CONFIDENTIAL and RESTRICTED

Overview Report

A Domestic Homicide Review (DHR) concerning the death of Val (pseudonym)

(March 2023)

Author: Mrs Jackie Dadd

Date: 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 his 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.

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Preface

The key purpose of any Domestic Homicide Review (DHR) is to examine agency responses and support given to a victim of domestic abuse prior to their death and to enable lessons to be learnt where there may be links with domestic abuse. For these lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. The victim's death in this case met the criteria for conducting a Domestic Homicide Review according to Statutory Guidance 1 under Section 9 (3)(1) of the Domestic Violence, Crime and Victims Act 2004. The Act states that there should be a "review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

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

The Domestic Abuse Act 2021 and the Home Office defines Domestic Abuse as:

Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if—

(a) A and B are each aged 16 or over and are personally connected to each other, and

(b) the behaviour is abusive.

Behaviour is "abusive" if it consists of any of the following—

(a) Physical or sexual abuse

(b) Violent or threatening behaviour

(c) Controlling or coercive behaviour

(d) Economic abuse

(e) Psychological, emotional, or other abuse

and it does not matter whether the behaviour consists of a single incident or a course of conduct.

"Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to—

(a) Acquire, use, or maintain money or other property, or

(b) Obtain goods or services.

For the purposes of this, Act A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child).

Controlling behaviour is:

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

Coercive behaviour is:

An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim The term domestic abuse will be used throughout this review as it reflects the range of behaviours encapsulated within the above definition and avoids the inclination to view domestic abuse in terms of physical assault only.

Recommendations will be made at the end of this report, however, there has been an ongoing action plan introduced by the Panel, parallel to this review to ensure that the areas that can be immediately addressed have not incurred unnecessary delay.

A glossary can be found in Appendix B at the end of this report to assist with acronyms utilised throughout.

Glossary

AAFDA: Advocacy After Fatal Domestic Abuse

ASC: Adult Social Care

BWV: Body Worn Video

CPD: Continuous Professional Development

CPS: Crown Prosecution Service

CSP: Community Safety Partnership

CPFT: Cambridge and Peterborough NHS Foundation Trust

DA: Domestic Abuse

DASH: Domestic Abuse Stalking and Harassment risk assessment

DASV: Domestic Abuse and Sexual Violence partnership

DHR: Domestic Homicide Review

GP: General Practitioner

ICB: Integrated Care Board

ICPC: Initial Child Protection Conference

ICT: Intermediate Care Team

IDVA: Independent Domestic Violence Advisor

IMR: Individual Management Review

MARAC: Multi Agency Risk Assessment Conference

MASH: Multi-Agency Safeguarding Hub

MHO: Mental Health Officer

NSFT: Norfolk and Suffolk Foundation Trust

RCPC: Review Child Protection Conference

SAR: Safeguarding Adult Review

Section 1 - Introduction

1.1 The Commissioning of the Review

1.1.1 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 was opened and adjourned awaiting the completion of this review. This was subsequently held in August 2024.

1.1.2 The Police made a referral to Norfolk Community Safety Partnership in 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.

1.1.3 Following a meeting held on 12th April 2023 with representatives from local authorities and the 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.

1.1.4 Contributors to the Review

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

1.1.5 Review Panel

The following agencies/organisations/voluntary bodies have contributed to the Domestic Homicide Review by the provision of reports, chronology, and discussion. Individual Management Reviews (IMRs) have been requested and supplied:

1.1.6

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

1.1.7 All members of the Panel and authors of the IMRs have complete independence from any subject in this review. The Review Chair and Panel gave due consideration for the content of the DHR and it was agreed that reports, chronologies, IMRs and other supplementary details would form the basis of the information provided for the overview. Thanks go to all who have assisted and contributed to this review with their valued time and cooperation.

1.1.8 Author of the Overview Report

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.

1.2 Purpose of the Review

1.2.1 The purposes of a DHR are to:

a) 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.

b) 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.

c) Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

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

e) Contribute to a better understanding of the nature of domestic violence and abuse; and

f) Highlight good practice.

1.2.2 DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for Coroners and criminal courts, respectively, to determine as appropriate. DHRs are not specifically part of any disciplinary inquiry or process. Part of the rationale for the review is to ensure that agencies are responding appropriately to victims of domestic abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and domestic abuse. The review also assesses whether agencies have sufficient and effective procedures and protocols in place which were understood and adhered to by their staff.

1.2.3 The death of Val has been submitted to the Coroner as suspected suicide by hanging. This review will ascertain whether domestic abuse could have been the cause or a contributory factor to this. It is not to apportion blame, but to view the circumstances through the eyes of Val.

1.3 Timescales

1.3.1 Norfolk Police made a referral for consideration of a DHR to Norfolk CSP on 20 March 2023 due to the history of domestic abuse incidents held on their records.

1.3.2 On 12 April 2023 Norfolk CSP in accordance with the December 2016 Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews commissioned this Domestic Homicide Review. The Home Office were notified of the decision in writing on 5 May 2023.

1.3.3 Mrs Jackie Dadd was commissioned to provide an independent Chair and author for this DHR on 16 June 2023. Three separate panel meetings then took place. The completed report was handed to the Norfolk Community Safety Partnership on the 21st of March 2024.

1.3.4 Table outlining timeline of the review:

March 2023	Val was found deceased
20/03/23	Norfolk Police send a referral to Norfolk CSP for DHR decision
12/04/23	Decision to commission a DHR made by Norfolk CSP
05/05/23	Norfolk CSP notify the Home Office
16/06/23	Mrs Jackie Dadd commissioned as Author and Chair
21/07/23	First panel meeting
18/10/23	Second panel meeting
26/01/24	Third panel meeting
21/03/24	Completed report handed to Norfolk CSP by Author

1.3.5 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. There was an initial delay whilst Norfolk CSP identified a Chair and Author and a further delay awaiting the first panel meeting due to availability of agencies.

1.4 Confidentiality

This report has been treated as Official sensitive and dissemination kept to those outlined at 1.9.

The pseudonyms used in this report were chosen by Val's sister to protect the identity of those referred to throughout the report. Full details are found at 1.6 of this report.

The CSP and Author have ensured that the collation of information and the information contained within this report complies with the Data Protection Act 2018 and the General Data Protection Regulation (GDPR).

1.5 Terms of Reference

1.5.1 The Full Terms of Reference can be found in Appendix A at the conclusion of this report. The Terms of Reference were discussed and agreed upon during the first panel meeting on 13 April 2022.

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

a) Domestic abuse (DA) in any form had been the causation or a contributory factor to Val taking his own life.
b) 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.
c) The effectiveness of agencies responses to support children who are victims of domestic abuse with multi-complex needs within the family home.
d) The effectiveness of the response of agencies to relationships with bi-directional violence within Cambridgeshire and Norfolk areas.
e) Services and agencies provisions to suicide, mental health difficulties and those contemplating taking their own life within the Cambridgeshire and Norfolk areas.

1.5.3 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.

1.6 Subjects of the Review/Family and Friends' Perspective

1.6.1 In accordance with Home Office guidelines to ensure confidentiality, pseudonyms have been utilised throughout this report for the following:

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

Kim – Estranged partner of Val and mother to his two children. A white British female aged 26 years old at the time of Val's death.

Ashley – Eldest child of Val and Kim, aged 8 years old.

Sam – Youngest child of Val and Kim, aged 3 years old.

Maureen – Sister of Val with Parental responsibility for Ashley and Sam

Addresses – Areas referred to as Norfolk and Cambridgeshire

1.6.2 The family of Val, represented by his sister, Maureen and his mother, wished to be fully engaged with the review and the author would like to express their gratitude for the significant contribution and assistance provided throughout. The family pseudonyms used in this report were chosen by them and 'Kim' was chosen at random by the author after consultation with the family for confidentiality purposes.

1.6.3 Maureen and Val's mother were sent letters by Norfolk CSP informing them of the review along with details of AAFDA for support and advocacy. The author communicated with them via Teams and through email with Maureen, as was their preference throughout the review. The intervals of contact were chosen by them 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.

1.6.4 As the person with Parental Responsibility for Ashley and Sam, Maureen gave permission for their information and records to be disclosed by all agencies for the purpose of the review.

1.6.5 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.

1.6.6 Numerous attempts to locate Kim through several agencies in Norfolk were unsuccessful. It is believed that she is sofa-surfing in the area. Therefore, the author has been unable to contact her and obtain her views for the purpose of this review.

1.7 Parallel Reviews

Coronial Process

1.7.1 The Coronial process has now taken place.

1.7.2 Val's death was reported to the Coroner by the Police and a file was opened. The report submitted stated that the death was considered to be non-suspicious and was treated as a sudden and unexplained adult death, indicative of suicide by hanging.

1.7.3 A post-mortem was subsequently held.

1.7.4 The result of that post-mortem examination was that in the opinion of the Consultant Histopathologist, the cause of death was:

1a) Hanging.

1.7.5 The post-mortem showed no anatomical cause of death. A ligature mark was noted around the neck and in conjunction with the history that had been provided was taken into consideration. Toxicology analysis showed that the combination of recreational cocaine and alcohol will increase risk taking behaviour (Both found). No anti-depressants or anti psychotics were detected.

1.7.6 The Coroner's inquest, held in August 2024 recorded the medical cause of death as hanging with the conclusion to his death being that Val died, having applied a ligature to his own neck, his intentions when doing so being unknown.

1.7.7 This case was considered and reviewed within the Norfolk Constabulary Professional Standards Department, to see whether it met the criteria requiring a referral to the IOPC

(Independent Office for Police Conduct) due to a death following recent Police contact. The conclusion of this was that the criteria was not met, and no referral was submitted.

NSFT Thematic Review

1.7.8 A Thematic review of 'Repeat Presentations' to NSFT Services has been undertaken. The case of Val is one of five cases being reviewed as part of an internal Patient Safety Thematic Review.

1.7.9 The purpose of the Thematic review is to explore and understand why repeat presentations to primary care mental health services has been a theme in NSFT patient safety incidents that have been reviewed by the Trust Clinical Decision Panel [CDP].

1.7.10 The purpose of this specific review is to understand the systems, policies and processes that influence repeat presentations of patients in primary care mental health services where these individuals do not then progress to accessing any secondary mental health services and explore to learn and improve service provision for these patients.

Incidental findings:

1.7.11 Service users report being confused by the names of different services.

There were operational differences between the two 111 MHO (Mental Health Officer) services leading to the service being inequitable across the two counties:

• This can result in one team having to close and re-direct calls to the other team to respond to required patient need.
• The Clinical supervision offer was different within adjacent services. In one service group sessions were arranged outside of working hours, paid as over time, which extended the working day impacting adversely on staff's attendance.
• Not all teams use team email inboxes to manage their communications, with the risk that information could be missed.

1.7.12 Joint working with third party providers (DAS – Domestic Abuse Service) is hindered by the use of different Electronic Patient Record (EPRs). There were differences in service funding between the commissioning bodies (ICBs) resulting in front line services having different resources and delivery approaches.

1.7.13 The terminology used by different services across the patient pathway, to describe different forms of patient review (such as triage; assessment; screening) was inconsistent and often misunderstood.

1.7.14 Several recommendations were made from this review, some with direct correlation to this review. These included:

- Training for assessing clinicians - to ensure correct and consistent application of MCA (Mental Capacity Act) in the assessment of service users who are presenting intoxicated.

- The review evidenced a need for training in formulation, to promote understanding of systemic factors that shape a person's crisis and the factors that could impact on their recovery – To deliver formulation training. Clinical Risk should also be formulated and recorded. Extended periods of assessment should also be considered, in cases where service users are repeatedly presenting. This would provide opportunity to complete a formulation, risk assessment and ensure that the service users are engaged with the correct agencies.
- To put in place a system that identifies when a service user has presented multiple times to different services, to take advantage of the opportunity that this presents to work with the service user and other services to formulate effective care and safety planning. To identify best practice to support the needs of frequent attenders. Consideration to be given to MDT frequent attender meeting to be convened to a) identify attendance and b) formulate most appropriate support / outreach for them according to their need and their expressed wish.
- The review evidenced that for some of the service users included within this review, there appeared to be an underlying assumption that their substance mis use needed to be addressed before addressing the underlying triggers for it. This thematic review highlights the need to provide clarity regarding the secondary care offer for service users with co morbidity drug and alcohol use - To take action to ensure that the sources of support / referral threshold and process of referring is well understood across NSFT services.
- Requirement for improved evidence that family engagement / external sources of personal support are discussed with the service user. Trust to confirm response to this recommendation / recognising current and planned work.

1.8 Equality and Diversity

1.8.1 The review gave due consideration to each of the protected characteristics under Section 149 of the Equality Act 2010. The relevant legislation that provided the context for the panel was The Disability Act 2016 and The Equality Act 2010.

1.8.2 Throughout this review process the Panel has considered the issues of equality in particular the nine protective characteristics under the Equality Act 2010. These are:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership (in employment only)
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

1.8.3 It was considered that Val's sex was relevant to the review as it took into consideration the support provisions within the areas available to him as a male and the fact that although,

at times, when the Police attended for incidents between him and Kim, it was often Kim who was drunk and aggressive towards the Police, yet he would be the one to leave the location to prevent a breach of the peace, leaving the children in the care of the female. He would allege assaults frequently but have no injuries and therefore, the panel have considered whether true consideration was given during these investigations or progressed sufficiently due to his sex.

1.8.4 Disability is relevant to this review due to the fact that, despite having no diagnosed mental disorder, Val was experiencing mental health challenges which manifested through suicidal ideations, alcohol abuse and drug abuse. These could be seen as coping mechanisms of the current stresses he was facing, including the financial debts he owed.

1.8.5 Val's age of 27 years at the time of his death is relevant for the panel to ascertain whether it was recognised that a person of his young age in an abusive relationship, with two young children and mental health difficulties should require additional support and be assessed holistically taking historical factors into account rather than relying on his account of the reasons behind events on that single occasion.

1.8.6 The National Confidential Enquiry into Suicide and Safety in Mental Health Annual Report 2023 outline several key themes which may reduce the safety of individuals.

1.8.7 The report identified risk factors that increased the suicide risk of men of a similar age to Val. Over a third (36%) reported a problem with alcohol misuse; 31% reported illicit drug use. Overall, 57% were experiencing economic problems – finances, or accommodation – at the time of death.

1.8.8 Almost all (91%) of the men had been in contact with at least one frontline service or agency, most often primary care services (82%). Half had been in contact with mental health services, 30% with the justice system. 44% of men who died by suicide had previously self-harmed, 7% in the week prior to death.

1.8.9 These statistics are all seen as relevant to the life and experience of Val.

1.8.10 Equality is about ensuring everybody has an equal opportunity and not discriminated against because of their characteristics. **Diversity** is about taking account of the differences between people and groups of people and placing a positive value on those differences.

1.9 Dissemination

Recipients who received copies of this report prior to publication:

Panel Members (listed in 1.1) and CPFT IMR author.

Maureen and Val's mother

Norfolk Coroner

Relevant Norfolk CSP stakeholders

Domestic Abuse Commissioner

1.10 Contextual Background

1.10.1 In Norfolk, the Community Safety Partnership is embedded and managed by the Office of the Police and Crime Commissioner (OPCCN), supporting and working directly with the Chair of the NCSP. The OPCCN play a critical role in the work of the NCSP. Meetings of the NCSP are chaired by the OPCCN's Chief Executive.

1.10.2 Norfolk has a population of 916,120 of which 449,251 are males. [1] Around 90 people die by suicide in Norfolk every year. Three in four suicides are men. 52% overall had seen primary care for their mental health and of those who were referred to the services, 30% refused or failed to engage.[2]

1.10.3 This report will refer to Situational Couple Violence (SCV) also known as Situationally Provoked Violence. This is violence that occurs where the couple has conflict which turns into arguments that can escalate into emotional and possibly physical violence. SCV often involves both partners.[3]

1.10.4 It will also refer to bidirectional violence. The term has been generated to capture relationships in which both parties use violence and/or abuse behaviours towards one another.[4] ManKind Initiative have provided data on bidirectional Intimate Partner Violence (IPV) from various sources of research finding that:

"the current consensus that bidirectional IPV is the most common pattern among couples" [5]

Mutual aggression was found in more than 50% of the couples.

1.10.5 While this result suggests the existence of a victim-offender overlap, it may also hide an upwards victimisation scores bias: when participants are aggressive toward their partners, they may bias their victimisation scores upwards to justify their levels of aggression ('I was aggressive because I felt victimised')[6]

1.10.6 Of the totals of 6507 deaths recorded as suicide in the UK in 2018, three quarters of these were men.[7]

1.10.7 The Vulnerability Knowledge and Practice Programme (VKPP) research into Domestic Homicides and Suspected Victim Suicides during the Covid-19 Pandemic 2020-2021 reported that the most common cause of suicide was by hanging at 46%.

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[1] ONS survey data 2021
[2] Infographic produced by Insight & Analytics -July 2022. Data taken from '2022 Norfolk Suicide Audit
[3] ref: johnson A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and ... - Michael P. Johnson - Google Books)

[4] New Dawn Aurora by Shonagh Dillan 31/01/18
[5] Low et al., 2021 – presentation on Bi-directional violence by Nicola Graham-Kevan – supplied by ManKind Initiative for this review
[6] Herrero et al., 2020 - presentation on Bi-directional violence by Nicola Graham-Kevan – supplied by ManKind Initiative for this review

[7]ONS, Suicides in the UK, 2018 registrations

1.10.8 A new Government Suicide Prevention Strategy was launched in September 2023 and for the first time, stated that DA was a risk factor for suicide:

https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028

Section 2 – The Facts

2.1 Background Information

2.1.1 The following information has either been taken from information provided in IMRs or from Maureen and Val's mother. Comments and observations from them are in their own words for authenticity and sentiment. Due to the transient nature of Val and Kim and the frequency of the on-off relationship, some of the dates within the chronology may not be exact.

2.1.2 Val's mother explains how she was three months pregnant when she first found out she was expecting Val. Her and her husband already had two sons and a daughter and in her own words, she explained how Val was not planned and that her husband did not want her to have the baby. She insisted on having him and this eventually led to the breakup of her marriage after Val was born.

2.1.3 Val would spend the weekends with his dad but would go on to have an on/off relationship with him throughout his life. His sister, Maureen tells how he was a happy and adventurous child with no cares. He was very hands on when he was involved with something and liked gardening. When he was about 15 years old, Val went off to work on the Helter Skelter with a fun fair. He would ring frequently as they were a close family and always had a strong hard work ethic which remained with him through the years. Having lost his best friend who died in a car crash a year later, he always stated that he wanted to 'live life to the full.'

2.1.4 In 2013, when Val was 17 years old, he was at a rave when he met Kim, who was 16 years old at the time. Both had been raised in the Norfolk area. Val was a scaffolder and Kim worked in a burger van. The family were accepting of her and they moved in with Val's mum so that they could all live together.

2.1.5 It was during this same year that Val first came to the attention of the Police along with Children's Services. He was investigated for three separate offences of which no further action was taken on two of them and he admitted the other. The Police received a call from an unknown person stating that Val had taken an overdose and attended the Queen Elizabeth Hospital in King's Lynn but left prior to seeing a Doctor. Whilst there, Val had stated that he had consumed 16 Paracetamol and just wanted to be left alone.

2.1.6 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. Val was not under any mental health services or receiving support from any other agency at this time.

2.1.7 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 as they had moved into a maisonette near Val's family. The Police completed Child risk assessments on each occasion. They then moved into a house and Val's sister states that whilst living there, they had trouble with drug dealers and Val's dad had to help him out with money. Val was always in employment and worked hard to earn money for his family.

2.1.8 In May 2018, Val reported an assault to Norfolk Police by Kim who assaulted the officer on arrest. Val stated he was living in Lincoln at the time and did not make a statement. However, Kim was later convicted of both offences.

2.1.9 During the same year, Val and Kim moved to Cambridgeshire. Val's mother thinks that this was because Kim wanted him all to herself and away from the family. His sister Maureen recalls how she started receiving regular calls from Val stating that he had been locked out of the house and that Kim was drunk. He would send pictures of bruising, cuts and bleeding that he said that she had caused.

2.1.10 His family knew that his mental health had 'dipped' during this time and he had a very supportive boss which helped. Sam was born in 2019 when Val was 23 years old. Maureen states that Kim had drunk alcohol and taken weed and cocaine throughout her pregnancy and found it hard to cope when she was born. Maureen had been pregnant at the same time and had spoken to her about it. The Health Visitor had problems in trying to get an appointment with Kim and Ashley due to them transferring counties and it was known that Ashley already had speech problems at this time.

2.1.11 When Sam was two months old, she allegedly broke her collar bone although GP notes state it was a minor shoulder injury. The hospital was informed by Val and Kim that she had been holding her and dropped her. Kim's sister later informed Childrens Services that Val had pushed Kim down the stairs whilst she was holding Sam and this was what caused her to be dropped. Val's family state that Kim was drunk on gin and fell down the stairs with Sam in her arms and that Val was at work when this happened. No action by any agency appears to have been taken in relation to this at the time.

2.1.12 According to their records, 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.

2.1.13 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.

2.1.14 CPFT first became aware of Val in February 2022 following a referral in relation to the children (not Val) to Cambridgeshire Children's Services. The MASH concluded the referral required no further action because there was parental consent for support services for the children and did not meet the threshold for escalation. In March, 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.

2.1.15 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. He blamed the alcohol and was released after assessment as he had stated he needed to get to his grandad's funeral that same day. Prior to this admission, Val had not been medicated or diagnosed with any mental health illness at that time.

2.1.16 Later that month, a multi-agency strategy discussion took place in relation to the children due to poor attendance at school, the couples lack of engagement and the number of Domestic Abuse notifications received. Kim had fled with the children to a Safer Places Refuge but informed Val of its location and having been visited by him numerous times, she left the location four days later and returned home with him stating that her family had forced her to make up lies and embellish incidents.

2.1.17 During this time, Social Services had received a call from Kim's sister raising concerns over the safety of the children and the process progressed to an Initial Child Protection Conference.

2.1.18 Kim was arrested in July 2022 for being drunk in charge of her children following an incident in public in which Val had to contact the Police. She received a conditional caution which included her obtaining assistance for her alcohol dependence from 'Bright Tomorrow' and completing an online Female Perpetrator domestic abuse course.

2.1.19 Further domestic incidents continued between Val and Kim and in the August, the children were put on a Child Protection Plan for neglect and following an incident at Kim's sister's house where Kim was drunk and argued with her sister, the children were removed voluntarily and went to stay with Maureen and her partner in Norfolk. It is believed that Kim was now staying in Norfolk and Val was living in a caravan in Cambridgeshire. A MARAC-to-MARAC transfer was made from Cambridgeshire to Norfolk.

2.1.20 Following an arrest for common assault in Norfolk in July 2022, both Norfolk and Cambridgeshire Liaison and Diversion (LaDS) Mental Health Custody Services attempted to make contact with Val throughout August to offer support, but no contact was successful until mid-August.

2.1.21 During September, Val spoke to a CPFT LaDS support worker and disclosed he was suffering from stress from his relationship break-up, mentioning domestic abuse. He was in debt and wanted to live nearer to his sister who was in Norfolk. Referrals and assistance were

offered for all aspects apart from the domestic abuse. The referral to Change Grow Live (CGL) saw him start receiving support for his alcohol and drugs that same month.

2.1.22 In October 2022, with the children settled at Maureen's, Ashley began to receive support from 'Wishes and Feelings' who were part of the Health visiting team. The Public Law Outline was commenced for them to live permanently with Maureen as their legal guardian. A Review Child Protection Conference took place which Val attended but Kim did not. The category of significant harm was changed from neglect to emotional abuse.

2.1.23 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 outlining their on/off relationship over nine years. Kim was arrested and no further action taken on both occasions. Kim reported an argument between them in Norfolk in which she did not support any Police action. The Police took him to a friend's house as the Police were aware he had posted on Facebook that 'he is done with everything and hopes his little children will always love him.'

2.1.24 On the other two occasions, Val was seen by the Police due to concern over his mental health. He disclosed he had thoughts of jumping off a bridge having been arrested for being drunk and disorderly in the middle of the night in which having been seen by a healthcare professional, he was released from custody with a conditional caution in which he had to speak with CGL Norfolk. Later in the month, he was again found drunk in the street in the middle of the night and the Police took him to the local hospital voluntarily for a mental health assessment as he had contacted a health representative. He left prior to being seen.

2.1.25 Val was now living in Norfolk. During that month, he 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.

2.1.26 Over the course of the next couple of months, there were a further four assaults attended by the Police between Val and Kim and three separate contacts with Val over his mental health and suicidal ideations during which he admitted to making several attempts on his life recently. Mid-January, Val was admitted to the Accident and Emergency Department (A & E) after Maureen had called an ambulance as he had admitted to intentionally overdosing with alcohol. Val told Practitioners that at times he struggled with living alone. At times like this he played "depressing" music and drank alcohol which he was aware is a depressant. He was deemed to have full mental capacity with no acute risks identified and was discharged.

2.1.27 Val's mental health deteriorated during February 2023 with him self-harming early in the month and declining treatment. Mid-February, Val contacted his brother telling him that he was at home attempting to take his life and that he was going to drive to the Lake District to forget about everything and make peace. His brother called the crisis team who, when they could not contact him, informed the Police. He was taken to A & E at the local hospital and assessed by the Mental Health Liaison Service and was then referred to the Community Health Team for full assessment. CGL attempted to contact him on a number of occasions through the month unsuccessfully.

2.1.28 At the end of February, Val contacted the NHS111 service to say 'Good-Bye'. He sounded distressed and his father was contacted to go and be with him. The following evening, Val sent his father a text message stating, 'I'm going to end it all.' Val was on a three-month waiting list for a mental health assessment with a private nurse (It cannot be confirmed if this was private health care or if a referral had been made or by whom). When found, he alluded to an attempt suicide near a river whilst intoxicated and had mud on his boots to substantiate it. Later that day, he reported to the Police that Kim was at his address refusing to leave. No offences were disclosed.

2.1.29 In March 2023, a Review Child Protection Conference was held in which neither Kim or Val attended in which the children were delisted from the Child Protection plan and made subject to a Child in Need (CiN) plan as they were still staying with Maureen.

2.2 Circumstances of the Death of Val

2.2.1 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.

2.2.2 First thing in the morning, Maureen went to Val's home address to check on him but the door was not answered when she knocked. She called the Police and informed them of what had happened overnight and her concerns. They attended and could hear music still playing inside the address and Val's phone ringing from inside when Maureen called it.

2.2.3 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.

2.2.4 Ambulance staff attended and did not attempt to perform CPR. They declared time of death as 10.17 hrs that day. Following a Police investigation, 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.

2.3 Individual Management Reviews (IMRs) inc: Good Practice

Cambridgeshire and Peterborough Foundation Trust (CPFT)

2.3.1 CPFT provide a number of services within Cambridgeshire which include:

CPFT Liaison and Diversion Service (LaDS) - The Liaison and Diversion Service consists of a multi-disciplinary team of mental health nurses, social workers general nurses and support workers. Support Workers/Support Time Recovery Workers are trained mental health workers who do not hold a professional registration. LaDS practitioners work within the

Criminal Justice Pathway supporting people in custody, courts and the community with a wide range of vulnerabilities by diverting them away from prison and signposting to other services where there are no public protection issues.

Support can include the following:

- Vulnerability assessment in custody or place of individuals choosing.
- Bespoke court reports if required highlighting vulnerabilities and support required to attend court.
- Primary mental health treatment requirements for women
- Signposting and referrals to other longer-term services.
- Support to attend initial appointments.
- Liaising with other services such as GP, housing, drug and alcohol services, probation
- Supporting those aged 10 years old and upwards with any vulnerability
- Person centred support plans, with short term support with named support worker.

2.3.2 CPFT S136 Suite - The 136 Health Based Place of Safety is a purpose-built facility in a Cambridgeshire hospital site. It has nursing and overnight facilities for people who are detained by the Police subject to Section 136 of the Mental Health Act (83). It provides a 'place of safety' whilst potential mental health needs are assessed, and any necessary arrangements made for on-going care. This unit is designed for one occupant for a maximum 24-hour period.

2.3.3 Change Grow Live (CGL) - CGL is a specialist drug and alcohol support and treatment service, providing recovery coordinators who will advise on the treatment options available. In addition, CGL also provides support and advice to carers and loved ones.

Chronology

2.3.4 01/02/22 - This is the first record of contact with the family for CPFT during the scoping period. Shared health records show a referral was made to the Cambridgeshire Children's Services (CCS) in relation to the children and in which the MASH concluded the referral required no further action because there was parental consent for support services for the children and did not meet the threshold for escalation.

2.3.5 14/06/22 - Maureen and Kim reported concerns for Val of his intention to harm himself or end his life, to the Police who detained him under s136 Mental Health Act (MHA) and an ambulance transported him to the Psychiatric hospital s136 suite following the Police pulling him down from a bridge. On realising that he would be staying in the suite until later in the day it was recorded that he "begged" the Police officers to lift the detention, stating that he wanted to attend his grandad's funeral at 10.00 am the same day. He blamed his behaviour

on alcohol. Val remained at the hospital overnight, having been explained to him that the Police could not lift the detention and he could only be discharged by a Doctor following assessment. He was assessed in the morning.

2.3.6 The outcome of the assessment was that Val was not suffering from a mental disorder therefore he could be discharged with immediate effect. He did not require a referral to secondary mental health services. The advice from the Approved Mental Health Professional:

- "should Val wish to rekindle the relationship, to seek relationship counselling…
- Avoid excessive alcohol, providing the rationale of the link between alcohol and low mood."

2.3.7 Val was discharged and provided with a taxi in time for him to attend his Grandfather's post funeral family gathering.

2.3.8 03/07/22 - Following Val being arrested and detained in Norfolk, there was a plan for NSFT LaDS to refer to CPFT LaDS to request support for the following:

1) Assistance with determining what his current debts are and look 'at resolving this'
2) Support him 'in terminating' his relationship with his partner while maintaining contact with the children

2.3.9 During this triage, Val told the Norfolk LaDS practitioner that his partner gave him the address of the refuge she was staying in and he visited her there on more than one occasion. Following the referral, CPFT LaDS could not make contact with Val and a message was left on his phone. Later in the month, CPFT were made aware of a S47 strategy meeting[8] and outcome.

2.3.10 August 2022 - Attempts to contact Val were continued through the month with missed calls from both parties and an appointment face-to-face was eventually arranged for the beginning of the following month with the CPFT LaDS practitioner.

2.3.11 September 2022 – During his consultation, Val admitted he was suffering from stress since the break-up of his relationship but stated his alcohol intake was under control and he had been free from cocaine and cannabis for four weeks. He agreed to referrals to CGL/Aspire and insight at MIND and was also interested in Talking Therapies.

Val was renting a caravan at a cost of £650 a month and disclosed debt of around £10,000 but wanted to get this under control. He agreed for the support worker to make housing enquiries for him to be nearer his sister and was provided details of the Citizen Advice Bureau and to consider a Debt Relief Order (DRO).

[8] Children Act 1989 S.47 - https://www.legislation.gov.uk/ukpga/1989/41/section/47

2.3.12 Val was not registered with a GP but was offered support to help him register which was accepted.

2.3.13 Domestic abuse was mentioned in the assessment in the context of the relationship break up and the care of the children, now placed with his sister under section 20, but no specific details are recorded. Val mentioned domestic abuse but no professional curiosity was recorded about his experiences as a victim and no consent obtained or rationale recorded for referring/not referring him to the to the Health IDVA service. All the referrals were undertaken with his consent.

2.3.14 The CPFT LaDS support worker liaised with Cambridgeshire Children's Social Care (CSC), shared information and was invited and attended the next Child Protection Conference. Val had been signposted to appropriate services and was discharged from CPFT LaDS.

2.3.15 October 2022 - CPFT LaDS received information from Norfolk NSFT in regard to Val being arrested near a railway line and CGL were contacted for information. They had assessed him that month following numerous missed appointments. Children's Services had made a referral to the mental health Adult Locality Team as they were concerned about his suicidal ideation.

2.3.16 He informed his CPFT LaDS worker near the end of the month that he was sofa surfing in Norfolk and due to start a new job. He provided consent to find out the situation with his children as he was not sure but felt he would never get them back due to all the arguments. Efforts to try and register him with a GP were made on his behalf but unable to due to lack of information for process. An offer was made to attend the GP surgery with him for him to show his identification.

2.3.17 November 2022 - The Cambridgeshire CPFT LaDS worker managed to make contact with Val who had recently jumped off a bridge and broke his ankle in Norfolk and informed him that Norfolk NSFT LaDS were trying to contact him. The process of transferring him was ongoing and the worker ensured that Cambridgeshire CGL also transferred him to Norfolk CGL. He was discharged from Cambridgeshire CPFT LaDS once Norfolk CPFT LaDS had contacted him and accepted him.

Terms of Reference Response Summary

2.3.18 CPFT Health Visitors (HV), and School Nurses (SN) all complete domestic abuse awareness training so they have knowledge and skills in identifying signs of DA in parents and children and providing initial support to victims and children when undertaking their routine roles and contacts. Routine contacts vary depending on the child's age and circumstance.

2.3.19 The HV wrote to Kim in regard to Ashley, offering a transfer-in visit in February 2019 following the family moving into the CPFT area of Cambridgeshire. When the HV arrived, there was no reply. The HV attempted contact by phone but was unsuccessful on all three occasions. The general rule is to offer two assessment appointments, however, as the family

had not been seen by CPFT since they moved into the area an additional appointment was offered. The HV demonstrated good practice through repeated attempts to contact Kim by phone and letter. Again, when HV attended there was no answer, and no access. Ashley would have been aged 4 years.

2.3.20 Ashley was known to CPFT Speech and Language Team (SALT) from January 2020 to May 2022.

2.3.21 The School Nurse (SN) received notification of a DASH involving Val and Kim on 24th May 2022. The SN contacted the school to offer support and share health information and ascertain if there were any concerns they could support with. The school felt that there was support in place and there were no unmet health needs, so no further action for SN was required at that time.

2.3.22 In December 2019, the Peterborough HV sent three letters in an attempt to undertake a virtual new birth visit for Sam, but these failed on all three attempts.

2.3.23 The Peterborough HV did complete a 6–8-week check in February 2020 and domestic abuse questions were asked to Kim. The clinical notes state the HV was already aware of historical DA between parents.

2.3.24 In June 2020, the HV contacted Kim and completed an additional home visit following notification that Sam has suffered a fractured clavicle after falling from the sofa. Kim discussed a history of DA between her and the children's father. However, she felt that they no longer had these issues. HV talked extensively around keeping the environment safe and ensuring the children were supervised.

2.3.25 In November 2020 Sam's one year review was completed by HV in the family home but there are no records of any DA questions being asked. The records state Val was no longer living in the family home.

2.3.26 Sam's 2.5-year review was offered but Sam was not brought for an appointment and there was no further contact with CPFT services. The HV notes show that at least one of the children (Ashley) had been directly spoken to.

2.3.27 The family moved shortly after with Kim, Ashley and Sam moving to Norfolk in August 2022.

2.3.28 CPFT support parents, carers, extended family and guardians through its children and young people mental health CAMH services. Where there is contact with adults taking on a parental role and the child has historical DA experiences, CPFT staff offer parent role guidance, emotional wellbeing advice, risk reduction planning and signposting.

Good Practice/Reflective Considerations

2.3.29 On the 14 June 2022, the 136 Suite staff were not aware of any DA experiences by Val. However, he was not asked about DA during his assessment or during his time on the suite.

Asking about DA as part of routine enquiry was not a statutory duty on health providers at that time but professional curiosity could have been used.

2.3.30 Advice regarding relationship counselling is inappropriate where DA is identified. This is stated in the CPFT DA guidance and training CPFT clinical staff will be given refresher sessions on appropriate signposting.

2.3.31 The breach of security in relation to Val being informed of the refuge location by Kim and visiting a refuge in Norfolk on 3 July 2022 does not appear to have been picked up by the Norfolk or Cambridgeshire LaDS team as a high-risk breach of security. It should have been reported to the refuge and/or the IDVA service and CSC. The CPFT LaDS manager has provided a reflective supervision session with the support worker around reporting when they are informed of a security risk at a refuge.

2.3.32 The voice and experience of the child is evident in the children's notes written by CPFT, but not within Val's CPFT mental health notes. There was no referral for the IDVA service considered.

2.3.33 Good practice was displayed in trying on multiple occasions in differing forms to contact Val when he was not engaging but there was a delay in returning his call when he did make contact, with no explanation. Also, good practice by the CPFT LaDS support worker in working across geographical borders and information sharing with Norfolk NSFT LaDS.

Norfolk and Suffolk Foundation Trust (NSFT)

2.3.34 NSFT deliver Mental Health services and the Liaison and Diversion Team (LaDS) amongst other services.

2.3.35 The Mental Health Liaison Team based in the hospital assess people where acute staff have identified potential mental health concerns in order to signpost them and refer to relevant services for further support and care on discharge from the acute hospital setting. They also risk assess and safety plan with the individual before they would be discharged.

2.3.36 When a Service User presents or seeks support from NSFT in an emergency such as attending A & E, calling the 111 Service mental health option, or being assessed in Police custody the Practitioners only have access to NSFT's electronic recording system Lorenzo and also GP Connect. It is then the decision and responsibility for the individual Practitioners to seek any further information from other Trusts if appropriate or if indeed they are aware that an individual may be known to other services in another area. Due to the pressures of emergency interventions, it may not always be possible to access information from other Trusts whilst an individual is with them and to inform how they respond during that contact. Having a GP outside of the County additionally makes it difficult for someone to access the services they need within the County they are living and Val was not often registered.

2.3.37 Val's first contact with Norfolk and Suffolk Foundation NHS Trust (NSFT) was on the 3 July 2022 whilst in Police custody. NSFT have 14 closed referrals recorded on their Electronic Patient Recording (EPR) system where he did not continue to access secondary care MH services. At the time of his first actual contact with NSFT he was living in Cambridgeshire.

2.3.38 During his contact with NSFT he was in an on/off relationship with Kim and his children were open to Children's Services and under Child Protection Plans. Children's Services removed Ashley and Sam from the care of their parents and placed them with Val's sister in August 2022.

2.3.39 Val reported that his family were supportive of him. His parents were separated, and he had a brother and a sister. At times it was challenging for him to seek support from his family because they were living in a different county to him.

2.3.40 Val took great pride in working as a tyre fitter, his role was a specialist one as he was trained to change tyres on lorries and large vehicles. He reported that his manager was supportive, and he enjoyed his job. Due to the increasing social stressors, he lost his job and then continued to engage in temporary employment for a period of time.

2.3.41 At various points during his contact with NSFT Val, was homeless, living in his car or staying with family. At the time of his death, he had secured housing in Norfolk however was struggling with living on his own after having lived as part of a busy young family.

2.3.42 Val's mental state and risk was assessed on nine separate dates between 03 July 2022 and the 18 February 2023 by NSFT Practitioners.

Chronology

2.3.43 03/07/22 - Val had been taken to King's Lynn Police Investigation Centre having been arrested following an allegation of Common Assault on Kim which was his first contact with NSFT. He was seen by the NSFT Liaison and Diversion Team (LaDS) as there was concern over his mental health that would need signposting to relevant mental health primary care or secondary care services for further assessment and interventions. Val denied any domestic abuse. He admitted that at a mental health assessment three weeks prior in Cambridgeshire, he had told them what they wanted to hear to get discharged as it was his grandfather's funeral the next day.

2.3.44 Val admitted drinking to excess at weekends and because Kim encouraged him to as she drank. Also, that he smoked cannabis every day. The discussions highlighted risks following Val having threatened to jump off a bridge 2-3 weeks previously after Kim left him, taking the children with her. At this point he had advised that he had no current thoughts to harm himself or others. His children were described by him as his protective factor. Emotional abuse from his partner was also identified as a risk from what he had said.

2.3.45 Plans and actions were made to:

- Write to his GP.
- Provide crisis information.
- Refer to services in local area to assist with debt management and with his emotionally abusive relationship.

Val stated that he was planning to stay with a friend in a caravan close to his place of work.

2.3.46 14/08/22 - Val was again seen in custody by LaDS following his arrest for controlling and coercive behaviour as Kim had alleged that he was checking her movements and

messages on her phone. There was concern about his low mood and suicidal thoughts. He was tearful throughout his assessment. The LaDS practitioner assessed that there was no evidence of acute mental health illness that required a referral to secondary mental health services and gave no reason to question his mental capacity. He provided information in relation to his children and his drugs and alcohol intake. A plan was recorded to:

- Notify his GP.
- Provide crisis information.
- Refer to Change Grow Live (CGL).
- Refer to NSFT Wellbeing services.
- Refer to homelessness services.

2.3.47 01/10/22 - Whilst in custody following a drunken argument with Kim, Val declined a discussion with LaDS stating that he felt 'alright'. A safeguarding referral was made to Cambridgeshire Social Services following his previous contact with LaDS services on 14 August 2022 however no details of the referral are recorded in his notes.

2.3.48 19/10/22 - Val contacted the 111-service mental health option. He was intoxicated and difficult to understand. He stated that he could not live without Kim and that the relationship was strained and toxic. The Crisis Care Practitioner called the Police as he disclosed that he had left his vehicle and was walking in the middle of traffic and that he would rather end his life than be picked up. Val was demonstrating at that point in time he was unable to safety plan and he was demonstrating little hope due to his being homeless, his children having been placed with his sister and because he had lost his job.

2.3.49 The Police located Val and took him to the hospital who requested that the Mental Health Liaison Team based there to assess him but he left the department before this could take place. A & E staff reported that they had notified the Police that Val had left before his mental state was assessed.

2.3.50 07/11/22 - Val again contacted 111 service mental health option. He outlined his circumstances and said that he had no reason to live and wanted to die. During the call, he was extremely distressed, left his vehicle and fell into a river. He reported that he was having thoughts to roll his car in the river, also thoughts to shoot himself in the head. The Police located him and took him to hospital where he stated that he regretted his actions and had no plans to harm himself or others. He acknowledged that jumping off the bridge was impulsive and demonstrated he was future planning as he was hoping to start a new job on the following Friday. He linked his excessive drinking to his social stressors and was given the details of CGL so he could self-refer for their support.

2.3.51 His mental state examination found there were no concerns evident. He was dressed appropriately; he engaged in the assessment with good eye contact. He made clear his mood was low due to his current situation. He did not express any thoughts to harm himself or others. There was no evidence of hallucinations or delusions. Val gave the Practitioner no reason to question his capacity. It was documented there was a risk of ending his life due to impulsive behaviour when under the influence of alcohol. A referral was made to MIND for ongoing support.

2.3.52 18/11/22 - Val was made subject to s136 MHA as he had consumed alcohol and was threatening to jump off the same bridge that he had jumped off the week previously. On arrival, he seemed settled with a reading of 30 from his alcohol breath test and was keen to be discharged to attend his grandfather's funeral. He reported having difficulties contacting his GP and the crisis team. He was seeking support and willing to engage with treatment. He denied experiencing suicidal thoughts. He was discharged.

2.3.53 14/01/23 - Val was admitted to A & E after Maureen had called an ambulance as he had admitted to intentionally overdosing with alcohol. Val told Practitioners that at times he struggled with living alone. At times like this he played "depressing" music, drank alcohol which he was aware is a depressant. Records document he had full mental capacity and no reason to question this as he was able to take part in discussions regarding future planning when he would leave hospital.

2.3.54 There were no acute risks identified at this time. Val had denied any current suicidal plan or intent to take his own life. He was discharged home with his father.

2.3.55 18/01/23 - Following an allegation by Kim that Val had snapped her key and dragged her out of the location by her legs, Val was assessed by LaDS in custody following his arrest. He stated that he was engaging with CGL. There was no evidence of acute mental illness that required secondary mental health service involvement. He had not recently seen a GP and was encouraged to register at a GP practice closer to where he was currently living.

2.3.56 A Safety Plan was agreed and put in place with Val. He was provided with Crisis contact information, a referral to Steam Café was made, and he agreed he would register at a new GP and make an appointment for a health review. The practitioner confirmed he had a CGL appointment for later that day at 6.00 pm, a referral to Julian Support was made for him and he agreed to make a dentist appointment, and a Next Steps Letter to help him remember this whole plan was given to him.

2.3.57 18/02/23 - Val's brother called the response service as he had received a call from him telling him that he was at home in his flat attempting to take his life. He had said that he was going to drive to the Lake District tomorrow to forget about everything and make peace. The Crisis Care practitioner attempted a couple of calls that went straight to voicemail.

2.3.58 Val attended A & E and was assessed by the Mental Health Liaison service. Val gave no reason to question his capacity. His mood was low due to his relationship issues and it was identified there was a risk of harm to himself when he had been drinking alcohol. Val agreed to a referral for a full mental health assessment, care and support in the community from the Community Mental Health Team.

Good Practice/Reflective Considerations

2.3.59 There were two referrals made to CGL, twice Val was advised to self-refer to CGL and on two further occasions it was recorded that he was engaging with CGL. NSFT Policies now have very clear guidance that practitioners must be referred and not expected or requested to self-refer to agencies like CGL. Audits and internal reviews evidence that referrals are taking place as standard practice across Trust Services.

2.3.60 Val was not assessed as having a significant mental health condition. The pathway for individuals who have been assessed as having a significant mental health condition is different from those assessed as having a mild to moderate mental health diagnosis. If an individual is assessed as having a significant mental health condition and significant substance abuse issue, there would be a joint assessment and an agreement on roles and responsibilities based on the severity of the mental illness resulting in regular joint case reviews and shared care plans.

2.3.61 It is recorded on five occasions that Val described his relationship as 'toxic' (03 July 2022, 01 October 2022, 19 October 2022, 14 January 2023, 18 February 2023) however practitioners may not have always been professionally curious and explored this with him. NSFT Practitioners should complete DASH and MARAC referrals as well as contributing to the MARAC process in Norfolk.

2.3.62 All frontline Practitioners undertake Suicide Prevention training, which is provided as an e-learning course. NSFT are currently undertaking a review of the Suicide Prevention training package. The Trusts Suicide Prevention Strategy is also being refreshed.

2.3.63 NSFT Practitioners have access to GP Connect where they can access patient summaries. They also write to GP's following assessments in A & E and Police Custody to inform them of the outcome and any referrals made.

Cambridgeshire and Hertfordshire Police

2.3.64 This IMR has been completed by an author from the collaborated Major Crime Unit. The purpose for the additional Police Constabularies research was that Kim and Val have lived in both Counties of Norfolk and Cambridgeshire at various stages in their relationship and that Kim had, on occasions, stayed with her sister in Hertfordshire for brief periods.

2.3.65 Both Val and Kim had been known to the Police since 2014. Between the period 2015 and 2023, numerous incidents relating to domestic abuse were reported by Val, Kim and their family members to the Police.

2.3.66 Between the period 13 December 2020 and 16 October 2022, Cambs. 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.

2.3.67 Val and Kim had been in relationship since 2014 and their DA history dates back to 2015, following Ashley's birth. Other relevant incidents that fell outside the date parameters agreed within the terms of reference, were:

- 31/10/2015 in Norfolk - Val (19yrs) assaulted Kim by pulling her hair and biting her arm. Val alleged Kim punched him in the face (no visible injuries sustained). Upon Police arrival, Val held a knife to his throat resulting in officers deploying their taser. Val was arrested for DA related Common Assault and detained, however, neither party pursued any

complaints, and no further action was taken. A DASH RA[9] was completed and graded as Standard, owing to Kim ending the relationship with Val.

- 29/05/2018 - Kim assaulted Val whilst she was intoxicated and he was driving his vehicle, causing him to stop the car and seek refuge at a petrol station. Kim received a caution for this offence (DA Battery).

2.3.68 13/12/20 - This was the earliest DA related incident reported in Cambridgeshire. The Police responded to a 999-call made by a male. The caller sounded frantic, and screaming was heard in the background. Research confirmed the mobile number was attributed to Val and the incident was correctly graded as requiring an immediate response.

2.3.69 Upon Police arrival, Kim answered the door and denied any such call had been made. However, following a discussion between the officers and Val, he became very emotional and tearful whilst Kim became very agitated and hostile towards the officers, accusing them of talking sides. Val explained that he and Kim had a verbal dispute regarding her contact with other men. He wanted to leave the property and return to his mother's address and refused to engage in the DASH RA process. The Officers attempted to establish further details from Kim, however she presented as confrontational, aggressive, and irrational. Kim stated that they had consumed large quantities of alcohol the night before, and a neighbour confirmed banging and shouting had been going on since 4.00 am. No offences were disclosed and neither made any allegations against each other, so no further Police action was taken in respect of them. Their two children were present during the altercation.

2.3.70 The property was described as, in a state of disarray with a strong smell of Cannabis noted, which Val and Kim accused each other of using. A DASH RA was completed by the officers based on their observations and findings, and separate child at risk referrals were submitted in respect of their children, for sharing with partners.

2.3.71 The referrals were submitted to MASH[10] and reviewed, resulting in a medium risk grading. The information was shared with, Probation, Childrens Services and Health. A non-crime DA record was generated, and safeguarding advice was given to Val, who left the location that afternoon to stay at his mother's address. Val was not known to Mental Health Services at that time.

2.3.72 18/03/22 - Kim called 999 stating that Val was smashing things up in her rented property. Val had left prior to Police arrival and Kim did not want to pursue a complaint and indicated it was the end of their relationship. Val was voluntary interviewed a few days later, admitted causing the damage under the influence of alcohol and showed remorse. He received a conditional caution for criminal damage with conditions which necessitated a referral to Change Grow Live (CGL) and completion of:

- A letter of apology.
- Electronic Intervention - Anger Management.
- Electronic Intervention - Domestic Violence.

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[9] Domestic Abuse, Stalking and Harassment Risk Assessment
[10] Multi-Agency Safeguarding Hub

2.3.73 Safeguarding measures were discussed with Kim and appropriate referrals made and a DA package was compiled. Despite Kim's reluctance to supply information relevant to the risk assessment process, a DASH (11 ticks) was completed and graded as medium, and MASH shared the information with relevant partners. Additionally, 'Child at risk' referrals were submitted to MASH who applied the CSC[11] Continuum of Need. This was the third time in the last eight months that the couple had separated, then reconciled and resumed their relationship.

2.3.74 Six further DA related incidents were reported to Cambridgeshire Police occurring between Val and Kim in the presence and hearing of the children. Allegations were made by Kim who refused to elaborate and engage, insinuating that family members had encouraged her to be dishonest to obtain priority housing. Kim and the children went to stay with her sister in Hertfordshire for a short while.

2.3.75 14/06/22 - Maureen reported concerns for Val's safety as he had been describing suicidal thoughts and was drinking and gone to a nearby river. CCTV saw him on a bridge and officers managed to pull him off and detained him under s136 of the Mental Health Act 1983 (MHA). Ambulance refused to take him to hospital as he had not taken an overdose or sustained injury so officers escorted him and left him in the care of mental health professionals. Prior to this admission, Val had not been medicated or diagnosed with any mental health illness at that time.

2.3.76 28/06/22 - Based on the continuing incidents of DA and the non-engagement of Kim with professionals, a strategy meeting was held regarding the safeguarding and protection of Ashley and Sam due to the risks exposed to them.

2.3.77 By **03/07/22** - 3 more DA incidents had been recorded in the last 90 days and 15 calls to service recorded within the last 18 months. (No MARAC referral was made)

2.3.78 20/07/22 - Val had agreed to meet up with Kim at a local pub with the children. Kim had been drinking for some time that day and was aggressive, knocking glasses and items to the floor. She left with the children to go to Sainsbury's to buy herself more drink and due to his concern over the children, Val followed her in his car. When she was refused at Sainsbury's, she became tearful, alleging that Val was following her. The staff called the Police and Kim was arrested for being drunk and in charge of the children, blowing 104ugs on the intoxilyser and being uncooperative. During interview, she accepted that she was alcohol dependent and was receptive to support and intervention. She received a conditional caution to complete the 'Brighter Tomorrow' program and she was required to work with CSC moving forwards and complete the online Female Perpetrator Domestic Abuse Course. Child at Risk forms were completed.

2.3.79 14/08/22 - Kim alleged controlling and coercive behaviour but later retracted the claim. Neighbours reported hearing shouting and when the police gained access to the address through the landlord, they found Val asleep downstairs and Kim asleep upstairs, who when spoken to, did not wish to pursue a complaint. Val was arrested and denied the allegations in an interview and due to lack of evidence, he was refused charge. A referral was

[11] Childrens Social Care

made to the IDVA service for Kim having completed a VRI (Visually Recorded Interview) and civil orders discussed although Kim did not wish to pursue these.

2.3.80 A MARAC referral was made from Cambridgeshire to Norfolk due to the location Val was residing at.

2.3.81 16/10/22 - This was the last recorded incident in Cambridgeshire. Val reported that Kim had thrown alcohol over him following them being out drinking for the evening and then returning to Val's caravan. Val then made further calls stating that Kim had cut her wrists in the caravan and was threatening suicide. When the Police attended, Val alleged that Kim had punched him in the face and kicked him in the leg, but he had not sustained any visible injuries.

2.3.82 The Police found Kim hiding under the caravan and arrested her. She had a graze to her forehead and replied 'no comment' to all questions during interview. Due to a lack of evidence, no further action was taken but relevant referrals made.

Risk Assessments

2.3.83 Whilst risk assessments and referrals were completed and graded appropriately, this process was compounded by the fact that both Val and Kim were categorised as victim and perpetrator at various stages. Kim was identified as a repeat victim on 21 January 2022 and 3 July 2022 and 14 August 2022, hence was entitled to an enhanced level of service under VCOP (Code of Practice for Victims), on the basis that 3 x DA incidents had been recorded within 90 days and 15 calls to service recorded, relating to both Val and Kim.

2.3.84 Kim and Val each met the criteria for victim and perpetrator; hence the DASH RA process was ineffective due to their lack of engagement and in Kim's case, concerns regarding her credibility, reliability, and veracity of events. The risk assessments were reviewed by the MASH (Multi-Agency Safeguarding Hub) and shared with partners and a number of agencies.

2.3.85 The current risk assessment process relies on officers completing the DASH documents on an individual basis, pertinent to specific incidents and dependent upon the score or number of ticks, to determine the grading. Consequently, incidents were dealt with in isolation, as opposed to an integrated approach, requiring officers/supervisors/managers, to apply their professional judgement during the RA process, and see the 'bigger picture.' This is particularly imperative in cases where:

- An extensive DA history already exists.
- Both parties have been characterised as perpetrator and victim.
- children are being exposed to DA.
- Other vulnerabilities have been identified such as mental health illnesses, drugs, alcohol, medication etc.

2.3.86 The relationship between Val and Kim was described as toxic, volatile, chaotic, and the DA was exacerbated by their dependency on drugs and alcohol. Both were known to have mental health issues, which also intensified the impact of DA on the family unit.

2.3.87 Whilst officers submitted adult at risk referrals relating to Val and his mental health, information suggests he was not open to mental health services prior to 20 June 2022, when he was detained under S136, MHA[12]. Furthermore, it is not known whether Val was afforded the CPSL[13] discharge buddy scheme, when he was discharged from hospital in June 2022, which supports individuals transition from hospital mental health wards to their home environment for up to six weeks. There is no information to confirm whether the Police were notified of Val's discharge from hospital, to enable a further risk assessment to be completed to safeguard Kim and the children.

2.3.88 In order to improve processes and services to victims, Cambridgeshire Constabulary launched Project KAIZEN in April 2022, which provides guidance and support to the workforce relating to all aspects of public protection and safeguarding. Following a previous DHR, a simple "top ten" Supervisory Safeguarding Review guidance was introduced and reiterated that safeguarding is a continuous process throughout the investigation, with a requirement to re-assess and review regularly, and specifically at salient points.

2.3.89 Of all the incidents recorded within Cambridgeshire and the reports generated on Athena, only one reference was made to DVPN (21 January 2022) and one to NCDV (14 August 2022). No rationale was recorded by officers or supervisors, pertaining to the consideration of DVPN/O's.[14]

2.3.90 Since June 2023, Cambridgeshire Police has introduced 'Prevention and Vulnerability Hubs' that consist of merged specialists from the Vulnerability Focus Desk, Out of Court Disposal team and Partnerships and Prevention team to embed preventative policing, problem solving and provide a continued focus on vulnerability across the force.

Good Practice/Reflective considerations

2.3.91 When reviewing the first response by officers to the incidents, it was identified that there were a number of actions and considerations that officers correctly and appropriately carried out including:

- Body Worn Video (BWV) was utilised and explanations obtained from both parties where practicable.
- Appropriate response to the children in the home and relevant referrals made.
- Appropriate recording of incident, circumstances and decision making.
- Collation of historic information for informed investigation.

2.3.92 The MASH/MARAC processes failed to acknowledge or take a holistic approach into consideration, given the lack of improvement in Val and Kim's conduct; the increase in DA incidents reported to Police, and the elevated the risks to the children.

[12] Mental Health Act 1983
[13] MIND Cambridge, Peterborough & South Lincs.
[14] Domestic Violence Protection Order / Domestic Violence Protection Notice

2.3.93 It is not known what if any, signposting to support agencies was offered to Val such as MIND, NCDV[15] or CALM[16] as this was not recorded.

2.3.94 Val was returning to an environment that was not conducive to his mental health and wellbeing when he was discharged from hospital, hence he presented a significant risk of harm to himself and others, given his:

- recurring suicidal ideation.
- deteriorating relationship with Kim.
- co-parenting responsibility for his two children.
- drugs and alcohol abuse.

Norfolk Police

2.3.95 The Norfolk Constabulary Domestic Abuse Force Policy document has been subject of recent review. The current version was published on 29 August 2023.

2.3.96 The overarching principle for the Norfolk constabulary mirrors that of the College of Policing's Authorised Professional Practice (APP) - every domestic abuse victim must be safer after Police contact. This links to the Norfolk Constabulary 1Chance culture and ethos.

2.3.97 The Force Policy identifies that risk assessment and safeguarding are increasingly becoming a core element of response, and everyone's business, rather than being reserved to specialists.

2.3.98 It is the responsibility of the attending officer to complete the primary risk assessment at the first opportunity, usually at the scene of the incident. The primary risk assessment should underpin the immediate safety planning and safeguarding to protect all parties involved.

2.3.99 During the period of this review, the risk assessment models used by the Constabulary switched from the Domestic Abuse Stalking and Harassment (DASH) framework to the current Domestic Abuse Risk Assessment (DARA) model. A DARA booklet is a requirement in all cases which meet the criteria of a domestic incident, regardless of whether a criminal offence is alleged. The risk assessment will be assessed as either Standard, Medium or High.

2.3.100 Safeguarding of high and medium risk domestic incidents is carried out within the Multi Agency Safeguarding Hub (MASH). Any actions taken will be documented on the relevant Athena record.

2.3.101 The investigation of domestic abuse offences will sit with the most appropriate department taking account of the circumstances, complexity, and risk of the allegation.

2.3.102 Documents reviewed include officer statements and pocket notebook entries, which are available through Athena and the Constabulary's Document Shared Storage portal. These documents have provided additional relevant information for this report.

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[15] National Centre for Domestic Violence
[16] Campaign Against Living Miserably

2.3.103 The first Police interaction with Val where suicidal ideation or mental health concerns were flagged was on 23 March 2013. Val was aged 17 years at this time and was alleged to have overdosed on Paracetamol. He had been taken Hospital but left prior to receiving treatment. A Child at Risk form (C39D) was submitted, for the awareness of Childrens Social Care.

2.3.104 Norfolk Police have been involved in domestic abuse interactions with both Val and Kim since 26 August 2015 when they were aged 19 years and 18 years respectively. Between 26 August 2015 to 29 May 2018, five Domestic abuse incidents were logged by the Norfolk Constabulary.

2.3.105 Of these five reported incidents, three were recorded as 'verbal arguments only,' with both Val and Kim recorded as involved parties. No arrests were made, or further action taken in respect of these incidents.

Chronology Summary

2.3.106 The first Police interaction with Val where suicidal ideation or mental health concerns were flagged was on 23 March 2013. He was aged 17 years at this time and was alleged to have overdosed on Paracetamol. He had been taken to the Queen Elizabeth Hospital in Norfolk but left prior to receiving treatment. A Child at Risk form (C39D) was submitted for the awareness of Childrens Social Care.

2.3.107 Norfolk Police have been involved in domestic abuse interactions with both Val and Kim since 26 August 2015 when they were aged 19 years and 18 years respectively. Between 26 August 2015 to 29 May 2018, five domestic abuse incidents were logged by the Norfolk Constabulary. Of these five reported incidents, three were recorded as 'verbal arguments only,' with both Val and Kim recorded as involved parties. No arrests were made or further action taken in respect of these incidents.

2.3.108 On 31 October 2015, the first incident of bidirectional violence and abuse is recorded. Despite making the initial call to the Police to report an assault and request assistance, Val was the first party arrested. He was seen to be pushing a knife into his throat in the officer's presence and stating he wanted to end his life. Kim was later interviewed for allegations of assault made by Val, after he claimed she had punched him to the side of his face.

2.3.109 On this occasion neither Val nor Kim supported a prosecution. The CPS made the decision to take no further action against either party. During the incident on 31 October 2015 and in subsequent interactions, Ashley (a baby at the time) was included as an involved party, who was present during some of the interactions and involvement with the Police.

2.3.110 DASH Risk assessments and Child Risk assessments were completed for the four domestic incidents that were reported between 31 October 2015 – 29 May 2018.

2.3.111 On 29th May 2018, Val called the Police to report an assault on him by Kim. He stated he was living in Lincoln at the time but had come to Norfolk to collect Kim when the assault occurred. Kim was arrested on suspicion of assault and assault on an emergency worker after she kicked, spat at and pulled an officer's hair. Val did not make a statement or support a

prosecution but charges were brought with evidence led prosecution. Two months later, Kim was convicted of both offences.

Chronology

2.3.112 16/08/22 - This is the first recorded incident of their presence in Norfolk since 2018. Police were called to the home address of Kim's sister as she alleged Kim had assaulted her whilst intoxicated. Val and both children aged seven and two years at the time were present. Child Protection Notification forms were submitted with Kim recorded as the suspect and Val an involved party.

2.3.113 The complaint was not supported and was recorded to that effect in the officer's pocket notebook. Val, Kim and the children left the location.

2.3.114 22/09/22 - Norfolk Police were informed of a MARAC-to-MARAC referral from Cambridgeshire which related to Kim re-locating due to experiencing domestic abuse from Val. As part of the process, Kim was contacted by the Police for secondary safeguarding. Kim stated that she was living and working in Norfolk, that her children were staying with Maureen in the same town and that she had limited contact with Val. Their relationship was over and he did not know where she was staying. Kim was engaging with CGL and accepted a referral to NIDAS as her focus was proving to Social Services that she was stable and fit to have her children back.

2.3.115 01/10/22 - Val was arrested for being drunk and disorderly in the middle of the night and whilst swearing at officers, he disclosed he was suffering from depression and anxiety and had tried to harm himself 2-3 months prior when he had thoughts of jumping off a bridge. He was seen by a Health Care Professional before he was released and received a conditional caution to attend an alcohol awareness course.

2.3.116 08/10/22 - Police attended Kim's address as she called to state that she had argued with Val and he had been ejected from the house. This was recorded as a non-crime domestic incident. Kim refused to complete a DASH or appear on Body Worn Video as she did not want Val to 'get into trouble' This was graded as standard risk. Val was taken to a friend's house. It was recorded that Kim raised concerns that she did not want Val to die by drink driving as he had posted on Facebook that 'he is done with everything and hopes his little children will always love him.'

2.3.117 19/10/22 - Police were called by a health representative having received a call from Val who was intoxicated, walking in the middle of the road stating that he wanted to end his life. When located, he said that he was feeling low due to his relationship break-up, loss of his job and his children being cared for by his sister.

2.3.118 Val was taken to hospital voluntarily for a mental health assessment. The Police completed relevant documentation and procedures. The Adult Protection Investigation was reviewed by the Police Mental Health Team and not referred onwards as it was deemed not to meet the criteria for further work.

2.3.119 29/10/22 - In the early hours of the morning, Val called the Police to report he had been assaulted by Kim. She was intoxicated and had kicked him in the face leaving no visible

injury. Val provided a statement, referring to their on/off relationship over nine years and said that the argument was caused by him taking a photograph of Kim to prove they were together for Social Services and she got upset.

2.3.120 Kim was arrested and denied the offence. She stated that both had consumed alcohol and Val had taken cocaine. She claimed that Val had accused her of being unfaithful, tried to initiate sexual intercourse and became aggressive when she said she was leaving. She had called a family member for help as she feared Val on this occasion.

2.3.121 The DASH was completed with Val and graded medium risk, with Val stating that he feared she would assault him again and he was suffering badly with his mental health and use of alcohol and cocaine. The investigation was closed due to a lack of evidence.

2.3.122 07/11/22 - Val was located on a riverbank in the early hours of the morning having called the police in a drunken state saying he was going to roll his car in to the river and fire BB pellets into his head. He was taken to his father's having stated that he planned to see a Mental Health Worker the following day. All relevant documentation was completed.

2.3.123 10/11/22 - In the early hours of the morning, Val reported that he had been assaulted by Kim. They were staying together in an Airbnb room and Val accused Kim of messaging an ex-partner. He stated she had punched him in the jaw and hit him around the face with a wine bottle. Kim had also caused damage to a desk fan and remote control. Val completed a statement and was referred to the NCDV (National Centre for Domestic Violence). Kim denied the offences in interview but admitted they had both consumed a significant amount of alcohol, stating that Val had initiated sex and accused her of infidelity when she refused. She stated there was no violence and Val had 'made it up.'

2.3.124 A decision was made to make no further action as it was considered that it was one word against another. The DASH was risk assessed as medium and it was documented that Val and Kim had met ten times in the past three months and argued every time. Val had cancelled his appointment to see his children earlier that day in order to meet Kim. DVDS (Domestic Violence Disclosure Scheme) was considered but was not appropriate in this case, as neither party has a domestic abuse history with another partner.

2.3.125 18/11/22 - Following a call to the Police in the early hours of the morning, Val was found by officers on the side of a bridge with a 30-foot drop as he did not feel he was receiving the help he needed. He was detained under s136 MHA. He was not detained when assessed.

2.3.126 December 2022 – January 2023 – During the course of these two months, a further four assaults were recorded/attended with Val being assaulted by Kim on three of these occasions and made statements for two of these but no further action was taken on each investigation. Kim also made a statement of assault by Val and following his arrest, no further action was taken which Kim was angry about. She accepted NIDAS support and stated she wanted to seek a non-molestation order.

2.3.127 Also, during this period, the Police had contact with Val three times in relation to his mental health and suicidal tendencies on which on one occasion, he admitted to having made several attempts on his own life recently.

2.3.128 February 2023 – Early in the month, Val self-harmed but declined treatment at the hospital. In the early hours of the morning on 25th February, Val called the NHS 111 service to say 'Good-Bye'. He sounded distressed and had been drinking earlier on. He stated that he had no intention to harm himself but alluded to having suicidal thoughts. His father was contacted and attended his home address so that he was not alone.

2.3.129 The following night, around the same time, Val sent his father a text message stating, 'I'm going to end it all,' explaining he was distressed about the breakdown of his relationship with Kim. He was not present when Police attended his home and he was recorded as a missing person and it was noted he had been served an eviction notice from his flat. He contacted the Police and had a safe and well check. Val was awaiting a mental health assessment with a private nurse but was on a three-month waiting list and wanted the Police to help with expediting this. He informed the Police that he was diagnosed with depression but not currently registered with a GP.

2.3.130 Val alluded to an attempt suicide near a river whilst intoxicated and had mud on his boots to substantiate it. He was provided with helplines and an Adult Risk Assessment was submitted which as stated on the report, per protocol, was sent to Val's GP outlining concerns.

2.3.131 The same day, Val reported that Kim was at his home address refusing to leave. No offences were disclosed and a non-crime report was completed with the risk assessment graded as standard.

2.3.132 Val made two calls to the Police on the 28 February 2023, alleging that Kim had assaulted him on two separate occasions that day causing no injuries. She was located and arrested, denying the offences in interview. A decision was taken to take no further action due to inconsistencies with Val's account which caused evidential difficulties.

2.3.133 March - In early March, Maureen contacted the Police as she was concerned about Val as she had received a video from him holding a knife to his throat and playing sad music. She also stated that Kim had received a photo of him with a black cable around his throat at 4.00 am that morning. Maureen provided some history of his domestic situation and mental health struggles.

2.3.134 The Police arrived and managed to gain access to the property as his phone was ringing inside and music could be heard. Val was found on the floor with a ligature around his neck and was cold to touch. Paramedics pronounced death on their arrival.

2.3.135 The Police conducted an investigation and were satisfied that this was a non-suspicious death with no third-party involvement and submitted a file to the Coroner as a sudden and unexplained adult death, indicative of a suicide by hanging.

Children

2.3.136 Ashley was present during the initial domestic abuse incidents reported in Norfolk between the parents between December 2015 and May 2018. There is one reported domestic incident where both Ashley and Sam were present which was on 16th August 2022 at Kim's

sister's house. They remained in care after this incident throughout the remainder of this review.

Good Practice/Reflective Considerations

2.3.137 The required response to Domestic Abuse incidents across the constabulary is well established. This features within the initial training period for all officers and refresher training is provided during Development Days, which are built into the shift pattern for all response officers and those who work within the investigation teams.

2.3.138 The Force Contact and Control Room (CCR) implement the Domestic Abuse Standard Operating Procedure (SOP) when a call relating to domestic abuse is received. The WebStorm report will be updated with a specific call type code to identify it as a domestic incident, and therefore officers are made aware of this categorisation before they attend any incidents. Officers understand the necessity and nature of safeguarding response, the service they are required to provide and importantly the need to take positive action when attending a domestic abuse related incident.

2.3.139 The force also provides additional supportive material accessible via the Op Investigate pages. Officers can access these pages to review the information on Domestic Abuse, which provides help and guidance on several relevant factors.

King's Lynn and West Norfolk Housing Department

2.3.140 The review interrogated the council's records held on its HomeConnections database - which holds all homelessness application records. This includes the Homelessness Application form, consent forms and officer notes.

2.3.141 The Housing Options service is part of the Housing Needs team at the Borough Council. The team comprises Housing Options and Homechoice and is supported by two Administrative officers. The team deals with a high volume of challenging work managing homelessness applications and providing housing assistance to people within West Norfolk. There were a number of vacancies within the team at the time of the involvement with Kim and Val. This was compounded by an ongoing lack of available housing for applicants which has significantly increased reliance on B & B accommodation.

Chronologies

Val

2.3.142 04.11.22 - A call was received from Purfleet Trust (homeless charity and outreach service) confirming that Val was sleeping in his car. He was called the same day and interviewed, with an assessment carried out of his circumstances in line with homelessness legislation. A relief duty was accepted for him (a duty to help him resolve his homelessness), but it was determined that he was not in priority need for housing and therefore, no offer of temporary accommodation was made. A consent form was sent to his sister's address for him to sign and return and an offer made to make further investigations into his mental health and support needs upon receipt of the returned consent form.

2.3.143 08.11.22 - A duty to refer form was received from District Direct. Val was a recent patient with a current ankle fracture and suicidal thoughts and had been discharged to his father's address. A call was made to Val on the same day and a voicemail message left for him to contact immediately if he required any urgent help.

Kim (including children)

2.3.144 18.08.22 - Contact was received from Kim who had fled DA and had been staying at the children's Aunt's house.

2.3.145 22.08.22 - Kim was interviewed by the council who stated that she could not stay where she was any longer. She had signed a s.20 with a social worker to leave the property but her children were to remain for their safeguarding. Kim withdrew from the interview before the end. She would have been offered temporary accommodation had she not done so. A DASH was completed with a score of six.

2.3.146 31.08.22 - The IDVA service contacted the department and stated that the risk to Kim was high and would be heard at MARAC. The council's notes were supplied.

2.3.147 08.09.22 - Kim was contacted and she stated that she had found a room to rent and no longer required homelessness assistance. She was asked to update her Homechoice with her current address and circumstances for them to assess the situation to which she agreed and the case was closed.

2.3.148 16.09.22 - A further call was received from Kim who was looking for accommodation so her children could return to her care. She was informed to complete a Homechoice form and provide all documentation.

Terms of Reference Responses

2.3.149 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?

- In such circumstances, the council would accommodate in the first instance and then carry out investigations once the applicant was in a place of safety. Depending on the circumstances, it can be difficult to track down the information. Usually, agencies are quite willing to provide information. Key barriers are around the complexity of individuals' lives (due to substances and mental health for example); additionally, they may not be able to confirm who their support worker/network is or may not want to disclose information to the council.

2.3.150 Was the response to Val's mental health appropriate and risk assessed holistically?

- The council's judgement must be made on the information provided by the applicant. Val stated that he had mental health issues, but the details provided were quite vague. "In process of being referred for mental health, anxiety and depression." A risk assessment was carried out and based on the information he provided. He was asked for consent to

make more investigations but did not provide this. He was asked to make contact following his call on 8 November 2022 but no response was received.

- The assessment was appropriate and in line with homelessness legislation; however, a holistic risk assessment could not be carried out as fully as it could have been, due to a lack of contact/consent.

2.3.151 How do agencies take account of the voice of the child?

- As a housing authority, we respond to and communicate with parents/guardians. However, we will always make referrals to social services and/or raise safeguarding alerts where there is a risk to a child's welfare. Additionally, we will consider the needs of children when making decisions such as location of temporary accommodation. We may make recommendations in an applicant's personal housing plan in line with the needs of children who form part of applicants' households.

2.3.152 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.

- In terms of processes:
    - A specific question is asked around domestic abuse on the assessment form – this leads to automatic priority need for applicants.
    - A DASH assessment is completed for applicants where DA is the reason for presentation.
    - Safeguarding referrals are made where appropriate.
    - Contact is made with DA charities and support agencies, and referrals to refuges and safe accommodation.
    - All staff have had DA training, updated regularly (last December 2022). The council is in the process of gaining DAHA accreditation.
    - There is extensive information on DA on the council's website.

- In terms of effectiveness:
    - Responses to clearly identified DA, where there is a clear victim-survivor and a limited level of additional needs are effective in terms of both processes and services.
    - As a Borough, they are less far forward in terms of sourcing appropriate accommodation for individuals with complexity of need (such as substances and mental health) and for people who are both perpetrators and victims.
    - The effectiveness of the process is always going to be contingent on support elsewhere that is both good quality and is available. It is also contingent on applicant engagement – though there is a question as to what we do as services to encourage engagement.

2.3.153 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.

- Services are accessible to a point, but there is a high threshold to get any kind of support due to demand.
- There is an expectation that suicidal people are going to proactively approach services for support (when people will undoubtedly have barriers to approaching services).

2.3.154 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.

- Housing departments do try to work collaboratively with other agencies but getting the engagement from others can sometimes be tricky.
- The intention to use multi-agency meetings is good. The ability to get an outcome is maybe less efficient. Even if services do work together, there is not always a particularly straightforward outcome. For example, what is the likely outcome for a DA victim-survivor who is also a perpetrator and has mental health and substance issues?
- The Domestic Abuse Partnership Perpetrator Approach (DAPPA) process can be instigated where appropriate.
- Any social services involvement can be inconsistent with a response, depending on their capacity.
- There is often a lack of understanding of the roles that housing services provide, and a lack of realism in terms of what accommodation can be offered to people in such circumstances.

2.3.155 Establish the sufficiency, availability and level of domestic abuse provision in Norfolk and the interoperability across county borders.

- This is subject to review with Norfolk County Council leading on this. The key gaps appear to be around complexity of need, as detailed above.

Good Practice/Reflective Considerations:

2.3.156 The requirement for consent from someone who is homeless highlights a potential weakness in our assessment process. Whilst consent is essential, the process of having to open an envelope (especially at a c/o address), sign a consent form and respond by post may act as a barrier to some homeless applicants. Also, Val did not approach the team due to DA; however, it would have formed part of the ongoing investigation if he had given consent. Without this, it was not identified.

2.3.157 On a strategic level, there are multiple forums to discuss issues of DA, housing and multi complex issues. However, this area needs reviewing to establish clear terms of reference, focus, outcomes and impact.

Change Grow Live – CGL

2.3.158 This is a combined report created by the two CGL localities, CGL Cambridgeshire (Cambs) and CGL Norfolk and confirms successful and unsuccessful contact with Val between 29 September 2022 and 10 March 2023.

2.3.159 CGL have sites in a number of Counties across the Country which are commissioned separately by each individual area for some or all of the services they offer. Although part of the same group, their computer systems are separate for each area and cannot be accessed so for example, Norfolk could not look at Cambridgeshire's notes on Val.

2.3.160 CGL routinely ask at the comprehensive assessment and at full risk reviews (a minimum of six-monthly intervals) if a service user identifies themselves as being at risk of harm from others. CGL also receives information pertaining to MARAC cases (Multi Agency Risk Assessment Conference) and Police CAADA-DASH notifications (Coordinated Action against Domestic Abuse - Domestic Abuse, Stalking and 'Honour'-based violence). All CGL staff undertake Safeguarding Adults training (classroom and e-learning) as well as training relating to specific aspects of domestic abuse (stalking, strangulation and working with perpetrators- all delivered by the Independent Domestic Violence Advisor service). CGL staff are also trained in the use of the DASH Risk Identification Checklist and CGL have representation at MARAC. CGL also have access to the Safeguarding training portal in both Cambridgeshire and Norfolk.

2.3.161 All CGL sites have one or more safeguarding lead as well as domestic abuse champions (individuals who have expressed an interest in supporting those who disclose domestic abuse and who have been upskilled in identifying and supporting with domestic abuse cases). Safeguarding meetings take place monthly and cases are discussed, and actions highlighted. In addition, safeguarding cases are highlighted and reviewed in daily multi-disciplinary meetings to ensure actions are completed/followed up. CGL hold national safeguarding surgeries on a weekly basis where complex cases can be discussed.

Chronology

2.3.162 29.09.22 - The Recovery Co-ordinator (RC) from Cambridgeshire contacted Val and introduced herself following a referral by Children's Services. Val stated he had refrained from cannabis and cocaine use for two months and that his aim was to have positive contact with his children. He stated he was living on private land in a static caravan and that he had no fixed address but that any mail could be sent to his work address if needed.

2.3.163 Arrangements were made for them to meet on 6 October 2022 and an email was sent to confirm this and also to the Social worker for joint working.

2.3.164 This appointment was subsequently cancelled by Val and re-arranged but Val did not attend. The social worker and CGL RC continued to share information that Val and Kim had been together drinking, he had lost his job and been evicted from his rented caravan. Several attempts to contact him were made.

2.3.165 October 2022 - A comprehensive assessment took place. Val disclosed consuming approximately half a bottle of spirits on some days and on other days consuming 5% lager (various amounts), depending on how he felt on the day. On average he would consume approximately 20 units per day. He reported abstinence from cocaine and cannabis use for two months. He stated his goal was to reduce his alcohol use, find stable accommodation, obtain employment, and register with his GP in order to address his mental health as he reported being low in mood, he also disclosed a previous suicide attempt within the last 3 months, feeling suicidal as well as experiencing thoughts of self-harm although he stated he had not acted on these. Val stated that this was due to losing his family, his home, and his

job. No physical health issues were disclosed and he reported feeling fit and well. He also stated he hoped to have contact with his children twice weekly. He reported that his ex-partner states that he hits her, shouts, and screams at her but he stated he has not done this.

2.3.166 Val appeared motivated to make changes and showed awareness of the impact of his drug and alcohol use on him and his children and was keen to address this. He was also aware of the impact of his drug and alcohol use on his mood.

2.3.167 Val was deemed as suitable for treatment and support from CGL. The importance of registering with a GP to address his mental health issues was reiterated. A urine drug screen was carried out and Val was negative for all substances. The RC attended the Child Protection core group meeting later that day.

2.3.168 Over the course of the next week, Val met with RC again and had an assessment and a plan agreed, however following that he appeared to disengage and did not return any attempts to contact him and were informed that this was also the case with his social worker. At the same time, the RC attended the Child protection meetings and held an information sharing meeting with the mental health worker and social worker.

2.3.169 **November 2022** - The RC attempted to contact Val on over ten occasions but was only successful twice. It was ascertained that Val had moved to Norfolk and a discussion took place about transferring him to Norfolk CGL for continued support. He disclosed that he had consumed too much alcohol and jumped off a bridge, hurting his ankle after he had met with Kim and she had punched him.

2.3.170 **December 2022** - Val was aware that he had to present himself to Norfolk CGL for the transfer to be completed but he did not attend the appointment, although was willing for the transfer to happen.

2.3.171 **January 2023** - Cambridgeshire CGL continued to try and contact Val and following him attending a hospital in Norfolk, a referral was officially made to Norfolk CGL although he remained open to Cambridgeshire.

2.3.172 In mid-January, Val spoke to CGL Norfolk stating that he was having a horrid day. He disclosed that he had been using Cocaine with Kim and things had become heated. Val had called the Police. The Police attended and arrested him. Val spent the night in Police Custody and was released the following morning with no further action. He returned home to find his flat had been ransacked and personal items were missing.

2.3.173 Val stated that the Police had given the keys to his property to Kim. He had reported the theft and damage to the Police and was awaiting their response. Val was encouraged by CGL Norfolk to cut all ties with his ex-partner which he agreed to do.

2.3.174 At the end of the month, CGL Cambridgeshire completed their discharge summary and Val's case was transferred to Norfolk.

2.3.175 **February 2023** - Several telephone contacts were made or attempted with Val during the month in which he was busy with work. Norfolk informed Cambridgeshire that if he did not attend within seven days then they would discharge him but he could self-refer at any time.

2.3.176 March 2023 - At the beginning of the month, a full risk review was completed by Cambridgeshire CGL RC over the phone with Val. He disclosed drinking two bottles of wine and a number of beers on 'drinking days.' He was unable to recall exact amounts or frequency of days. He also stated he was using cannabis most days again although had not used since 26 February 2023. He stated he was ready for support with his alcohol use and would attend CGL Norfolk the following day after a 'good sleep.' Alcohol reduction advice was provided. It was noted that he appeared worried about his alcohol use and acknowledged that he was probably alcohol dependant. Val did not want to discuss his injury/assault (unclear who he was assaulted by). He stated he had not eaten for 8 days as was feeling unwell and was again encouraged to register with a GP and to eat little and often. He also reported an assault from his ex-partner the previous evening after they had both consumed alcohols. He showed insight into this relationship stating he 'should have listened to people ages ago and stayed away from her' but acknowledged that he still had feelings for her.

2.3.177 Val also disclosed trying to hang himself earlier in the week. He was again advised to register with a GP to address his mental health and to reduce his alcohol use. Out of hours support numbers provided. The RC also advised him to attend a Police station or A & E if he was feeling suicidal. He was also able to identify family he could contact. The impact of his alcohol use on his risk-taking behaviour and mood were also discussed. He did not disclose any suicidal ideation during the contact with and no concerns around his presentation were noted.

2.3.178 He reported being in stable rented accommodation. This information was sent to CGL Norfolk. A safeguarding review was held with the CGL Senior Social worker.

Good Practice/Reflective Considerations

2.3.179 On review of CGL involvement with Val, Domestic abuse support was not offered despite him disclosing details of abuse/assaults from his partner. CGL would expect a DASH risk assessment to be offered to Val and for him to have been signposted to domestic abuse services.

2.3.180 The communication between the two CGL localities involved with Val was not robust as it was reliant on email and there was a delay in transference of information. Other methods such as the telephone could have yielded a more efficient transfer.

Cambridgeshire Children's Services

2.3.181 The summary of Cambridgeshire Children's Services involvement gives an overview of the activity that was undertaken. Procedure was followed by Cambridgeshire when Ashley and Sam were transferred from the Assessment Team to the Family Safeguarding Team (FST) after the Initial Child Protection Conference (ICPC).

2.3.182 There was a total of four different Social Workers who worked with the family unit from August 2022 to July 2023. On transfer to the FST it was the same Team Manager who line managed the Social Workers and therefore had oversight of this case. Records show that supervision was held between the Social Worker and Team Manager in respect of this case. The supervision sessions were of an acceptable standard.

2.3.183 There were two different Independent Chairs who chaired the child protection conferences held in respect of Ashley and Sam. The Chair for the ICPC was an agency Chair but thereafter, Cambridgeshire appointed a permanent Chair. Once a permanent Chair was appointed this Chair became the responsible Chair for Ashley and Sam's conferences. The process for requesting Legal Advice was followed and Legal Advice given in a Legal Planning Meeting was that the threshold had been met for Public Law Outline (PLO) to be implemented. Initial, Review and Final PLO meetings were held with Val and Kim having legal representation. A letter of expectations was sent to them both.

2.3.184 The Children In Care (CiC) process was followed once Ashley and Sam became 'looked after'. Due to them being subject of a CP plan and the case being in PLO there were three different processes running at once – CP, PLO and CiC. It is understood by Children's Services that these processes all running together can be confusing and overwhelming for families.

2.3.185 The Independent Chair responsible for Chairing the CiC reviews in respect of Ashley and Sam remained the allocated Chair for the duration of the time they were looked after. The Independent Chairs for both CP and CiC followed internal processes for ensuring the CP plans and CiC plans were progressing and ensured all statutory policies and procedures were being followed.

2.3.186 The allocated Social Worker made relevant referrals to partner agencies for support for Val. A Family Group Conference (FGC) was held. Once Ashley and Sam had moved to live in Norfolk, the allocated Social Worker liaised with relevant partner agencies who became members of the multi-agency core group.

2.3.187 Ashley and Sam were never open cases to Norfolk Children's Services, Cambridgeshire Children's Services remained case responsible until closure of this case (this occurred once the Special Guardianship Order had been granted to Maureen and her partner).

2.3.188 Cambridgeshire liaised with Norfolk to advise Sam and Ashley were living in Norfolk and were subject to a Cambridgeshire CP plan. A call was made to Norfolk Children's Services on 21 October 2022 by Cambridgeshire Childrens Services to enquire if Ashley and Sam were known to Norfolk. Confirmation received that these children were not known to Norfolk.

2.3.189 At the RCPC's held in respect of Ashley and Sam, it was partner agencies from Norfolk education and early years who attended the conference.

Chronology

2.3.190 15/06/22 - Early Help were contacted by a professional from a Primary school within Cambridgeshire, advising them of previous concerns raised over a number of Domestic Violence notifications that had been received and the chronic poor attendance of Ashley and Sam to the extent that they had called the Police to complete 'safe and well' checks.

2.3.191 The family had been evicted from their previous address and were moving elsewhere within Cambridgeshire and requested enquiries in the Multi Agency Safeguarding Hub (MASH). Authorisation was given for a MASH enquiry.

2.3.192 16/06/22 - A full MASH enquiry was not undertaken as Kim and the children had moved out of the area and were safe in a refuge. It found Kim had acted protectively for herself and the children and the Children's Services in the area of the refuge were notified.

2.3.193 21/06/22 - A further Early Help enquiry was raised as the maternal Aunt who wished to remain anonymous had called advising that Kim had told her that when she was drunk, Val had tried to drown Sam, said 'vile' things like she was a mistake. Both parents took cocaine and drank alcohol every day and Val had tried to sexually abuse Kim several times in front of Ashley.

2.3.194 She disclosed that Ashley would be shut in her room for hours if she had an accident whilst potty training and when Sam was three months old, she was taken to hospital and had a fractured collar bone where Kim had been pushed down the stairs by Val whilst she was holding her although they did not tell authorities that. The seriousness of the injury was in contradiction to a GP report submitted to the ICPC. However, other information provided matched with records held by Children's Services. The MASH found that further assessment was needed.

2.3.195 Further information was shared by the maternal Aunt and following the contact, Children's Social Care decided that a Child and Family assessment should take place.

2.3.196 Information received from Safer Places Refuge was that Kim had fled to a refuge on 14 June 2022 and left on the 18 June 2022 stating that her allegations of domestic abuse had been untrue, and they were safe. The professional from the Refuge advised that Kim had disclosed that during a domestic dispute on 10 June 2022 Val had hit Ashley when she got between them. The DASH was risk assessed as high. Kim returned to the family home with the children.

2.3.197 Over the course of the next week, the Police spoke to Kim who minimised her sister's allegations and said that she did not like Val. A further domestic took place with Police attendance where Kim was abusive to the Police having been drinking and Val was taken to his place of work to sleep in his van. The DASH referred to the children being scared of their parents arguing.

2.3.198 A single agency section 47 was undertaken with Ashley spoken to at school but Sam refusing as she was at home. The outcome was to continue with Child and Family assessment.

2.3.199 July 2022 - A referral was received whereby the Police had dealt with an incident reported by Val that Kim was knocking glasses over in a pub and then took the children to a supermarket to purchase more alcohol. Kim was arrested for being drunk in charge of the children and they were left in the care of Val. A multi-agency strategy meeting was held the same day and the outcome of the s.47 investigation was to proceed to an Initial Child Protection Conference (ICPC).

2.3.200 August 2022 - A further domestic incident occurred with Val being arrested and both Ashley and Sam became Children in Care. They were placed with Maureen, the paternal Aunt with the appropriate assessments taking place. That recommended to progress to regulation 24 status and a Special Guardianship Order.

2.3.201 September-December 2022 - The Public Law Outline was commenced. Val attended the review meeting but there is no record of Kim attending. A Review Child Protection Conference (RCPC) was held in November and it was deemed that the children were at

continuing risk of significant harm and were made subject to a CP plan under the category of emotional harm. All conference attendees were of the view the significant harm threshold continued to be met and advised the Emotional Abuse category.

2.3.202 March 2023 - An RCPC was held in which Val and Kim did not attend. Maureen and her partner attended as Ashley and Sam remained in their care and care proceedings were in progress to secure long-term permanency for both children. A decision was made that the significant harm threshold was no longer met and they were delisted from the CP plan and made subject to a Child in Need (CiN) plan.

2.3.203 July 2023 - Court proceedings concluded with a Special Guardianship Order being granted to Maureen and her partner in respect of Ashley and Sam. Cambridgeshire Children's Services ended their involvement at this time.

Terms of Reference

2.3.204 Cambridgeshire Children's Services records show there was early evidence of Val's poor mental health. It is recorded that Val was previously known to Child Adolescent Mental Health (CAMS) as a young person.

2.3.205 Val's mental health struggles were included and commented on by Police at the ICPC's, outlining incidents that they had attended and an occasion when he was detained under s136 MHA. The Child and Family Assessment (C&F) written prior to the ICPC makes reference to Val's poor mental health. The Social Worker undertaking the C & F spoke to Val about his mental health. At this time, the C & F records that Val said that whilst he had previously struggled with his mental health, he did not believe he needed support as working full time helped him feel focussed and more on top of things.

2.3.206 Cambridgeshire Children's Services received confirmation that Val had registered with a GP surgery, but he did not give consent for them to access his medical records.

2.3.207 Records show that Val did not engage with professionals. He moved from Cambridgeshire to Norfolk and did not have a permanent address. It was difficult for adult mental health services to work with Val due to his poor engagement and lack of a permanent address.

2.3.208 The voice of Ashley and Sam is evident in recording. Ashley, the older of the two children voice is clearer. It is recorded that Sam's verbal speech was limited.

2.3.209 Ashley was spoken to as part of the S47 undertaken on 22 July 2022. When Ashley was asked about what made them sad, Ashley said nothing made them upset but then went on to talk about 'mummy and daddy' arguing. Ashley talked about the Police going to the house saying they went to the house to see if Sam and I were 'sort of alright.' Ashley had told the Police they were alright.

2.3.210 Ashley's voice in the ICPC conference minutes is clear and evidences the impact made from their parent's behaviour. Ashley talked to professionals about Kim's drinking, about mummy being banned from pubs and how angry this made them feel as mummy got moody and shouted.

2.3.211 Ashley said things had been better since daddy came home but was worried about daddy hurting mummy and was worried about the screaming and shouting. Ashley asked if mummy and daddy loved them and if they had done something wrong as they were not seeing them. A social worker drafted a story book to try and help them understand why they were living with their Aunt and additional work with therapeutic cards was given to Ashley.

2.3.212 The final Care Plan for Ashley and Sam refers to Maureen and her partner being aware of the Targeted Support Service should they require any help or support with the care of Ashley and Sam in the future. They are also entitled to support from Cambridgeshire adoption team until 2026 when the responsibility is passed to Norfolk.

Good Practice/Reflective Considerations

2.3.213 The author is of the view that whilst it is important to listen to the views of family members Children's Services work with, there should have been a more in-depth conversation with Val as to whether it would be beneficial for him to receive support for his mental health. There could have been a discussion about the impact on Ashley and Sam when Val's mental health was poor and how he could be supported to manage this to reduce the impact on his children.

2.3.214 The draft CP plan makes recommendations for a referral to a Domestic Abuse Practitioner (DAP) to address the domestic abuse concerns and a referral to Change Grow Live (CGL) to address the alcohol and substance misuse problems. These referrals were made. This was also the case following the RCPC.

Norfolk Children's Services

2.3.215 The chronology on behalf of Norfolk Children's Services focuses on the relevant period of time of January 2019 to March 2023.

2.3.216 Val had a history of offending before 2015 and there were occasions where he presented as homeless and sofa surfing. The final contact into Children's Services was in 2013 for homelessness.

2.3.217 Kim had a turbulent childhood, there are three periods of Child Protection planning recorded: May 2003 – February 2004 emotional abuse, December 2006 – June 2007 neglect, December 2011 – March 2012 neglect. Prior to this there had been numerous assessments undertaken relating to lack of parental supervision, boundaries, poor home conditions acrimonious relationships, alcohol and neglect. The family generally received support from universal services. Since the end of the Child Protection planning in 2012, referrals continued until 2014 with concerns about the care of Kim and her sibling, their home conditions and poor school attendance.

2.4 Summary Reports

2.4.1 In addition to the IMRs, certain agencies/organisations were requested to provide supplementary information into processes and provisions.

Pandora

2.4.2 Pandora provides a number of services for victims of domestic abuse in the Norfolk area. These include:

- DA outreach support for women over 16 years - 1-1 in the community, standard to medium risk.
- DA outreach support for CYP 5-18 years - 1-1 in schools, community.
- Group recovery programme for adults, programme for teenagers, programme for parents.
- Dispersed accommodation - 2 safe houses (for men or women), all risk.
- Drop-in sessions.

2.4.3 On 11 October 2022, Pandora received a self-referral from Kim. The initial contact with Kim was made within the policy guideline of five working days. On the initial call, she discussed the suicide attempts by Val and also referenced an incident with a knife. It was explained that there was a waiting list and she was provided other agency details. Pandora has a full list of various agencies that are emailed out to clients after that first call. Kim was put on a waiting list.

2.4.4 On 13 February 2023, Pandora contacted Kim, which was the first time this had been made since the initial call. Kim said she was busy. An attempt to contact her the following day was unsuccessful and the case was closed. The policy is to call five times over five weeks before closing; however, no dates were recorded.

2.4.5 Pandora's opinion is that all Norfolk DA services are very stretched and short staffed. Recruitment has been challenging for the past year, so current staff are under a lot of pressure. However, there is definitely room for DA providers to work better together and have a more joined up approach.

2.4.6 Norfolk County Council commission Pandora to offer support in two properties owned by Freebridge Housing Association. This target hardened dispersed accommodation is available for victims of domestic abuse, male or female. Intensive weekly support is offered for victims and for their children for up to a year and Pandora works collaboratively with other support agencies to offer a wraparound support package. Vacancies are advertised on Routes to Support and Mankind, referrals are only accepted by other agencies at this time.

Cambridgeshire MARAC and IDVA service

Transfers/Frequent moves to MARAC areas

2.4.7 High risk DA victims and perpetrators may move between MARAC areas and as a result, information needs to be transferred in a timely manner as it provides challenges for MARAC partners in managing risk and providing continuity of support.

2.4.8 Cambridgeshire and Peterborough MARAC hold three meetings per week. When a case is transferred from one MARAC to another MARAC area, MARAC meetings may be held less frequently than Cambs and Peterborough, resulting in that case not being discussed for up to several weeks after the transfer is lodged. If the same MARAC DA victim decides to return to Cambs in the meantime, the transferred area would need to be informed and the case re-listed in Cambs. This creates an unavoidable delay in the case being discussed and a gap of unknown risk to the victim and possibly children in the household.

2.4.9 Areas using a 'Flag and Tag System' when receiving a MARAC transfer are reliant on information shared by the victim, in order to assess risk. If a victim does not feel they can be open about current risk, a true picture may not be gained and opportunities to safeguard may not be effective. Victims who frequently move areas, may be less likely to engage with support because they are unable to build trusting relationships with safeguarding professionals. Administrative delays may lead to gaps in sharing risk-led information in a timely fashion.

2.4.10 Children in transient DA households can often fall under the radar of statutory and voluntary services causing significant disruption to education, accessing health services and fractured support networks, thus causing development delays, isolation and increase in risk. Often, there is intentional avoidance of having to engage with Children's Social Care and other statutory services, often borne out of fear.

How are victims assessed who are previously known as perpetrators and does this create barriers to provision access?

2.4.11 When a referral is received for a victim (having previously been a perpetrator) that reaches MARAC threshold, the referral is received on that basis. A tag/alert is set on the case management system to signify the victim has been previously known to the service as a perpetrator. The victim is called to make them aware of the MARAC referral and the process is explained. An offer to provide feedback from the meeting is made. An offer of IDVA support is not made if there is a conflict of interest to the service.

2.4.12 If the victim identifies as male, then he would be signposted to Mankind or a similar service. If a medium risk referral is received, the MARAC threshold is not met and where the victim has been previously known as a perpetrator, there is a careful review of information already held. This includes reading the referral, the case notes for the original victim, any MARAC minutes and actions and Police Athena records. This is to form a 'picture' based on the information available at that time, about whether the person is suitable for support from our service.

2.4.13 Cambridge IDVA policy is not to offer support to persons who are on the case management system as identified perpetrators and who they consider would be a conflict of interest to support as an IDVA client.

2.4.14 If a person is identified on the incoming referral as a victim and the IDVA service are already working with the person named on the referral as a perpetrator, then this would be considered to be a conflict of interest and support would not be offered.

2.4.15 On occasions, IDVA referrals for both parties are received and it is acknowledged that both may present as victims. However, the conflict-of-interest policy is followed and IDVA support is only offered to the victim who was referred first. There can be concerns and challenges around this that could result in some victims not being offered support by the service, particularly in cases of co-directional violence, situational couple violence and perpetrators presenting themselves to professionals as victims. An open mind is kept and they are signposted to alternative support services where appropriate. The policy is to prevent IDVA staff educating or empowering DA perpetrators and thereby disempowering potential victims and being mindful of safeguarding IDVA staff in a voluntary service.

NIDAS (Norfolk Integrated Domestic Abuse Service)

2.4.16 NIDAS is the joined-up domestic abuse support in Norfolk. Its commissioners are:

- Police and Crime Commissioner of Norfolk
- Norfolk County Council
- Broadland District Council
- South Norfolk Council
- Norwich City Council

2.4.17 It has been brought together with the intention of mitigating the postcode lottery, providing consistency and standardisation with early identification of long-term positive outcomes and provided a whole system change.

2.4.18 NIDAS provides support for those affected by domestic abuse in a number of formats. The service providers are:

- Leeway Domestic Violence and Abuse Services
- Daisy Programme
- The Sanctuary Safe Partnership

2.4.19 Data from April 2022 – March 2023 shows that NIDAS received 3487 adult referrals of which 454 were self-referrals. There are a number of specialist provisions which include IDVAs for males, health and drugs and alcohol.

Provision of support

2.4.20 NIDAS is a county wide domestic abuse service, providing support to all service users regardless of gender who have experienced domestic abuse, and have been identified as being at medium or high risk of significant harm. NIDAS IDVAs provide practical and emotional support, and safety planning to help victims of domestic abuse to become and remain safe from harm. This may include supporting service users to understand and navigate key processes and systems (like the justice system, housing, or health services), or supporting service users to access other related services. IDVAs also help service users to understand their experiences and complete interventions that will help with long term recovery following domestic abuse.

Chronology

2.4.21 26/09/22 - A MARAC referral was received from Cambridgeshire in relation to Kim.

2.4.22 20/01/23 - A referral was received for Kim but despite several attempts to contact her, no contact was made.

2.4.23 15/01/23 - A further referral was received for Kim and a dual allegation toolkit opened for both Kim and Val. Val declined support and a toolkit assessment.

2.4.24 02/03/23 - A referral was received for Val. Contact was tried but not established.

Referral Mechanisms

2.4.25 Self-Referrals can be made directly to the NIDAS Triage team via website referral, telephone referral, text, or email. Once the referral has been received, contact will be made with the service user and an assessment will be completed to determine the level of risk, initial safety planning completed, and then if the remit for support is met for NIDAS intervention the service user will be placed into service and an IDVA allocated. Professional referrals from the Police are made directly through the Police system Athena.

2.4.26 Professional referrals from other organisations can be made via the NIDAS website or over the phone. Again, contact will be made with the service user to determine the level of risk, initial safety planning will be completed, and the case will be allocated to an IDVA for ongoing support. As part of the referral process, systems are checked to see if there are any conflicts of interest.

Dual Allegations

2.4.27 Where there are dual allegations or evidence of bidirectional abuse, we will undertake the RESPECT dual allegation toolkit. Respect-Toolkit-for-Work-with-Male-Victims-of-Domestic-Abuse-2019.pdf (amazonaws.com) The purpose of the toolkit is to assess all the presenting information, to ascertain which of the parties (if any) can access IDVA intervention. The toolkit includes guidance for how to work with any male presenting, including male victims; those in unhappy but not abusive relationships and perpetrators presenting as victims.

2.4.28 A dual allegation toolkit assessment was opened for Val following referral from the Police and he declined to complete the assessment or access IDVA support. He said that he was no longer in a relationship with the other party, and that he was fine and not in need of help.

Failure to Contact

2.4.29 All cases will be held open for 28 days to attempt initial contacts. If NIDAS workers cannot contact the service user, they will contact the referrer to advise as such and enquire whether they have had any recent contacts, or whether they are aware of any other agencies that the service user may be engaging with.

2.4.30 If IDVAs are concerned about a case, this will be fed back to the referring agency, and the case may stay open for an extended period of time for further contact attempts.

Training

2.4.31 In conjunction with the Respect training, they have worked with male victims training, so that IDVAs are aware of the different barriers to accessing support that may be in place for male victims, and the unique experiences that may be experienced by heterosexual, gay and bisexual men. IDVAs also are required to undertake the accredited IDVA training course, to ensure that they are efficient in their roles.

Multi-Agency Working

2.4.32 NIDAS IDVAs are based within Norfolk's MASH (Multi-agency Safeguarding Hub), and work across the district council Early Help Hubs. IDVAs are proficient in working with other professionals across Norfolk to get the best outcomes for service users.

2.4.33 Where it is known that other agencies are working with NIDAS service users, IDVAs will contact the other agencies to get an overview of where they are at with the case and what work has been completed. This ensures that agencies are working together and not duplicating work. NIDAS will also approach and enlist support from other agencies where there is an identified support need.

2.4.34 There is currently a redevelopment of the NIDAS/OPCC website which in the past has had a generic voice for males but going forward, will have a specialist voice for male victims and ensuring the upskilling of the workforce in this area.

Domestic Abuse Partnership Perpetrator Approach (DAPPA)

2.4.35 DAPPA is a multi-agency approach to addressing domestic abuse within Norfolk, managing perpetrators of domestic abuse and thereby protecting the most vulnerable victims.

2.4.36 A matrix identifies the perpetrators who present the most serious or repeated risk of harm and a monthly meeting is held to develop robust risk management plans and a problem-solving approach.

ManKind Initiative

2.4.37 During the first panel meeting, the author identified the need for specialist representation for male victims. Norfolk CSP enlisted a representative from ManKind to attend the panel meetings to provide specialist knowledge and the author also made requests for relevant insight and data into the core issues identified in this review which are commented on throughout this report.

2.4.38 The ManKind Initiative is the principal, expert and specialist charity in the UK focussing on male victims of abuse. The charity collaborates and works in close partnership with other organisations and practitioners to support these victims too. They also provide a national

helpline and give male victims a voice by engaging with stakeholders such as the government, statutory agencies, politicians, academia and the media.

2.4.39 Research into bidirectional IPV found that:

- Partners' antisocial behaviour & depression were significantly associated & both were related to IPV

"Findings suggest that both partners' levels of psychopathology increase the levels of partner abuse…it is important to consider aggression & associated psychopathology for both partners"[17]

2.4.40 Where substance use was identified, results showed that 33.6% of people in treatment for addiction had committed violence against their partners. This prevalence was significantly higher in women (63.3%) than in men (24.2%). 98.4% of cases were bidirectional IPV.[18] Frequency of intoxication was associated with perpetration and bidirectional IPV in emergency departments with the severity of aggression associated with increased depression.

2.4.41 Over the past fifteen years, there has developed a significant understanding of the ways in which men experience domestic abuse. Barriers for male victims to seek help are affected by perceptions of the public, service providers, criminal justice professionals and men themselves.[19]

2.4.42 Further research provided by ManKind Initiative found that:

- Men were not always recognised as victims of domestic abuse as women were, even when presenting with the same level of risk and experience as a woman.
- Missed opportunities to talk to men – direct questioning is crucial for many abuse victims regarding disclosure[20]

2.4.43 Saxton et al (2020) indicate that there is a narrative around being "lucky" in finding the 'right' person to speak to, having a significant impact in terms of an effective and helpful response.

2.4.44 There are service provisions for male victims across Norfolk which is part of the mainstream provision based on the online directory https://mankind.org.uk/help-for-victims/directory/

These are:

- Daisy Programme (The)
  Services :1-1 & Group / Counselling
  Location: Breckland

[17] Arteaga, A., Fernández, M. J., & López, G. J. J. (2015)
[18] Arteaga, et al., 2015
[19] Taylor et al., 2021
[20] Jahanfar & Malekzadegan, 2007

- Dawns New Horizon
  Services: Information/Support / 1-1 / Counselling
  Location: Norwich

- Leeway DAS
  Services: Information/Support
  Location: Norfolk

- Norfolk Integrated Domestic Abuse Service (NIDAS)
  Services: Information/support / IDVA - Med - high risk only
  Location: Norfolk

Domestic Abuse and Sexual Violence Partnership – Cambridgeshire DASV

2.4.45 In order to address and support male victims of domestic abuse and signpost them for the provisions available, the DASV have completed the following in the past couple of years in this area:

- eLearning for professionals includes a section on male victims.
- All services (IDVA and Outreach) support male victims.
- In 2023, new posters and information are gender neutral.
- 2023 – specialist session for 80 housing professionals about counter allegations and working with male victims.
- 2024 – Respect is delivering training to housing professionals re Male victims.
- 2022-24 – Peterborough Women's Aid "B-UNITED project for male victims across Cambs and Peterborough.
- Late 2024 – Domestic Abuse Champions Session re Male Victims by B United.

A page has been included on the Cambridgeshire DASV website aimed at male victims of DA https://www.cambsdasv.org.uk/website/male_victims/90534 .

Section 3 - Analysis

3.1 Family Involvement and Perspective

3.1.1 Maureen and Val's mother spoke on behalf of the family as they knew the circumstances as Val would ring to tell them and confide in them.

3.1.2 Although Maureen is aware that not being able to live with his children seriously affected Val's mental health, she believes that Children's Services should have stepped in sooner. There were multiple occasions that referrals were sent where it was clear that the children had witnessed abuse between their parent's that they could have been protected from if action had been taken. They spoke with Children's Services themselves over their concerns for the children but did not feel their voices were heard, yet they could speak from witnessing and hearing directly what was going on in Val and Kim's relationship.

3.1.3 Val's mother went to the Police station to complain about the fact that each time they attended an incident, the Police would remove Val from the situation and take him to a different location if not arrested and they did not seem to believe or listen to anything he had to say. This would also leave the children in the care of Kim, who was often drunk and under the influence of drugs. His mother firmly believes this is because he was male and therefore, treated differently.

3.1.4 They stated that Val used to tell authorities what he wanted them to know rather than the reality and was believed which is why his mental health was never addressed appropriately as he always stated that he did not mean to do it and blamed it on the alcohol. They feel the mental health services failed him as they did not speak to the family enough and engage them in his support. They feel that they should involve the family more and work together with them.

3.1.5 Maureen and Val's mother hope that this review will highlight areas that can make a change so that the response to these issues can be addressed both quicker and more efficiently in the future. Maureen feels that more assistance could have been given to both her and the children when they went to live with her as it has a big effect on all parties and the children were worried that they had done something wrong which was why they did not see their parents. They did receive some help, but it is felt that more could have been done.

3.1.6 The family tell of how Val was 'beaten up' and injured by Kim's new boyfriend one night and that they do not feel the Police believed him due to his previous DA and mental health history. They feel that the Police did not see him as a victim and always believed Kim.

3.2 Terms of Reference Areas

Domestic Abuse (DA) in any form had been the causation or a contributory factor to Val taking his own life.

3.2.1 Val and Kim began a relationship at the young ages of 17 and 16 respectively, both having had young experiences of involvements with Children's Social Services and the Police. Val showed vulnerabilities when he was taken to hospital having consumed 16 paracetamol tablets and just wanted to be left alone. They moved in together at Val's mothers soon after meeting. It was at this point that the Police began to attend domestic incidents between Val and Kim. The initial incidents were recorded as verbal only.

3.2.2 Within two years, they had their first child, Ashley, having moved into a maisonette by themselves. The family report that there was use of alcohol and drugs during the pregnancy. The same year Ashley was born was the first recording of bidirectional violence between them in which Val put a knife to his throat in front of Police officers saying he wanted to end his life. There was no mental health services involvement for Val at this time.

3.2.3 Neither Val or Kim was afraid to contact the Police during their domestic incidents and allege assaults against each other. However, they did not support Police action thereafter and the lack of multi-agency scrutiny on the family situation to safeguard Val and the children meant that the cycle continued of an on/off relationship over the years and the continuance of abuse by both parties without it being addressed.

3.2.4 Once the children had been taken into care and Val did not see them frequently, there was a noticeable deterioration in his mental health with multiple Police attendances crisis situations and he still frequently contacted Kim, even though he knew that this may impede them being returned home.

3.2.5 Val would contact his family with pictures of injuries that Kim had caused and had no stability in his life as at times he was sofa surfing and living in a caravan.

3.2.6 There are a number of factors that affected Val's mental health with the main one that he reiterated to services being the status of his relationship with Kim, both when they were together and when they had parted ways. This relationship then had repercussions on their ability to parent their children and keep them from harm.

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.

3.2.7 This review has considered the effectiveness of communication of agencies within the given Counties involved and also between Counties when the parties involved are of a transient nature as in the case of Val and Kim.

3.2.8 Where a person is open to CPFT services and moves out of area, CPFT, where possible, will work with the person until they have been taken on by a service in the new area. There is evidence in the notes that LaDS worked very hard to ensure Val received support in the new area which included helping him register with a GP, advice and signposting to acquire suitable accommodation, and practical and emotional support. Where a person is open to CPFT long term treatment or inpatient care, the treating team or consultant will write formally to the new team and the GP to inform them of the case transfer. If there is information contained in a person's clinical notes and risk assessment regarding DA then this information is transferred in line with GDPR.

3.2.9 The draft CP plan makes recommendations for a referral to a Domestic Abuse Practitioner (DAP) to address the domestic abuse concerns and a referral to Change Grow Live (CGL) to address the alcohol and substance misuse problems. The onus on Val to attend the appointments offered by the above professionals could have been too much when he was not well. Consideration needs to be given by the multi-agency core group as to what help and support can be given to family members in line with what they are able to manage at the time.

3.2.10 However, it is noted that on several occasions when Val had already declared his intentions prior to the event and then been either detained by the Police or transported to the hospital due to injuries that he had self-inflicted, that he would blame his behaviour on alcohol and state that he didn't mean to do it and along with other points taken into consideration in his assessments, it would appear this explanation was accepted although he was very open in discussion about what was affecting him. The accumulative history and escalation of events was not taken into consideration. Also, it was not identified that he

utilised a grandad's funeral, clearly recorded, as a reason for a quick and early release on more than one occasion.

3.2.11 Cambridgeshire Police dealt with the domestic abuse incidents in what is referred to as positive action with out of court disposals or restorative justice options having been explored and executed, however the DA and safeguarding issues continued to perpetuate, questioning the effectiveness of the response. It would be prudent to consider other strategies and initiatives through partnership working. A recommendation in relation to the consideration of DVPN/Os for all domestic abuse cases and recording of rationale for decision making in this area has been made in a recent DHR (Emily) and has been addressed by Cambridgeshire Police, therefore, no recommendation has been made for them in relation to this within this DHR.

3.2.12 The reactive Police response proved ineffective in dealing with repeated incidents of DA, and more a proactive response through a problem-solving approach, may have enabled, multi-agency and co-ordinated management of the DA issues. Ultimately, this strategy may have proved more proportionate to the family's needs, thereby ensuring:

- Safeguarding of all parties involved transparency and accountability with SMART[21] action plans.
- Designation and responsibility of actions to relevant partners/agencies.
- Positive outcomes given the vulnerabilities of all parties.
- Combined partnership approach to addressing the family's complex needs including support for Val's mental and emotional well-being.

3.2.13 This review has revealed that Norfolk Police DASH or DARA Risk assessments were completed by attending officers in all cases where officers have attended a reported domestic incident between Kim and Val, within the agreed timeframe. This is compliant with the Force Policy for officers attending Domestic Abuse incidents.

3.2.14 Twelve risk assessments have all been reviewed. Two were standard risk and ten were medium risk. There were no Domestic Abuse risk assessments which were recorded as high.

3.2.15 During the period of this review there were eight domestic abuse incidents graded as medium risk. Seven Secondary Risk Assessments were completed by the Domestic Abuse Safeguarding Team and added to the Athena investigations of which all maintained medium risk assessment. Whilst the obligation is met, the cumulative risk element was missed. (**Recommendation refers**)

3.2.16 Several of these secondary risk assessments acknowledge the significant domestic history between Val and Kim that had occurred over the years and the presence of some identifiable indicators of risk of serious harm. However, this did not influence the level of risk assessment, which remained largely as medium throughout the period of this review. Therefore, although force processes and the APP (Authorised Professional Practice) framework were arguably adhered to by recognising repeat victims and taking steps to

[21] Specific, measurable, achievable, realistic, timed.

safeguard, perhaps a holistic view considering the impact around cumulative risk could have been considered, to assess and elevate the risk level up to High.

3.2.17 A high-risk domestic abuse case may receive increased opportunities to safeguard. This could be through the possibility of alarm installations, Independent Domestic Violence Advocate (IDVA) support, MARAC referral and consideration of Domestic Violence Protection Notices. (Although a DVPN should be considered for any level of risk)

3.2.18 The transfer between forces was facilitated smoothly, largely by the fact that both forces are on Athena.

3.2.19 The MARAC-to-MARAC transfer between Cambridge and Norfolk was completed in a timely manner. The MARAC process is an effective Multi-Agency information sharing, planning and safeguarding procedure. In Norfolk however, because cases heard at MARAC need to be high risk, this was not a viable option for Val and Kim for the period of this review.

3.2.20 This highlights the issues that can be caused in inconsistencies with MARAC processes in different Counties. Although all Counties follow guidance from Safelives, over the past seven years or so due to demand pressures, each County has taken their own interpretation of these. Norfolk MARAC only hear high risk cases that have been assessed by the DASH/DARA question set and do not receive professional judgement referrals based on accumulative or escalating circumstances whereby Cambridgeshire MARAC do. (**Recommendation refers**)

3.2.21 Cambridgeshire CGL showed good practice in the number of times that contact was attempted with Val when they were not receiving a reply. When Val disclosed that he lived in Norfolk, it was identified straight away that a referral should take place, yet this was not completed until three months later. During this time, Val was having contact from both Norfolk and Cambridgeshire which can be confusing for someone who already has multi-complex needs. Val had consented to the transfer yet during the panel meeting, the CGL representative stated that the information could not be transferred from one CGL area to another without the first obtaining consent due to GPDR although they are the same company. (**Recommendation refers**)

3.2.22 When reviewing the effectiveness of communication and working together from provisions within Norfolk, the panel considered the area of support services. NIDAS is commissioned by Councils throughout Norfolk with three service providers. When Pandora received a self-referral from Kim and could not provide for her needs at that time due to capacity, she was placed on a waiting list for four months and provided with other agency details. To self-refer for support is a big step for anyone in an abusive relationship and may be the only time they have the energy to do so. No practical assistance or help has been identified in referring to another agency on her behalf. Pandora are not one of the service providers commissioned by NIDAS. This has to be considered within this review as to whether this is a barrier that deters non-commissioned services from referring to NIDAS even when they are not in the position to provide the service at that time and how these barriers can be eliminated. (**Recommendation refers**)

The effectiveness of agencies responses to support children who are victims of domestic abuse with multi-complex needs within the family home.

3.2.23 Domestic abuse occurred within the home in front of at least one of the children in both Cambridgeshire and Norfolk. Val and Kim had been in relationship since 2014 and their DA history dates back to 2015, following Ashley's birth. It is also known that at two months old, Sam received an injury to her shoulder. Ashley had to have assistance with her speech and language and the attendance at school was poor with a lack of cooperation by Val and Kim.

3.2.24 All panel members reported that their organisations were fully aware of the Voice of the Child and its relevance in relation to domestic abuse and that it was reflected in their training and their policy and procedures.

3.2.25 Between the period 13 December 2020 and 16 October 2022, Cambridgeshire Constabulary's databases shows that twenty-one safeguarding referrals relating to Val, Kim, and their children were made. Ashley and/or Sam were not always spoken to on attendance which would have been best practice but their presence and safeguarding was acknowledged by attending officers.

3.2.26 It should be recognised within this review of the good work carried out by Cambridgeshire Children's Services in relation to beginning a s.47 investigation that continued through due process to the children being taken into voluntary care with a family member and eventually the PLO being implemented for the children to stay permanently with Maureen. This has undoubtedly safeguarded the children from being subject to receiving or observing further abuse in the household.

3.2.27 However, the summary of Cambridgeshire Children's Services involvement shows there was a wealth of information shared with Children's Services about Ashley and Sam with early recordings of information shared with Children's Services providing evidence of the impact of Kim and Val's behaviour on their children. A question needs to be asked as to why this information was not acted upon until June 2022, when the primary school contacted Children's Services with concerns at the same time that Kim's sister contacted them with a wealth of information. This was only acted upon once it was ascertained that Kim had returned to Val and not stayed at the refuge with the children.

3.2.28 A multi-agency strategy discussion was held within six working days of this information and subsequent information being shared and a single agency S47 investigation. With the amount of information available to Children's Services, the ages of Ashley and Sam and the fact this family unit had only recently been known to Cambridgeshire, the significant harm threshold was met at this time and the significant harm threshold for an ICPC should have been tested at this time. It was nineteen working days before it was agreed the significant harm threshold was met with the outcome to proceed to ICPC, which was an unnecessary delay.

3.2.29 Also, that the category was initially deemed as neglect which does not fully recognise the effects of the domestic abuse and was not changed to emotional abuse until PLO was being implemented.

3.2.30 The ICPC minutes focus on the risks to Ashley and Sam and the impact on them as a result of the behaviours displayed by their parents. Key information was shared by Police colleagues with clear information about Val's poor mental health as early as 2015. The draft CP plan drawn up at the ICPC did not reference Val's mental health, which was an oversight.

3.2.31 It is clear Ashley and Sam had suffered significant harm and were at risk of continuing to suffer significant harm. The ICPC minutes refer to domestic abuse, poor parental mental health and alcohol and substance misuse. Ashley's voice is clear in the minutes, talking about mummy being banned from pubs and even named the specific pubs from which she was banned.

3.2.32 The outcome of the ICPC was the significant harm threshold was met and Ashley and Sam were made subject to CP plan under the category of Neglect. It could be argued that the overriding concern for them both was witnessing the domestic abuse between their parents and the emotional impact of this, alongside the potential of them becoming physically harmed in the crossfire. The Working Together to Safeguard Children definition of Neglect includes the following – protect a child from physical and emotional harm or danger, neglect of, or unresponsiveness to a child's basic emotional needs. The Neglect definition encompasses all the perceived risks to Ashley and Sam but does not directly reflect domestic abuse.

3.2.33 The need for this was identified at the first RCPC when the category of Emotional Abuse was selected. The Emotional Abuse definition includes – emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may also involve seeing or hearing the ill-treatment of another.

3.2.34 Legal advice was sought, and the PLO implemented. This occurred when the children were safe living with their paternal aunt and her partner, but it ensured there were robust assessments undertaken in appropriate timescales for Ashley and Sam to help inform of best decisions for their long-term permanence.

3.2.35 Norfolk Constabulary's Force Policy Document for domestic abuse recognises the impact on a child who sees, hears or experiences the effects of the domestic abuse which is best practice. Ashley was present during the initial domestic abuse incidents reported in Norfolk between the parents between December 2015 and May 2018 and the only recorded incident within Norfolk that the Police attended where both children were present was when the children were voluntarily taken into care and placed with the paternal Aunt, Maureen.

3.2.36 During further incident in regard to child safeguarding, officers were compliant with force policy and considering that the children were not physically present, their existence was acknowledged by the officers in the reports they submitted. This is good practice and illustrates that the safeguarding needs of the children were being recognised.

3.2.37 Reviewing the reports from Cambridgeshire and Norfolk County Council's records there is evidence that the impact of their lived experiences on Val's children could have been significant in terms of trauma. This would be from experiencing neglect, witnessing domestic incidents. The fact the children were placed with Val's sister was a protective

factor and this stability would award them the opportunity to receive and engage with therapeutic input to help address the trauma. This would be available via the Adoption Support Team that they have access to currently. In Norfolk there is also a service called Nelson's Journey that offer a course of support to bereaved children. As Norfolk residents now they would be able to access this though it is not known whether this was accessed by the family.

3.2.38 Although the children were placed in Norfolk, the case and oversight remained with Cambridgeshire Children Services. Information is only provided to Norfolk if they request it, following a referral from another organisation. This does raise a concern that Children's Services in Norfolk would be unaware of the children living within their area who may have needs and would be unable to immediately identify what services they may need or be unable to understand the impact there has been on them. A number of services are available within Norfolk for support but are offered from Norfolk Children's Services if the case is open to them or under their jurisdiction.

3.2.39 However, the Adoption Support Services have a care worker for the children and can refer in if they identify any specific support or need that the children may require so this can fill the void aforementioned but does put the sole onus of referral on themselves.

The effectiveness of the response of agencies to relationships with bi-directional violence within Cambridgeshire and Norfolk.

3.2.40 When a domestic dispute is bidirectional and has a previous history of abuse, this can make the decision making of the Police more complicated when they attend as they can often be provided conflicted information and unconscious bias can sometimes unintentionally lead to the male being viewed as the perpetrator. However, the Police did display a balanced approach at times when taking positive action.

3.2.41 Kim was arrested for an assault on Val on four occasions. On each of these occasions she provided an account and was released from custody with no further action to be taken.

3.2.42 On three of these occasions, Val did provide a statement of complaint, although his position regarding whether he would support appeared to change frequently.

3.2.43 Val was arrested on one occasion for an assault on Kim. She did support a prosecution and provide a statement, but Val was released from custody with no further action to be taken.

3.2.44 There were two additional occasions where Val reported being the victim of assault by Kim. He decided not to provide an account of the former incident and subsequently changed his mind after providing a statement for the latter.

3.2.45 By making an arrest, officers were taking positive action at that moment, but there were three occasions where Val would not support a prosecution which were not considered for Evidence Led (ELP) which were missed opportunities as there was mention of photographs of injuries and damage along with repeated behaviour. On each occasion the supervisor commented that ELP was not appropriate although it does not state why.

3.2.46 It is also worthy of note that only one referral was made to domestic abuse provisions to support Val although he disclosed this a number of times, yet Kim, who reported far less Police investigations and did not disclose openly to other organisations was offered support and referrals were made. She was also the person left with the children following domestic arguments where no perpetrator was identified yet appeared to be the more aggressive on these occasions.

3.2.47 On all occasions, when either Kim or Val was arrested, they were released after interview, without consideration of the use of bail conditions. Bail conditions can only be used where appropriate and justified, and if all relevant lines of enquiry have been completed, then to release on bail is not a viable option. However, following the assault on 10 January 2023 there was a rationale for Kim to be released on bail, to allow further engagement with Val.

3.2.48 Bail conditions allow breathing space and force time apart. They can be a useful tool in moderating behaviour and thus mitigating risk, and perhaps this was not fully considered by the investigating officer or their supervisor. Neither were DVPN/Os which offer similar opportunities. The non-molestation part of the notice could have enforced time apart.

3.2.49 The officers should have identified the pattern of behaviour. They recognised in the risk assessments that the couple had a protracted history of domestic abuse, often exacerbated through their shared drug and alcohol misuse and mental ill health but were drawn to each other yet did not see this as an escalating factor when grading the risk.

3.2.50 Norfolk Constabulary only consider those cases of high risk at the initial assessment for DVPNs which provides many missed opportunities to safeguard Kim and Val as they were only ever graded as medium. (**Recommendations refer**)

3.2.51 Due to their unreliability and dependency on each other, exacerbated by drugs and alcohol abuse, and deteriorating MH issues, both Val and Kim were considered victim and perpetrator at various stages. Whilst safeguarding plans were effective in the short term, their individual under-lying issues remained unresolved. Focussing on the problem, as opposed to Val or Kim as victim/perpetrator, may have improved outcomes by:

- regular sharing of information and reviews.
- interventions specifically aimed at the family's needs.
- prevention of further DA incidents.
- monitoring progress and periodic reviews.
- signposting Val to support agencies/programmes relevant to his needs.

Services and agencies provisions to suicide, mental health difficulties and those contemplating taking their own life within the Cambridgeshire and Norfolk areas.

3.2.52 Good practice was demonstrated by the CPFT LaDS support worker who was very proactive with ensuring Val was properly transferred to not just NSFT but also CGL when he moved and went above and beyond in trying to maintain contact with him until this process was complete.

3.2.53 The report highlights the need for family and carer involvement in the risk assessment process. Val did have support from his parents and siblings however their views were not sought in relation to his presenting risks and his safety planning which could have proved pivotal. The Trust is currently reviewing their Clinical Risk Policy and a refresh of the Trust Suicide Prevention Strategy, both to be published early 2024. They are aware of the findings in this review.

3.2.54 In accordance with Cambridgeshire Police PVP[22] policy, officers did submit an adult at Risk referral, which was not shared with IMHT at the time Val was detained under S136. This was on the basis that Val had already been sectioned and the assumption was made, that IMHT should already have been aware. Organisationally, this type of assumption presents a risk, where vulnerability and safeguarding issues exist. Regardless of whether an individual has been detained under the MHA or not, there is a professional duty of care, and responsibility to share that information with partners, for the purposes of safeguarding and to ensure vulnerable people's needs are met. (**Recommendations refer**)

3.2.55 The Norfolk Constabulary Adult Abuse Force Policy document has been subject of recent review. The current version was published on 19 July 2023. The overall aim of the Policy is to inform operational personnel of their responsibilities in relation to the protection of vulnerable adults from abuse, criminal or otherwise.

3.2.56 During the period of this review, 13 Adult Risk assessments pertaining to Val were completed. One of these was graded as a standard risk and the other 12 were medium risk. There were no adult risk assessments which were graded as high.

3.2.57 Of these 13 submissions, only nine had a primary or secondary classification of Mental Health, despite including an Adult Risk Assessment on Athena. This classification is significant when considering whether the Police Mental Health, Learning Disabilities, Drug and Alcohol Team are alerted to these adult risk assessments. This Team, whose role is to offer additional safeguarding through support to Police teams and information sharing to partner agencies, only review those Athena investigations where there is a Mental Health Qualifier on the WebStorm Report or a Mental Health Classification on Athena. Therefore, potentially opportunities are missed to seek their assistance if these correct identifiers have not been added to the incidents.

3.2.58 Val was undeniably vulnerable due to his circumstances, his alcohol and drug misuse and his mental health struggles. The service he received when calling the Police and asking for assistance was generally good; the right actions taken, and appropriate safeguarding measures put in place. However, this review has identified two occasions both on 13 January 2023, where calls for service were received due to Val's deteriorating mental health and threats to self-harm. On both these occasions officers attended to see him, and he was either left with family members or in the care of the health service. Ultimately, he was safeguarded; however, no Adult Protection Investigations were added to Athena, which means potentially opportunities for additional support and information sharing processes to further safeguard Val may have been missed. (**Recommendation refers**)

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[22] Protecting Vulnerable People

3.2.59 NSFT state that Val appeared to be suffering from depression, anxiety, and mental health problems. The frequency, severity and escalation of hostility undoubtedly had a cumulative and deteriorating impact on Val's health, which was intensified by lack of access and contact with his children. There were several opportunities not taken where Val could have been signposted to organisations that could support him with his mental health and suicide ideation.

3.2.60 Cambridgeshire Children's Services showed good practice when they referred Val to ALT CPFT due to his suicidal ideations, even though their focus was on the children. This shows wider thinking to address what may be the root cause of a problem rather than just re-act.

Section 4 – Conclusions and Recommendations

4.1 Conclusions

4.1.1 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.

4.1.2 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.

4.1.3 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.

4.1.4 Incidents of mental health struggles and domestic abuse incidents were treated in isolation with the intersectionality not recognised 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.

4.1.5 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.

4.1.6 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.

4.1.7 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.

4.1.8 This panel recognises the good work that the Cambridgeshire Children 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.

4.1.9 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.

4.1.10 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.

4.1.11 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.

4.1.12 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.

4.1.13 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.

4.1.14 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.

4.2 Lessons to be Learnt

Wider considerations from the Police when dealing with domestic abuse

4.2.1 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.

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

4.2.3 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.

4.2.4 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.

4.2.5 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**)

NSFT transference of those presenting on multiple occasions to secondary care

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

4.2.7 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.

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

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

4.2.9 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.

4.2.10 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**)

Overshadowing

4.2.11 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.

4.2.12 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.

4.2.13 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.

4.2.14 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**)

4.3 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 bidirectional 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 Children Services.**
   - **Review docs to support info and learning on suicide risk and prevention on the Children Services '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.

Appendices

Appendix A

Terms of Reference

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 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 death of Val 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.

Home Office

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Isabel Allison
Community Safety Officer
Office of the Police and Crime Commissioner for Norfolk
Jubilee House, Falconers Chase
Wymondham
Norfolk
NR18 0WW

28th November 2024

Dear Isabel,

Thank you for submitting the Domestic Homicide Review (DHR) report (Val) for Norfolk Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 16 October 2024. I apologise for the delay in responding to you.

The QA Panel felt that Val's voice was heard throughout this review, and that the tribute from Val's mother and sister provided an insight into who he was and the adversities he experienced during his life. The report is thorough and sensitive, and included relevant themes. The report is also open and reflective, identifying lessons learned and correlating recommendations. The equality and diversity section is well addressed; specific protected characteristics were identified, and the barriers the victim may have experienced as a male experiencing domestic abuse were well considered.

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

Areas for final development:

- The layout should follow the template set out within the DHR Statutory Guidance where possible.
- The review requires a confidentiality section.
- Confidentiality is compromised by revealing the exact date of death, the exact date the police referred the death to the CSP and the children's genders. These references should be amended.

- The Panel felt that poor mental health, drug and alcohol misuse and the intersectionality with domestic abuse could be considered further within the review.
- There could also be further considerations and recommendations as to the impact of domestic abuse on the children.
- Information regarding the inquest is uncertain and it would be helpful to clarify whether the inquest process has taken account of the DHR. Paragraph 1.1.1 states that the Coroner's inquest has been opened and adjourned awaiting the completion of this review. However, section 1.8 states that the report has already gone to the Coroner, and paragraph 1.6.6 states that the inquest has been set for early July.
- The Mental Health Thematic Review of 'Repeat Presentations' is still ongoing, and the report currently lacks clarity on how the two reviews dovetail.
- Section 7 (Key issues arising from the review) should be completed.
- The second Term of Reference at Appendix A refers to a 'domestic homicide' instead of 'suicide'.
- The glossary would be better placed at the start of the report.
- All acronyms should be explained.
- A thorough proofread is required.

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

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

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

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

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

Yours sincerely,

Home Office DHR Quality Assurance Panel

Office of the Police and Crime Commissioner for Norfolk
Jubilee House
Falconers Chase
Wymondham
NR18 0WW

18th of February 2025

Domestic Abuse Policy Team
Home Office
2 Marsham Street
London SW1P 4DF

Sent via email: DHREnquiries@homeoffice.gov.uk

Dear Sir/Madam,

Thank you for the advice and comments contained in the letter received from the Home Office DHR Quality Assurance Panel (QA panel), on the 28th of November 2024 regarding the DHR of Val.

As Chair of the Norfolk Community Safeguarding Partnership, I am satisfied full consideration has been given to the points raised by the QA panel and addressed by the Norfolk panel members together with the independent chair and author of the review.

I am aware your office will not be able to amend the QA panel letter to reflect the changes that have been made to the final review without further submission to the QA panel. We have attached the QA panel considerations and this NCSP response to yourselves to demonstrate the changes made to that review. The changes made to the report are included in this letter.

Every DHR undertaken by our partnership champions the voice of the victim. This independent review process has ensured that Norfolk partners understood the circumstances of Val's death, how agencies work individually and together and established the lessons to be learned. As a partnership we will continue to apply these lessons learned to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

Yours faithfully,

Mark Stokes
Chair of the Norfolk Community Safety Partnership
Chief Executive of the Office of the Police and Crime Commissioner for Norfolk

NORFOLK COMMUNITY SAFETY PARTNERSHIP

DHR Val report changes following Home Office Quality Assurance feedback.

Area of Development	DHR Author/Panel Comment
The layout should follow the template set out within the DHR Statutory Guidance where possible.	*The author has reflected on the HO feedback and feels the report does follow the DHR Statutory Guidance.*
The review requires a confidentiality section.	*Now included at 1.4*
Confidentiality is compromised by revealing the exact date of death, the exact date the police referred the death to the CSP and the children's genders. These references should be amended.	*The author has amended the report.*
The Panel felt that poor mental health, drug and alcohol misuse and the intersectionality with domestic abuse could be considered further within the review.	*The author believes the report clearly identifies that poor mental health, drug and alcohol misuse and the intersectionality with domestic abuse has been considered in the following sections of the report.* *1.8.4, 3.2.9, 3.2.10, 3.2.38, 3.2.44, 3.2.45, 4.1.3, 4.1.4, 4.1.11, 4.2.11-4.2.14* *Recommendations 7, 9 and 11 relate to the above sections.*
There could also be further considerations and recommendations as to the impact of domestic abuse on the children.	*2.3.136 outlines the incidents the children were exposed to.* *Analysis 3.2.23 – 3.2.36 headed* The effectiveness of agencies responses to support children who are victims of domestic abuse with multi-complex needs within the family home is explored. The author working with Norfolk CSP and Norfolk CSC have been made aware of the QA panels request for further consideration. To support the learning from this DHR this will be discussed in full at the Norfolk DASVG Children and Young People group to support partnership learning of the impact of abuse on children.

Information regarding the inquest is uncertain and it would be helpful to clarify whether the inquest process has taken account of the DHR. Paragraph 1.1.1 states that the Coroner's inquest has been opened and adjourned awaiting the completion of this review. However, section 1.8 states that the report has already gone to the Coroner, and paragraph 1.6.6 states that the inquest has been set for early July.	*Section 1.1.1 has been amended to reflect the QA panels comments.* *Section 1.7 in the report discusses the Coronial process. In section 1.9 the report identifies the report had been shared in confidence with the coroner for awareness purposes.* *At no point has the author detailed within the report the inquest was set for early July.*
The Mental Health Thematic Review of 'Repeat Presentations' is still ongoing, and the report currently lacks clarity on how the two reviews dovetail.	*This Menatl Health review has been completed* *The Thematic review findings have been added and found from 1.7.8 – 1.7.14. They have been integrated into the conclusion at 4.1.5 and the exec summary at 8.5*
Section 7 (Key issues arising from the review) should be completed.	*Please refer to Section 7 of the Executive Summary*
The second Term of Reference at Appendix A refers to a 'domestic homicide' instead of 'suicide'.	*Amended to 'death of Val'*
The glossary would be better placed at the start of the report.	*The author has amended the report and moved to Pg 6 of the overview report.*
All acronyms should be explained.	*The author has amended the report.*
A thorough proofread is required.	*The author and panel have fully reviewed this report and used both manual and electronic measures to ensure it meets the standards required for Home Office QA submission.*