Domestic Abuse Related Death Review

Melissa

May 2023

Executive Summary

Author: Deborah Cartwright

Commissioned by:

Kent Community Safety Partnership

Medway Community Safety Partnership

Review completed: June 2025

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Tribute

Melissa died by suicide after living a life marred by traumatic experiences, both in childhood and adulthood. Her life experiences caused her to become socially isolated and dependent on a marriage that was abusive. She suffered from many health issues, both physically and mentally.

Her life became more isolated following her medical retirement from her work in the NHS. She was a well-educated woman, with a lively mind, often contributing her thoughts and insights to publications including contributing to the BBC programme Points of View.

She was a dog lover, taking great comfort from her German Shepherd in later life.

The members of this Review Panel offer their sincere condolences to the family of Melissa for this sad and tragic loss.

1. The Review Process

1.1. This summary outlines the process undertaken by the Kent and Medway Community Safety Partnership domestic homicide review panel in reviewing the death of Melissa, who was a resident in their area.

1.2. Melissa is a pseudonym, and Melissa's ex-husband is also referred to by a pseudonym – Jerry. This is to protect their identities and those of their family members.

1.3. Melissa was a resident of Town X. She was a White British woman who was in her sixties when she died in May 2023.

1.4. At the time of her death, Melissa had been living as a tenant of her ex-husband. Jerry is a White British male, also in his sixties at the time of the fatal incident. They had no children.

1.5. The Coroner's Inquest was heard and concluded in the Spring of 2024, with the finding that Melissa died by suicide.

1.6. The decision to undertake a domestic homicide review was agreed upon in an initial meeting of the Community Safety Partnership in July 2023. All agencies that potentially had contact with Melissa and/ or Jerry before her death were contacted and asked to confirm whether they had involvement with them. The first panel meeting took place in December 2023.

1.7. Twelve agencies were confirmed to have had contact with Melissa and/ or Jerry. They were asked to secure their files. Of those twelve, only ten had records to share with the panel.

2. Contributors to the Review

2.1. The agencies that contributed to the review were:

Agency	Contribution
Kent Police	Independent Management Report
Medway NHS Foundation Trust	Short Report
Kent Community Health Foundation Trust	Independent Management Report
Integrated Care Board: General Practice	Independent Management Report
South East Coast Ambulance Service	Short Report
Kent Adult Social Care	Short Report
Look Ahead Care and Support	Independent Management Report
Town A District Council[1]	Short Report
Town A/B Housing Association	Short Report
Town B Borough Council	Short Report

2.2. Contributing agencies were asked to submit either a Short Report or an Individual Management Report (IMR) – as shown above. The report authors were independent of any direct practice or practice supervision with Melissa and/ or Jerry. All reports were signed off by a senior manager before panel submission.

2.3. Two family members were identified for Melissa: her mother and a brother. Sadly, her mother had died shortly after Melissa. This left only Melissa's brother. The Panel only had an address for her brother and wrote on three occasions with no response.

2.4. No friends or colleagues could be identified for Melissa.

[1] The panel determined not to identify local authorities.

3. The Review Panel Members

3.1. The Review Panel consisted of an Independent Chair and senior representatives of organisations that had relevant contact with Melissa and/or Jerry. It also included a senior member of the Kent Community Safety Team and an independent advisor from a Kent-based domestic abuse service. The Kent Public Health team were also engaged to act as a report reader in recognition of their specialist suicide prevention practice knowledge. No other specialists were identified as required by the Panel.

3.2. The panel members were independent of any direct practice or practice supervision with either Melissa and/ or Jerry. They met on 3 occasions between December 2023 and July 2024. They were:

Agency	**Name**	**Job Title**
SociaLed	Deborah Cartwright	Independent Chair
Kent & Medway ICB	Tracey Creaton	Designated Nurse - Adult Safeguarding
Kent Police	Zoe Traynor	Detective Inspector
Kent Adult Social Care	Natalie Bagnall Matthew Turner	Adult Safeguarding Officer Adult Safeguarding Officer
Kent Community Safety	Honey-Leigh Topley	Community Safety Officer Independent Panel Member
Town B Borough Council	Suada Rahman (first panel only)	Domestic Abuse Lead

Look Ahead Care & Support	Mike Bansback (first panel only) Rouhee Aziz (second panel only) Lorraine Lawson (from third panel)	Director of Practice Development, Safeguarding and Quality Safeguarding Lead Head of Domestic Abuse Services
Town A & B Housing Association	Sean Richards	Community Safety Manager
Town A District Council	Kelly Webb Julie Hall (from third panel)	Health & Communities Manager Domestic Abuse and Safeguarding Officer
Domestic Abuse Volunteer Support Services	Sam Haspall (from second panel)	Chief Executive Independent DA Advisor to the panel
Kent Community Health Foundation Trust (KCHFT)	Annette Martin	Named Nurse for Safeguarding Adults
Kent Public Health Suicide Prevention Team	Tim Woodhouse	Report reader

4. Author of the Overview Report

4.1. The Independent Chair, who is also the Author of this Overview Report, is Deborah Cartwright. Deborah formerly worked as a Chief Executive of a Kent domestic abuse charity but stepped down from that role one year prior to this Review and that organisation's work was not in scope in this Review. Deborah is independent of all agencies in Kent and specifically in this Review.

4.2. The Independent Chair has a background in mental health and domestic abuse both operationally and strategically in the social sector with 35 years' experience across both fields. Deborah has extensive experience in developing systems-focused, trauma-informed services and has contributed to both the strategic and operational development of services in London, Kent and Medway. Deborah was trained by AAFDA in 2022 and was re-trained in the Home Office accredited Chair's training in August 2024.

5. Terms of Reference for the Review

5.1 The draft Terms of Reference were considered by the Review Panel at its first meeting in December 2023. During this meeting, the Panel also determined the scope of the Review and those organisations whose involvement would be examined. Based on the information available, the panel determined that the temporal scope should be from January 2016 to May 2023.

5.2 In conducting the review into the death of Melissa, the panel had regard to:

i. Were practitioners sensitive to the needs of Melissa and/ or Jerry, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

ii. Did the agency have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic abuse victims or perpetrators, and were those assessments correctly used in the case of Melissa and/ or Jerry? Did the agency have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was Melissa and/ or Jerry subject to a MARAC or other multi-agency fora?

iii. Did the agency comply with domestic violence and abuse protocols agreed with other agencies including any information sharing protocols?

iv. What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

v. Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

vi. When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

vii. Was anything known about the perpetrator? For example, were they being managed under MAPPA? Were there any injunctions or protection orders that were, or previously had been, in place?

viii. Had the victim disclosed to any practitioners or professionals and, if so, was the response appropriate?

ix. Was this information recorded and shared, where appropriate?

x. Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

xi. Were senior managers or other agencies and professionals involved at the appropriate points?

xii. Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?

xiii. Are there ways of working effectively that could be passed on to other organisations or individuals?

xiv. Are there lessons to be learned from this case relating to the way in which an agency or agencies worked to safeguard Melissa and promote their welfare, or the way it identified, assessed and managed the risks posed by Jerry? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

xv. Did any staff make use of available training?

xvi. Did any restructuring take place during the period under review and is it likely to have had an impact on the quality of the service delivered?

xvii. How accessible were the services to Melissa and Jerry (as applicable)?

6. Summary Chronology

6.1. Melissa was living with her ex-husband (Jerry) as a tenant, they had divorced in 2004. She had moved away for approximately 2 years after their divorce, but following the death by suicide of her boyfriend, she returned to lodge with Jerry around 2006.

6.2. Both Melissa and Jerry had significant contact with health services, and Jerry had multiple points of contact with Kent Police, usually in the context of being reported for or for reporting bad behaviour. Of note are that these included false accusations of being assaulted by others and frequently being reported for acting abusively towards others, often whilst intoxicated.

6.3. Melissa had a history of poor mental health with suicidal ideation and at least two attempts at suicide. She described feelings of hopelessness and despair regularly in her contact with health services and had various interactions with mental health services. As she suffered from Lyme disease and chronic pain, she found it difficult to access services. Following medical retirement from the NHS, she was increasingly isolated and described Jerry as controlling, financially exploitative and later, violent.

6.4. Melissa received some support from the Kent Enablement Service and had contact with housing in attempts to secure alternative accommodation. She also had contact with health services for pain management. She often described Jerry as a bully, controlling and treating her as a ‘skivvy’ and taking money from her in these settings.

6.5. In 2022, Melissa disclosed physical assaults by Jerry to her GP who referred her to a domestic abuse organisation. They assessed her as at high risk of harm. During this assessment, she disclosed that she had stood on a window ledge and contemplated jumping the year before. A referral was made to MARAC, and the police became aware of the assault.

6.6. Melissa’s safety plan depended on her moving out of the home she shared with Jerry, and extensive work was undertaken by the IDVA and the housing team to secure her an alternative property. Sadly, at the point that she may have been offered a property that suited her need to have a large breed dog, the offer was not made as she was noted to have more than the allocation policy savings level. Consequently, she was deemed to only qualify for over-55 accommodation, which she considered to be an old people’s home. She withdrew from the re-housing process, and her IDVA lost contact with her.

6.7. Jerry was not held accountable for his behaviour as the police officer had been waiting for Melissa to be made safe in alternative accommodation before undertaking an investigation or making an arrest.

6.8. Melissa was not in any agency's scope for several months following this, apart from some medical appointments. She died by suicide in May 2023. Jerry was arrested on suspicion of murder due to concerns about a history of domestic abuse. A subsequent investigation did not provide any evidence of Jerry's involvement, and he was refused charge.

7. Key Issues Arising from the Review

7.1. The Panel identified the need for all agencies to be attentive to the indicators for domestic abuse, the nuances of the concepts of primary and secondary perpetration and issues of allegations/counter-allegations made by perpetrators/service users – all of which can serve to enhance our recognition of this issue.

7.2. The Panel also recognised some key areas of learning for the coordinated community response to the issue: dynamic safety planning as well as a considered application of policy and shared decision-making.

7.3. Finally, the Panel reflected on the application of trauma-informed and suicide-aware practice across the service landscape. Those who find themselves living with complex trauma and the aftermath of these experiences require holistic and continued support and consideration, and it was the Panel's view that Melissa's interaction with services was episodic and lacking both in continuity and adequate safety considerations regarding her risks in relation to suicidality.

8. Conclusions

8.1. The Panel were guided by the key lines of enquiry in undertaking this Review, with the primary concern being analysing the lessons that could be learned to make the future safer for someone in Melissa's position.

8.2. They recognised that the gaps in disclosures made by Melissa represented significant timeframes in which the policy and practice landscape underwent key changes, as well as the ongoing development of domestic abuse practice across the multi-agency landscape.

8.3. However, they identified some key opportunities for learning in the recognition and response to domestic abuse, as well as in understanding the impact of multiple, complex traumas on the risk of suicide and how services identify and respond to these.

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9. Lessons to be Learned

9.1. ***Professionals dealing with victims of domestic abuse must consider the impact of complex trauma in their lives.***

9.1.1. This is necessary to ensure that responses are appropriate to individuals and not simply the result of adherence to policy. Trauma-informed practice urges services to offer choice and control to those that use services, which means that agencies must consider service flexibility in supporting those trapped in cycles of abuse.

9.1.2. Compassionate practice that does not blame the victim but understands the difficulties of making significant life changes, and engaging with services where complex trauma has been the life experience of the individual is essential across the system.

9.1.3. Social isolation as a feature of complex trauma in childhood must be understood and agencies should consider whether practices, such as signposting, are adequate in ensuring that individuals are able to engage with service provision.

9.2. ***Agencies working with domestic abuse survivors must ensure that training and awareness are embedded in practice through reflective case oversight mechanisms.***

9.2.1. These are necessary to ensure that knowledge and practice developments are embedded into practice, as well as ensuring that safeguarding is overseen effectively.

9.2.2. Where possible or relevant, case holding practitioners should be subject to random case auditing to check and balance safeguarding practice in relation to domestic abuse.

9.2.3. Organisations should recognise the importance of shared accountability for safeguarding practice that reduces the burden on sole practitioners.

9.3. ***Agencies working with domestic abuse survivors must ensure that suicidality awareness and associated risk management practices are embedded.***

9.3.1. Practitioners assessing and referring victims of domestic abuse, must ensure that suicide risks are flagged to all agencies and that decisions are not arbitrarily taken as to whether an action presents a real risk.

9.3.2. Agencies must shape suicidality training, policy and practice to incorporate awareness that domestic abuse is a significant risk factor for this outcome, and that those who live with the impact of complex trauma are subject to higher risk of completing suicide.

9.3.3. Health systems should ensure that suicidality vulnerability is flagged routinely.

9.4. ***Multi-agency processes must ensure that current and complete information is in scope in any safety planning processes.***

9.4.1. MARAC systems must be developed to ensure that suicide risk information is sought from the appropriate agencies to inform safety planning processes.

9.4.2. MARAC systems must introduce joint ownership of safety planning to ensure that these plans are victim-focussed, subject to ongoing oversight and dynamic in nature.

9.4.3. MARAC decisions regarding interventions must be considered in the context of the potential for barriers to arise that could impact the entire safety plan.

9.5. ***Agencies must be aware of the impact of perpetrators utilising allegations and counter-allegations as a tactic of domestic abuse, and the ways in which this enacts control via the state, further isolating victims from support.***

9.5.1. MARAC agencies must be able to bring nuanced thinking to their assessments, understanding the concepts of allegations/ counter-allegations and their use in domestic abuse.

9.5.2. All agencies must consider whether professional curiosity is featured adequately in their assessment of those who may exhibit signs of domestic abuse.

9.6. ***Agencies must be attentive to the presence and impact of economic abuse in the lives of those experiencing domestic abuse.***

9.6.1. This should ensure that they consider the ways in which this form of abuse traps a victim in an abusive relationship.

10. Recommendations from the Review

	Recommendation	Organisation
1.	Kent CSP disseminates the learning from this DARDR specifically to raise awareness of the importance of considering suicide risks and including these in domestic abuse safety planning.	Kent Community Safety Partnership (KCSP)
2.	Kent Domestic Abuse Service Commissioners to utilise the learning from this review in any service specifications for the funding of organisations to deliver domestic abuse training, specifically, regarding the typologies of domestic abuse, counter-allegations, non-fatal strangulation and suicidality.	KCC Integrated Commissioning Team

	Recommendation	Organisation
3.	Kent & Medway MARAC operating protocol is reviewed to ensure that safety planning actions are held in scope by coordinators, suicidality risks are proactively considered, that appropriate orders are considered in individual cases, that DARA/ DASH-RICs are included where appropriate and that appropriate agencies are brought into meetings, potentially for one-off cases.	Kent and Medway Domestic and Sexual Abuse Executive Group
4.	Kent Domestic Abuse Service Commissioners ensure that commissioned agencies utilise best practice frameworks in the delivery of IDVA services, preferably with a quality mark for those services.	KCC Integrated Commissioning Team
5.	District Council to include the requirement to assess housing needs for those affected by domestic abuse flexibly to ensure that local policies do not adversely affect access to safe housing set out in the Domestic Abuse Act, 2021.	Town A District Council
6.	Town A District Council will share the learning from this review with the Kent Housing Group. The Kent Housing Group to communicate this to the Kent Housing Teams to use the learning from this review to reflect on DAHA accreditation and the recommendation of flexibility in seeking appropriate safe accommodation options for high-risk victims of domestic abuse.	Town A District Council Kent Housing Group

	Recommendation	Organisation
7.	All agencies to consider relevant policy frameworks with regard to signposting practice and develop alternative approaches, specifically in relation to those living with multiple disadvantages, ensuring that support is given with onward referrals as necessary.	ALL

8.	Kent and Medway Public Health Teams undertake a review of the 'Co-occurring Conditions Policy' expanding on the implications and expected practice for survivors of domestic abuse living with co-occurring issues.	Kent and Medway Public Health Teams
9.	KMDASG to raise awareness of the barriers to help seeking faced by domestic abuse victim-survivors who are digitally excluded.	Kent and Medway Domestic and Sexual Abuse Executive Group
10.	General Practice to ensure that patient vulnerabilities are appropriately flagged on case management systems.	Integrated Care Board (ICB)
11.	Safe Lives to review guidance given to IDVAs in training regarding the sharing of the full DASH, stating that decisions not to share in MARAC processes should only be taken where adequate case management systems are in place.	SafeLives