Executive Summary

A Domestic Homicide Review

concerning the death of Val (pseudonym)

(March 2023)

Author: Mrs Jackie Dadd

Date completed: March 2024

Family Tribute

From the day Val was born he was the light that glowed, very playful like laughing, parties.

He loved being a father and being with his children every moment and family friends was a big part of his life; he enjoyed every moment.

Val worked hard and played hard. He enjoyed life. So now you're gone, that star shines bright every night and you're always here with us, you're never alone. We all love you and miss you.

Mum

Val was born and instantly I had a best friend to get into mischief with, as thick as thieves. He would always be up for a laugh and have an epic sense of humour, 'the life and soul of the party' everyone would say.

Becoming a Dad made Val, he adored those little children and put every minute he could into being with them.

His heart was made up of gold and he was very forgiving and very trusting, but this was who he was, this made Val.

He loved family events, any excuse for a BBQ, that was our lad!

He was and still is an amazing soul and a massive part of our everyday routine, we talk about you daily, we will always do this.

We love you so much, you will forever be here with us brother.

Val's two children will live on as his legacy and are living memory of how amazing his life was and will be celebrated through those two beautiful children.

Your Sister

The Domestic Homicide Review Panel and the members of the Norfolk Community Safety Partnership would like to offer their sincere condolences to the family of Val, who have lost their loved one in tragic circumstances, and which has caused this Review to take place. They have been left with a huge gap in their lives.

Contents

1. The Review Process

1.1 This review is into the death of Val, a 27-year-old male, who was found deceased at his home address in Norfolk during March 2023. The Police have investigated the circumstances and submitted a report to the Coroner with a finding that the death was non-suspicious, indicative of suicide by hanging. The Coroner's inquest has been opened and adjourned awaiting the completion of this review.

1.2 A standard post-mortem took place. The result of that post-mortem examination was: -

1a) Hanging

1.3 The Police made a referral to Norfolk Community Safety Partnership on 20 March 2023 due to a number of previous incidents and recordings of domestic abuse previously of which Val was recorded as both the victim and at times, the perpetrator.

1.4 Following a meeting held on 12 April 2023 with representatives from local authorities and voluntary sector, a decision was made by Norfolk Community Safety Partnership to undertake a Domestic Homicide Review as it was agreed that the definition in Section 9 of the Domestic Violence Crime and Victims Act (2004) had been met. The Home Office were notified a month later.

1.5 The following pseudonyms have been in used in this review to protect their identities and those of their family members:

Val - Deceased, who was a 27-year-old, white British male at the time of his death.

Kim –Ex-Partner of Val. White British female aged 26 years old at the time of his death.

Ashley – Eldest child of Val and Kim.

Sam – Youngest child of Val and Kim.

Maureen – Sister of Val. Now has Parental Responsibility for Ashley and Sam.

Address – Name of location provided as Norfolk

1.6 Maureen was contacted at various times during the review by the author to provide updates having initially been sent a letter from Norfolk CSP. The intervals and method of contact were chosen by her and agreed. On all occasions, the author outlined the benefits of AAFDA support, but these were declined, as was the opportunity to attend a panel meeting.

1.7 Maureen and Val's mother both received copies of the report prior to submission to the Home Office and following the author meeting with them and slight changes being made for accuracy, they were both content with the report and felt it portrayed Val's struggles and humanised him.

1.8 IMRs were requested from the agencies who had come into direct contact with Val or Kim or held significant information. Selected agencies were asked to submit a Summary Report to reflect the Terms of Reference and provide context to prevalent areas including

age, children, suicide and male victims. This was to assist in analysing the depth of knowledge and support already in existence and being required in these areas in the Norfolk community.

2. Review Panel Members

2.1 The following individuals and agencies/organisations/voluntary bodies have contributed to the Domestic Homicide Review panel:

Name	Area of Responsibility	Organisation
Gavin Thompson	Director – Police, Commissioning and Communication	Norfolk OPCC overseeing Norfolk CSP
Mark Whitmore	Assistant Director Health wellbeing and Public Protection	Borough Council of King's Lynn and West Norfolk
John Mosedale	Complex Review Manager	Norfolk Adult Social Care
Matthew Armitage	Deputy Service Manager/Designated Safeguarding Lead	Norfolk Change Grow Live (CGL)
Rachel Bell	Detective Chief Inspector	Norfolk Constabulary
Christine Hodby	Associate Director for Patient Safety & Safeguarding	Norfolk and Suffolk NHS Foundation Trust (NSFT)
Mark Brooks	Chairman	ManKind Initiative
Sharon Rowe	Deputy Designated Professional for Safeguarding Adults	NHS Norfolk and Waveney Integrated Care Board (ICB)
Vickie Crompton	Domestic Abuse and Sexual Violence Partnership Manager	Cambridgeshire County Council
Carol Manning	Head of Service for Children with disabilities	Norfolk Children's Social Care
Charlotte Richardson	NIDAS Service Manager	Norfolk Integrated Domestic Abuse Services (NIDAS)
Lesley Rich	Senior Health IDVA	Cambridgeshire IDVA Service and MARAC

2.2 Each Panel Member is independent of any involvement in the case including management or supervisory responsibility for the practitioners involved.

2.3 A total of three panel meetings have been held during this review, excluding the initial meeting to decide on the commissioning.

3. Contributors to the Review

3.1 The following agencies have contributed to the review: Each of the agency authors is independent of any involvement in the case including management or supervisory responsibility for the practitioners involved.

Agency	Contribution
King's Lynn and West Norfolk Housing	IMR, Panel Member
Cambridge MARAC and IDVA service	Panel Member and Summary Report
Norfolk and Suffolk NHS Foundation Trust (NSFT)	IMR, Panel Member
Change Grow Live – CGL Norfolk	IMR, Panel Member
Norfolk Adult Social Care	Panel Member
ManKind Initiative	Summary Report, Panel Member
Norfolk Police	IMR, Panel Member
Pandora	Summary Report and Panel Member
Cambridgeshire Police	IMR
Hertfordshire Police	IMR
Cambridgeshire and Peterborough Domestic Abuse and Sexual Violence Partnership	Panel Member, Summary Report
Norfolk Community Safety Partnership (CSP)	Oversight and Panel Member
Norfolk Integrated Domestic Abuse Service (NIDAS)	Summary Report, Panel Member
Norfolk and Waveney Integrated Care Board (ICB)	Panel Member
Norfolk Children's Social Care	IMR, Panel Member
Norfolk hospitals	Scoping, Chronology
Cambridgeshire Children's Social Care	IMR
Cambridgeshire and Peterborough Foundation Trust (CPFT)	IMR

4. Author of the Overview Report and Chair

4.1 The Chair of the Review Panel and author of this report is Mrs Jackie Dadd, an independent consultant who is also independent of the organisation and agencies contributing to this report. She has no knowledge or association with any of the subjects in this report prior to the commissioning of this review. She is a retired Detective Chief Inspector with Bedfordshire Police with vast experience of safeguarding and domestic abuse related issues and has been involved in the DARDR process since its inception in 2011. She has completed the Home Office online training, the Continuous Professional Development accredited AAFDA DARDR Chair training and is a member of the AAFDA DARDR network, regularly attending the monthly forums for CPD and discussion. Mrs Dadd has completed a large number of DARDRs and has several published reports.

5. Terms of Reference

5.1 The Terms of Reference were discussed and agreed upon during the first Panel meeting on 13 April 2022.

5.2 It was agreed that the main areas of focus and discussion would be based on the following:

1) Domestic abuse (DA) in any form had been the causation or a contributory factor to Val taking his own life.
2) The effectiveness of communication between agencies to ensure safeguarding is fully informed, particularly when there is the moving of a victim or perpetrator cross border.
3) The effectiveness of agencies responses to support children who are victims of domestic abuse with multi-complex needs within the family home.
4) The effectiveness of the response of agencies to relationships with bidirectional violence within Cambridgeshire and Norfolk areas.
5) Services and agencies provisions to suicide, mental health difficulties and those contemplating taking their own life within the Cambridgeshire and Norfolk areas

5.3 It was agreed that the scoping would be from January 2019 which was the year of birth of Sam and initially, there had been an assumption that Val and Kim had lived in Hertfordshire at that time, so scoping was sought from agencies within Hertfordshire, Cambridgeshire and Norfolk. The scoping ascertained that there was no relevant information or records of them within Hertfordshire and they had only stayed in the area momentarily.

The full Terms of Reference are below:

1. To review the involvement of each individual agency, statutory and non-statutory, with Val and Kim during the relevant period of time 1 January 2019 to 8 March 2023. To summarise agency involvement prior to 1 January 2019 if relevant to review.

2. To establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims and highlight good practice.
3. This is to be reviewed as a suicide based on the investigation by appropriate authorities. The purpose is to establish if DA was a contributory factor in the death of Val.
4. When a victim or family subject to DA move cross-border, how effective are the agencies with communication and transfer of information to the new area? What are the perceived barriers?
5. Establish the response to Val's Mental Health and establish:
   - Was it appropriate and risk assessed holistically?
   - Was DA considered by the professionals and spoken about with Val with subsequent appropriate referrals made?
   - What sharing information processes and referrals are in place when multiple complex needs are identified and did these occur in Val's case?
6. How do agencies take account of the voice of the child?
7. What support mechanisms are available to children who are victims of DA including those that have been removed from their parent/s? Have these been available to the two children of Val?
8. What specialist support is provided for those taking on a parental role when a child has been removed due to DA within the home?
9. Identify the processes and risk assessing that Housing associations and Local authorities have available in relation to domestic abuse victims and perpetrators and whether they are effective in these circumstances. To include Homelessness considerations, good practice and barriers.
10. Establish accessibility of services for those contemplating suicide and whether training for professionals has been received in relation to the effects DA and multiple attempts may have towards this.
11. How effective are agencies within Norfolk on a collaborative approach to supporting those who are vulnerable and require safeguarding, particularly with multi-complex needs including:
    - Fostering relationships.
    - Utilising existing multi-agency meetings for planning.
    - Improving communication between agencies.
12. Establish what processes are in place to record appropriately, decision make and provide support when it may be unclear who the victim and the perpetrator are within the relationship.
13. What provisions are available for male victims in Cambridgeshire and Norfolk and were these considered for Val?
14. Establish the sufficiency, availability and level of domestic abuse provision in Norfolk and the interoperability across county borders.
    - Identify any recommendations for practice or policy in relation to their agency.
    - Consider issues of agency activity in other areas and review the impact in this specific case.

6. Summary Chronology

6.1 Val met Kim at a rave in 2013 when he was 17 years old, and she was 16 years old. It was this same year that Val first came to the attention of the Police and Social Services for what are deemed to be minor offences. It was also the same year that the police received a call stating that Val had attended the local hospital in Norfolk stating that he had consumed 16 Paracetamol tablets, but he left prior to seeing a Doctor.

6.2 Val and Kim went on to have an on/off relationship for several years where bidirectional violence was present with both parties being recorded as the victim and the perpetrator on different occasions.

6.3 Norfolk Police first attended incidents of domestic abuse between Val and Kim in 2015, the same year that their first child, Ashley was born. It was also the year that the first bidirectional violence was recorded and an incident where Val held a knife to his own throat in a police officer's presence and stated he wanted to end his life.

6.4 Five incidents of domestic abuse were attended by Police between 2015 and 2018 of which three were recorded as 'verbal only' with both Val and Kim recorded as involved parties and no arrests made. Ashley was present during these incidents. Val and Kim moved house on more than one occasion over these years, eventually moving from Norfolk to Cambridgeshire in 2018.

6.5 It was in 2018 that Val made a complaint of assault against Kim who also assaulted the arresting Police Officer for which she was convicted of both offences. Sam was born the following year when Val was 23 years old. His family think that his mental health 'dipped' that year and Maureen stated how Kim had drunk alcohol and taken weed and cocaine throughout her pregnancy, and she had spoken to her about it.

6.6 Cambridgeshire Police first attended a domestic incident between Val and Kim in 2020. The call to the Police was made by Val who sounded frantic and smashing of items could be heard in the background. This was recorded as a verbal only domestic on Police attendance and Val left to go to his mother's. The children had been present, and the house smelt of cannabis. Referrals were made but no action taken by any agencies in response.

6.7 Between the period 13 December 2020 and 16 October 2022, Cambridgeshire Constabulary's databases showed:

- Athena - 26 and 24 investigations recorded against Val and Kim respectively.
- Storm - 14 x DA related separate incidents, necessitating a police response, safeguarding and protective measures being implemented, monitored, and reviewed.
- Safeguarding – 21 referrals relating to Val, Kim, and their children

6.8 In March 2022, Val received a conditional caution following a domestic dispute in which he had caused damage under the influence of alcohol which necessitated a referral to Change Grow Live (CGL). Kim did not wish to pursue a complaint. The children were present. This was

the third time in the last eight months that the couple had separated, then reconciled and resumed their relationship.

6.9 In June 2022**,** Val was detained under s136 Mental Health Act 1983 having been pulled down from a bridge by the police where he was drinking vodka after Kim and Maureen had raised concerns. Val had not been medicated or diagnosed with any mental health illness at that time. The Police would be called to two further similar incident for Val that year, but he would always blame it on the alcohol.

6.10 The following months saw a catalogue of incidents in which Kim fled to a refuge with the children but returned within a week having called Val to collect them. A s.47 enquiry progressed to an ICP following Cambridgeshire Children's Social Care (CSC) receiving a phone call outlining concerns for the children from Kim's sister. Both Val and Kim were arrested on separate occasions following incidents between them and the police being called with Val being referred to Change Grow Live (CGL) to support him with his alcohol intake and Kim having to attend an online Female Perpetrator domestic abuse course following a Conditional Caution.

6.11 Kim had moved to Norfolk with the children and following an incident at her sister's house where she was drunk, the children were voluntarily removed to live with Maureen. Later, a Review Child Protection Conference would change the category of significant from neglect to emotional abuse.

6.12 Val had contact with both Cambridgeshire and Norfolk Police on five separate occasions in total during November 2022, all of which included either him or Kim consuming alcohol. On two of these occasions, Val reported being assaulted by Kim and provided a statement on two occasions with no further action being taken. Val had now moved to Norfolk. They were not living together. Val had openly stated to Police, mental health professionals and CGL that he was struggling due to the break-up of his relationship and his children being taken into care.

6.13 Val continued to have suicidal ideations and made several attempts on his life over the next few months. He had contact with CGL and was referred to the Community health team for a full mental health assessment.

6.14 In the early hours of one morning in March 2023, Val text his sister, Maureen with a video playing sad music with a knife in the shot which at times he was waving around and then put to his throat. He also sent messages to Kim with photos and videos of a black cable and a kitchen knife with messages to the effect of 'I am going to hang myself' and 'Good-Bye.' This was not the first time that Val had done this.

6.15 The Police forced entry to the address and found Val sat directly opposite the front door with a wooden television unit upside down laying on his leg. He had a black cable around his neck and was cold to touch. The cable had been tied to the inside of the door handle and looped over the top of the door.

6.16 A file was submitted to the coroner stating that the death was considered to be non-suspicious and was treated as a sudden and unexplained adult death, indicative of a suicide by hanging.

7. Key Issues arising from the Review

7.1 The communication of organisations both internally and externally when a victim/perpetrator moves to another area

7.1.1 The movement of both Kim and Val between different counties highlighted issues of communication between organisations both internally and collaboratively.

7.1.2 A MARAC to MARAC was made from Cambridgeshire to Norfolk when Kim moved with the children but due to differing criteria, no action was taken which will have impeded the dissemination of information to the Norfolk organisations.

7.1.3 CGL Cambridgeshire worked with Val and made practical attempts to assist him with housing and registering with a GP. Val's contact was sporadic and when Norfolk received a referral from the local hospital, there was a delay of months for the transfer of Val's information being sent and a Norfolk support worker speaking with him. This was partly due to Val not attending arranged meetings, but he was also still communicating with Cambridge CGL which must have caused confusion. It was also stated that GPDR was the reason although CGL is the same company.

7.1.4 Communication between commissioned and non-commissioned support workers was identified as an issue when there was a failure to notify and practically assist her with contacting another support provision such as NIDAS when Pandora had a four-month waiting list leaving her with no support.

7.2 The Practical side of 'Voice of the Child'

7.2.1 All organisations are aware of the importance of 'Voice of the Child' and receive training in this area, but this review has identified that in practical terms, the children are not always spoken to, and their voices are not heard. Also, the processes are not always as expeditious as they should be.

7.2.2 Cambridgeshire Children's Services received 21 referrals from the Police between the period 13 December 2020 and 16 October 2022 due to attending domestic incidents involving Kim and Val where the children were present, yet proceedings for a s.47 enquiry did not begin until they received a phone call from Kim's sister expressing concern. This caused a significant period of time that the children were exposed to additional trauma and witnessing incidents that could have potentially been avoided. Ashley's voice was provided during an ICPC and was noted in the minutes.

7.2.3 On police attendance at these incidents, the children were rarely spoken to or checked upon by the officers attending and when spoken to, Ashley said they were alright which was a mirror of the question they had asked her.

8. Conclusions

8.1 NSFT professionals state that Val is likely to have experienced multiple layers of oppression. During his contact with NSFT he faced several life changes which included separation, his children being removed from his care and placed with a family member, job loss, financial difficulties and homelessness which exacerbated his alcohol and drug use.

8.2 This identifies a person with multi-complex issues that requires specialist support in a number of areas and added to that complexity was the move in locality of where Val lived, requiring the transference of information between counties. This is the situation that requires a multi-agency holistic approach with good communication between all to ensure that one area does not overshadow another.

8.3 This review identifies aspects of good practice with working together in examples of the Cambridgeshire CGL communicating with Children's Services and at times, the mental health worker but the review highlights examples of when this communication and transition could have been more efficient in order to enhance the support that Val received.

8.4 Incidents of mental health struggles and domestic abuse incidents were treated in isolation and were therefore not seen to require a holistic approach across stakeholders. One barrier to this was the fact that the domestic abuse risk assessments following incidents between Kim and Val were not assessed as high, even with professional judgement, escalation and accumulation and this prevented referral to MARAC.

8.5 NSFT have completed a thematic review into five cases including the circumstances surrounding Val. Out of seven recommendations, five of them directly correlate with discussions of the panel. The panel is satisfied that the actions are 'SMARTER' and although overseen by the Trust, they will frequently update the CSP of progression for further scrutiny. Due to this, the panel will not duplicate the recommendations as emulating from the DHR.

8.6 The transference of Val and his information cross border had many barriers which include different computer systems, different working practices and different processes. Good practice was identified in the efforts of both the CPFT support worker and the Cambridgeshire CGL worker doing all they could to ensure the transfer of information was not missed, not only for their own organisations but in others as well. However, there was a significant delay in the case transference by CGL which has been stated was due to consent and GPDR issues which has been questioned by this panel as they are the same company. There was also an issue where Cambridgeshire made a MARAC-to-MARAC referral to Norfolk who, due to the fact it had been received as risk assessed as medium, did not act upon it due to differences in processes for acceptance. This early identification and multi-agency knowledge of the relationship may have assisted in the responses to the many incidents of differing kinds that were then dealt with.

8.7 All agencies are aware of the importance of the Voice of the Child and the effect that domestic abuse may have on them. The response to this area on the whole has been good but the review has identified aspects that can be enhanced/improved. The Police from both areas submitted relevant referrals after each incident which was good practice, but it was

clear in this review that the children had not been seen on every occasion when an incident had been attended and they were present. Cambridgeshire Children's Services did not act upon these referrals or the accumulative aspect of them for some time until information was received from other sources, causing a delay and potentially exposing the children to further risk that could have been prevented.

8.8 This panel recognises the good work that the Cambridgeshire Children's Services then took to safeguard the children and ensure they were placed in a safe environment and loving home. Any incidents of DA that are notified to Children's Services will always consider the children as victims and the Social Work teams will link with commissioned DA services (if they need advice) or NIDAS directly, to seek support for the children. It is felt that Cambridgeshire Children Services should have informed Norfolk Children Services of the placement of the children in their area to immediately offer local support but understand that this happens frequently across the country and may seem unmanageable to make it an overarching process.

8.9 The panel considered the efficiency of support agencies within Norfolk working together in order to support and safeguard those suffering from domestic abuse and ascertained that the commissioning aspect of services may be a barrier to them all working together for those who are not commissioned as part of the wider NIDAS support group.

8.10 Val clearly loved Kim in some form even though he was abused by her and admitted that he did not like being alone. He was part of a bidirectional abuse relationship that had been on/off for nine years. His mental health state was clearly affected by events that happened in his life as the Police and mental health services dealt with incidents pertaining to this which often followed either a domestic incident with Kim or a significant event in the children's proceedings.

8.11 Val was very open with professionals that these were the key issues in his life and was not afraid to contact the Police if he had been assaulted. He was also open to referrals to other professionals although he did not always engage, which showed that he was aware of the support available to him. However, these referrals did not include provisions for support with domestic abuse which do not appear to have been considered by multiple organisations. It cannot be concluded that this was due to Val being male, but can be commented that Kim, with lesser allegations was afforded those services.

8.12 Val had lived in an abusive relationship for nine years in which a number of abusive incidents and/or mental health episodes with high risk to himself had coincided with the consuming of alcohol (which he stated numerous times that Kim had made him) and at times, the taking of illegal drugs. The review found that Val had suffered domestic abuse from Kim over a number of years in the form emotional abuse, physical violence and controlling and coercive behaviour. No evidence of economic abuse was found, even though he was in debt.

8.13 His suicidal tendencies which had been present since he was 17 years old, came to the fore once he realised that he would not get custody of his children back (caused by the history of DA) and that his relationship with Kim was over.

8.14 These events clearly contributed towards his state of mind and the panel have concluded that the history of domestic abuse in his relationship with Kim and the consequences that resulted from this will have played a significant part in him taking his own life.

9. Lessons to be Learnt

9.1 Wider considerations from the Police when dealing with domestic abuse

9.1.1 The Norfolk Constabulary could consider a holistic approach when completing secondary safeguarding risk assessments. This would acknowledge the cumulative impact caused by the frequency of domestic abuse occurrences, rather than simply assessing the risk presented in the individual incident.

9.1.2 This holistic assessment may have raised the risk level to high, where additional safeguarding opportunities including Multi-Agency options would be available to access.

9.1.3 In addition, the constabulary could consider how to maximise and promote Evidence Led Prosecutions, particularly in domestic abuse investigations. This is an ongoing challenge, and one which will be considered during future training.

9.1.4 Responding to those in mental health crisis is a challenge for the organisation. This review identified two occasions where Adult Protection Investigations should have been created on Athena and Adult Risk assessments completed. This is an example where best practice was not followed.

9.1.5 Finally, the use of DVPNs and DVPOs could be an area for improvement. These are currently generally only considered in those high-risk cases but perhaps the scope for use in situations where there is frequency rather than gravity of occurrences should be considered. (**Recommendations refer**)

9.2 NSFT transference of those presenting on multiple occasions to secondary care

9.2.1 Val's case has been included in the Thematic Review of Repeat Presentations the terms of reference are outlined below.

9.2.2 The purpose of this Thematic Review is to identify trends between cases that were selected at the Clinical Decision Panel [CDP]. In each case it was noted that the service user had presented on multiple occasions to Trust services and had not been transferred to secondary care.

9.2.3 Each of the cases had contact with one or more of the services below:

- 111 Mental Health Option service.
- Liaison and Diversion.
- Mental Health Liaison Service.

9.2.4 The review has been commissioned in response to concerns that mental health, physical health, drug and alcohol support and safeguarding concerns were not being identified and appropriately actioned. The review will explore the pathways around these service lines to map routes for referral, to ensure they meet NICE and other national guidance, and to explore the differences in service provision across both Norfolk and Suffolk.

9.2.5 At the time of writing this review is currently awaiting publication approval from the Clinical Decision Panel before the learning can be shared across the wider Trust. (**Recommendation refers**)

9.3 Overshadowing

9.3.1 This review highlights how substance and alcohol misuse issues can overshadow the level of an individual's mental wellbeing needs. Clear direction is required around the assessment and support of an individual's Mental wellbeing alongside their alcohol and substance misuse. There is a need for robust joint working to bring together separate care plans with a clear safety plan to manage the risks.

9.3.2 Therefore, a review of the joint policy with substance misuse services Co-Morbidity (Co-occurring Mental Health and Alcohol/Drug use Conditions) in Norfolk may be beneficial. This policy is currently planned to be reviewed in December 2024. The learning from this review may indicate an earlier review and refresh of this would be required.

9.3.3 All frontline Practitioners undertake Suicide Prevention training; this is provided as an e-learning course. NSFT are currently undertaking a review of their internal Suicide Prevention training offer for staff as part of the review and refresh of the Trust's Suicide Prevention Strategy.

9.3.4 NSFT's Clinical Risk policy is undergoing a review and additional work to improve assessing and managing risk operationally. All of this work has oversight and being brought together within a Trust Clinical Safety Strategy workstream. This work is part of the NSFT internal strategic safety pillar work. (**Recommendation refers**)

10. Recommendations

National

1. **CGL to review the effectiveness of communication and transfer of information between Counties when vulnerable service users are transient and to escalate inter-service communication issues to service managers and above.**

   This will ensure that CGL communicate across Counties with information that will assist in risk-assessing new clients and provide them with sufficient background information to provide the most appropriate support. It will also ensure escalation of matters are timely and overseen.

Local

2. **Norfolk Constabulary to review the current DVPO/N process to ensure it includes:**
   - **The recording of rationale and decision making for consideration of DVPN/O on all reports of DA.**
   - **DVPN/Os to be considered in all cases of DA and not just limited to high risk.**
   - **DVPN/Os to be utilised more frequently as a safeguarding tool in DA, particularly where bidirectional violence has been identified.**

   This is an area that has been identified by both Police areas as not always being considered as a safeguarding tool with no rationale recorded as to why this may be the case. This impedes any review as to whether or not there is the required understanding of the process and application of it.

3. **Norfolk Constabulary should encourage and promote the consideration of Evidence Led Prosecutions.**
   This will assist with those cases that have bi-directional violence and/or non supporting victims as the evidence alone will be relied on to bring a prosecution and assist with the safeguarding of all parties involved.

4. **Norfolk Constabulary to refresh and promote the use of Adult Protection Investigations.**
   This will improve the response to those struggling with their mental health. They should be implemented for incidents where there is an immediate risk to life or a risk of serious harm. An Adult Protection Investigation with the adult risk assessment should be completed and add an additional layer of scrutiny and support.

5. **Norfolk Constabulary should consider a holistic approach and apply professional judgement to assess risk when completing the domestic abuse secondary risk assessments.**
   In addition to the skilled professionals who work in the Domestic Abuse Safeguarding Team, this will provide a wider opportunity to consider the cumulative impact which could increase the risk level.

6. **NSFT to implement a process that ensures that if any patient is presented to them by the Police, that they gain any available history of Police contact that is available and also make checks with the crisis team and mental health team records so that a holistic assessment can be made taking into account all relevant history.**

This will prevent the patient providing an explanation to deflect from any suicidal ideations such as in this case with alcohol and only being treated for physical injuries and will provide sufficient information from more than one source to enable judgement on whether a mental health assessment should take place.

7. **Cambridgeshire Children's Services to raise awareness of the benefits of showing professional curiosity in relation to domestic abuse and suicidal ideations including males within relationship and family settings by**
   - **Review of learning and development offer on DA for CS.**
   - **Review docs to support info and learning on suicide risk and prevention on the CS 'portal'.**
   - **Workshops on professional curiosity across service.**

   This may provide earlier identification, support and collaborative approach to each of these areas and assist with prevention rather than reaction. This must be fully inclusive so that it also emphasises males. This will also enable the DHR findings to be included alongside other ongoing pieces of work.

8. **All Norfolk Council's housing departments to revise their communication methods to:**

- **Include Domestic Abuse information when issuing advice letters in all cases, not just where DA is identified as a factor.**
- **Improve maintaining contact with applicants who disengage at an early stage.**
- **Ascertain most appropriate method of contact for those who are making homeless applications**

This will ensure all receive domestic abuse advice in case they have not disclosed it but may need support, negate letters being sent to family members and the applicant not necessarily receiving the information and ensure that prolonged attempts to engage with applicants are made to become more informed as to why they may have disengaged in order to offer support if required.

9. **CPFT and NSFT (mental health services) to implement additional training and reflective supervision sessions across the Trust with a focus on DA awareness and professional curiosity.**
   This is to improve referrals to the health IDVA located at the hospital, increase awareness of staff to open conversations for disclosure of DA and to correctly signpost victims (including males) for specialist support.

10. **Norfolk MARAC to review referral process to ensure its effectiveness in identifying cases that may not reach high risk on a question set but have escalated in risk due to the number of incidents that have occurred.**
    This will ensure that the holistic approach of the history of the relationship is taken into account when deciding on a multi-agency approach and that when a case is transferred, the risk is re-assessed based on all information.

11. **CGL Norfolk to ensure that discussing and exploring the perpetration and risk of domestic abuse is included in the high-risk service user's category in the safeguarding team meetings and daily MDT agendas.**
    This is to ensure that domestic abuse is not overshadowed by their purpose of treating alcohol and drug abuse and that referrals are appropriately made for specialist support when it is disclosed or identified.
12. **Commissioners of community based domestic abuse support to review the referral processes within the County between commissioned and non-commissioned service providers to identify any specific barriers that impede them from working collaboratively for the purpose of safeguarding.**
    This will be to ascertain and amend any processes or issues that are identified to enable all domestic abuse provisions and service providers within Norfolk to work together in their common purpose whether they are a commissioned service or not. It will not determine who should be commissioned.

13. **All organisations on this DHR panel to review their publicity, awareness of professionals and propensity to refer in relation to male victims of DA (including those in bidirectional relationships) and ensure that any policies already implemented are being executed by practitioners.**
    This will provide oversight on all organisations from this panel for awareness and referral to male provisions and identification of male victims.

14. **A working party to examine the communications for those with suicidal ideations seeking assistance to assist them to navigate the most appropriate support by making it person centric.**
    A review into the material and delivery of this will provide an enhanced response to all individuals, assisting them identifying their own needs and will be unified communications from all organisations to prevent confusion or mixed messaging.