DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Into the death of

Kelly in February 2015

Report Author

Gaynor Mears OBE, MA, BA (Hons), AASW, Dip SW

Date Completed:
22 April 2016

The Norfolk County Community Safety Partnership and the Review Panel would like to express their sincere condolences to the family members and friends of Kelly whose unexpected death has brought about this Review.

She is greatly missed by her family.

CONTENTS

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 This Review follows the procedures required for a Domestic Homicide Review, however 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 Kelly's untimely death. However, as there had been recent contact with the Police in connection with domestic abuse, in line with legislation, the Community Safety Partnership decided to conduct a review to consider agency contact and involvement with Kelly 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 Norfolk County Community Safety Partnership on 25 June 2015 when 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 began with a first Panel meeting on 17 September 2015 and was concluded on 22 April 2016. This is over the statutory guidance timescale to complete a Review due to the time taken to gather the necessary information. The Review remained confidential until the Community Safety Partnership received approval for publication by the Home Office Quality Assurance Panel.

Agencies Participating in this Review:

1.4 A total of 13 agencies were contacted and 6 responded as having had involvement with the individuals involved in this Review; 7 had no contact. Agencies participating in this case Review and the method of their contributions are:

- Norfolk & Suffolk NHS Foundation Trust including Mental Health Liaison Team and Improved Access to Psychological Therapies - chronology & Individual Management Review (IMR)
- Norfolk & Suffolk Recovery Partnership - chronology & IMR
- Norfolk Police - chronology & IMR
- Norfolk & Norwich University Hospital Trust - chronology & IMR
- Local Authority Housing Department - chronology & information
- GP Practice - chronology and information

A family member has kindly contributed on behalf of the family, and information made available at the Coroner's Inquest has informed the Review.

1.5 To protect the identity and maintain the confidentiality of the victim, perpetrator, and their family members pseudonyms have been used throughout the Review. They are:

The deceased: Kelly aged 31 years at the time of her death. Kelly was of white British ethnicity.

Her former fiancé: Paul aged 32 years at the time of Kelly's death. Paul 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 the events occurring during Kelly's relationship with her former partner from 2010 when the first notification of domestic abuse was made to the Police, and her death in February 2015. Agencies with information relevant to Kelly before 2010 are to provide a chronology and summary of that information.

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

3) To establish what contact agencies had with Kelly 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 Kelly's mental ill-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 Kelly 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 Kelly 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, and were there any resource issues which affected agencies ability to provide services in line with best practice?

9) Over the period of time covered by this Review two criteria applied for assessing an adults' 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 Kelly assessed or could she 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?

10) To examine whether there were any barriers which prevented Kelly 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?

11) 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 content of this Review is confined to information available from records concerning Kelly or information which is already in the public domain concerning Kelly's former partner Paul. Paul did not respond to an invitation to take part in the Review, therefore it was not possible to seek his permission to access his personal data to inform the Review.

1.8 Kelly had a troubled time in her teenage years. A family member described how she became involved 'with the wrong crowd' at school and this set her on a life course very different to her other family members. It is believed that Kelly's relationship with Paul began approximately 8 years ago. The relationship was volatile, on occasions this resulted in arguments and assaults; sometimes there was mutual aggression. Incidents were usually exacerbated by alcohol and illicit drugs. The couple moved into rented accommodation in a Norfolk village approximately 18 months before Kelly's death. One consequence of the move was that Kelly found it difficult to afford to run a car to reach

the job she had held for 4 years. She found another job nearby in a home for older people, but she found this difficult as she was upset when residents died. At the time of her death Kelly was unemployed. Paul was also in receipt of benefits.

1.9 The first domestic abuse related incident attended by the Police was in December 2010 when they were called to what was described as a heated argument. Paul had called fearing violence from Kelly. The situation had calmed down by the time officers arrived; both parties had been drinking. Kelly is recorded as saying "*he is more afraid of me than I am of him".*

1.10 There was a gap in Police callouts until a second call in September 2013 when a neighbour called the Police due to a very loud argument between the couple. Paul had come home drunk, but all was calm on the officer's arrival. This call was recorded as a non-crime incident and standard risk.

1.11 The third and fourth callouts were in December 2013. In the third incident Kelly phoned the Police sounding very upset; when they attended they found an argument had taken place, Paul had told Kelly to leave and she had refused. He had then left prompting her to call the Police concerned for his welfare. Kelly was noticed to have a bleeding nose, but she told officers she suffered from nose bleeds. The incident was risk assessed as medium risk. 4 days later the fourth callout involved Kelly reporting that she had "beaten up her boyfriend" and she had taken some tablets provided by a friend. An ambulance was called and when officers arrived Kelly was unresponsive. Paul denied any assault had taken place. Kelly was taken to the hospital where she admitted to binge drinking too much. She was seen by the Mental Health Liaison Team for assessment, but was not found to be suicidal or at risk of self harm. Again both these incidents involved alcohol and arguments.

1.12 In September 2014 Kelly saw her GP for a routine appointment. As she was just about to leave she said she wanted to discuss anxiety issues, but wanted a longer appointment for this. A further appointment for a week's time was made, however Kelly did not keep the appointment. Her GP phoned her and Kelly said she had been running late and so decided not to come. She was advised to make another appointment; however, between September 2014 and January 2015 Kelly did not make any further appointments with her GP.

1.13 A fifth Police callout took place in November 2014. The call taker heard screaming and then a male voice before the call was terminated; the number was identified as Kelly and Paul's home number. On attending officers found Kelly and Paul arguing and both were intoxicated. Two males were also present. Kelly had visible injuries to her right shoulder and arm. She refused to divulge how the injuries had occurred. Officers were concerned that Paul had assaulted Kelly and gathered evidence to support a victimless prosecution including photographs and damage to the property. Paul was arrested for Actual Bodily Harm, but denied causing Kelly's injuries saying they were caused by falling and being drunk. On the advice of the Crown Prosecution Service no further action was taken.

1.14 In December 2014 there were two further callouts. Incident number six involved a call from Kelly reporting that she and Paul had had an argument and she was concerned for his whereabouts as he had threatened to throw himself from a bridge. Kelly also disclosed that he had grabbed her around the throat and had head-butted her in the face. Officers attended and photographed the reddening to her cheek and marks around her neck and house to house enquiries were made for corroborative evidence which were negative. Attempts were made to locate Paul without success, however during a welfare check to Kelly later that day he was found to be at home with her. He

was arrested for the assault, but due to both Kelly's lack of engagement and supporting evidence the Crown Prosecution Service made the decision to take no further action. The second call in December resulting in callout number seven was from Paul stating that he had had an argument with Kelly who was drunk, and he wanted her removed. During the call the situation changed as Kelly had reportedly left with a friend. Officers attended, but Paul said he regretted phoning the Police and did not want to speak to them. Kelly made her own call to the Police, but would not disclose where she was. Numerous calls were made to Kelly to check on her welfare during 1 and 2 January 2015 without success.

1.15 Police callout number eight was received at 01:27 hours on 3 January 2015 when a member of the public reported an incident in the street between a male and female, and they had heard a female scream "*You just punched me in the face*". On attending officers found a tearful Kelly who reported that she had wanted to leave the house, but Paul would not let her. She had managed to climb out of a window into the garden, but Paul had caught her and pushed her through the fence. Kelly reported that she had punched Paul to get him off her and they continued arguing in the street, then Paul had pushed her to the ground and sitting astride her he had put his hands around her throat and bit her lip. Officers noted a reddening to her neck, but no other injuries were visible. Kelly kept telling the officers that she had not called the Police and she did not want them there. Paul was not present.

1.16 Officers tried unsuccessfully to engage Kelly in making a statement during the attendance at this incident, and they tried to help her understand the level of risk that was present. She declined refuge accommodation or offers to take her to friends or family, and fitting an alarm to the property was also declined, although Kelly did agree to regular welfare checks by officers and accepted to be contacted by the IDVA Service. In the officer's records from this incident it was recorded that Kelly gave no indication that she was suicidal, but she did appear depressed and detached from the situation. Kelly is also recorded as stating that the relationship would probably end by either Paul killing her or her killing him. The officer challenged this statement saying this would not be an acceptable conclusion and there were things they could do to help her. Kelly was noted as saying she did not care, and she stated that when she and Paul were arguing earlier that night she wished she had stabbed him so that "*at least it would be over"*. She would not elaborate on this statement, but simply repeated *"I didn't even want the Police involved".*

1.17 This incident was risk assessed as high and referred to the next MARAC[1] to be held on 22 January 2015. Meanwhile an officer in the MASH[2] continued to offer Kelly support including with a housing application, all of which she turned down. Kelly said that she had been in touch with the Housing Department herself, but no evidence of contact was found during the Review either in her Local Authority area or a neighbouring Authority. She also admitted being in touch with Paul. The IDVA appointed to support Kelly had one telephone contact where the MARAC process and the range of support available was explained, but after this initial contact despite numerous phone calls the IDVA did not achieve contact with Kelly again.

1.18 Paul remained at large until 13 January 2015 when he handed himself in to a Police station in the county. The Crown Prosecution Service made the decision not to proceed to prosecution due to lack of evidence. However, the Police applied to the Magistrate's Court for a Domestic Violence Prevention Order which was granted on 15 January. Notification of the Order was received by the IDVA Service on 20 January; this was

[1] Multi-Agency Risk Assessment Conference
[2] Multi-Agency Safeguarding Hub

within 3 working days. The Order stated Paul was to have no contact with Kelly or go within half a mile of her address for a period of 21 days. He was also prohibited from molesting or evicting her from the property. Kelly was informed of the Order and its conditions by the Police on 23 January 2015.

1.19 On 7 January 2015, 3 days after the domestic abuse incident, Kelly attended her GP practice and saw a nurse practitioner. She complained that she felt she was no longer able to cope. Kelly reported long standing problems with excessive alcohol, and of using recreational drugs since she was in her mid teens. She reported that alcohol triggered anger and as a result she would 'get cross' with her partner, and it caused her to be paranoid about her partner and friends. Kelly said that things had come to a head at the weekend when her partner of eight years had left as he was unable to cope with her anger and mood swings. She had attended anger management classes when she was 20 years old which had helped. Kelly informed the nurse that she had been working in a care home, but left before Christmas as she felt unable to cope when residents passed away. She reported thoughts of self harm that weekend, but now realised that this was not the way to make things better. Kelly was noted to have good eye contact, was well presented and she was wearing make-up. She was tearful, but was able to smile and laugh by the end of the appointment. In addition to a clinical assessment a Generalised Anxiety Disorder Seven Item Score produced a score of 19[3] (over 15 indicates severe anxiety) and a Patient Health Questionniare resulted in a score of 18[4] (within the scale indicating moderately severe). On GP advice a prescription for Escitalopram 5 mg was given. A referral was also made to the Wellbeing Service and Kelly was signposted for self referral to the drug and alcohol service the Matthew Project. Blood tests were arranged to rule out any underlying conditions.

1.20 The following day a referral to the Wellbeing Service was faxed and received by the Norfolk & Suffolk NHS Foundation Trust Access and Assessment Team. Following triage her referral was passed to the Improved Access to Psychological Therapies (IAPT) service. In line with normal procedures Kelly was contacted by phone on 15 January to be invited to attend a taster session of a psycho-educational class which teaches about stress, low mood and anxiety, and to explain what the service has to offer. Alternatively, an initial telephone assessment was offered. Kelly declined to attend the taster session and a telephone assessment was booked for 9 February 2015. Sadly, this call came after Kelly's death.

1.21 On 14 January Kelly missed a follow up appointment with the nurse practitioner she had seen the week before. The practice received a letter from the Wellbeing Service on 15 January confirming their assessment that Kelly would benefit from psychological therapies. On 16 January Kelly saw another nurse practitioner; she said a friend had made her come that day. Kelly was assessed once more and it was noted that her eye contact was poor, otherwise she was well presented. The scores using the assessment tools as before were 15 for Generalised Anxiety Disorder, and 21 for the Patient Health Questionnaire. Both scores represent a severity scale of 'severe'. After discussion with

[3] The GAD-7 originates from Spitzer RL, Kroenke K, Williams JB, et al; A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006 May 22;166(10):1092-7. Scores of 5, 10, and 15 are taken as the cut off points for mild, moderate, and severe anxiety, respectively. When used as a screening tool, further evaluation is recommended when the score is 10 or greater. http://patient.info/doctor/generalised-anxiety-disorder-assessment-gad-7 accessed 08.01.16.

[4]The Patient Health Questionnaire is not a screening tool for depression but it is used to monitor the severity of depression and response to treatment. However, it can be used to make a tentative diagnosis of depression in at-risk populations. Depression Severity: 0-4 none, 5-9 mild, 10-14 moderate, 15-19 moderately severe, 20-27 severe. http://patient.info/doctor/patient-health-questionnaire-phq-9 accessed 08.01.16

a GP her medication was increased to 10mg. Kelly was open about her use of alcohol and drugs; it was noted that she was drinking 38 units of alcohol per week (the recommended weekly consumption level for women is no more than 14 units per week[5]). She was given a leaflet for the Norfolk Recovery Partnership (a drug and alcohol service) and strongly advised to contact them. Kelly is known to have made an online referral to the Norfolk Recovery Partnership on 19 January 2015. A letter was sent to her on 22 January 2015 inviting her to attend the Norfolk Recovery Partnership assessment clinic stating the times and days this was available. Kelly's referral was passed to the team which covered her area.

1.22 At the MARAC held on 22 January 2015 the contents of DASH[6] risk assessment was noted which included: Kelly reported trying to separate from Paul in the past year; that he constantly wanted to know where she was and what she was doing; the abuse was getting worse and more frequent; there were also money worries as both were unemployed. Other positive answers in the assessment are related to Paul, but as the DASH is not in the public domain this information is not included in the Review. It was noted that Kelly had recently referred herself to a drug and alcohol service, and the repeated difficulty in making IDVA contact was noted. The Housing representative advised that changing locks on the property was not an option as Kelly did not hold the tenancy. Actions from the MARAC were for the IDVA Service to update the MARAC when contact was made with Kelly, and to request that the relevant drug and alcohol service liaise with the IDVA.

1.23 Following the MARAC the representative from the Norfolk & Suffolk Foundation Trust Safeguarding Team sent an email on the day of the MARAC to the Norfolk Recovery Partnership to highlight the risk of domestic abuse and passing on the MARAC information. The service was advised to treat Kelly as a priority. The IAPT service was not informed of the MARAC information as the Safeguarding Team had no access to the system which showed she had been referred to them.

1.24 The Norfolk Recovery Partnership telephoned Kelly twice on 26 January, but there was no response. A letter was sent to her GP practice to inform them of this outcome. This was followed by a phone call on 29 January to the nurse practitioner who saw Kelly on 16 January to let them know of their difficulties contacting her. The next day, 30 January, Kelly saw a phlebotomist at the surgery for a blood test. There is no indication that the Partnership's attempts to contact her were raised, but the phlebotomist would not have had occasion to look at Kelly's notes.

1.25 Safety measures in place for Kelly were reviewed by the Police on 1 February 2015. These were deemed appropriate and she was to remain high risk and be reviewed again on expiry of the Domestic Violence Prevention Order. Welfare visits to Kelly were to continue, but these had been unsuccessful so far as no answer had been obtained when officer's knocked on the door. Enquiries of neighbours confirmed they rarely saw Kelly anymore and they had not seen Paul for a long time. The Police system was updated and a request for an evening visit outside working hours was made.

1.26 At 05:59hrs on 4 February 2015 the Police received a 999 call which was discontinued. A request was made for the call content to be played which was "*It's not an emergency*,

[5] http://www.nhs.uk/Livewell/alcohol/Pages/alcohol-units.aspx

[6] 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.

it's not an emergency. I just wanted to ring you to tell you that I've got the biggest kitchen knife and I aint walked out the door with it. What I want to do is hang myself, do you know what I mean? so I don't have to do that and I..". The number was identified as Kelly's mobile and connection to previous domestic abuse incidents was made. The number was called and Kelly was spoken to at 06:03hrs. When asked if everything was alright Kelly said "*Yeah I'm fine, just acting a little bit crazy that's all*". The officer asked several times for Kelly to give her name and eventually she confirmed that she was Kelly and said "*I'm just aaagh, I'm, I'm just acting crazy. I tried hanging myself twice today, and I just, I don't know I just rang 999 that's all*". The officer asked where Kelly was and said it sounded as though she needed some help and support, to which Kelly replied *"I don't need that erm apparently Police, I've had help and support since Christmas, I've had f*** all!*" The officer tried again to find out where Kelly was, but at 06:05hrs Kelly hung up. Officers were despatched and arrived at Kelly's address at 06:16hrs. The officers had to break into the house where they found Kelly hanging in the hallway. Officers started CPR and an ambulance was called. Kelly was taken to hospital, but she did not regain consciousness. She died 3 days later. No note from Kelly was found in the house.

1.27 Information from members of the public obtained by the Police following Kelly's death identified that Paul had been seen at the address in the days leading up to her death. Mobile phone records also showed that Kelly and Paul had been in frequent touch with each other in breach of the Domestic Violence Prevention Order. Paul confirmed in his statement to the Inquest that he had been in the company of Kelly following the issuing of the Order. He was arrested on 5 February 2015 for a breach of the Domestic Violence Prevention Order and fined £25 at the Magistrates Court.

1.28 In his statement to the Coroner Kelly's father said "*It is my firm belief that the effects of Paul's behaviour over the years have had a major impact on Kelly and have contributed significantly to her decision to end her own life. I am not aware of any other factors which may have led her to these actions*".

2 Key Issues Arising from the Review:

Information Sharing:

2.1 This Review has identified that the Police were the primary agency with information about the domestic abuse within the relationship until the last incident when the MARAC referral meant information was shared more widely, but this information did not reach the GP practice or the section of the Mental Health Trust to which Kelly had been referred. This meant that key information about the risk and difficulties Kelly faced in her life were not known to her GP practice with whom she had close contact and the Mental Health service to which she had been referred. This affected both her assessments and the level of priority she was given. A way needs to be found to include information sharing with GPs and to ensure that all services to which a victim has been referred are fully appraised of their needs and the risks they face to enable safe coordination of services to take place.

2.2 The local housing provider had no knowledge of the Domestic Violence Prevention Order, and this information would have assisted them in managing the tenancy and the problems which were arising from it. It was the view of the Panel representatives for the housing provider and the Local Authority Housing Department that had they known they could have assisted the Police with the management of the order. A lesson learnt from

the national evaluation[7] of these orders highlighted the value of multi-agency coordination and processes. It would be helpful if formal agreements could be put in place to assist in what is a relatively new tool in the box for protecting those affected by domestic abuse.

2.3 Kelly's GP practice had information from the Norfolk Recovery Partnership informing them of their inability to contact her. This was not passed on to Kelly when she next came into the surgery the day after. Given her good relationship with practice staff and a practice nurse's recommendation that she self refer to this service, it would have been positive reinforcement if she had been contacted by a practitioner to let her know of the missed contact.

Assessments:

2.4 Whilst assessments undertaken for assessing depression and anxiety were in line with the purpose for which they were intended, namely looking for evidence of mental disorder rather than the cause, the PHG-9 and the GAD-7 used by Health do not include trigger questions or guidance to ask about domestic abuse despite the proven links between mental health disorders and domestic abuse. It is important that services ensure that health professionals are fully aware of this link and steps are taken to amend or augment assessment tools to include questions about domestic abuse.

Access to Services and Lack of Engagement

2.5 Professionals had great difficulty in engaging and contacting Kelly. It is likely that there were a multitude of reasons for this compounded by what has become known as the toxic trio of domestic abuse, mental ill-health, and the misuse of substances such as drugs and alcohol. Services need to understand the additional internal and external barriers that victims face, which sometimes appear as barriers they themselves are putting up against engaging with those trying to support them. Learning from this Review should generate a review and discussion concerning the coordination and delivery of the relevant services, taking into account that those affected by the three issues may feel stigmatised and nervous about engaging with services. Therefore extra efforts may be required to encourage and support engagement with services and this needs to be informed by service users themselves to find the most appropriate ways of overcoming these barriers.

2.6 There were practical barriers in accessing Kelly. Her phone had no voicemail facility, and her family member reported that she often ran out of credit on her phone making it impossible for her to make phone calls. We also know that Paul was in the property with Kelly in breach of the Prevention Order, and his presence may also have prevented her from answering her phone. A Panel member also advised that some service users do not like to answer phone calls from 'withheld' numbers which are often used by services. These situations provide a significant barrier when service's systems of operating are reliant on a set number of attempts at telephone contact and then closing the case when this is not successful. The system does not take into account these difficulties. There needs to be more flexibility in services' procedures in recognition of the barriers identified in this Review especially where domestic abuse brings added risk and vulnerability.

[7] London Metropolitan & Middlesex University (November 2013) *Evaluation of the Pilot of Domestic Violence Prevention Orders*, Research Report 76, Home Office

2.7 Whilst recognising that there needs to be a degree of motivation to change and engage with services, there is a tendency for too much onus to be put on the patient or service user to take responsibility for this. When an individual is suffering from a depressive illness the effort to respond to letters, phone calls and to find the means to travel to appointments can seem too much. The Review has heard that patients referred to mental health services now have one phone call and if this is missed then a letter is sent giving 7 days to respond after which the case is passed back to the referrer for further risk assessment.

Victim as Both Victim and Perpetrator

2.8 Judging a victim who is also a perpetrator of violence is not always straightforward and care is needed to assess underlying factors. Kelly's troubled teenage years appear to have set her on a life course different from her family members. It led her into a peer group seen as 'the wrong crowd' and into a relationship which was abusive as well as inconsistent in the degree of loyalty shown to her. Whilst she appeared to settle and have steady employment for a number of years the move to the small community in which she lived seems to have changed her life in a negative way; she left her job due to transport difficulties which in turn left her short of money and lacking structure to her day. She and her partner also socialised with a group of people who were engaged in drinking and the use of illicit substances which exacerbated her problems.

2.9 Although Kelly admitted to using various substances for many years previously the Police callouts to incidents involving alcohol in particular appeared to be increasing. This was a problem for Kelly as she herself admitted that she became angry and aggressive when she was drunk and on some of the Police callouts she was the aggressor. It is hard to judge from the facts known whether Kelly's drinking was in response to the abuse she was experiencing, especially the psychological and verbal abuse, but alcohol and drugs are frequently used to self-medicate to block out thoughts and to cope with feelings arising from abuse. So although at times the violence in the relationship seemed to be mutual, in the context of domestic abuse Kelly's violence appears to have arisen from her alcohol use when she felt less inhibited and less aware of the risks attached to her actions.

2.10 It is noteworthy that at the time of the last assault involving Police intervention in January 2015 Kelly was not intoxicated and she had appeared genuinely frightened by the assault she had sustained. She told a Police officer that the relationship would end by Paul killing her or her killing him, and that she wished she had stabbed him so that "*at least it would be over*". These comments give a strong sense that she had been worn down over time by the relationship and her depression was increasing. Recognising the victim underneath the aggression is sometimes difficult, but Kelly had complex needs for care and safety which required a multi-agency approach which she may have been finding difficult to navigate.

Early Intervention

2.11 Looking back to her teenage years and into her 20's could more have been done to address the damage of her chaotic and risky lifestyle? The Review has not researched the interventions by agencies at that time; however, it is known from Kelly's comments that she found an anger management course useful in her 20's. She clearly recognised she had difficulties in her personal life and her behaviour at that point. What was behind her anger we do not know, but early psychological and therapeutic interventions may have been helpful at that stage of her life.

3 Conclusions:

3. 1 From the information known to agencies, particularly from the beginning of contact with Kelly in January 2015, her death was indeed unexpected and was therefore not considered predictable. She herself told Police officers and health professionals that month that she did not feel suicidal even though her anxiety and depression scores appear to be high from the assessments used. Key health professionals such as her GP, nurse practitioners, and IAPT did not know she was considered a high risk domestic abuse victim, had they done so the urgency of referral and speed with which she was seen might have been different.

3. 2 Sadly, Kelly died unexpectedly just as she appeared to begin seeking help for some of her problems. There is no definitive evidence to support an hypothesis that faster access to mental health support may have prevented her actions. Therefore it is speculation as to whether face to face contact with a mental health professional soon after the initial phone call might have made a difference instead of having to wait for a telephone assessment in a month's time. However, something clearly changed for Kelly which drove her to take the action she did, but as she left no note what that was we do not know.

3. 3 Kelly's family members do feel that her experiences within her relationship with Paul had an effect on her. Her father's statement for the Coroner stated that he believed Paul's behaviour contributed significantly to her decision to end her own life.

3. 4 The Police acted as fast as they could on receiving the call from Kelly in February 2015, but were unable to save her. The Review is unable to find with any certainty that her death was preventable.

4 Recommendations

The following recommendations arise from agency's IMRs and from the lessons learnt from this Overview Report. A SMART action plan containing the recommendations and the method of their implementation has been developed.

National:

1) The Home Office Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Section 2 subsection 4 should be amended to specifically include GP practices as having a duty to participate in a Domestic Homicide Review and to have regard to any guidance issued by the Secretary of State

2) A clause should be added to the NHS GP contract to stipulate their active participation in Domestic Homicide Reviews and Safeguarding Adult Reviews

3) That Intercollegiate Guidance for adult safeguarding which informs national training should include specific focus on domestic abuse including the Home Office definition of domestic abuse[8], recognition of risk, and a process to escalate those risks and concerns.

[8] https://www.gov.uk/government/news/new-definition-of-domestic-violence

County:

4) The MARAC process should be reviewed to ensure that information concerning risk relevant to the service user is passed safely and promptly to any services to which they have been referred, as well as their GP practice.

5) A multi-agency protocol should be put in place to set out a process for sharing information with partner agencies when a Domestic Violence Prevention Notice or Prevention Order is being considered and/or put in place to support effective implementation and monitoring of the Order.

6) Mental ill health, depression or anxiety presentations to GPs, other health and social care practitioners and wider partners should ensure that the known links between these conditions and domestic abuse are recognised and that:

- assessments include sensitive routine enquiry about domestic abuse
- appropriate action is taken if abuse is identified

7) The Domestic Abuse & Sexual Violence Board to form a working and consultation group to examine the most practical and effective method of supporting GPs and their clinical staff to:

- implement a system of identification and risk assessment for patients who disclose, or who may be experiencing domestic abuse
- ensure a process for referring to specialist support and safety planning
- explore feasibility of providing in-house counselling services

8) Learning from this Review should be disseminated and generate a review of service delivery to those with the coexisting issues of domestic abuse, mental ill-health, and/or substance misuse, and be informed by service users themselves.

The aims of this review should include:

- coordinating service provision to improve access and engagement
- ways and means of maintaining active engagement of the service user through the most appropriate agency and means of contact
- developing a clear policy for how to deal with non-attendance or failed contact, with a process for escalation where this gives cause for concern
- consideration of referral to Adult Safeguarding.

(The review may wish to consider the whole system and holistic approach advocated by Alcohol Concern's Blue Light Project

9) The Norfolk & Suffolk Foundation Trust to ensure that the Safeguarding Team have access to all patient record systems to effectively identify when a patient has been referred to any branch of their service and to MARAC, and to alert the service of the MARAC referral and outcome quickly to ensure appropriate and timely services to high risk victims of domestic abuse

10) The Trust should work together with CCGs to review the referral timescale choices to provide appropriate and timely options for referrers and their patients and to ensure that this is communicated to front line practices.