to the schools within their area identifying the importance of good record keeping and the role of the Safeguarding Lead within their school.	To consider various different ways of sharing the message regarding the need for accurate and useful recording mechanisms. Various methods have already been tried following this previously being a recommendation.	**Head of Education Safeguarding**	Academic year 21/22 with reminders thereafter.	The Education Safeguarding Service have launched a new E-learning course for DSLs in schools and Early Years settings: 'Safeguarding Record Keeping for Designated Safeguarding Leads'. This course will support DSLs in schools and early years settings to understand their role and responsibilities with regards to keeping "detailed, accurate, secure written records of concerns and referrals". The course explores the importance of effective record keeping within the current legislative framework, including data protection. It will also consider examples of best practice with regards to robust record keeping, including storage and transfer and retention of records. We also directed schools to an Ofsted briefing in May 22 which included a big section on recording and are including something in our newsletters in September 22. HoS also plans to talk to the Director of Education as it is a repeated issue to see if she has any ideas as to how best address it as we keep having the same recommendation with not as much success as there should be and will cascade recommendation via the newly reformed KSCMP education subgroup. 09.02.23 Update. Issue	Green	Difficult to measure, but best outcome would be for schools and early years settings to no longer have issues with poor recording. Due to this, the recommendation will continue to be on the agenda of the work the service completes.

Recommendation	Action to take	Lead Agency/ Accountable Professional	Target Date	Progress (Milestones, risks, further actions)	RAG	Outcomes / Measures
				has now been taken to the KSCMP Education Safeguarding Subgroup - working party of DSLs are to peer review their records with input from the Education Safeguarding Service once this action is completed. Following this, further activity will be identified with the Education Safeguarding Subgroup members (which includes ESS HoS) responsible for taking this forward and will report to KSCMP Exec. Constant reminders in training, DSL catch ups and newsletter are ongoing. For the purposes of this DHR, the section is now complete.		
17. The NICE guidance regarding pain management is to be circulated to GPs within Kent and Medway with a request that they review their patients in light of the new guidance. This recommendation links into the Kent and Medway SAR	the KMCCG Medicines Optimisation Team Programme regarding Opiate prescribing to be circulated among all Kent and Medway GPs in the GP Bulletin	**Kent and Medway Integrated Care Board**	Jul-22	completed in 2020 - see evidence submitted.	Green	Evidence of bulletin to be embedded when action completed. ICB Medicines Optimisation team will undertake quality improvement work with the surgery which will be monitored for improvement in the duration of the support.

Recommendation	Action to take	Lead Agency/ Accountable Professional	Target Date	Progress (Milestones, risks, further actions)	RAG	Outcomes / Measures
David (2021) which also made a recommendation regarding the new NICE guidance.	KMCCG Medicines Optimisation Team to work with the identified GP surgery to review and monitor opiate prescribing in accordance with their improvement protocols (see embedded evidence)	**Kent and Medway Integrated Care Board**	Oct-22	GP Surgery completed 2021/22 MOS opioid review project. Following this project the practice identified those patients with a prescription for opioids and implemented a process to ensure patients are reviewed and where possible their opioid prescribing was reduced. KM ICB Med Ops team meeting to review the ongoing monitoring by the practice Feb 2023.	Green	Meds op team will provide projection of expected improved outcomes once engagement with surgery has taken place to evidence engagement. Monitoring of quality improvement will continue while the surgery is engaging with support

Appendix B- Home Office Letter

Home Office

Interpersonal Abuse Unit
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Tel: 020 7035 4848
www.homeoffice.gov.uk

Cllr Michael Hill
OBE Kent County
Council Sessions
House County Hall
Maidstone
ME14 1XQ

18 October 2023

Dear Cllr Michael Hill,

Thank you for submitting the Domestic Homicide Review (DHR) report ('Diana') for Kent Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 6th September 2023. I apologise for the delay in responding to you.

The QA Panel are grateful for your comprehensive, open and transparent report into a challenging case, which highlights the links between suicide and domestic abuse. The Panel felt that the report reflected the lived experience of the victim, with good and respectful family engagement.

At 16:17, it was felt that the work of the transforming health and social care on cross- training could usefully be highlighted as good practice to be adopted more widely.
Recommendations 8 and 11 were also flagged as especially helpful.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

- It would be helpful to make a final check on the draft for dates and references on academic research, but also on dates which may be relevant to the course of events (for example, 15.4.8 mentions that GPs were *recently* trained in DA and it would be helpful to know if this was before or after 'Dianna's death and the subsequent DHR process).

- 5.1.17 states "It is not understood at this stage whether officers did not ask the right questions or whether the training had not taken place to give the officers the tools to identify the behaviour". It would be helpful to clarify this.

- 5.2.1.12 The terms of reference might be trimmed down to focus on the specific agencies involved, and the references to homicides broadened to include suicide.

- 15.1.14 states: *Diana had prosecuted Nathan for the initial assault which had led to them separating.* It would be useful to reword this as *'Diana had supported the prosecution against Nathan'* as there are common misconceptions in the DA sphere about the victim rather than the crown prosecution service choosing to press charges.

- Section 15.4 analysis of Kent and Medway Clinical Commissioning Groups' IMR for the GP practice covers information-sharing, but might also look at whether the GP could have referred Diana to further help and support on DA. A specific action point for GP services may be appropriate. It may be worth considering a model of having a health representative who liaises with GPs and represents them at the multi-agency risk assessment conference (MARAC). This model is well established in Hackney and would be worth exploring. Likewise, an action around the role of schools in safeguarding children and information-sharing.

- It would have been good to see more probing of the prison service regarding how the perpetrator continued to contact the victim whilst in prison. It is understood that it may not be possible to obtain further timely information to feed into the report itself, however, an action point from this may be appropriate.

- There is a specific recommendation around information-sharing and MARACs which the Panel felt should be clarified: '*The MARAC process needs to consider that hearing from the perpetrator can be beneficial'.* The Panel felt that it may be appropriate to consider the background and mindset of the perpetrator, for example around drug misuse or mental illness. However, as a rule perpetrators should not be informed that a MARAC is in progress, in order to protect the safety of the victim.

- The Panel felt that the Action Plan could be strengthened on some points, where alerting or informing key parties of the issues might be sharpened into a request for action and a clear outcome. This may be especially relevant for national recommendations, where it may not be clear who should be held to account for delivery.

- As a drafting point, some Panel members found the Action Plan difficult to read with small typeface and dense columns of information. If there is a way to expand this, it may be helpful for future readers.

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,

Lynne Abrams

Chair of the Home Office DHR Quality Assurance Panel