Executive Summary

Norfolk CSP

A Domestic Abuse Related Death Review (DARDR) concerning the death of Robyn (May 2024)

Author – Jackie Dadd

Date completed – November 2025

Family and Friends tributes

NB:(Robyn has been referred to as ‘B’ within these tributes as this was the wish of the family)

B was a rare and beautiful combination of grace and resilience. Her strength wasn’t just about enduring hardship; it was about her incredible, constant ability to make light of any situation, to find the positive, and to use every burden she carried to better herself and uplift those around her. She was a truly unique light and strength to us and everyone she cared for. Her profound resilience was deeply rooted in her fierce dedication to motherhood. Being a mother was the absolute core of everything she did, and when she was with her son, she felt truly calm, complete, and fully herself. They weren’t just mother and son; they were best friends. She strove every day to be the best possible role model, determined to ensure he had the happiest, best childhood possible. Her commitment to him and to her own self-improvement was the great, unwavering work of her life.

To know B was to witness a constant striving for beauty and excellence, qualities that defined her long before she became a mother. Even as a little girl, she had a sweet nature, taking pride in her schoolwork, loving to write, draw, and create dance routines with her sisters, and treating everything she owned with care. That same commitment followed her into adulthood. She didn’t just maintain a home; she mastered it. Her classic and fresh taste in interior design, along with her ability to make any space pristine and welcoming, were true reflections of her personality—always wanting to make her surroundings warm and beautiful.

She had an authentic love for all things related to food, finding comfort and joy in every aspect of it. Her passion for cooking and baking was matched by her enthusiasm for discovering new restaurants and enjoying sweet treats, each experience bringing her happiness. For B, food was many things; it was a heartfelt expression of care and a way of nurturing her son, as well as a way to experience meaningful connections with friends and family. To her, food embodied love and the essence of togetherness.

Her creative flair shone brightly in her job roles, where her artistic spirit brought beauty to others. She was incredibly proud of a career role that was a testament to her powerful capability; she could juggle countless tasks to an exceptionally high standard whilst training hard outside of work to improve her skills—driven by sheer hard work and focus.

B was a breathtakingly beautiful person, with a natural radiance that shined through in every aspect of her presence. Her captivating, graceful smile, with mesmerizing, kind, and sparkling eyes, and her glowing skin reflected her inner kindness and warmth, which left everyone she met in awe of both her outer and inner beauty and elegance. She demonstrated self-care each day and consistently encouraged her loved ones to prioritize themselves as an essential act of self-love. Her impeccable style and fashion sense were evident in the thoughtfully chosen outfits she wore, inspiring others around her—an effortless, natural, and graceful beauty.

If you needed her, she was there—no question. Her loyalty wasn't passive; it was an active, fierce defence of the people she loved. That is what true strength looks like. Her presence in the lives of her friends and family was one of peace, protection, laughter, and unshakeable strength. If anyone was going through challenges, they knew she would show up without question, offering practical advice and continuous support. She was trustworthy, reliable, and incredibly warm qualities she chose to embody and share. Her humour was unmatched; her quick wit and humour would catch you off guard, making everyone around her laugh and feel uplifted. She made strong friendships everywhere she went, always leaving a powerful impression with her bright personality and her inspiring ability to spread happiness and wisdom.

B was determined not to be defined by the tough environment she grew up in. She never wanted others to feel how she had been made to feel. Her decision to rise above her own experiences and choose a life of joy and giving is the greatest proof of her power and beautiful spirit.

Until her last breath, she was fighting for a peaceful future that was rightfully hers. She did all of this to protect her son and to build the new, beautiful life she had meticulously planned for happiness and safety.

The hardship she endured will never silence her voice or diminish her light.

Her legacy is not in the struggle she endured, but in the boldness with which she lived and the grace with which she loved. Her final message is simple: Never let anyone extinguish your light.

We love you, B. We promise to carry your fierce spirit and determination with us and to be the best we can be. Your memory will always live on. Your sister.

Below are two meaningful tributes from B's closest friends:

"Bringing our babies into the world at the same time fostered a close bond between us, for which I am eternally grateful. We shared those very special milestones, the challenging moments, as well as the everyday joys whilst raising our children. Not only did we experience those times, but I also had the privilege of spending many years with a fabulous, creative, selfless woman. She had an extraordinary ability to solve any problem instantly, to talk for hours on end, to think deeply, and to navigate life with insight. Throughout our friendship, she consistently demonstrated love, compassion, excitement, and humour. All while embodying maturity, class, and elegance. She was truly a one-of-a-kind, beautiful soul and now our angel."

"My memories of B are some of the most special times of my life. Helping me navigate through my secondary school life into adulthood and then having my son. I hold close in my heart memories of her making my 16th birthday so special while I was going through a hard time at home. Her support was unwavering every step of the way—always. I will always remember, forever, B meeting my son for the first time, guiding me and supporting me through what I found so hard. She taught her brilliance, and it shone so bright. From

dancing to Beyoncé in the park to running away from teachers, B gave me my best and favourite times. I feel the most privileged and blessed to have known such a phenomenal person."

Our beautiful B, you were, and remain, our inspiration. We love you.

The Domestic Abuse Related Death Review Panel and the members of the Norfolk Community Safety Partnership would like to offer their sincere condolences to the family of Robyn, who have lost their loved one in tragic circumstances.

Contents

1. The review process

1.1 This review examines agencies responses, provisions and support provided and/or available within Norfolk to Robyn, a 34-year-old female, prior to her death, having been found deceased at her home address in Norfolk by her ex-partner, Mark in May 2024. Norfolk Police have investigated the circumstances surrounding her death and have submitted a report to the Coroner with a finding that the death was non-suspicious and indictive of suicide by hanging.

1.2 Norfolk Police made a referral to Norfolk Community Safety Partnership in June 2024 due to information found at the scene, concerns raised by Robyn's family and information from a support service that they discovered during their enquiries and a decision was made to undertake a Domestic Homicide Review as the definition in Section 9 of the Domestic Violence Crime and Victims Act (2004) had been met.

1.3 In accordance with Home Office guidelines to ensure confidentiality, pseudonyms have been utilised throughout this report for the following: (All ages are recorded at the time of Robyn's death).

Robyn – Deceased. A white British female, aged 34 years.

Rory – Only child of Robyn. Aged 11 years.

Tony – Ex-partner of Robyn and father of Rory.

Danny – Older brother of Robyn.

Debbie – Older sister of Robyn.

Mark – Ex-Partner of Robyn. White British male, aged 33 years.

Peter – Robyn's employer and friend.

1.4 Family members were informed of the commissioning of the DARDR and informed of how to contact AAFDA if they so wished but were already receiving counselling locally and chose not to accept this offer. This was re-iterated on more than one occasion. The Author communicated with Danny and other family members via phone, email and Teams as was their choice at the time. Danny attended the third panel meeting online to meet the panel members and be part of the discussions for recommendations. He received and reviewed the draft of the overview to provide his input prior to completion and submission. Danny was appreciative of the review and the findings.

1.5 A letter was sent to Tony (Rory's father) at the commencement of the review informing him of its commencement. A letter was sent to Rory via his father having sought expert advice from a child specialist on the wording, in order to offer Rory the opportunity to partake in the review if consent was provided. The author has not received a response from Tony to either letter.

1.6 The author held a lengthy interview with Mark via Microsoft Teams in which he denied any domestic abuse.

2. Review panel members

2.1 The following agencies/organisations/voluntary bodies have contributed to the Domestic Homicide Review by the provision of IMRs, Summary reports and chronologies.

2.2 The panel comprised of the following:

Name	Area of responsibility	Organisation
Liam Bannon	Community Safety Manager	Office of the Police and Crime Commissioner for Norfolk (OPCCN)
Dr Anonymous	General Practitioner	GP Surgery
Gary Woodward	Senior Designated Professional for Safeguarding Adults	NHS Norfolk and Waveney Integrated Care Board (ICB)
Nadia Jones	Public Health Principal	Norfolk Public Health
Diana Pooley	Service Manager – Child Protection Independent Chairs	Norfolk Children Service's
Charlotte Richardson	NIDAS Service Manager	Leeway Domestic Violence and Abuse Services
Isabel Allison	Community Safety Officer	Norfolk Community Safety Partnership
David Burke	Detective Inspector for Domestic Abuse Safeguarding Team	Norfolk Police
Rebecca Moden	Detective Sergeant – Investigative Improvements	Norfolk Police
Lorraine Curston	CEO	Dawn's New Horizon
Sonja Chilvers	CEO	Norfolk and Waveney MIND
Nyree Grieve	Community Safety Officer	Office of the Police and Crime Commissioner for Norfolk
Amy Jolly	Head of Safeguarding Families	Norfolk and Suffolk Foundation Trust (NSFT)
Katie Hoddy-Brown	Commissioning Support Officer	Office of the Police and Crime Commissioner for Norfolk

2.3 Thanks go to all who have assisted and contributed to this review with their valued time and cooperation.

3. Contributors to the review

3.1 The following agencies/organisations/voluntary bodies have contributed to the Domestic Homicide Review by the provision of scoping their records and if necessary, providing reports and chronologies.

Agency	Contribution
Norfolk Office of the Police and Crime Commissioner (OPCC)	Oversight, Panel member
Dawn's New Horizon	IMR, Panel member
GP Surgery	IMR, Panel member
Norfolk and Waveney Mind	Scoping, Panel member
NHS Norfolk and Waveney Integrated Care Board (ICB)	IMR, Panel member
Norfolk Public Health	Summary report, Panel member
Norfolk Children's Services	IMR, Panel member
Leeway Domestic Violence and Abuse Services	Panel member
Norfolk Police	Summary report, Panel member
Norfolk and Suffolk Foundation Trust - NSFT	Scoping, Panel member
Norfolk Education	Scoping

3.2 Several further agencies were scoped but did not hold any information.

4. Author of the Overview report and Chair

4.1 The chair of the review panel and Author of this report is Mrs Jackie Dadd, an independent consultant who is 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, having been the Force Lead for domestic abuse, stalking and harassment and serious sexual offences and has been involved in the DARDR process since its inception in 2011.

4.2 She has completed several training courses including the Home Office online training, the Continuous Professional Development accredited AAFDA (Advocacy After Fatal Domestic Abuse) DARDR Chair training, the domestic Abuse and suicide accredited course, and is a member of the AAFDA DARDR network, regularly attending the monthly forums for CPD and discussion. Mrs Dadd has obtained the accredited Home Office qualification of a level three certificate in Chairing a Domestic Homicide Review and is on the register of accredited DHR/DARDR Chairs for England and Wales.

4.3 Mrs Dadd has completed and published several DARDRs.

5. Terms of Reference

The Terms of Reference were discussed and agreed upon during the first panel meeting and was a working document throughout the review.

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 Robyn taking her own life.
b) Evaluate the communication and promotion of information within Norfolk to assist others with identifying and obtaining support in regard to domestic abuse and those contemplating suicide.
c) Is signposting sufficient for those needing support or can more be done.

The Terms of Reference requiring a response are below:

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 Robyn.

What safeguarding options are available for agencies if offers of support are declined and there does not appear to be immediate danger.
Is professional curiosity shown as to why a person does not want to engage?

How do Norfolk agencies communicate information that will assist someone with identifying domestic abuse and is this effective?

Are agencies in Norfolk able to both identify and understand the impact of Adverse Childhood Experiences (ACES), the correlation to vulnerability of domestic abuse and how to respond to this?

Are agencies considering Clare's Law and providing guidance and advice when it is identified that this may be relevant?

Should agencies offer practical assistance to refer to support agencies as well as providing the information for support

What difficulties do professionals face in identifying DA perpetrators and what training is available to assist them in correlating information to DA?

Establish accessibility of services for those contemplating suicide and whether the communication methods to the public are effective.

Identify avenues to strengthen work in Norfolk to support third sector agencies and increase information sharing.
How effective are agencies within Norfolk on a collaborative approach to identifying and supporting family members following the loss of a loved one?

6. Summary chronology

Robyn

6.1 Robyn is one of four siblings in which they all share the same mother. She has an older brother and sister, Danny and Debbie and a younger sister. Robyn lost contact with her father when she was 13 years old in 2003 as, Danny says, that he was pushed out of her life by their mother.

6.2 In 2012, Robyn was in a relationship with Tony who was older than her and gave birth to their child, Rory. Tony did not live with Robyn. In 2013, Robyn informed a student Health Visitor that Rory's father was being controlling and bullying but she denied domestic abuse. The Health Visitor implied in her notes that this was discussed at length. No referrals are apparent. In 2014, Robyn registered with her GP Surgery which she would remain with throughout her life.

6.3 An incident occurred in 2020 when Tony tried to push his way into Robyn's home whilst dropping Rory off after a contact visit. She contacted the police and Children's services and the school were made aware. Robyn was signposted to several relevant support services and no further action was taken.

Mark

6.4 In 2019, just prior to meeting Robyn, a local newspaper printed an article with Mark in which he spoke about his depression and anxiety struggles and how he was launching a mental health campaign.

Combined chronology

6.5 Robyn and Mark met in 2019 as they worked next door to each other and after seeing her a couple of times, Mark chatted to her over the wall. They began a relationship in 2020. Lockdown, due to Covid 19, occurred a couple of months in and they would speak on Zoom each day.

6.6 In February 2020, Robyn attended counselling for acute anxiety following a referral from her GP. She disclosed to her counsellor that the unreliability of Rory's father and her own upbringing made her feel like a mess and she wanted to unpick things. She attended ten sessions of counselling in all with this particular counselling service.

6.7 Having stayed over at each other's houses during second lock down, Mark bought a house in the city 'as a surprise' for Robyn so that the three of them could all live together and see each other every day. They moved in shortly after.

6.8 In 2021, Robyn received five sessions of CBT before withdrawing from the treatment and then in 2023, self-referred to her original counsellor where she requested sessions on family and abuse. She had just begun a job as a personal assistant at a Farm Administration Company in which she did well and made friends quickly.

6.9 As time went on, Robyn's anxiety had impacted her and she had to have days off work as it worsened and she feared she would lose her job. This fear was manifested by Mark who repeatedly told her that she would lose her job.

6.10 In February 2024, Mark was due to go abroad for a week and although she asked him not to as her anxiety was bad, he left and she had her brother move in with her for the week. During this time, they spoke about her relationship and Robyn disclosed a number of incidents where the way Mark had treated her and caused her anxiety and she came to realise that he was the cause. She told Danny that Mark's response to her not wanting to be left alone was to put his hands on her shoulders and shout in her face "Sort yourself out or you'll get sectioned. Get this through your head, I just don't care."

6.11 Robyn spoke of how he would get in a mood with her and then not speak to her for days for no apparent reason and did this in front of Rory. Mark would dictate what her and Rory ate and would not let them eat in the same room as he could not stand the noise. Robyn had lost considerable weight as he would comment on her putting weight on when she ate and did this in front of his parents whilst they were staying there on more than one occasion.

6.12 By Mark's return, Danny states that Robyn seemed a lot brighter but soon after, had to go to her GP surgery as she was not sleeping and her anxiety was the worst it had been. Robyn asked Mark to move out and give her space so he went to stay at his parents. Robyn had to have time off work and in confiding to her employers, they had arranged counselling and found a cottage for her to live in on the farm which needed some work on first.

6.13 Robyn self -referred to Dawn's New Horizon (DNH) and disclosed the behaviours of Mark that she had told Danny and also disclosed further details of what happened between them in which the counsellor identified to her that she had been suffering both domestic and sexual abuse. Practical assistance was offered by DNH in attending with her to report it to the police but she declined. No referrals were made as DNH did not identify any risk.

6.14 Robyn made further disclosures on controlling behaviour by both Mark and his mother with texts and visits to her home. During the same week, Robyn rang 111 and explained that she was struggling with anxiety and panic attacks since February and felt like she was having a break down. She was having daily panic attacks and had been in bed for two days. She was struggling to eat and had lost two stone since February. The MIND café was discussed and support from family and friends along with Talking Therapies and psychiatric medications. Robyn felt that she was not able to accept the advice as she felt more immediate response

was needed for her current deteriorating mental health. A discussion was held in relation to next level intervention due to her breakdown and panic attacks and was advised to present to a mental health professional in A & E.

6.15 One evening in May 2024, a friend of Robyn's contacted the family as they were worried as they had not heard from her for a few days which was unusual. Due to the fact that Mark had a key, the family contacted him and asked if he could go to the home and check on her.

6.16 Upon arrival, having entered through an upstairs window, Mark found Robyn in her bedroom hanging from a clothing rail. No suicide note was found. There was no indication of third-party involvement.

6.17 Due to the information the family provided to the police and disclosures made to counsellors, the police have interviewed Mark in relation to domestic abuse offences and a decision is to be made as to whether there is sufficient evidence to submit a file to the CPS.

7. Key issues arising from the review

7.1 The impact of childhood experiences on Adult Mental health

Robyn outlines to a number of counsellors that she was abused by her mother when she was growing up and this is re-iterated by her siblings who were also abused with Danny being open as to how they have all had to receive counselling and medication in relation to this in their adult years.

This is clearly something that troubled Robyn who openly asked more than one counsellor if they could help her understand it. Robyn struggled with anxiety and panic attacks as well as depression. Anxious Minds Supporting people in Crisis have outlined on their website[1] that these are indicative of how early life events often shape mental health outcomes in later years.

Their Key Takeaways state:

- Adverse childhood experiences (ACEs) significantly affect mental health in adulthood.
- Physical Abuse and parental separation are common ACEs.
- Research links ACEs to higher risks of depression and anxiety.
- Understanding ACEs is vital for improving mental health strategies.

This is an area that may not automatically be taken into consideration when someone presents with mental health struggles and may need specific specialist counselling. Robyn received counselling from four different providers which may have conflicted each other and caused confusion.

[1] The Impact of Childhood Experiences on Adult Mental Health

7.2 How can we best understand a person needs

Danny attended a panel meeting and spoke at length with the panel on his thoughts about the difficulties faced by victims of domestic abuse who have had a traumatic childhood and those professionals who have to make decisions on their treatment.

Danny explained how Robyn did not know that she was suffering from domestic abuse and was not aware of what a normal relationship was as she had no benchmark due to her upbringing and treatment from her mother. She also did not realise, due to her reliance on Mark's presence, that he was a large causal factor of her present anxiety. Therefore, if she was asked specific questions relating to domestic abuse by professionals or the GP, then she would not necessarily have related those to her current situation. Equally, she would not have known which support and services were applicable to her. Without this information, the professional may find it difficult to diagnose or identify the core issues in order to be able to plan their recovery or treatment.

The panel discussed how a conversation could take place, particularly between a GP and their patient that may 'draw out' the core issues of a person's anxiety and not be reluctant to name domestic abuse if identified. The conversation should be able to allow the patient to open up, taking into account that there are time demands on professionals.

8. Conclusions

8.1 Norfolk Domestic Abuse and Sexual Violence Group (DASVG) have completed focussed work in contacting third sector non-commissioned support services in the area over the past few years to ensure that they feel included within a partnership to share information, speak to other agencies and learn from each other, having access to tools that they can use. However, this review does highlight that as they have no jurisdiction over them, there is little oversight as to the comparable standard of policies and procedures that they follow or do not have in existence.

8.2 Professionals expressed the difficulty of identifying perpetrators of domestic abuse without the victim reporting this to a party and what response they could take if they did as the only perpetrator programme in the area is for those who have been through the Criminal Justice system. Identification and support for those who are perpetrators of domestic abuse prior to criminal prosecution is desirable to prevent abuse at the earliest opportunity.

8.3 The NICE guidance for medical practitioner's has not been reviewed since 2016 and advice is not up to date with current legislation in relation to both safeguarding and in particular, domestic abuse. This causes differing responses from health staff as to what questions or professional curiosity is made around domestic abuse and adult safeguarding.

8.4 It is clear that Robyn's experiences in her childhood of abuse, relationship with her mother and separation from her father were all contributory factors to her anxiety and

depression struggles in her adult life in which she sought to gain understanding from counselling, which in turn caused her upset talking about it.

8.5 Robyn was prepared to contact the police if she identified that actions required it, as she displayed in 2020 when Rory's father tried to push his way into her house. Due to disclosures to Dawn's New Horizon and conversations with her brother just prior to her taking her own life, it is clear that although she had clearly known something was wrong with the way in which she was being treated by Mark, she had not identified that this was domestic abuse and that he was the present trigger of her anxiety. This may be due to her not understanding how to be treated in a relationship, as mentioned by her brother Danny.

8.6 The failure to assess the risk to Robyn when disclosures were made, particularly following the end of the relationship which is heightened risk in itself was a missed opportunity to safety plan for both her and Rory.

8.7 Robyn had sessions with at least three different counsellors in order to try and assist with her understanding of relationships and reduce her anxiety. She clearly felt protective over Rory as highlighted when she stopped Mark from seeing him as she had seen his anxiety when in his presence. She had pride as recognised when she stated she felt ashamed if other parents from Rory's school knew what had happened.

8.8 Dawn's New Horizon showed good practice when offering practical help to Robyn in the manner of supplying clean sheets, offering to go to the police station with her to report offences against Mark and his mother and offering to complete referrals for her rather than herself refer. These are all actions that can assist somebody to get the help they need in a moment of crisis where if left to complete themselves, they may not have the energy or inclination to do so.

8.9 Robyn disclosed numerous forms of domestic abuse to her counsellors, with more detail being disclosed of the abuse that she suffered from Mark than in her upbringing. She spoke of her sexual abuse and her coping mechanism for this as she did not want the consequences of if she refused but needed Dawn's New Horizon to clarify that this was rape and she outlined how dirty this made her feel.

8.10 Robyn suffered from emotional and psychological abuse from Mark and Mark's mother was also assisting with his controlling and coercive behaviour and abuse by re-enforcing his message that it was all Robyn's fault and due to her mental health issues. Robyn spoke of how he masked his behaviour and no-one knew what it was like to live with him.

8.11 Referrals were not made by any counselling service for Robyn and Clare's Law does not appear to have been considered as advice. The heightened risk that she had due to having just left a relationship was not recognised. Her employer showed excellent support in gaining her counselling and reassuring her security within her job whilst finding accommodation for her to move out of Mark's house.

8.12 It is clear that Robyn was in crisis within her last few weeks as she was reaching out to more than one counsellor, her GP surgery and her employer for help and when she rang 111 who provided advice of pathways for help, she informed them that she felt more immediate

response was needed for her current deteriorating mental health. A discussion was held in relation to next level intervention due to her breakdown and panic attacks and she was advised to present to a mental health professional in A & E but never did.

8.13 The panel conclude that although Robyn was clearly suffering from issues and abuse in her childhood, the current abuse that she had been receiving from Mark, perpetuated by pressure from his mother and friends was most certainly a contributory factor in her sadly taking her own life.

9. Lessons to be learnt

Inclusion of father's in Children's Services practices when a referral is received

9.1 Following the referral to Children's Services in 2020 where Tony tried to push his way into Robyn's home whilst returning Rory, it was noted that only Robyn was contacted and spoken to in relation to this incident and although this could have been due to fear of repercussions, it was noted that it would have been equally appropriate to call Tony and ask how he intended to avoid this conflict in front of his son in the future. It was the female who instigated the referral due to the males actions. Speaking to both parties will allow faster information gathering to allow for risk assessment.

9.2 There has been considerable research and work on father inclusive practice within Norfolk, providing advice to all practitioners on successful practice with fathers who become involved with Children's Services, however, this work was not ongoing at that time.

9.3 It is notable that in child and family social work in Norfolk, there can be an over reliance on females giving account for childcare issues and on females protecting themselves and children and there is further work to be completed in this area. (Recommendation refers)

Alignment of procedures and policies for commissioned and non-commissioned support services.

9.4 During this review, it has been identified that Robyn received counselling from at least three different providers, all of whom were not a commissioned service by the Office of the Police and Crime Commissioner for Norfolk.

9.5 It was identified that at least one of these providers had not received training in suicide on how to identify, respond or provide pathways for specialist assistance. Also, that there was no bespoke safeguarding policy on how to identify, risk assess or respond to any safeguarding needs that were disclosed or had been identified which led to the absence of relevant referrals being made and an inaccurate assessment of the risk that Robyn may have faced.

9.6 Commissioned Services have the scrutiny of their commissioners in relation to policies, procedures and access to knowledge sharing from the partnerships. It is important for non-commissioned services to take an active part in partnerships such as the DASVG in Norfolk to share and learn from like-minded professionals and not work in silo. This will provide both scrutiny and support for all. (Recommendation refers)

10. Recommendations

National

1. **The OPCCN to recommend to NICE to review and update the NICE guidance QS116 for staff working in general practice to ensure it is relative to current legislation.**
   This will ensure it is current and reflects up to date guidance and legislation.

Local

2. **GP staff and Clinicians to ensure that when they have spoken to a patient in relation to domestic abuse, that the conversation is fully recorded, even if the patient denies the abuse.**

   This provides an audit trail of disclosure and conversation surrounding domestic abuse to ascertain risk and safeguarding of a patient with holistic, historic information and not just silo information provided at that time.

3. **Norfolk Children's Services to provide training and support to CADS staff to ensure that domestic abuse is named and provide guidance on relevant communication with both parents in an abusive relationship who are attempting to manage child contact.**
   This will provide specific, focussed training in these areas and will incorporate the needs of the child to ensure they are not hidden within the DA in these circumstances.

4. **All organisations offering therapeutic services such as counselling or psychological services in the Norfolk area, regardless of size, should be provided with the resources to ensure their staff and volunteers are equipped to deal with and respond to suicide. National guidance and training are affordable and accessible, and every effort should be made by organisations and individuals offering these services to keep up to date on how to respond safely, including informing authorities as appropriate.**
   This will ensure that they are constantly accessing available information, are up to date with guidance and training and know how to appropriately respond if they identify or an individual discloses suicidal thought or ideations.

5. **Office of the Police and Crime Commissioner for Norfolk to be a critical friend to Dawn's New Horizon for safeguarding policies and procedures, providing written feedback and recommendations. The policies should outline processes and procedures for staff to follow in the event of disclosure or identification of domestic abuse or safeguarding risk.**
   Although Dawn's New Horizon are not a commissioned service in the area, this will ensure that they have support and that their policies and procedures are the standard and in line with commissioned services.

6. **Dawn's New Horizon to ensure a DASH Risk Assessment is completed each time a client discloses any form of domestic abuse, providing monitoring statistics to the CSP one year after implementation.**
   This will ensure that it is completed in the correct manner and that there is consistency in risk assessments and identification of risk for referrals to be made and safeguarding to be implemented.

7. **Dawn's New Horizon to ensure their staff and volunteers are equipped to deal with and respond to suicide by providing training and information on how to respond to those with suicidal ideations.**
   This will create knowledge on correct pathways and referrals to be made in crisis situations.

8. **Norfolk CSP perpetrator sub-group to identify services that could be utilised or commissioned within Norfolk for those perpetrators who have not come to the attention of the police but wish to seek help for their behaviour.**
   A gap in provisions was identified during this review that on the occasion a perpetrator was either identified by a professional or identified themselves that they needed help to change and understand their behaviour and hadn't come to the attention of the police previously for a DA matter, there was no service to refer or guide them towards.

9. **Norfolk and Waveney ICB to promote the National Respect helpline to GP Surgery's for signposting to patients when relevant.**
   This is to provide a direct pathway for them to advise patients who ask for help with their behaviour as DA perpetrators.

10. **GP's to take a trauma informed approach to explore whether domestic abuse is taking place, whilst being sensitive to the possibility that they may not have recognised this or may not be able to articulate this.**
    Often the sole agency contact with individuals, this will allow the GP to ascertain a holistic view of the potential cause of symptoms and make relevant referrals to provide both clinical and specialist support to the patient.