DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Into the death of

Emily in May 2015

Report Author

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REVIEW EXECUTIVE SUMMARY

1 The Review Process:

1.1 This summary outlines the process undertaken by the Norfolk County Community Safety Partnership Domestic Homicide Review Panel in reviewing the unexpected death of a resident in the county.

1.2 Although this Review follows the procedures required for a Domestic Homicide Review it should be noted that the unexpected death which has brought about this review is not due to a homicide. No one is or has been under investigation in respect of Emily's untimely death. However, as there had been recent contact with the Police in relation to domestic abuse, in line with legislation, the Community Safety Partnership decided to conduct a review to consider agency contact and involvement with Emily and to establish if there are lessons to be learnt.

1.3 The Review process began with a meeting called by the Chair of the Community Safety Partnership on 25 June 2015 where the decision was taken that the circumstances of the case met the requirements to undertake a Domestic Homicide Review. The Home Office was notified of this decision on 28 July 2015 as required by statute. The Review commenced with a first Panel meeting on 17 September 2015 and was concluded on 31 March 2016. The Review remained confidential until the Community Safety Partnership received approval for publication by the Home Office Quality Assurance Panel.

Agencies Participating in the Review

1.4 A total of 13 agencies were contacted and 4 responded as having had involvement with Emily; 9 confirmed no contact. Agencies participating in this case Review and the method of their contributions are

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

The Review was assisted by information from the Norfolk Coroner's office.

Family and friends have also contributed to this Review.

1.5 To protect the identity and maintain the confidentiality of Emily and her family pseudonyms have been used throughout the Review. They are:

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

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

1.6 Purpose and Terms of Reference for the Review:

The purpose of the Review is to:

- Establish what lessons are to be learned from the unexpected death regarding the way in which local professionals and organisations work individually and together to safeguard victims;

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

- Apply these lessons to service responses including changes to policies and procedures as appropriate; and

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

  This Review is not an inquiry into how the victim died or who is culpable. That is a matter for the coroner.

Specific Terms of Reference for the Review:

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

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

3) To establish what contact agencies had with Emily and;

   a. what assessments had been undertaken
   b. what treatment plans or support services were provided
   c. whether plans or services were appropriate and in line with procedures and best practice.

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

5) Was communication and information sharing between agencies or within agencies adequate and timely and in line with policies and procedures?

6) Did agencies in contact with Emily have knowledge that she was a victim of domestic abuse, ask about domestic abuse as part of assessments, and how did this impact on the support she received?

7) What training had those practitioners in contact with Emily received on domestic abuse, risk assessment and referral to MARAC and specialist support services, and do their agencies have appropriate domestic abuse policies and pathways in place to support their practitioners?

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

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

10) Over the period of time covered by this Review two criteria applied for assessing an adult's vulnerability. Up to March 2015 a 'vulnerable adult' was defined by the Department of Health 'No Secrets' guidance as:

> *"An adult (a person aged 18 years or over) who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or serious exploitation." No Secrets, Department of Health 2000*

Under the Care Act 2014 which was enacted in April 2015 the term an 'adult at risk' was adopted. An 'adult at risk' is considered in need of safeguarding services if she/he:

> *(a) has needs for care and support (whether or not the authority is meeting any of those needs),*
> *(b) is experiencing, or is at risk of, abuse or neglect, and*
> *(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.*

Was Emily assessed or could have been assessed as a 'vulnerable adult' pre 31 March 2015 or an 'adult at risk' post 1 April 2015? If not were the circumstances such that consideration should have been given to this risk assessment?

11) To examine whether there were any barriers which prevented Emily from seeking or accepting help in respect of experiencing domestic abuse, her health needs, or any other relevant support services. Are there lessons to be learnt from the identification of any barriers which could assist agencies in adapting their procedures and processes which could alleviate or break down these barriers in future?

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

Summary of Agencies Contact:

1.7 The first service to be made aware that there were problems in Emily's relationship with her husband Peter was her GP during an appointment on 19 January 2015. Emily asked where she could get advice as she said her husband was being critical of her appearance and everything she did. Her GP suggested relationship counselling, or a joint appointment for them both. Emily stated that her husband would not agree to either of these suggestions. She was given details about Age UK and Relate.

1.8 Emily saw an Age UK adviser on 13 February 2015 and informed them that she had been married for over 40 years, but her husband's behaviour over the past year had become very controlling; he did not like her going out with friends, questioned her movements, and often locked her out of the house. There were occasions when Emily had to phone her daughter to reason with Peter to let her into the house. Emily reported that her husband had not been physically violent, but she was finding his behaviour distressing.

She liked to go out with friends, but was increasingly unable to do so as she worried what she would face when she went home. Various options were discussed with Emily concerning leaving the marriage and living independently and the support she would be eligible for should she take that step including benefits, help with rent etc. The adviser also discussed contacting the local voluntary sector domestic abuse service Leeway. Emily was accompanied on this visit by her adult daughter who does not recall Leeway being mentioned, but says there was a great deal of information given during the appointment which Emily found rather overwhelming. Emily was also hoping to access the legal advice service available from the Age UK voluntary solicitor, but the advice they were able to give did not cover the area Emily was seeking concerning her marital rights, therefore she did not have a further appointment.

1.9 On 23 February Emily sent a letter to her GP informing them that she had been to Age UK, but they were unable to help; she wrote that the situation was getting worse and asked if her GP could put her in touch with anyone who could. On the 12 March Emily visited her GP and it is recorded that they had a long chat about her "ongoing problem at home". Emily was prescribed Pericyazine, medication used for the short-term treatment of severe anxiety or tension.

1.10 The next agency Emily contacted was the Police. On 2 April 2015 she reported that during an argument Peter had been threatening towards her and had whipped her round the face with an item of clothing knocking off her glasses. Officers attended and Peter was arrested and cautioned for common assault. A DASH[1] risk assessment was assessed as standard risk. Emily was happy with the Police action and said she did not want to prosecute Peter; she was concerned that his actions were due to his mental state as she thought he may have early signs of dementia. Peter was returned home. A secondary risk assessment later increased the risk level to medium as Peter was now back in the home with Emily. Police made a follow up call to Emily a few days later and she confirmed that all had calmed down; although she thought that the situation would escalate again at some point. Emily told the officer that the marriage had broken down, but she was not prepared to leave and go into a hostel. She was given the officer's contact details and advised to contact Leeway which she said she would do. No record of contact with Leeway by Emily has been found.

1.11 In line with normal procedure, in follow up to the incident on 2 April, Emily was telephoned by Victim Support. She was given safety advice including contacting the Police and Leeway, and family and friends for support.

1.12 On 20 April Emily wrote another letter to her GP informing them that the situation had become worse and she had called the Police. She informed the GP that her address was now flagged which was 'reassuring should anything happen again'. Emily concluded the letter by writing "his temper seems to be escalating. Thought it best to inform you of the situation".

1.13 On an afternoon in May Emily was due to go out with a friend, but she had put a note through her friend's door explaining that she would not be able to go as her husband was "prowling around the room, slinging papers everywhere, banging doors etc". He was threatening to cause trouble at the venue they were due to visit, and had then driven off in the car. Emily's friend was concerned and phoned the Police, explaining that there was a history of Emily's husband being verbally abusive and he could be a bully at times.

[1] DASH - Domestic Abuse, Stalking and Harassment risk assessment checklist is a list of 27 questions which assist in assessing the risk faced by a victim. Risk is judged Standard, Medium or High. 14 positive answers and above is judge High Risk and results in a referral to the Multi-Agency Risk Assessment Conference (MARAC) for additional safety planning to protect the victim.

1.14 An officer visited and found Emily in the garden of her home, but she was unwilling to discuss the matter as she said she could not be sure that her husband would not be watching and hearing. She did, however, explain that her husband had not been violent he was just making himself known and making her feel small. He did not want her to go out of the house for some reason unknown to her. He had also blocked telephone numbers so that outside companies could not get in touch with her. When Peter appeared the officer said he was making enquiries locally about a Police matter. On return to the station the officer completed a DASH risk assessment from the information Emily had chance to provide. Risk was assessed at standard level. There had been no crime to report from this incident. The officer felt the atmosphere in Emily's home was uncomfortable and there was more to the situation than was said. The officer recorded that he would request an advocacy worker to contact Emily; such a request was not received. However, as advocacy workers are only able to support high risk victims it is unlikely that their support could have been offered.

1.15 The officer discussed the case with a senior officer and was asked to ensure that everything was in place to safeguard Emily. There was judged to be no immediate danger of harm to Emily, but she needed a point of contact and her husband may need support. The officer emailed the MASH[2] requesting a second risk assessment. However, as this was a non-crime and due to the high level of referrals they receive the MASH was unable to help and requested that the officer take responsibility locally for any further actions needed.

1.16 A few days later Emily visited a contributor to the review. She talked about the Police visit and they had discussed the possibility that Peter might have dementia. Emily also described to another contributor how she and Peter had both bought iPads and he had accused her of paying more for hers, and so she had hidden it. She then reported that Peter had come up behind her and put his hands around her throat and said 'I can tighten'. Emily said she had made up her mind to go to her GP and the Police station. At the end of her visit Emily said she felt much better and she left on foot to go to the GP surgery. As she left the contributor reports that they hugged goodbye and Emily said "All I want is to be loved".

1.17 Information from the Coroner's inquest confirmed that Emily phoned her GP practice around mid-day asking to speak to her doctor, but her GP had left for the day. It was reported that the receptionist phoned the GP and was asked to tell Emily that her GP would call her in the morning next day. Emily mentioned that her GP had said they would 'intervene when the time came', Emily said the 'the time has now come'.

1.18 Following this call Emily went to her local Police station and as the officer she had asked to see was not on duty she was seen by a Police Community Support Officer ((PCSO). Emily requested advice about whether she could put up cameras in her home to record the actions of her husband. She reported that her GP did not believe her and she wanted proof to show the kind of erratic behaviour he was exhibiting as she believed he was suffering from dementia. Emily was advised that as it was in her own home she could do what she liked, but to be 100% sure he advised that she consult a solicitor regarding civil matters and the breakdown of her marriage. Emily said she had put off going to a solicitor as she did not want to pay to have matters sorted out. Emily gave a brief history of events involving the Police and said that over several years her husband had been calling her derogatory names and making insulting remarks about her appearance. She confirmed that the Police already had this information. Emily said she was not worried

[2] The Multi Agency Safeguarding Hub (MASH) physically and virtually co-locates key professionals including Children's Services, Health and Independent Domestic Violence Advocates (IDVAs) to facilitate early information sharing, analysis and decision making in relation to children, young people, and adults.

and did not feel at risk of harm, she just wanted her husband to go to the doctor. Emily was described as calm during her conversation with the officer; she did not appear unduly concerned about returning home. As Emily had come for advice and no incident was reported no further DASH assessment was undertaken. The officer asked if Emily would like to be referred to any agency, but she said she had an officer's number to contact if she needed. After she left the officer emailed the Police officer Emily had come to see to inform him of her visit.

1.19 Later that day Emily's death occurred on a railway line in the county. At a Coroner's inquest in December 2015 a verdict of suicide was recorded.

1.20 During the course of the review it was learnt that Peter had access to Emily's GP practice database log in and could see when she had appointments etc. He was also able to monitor her mobile phone and bank card spending as he had online access to her mobile phone account and bank account.

2 Key Issues Arising from the Review:

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

2.2 Emily was prescribed medication used to treat anxiety, however research shows there can be devastating effects on mental health and to self esteem from psychological abuse and control, but this was not recognised in Emily's case. However, the impact of psychological abuse is difficult for a practitioner such as a Police officer or advice worker to assess in a short interaction with a victim; it requires clinical knowledge. Nevertheless, training in this aspect of domestic abuse would be valuable for frontline practitioners who come into contact with victims as part of their work. This is especially important given the inclusion of coercive control in the definition of domestic abuse, and the introduction of a new offence identifying a course of coercive and controlling behaviour as a criminal offence from the 29 December 2015. The accurate recording of incidents or reports involving coercive control by all practitioners whether Police, GPs or advice workers will be essential to support evidence of a course of such behaviour.

2.3 Emily was trying all means she knew of to get help. She especially wanted medical help as she thought Peter's change of behaviour was a health issue. However, she had reached an impasse; Peter would not go to the GP, and Emily said the GP told her they were unable to help without proof, yet the GP knew that Peter did not have dementia. A way needs to be found to address this situation so that the welfare and safety of the patient with concerns about their partner's health which is impacting on their own health can be met, as well as addressing professional ethics in regarding patient confidentiality in relation to the patient about whom their partner has concerns. Emily's GP told the Coroner's inquest that they thought Leeway Domestic Abuse Services were part of the Police and that referral to services such as Police or Social Services would 'complicate' matters. This negative view of statutory services and incorrect assumption about Leeway is most concerning. On the one hand it denies a patient access to public protection services and on the other hinders access to a voluntary sector specialist domestic abuse service who could have provided Emily with the holistic advice and support she needed.

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

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

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

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

2.8 Emily was given a range of advice most of which she chose not to follow. The barriers to leaving undoubtedly played a part in that decision, but also when someone is under stress they may not always hear all that is said to them. Apart from her need for a medical assessment for Peter, Emily appeared to be trying to seek legal advice, but she said she did not want to pay for it, or perhaps she did not have the independent funds to pay for it; her family member confirmed that Emily had limited financial means. There was a missed opportunity to direct her to the free advice of the Norfolk Community Law Service or the Rights of Women helpline when she said this to the PCSO, and when Age UK could not meet her needs through their legal services. Whilst Emily was given a range of good advice this demonstrates how important listening is, as identifying one small thing which might engage a victim can lead them to accepting further support.

3. Conclusions:

3. 1 It is not the place of this review to determine the cause of Emily's death; that is the role of the Coroner. However, term of reference 2 asked that the Review 'determine as far as is possible if there is evidence to suggest that the unexpected death of Emily was in any way connected to her being a victim of domestic abuse'. In her summing up the Coroner began by acknowledging that there was a background of Emily having relationship difficulties and she had spoken of psychological abuse which had greatly played on her

mind, and although this in itself was not enough to confirm why she took the actions she did, her actions do lead to the conclusion of suicide. The information provided to the review by contributors who knew Emily well, plus her interactions with her GP and the Police, suggests that she was affected by the psychological and verbal abuse she was experiencing, but in the absence of any explanatory note by Emily it is not possible to speculate whether it was the sole reason for taking her life, but it would appear to have been a significant contribution.

3. 2 The Coroner commented that Emily was seeking help, but she was unable to get across how much it was playing on her mind. It was the Coroner's opinion that it is important that professionals recognise this. The review author would also wish to reinforce that domestic abuse is not solely a matter of physical violence; it is important to recognise the harmful impact of control and psychological abuse on a victim's mental wellbeing.

3. 3 The GP practice had a flowchart to guide referrals to the MASH, but the Coroner was not convinced that this was effective. The practice risk assessed for depression, but not for domestic abuse and the Coroner felt the DASH could be used by GPs and more robust procedures needed to be in place. There was also concern that there was no method available to members of practice staff to recognise when a patient's call should be escalated and dealt with immediately. The Coroner sent a Regulation 28: Report to Prevent Future Deaths report to the GP practice setting out these concerns and that action should be taken to prevent future deaths.

3. 4 The fact that Emily was not referred to a specialist domestic abuse agency where she could have received the type of legal advice and support she was seeking for her particular situation formed a barrier to resolving her problem. She did not want to leave her home, and she did not appear to have the information she needed about her rights.

3. 5 Emily may have met the criteria for care and support under the Care Act 2014 under the wellbeing principle, but no referral was made to Social Care to establish whether this would have been the case. The Act provides 5 aims under which agencies should cooperate to provide care and support; Emily's needs met 4 of these aims. The Act also actively encourages cooperation and coordination between 'relevant partners'; the agencies who feature in this Review are all named in the list of 'relevant partners'[3].

3. 6 Emily's death was a shock to those who knew her. Her friends are of the view that she was a strong woman who disapproved of suicide; the thought that she might take her own life was very much out of character. Peter also commented that Emily said she would never leave her grandchildren, and contributors describe her as a doting grandmother who thought the world of her grandchildren. No note or letter was found to indicate what she was thinking or feeling on the day of her death.

3. 7 Evidence to the review suggests that Emily felt her husband's behaviour had changed in the past 2 years. Peter himself acknowledges their relationship changed, but he has stated that he took exception to Emily saying he was senile. He reports that the couple exchanged verbal insults, but he did not realise that this was having such an impact on Emily. Other descriptions of his actions such as locking Emily out of the house, making it difficult for her to use the car or to go out with friends are a different matter. Along with verbal abuse they are behaviours which fit the definition of domestic abuse, particularly psychological and emotional abuse, and coercive control.

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

3. 8 The Police dealt with one domestic abuse incident and had two interactions which could be called symptoms of the abuse. They handled the incidents with sensitivity, but with limited success for two reasons: Firstly, Emily was looking for a medical solution to the problem believing that the onset of dementia was the catalyst for Peter's behaviour. Secondly, she would not contemplate leaving her home with all that entailed to remove herself from the situation. Emily may not have followed up the advice from Age UK for the same reason.

3. 9 The effects of psychological and emotional abuse can be very damaging to a victim's self esteem and undermine their resilience to cope. Every day almost 30 women attempt suicide as a result of experiencing domestic abuse and every week three women succeed in taking their own lives[4]. We cannot know if Emily's struggle to achieve a medical assessment of her husband and help with his behaviour proved too much. We do know she was 'fed up' with his behaviour and felt it was becoming worse. The fact that she was prescribed medication for anxiety suggests her coping mechanism was possibly weakening. However, it is arguable that the support Emily needed was not pills, but tangible practical support which was not available from a clinician.

3. 10 It is not unusual for victims of domestic abuse to seek help from a number of sources sometimes with limited success, and this in itself can be very disheartening and confusing. However, when an area has well established domestic abuse services as Norfolk does, the pathway to support should not be strewn with barriers, some of which are put in place due to other agencies lack of knowledge. Emily felt things were escalating and shared this with her GP and with the Police, but the incidents attended by the Police did not meet the high risk criteria, and therefore fell outside of the process for inter-agency information sharing such as exists via the MARAC. And yet this case cries out for a coordinated response between GP, Police and preferably the advocacy of a specialist domestic abuse service. It is disappointing that Emily's GP did not make a referral to Leeway because they thought they were part of the Police. The GP also stated at the inquest that they thought a referral to a statutory agency would 'complicate' matters. This negative view of such agencies is of concern.

4. Recommendations:

The following recommendations are drawn from those arising in the IMR provided and the deliberations of the Panel taking into account the information gained and the learning from the Review.

4.1. National

Recommendation 1:

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

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

Recommendation 2:

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

Recommendation 3:

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

Recommendation 4:

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

a) they have a stand-alone policy & referral pathway for patients experiencing physical, psychological, financial or emotional domestic abuse and/or coercive and controlling behaviours from a partner, former partner or family member.
b) the referral pathway clearly advises practitioners how to refer to specialist domestic abuse services who can provide the appropriate practical advice, legal options, safety planning and emotional support.
c) they identify a domestic abuse lead, who has specialist domestic abuse training, and who then leads on the practice's response to concerns on domestic abuse for individual patients.
d) they have in place clear guidance and a method of recognising and escalating when a patient's request to speak to their GP (where domestic abuse is expected/anticipated) requires an immediate response, or in their GPs absence an appropriate escalation process is activated.

4.2. **Local Level:**

Multi-Agency

Recommendation 5:

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

Recommendation 6:

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

Recommendation 7:

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

(a) Older victims of domestic abuse and the additional barriers they face form part of the training.
(b) The content of training covering psychological abuse and coercive and controlling behaviour is covered in sufficient depth and takes into account the Home Office 'Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework, December 2015', to enable practitioners to identify its effects and support victims appropriately.
(c) Training should include reinforcing the importance of record keeping, particularly the use of a chronology to record information about all abusive and controlling behaviours experienced by a victim to identify and evidence any pattern of abuse.
(d) Completion of risk assessment should include clarity of the mental well-being of the person being assessed, e.g. depressed and/or suicidal.

4.3. **Police:**

Recommendation 8:

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

Recommendation 9:

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

4.4. **GP Practice:**

Recommendation 10:

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

4.5. **Leeway Domestic Violence & Abuse Services**

Recommendation 11:

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

Recommendation 12:

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

4.6. Age UK Norwich

Recommendation 13:

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

Recommendation 14:

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