Overview report

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 is referred to as B throughout 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.

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Preface

The key purpose of any Domestic Abuse Related Death Review (DARDR) 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 DHR according to Statutory Guidance 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 define 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.

Glossary

ADHD – Attention Deficit Hyperactivity Disorder

CADS – Child Advice and Duty Service

CPS – Crown Prosecution Service

DA – Domestic Abuse

DARA – Domestic Abuse Risk Assessment

DARDR – Domestic Abuse Related Death Review (Agreed new title for DHR yet to be implemented)

DASH – Domestic Abuse Stalking and Harassment (risk assessment)

DHR – Domestic Homicide Review

GP – General Practitioner (Doctor)

IDVA – Independent Domestic Violence Advisor

MARAC – Multi Agency Risk Assessment Conference

OPCCN – Office of Police and Crime Commissioner for Norfolk

OTR – Off the record (counselling service)

THRIVE – Threat, Harm, Risk, Investigation, Vulnerability and Engagement

Section 1 - Introduction

1.1 The commissioning of the review

1.1.1 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.

1.1.2 The 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.

Contributors to the review

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 County Council Public Health	Summary report, Panel member
Norfolk County Council 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 County Council Education	Scoping

1.1.3 The following agencies completed scoping[1] and responded to state that neither, Robyn, Rory or Mark were known to them:

- Adult Social Services
- Leeway Domestic Violence and Abuse Services
- Norfolk Integrated Domestic Abuse Service (NIDAS)
- Cambridgeshire Community Services NHS Trust
- Norfolk Fire and Rescue Service
- Queen Elizabeth Hospital

[1] The scoping consisted of each agency reviewing their records for any previous contact they may have had with either Robyn, Rory or Mark.

- James Paget University Hospital
- Great Yarmouth Borough Council
- Norwich City Council
- South Norfolk and Broadland District Council
- IC24
- Norfolk and Norwich University Hospital
- King's Lynn and West Norfolk Borough Council
- East Coast Community Health Care

Review Panel

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

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)

1.1.5 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 DARDR and it was agreed that reports, chronologies, IMRs and other

supplementary details would form the basis of the information provided. Thanks go to all who have assisted and contributed to this review with their valued time and cooperation.

Author of the Overview report

1.1.6 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 DHR process since its inception in 2011.

1.1.7 She has completed several training courses including the Home Office online training, the Continuous Professional Development accredited AAFDA DHR Chair training, the domestic Abuse and suicide accredited course, and is a member of the AAFDA DHR 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.

Mrs Dadd has completed and published several DHRs.

1.2 Purpose of the review

The purposes of a DARDR 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.

DARDRS are not inquiries into how the victim died or into who is culpable; that is a matter for the Coroner and criminal courts, respectively, to determine as appropriate. DARDRs are not 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.

This review will ascertain whether domestic abuse could have been the cause or a contributory factor to the death of Robyn. It is not to apportion blame, but to view the circumstances through her eyes.

1.3 Timescales

1.3.1 Norfolk Police made a referral for consideration of a DHR to Norfolk CSP on the 25th 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.

1.3.2 On 30th of July 2024, 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 6th of August 2024.

1.3.3 Mrs Jackie Dadd was commissioned to provide an independent Chair and author for this DHR on the 21st of November 2024. Three separate panel meetings then took place. The completed report was handed to the Norfolk Community Safety Partnership on the 6th of November 2025.

1.3.4 Table outlining timeline of review

May 2024	Robyn is found deceased
25/06/24	Norfolk Police send a referral to Norfolk CSP for a DHR decision
30/07/24	Decision to commission a DHR made by Norfolk CSP
06/08/24	Norfolk CSP notify the Home Office of their decision
21/11/24	Mrs Jackie Dadd commissioned as Chair and Author
11/02/25	First panel meeting
07/05/25	Second panel meeting
07/08/25	Third panel meeting
06/11/25	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 agreement of recommendations by the ICB.

1.4 Confidentiality

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

1.4.2 The pseudonyms within this report were chosen between the Author and the family to protect the identity of those referred to throughout the report. Full details are found at 1.6 of this report. The reference to Robyn as 'B' within the tributes from family and friends was at their request and does not relate to any specifics with no confidentiality breaches.

1.4.3 The Norfolk 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 (ToR)

1.5.1 The Terms of Reference were discussed and agreed upon during and following the first panel meeting having discussed and agreed them with Danny who did not wish to add any points. The ToR was a working document throughout the review.

1.5.2 The Full Terms of Reference can be found 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 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?

- Identify Good practice

1.5.3 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.

1.5.4 This was based on the areas identified from scoping and comments from family members that the panel, author and family felt could potentially have learning points identified.

Methodology

1.5.5 Initial scoping was completed and it was evident that there had been contact with support services by Robyn but limited contact with statutory agencies. A meeting was held with the investigating officer of the police investigation prior to the first panel meeting to gain an overall view of the circumstances. During this meeting, the Terms of Reference areas were agreed. The panel were provided guidance by the police on who could be approached for further information.

1.5.6 The family were informed of the DHR and following the scoping period, Danny (Robyn's brother) became the main point of contact. Panel meetings were held to provide discussion, debate and confirmation of actionable recommendations. All panel members and Danny were sent the report to read and have opportunity to comment and amend prior to submission to the CSP and Home Office.

1.5.7 The Author made contact with Mark and held a lengthy interview with him of which is summarised at 3.3 of this report to gain the perpetrator's perspective.

1.6 Subjects of the review/Family and friends' involvement

1.6.1 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. Alleged perpetrator of domestic abuse against Robyn and Rory.

Peter – Robyn's employer and friend.

1.6.2 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 take up 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.

1.6.3 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.

1.7 Parallel reviews

Coroner

1.7.1 The Coronial process was suspended for 18 months in August 2024 to allow for the criminal investigation and this review to be completed.

IOPC

1.7.2 Debbie was not accepting of the Police findings at the scene and made a complaint to the IOPC as she did not believe that her sister would have taken her own life. This investigation is still ongoing. However, a decision was made that due to the fact that it was concerning the events post Robyn's death, it would not affect any findings of the review as it was outside of the reviews jurisdiction.

Police investigation

1.7.3 A police investigation into domestic abuse related offences against Robyn was undertaken due to the information that has been provided since her death. Mark has been interviewed under caution as the suspected perpetrator. The investigation is now complete and the evidence does not meet the threshold to be sent to the Crown Prosecution Service (CPS) for a charging decision. Therefore, there will be no further action taken. This investigation has not informed the review above and beyond the information the family have provided when speaking with the author.

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 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

Key considerations for the panel were age, sex and disability.

1.8.3 It was considered that Robyn's sex was relevant to the review as 3-10 women a week die of suicide where they have suffered domestic abuse[2] and in 2018, eighty-three per cent of victims reporting coercive control to the police were female[3]. Statistics show that women are more likely to experience domestic abuse with 1 in 4 women in the UK.[4]

1.8.4 Her age was deemed relevant as the Office for National Statistics estimates that around 1% of children are likely to experience the death of their mother before they reach the age of 16 years. This data research was completed up until 2000 with nothing more recent. Robyn died at the young age of 34 years. Data supplied from 28 police forces showed that over 50% of police recorded violence against the person offences against women in age groups between 20 and 44 years were domestic abuse related.[5]

1.8.5 Disability was deemed relevant due to the struggles faced by Robyn with anxiety and depression. The Government website[6] states that a mental health condition is considered a disability if it has a long-term effect on your normal day-to-day activity which was the case with Robyn who missed work at times and sometimes couldn't leave the house.

1.8.6 Research by Safelives[7] shows that domestic abuse can have a severe and long-lasting impact on mental health and that victim's often find it difficult to access the support that

[2] hoping to help: Identifying and responding to suicidality amongst victims of domestic abuse - Vanessa E Munro, Ruth Aitken, 2020 (sagepub.com)

[3] Office for National Statistics, 2018 Home - Office for National Statistics

[4] Violence against Women and Girls and Male Position Factsheets – Home Office in the media

[5] Home Office statistics - ONS 2023

[6] www.gov.uk/when-mental-health-condition-becomes-disability

[7] Domestic abuse and mental health spotlight - SafeLives

they need. This review outlines Robyn accessing counselling to try and find understanding of both her past and present relationships with family and partners but highlights the lack of disclosure to other agencies including the medical profession.

1.8.7 Equality is about ensuring everybody has an equal opportunity and is not treated differently or 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

1.9.1 Recipients who received copies of this report prior to publication:

Relevant members of Norfolk Community Safety Partnership

Panel members outlined at 1.1.4 (A further offer of support will be offered prior to publication and also consultation over any key dates to avoid)

Norfolk Coroner's office

Family members

1.9.2 To receive following publication:

Norfolk Police and Crime Commissioner

Domestic Abuse Commissioner

1.9.3 The Norfolk Community Safety Partnership (NCSP) is responsible for the publication and dissemination of the DARDR as per the statutory guidance. The executive summary, overview report, action plan and any other relevant information is published on the NCSP website: Published Domestic Abuse Related Death Reviews for Norfolk with an accompanying statement. Following publication, a press release is issued to local media and relevant stakeholders. The NCSP brings awareness to the report via their monthly newsletter, learning assets, training events and practitioner webinars, which follow the publication of each webinar. These webinars are recorded and held in a password protected area of the NCSP website for professionals to access.

Section 2 – The Facts

2.1 Background information

Robyn

2.1.1 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.

2.1.2 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.

2.1.3 On the 2nd of November 2020, a police report was received by Children's Services into the Child Advice and Duty Service (CADS). It outlined that during the afternoon of the 17th of October 2020, Tony returned Rory to her home and Robyn remained behind the front door. Tony stated that he was going to come inside and when Robyn refused, a small argument took place on the doorstep. Tony then tried to push his way in and in the process, pushed the door against Robyn causing no injury.

2.1.4 CADS assessed that there were no safeguarding concerns for Rory and sent the information to the Community and Partnership Focus team for information gathering. Appropriate guidance and advice were offered to support and ensure Rory was not at risk of witnessing further incidents of abuse between his parents when he has contact with Tony. An email was sent to Robyn signposting her to several relevant support service websites.

2.1.5 The Headteacher of Rory's school spoke to Rory and offered support as they had been informed from the Operation Encompass scheme that notifies schools of any domestic abuse incidents in their pupils homes.

2.1.6 In October 2021, CAFCASS requested safeguarding information as Tony was applying to the courts for more regular access to Rory.

Mark

In 2019, just prior to meeting Robyn, Mark did an interview in a local newspaper speaking about his depression struggle and launching a mental health campaign. He stated how he was overwhelmed by panic attacks and anxiety and depression were getting the better of him. He spoke about his medication.

Combined chronology

2.1.7 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.

2.1.8 In February 2020, Robyn spoke to her GP for acute anxiety citing her ex-partner and the father of her child (Tony) as being unreliable which causes frustration and anxiety and thinks she is being triggered by her counselling. A discussion was held in relation to protective factors. The counselling was with 'Off the Record' (OTR) where it was recorded that Robyn had realised since having her own child, that her childhood was 'not normal' and

she had no contact with her mother at that time. She stated that she felt a 'mess' and would like to unpick things. Robyn outlined how she gets frustrated with issues relating to Rory's father and feels anxious and lacking in confidence when there is no routine with the closest person to her being her brother who lives in London. She attended ten counselling sessions.

2.1.9 During the second lockdown later that year, they bubbled together and would stay at each other's houses along with Rory if he wasn't staying over at his father's. Mark informed the Author that in 2021, he bought a house in the city, took Robyn to see it and told her that he had bought it for them as a surprise and the three of them all moved in together so that they could see each other every day. He said that the location worked for school and work.

2.1.10 She was signposted to MIND early in 2021 and her wellbeing scores indicated that she was on the low end of severity. Robyn told Talking Therapies that she was emotional, lacked confidence, had a poor appetite and an increased heart rate. She felt that she had been nervous since a child. She continued to have one to one therapy over the next couple of months where she attended four sessions, all with anxiety and panic being the forefront of Robyn's disclosures and it was suggested that Robyn received Cognitive Behaviour Therapy (CBT) and counselling.

2.1.11 Robyn first mentioned her new relationship to the GP during the summer of 2021 and spoke positively about her partner and stated that she felt better. In December, Robyn received five sessions of CBT in which she stated her protective factors were her current partner and her family. She withdrew from the treatment in January 2022 and the referral was closed.

2.1.12 Robyn saw her GP twice in two months in the Spring of 2022 and revealed she was generally 'numb to things' and although she was trying to stop her medication, she was struggling with anxiety. She denied suicidal thoughts and whilst family history in respect of mental health was explored, Robyn disclosed a challenging upbringing in which all her siblings also struggled.

2.1.13 In June 2023, Robyn had a telephone consultation with a clinical Pharmacist at the surgery where she disclosed that she was irritable and arguing with her partner in the evenings so she changed the time of taking her medication. The Clinician involved was asked if she had screened for domestic abuse due to Robyn's comments and stated that she is very aware of the risks of DA and would usually ask but not always document it if it was denied.

2.1.14 A month after this, Robyn again self-referred to Off The Record (OTR) counselling where she was clear and concise that the purpose was to look at her childhood experiences and how it impacted her today in her behaviours and feelings. She requested 20-30 sessions. A couple of months later when asked to complete a monitoring form and record her presenting problems in order of priority, she wrote Family and then Abuse.

2.1.15 Robyn began working for a Farm Administration Company in March 2023 as a Personal Assistant (PA) just outside of Norwich. At that time, her employers describe her as a bubbly, fun person who was likeable and very good at her job. It was a small company and she became friends with her colleagues rather than a work relationship with them.

2.1.16 In February 2024, Mark was due to go abroad to work for a week and Robyn asked him not to go as she was anxious in the house on her own. Robyn later confided to her brother Danny that Mark's response to this 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." Danny moved in with her for the week so that she was not alone.

2.1.17 Robyn went to see her MIND worker, supported by her brother. She advised that her anxiety 'is the worst it has ever been' and that she had negotiated a break in her studies until September. She had long chats with her brother during the week about her anxiety and came to realise that the cause of this was her relationship with Mark.

2.1.18 During March 2024, Robyn had contact with her GP surgery once a week following a face-to-face appointment at the beginning where she was very panicky as she was worried about not working, her partner was back and she was not sleeping. Her medication was amended. By the end of the month, she stated that she felt much better and settled since she had been able to identify the trigger for anxiety and panic disorder. It is documented that it might have been triggered by her current relationship and she was currently taking steps on how to address this. She finds Occupational Health supportive and is documented as looking happy and excited. Strategies were discussed including forming her own social circle.

2.1.19 Towards the end of April 2024, on the advice of her sister, Debbie, Robyn self-referred to Dawn's New Horizon (DNH), who are a support service within Norfolk following her asking Mark to move out and give her space. During the first meeting, she did not disclose any of her personal details and asked for clarification as to what domestic abuse was due to what her siblings had told her. She was crying and upset during the appointment as she had not realised that she was experiencing domestic abuse and made it clear that it was from her recent ex-partner who was not the father of her child.

2.1.20 Robyn said that Mark had forced her to have sex when she did not want to and stated that she didn't always say no as she felt her life would be hell if she didn't do it. Mark would be grumpy and moody so she gave in and would look at the ceiling. She was offered signposting to both the Harbour Centre and Rape Crisis but declined referrals for both as she felt ashamed and dirty. Robyn had not been sure if it was rape but had thought it might be and described anal rape as well where he would tell her to shut up. Robyn was provided clean sheets and bedding.

2.1.21 Robyn also outlined issues with Mark's mother who was controlling and would 'get between them.' She wanted to block her from her phone but knew it would upset Mark. She was sending unkind messages to Robyn telling her how she was a bad mother and a bad partner. She was advised that she could report her for harassment but Robyn was worried it would make things worse. The counsellor offered to go with her to the police for support.

2.1.22 Robyn expressed her fear of Mark coming to the property unannounced and was offered CCTV but declined as she said that there were already cameras at the address. She had a date to vacate the property and a discussion took place around how she could be supported when she moved in.

2.1.23 Robyn then attended a further appointment for counselling where they discussed the controlling behaviour of Mark with his and his mother's constant texting. She never expressed suicidal ideations but did outline how she felt anxious. A discussion took place around Robyn's eating and potential anorexia as she stated that she felt malnourished and hadn't eaten for about two weeks although she was feeding her son. She spoke about how Mark made comments about how and what she ate, stating that she made noises and commented on the amount she ate. She was offered referrals in relation to her eating but declined.

2.1.24 At the beginning of May, Robyn contacted the surgery and requested an appointment with a specific GP and after being given options, she chose to make an appointment for when the GP was next at work. She had a telephone appointment with the GP on that day to discuss anxiety as she said she was constantly panicking and her medication wasn't helping. She was prescribed a low dose, short course of Diazepam[8] and an appointment was booked for a week later.

2.1.25 In the same time period, Peter, her friend and employer, received a text from Robyn asking him to take her to the hospital as Mark had sent some of his male 'church friends' around her house and they had tried to put pressure on her to rekindle her relationship with him and told her that the only reason she wanted to 'break up' with him was because of her mental health and she wasn't thinking straight. She also told this to her brother, Danny. Peter didn't see the message at the time but spoke to her about it afterwards in which she apologised but said she was panicking and didn't know what to do. He confirmed that she had not been physically hurt and she wasn't sure why she had wanted to go to the hospital. On behalf of the company, Peter obtained some counselling sessions with YANA for Robyn so that she had someone trained to speak to.

2.1.26 Robyn immediately had a telephone conversation with a counsellor and stated that she did not think that her medication was helping her that she had been on since February. She outlined that she had been in a relationship with Mark for four years which had recently ended and he had moved out two weeks ago and she was waiting for alternative accommodation which would be ready in four weeks. She stated how Mark had undiagnosed autism and had been masking his behaviour. She found it difficult at work as she was trying not to let her colleagues see how hard she was finding things.

2.1.27 Robyn disclosed how Mark and his mum were disappointed in her and that she found Mark's behaviour towards her and her son Rory difficult and it put them on edge, referring to mealtimes and how he made it uncomfortable. She mentioned her upbringing and abuse from her mother.

2.1.28 Robyn then had another appointment with Dawn's New Horizon a few days later where she disclosed Mark's mother and his friends kept turning up at the house and contacting her on his behalf. She stated they were saying that it was her mental health that was coming between them and disclosed how Mark called her selfish for not letting him see Rory since their break-up. The reason she didn't was due to the anxiety she could see in Rory

[8] Diazepam is a short-acting benzodiazepine drug used for acute anxiety. It works as a mild tranquiliser to help people feel more relaxed whilst they wait for slower acting drugs to take effect. Only to be used short-term.

when he was around Mark and she was protecting him. She said to the counsellor that no-one knew what Mark was like to live with as 'he masks it well' and did so for the first two years that they were together. Robyn was due to have another session a couple of days later.

2.1.29 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.

2.2 Circumstances of the death of Robyn

2.2.1 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. Rory was staying with his Dad at his address at that time. 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.

2.2.2 Mark went to the address that same evening, driven by his father and found that both the back and front entrance doors were locked secure. He managed to access the property from the top bedroom window at the rear of the property which was ajar. In order to access the rear bedroom window, Mark climbed onto the roof of the kitchen annex. He had not taken his key.

2.2.3 Upon entering the upstairs of the property, Mark called for Robyn but heard no answer. When he walked into Robyn's bedroom, he found her hanging from a clothing rail situated in an alcove on the wall. Police and paramedics attended, and paramedics confirmed that Robyn had passed away.

2.2.4 Whilst conducting enquiries at the scene, handwritten notes believed to have been made by Robyn were found in the property indicating that she was planning on permanently leaving the relationship. No 'suicide note' was found. The Police found that there was no evidence that this was anything other than a suicide. The injuries were consistent with hanging, with no other injuries found on Robyn's body. There was no indication of third-party involvement.

2.2.5 Following a forensic search of Robyn's mobile phone for the days prior to her death. The Google search history showed some searches had been made around an interest in suicide, drugs relating to overdose and other methods of suicide which they deduce, clearly show her state of mind.

2.2.6 Rory's school were advised of Robyn's death at the beginning of July 2024. Following his mum's death, Rory has received support via a pastoral worker and he has been monitored and supported closely.

2.3 Individual management reviews (IMRs)[9]

NHS Norfolk and Waveney Integrated Care Board (NWICB)

2.3.1 The Norfolk and Waveney ICB plan and buys healthcare services for our local population; this includes 105 GP practices. Although these services are commissioned, they operate as businesses in their own right and the ICB supports them to meet their statutory responsibilities around safeguarding, such as having the relevant policies and processes in place and understanding and responding to domestic abuse. The two Safeguarding Named GPs within the ICB All-Age Safeguarding Team deliver regular safeguarding training to primary care staff (this includes sessions and case studies on domestic abuse), as well as ensure a wide array of domestic abuse related resource is available and disseminated.

2.3.2 They are content that the practice that Robyn was registered with are at the forefront with safeguarding and domestic abuse due to the experience of some staff in these areas. Whilst this review relates to two surgeries, the learning and recommendations will be disseminated across all the general practices that NWICB commissions.

2.3.3 The ICB have two named GPs for Safeguarding Adults and Safeguarding Children respectively and they deliver training, case studies and updates to the safeguarding GPs in these services. They have created template policies on Safeguarding, Domestic Abuse and patients not attending appointments.

2.3.4 NWICB also commission IC24 within the area who also hosts the out of hours GP Service. They are also the response to 111(option2) which is a telephone line for crisis mental health support[10]. This is a 24hour service who offer self-care advice and signposting over the phone, transfer you to the crisis service if needed or refer you to other local services.

2.3.5 The GP Surgeries follow the National Institute of Health and Care Excellence guidance (NICE)[11] which provides advice on all aspects of their work. This guidance includes advice on Domestic Violence and Abuse quality standard and was last reviewed on the 29th of February 2016 despite there being new domestic abuse legislation. Part of this specific guidance refers to routine enquiry of domestic abuse for all patients is not feasible.

GP Surgery

2.3.6 Robyn registered with the surgery from March 2014 until May 2024. She had a long history of anxiety and intermittent depression predating the Covid19 pandemic. She was

[9] An IMR is an in-depth report completed by an agency on its own interactions and analysis of this with any subjects within this review.
[10] https://www.ousevalleypractice.nhs.uk/2024/08/09/nhs-111-option-2-for-crisis-mental-health-support/#:~:text=You%20should%20call%20NHS%20111,anxious%20about%20leaving%20the%20house
[11] www.nice.org.uk

prescribed a number of medications to help treat her symptoms, which were dosed (or changed) according to her tolerance and their efficacy. She never disclosed any domestic abuse or feelings of being unsafe etc at home, during the scoping period.

2.3.7 Robyn engaged with the Practice well and whilst she was seen by a number of different clinicians over the decade she was registered, there were blocks of continuity with most of these, mainly changing as a result of timings of consultations following contact with the surgery, seeking an appointment.

2.3.8 In February 2021 the receptionist counter provided signposting to Samaritans for mental health. Doctors were alerted to this but the receptionist did not document this.

2.3.9 Robyn interacted with the Practice on a number of occasions over the time she was registered with them, where the majority of the consultations related to her on-going and ultimately, escalating anxiety. The clinical records indicate that there were discussions around trying to identify the cause and triggers and whilst there were some historical references to her ex-partner being controlling, a bully and unreliable, little was disclosed or explored, in terms of her final partner (Mark).

2.3.10 The GP who spoke to Robyn for her last few appointments, knew her quite well and knew that she had never expressed any suicidal thoughts nor given any reason for them to suspect domestic abuse. Continuity of clinicians was promoted with Robyn, but the practicalities of this can be challenging with staff rotas, locum GPs supporting Practices and the normal churn of personnel, as well as how soon the patient wishes to be seen.

2.3.11 The appropriate policies and procedures are already in place and were followed. Domestic abuse training has been delivered and forms part of an on-going suite of sessions that are provided for safeguarding GPs. Professional curiosity is constantly promoted and this specific case has already been explored at a Significant Event meeting held at the surgery, where staff were again reminded of this.

Dawn's New Horizon (DNH)

2.3.12 Dawn's New Horizon is a non-profit making domestic abuse support organisation, providing help and support services to both men and women in Norwich, both over the phone and face to face. DNH offer a range of well-being services including an advice and information service about domestic abuse support on a drop-in basis, as well as ACT therapy, counselling and coaching by appointment.

2.3.13 DNH also offers practical assistance with a shop providing items and clothing to set up a new home and a range of children's toys and needs.

2.3.14 Whilst speaking with Robyn and her disclosing domestic abuse, no risk assessment was completed. Dash risk assessments are used with clients but not routinely. This wasn't completed as the counsellor felt that Robyn was not at risk as she was no longer living with Mark and due to this assessment, didn't consider making referrals without her consent. DNH have referred into MARAC previously but did not consider it on this occasion due to the assessment of no risk.

Norfolk Children's Services

2.3.15 Norfolk's Children's Advice and Duty Service (CADS) is the 'front door' to Norfolk Children's Services. It receives all referrals about children at risk of harm, by professionals and members of the public. It comprises of a team of consultant social workers, trained to offer support and offer advice to professionals and family members. Currently all professionals work with the Continuum of Need in Norfolk, to determine the level of need and therefore the level of support that should be offered to the family. It is this continuum of need that is referenced by the consultant social workers when they make their decisions about which children's services team to refer the family to if this is needed. When there are safeguarding concerns for a child, CADS are responsible for ensuring that the child's known details are forwarded to the Family Help service, where a social worker or family practitioner will be allocated to assess the child's needs. To give an idea of scale, CADS dealt with an average of 4020 enquiries per month in 2024.

2.3.16 Within CADS there is a small team of pathway advisors for the Community and Partnerships service, with a team manager who supports them. The pathway advisors are responsible for offering advice and guidance to professionals and family members, where it is deemed that there are no safeguarding issues, but there is a need to offer further focused support. Managers in CADS and team members have used their combined experience of telephone enquiries and conversations with families to produce some informal guidance for advisors to use. These serve as an aide memoir and to provide consistency of service. Please see appendix 1, which is an extract of the MASH scripts for team advisors and signposting ideas for victims of domestic abuse and child contact, which go along with these. All staff have access to NSCP and internal training about identifying and supporting people where domestic abuse is in the family.

2.3.17 The legislation CADS work under is as follows:

- Working Together to Safeguard Children (2018) and updated guidance in 2023
- Children Act 1989
- Framework for the Assessment of Children in Need and their Families (2000)

Both the 'Continuum of Need' and the "Threshold Guidance' take into account the duties of the local authority to support and safeguard children.

2.3.18 The setting in November 2020:

At the time that CADS called Robyn, it was referred to as MASH (the Multi-Agency Safeguarding Hub) and the team was organised in a similar way to now. There are two notable differences. Firstly, professionals worked with the 'Threshold Guidance' published by the NSCP (Norfolk Safeguarding Children's Partnership) which they would read alongside any referral to determine the level of support that needed to be offered to a child and their family. Secondly, advisors from the community and partnerships pathway for referrals, while well established at the time, sat in different locations to other MASH staff members.

2.3.19 The number of referrals was similar in November 2020, with 3939 referrals coming into MASH. While it is not possible to collect exact figures, 480 enquiries made in that month were

deemed to be tier 2 of the threshold guidance. The community and partnerships team will have been asked to deal with a number of those enquiries, Robyn and her child Rory being one of them. I am told that the team was a stable team with around ten advisors. They were asked to call families where a recent incident had been a cause for concern, but where there had been no previous involvement with Children's Services. The purpose of the call would be to encourage family members to seek support from their community networks where needed, and to signpost to agencies they may not know of who could support them.

2.3.20 The same training and service delivery arrangements were in place in 2020, so the team worked in a similar way. However, the scripts and what is advised has moved on since that time, with the last update being 2024.

2.4 Summary reports[12]

Norfolk Police

2.4.1 An investigation has been recorded for controlling and coercive (C&C) behaviour following concerns raised by family members. The C&C element is the opinion of friends / family as opposed to information known from Robyn as recorded in her notes and journals. The C&C is related to controlling what she eats and when, ignoring her for periods of time, cutting her off from friends.

This is a live investigation. Mark has been interviewed by the police and the evidence is now being reviewed for a decision as to whether there is sufficient evidence to present to the Crown Prosecution Service (CPS).

2.4.2 Following information received by Dawn's New Horizon post Robyn's death, a rape offence has been recorded. However, there is insufficient information in order to investigate this offence.

Domestic Abuse Processes.

Reporting.

2.4.3 There are several methods in which police are made aware of Domestic Abuse:

1) 999 calls
2) 101 calls
3) Online reporting
4) Police discovered
5) Third party referral (such as MARAC referral)

2.4.4 With the exception of a third-party report, once an incident of domestic abuse is reported then the victim is visited to by a police officer where details are obtained and a risk

[12] A summary report is a short explanation relating to policies/processes/procedures or where limited contact had been made with any person within the report

assessment completed (DARA for all intimate and crime only non-intimate relationships). In some cases, this is by way of a video consultation through the Rapid Video Response (RVR) team, who deal solely with incidents of Domestic Abuse which have been THRIVE assessed as lower risk. The attending officers are responsible or the initial safeguarding actions, identification of any others at risk (such as children, other vulnerable adults) and completing adequate risk assessments.

2.4.5 A supervisor will review all domestic abuse investigations, consider the risk assessment and either endorse or set an investigation plan for progression.

2.4.6 Where a Visually Recorded Interview (VRI) is deemed the most appropriate method of evidence capture, appropriately trained officers are requested to assist. Op Engage is a team of VRI qualified officers who specialise in building rapport, offering support and gathering evidence from victims in fear. They specialise predominantly in serious sexual offences but are utilised and available to assist in all crime types.

2.4.7 Following a third-party referral, the Domestic Abuse Safeguarding Team will assess the information to ascertain if there is any police record of the report and provide secondary safeguarding support to the victim. During this, it is established whether there is any support for police action or whether the initial referring agency is able to adequately support the victim. If further investigation is deemed necessary, then this is allocated to an appropriate officer to visit the victim and conduct an investigation.

2.4.8 All incidents that are domestic related are recorded on our crime and intelligence system (Athena) as either a crime, with the appropriate offence(s) being recorded, or as a non-crime incident.

<u>Investigation.</u>

2.4.9 Domestic Abuse is a priority for Norfolk Constabulary. They have a positive action policy, and in most cases, there will be necessity to arrest the suspect.

Officers are encouraged and expected to adopt an ‘evidence led’ mindset and consider all reasonable lines of enquiry to support an investigation regardless of whether the victim is supportive of a Criminal Justice process.

2.4.10 The Officer in the Case (OIC) is responsible for ensuring initial safeguarding is completed, adequate risk assessments are undertaken to establish the risk of harm to a victim.

2.4.11 In high-risk investigations, support is provided to front line teams by suitably qualified detectives. A Detective Sergeant will review the initial investigation plan and suggest any additional lines on enquiry or investigative actions. If a decision is made to take no further action, this is peer reviewed by a Detective Sergeant to ensure a more positive outcome cannot be achieved.

2.4.12 Investigations are allocated to appropriate resources, dependant on the complexity and nature of the offending. The use of appropriate bail is promoted.

2.4.13 The consideration and use of Preventative Orders (e.g. Domestic Violence Protection Notices/Orders, Stalking Protection Orders, Sexual Risk Orders), supplementary to an investigation is also promoted.

2.4.14 An investigation concludes when all reasonable lines of enquiry are completed and a suitably trained officer has completed an Evidential Review, assessing whether there is a reasonable prospect of a conviction (RPOC). In cases where a RPOC is considered, then the investigation is referred to the Crown Prosecution Service for a charging decision.

Safeguarding.

2.4.15 All investigations with a HIGH or MEDIUM risk assessment are subject to secondary safeguarding from the Domestic Abuse Safeguarding Team (DAST). The DAST is part of the Multi-Agency Safeguarding Hub (MASH) and have close links with a wide variety of partner agencies.

2.4.16 During the secondary safeguarding process, the victim is contacted by a member of the team and safeguarding options are discussed, with appropriate referrals being made where necessary. The team work closely with Norfolk Integrated Domestic Abuse Service (NIDAS) to provide IDVA support to victims. In addition, they are able to share appropriate information with partner agencies, such as health, Children's Services, NSFT (Mental Health), Probation.

2.4.17 Safeguarding remains in place for as long as is necessary. In some cases, victims are already supported, and the support has led to police involvement.

Other information.

2.4.18 Victims have certain rights under the Victim's Code, including to be regularly updated regarding their investigation. This is monitored by Supervisors.

2.4.19 Victims are advised by the DAST when there is nothing further that can be offered, and no further safeguarding contact will be made from DAST. This is usually because another agency or support service is working with the victim or additional support has been declined by the victim.

MARAC referrals – Multi-Agency Risk Assessment Conference

2.4.20 Norfolk adopts a slightly different process to other areas. MARAC is a process used to share information regarding an individual or individuals between partner agencies and the police. Once the police receive information, it is checked against any existing police reports and subsequently cross referenced if necessary.

2.4.21 An ISL (Information Sharing Log) is then sent to partner agencies requesting any information they may hold and any concerns they may have. Where it is felt necessary, a meeting or conference is held although this doesn't happen routinely.

2.4.22 Norfolk MASH has just had a Joint Targeted Area Inspection (JTAI) where it was identified that not all partners are fully engaged with the current process. A JTAI improvement group is being developed and an interim response is being drafted.

Norfolk Public Health

2.4.23 Norfolk Public Health work closely with the Office of the Police and Crime Commissioner for Norfolk in regard to the correlation between domestic abuse and suicide, ensuring that they attend each other's strategic groups and partake in the deep dive into local DA and suicide, to discuss how their respective partnerships can progress actions outlined in the Norfolk and Waveney Suicide Prevention Strategy[13].

2.4.24 The Norfolk Suicide Audit 2024[14] states that 22% of Norfolk Coroner inquest files mention DA either as a victim or perpetrator. Domestic Abuse either from family members or intimate partners can severely impact on mental health and suicide risk.

2.4.25 Training for professionals in relation to identifying and understanding suicide is available in a number of forms.

2.4.26 The British Association for Counselling and Psychotherapy (BACP) have good training programmes available including:

https://www.bacp.co.uk/cpd/exploring-suicidal-risk-with-clients-gpiael2/ and https://www.bacp.co.uk/media/18112/gpia-126-ro-suicide-risk.pdf

Basic free training is available for anyone - https://www.zerosuicidealliance.com/suicide-awareness-training

Government guidance on when to share information is provided - https://www.gov.uk/government/publications/consensus-statement-for-information-sharing-and-suicide-prevention/information-sharing-and-suicide-prevention-consensus-statement

Perpetrator services in Norfolk

2.4.27 Project CARA (Cautioning and Relationships Abuse) is an early intervention initiative in Norfolk aimed at first-time, low-risk domestic abuse offenders who have received a conditional caution. This is delivered by The Hampton Trust and funded by the OPCNN. CARA provides rehabilitative workshops designed to raise awareness of abusive behaviours, promote self-reflection, and encourage positive behavioural change. The program is closely integrated with the criminal justice system and has shown measurable success in reducing reoffending rates and improving outcomes for victims and families.

2.4.28 DAPPA (Domestic Abuse Partnership Perpetrator Approach) is a multi-agency approach to addressing domestic abuse within Norfolk, managing perpetrators of domestic abuse and thereby protecting the most vulnerable victims. Police and key partners work together in an innovative way to tackle behaviour and break the cycle of abuse. Using evidential calculations generated by the RFG (Recency, Frequency, Gravity) matrix, perpetrators who present the most serious risk of harm are identified. These cases are

[13] Norfolk_and_Waveney_Suicide_Prevention_Strategy_2024_to_2028 (1).pdf
[14] https://www.norfolkinsight.org.uk/wp-content/uploads/2025/02/Suicide_Audit_2024.html#suicide-risk-factors (section 4.2)

discussed at monthly partnership meetings for ongoing management. DAPPA develops robust multi-agency risk management plans around perpetrators during a problem-solving approach with a full menu of tactical options.

2.4.29 It will feature two pathways – those that are adopted onto the diversion pathway and those who are adopted onto the pursue pathway. In 2024/25, 28 individuals were managed by DAPPA, mostly identified by the Police's RFG matrix. DAPPA held 72 meetings through the year and 6 DVD referrals were submitted by the DAPPA team. Analysis completed in 2024 showed that 12 months following engagement with DAPPA, RFG 'scores' decreased by more than 50%, indicating preventative impact of DAPPA.

2.4.30 The diversion of the DAPPA pathway was provided by The Change Project until March 2025 but is presently unfunded locally. In 2024/25, there were 225 referrals to The Change Project from the MARAC and DAPPA. During the year, a total of 39 perpetrators completed the programme.

2.4.31 In 2024/25, the Probation Service delivered the Building Better Relationships (BBR) and Stepwise programmes. BBR is a structured intervention aimed at male perpetrators of intimate partner violence assessed as medium to high risk. BBR focusses on helping participants understand the impact of their abusive behaviour, develop empathy for victims and learn strategies to manage emotions and build healthier relationships. The programme runs over several months and includes both group and individual sessions. However, this programme is no longer offered.

2.4.32 Stepwise Relationships is a strengths-based intervention that aims to support desistance from intimate partner violence offending by enabling participants to overcome challenges such as:

- Relationship problems
- Social skills deficits
- Attitudes that support relationship violence
- Aggression and anger
- Emotional mismanagement/self-regulation.

2.4.33 During 2025/26 the Probation Service will replace BBR with Building Choices, a newly accredited cognitive-behavioural programme. It was developed by HM Prison and Probation Service to address a wide range of criminogenic needs linked to reoffending. Designed for both men and women, including individuals with learning disabilities, the programme adopts a strength-based, person-centred approach. Building Choices has now been accredited for national roll out. No local data is available at the time of writing.

Section 3 - Analysis

3.1 Family and friends' involvement and perspective

Danny

(The below is in the words of Danny so that context is not lost)

3.1.1 Danny is Robyn's eldest brother by six years and was the closest family member to her. They would always message, call and visit each other and towards the end of Robyn's life they were speaking on the phone nearly every day, often for several hours. They shared the same mother but not the same father. Both fathers were absent during their childhood and Danny states that their mother turned all of the siblings against their respective fathers.

3.1.2 Danny states that their mother was an emotionally abusive and neglectful parent. She wouldn't tell you she loved you or show any physical care or affection, but she would constantly insult you, tell you that you were worthless, embarrassing and that everything that the children did was wrong. This was all that he and his siblings saw and received in terms of parental care guidance and therefore they felt it was normal and correct that they were to blame for her unhappiness. They felt a heavy burden and developed a deep sense of shame as they were told daily that they had ruined her life.

3.1.3 Danny recalls that when Robyn was seven or eight years old, she went to a friend's house for her first sleepover and was shocked and confused at how kind and loving her friend's parents were behaving, so much so that she felt sick and uncomfortable and had a form of a panic attack where she needed to come home early.

3.1.4 Danny commented on how young and immature Tony was when Rory was first born. Robyn would tell Danny he would be incredibly unreliable and would let her down get upset with her when he didn't get his own way, Despite this sometimes-unacceptable behaviour Danny never felt that Robyn was in fear of him. Over the years, Danny observed Tony having a much more active and reliable role in Rory's life and his relationship with him has been very positive.

3.1.5 On first meeting Mark, Danny found him to be arrogant and pompous. He came across as incredibly try-hard and idiotic and seemed to crave Rory's attention above Robyn's. Danny was still able to get on well with him in the beginning because he seemed to make Robyn happy and wanted to be in Rory's life, but he would often say ridiculous and egotistical things and be totally unaware of how he came across.

3.1.6 All of the four siblings have had to receive some form of counselling or support for depression in adulthood and have all been prescribed anti-depressants. He outlines that Robyn had an on-off relationship with her youngest sister but had barely seen Debbie for the last four years of her life.

3.1.7 Robyn had concerns about Mark even before the start of the relationship, with Robyn discovering that Mark's ex had made a number of public allegations of abuse against him. She shared these concerns with Danny who advised her that it was not safe to continue

dating him, but Mark convinced her that they were not true. Within a year and a half of their relationship, Robyn had held a four-hour conversation with Danny, outlining that she had feelings of neglect and she didn't think that Mark cared about her.

3.1.8 As time went on, she would say how they never did anything she wanted, that their lives revolved around Mark's needs and career and that Mark's behaviour was increasingly critical and controlling including what they could and couldn't do together, what she ate and what she wore. Robyn asked Danny to stay with her for a week in February 2024 as she was struggling with panic attacks and Mark was out of the country. They held some really good talks and worked together to help her feel better but Mark then came back in a mood and Danny saw Robyn descend again.

3.1.9 In the final month of her life, Robyn was suffering daily panic attacks and would speak to Danny whenever she felt one rising. On one occasion she used the words "dark thoughts" and that she couldn't cope because she didn't think the panic attacks were going to end. Danny didn't for one moment think that she was talking about suicide and as soon as the panic attacks subsided, she would be back to having a positive mindset and discussing her future away from Mark and living with Rory in her new home on the farm.

3.1.10 Reflecting on the circumstances, Danny observed how Robyn experienced many painful and unfair situations in her life which had left her very anxious and vulnerable. This vulnerability meant that she was not equipped to fully understand what a healthy relationship with a partner should look like, or how to accurately diagnose the causes of her problems in life. This made it very difficult for her to then provide the right information to her GP or be able to get the right public health or social support.

3.1.11 Danny has read the report and the perpetrator's perspective at 3.3 below and makes it clear that his account is completely false. Robyn explained the full situation to Danny and he refutes everything that Mark has said. Robyn had completely broken up with Mark and asked him to move out as he had been inflicting domestic abuse. She wanted no further contact with Mark and refused to allow him to ever see Rory again. She had packed her belongings ready to move to a new home. She had a good relationship with Rory's father who was taking extra care of Rory during her breakup with Mark. Robyn had successfully met with her own father before her death and was happy to have reconnected with him. She made clear to Danny that Mark did not support her mental health and that he frequently told her that he did not care about her suffering.

Debbie

(The below is in the words of Debbie so that context is not lost)

3.1.12 Debbie had a close relationship with her sister that she would describe as 'best friends' as they were close in age and would speak daily up until they lost contact for a while. Debbie recalls that the relationship between them changed a year after Robyn had met Mark.

3.1.13 Robyn had always been quite secretive about her boyfriend due to her upbringing and wanting them to be something that she had, and therefore, Debbie only met Rory's father a couple of times and never met Mark, even though she lived a couple of streets away for some time.

3.1.14 Robyn and Debbie got back in touch in 2023 but would communicate through texts rather than phone calls or visiting each other. Robyn would text that she couldn't ring late at night as it would disturb Mark. They would make arrangements to meet up in the park with their children but Robyn wouldn't turn up and Debbie thought that she was just being wary as they hadn't seen each other for so long.

3.1.15 In February 2024, Robyn rang Debbie distressed and started to tell her how unhappy she had been and that she had been going through a lot. She said that she had realised that Mark was the problem to all her anxiety and stress when she had been talking to her brother, Danny and made the decision she was going to leave Mark.

3.1.16 Once Mark had moved out of the house, she rang me frequently and began to disclose how she had always been accepting of Mark's behaviour as he had told her he had ADHD or autism (Debbie unsure which) and thought it was because of that. He would not let her eat in the same room as him as he did not like the noise of her eating and she and Rory could only eat meat when he wasn't there yet he ate meat all of the time.

3.1.17 Debbie was aware that her sister had been struggling mentally but was shocked at Robyn's certainty when she said that the relationship was over. Robyn was making plans to move into her new home with Rory and seemed excited to order new items for the house. Although she had been employed, she told Debbie how all of her money either went on bills or into the joint account and she had no control over her own finances so it would be nice to get that control back.

3.1.18 Robyn visited Debbie at her home the week before she died and they saw each other for the first time in years. She told Debbie how she lived in fear whilst at Mark's address as he kept turning up and sending people from the church to tell her that this was all to do with her mental health.

Debbie does not believe that Robyn would have taken her own life.

Peter

(The below is in the words of Peter so that context is not lost)

3.1.19 Peter was Robyn's employer but counted himself as a friend first and foremost. He recalls seeing her deterioration in both her mental health and physical appearance in January. They would go for walks during work time as the countryside allowed them to and she would talk to him if she was feeling anxious as she trusted him and some other people who worked there.

3.1.20 Robyn told him how Mark would control what she and Rory ate and would not allow them to eat in the same room as him as the noise they made when eating 'made him feel ill.' Peter noticed how much weight she lost and a short time before she ended the relationship,

she told him how they had been to Mark's mother's house and when dinner was served, he stopped her eating hers saying, 'you don't want to put all of that weight back on, do you'.

3.1.21 When Mark worked from home, he would make Robyn and Rory sit in a room upstairs so that they didn't disturb him and would get angry if they made a noise.

3.1.22 She told Peter how she was embarrassed as she had heard of how he abused his previous partner and read what she had put on Facebook but had still believed him when he said that it was all lies, yet he was now treating her the same. Once she had told him the relationship was over and he had moved out of the house which he owned, Robyn lived in fear as he would keep turning up and letting himself in with the pretence of getting things he needed and Peter was present during two different phone calls with him just to support her. Mark did not know he was present.

3.1.23 Due to her fear, Peter contacted the company where they worked as a house had become vacant on the land and it was arranged that Robyn would be able to move into it with Rory and pay rent. They were in the process of restoring it for her and she was only four weeks at the most away from moving in. It was walking distance to Rory's school and was ideal. She seemed really excited about it but obviously still had lighter and darker days.

3.1.24 Robyn had been very anxious at times that she would lose her job due to her anxiety and sick days. Peter said that this was never the case and had been manifested by Mark and his mother telling her this to the point where she believed it and he had to constantly reassure her. He arranged some counselling for Robyn at YANA which was a company that they had used previously for a colleague and were prepared to give her all the support she needed as she was a valued member of the company.

3.1.25 Robyn never mentioned suicide to Peter or any other work colleagues she confided in and never stated that she had been physically assaulted. It was more belittling her and controlling her and Mark's mother was also to blame for this as she also did it.

3.2 Terms of reference areas

Domestic abuse (DA) in any form had been the causation or a contributory factor to Robyn taking her own life.

3.2.1 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.

3.2.2 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[15] that these are indicative of how early life events often shape mental health outcomes in later years.

3.2.3 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.

3.2.4 Robyn knew to call the police if she felt in danger as she did this during the incident in 2020 when Rory's father, Tony tried to push his way into her home. However, she never called the police in relation to Mark which could be explained by the fact that she had to ask Dawn's New Horizon if how she had been treated was rape and domestic abuse and so if she did not know this was what was happening to her, then she wouldn't be in a position to report it.

3.2.5 Due to her struggles, this would have made Robyn vulnerable and when Mark would then tell her that she had mental health problems and criticise and belittle her in front of her son and his family, then this could have made her even more insular and doubt herself. The fact that Mark used Robyn's mental health as leverage to demean her when he clearly had previous mental health struggles of his own illustrates a knowledgeable way of trying to assert his control.

3.2.6 She expressed the emotional abuse towards both her and her son Rory, by means of criticising the way they ate and not letting them eat in the same room whilst also criticising how she looked and the amount she ate which was identified by Dawn's New Horizon as having manifested into an eating disorder as she had lost a lot of weight in a short amount of time and couldn't bring herself to eat.

3.2.7 There is evidence of psychological abuse that Robyn has disclosed in relation to her mental health struggles being the cause of problems which was also then reinforced by Marks mother. Once Robyn had built the strength to end the relationship with the realisation that Mark was the cause of her anxiety, he then sent family and friends around to the address to harass her and turned up unannounced to try and maintain control over her anxiety and panic that she felt.

3.2.8 Robyn disclosed sexual abuse to Dawn's New Horizon and what her coping mechanisms were to get herself through each occasion so as not to perpetuate even more trouble from him and although she though this may have been rape, she was not sure due to her uncertainty of how to be treated in a relationship until it was confirmed for her.

3.2.9 She disclosed to her brother, Danny the way Mark would 'give her the silent treatment' which could last for days and was in front of Rory and also belittle her in front of others including his family and friends. She disclosed how her finances were controlled by a joint account and bills, although there is no direct evidence to show economic abuse.

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

3.2.10 Once she had ended the relationship, Robyn identified that Mark had his own issues which she explained he had masked well against her in the first few years and masked well to others outside of the home.

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.

3.2.11 There is evidence of collaboration between domestic abuse services commissioners and Norfolk Public Health suicide prevention that they are working together with a holistic approach and have understood the correlation between the two. There are numerous outreach and support services available and their websites hold a myriad of information on the two subject matters, providing pathways for support and information.

3.2.12 NICE guidance from 2016 (NICE QS116) states there is insufficient evidence to recommend screening or routine enquiry in most healthcare settings, but the Safelives Pathfinder Toolkit recommends that GPs practice clinical enquiry, which sets the threshold for asking low and uses information from the interaction with the patient to make an assessment. This would include presentations of anxiety, depression and difficulty sleeping, all of which Robyn disclosed.

3.2.13 Although NICE guidance for General Practitioners includes the area of domestic abuse, it has not been updated for nine years and holds outdated advice in the area of domestic abuse as there have been numerous changes in legislation since then. Due to advising on routine questioning not being feasible for domestic abuse, this negates the identification of the psychosomatic responses to DA with the reasoning being the tight timeframe that a GP has with a patient.

3.2.14 NWICB worked together with one of the in-county hospitals for all out-patients in the accident and emergency department to have routine questioning in this area implemented which has provided wider support and the time targets have still been achieved. (Recommendation refers)

3.2.15 The Domestic Abuse and Sexual Violence Group (DASVG) Partnership within Norfolk have recently reached out to non-commissioned services to ensure that they have access to the Partnerships knowledge and support mechanisms and know that they can partake in learning events etc. This is vital to ensure that all services within the area are working together and not in isolation. The DASVG maintains a subgroup for domestic abuse and sexual violence providers which enables them to access key information from partner agencies and access training and other developmental opportunities.

3.2.16 It was identified during discussion in a panel meeting that professionals may find it difficult to identify perpetrators of domestic abuse and if they did, what would their response be to this and what services are available to get them treatment. Norfolk has a perpetrators programme that is only available for those who have been through the criminal justice system.

Is signposting sufficient for those needing support or can more be done to assist?

3.2.17 Robyn and Rory first came to the attention of Children's Services when Tony tried to push his way through the door in 2020. The CADS decision maker forwarded the police information to the Community and Partnership Focus team for information gathering as guidance and advice is required to offer support and ensure Rory was not at risk of witnessing further incidents of abuse between his parents when he has contact with his father. Records state that an email was forwarded by a Pathway Advisor (Partner and Community Focus), signposting Robyn to services. Whilst this would have been useful information, it is noted that the information relates to 'relationship break up' guidance and was not specific to domestic abuse information/relationships and could have been a missed opportunity.

3.2.18 Police information within the report gave indication of a domestic abusive relationship and a referral to Family Support Services could have been considered at this juncture. A family support assessment would have provided opportunity to understand more about Robyn and her thoughts and expectations of relationships. If it was then felt relevant, intervention could have been offered to help her understand safe and healthy relationships and the impact of abusive relationships both on herself and her child.

3.2.19 However, it must be recognised that good advice and signposting was given to Robyn on this occasion in relation to formalising contact with the Family Court, which became evident that she had followed, due to proceedings the following year.

3.2.20 Dawn's New Horizon offered to make referrals on Robyn's behalf and physically go with her to the police for support if she wished to report Mark's mother for harassment. This is good practice as Robyn may feel that she can't do this on her own or have the strength to so this allows her extra strength if she wanted it. However, a DASH risk assessment was not completed when domestic abuse had been identified and if it had been, then there may have been referrals made to assist with minimising the risk. (Recommendation refers)

3.2.21 The entry made in 2013 by a student health visitor relating to Rory's father being a bully predates the statutory definition laid out in the Serious Crime Act 2015 and the Domestic Abuse Act 2021 and processes have changed and therefore, this was not considered for relevancy of a recommendation.

Are children in the home being identified as domestic abuse victims and what support is available?

3.2.22 Following the incident at the door in November 2020 with Rory's dad, the worker from Children's Services spoke at length with Robyn and provided signposting, taking the referral seriously and remembers the feelings of shame that Robyn felt that Rory's school was aware of what had happened and her anxiety that other parents may find out. Robyn did not indicate whether or not the relationship with Rory's father was abusive and further professional curiosity could have been shown as child contact may have been hard to manage going forward and Rory exposed to further incidents.

3.2.23 Robyn's Health Centre contacted CADS by phone to inform them that they had received notification of Robyn's death and stated that they did not have another parent

recorded for Rory and are concerned that they do not know if Rory is registered with health services elsewhere or who is caring for him.

3.2.24 CADS called Rory's school, who advised that he is living with his father, Tony. Tony had been spoken to and support had been offered, however he feels at this time, that no additional support is required. He said that he would register Rory with health services in the area where he lives. No further action taken.

3.2.25 Had the Health Centre not made the call to Children's Services, then it is quite possible that they would not have been aware of this and Rory may not have been offered any form of support from them or oversight in relation to either the domestic abuse he may have witnessed or the loss of his mother. At this time, there is not a pathway in place.

3.2.26 Norfolk Police are currently working on an initiative with their Major Investigations Team and the Central Policy Unit to explore whether there can be a multi-agency referral or information sharing document following the police attendance at a death. This would then notify agencies including ASC, Children's Services, Probation etc and be incorporated into the Force Policy Document for Death Investigations.

3.2.27 Education has a similar associated issue where a serious incident has occurred which includes the matter of a parent and includes certain circumstances where it relates to suicide. (Recommendation refers)

3.2.28 The review has identified through family and counselling notes from YANA that in addition to Rory witnessing abuse on his mum, he was also subject to forms of abuse including criticism over the way he ate and not being allowed to eat in the same room with Robyn speaking about how anxious he was in Mark's company. Danny observed that Mark disproportionately craved Rory's attention above that of Robyn which may have an adverse effect on a child who is witnessing their parent being abused.

3.3 Perpetrator's perspective

Mark

Mark did not consent to the review directly utilising his medical records. Any references to Mark's health in the report are from disclosures of Robyn or comments made by those interviewed.

The following is from a lengthy meeting between Mark and the Author.

3.3.1 Mark denies all forms of domestic abuse against Robyn, stating that the disclosures that she has made are indicative of what she had portrayed to him about her previous relationship with Rory's father and that it was him she was referring to and not himself. He states that he was the one to encourage her to speak about this.

3.3.2 Mark stated that Robyn peaked and troughed in moods for days and sometimes months in their relationship and he always tried to be supportive. In 2023, Robyn was trying to re-connect with her father who she hadn't had a relationship with for a number of years and he recalls things were particularly difficult that year as she was constantly disappointed with her father not meeting up with her.

3.3.3 Mark says that he tried to support Robyn but she was constantly talking things over all of the time and it was emotionally draining… for both of them. He states that Robyn was critical of everything he did during 2024 and she wanted space and time to reflect so he moved back to his parents for a couple of weeks but insists that their relationship was not over and that he looked on Rory as his own son.

3.3.4 Mark did not disclose any mental health struggles of his own.

Section 4 – Conclusions and Recommendations

4.1 Conclusions

4.1.1 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.

4.1.2 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. Professionals and perpetrators can access support through the Respect phoneline.

4.1.3 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.

4.1.4 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.

4.1.5 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.

4.1.6 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.

4.1.7 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.

4.1.8 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.

4.1.9 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 letting it happen as she didn't want the consequences of if she refused, but she needed Dawn's New Horizon to clarify that this was rape and she outlined how dirty this made her feel.

4.1.10 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. Rory should also be seen as a victim of domestic abuse in his own right.

4.1.11 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.

4.1.12 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. This advice can depend on the reliance of the individual receiving this to have the strength and willingness to attend A & E and is not pro-active prevention.

4.1.13 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.

4.2 Lessons to be learnt

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

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 vaster information gathering to allow for risk assessment.

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.

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.

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.

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.

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)

4.3 Recommendations

National

1. **The Office of the Police and Crime Commissioner for Norfolk 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.

Appendices

Appendix A

Terms of Reference

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 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?

Identify Good practice