Domestic Abuse Related Death Review

Melissa

May 2023

Overview Report

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.

1. Introduction and background

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

1.1 Introduction

1.1.1 This Domestic Abuse Related Death Review (DARDR)[1] examines agency responses and support given to Melissa, a resident of Town A, prior to her death in May 2023. Melissa was a White British woman and was in her sixties at the time of her death.

1.1.2 Melissa appears to have been isolated in her community with little information available about her. However, research undertaken informed the Panel that she had a lively mind, evidenced through her education history (at master's level) and by her engagement with local press and talk shows. She offered commentary in these arenas about local and global issues.

1.1.3 At the time of her death, Melissa had been living as a tenant of her ex-husband (Jerry, a White British male, in his sixties at the time). They were married in 1986 and divorced in 2004. Following Melissa's divorce from Jerry, he had bought her out of their marital home leaving her with no home but some significant savings. Melissa had a subsequent relationship with another male, but he died by suicide in 2006 and, having struggled following this death, she had returned to Jerry's home as a lodger.

1.1.4 On the day of her death, Jerry called an ambulance, having found Melissa hanging from the stair bannisters. Police officers attended following notification of a sudden death by the ambulance crew.

1.1.5 Police initially arrested Jerry on suspicion of murder but a subsequent investigation did not provide any evidence of his involvement in her death and charge was refused.

[1] Despite the death occurring prior to the official name change from DHR to DARDR the panel determined that as this was a death by suicide, this name was the most appropriate naming convention to adopt.

1.1.6 However, police information identified that Melissa had been a high-risk victim of domestic abuse perpetrated by Jerry and that multiple agencies had been involved with both parties.

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

1.2 Purpose of the Review

1.2.1 The Domestic Violence, Crime and Victims Act 2004, establishes at Section 9(3), a statutory basis for a Review[2]. Under this section, a Domestic Homicide Review means:

"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."

1.2.2 In December 2016, the Government issued updated guidance on what were then termed Domestic Homicide Reviews especially about deaths resulting from suicide. The guidance states:

"Where a Victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a Review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted."

1.2.3 Where these definitions have been met a Review must be undertaken.

[2] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office, 2016.

1.2.4 The key reasons for conducting a Review are to:

a) establish what lessons are to be learned from the domestic homicide about 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 organisations, how and within what timescales will be acted on, and what is expected to change;
c) apply these lessons to service responses including changes to policies and procedures as appropriate; and
d) prevent domestic violence and abuse, and improve service responses for all domestic violence and abuse victims and their children, through improved intra and inter-organisation working;
e) contribute to a better understanding of the nature of domestic violence and abuse; and
f) highlight good practice.

1.2.5 In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Kent and Medway Domestic Abuse Related Death Review (DARDR) Core Panel meeting was held in July 2023. It agreed that the criteria for a Review had been met and this Review will be conducted using the DARDR methodology. That agreement has been ratified by the Chair of the Kent Community Safety Partnership (KCSP) and the Home Office was duly informed.

1.2.6 In February 2024, the Home Office issued notice that in future Domestic Homicide Reviews would be called Domestic Abuse Related Death Reviews (DARDR) in a recognition that they include those who die by suicide where domestic abuse is a concern. Although Melissa's death occurred before this change the Panel decided to adopt this naming convention considering the circumstances of Melissa's death.

1.2.7 This Review aimed to establish whether any agencies identified possible and/or actual domestic abuse that may have been relevant to the death of Melissa. If such abuse took place and was not identified, the Review will consider why not and how such abuse can be identified in future cases.

1.2.8 If domestic abuse was identified, this Review will focus on whether each agency's response to it was in accordance with its own and multi-agency policies, protocols and procedures in existence at the time. If domestic abuse was identified, the Review will examine the method used to identify risk and the action plan put in place to reduce that risk. This Review will also consider current legislation and good practice. The Review will examine how the pattern of domestic abuse was recorded and what information was shared with other agencies.

1.2.9 The aim of this Review is to identify any lessons that can be learned to make the future safer for those in Melissa's circumstances.

1.2.10 The full subjects of this Review will be the victim, Melissa and the alleged perpetrator, Jerry.

2. Confidentiality

2.1 The findings of this DARDR are confidential. During the Review process, all information was available only to participating officers/professionals and their line managers, who were all subject to a confidentiality agreement. All identifying features and information have been excluded before submission for approval by the Home Office.

2.2 Dissemination is addressed in S11 Publication below. As recommended by the statutory guidance, pseudonyms have been used and precise dates obscured to protect the identities of those involved. Pseudonyms have been provided and agreed by the Panel in the absence of any family involvement.

2.3 Details of the deceased and significant others:

Name (Pseudonym)	**Gender**	**Age at time of death**	**Relationship to deceased**	**Ethnicity**
Melissa	Female	Mid-sixties	*Deceased*	White British
Jerry	Male	Mid-sixties	*Ex-husband*	White British

2.4 Two family members were identified in relation to Melissa. A brother, who is not present in the Review information and her mother, who is referred to as Mum or Mother at times when she is present in the information.

3. Timescales

3.1 This Review began in December 2023 and was concluded in June 2025. Reviews, including the overview report, should be completed, where possible, within six months of the commencement of the Review. This Review has exceeded that timescale due to the following factors:

- Adequate time was given for agencies to gather information due to holiday periods.
- Enabling the core panel with adequate time to analyse the material due to holiday periods.
- Persistent attempts to engage family members in the review.
- There were delays to the production of the action plan as some negotiation took place to establish an achievable housing recommendation.

4. Methodology

4.1 The detailed information on which this report is based was provided in Independent Management Reports (IMRs) and Short Reports completed by each organisation that had significant or some involvement with Melissa and/or Jerry. An IMR is a written document, including a full chronology of the organisation's involvement, which is submitted on a template. Where information held by an agency was limited, they were asked to produce a Short Report without the requirement of a chronology or fuller analysis.

4.2. Each IMR/Short Report was written by a member of staff from the organisation to which it relates. Each was signed off by a Senior Manager of that organisation before being submitted to the Panel. Neither the IMR Authors nor the Senior Managers had any involvement with Melissa or Jerry during the period covered by the Review.

4.3 The IMR authors were asked to consider key lines of enquiry as determined in the Terms of Reference. The lines of enquiry were considered by the Panel at its first meeting, ensuring they were specific to Melissa and were:

i. Were practitioners sensitive to the needs of Melissa and/ or Jerry and 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, or other suitable tool, 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 (Multi-Agency Risk Assessment Conference) 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 this incident the only one of its nature that had happened 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)? With especial consideration to Melissa's description of the emotional wellbeing attachment to her dogs.

4.4 All submissions were reviewed by the Panel with an analysis made of their contents and the lessons that could be learned to make the future safer for people in Melissa's position. Details of contributing organisations can be found in Section 7.

5. Terms of Reference

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. The Terms of Reference were agreed and form Appendix A of this report.

6. Involvement of Family Members and Friends

6.1 The Panel identified that Melissa had close contact with her mother and had a brother living some distance away. Research was undertaken to establish contact with Melissa's mother, but it sadly identified that she had taken her own life within weeks of hearing about her daughter's death. The Panel wished to extend their condolences to remaining family members for their loss.

6.1 The Panel were able to identify the location of Melissa's brother and the Chair wrote to him, sending this by registered post, with the inclusion of the Home Office, AAFDA and AMPARO[3] leaflets. Further letters were sent as the report progressed. There were no other available avenues of contact and having received no response to letters, the Panel were unable to include him in the Review.

[3] AAFDA provide support to families who lose loved ones in domestic abuse related deaths; AMPARO support families bereaved by suicide.

6.2 The Panel discussed the potential inclusion of Jerry in the Review. It was noted by Panel members that Jerry has a history of aggression towards agency staff, to the extent that he would not be visited by a sole practitioner. It was the Panel's view that given the information received in the Review and the safeguarding concerns about Jerry's behaviour, that he would not be approached to participate in the Review.

6.3 Melissa lived an isolated life and no friends or colleagues were identified as part of the Review.

7 Contributing Organisations

7.1 Each IMR was written by a member of staff from the organisation to which it relates and signed off by a senior manager of that organisation, before being submitted to the Review Panel. None of the IMR authors or the senior managers had any involvement with Melissa during the period covered by the Review.

7.2 Twelve agencies were identified as having contact with Melissa and Jerry and all were issued with requests for information from the Panel. Two agencies had no records available for the Review. Ten agencies completed reports for the Review as shown on the table below.

Agency	**Contribution**
Kent Police	Independent Management Report
Medway NHS Foundation Trust	Short Report
Kent Community Health Foundation Trust	Independent Management Report
NHS Kent and Medway 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[4]	Short Report
Town A/B Housing Association	Short Report
Town B Borough Council	Short Report

8 Review Panel Members

8.1 The Review Panel was made up 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.

8.2 The members of the Panel were:

Agency	**Name**	**Job Title**
SociaLed	Deborah Cartwright	Independent Chair
Kent & Medway ICB (Integrated Care Board)	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

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

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

8.3 Panel members hold senior positions in their organisations and have not had contact or involvement with Melissa or Jerry. Neither have they had any direct line management responsibility for the practitioners within the reports. The Panel met on three occasions during the DARDR between December 2023 and July 2024.

9 Independent Chair and Author

9.1 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.

9.2 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.

10 Other Reviews/Investigations

10.1 Following the death of Melissa, Jerry was arrested on suspicion of murder, no charges were brought.

10.2 The Coroner undertook an inquest and the findings from this were that Melissa died by suicide.

10.3 There were no other parallel Reviews.

11 Publication

11.1 This Overview Report will be published on the websites of Kent and Medway Community Safety Partnerships following quality assurance by the Home Office.

11.2 Family members will be provided with the website addresses and offered hard copies of the report, should they wish to take them.

11.3 Further dissemination will include:

a. The Domestic Abuse Commissioner for England and Wales
b. The Kent and Medway DARDR Steering Group, the membership of which includes Kent Police, Kent and Medway Integrated Care Board and the Office of the Kent Police and Crime Commissioner amongst others.
c. The Kent and Medway Safeguarding Adults Board.
d. The Kent Safeguarding Children Multi-Agency Partnership.
e. Additional agencies and professionals identified who would benefit from having the learning shared with them.
f. Briefings are offered to the local CSPs by KCC's Community Safety Unit at the partnership meetings.
g. A short briefing document highlighting key learning is circulated upon publication.
h. Learning events held by the KCSP.

12 Equality and Diversity

The Panel considered the nine protected characteristics (age, disability (including learning disability), gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, ethnicity, sex and sexual orientation) as prescribed in the Equality Act, 2010 and sought to establish if they were relevant to any aspect of this Review. The Panel considered whether access to services or the delivery of services were impacted by them and if any of these characteristics had in any way acted as a barrier. The Panel identified three main characteristics that required consideration in relation to this Review.

12.1 Sex

12.1.1 There is extensive research to support that in the context of domestic violence and abuse, females are at greater risk of being victimised and significantly harmed or dying because of this abuse. In fact, the term 'femicide' was coined in the 1970's in recognition of the extent of the violent deaths of women.[5]

[5] South African feminist activist and scholar Diana Russell popularized the term to help rally activists to protect women. Russell's definition has since been refined to include only partner crimes.

12.1.2 Homicide represents the most extreme form of violence against women, a lethal act on a continuum of gender-based discrimination and abuse. Research shows that, gender-related killings of women and girls is a problem across the world, in countries rich and poor. Whilst most homicide victims are men, killed by strangers, women are far more likely to die at the hands of someone they know.[6]

12.1.3 The third annual report from the national Domestic Homicide Project which works across England and Wales was published in March 2024. This report identified that, in line with wider literature on domestic homicide and suicide following domestic abuse, the majority of victims were female (71%, n=514/723).[7]

12.1.4 Melissa's account of her abuse at the hands of her former husband is congruent with the concept of gender-based violence against women. She described the types of abuse (most specifically financial, emotional and physical violence) that can erode a woman's self-esteem and sense of agency, inhibiting their ability to find 'space for action' in order to escape that violence.

12.2 Disability

12.2.1 Individuals are disabled under the Equality Act, 2010, if they have a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on their ability to do normal daily activities.[8] Chronic pain can be considered a disability if it affects a person's ability to perform normal daily activities for 12 months or longer. The effect must be "substantial, adverse and long-term".

12.2.2 Melissa was involved in a road traffic accident (sustaining a head injury) as an adult and was identified as suffering from Lymes Disease because of a tick bite (this latter went undiagnosed for some years, but it was later confirmed that Borrelia bacteria was present in her system). She was also being treated through

[6] According to UN Women, around 48,800 women and girls were killed by intimate partners or other family members in 2022, which is more than five women or girls every hour. This is known as femicide or feminicide, and it accounts for 55% of all female homicides. The true number of femicides is likely to be higher.

[7] Vulnerability Knowledge and Practice Programme (VKPP) Domestic Homicides and Suspected Victim Suicides 2020-2023 Year 3 Report, Published March 2024

[8] 'substantial' is more than minor or trivial, e.g. it takes much longer than it usually would to complete a daily task like getting dressed; 'long-term' means 12 months or more, eg a breathing condition that develops as a result of a lung infection

a pain management programme because of the chronic pain she experienced[9] and she received support, medication and health services in relation to ongoing mental health needs.

12.2.3 These issues were separate in terms of their treatment but together they were significantly debilitating. Issues caused by them created significant barriers to her ability to gain support, for example, describing to service providers that she found it difficult to get out of bed in the mornings for appointments due to the pain she experienced. She had also been medically retired from her role in the NHS after finding the impact of the head injury had a detrimental impact on her cognitive ability. This loss of purpose would have been likely to have an isolating effect on her, along with her other disabilities.

12.2.4 Disabled women are twice as likely to experience abuse than non-disabled women, yet national data shows referrals for women living with disability to the MARAC process to be low.[10] Melissa is congruent with this data, her domestic abuse experience was hidden from view for a significant amount of time, despite her interactions with health agencies routinely.

12.3 Age

12.3.1 According to research by Safe Lives, on average, older victims experience abuse for twice as long before seeking help as those aged under 61. And nearly half have a disability (48% with 34% having a physical disability). The research also found that older victims are more likely to be living with the perpetrator despite support, as they are generally less likely to leave the relationship.[11]

12.3.2 The report cited above noted some key issues that were apparent to the Panel in Melissa's situation, in the first instance, long-term abuse and dependency issues, and in the second the targeting and coordination of services in response to older people. One survivors' contribution to the Safe Lives research is especially poignant and relevant to Melissa's situation, *'I felt pressured to leave my*

[9] Chronic pain is pain that lasts longer than three months. Its severity can vary from mild to excruciating and can be continuous or sporadic. It can be caused by another condition such as arthritis, diabetes, or nerve pain, but is often an illness in its own right (British Pain Society).
[10] Disabled people and domestic abuse spotlight, SafeLives [Accessed 6.7.25]
[11] Safe Lives spotlight series, Safe Later Lives: Older People and Domestic Abuse, 2016.

husband. I told them that this was my house and that I did not want to go into a council flat on the ground floor where I would not feel safe. I told them of my other physical issues, but I did not feel listened to. They just wanted me to leave.'

13 Background Information

13.1 According to Police and South-East Coast Ambulance (SECAmb) background information, Melissa was a resident of Town A in Kent and died there at her home in May 2023. Melissa was living with her ex-husband (Jerry) as a tenant, them having divorced in 2004. They had no children.

13.2 Melissa and Jerry had been married for 18 years, having married when she was in her late 20s. Jerry had bought Melissa out of their shared property when they divorced but she later returned to live with him as a tenant; they had co-habited in a landlord relationship for the 16 years prior to her death.

13.3 On the day of her death Jerry called the ambulance service, stating that he had found her hanging on the stairs. He stated that he had seen her twenty minutes previously, had been cooking dinner, had subsequently eaten and then looked for her as she had not come down for her dinner.

13.4 The ambulance responder administered CPR but she was confirmed dead within an hour of being found. The responder was concerned about the nature of her death and the Police were notified.

13.5 On Police attendance, attending officers were concerned over several issues, one of which was disclosures of domestic abuse, which included incidents of strangulation and Jerry was arrested on suspicion of murder. A subsequent investigation did not provide any evidence of Jerry's involvement in Melissa's death and he was refused charge.

13.6 Given the circumstances of Melissa's death and the significant background history of domestic abuse, the situation was deemed to have met the requirement for a Domestic Abuse Related Death Review.

14 Chronology

14.1 Agencies supplied chronological information held by them in relation to Melissa's and Jerry's individual and relationship histories, from the 1st of January 2016 up to Melissa's death. This information has been collated and set out below to show their interactions with service providers across the public, health and social systems.

14.2 Both Melissa and Jerry had significant contact with health services. However, Jerry's records were only accessed where they had a domestic abuse context.

14.3 Also, for note is that 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. These have not been included in the timeline unless they have some bearing on the context of domestic abuse and/or suicide risk for Melissa.

14.4 Agency records began with Melissa seeing her G.P. for tinnitus and arthritic pain symptoms early in 2016. Melissa had been in contact with multiple health services for many years prior to 2016 with these and other symptoms associated with Lyme disease and a road traffic accident. The 2016 record also states that a referral to IAPT (Improving Access to Psychological Therapies) was made, there are three further records (letters and follow-up appointments) associated with these health needs.

14.5 In the Spring of 2016 Melissa was assessed by the SPoA (Single Point of Access), having been referred by Insight[12] after expressing suicidal thoughts. The SPoA team recorded, '*she has days when feels no hope. She is renting a room in her ex-husband's house, has no job and is in poor physical health. Has been prescribed several anti-depressants without effect. Discussed ways in which she could move on re housing. Needs talking therapy regarding issues in her past and would benefit from a review of medication, anti-depressant.'* The records

[12] A commissioned talking therapies service in Kent.

from Adult Social Care (ASC) showed that this assessment triggered a referral to the ASC team.

14.6 In the Summer of 2016 Melissa was seen by a Consultant Neurologist at Queen Mary's Hospital Sidcup. The record described her as experiencing *'multiple dissociative symptoms'* and confirmed that she had tested positive for Borrelia infection (the cause of Lyme Disease), and that medication had not made an impact on her symptoms. The consultant also noted that she had post-concussive syndrome, a history of anxiety and depression and a history of emotional and sexual abuse in childhood. A referral was made to neuropsychology. As a result of this appointment, Melissa's G.P. implemented the use of the Amitriptyline anti-depressant due to its benefits for sleep and neuropathic pain.

14.7 In the autumn of 2016 ASC contacted Melissa to arrange a home visit for assessment of her needs. The assessment took place shortly after initial contact and it is noted, '*She advised she feels trapped as she cannot afford to move out at present, she is contributing all of her ESA payment for rent and using savings to pay for food and bills etc. [Melissa] also advised he asks to borrow money etc.'*. The assessing social worker also notes*, '[Melissa] disclosed she was diagnosed with Limes [sic] disease last year, after having it for 32 years undiagnosed. [Melissa] advised she was made out to be a hypochondriac by GP and neurologist, however after demanding a test for Limes disease, she tested positive for it. [Melissa] has now been advised that this is incurable.'.* Melissa was referred for assessment by KERS[13] because of this initial contact.

14.8 Around the same time, Melissa was in contact with the Community Mental Health Team who noted that she was *'Currently living with her ex-partner [Jerry] who she stated has been abusive towards her. Feeling very socially isolated.'.* She described returning to live with Jerry, following a period of personal difficulties and losing her home after a boyfriend died by suicide in 2006. She also advised that she had attempted suicide at the age of 18, as well as a further attempt when her marriage broke down (in 2004). She described Jerry as a *'bully'*. The practitioner noted *'She is aware of how to keep herself safe and it was felt that*

[13] Kent Enablement and Recovery Service (KERS) works with people experiencing mental health difficulties to address social care needs over a short period of time (up to 12 weeks)

she had capacity in regards [sic] to this issue. She was advised to contact the Police if she feels at risk. It was not felt that [Melissa] is currently presenting with any significant mental health needs that require input from the secondary mental health services. Referred to Social Care, Occupational Therapy, Primary Care therapy for anxiety and low self-esteem. Agreed to contact Citizens' Advice Bureau for housing and benefits.'.

14.9 The KERS team established contact with Melissa within 3 weeks of her initial assessment. In scheduling the appointment Melissa requested that it not be held at her home. In the notes, Melissa described having to stop working in 2014 after an increase in mental health symptoms, as well as physical and cognitive issues following the road traffic accident in 2009. She described finding living with Jerry as stressful and a desire to move out of the area. Plans were made to continue to support Melissa through the development of an enablement plan.

14.10 The KERS team developed this plan with Melissa which included supporting her to appeal a negative PIP[14] decision, accessing a bus pass and engaging with support groups. Melissa stated that she would contact her local Mind, a community mental health charity, during one meeting but there is no record that she did. Her support from KERS ended in the Winter of 2016.

14.11 In the Spring of 2017 Melissa was seen by the Specialist Registrar for Neuropsychiatry at a London hospital who recommended that she receive psychodynamic psychotherapy and CBT (cognitive behavioural therapy). In a follow-up meeting later that year it is recorded that she did access a short course (twelve weeks) of CBT which she found helpful, and the clinician recommended that she continue to have Diazepam prescribed for symptomatic use. She was also issued with a letter in support of her housing application.

14.12 In 2018 Melissa was reviewed two further times by the Consultant Neuropsychiatrist at the London Hospital and reported continuing to find the CBT practices helpful noting that it *'maintained her ability to deal better with stress and anxiety and the extraordinarily difficult circumstances she faces daily in her living*

[14] Personal Independence Payment (PIP) is money for people who have extra care needs or mobility needs (difficulty getting around) as a result of a disability. There are two parts called components: The daily living component, and the mobility component. PIP replaced DLA (Disability Living Allowance) from 2013.

*circumstances.' a*nd that housing was her key priority. She was discharged on her final appointment.

14.13 Shortly after Christmas in 2018, Melissa attended a West Kent minor injuries unit (MIU) stating that she had tripped and fallen whilst walking downstairs the previous evening. This resulted in a soft tissue injury to her arm/hand. She returned a few days later and an avulsion fracture (injury to tendons or ligaments) was diagnosed. She returned a further time due to numbness and tingling.

14.14 In spring 2019 she attended the MIU again with impacted ear wax and the clinician suspected a ruptured ear drum, referring her to her G.P. Three days after this Jerry contacted the Police wanting to surrender a firearm (a starting pistol). Ten days later Melissa contacted the Police to report Jerry for abusing their dog; she was advised to contact the RSPCA (Royal Society for the Prevention of Cruelty to Animals).

14.15 In winter of 2019 Melissa was seen by the Pain Management Consultant Specialist at Maidstone Hospital. She described multiple sources of pain including headaches, muscular pain and tension throughout her body as well as insomnia. It was noted that her questionnaire showed *'she had significant psychosocial issues that might have been 'impinging' on the pain.'.* The clinician also noted her significant polypharmacy[15] and that PMP (Pain Management Programme) was the only available treatment offer. KCHFT (Kent Community Hospital Foundation Trust) received the PMP referral within four weeks and she was offered an appointment for February 2020. At this appointment, Melissa described her history, including that it had taken thirty-three years to be diagnosed and treated for Lyme disease following a tick bite. She stated that her bad days were increasing and that she awaited a neurology appointment for a possible Neuroborreliosis diagnosis[16]. In this appointment she described Jerry as a '*serial adulterer'* and that she found day to day living physically and emotionally exhausting. She also described finding Jerry's dog a *'great source of comfort',* and that she was socially isolated and struggled with '*social circumstances*.'

[15] Use of multiple medications.
[16] Neuroborreliosis is a disorder of the central nervous system. A neurological manifestation of Lyme disease.

14.16 As a result of this appointment, the practitioner discussed with Melissa the multidimensional nature of her pain requiring a biopsychosocial approach and the aims, content and format of the programme. She was made aware that the PMP sessions were group sessions and felt she could cope with the group session if everyone was there for the same reason. She felt the PMP would be worth the commitment, but she could not guarantee being physically able to do it. The practitioner offered Melissa the option of online PMP if she later felt she could not manage the travel or mornings. Melissa described not having accessible IT to use this option. She was also offered mindful movement classes, was given a pain toolkit booklet, contact details of DISK (Disability Information Services Kent) and the web details for Think Action[17].

14.17 Starting in March 2020 and lasting until July 2021 the UK experienced the COVID pandemic. This comprised two full lockdowns of society (March 2020 – June 2020 and January 2021 – July 2021), and a series of tiered restrictions to society in between.

14.18 Several weeks after the KCHFT appointment Melissa, wrote to her G.P. stating '*Something's not right and I'm feeling ill and fatigued. On top of this I've just had the shock of having my PIP [Personal Independence Payment] withdrawn*.'

14.19 In spring of 2020 a physiotherapist from the Pain Service at Maidstone Hospital phoned Melissa to follow-up after referring her to the PMP. She described Jerry as '*very controlling'* and her mother as '*stressful at times'*. She advised the practitioner that she was not able to access mindful movement classes as they were online and she had limited access to online technology, but that she would like to do them in person – she was advised that there could be a long wait for this option. Mindfulness and breathwork were recommended to her as helping to relieve stress generally.

14.20 During the summer of 2020, Jerry contacted the Police stating that Melissa was drunk and aggressive. Officers found on attending that both had been drinking alcohol. They described the difficulties of their post-divorce living arrangement and Jerry stated that after walking his dog he had arrived home to find Melissa

[17] Now known as We are With You this organisation specialises in supporting people with stress, sleep issues and/or anxiety or low mood.

'drunk and lairy' – during the call to the Police, Melissa could be heard to say that he had attacked her earlier. She agreed to go and stay with her mother and Jerry was subject to a DARA (Domestic Abuse Risk Assessment) with a Standard Risk rating.

14.21 Two weeks after this incident Melissa, wrote to her district council's housing team asking for some resolution to her housing application, after waiting for three years. In the letter she states, '*I have been living in unsuitable private lodgings for the past 8 years becoming my controlling ex-husband landlord's carer unwillingly on my behalf". As I have no income (only basic ESA and PIP both of which are regularly confiscated), no partner and no guarantor, I am forced to apply to the council. My criteria is to get away from my grabbing ex-husband and I am desperately trying to find peace…* '

14.22 In early winter 2020 Melissa was offered and accepted face-to-face PMP four months hence. Six days after the offer she wrote to say she could not attend morning sessions due to ill health; due to this and her inability to access online services, she was discharged from the service.

14.23 Following a referral Melissa was seen by an ENT (Ear, Nose and Throat) specialist at Maidstone Hospital in summer of 2021. It is recorded that she *'suffers from stress, anxiety, fibromyalgia, temporo-mandibular dysfunction, suicidal ideas, poor quality of life, homelessness and lives in lodgings. On examination the tympanic membranes are intact, throat and nose looked clear. Hearing test within normal limits. I will organise a CT scan of her neck. Please make a psychiatric referral as she is suffering from suicidal ideas. We will review in 10 weeks.'*

14.24 One month after the above appointment Melissa wrote to her G.P. again stating she was experiencing '*ongoing stress of lodging in the house of my abusive ex-husband who sees me as nothing more than a skivvy.*'

14.25 In early 2022 Melissa writes to her G.P. again stating '*I am writing to notify you I have recently fallen victim to Identity Theft Impersonation Fraud. This crime is registered with the national Fraud database*.' and one week later she writes again, '*Life is full of ups and downs but what happens to me borders major catastrophes (sic) on top of a bad start in life. [Two weeks previously] I received a*

telephone call from my bank stating my entire life savings of £43,000 had been emptied in one fall sweep by a fraudster who's stolen my personal identity details. On the very same day my 86-year-old mother telephoned me to say she's been diagnosed with breast cancer. In the interim, my ex-husband/landlord is in ill-health expecting me to dog-sit his dog and look after it whilst I am still doing all the shopping, housekeeping, cleaning and paying him rent.'

14.26 In early summer of 2022, Melissa had a telephone consultation with her G.P. describing her relationship as having a *'lot of tension'* stating that he is her ex-partner whom she rents a room from and who *'treats her like a carer/domestic help, has hit her and thrown her against the stairs at least four times in the last year'.* The practitioner noted that she stated she had taken photos of her bruising and that he borrows money from her and does not pay it back. In this call, she also describes her mother as emotionally abusive and neglectful but due to her mother's cancer diagnosis and mental health issues, she feels obliged to care for her. The G.P. made onward referrals to a domestic abuse agency and social prescribing, she was also supplied with the domestic abuse triage service telephone number. On the same day the practitioner referred Melissa to Look Ahead, a domestic abuse service provider.

14.27 One week after this consultation Melissa sent a letter to the practice stating *'I never get any peace. I am surrounded by 24-hour noise which activates my tinnitus, my nerves are in shreds and I suffer extreme anxiety. I have to pay my ex-husband monthly rent and yet he expects me to carry out his gardening, housework, laundry, shopping, bagging and putting out the rubbish, collecting his prescriptions, dog-sitting. I contribute to food and maintenance costs, help him with his tasks, plus he keeps asking me for loans. He is dictatorial and tries to control me. He keeps telling others that I'm his partner which is a complete lie.'.*

14.28 Look Ahead allocated Melissa to an IDVA (Independent Domestic Violence Advisor) who made timely contact with Melissa, offering immediate safety advice and an appointment for a face-to-face meeting. The IDVA updated the G.P. regarding the status of Melissa's referral to them.

14.29 The day after the IDVA's first call with Melissa they contacted the housing team to check Melissa's status. The housing team advised the IDVA that Melissa had declined previous property offers and that only two further offers would be made.

14.30 In early July Melissa meets with her IDVA for the pre-arranged face-to-face meeting. The IDVA made a risk assessment using a DASH risk indicator checklist, scoring 16 yes responses. Melissa shared photos of bruising she had sustained in incidents. As a result of the risk score and professional concerns, the IDVA referred Melissa to the local MARAC process. The MARAC referral states in the background information section *'[Melissa] disclosed last year she stood on a 3rd floor window ledge but decided [Jerry] wasn't worth it.'*

14.31 In late July, Kent Police received the report of domestic abuse by Jerry towards Melissa via the MARAC referral. The officer liaised with the IDVA who advised that Melissa did not want police involvement. The officer was also advised that police intervention while Melissa was still living in the shared house with Jerry would increase risk and should come after she had moved.

14.32 Throughout July the IDVA maintained contact with Melissa supporting her with her housing and safety plan.

14.33 In early August Melissa was discussed at the MARAC. The issues identified in the agency presentations on Melissa's situation were escalation of abuse, the submission by Melissa of photographs across 3 months showing extensive bruising to the back, chest and neck ('strangulation marks'), her disclosure that Jerry targets her chest and neck in assaults, descriptions of being physically abused by Jerry in front of his visiting 'lady friends' and economic abuse. The discussion also included her vulnerability both physically and in health terms, as well as her fear of speaking to the police due to his counter-allegations, her desire for a support dog and her problematic housing situation (in terms of having nowhere else to go and having particular needs in relation to housing and her physical health).

14.34 Actions discussed at the MARAC included exploration of a DVDS (Domestic Violence Disclosure Scheme), a letter to support her housing need and some exploration of a potential direct void offer to enable a move, as well as auto-bid

being activated and for police to action arrest (this was made inter-dependent with the exploration of a housing solution).

14.35 In notes relating to MARAC the housing team started to explore the possibility of a direct let through a local Housing Association noting concerns as *'DA plus modern-day slavery, concerns of an air rifle also at the house to be aware of.'.*

14.36 Over the few days following MARAC, extensive work was undertaken between the local authority housing team and the housing association to ascertain whether a suitable housing arrangement could be made. The teams acknowledge her health vulnerabilities and need for an emotional support dog in any identified property. During these discussions two bungalows are identified, both of which Melissa has bid on and conversations take place regarding removing these from the bidding system in order to make a direct let.

14.37 Melissa's IDVA was on leave during this time and on her return Melissa contacted her upset that properties had been bid on for her (as her account has been placed on auto-bid). The IDVA writes to the housing team who feel that auto-bid had been an agreed plan. During the week following this a housing officer notes that Melissa had savings in excess of the limit allowed in the local allocations policy, which excludes her from the bungalows and means she can only be considered for accommodation for the over-55's. Consequently, she was offered a place in a sheltered housing scheme with the housing team noting that she would be assisted to live in the private sector should this not be accepted.

14.38 Melissa visited the over-55's housing scheme, accompanied by her IDVA. She advised the staff member showing her around that she had a dog (German Shepherd). The staff member fed back to the housing team that only small dogs are allowed. Melissa is very unhappy with being offered an *'old people's home'* and later sent a text message to her IDVA saying that she did not wish to accept the flat offer and would be contacting the housing team herself about the bungalow issue. This text message, at the end of August, was the last contact between Melissa and the IDVA service.

14.39 In mid-October Melissa has a telephone consultation with her G.P. as her pre-existing rash has worsened with stress.

14.40 In early November the housing team reduced Melissa's housing band as she had declined several offers. They notified Look Ahead, who advised that Melissa had disengaged from the service.

14.41 From December 2022 to May 2023 Melissa had several G.P. contacts for varying issues including requests for painkillers for back pain, COVID infections and other respiratory infections and follow-ups from a neurology appointment.

14.42 In late May Jerry called an ambulance stating that he had found Melissa having hanged herself. He advised the call handler that he is a first responder and that they should, *"stop asking me stupid questions".* He said she had been seen twenty minutes before he found her. On attending the ambulance crew felt her condition indicated that she had been there for longer.

14.43 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.

15 Overview

15.1 Melissa was an older woman, in her mid-sixties at the time of her death, who had experienced domestic and sexual abuse as a child and had a history of suicidal ideation and attempts at suicide.

15.2 At the time of her death, she was living as a lodger with her former husband (Jerry), who was abusive towards her. They had divorced in 2004. Melissa had lived alone and had a new relationship after the divorce. Her new boyfriend died by suicide in 2006. Melissa struggled after this death and subsequently returned to live with Jerry.

15.3 Melissa had complex health issues which were both physical and emotional in nature, the result of complex childhood trauma, untreated Lyme's disease and a serious road traffic accident. Both she and Jerry were known to drink alcohol routinely.

15.4 In the period under review Melissa made several disclosures regarding Jerry's behaviour. These were most often made to health professionals; the final disclosures resulted in her being identified as a high-risk victim of domestic abuse.

16 Analysis

16.1 The Review Panel analysed seven years (2016-2023) of agencies' records in relation to Melissa and Jerry's relationship, seeking to understand the abuse experienced by Melissa and whether there were any lessons to be learned that would make the future safer for people in Melissa's situation.

16.2 The Panel acknowledged the benefit of hindsight, especially given the complexity of Melissa's history. She had described abuses in childhood of both a physical and sexual nature and exhibited many signs of someone whose life had been destabilised by complex trauma, including chronic pain and interpersonal difficulties; and, following the death by suicide of another partner in 2006, her living circumstances became unstable and she returned to lodge with Jerry.

16.3 Kent and Medway have a commissioned bereavement service today enabling those who have lost people through suicide to gain vital support. This recognises the impact of this type of loss and the risk to those left behind of possible future death by suicide. It is essential that the traumatic grief and loss associated with this issue is recognised and that appropriate support is made available to those who remain.

16.4 In recognition of the significant impact of childhood trauma of this nature, the Panel also adopted a trauma-informed lens to consider Melissa's life and death, and how agencies worked with this understanding and what opportunities for post-traumatic growth were or could have been generated to enable her to live free from abuse. This also extends to an analysis of Melissa's risk of suicide and how this risk was considered during any relevant interventions.

16.5 The Panel considered several themes relating to the key lines of enquiry that needed to be addressed in the analysis: the recognition of and response to domestic abuse, the housing needs of vulnerable victims and the ways in which trauma-informed practice could assist lessons to be learned for those in Melissa's situation.

Recognising domestic abuse

16.6 There were key opportunities to recognise domestic abuse as an issue for Melissa and consequently develop opportunities for intervention. These occurred between 2016 and 2020, with the first being when Melissa was assessed by the Community Mental Health Team and described co-habiting with her *'abusive ex-partner'* During this appointment she also described a suicide attempt at 18 years old; the second when Melissa attended the Minor Injuries Unit (MIU) following a fall; the third when she had an appointment with a Physiotherapist regarding pain management services; the fourth when police officers attended her home after Jerry called them about her behaviour; and the fifth, when she contacted her local housing team shortly after this incident.

16.7 In 2016 Melissa was seen by the Community Mental Health Team, she had expressed suicidal thoughts to the Insights Team who had made an appropriate referral onwards based on this risk. She described residing with her *'bully'* ex-husband who had been abusive to her in the past. The worker's perception was of this as historic abuse; however, this was an opportunity for the abuse to be explored further, potentially with the support of a worker from domestic abuse services.

16.8 In 2018 Melissa attended the MIU[18] following a fall. When she described the fall, an opportunity existed for a routine enquiry to take place; it didn't. MIU systems and practices have since been updated, with an approach in place that ensures that injuries are congruent with the descriptions of their occurrence. It was the view of the Panel that this new system would have ensured that, in the same situation today, Melissa would be asked the right questions, enabling her to disclose abuse.

[18] Minor Injuries Unit

16.9 In 2020 Melissa spoke with a Physiotherapist regarding pain management. It had already been acknowledged that she had significant psychosocial stressors which would exacerbate pain and during the call she described Jerry as *'very controlling'* and that she found her mother, whom she cared for*, 'stressful'.* The IMR author acknowledges that the word 'controlling' should present a 'red flag' to a practitioner and that further enquiries should have taken place to explore what Melissa meant in using this word.

16.10 Practitioners at this time were working in difficult circumstances, as the nation was experiencing the early waves of the Covid-19 pandemic. The practitioner was interviewed by the IMR author and stated that many people were living in difficult circumstances, having been locked down with their cohabitees, and this led her to presume that this was a pandemic impact. However, the Panel felt that this lacked the professional curiosity regarding the reality of someone's experience that is essential in domestic abuse practice.

16.11 In this appointment, Melissa's description of her living circumstances should have been a trigger for a DASH assessment being undertaken and the IMR author notes that the contemporaneous policy document and associated safeguarding training should have triggered this response. They also note that routine safeguarding newsletters are issued which remind practitioners of the need for safeguarding practices. The practitioner in this situation also had a case review process. The Panel discussed the policy being a practitioner-led case review process for the benefit of the practitioner's learning. However, this does not enable the supervisor to quality assure practice, meaning that safeguarding issues that are missed by practice staff are not subject to checks and balances. It was the Panel's view that there should also be some case auditing to complement this approach, whereby supervisors can dip sample casework to check and balance safeguarding practice.

16.12 Also in 2020, the Police received a call from Jerry stating that his *'wife'* was drunk and aggressive. During the call, the handler heard Melissa state that she had been *'attacked'* earlier. On attending, the responding officers undertook a DARA with Jerry, which was good practice.

16.13 It is unclear whether Melissa's statement about being attacked was passed on to officers, or whether the officers did not pursue this information. The IMR author identified that this should have been passed on (or acted on) to explore the dynamics of the relationship further. If it had then a DARA would have been undertaken for both Jerry and Melissa. This would have created an opportunity for Melissa to be identified as the victim of domestic abuse in the household.

16.14 Melissa made a call to housing to pursue her housing register status very quickly after this incident and the Panel also acknowledged that this was another missed opportunity to recognise the domestic abuse she experienced as she described Jerry as my *'controlling ex-husband'* and that she had unwillingly become his "carer" (he did not have formal care needs). Kent Housing Teams are currently undergoing DAHA accreditation which should provide a significant development in housing practice across the County in relation to domestic abuse.[19]

16.15 In combination and with the benefit of hindsight, the Panel were able to see the potential for a coordinated response where recognition of domestic abuse takes place. Melissa is likely to have been pursuing her housing based on a recent incident of abuse, and both the police and housing had the opportunity to enable her disclosure and subsequent safety processes.

16.16 It was the Panel's view that these situations underline the importance of curious and critical thinking in relation to domestic abuse and the importance of the coordinated community response. In the first instance, practitioners must have a culture of domestic abuse curiosity when faced with those that use their services, understanding that exploring circumstances, hypothesising and then exploring our hypothesis (as opposed to presuming) and being nuanced in our consideration of the dynamics of domestic abuse are all crucial elements of practice.

[19] DAHA accreditation is the UK benchmark for how housing providers should respond to domestic abuse in the UK. DAHA accreditation is recognised in the government's Ending Violence against Women and Girls Strategy: 2016 to 2020. By becoming DAHA accredited, housing providers and services are taking a stand to ensure they deliver safe and effective responses to domestic abuse.

16.17 Finally, the Panel noted that Melissa's financial situation was unclear throughout this time. She regularly described issues with finances in relation to Jerry, but no agency showed professional curiosity in relation to economic abuse.

Responding to domestic abuse

16.18 The Panel discussed the importance of responding appropriately to disclosures of domestic abuse and acknowledged several areas of good practice in this area. These were largely focused on the disclosures and events leading up to Melissa's death where her G.P. made appropriate referrals to a domestic abuse service, her assessment and subsequent referral to MARAC and the Housing Team's dynamic response once a MARAC referral was in place, and their attempts at a flexible response to Melissa needs.

16.19 The Panel also acknowledged that there were lessons to be learned in the responses to Melissa as a victim of domestic abuse, the first being the missed opportunity in 2020 to undertake a DARA for Melissa outlined in 16.12.

16.20 In this instance the Panel discussed the importance of agencies recognising the complexity of the dynamics of domestic abuse, including the use of allegations and counter-allegations to enact control via state interventions. It is not possible to understand what Jerry meant when he described Melissa as *'being lairy'* but the Panel recognised that it is not unusual that perpetrators of domestic abuse may feel genuinely aggrieved where a victim resists abuse[20]. Indeed, there were multiple examples of Jerry feeling aggrieved and calling the police for other perceived slights, ones that often led to his being identified as the aggressor.

16.21 The Panel believed it is important that *'violent resistance'*[21] is understood as a possibility in the context of coercion and control. Counter-allegations made by perpetrators of abuse can cause agencies to view the controlled person as a perpetrator of abuse, mentally unwell, and/or increase their fear of children being removed from their care. Safe Lives guidance notes, *'It is also essential to highlight, as previously noted, that violent resistance does not always sit with*

[20] Michael Johnson: A Typology of Domestic Violence: intimate terrorism, violent resistance, and situational couple violence (2008)
[21] Ibid.

professional and societal views of a 'typical' victim, especially if this is compounded by issues such as substance or alcohol use, homelessness, mental health or being a mother. It is this behaviour that when misidentified can create hostility from services. It reminds us that 'nice' victims are preferable for us to engage with. It can also cause…victim blaming judgements.'[22]

16.22 The panel considered that both Melissa and Jerry were known for anti-social behaviour, so Melissa would not be viewed as the 'ideal victim'. Consequently, her needs could be lost in the complexity of both her and Jerry's presentations to services. The Police IMR author acknowledged that there was a clear opportunity for the police to enable Melissa to disclose her experiences when officers attended the home and that the communication between the call handling staff and police officers could have raised officers' awareness that Melissa had been heard to say she had been assaulted during Jerry's call to the police. It is possible that she may have been recognised as high risk of harm at this point which could have led to a multi-agency process for her safety.

16.23 From this point onwards, Melissa routinely describes her home circumstances in terms that could raise curiosity in relation to domestic abuse. One of the ways in which she did this was through her letter writing to her G.P. She wrote to them in 2021 describing Jerry as 'abusive'; there is no record of a response to this letter and such communications should help to build a safeguarding picture. On receipt of letters at a G.P. surgery, an administrator should triage them, ensuring that any safeguarding concerns are flagged. It is unclear whether these were flagged appropriately. However, for future learning it is important that services acknowledge the need to take every contact seriously, even where someone is writing routinely about a range of issues.

16.24 The key area of response to Melissa as a victim of domestic abuse occurs in the summer of 2022 when she speaks to her G.P. and describes physical assaults, including strangulation by Jerry, as well as economic exploitation. The Panel acknowledged the appropriate and timely response of the G.P. in this instance, who made an immediate referral to a domestic abuse organisation, Look Ahead, which resulted in a MARAC referral.

[22] SafeLives: Responding to Counter-Allegations: Guidance – a Review of practice (2023)

16.25 The IMR Author for the Integrated Care Board identified that the G.P. practice should have made a safeguarding referral for Melissa based on her disclosure, in line with their policy. They also noted issues regarding the flagging of her records – her disclosures of domestic abuse could and should have been flagged, but also her risk factors regarding her complex childhood trauma. The author notes *'It is possible professional curiosity may have elicited evidence of deteriorating social and mental health'.* Flagging on systems enables awareness of 'issues' faced by individuals, especially where they are seeing multiple practitioners on an episodic basis and is relevant for both domestic abuse and suicidality practice.

16.26 The Panel noted that the G.P. did not attend the MARAC meeting that heard Melissa's case. The Panel acknowledged that it would be impossible for G.P.s to routinely sit on all MARAC meetings, however, they were of the view that where a professional has good engagement with and insight to an individual, that person should attend the meeting. The Panel were of the view that MARAC co-ordinators could determine whether professionals should be called upon to attend virtually for one-off cases and that in Melissa's situation this would have been important.

16.27 On contacting Melissa, Look Ahead undertook appropriate assessments and were swift to engage with the housing team for Melissa's needs. The DASH risk assessment contained sixteen yes responses which resulted in the referral to MARAC. The Panel acknowledged the IDVA's initial advocacy work as good practice, in bringing agencies together, safety planning and pursuing a housing outcome for Melissa quickly in response to her identified risk level.

16.28 The MARAC referral from Melissa's IDVA contained relevant information, which informed the process of the risks that she faced. Melissa's considerations of suicide the year before were noted in the background information on the referral. However, the DASH assessment, which is appended to the referral, was not complete. Look Ahead reported that Safe Lives trainers stated, in the IDVA course, that DASH assessments should not be shared outside of the organisation and that this led them to not share the assessment document.

16.29 Safe Lives were asked for their position by the Chair on this and stated, *'Our position would be that a MARAC referral form should be sufficient to make a MARAC referral as the form would include a space to summarise the risks posed to the victim and include a rationale for the referral as well as the DASH score. The Information Sharing Agreement is essential in providing the basis for which professionals can share details about the victim and their family, but we would still advise proportionality - that the information shared at each stage of the process is only what is necessary to understand the risk at that stage. For that reason, the MARAC referral form should contain what is needed for adding to the agenda, and more specifics about the domestic abuse can be shared by the referrer at the meeting itself. This approach would avoid the unintended consequence of more information than necessary being cascaded to multiple professionals.'*

16.30 The Panel acknowledged and understood the approach outlined by Safe Lives and that the referral form submitted on Melissa's behalf did contain a summary of the key information. However, Look Ahead had no case review process in operation at this time (this practice was introduced in late 2023), leaving the IDVA with the sole responsibility of getting this right. It was the Panel's view that the completion of the DASH assessment contained within the referral form, under the auspices of the Kent and Medway information Sharing Agreement, would constitute safe and effective practice and that IDVAs should be clear in the MARAC meeting if sensitive information has been withheld.

16.31 The Panel acknowledged that Look Ahead described being under significant referral pressure at this time which they communicated to commissioners. The Panel acknowledged that the availability of services with best practice models, for example, Leading Lights or Women's Aid accreditation and appropriate resourcing for the work is an issue that should be addressed by Kent Domestic Abuse Service Commissioners in any future commissioning activity.

16.32 The Panel also considered the role of the IDVA in managing the safety plan for Melissa. Melissa's safety plan hinged on her being moved to another property and the officer in the case was asked not to progress an arrest of Jerry until this

had happened as it would place her at greater risk. The officer was also advised that Melissa did not wish to speak with the police. Work was undertaken to address Melissa's housing needs which is addressed in the next section, but as this did not happen, the safety plan became unachievable.

16.33 In the first instance, the Co-ordinated Community Response (CCR) model is described by Standing Together as, *'A CCR brings services together to ensure local systems truly keep survivors safe, hold abusers to account and prevent domestic abuse.'*[23] This approach should create a shared accountability for the safety of victim-survivors with the MARAC process being the space to coordinate dynamic safety responses and the role of the IDVA being to coordinate that work, to represent the voice of the victim, and to negotiate safety mechanisms with partners.

16.34 Safety Plans should be live documents, and it was the Panel's view that this situation presented a missed opportunity for Melissa's safety needs to be met. The inflexibility in Melissa's safety plan has particular relevance for older victims, who in some research, identify that leaving the relationship for a variety of reasons, including dependency on the other person, is an inadequate standalone safety plan response.[24] It seems clear from the records that Melissa was going to find leaving challenging, and her safety plan should have acknowledged her need to have a dog live with her, in this case, a large breed. IDVA services and other multi-agency partners must have the creativity and knowledge to form safety plans that are victim-focused, and that are based on varying eventualities, including consideration of planning for those who may not be able to leave a relationship.

16.35 Neither the IDVA nor the MARAC process maintained oversight of Melissa's safety plan and its inability to deliver safety for her; consequently, at the point of her dropping out of the scope of the IDVA service, she remained a high-risk and unsupported victim of domestic abuse.

[23] https://www.standingtogether.org.uk/what-is-ccr - ACCESSED: June 2024
[24] Safe Lives, Spotlight Series: Older People and Domestic Abuse, 2016.

16.36 The police officer in the case pursued updates with the aim of undertaking an arrest, which was acknowledged by the Panel. However, they were deterred from such action by the IDVA as described above. In addition to having an effective coordinated response, the IMR author noted that the officer found not making an arrest counter-intuitive, with the Detective Inspector in the case noting that it is not unusual to follow the IDVAs guidance in these matters. The author notes that the officer, *'should have been more directive'.* By this, they mean that the officer should have ensured their views had parity with the IDVA and that a negotiation should have taken place. It was noted on the MARAC minutes that Melissa was concerned about engaging with the police due to Jerry's tendency to make counter-allegations; consideration of reassurance for her in relation to this could have been made as part of the MARAC process. It is also noted on the Housing Team's IMR that there had been consideration of a professionals' meeting (this was considered after the police officer pursued an update). This might have enabled a more assertive position to have been taken in relation to police access to Melissa, although it is acknowledged that Melissa may not have engaged with the police.

16.37 Melissa was heard at MARAC, and her housing band was uplifted to Band A, which the Panel acknowledged as good practice. The MARAC group also discussed a DVDS (Domestic Violence Disclosure Scheme), also known as Clare's Law. The Panel noted that a more appropriate intervention would have been a DVPO (Domestic Violence Protection Order).

16.38 Melissa had been married to or living with Jerry for a significant proportion of her adult life and appears to have been well-versed in his status as a perpetrator of abuse. The Panel held the view that a DVDS would have been an irrelevant mechanism given her pre-existing insight. However, they believed that a DVPO, a valuable tool that enables victims time away from the perpetrator of the abuse to consider their options and cultivate '*space for action*'[25], could have been considered with the potential outcome that the removal of Jerry from the property might have enabled intensive support to be given to Melissa.

[25] Professor Liz Kelly, Domestic Violence Matters, 2010

16.39 The MARAC referral for Melissa also identified that she had submitted images evidencing *'strangulation marks'* bruising and had described several incidents of strangulation, to the point where she would see '*black spots'* and think *'that was the end.'* The devastating impact of non-fatal strangulation (NFS) is increasingly understood in research today, due to the work of the Institute for Addressing Strangulation and Safe Lives; however, the risks associated with it were already known. It was a pre-existing high-risk indicator on the DASH checklist for this reason. Non-fatal strangulation can lead to physical and psychological problems. The Institute note that *'Recovery is variable, it may be complete or lead to long term problems.'* They further note that the brain is particularly sensitive to oxygen deprivation, as loss of consciousness can take as little as 6.8 seconds.[26]

16.40 Recognising the risks associated with non-fatal strangulation is essential for practitioners. In Safe Lives research, 32% of IDVA clients had experienced this issue with almost all of them being women.[27] On the 7th of June 2022 Section 70 of the Domestic Abuse Act, 2021 introduced *'Offences of non-fatal strangulation and non-fatal suffocation'* in recognition of the prevalence and harm of this issue. This act can also be considered an enactment of coercive control and as such Section 76 of the Serious Crime Act is relevant. Although this statute occurred after Melissa's death, the Panel noted the importance of agencies recognising the high-risk nature of this issue in future practice.

16.41 The potential for an evidence-led prosecution was addressed by the Police IMR author. The photos submitted by Melissa would have been a key part of this decision and the author notes that the officer should have also spoken to Melissa's G.P. to ascertain whether any additional evidence was available. It was the Panel's view that the risks associated with Melissa's experience of strangulation and prevailing evidence, which could have informed an evidence-led prosecution (ELP), should have been further considered within the MARAC process.

16.42 Finally, the Panel considered the implications and rationale of Melissa's end of support with Look Ahead. Melissa's last contact with her IDVA was a text to advise that she had rejected a property and would talk to the housing team about

[26] Institute of non-fatal strangulation, *Non-fatal strangulation: in physical and sexual assault,* 2023
[27] Safe Lives, *Insights Idva Dataset 2021-22 Adult Independent domestic violence advisor (IDVA) services*

it. She was not contacted again and had no case closure process or review of her risk status. There was no revisiting of the safety plan to re-form it around her current situation and the police had not effected an arrest based on the contents of the original safety plan. Look Ahead did not communicate that Melissa was no longer receiving support to other agencies, leaving Melissa in an isolated and vulnerable position.

16.43 Look Ahead described this as 'disengagement' from the service. However, there is no evidence that any attempts were made to contact Melissa after this text message. We are unable to know if Melissa would have continued to work with services in relation to her safety plan had contact been maintained with her.

16.44 The Panel made one final consideration of this issue, identifying the need for a central ownership of safety via the Kent MARAC process. The MARAC Manager for Kent and Medway described to the report author that this would form part of the new 2024 incoming process, that safety actions would have a maintained oversight by the MARAC team and would be hosted on a client database. The Panel were of the view that this is an essential part of developing safety practice, ensuring that any future victim-survivor who falls out of scope for an agency can still be seen by other MARAC partners and is not, mistakenly, believed to still be receiving support.

Housing needs of vulnerable victims

16.45 The Panel acknowledged that whilst Melissa's case was active with Look Ahead the IDVA worked dynamically to facilitate her re-housing and that the local housing team were dynamic and attempted to be flexible in their approach to her needs.

16.46 It is not possible to say whether the outcome could have been different, as Melissa did reject multiple property offers and had her heart set on a property type that was unlikely to be available. The Panel discussed the level of entrapment that Melissa may have experienced, which could have made it very difficult for her to leave; this is addressed in the next section.

16.47 The Panel identified some learning from the Review in relation to local housing policy. There were multiple and creative attempts to meet Melissa's need for re-housing by the housing team, for example, drawing on local housing association partnerships and trying to be flexible in the allocating of properties. In fact, they came very close to offering a property that might have been suitable for Melissa's wishes. However, during the process someone flagged that Melissa should be excluded from this property type because of her level of savings and consequently the offer types were changed to those for over-55's only. This meant that Melissa was finally offered (and viewed) a scheme that she considered an *'old people's home'.* She was also advised at this viewing that her large breed dog would not be allowed on the premises. After this Melissa did not make further attempts to be re-housed.

16.48 Melissa's exclusion from housing based on her desire to keep owning German Shepherd dogs, as previously stated, should have been central to her safety planning approach. Pet ownership has been linked to enhanced physical and mental health in the general population, as well as in patients with physical and mental disorders[28] and research shows that traumatised children showed more adaptive coping strategies when owning a cat or a dog than those without,[29] Research also tells us that pet ownership has a distinct effect on reducing issues of loneliness in older people.[30] The Panel acknowledged the challenges to finding suitable social housing generally in today's climate but also acknowledged the importance of dogs in Melissa's life.

16.49 The housing team activated Band A priority for Melissa in early August 2022, following a MARAC meeting which was appropriate practice as the Domestic Abuse Act, 2021, enhanced housing policy for survivors of domestic abuse, ensuring that they were able to consistently access priority need housing. Prior to the Act local housing policy was inconsistent in its treatment of survivors' housing needs.

[28] Wells D.L. The effects of animals on human health and well-being. *J. Soc. Issues.* 2009;**65**:523–543
[29] Arambašić L., Keresteš G., Kuterovac-Jagodić G., Vizek-Vidović V. The role of pet ownership as a possible buffer variable in traumatic experiences. Studia Psychol. 2000;42:135–146
[30] Stanley I.H., Conwell Y., Bowen C., Van Orden K.A. Pet ownership may attenuate loneliness among older adult primary care patients who live alone. Aging Ment. Health. 2014;18:394–399

16.50 The Act ensured that a victim of domestic abuse has an automatic priority need and does not need to be considered vulnerable. Importantly, there is no requirement that the person must have ceased to occupy the accommodation for this category of priority need to apply. A person is homeless if accommodation is unreasonable to continue to occupy because it is probable that this will lead to domestic abuse against them or someone in the household.[31] The housing team's practice was in line with this requirement.

16.51 However, the Panel noted that the progress being made in relation to Melissa's housing and its importance for her safety plan was disrupted by the local policy in relation to social housing for those with savings. The local housing team current policy identifies financial criteria in relation to social housing, noting that *'If you have a total household income or capital (including savings) above the thresholds described below, you will not usually be included on the Housing Register. The current thresholds for households are: Without dependent children and with a shared accommodation/one bedroom need, a total gross annual income of up to £40,000'.*

16.52 It was difficult for the Panel to explore issues of economic abuse faced by Melissa due to a lack of information, but what the Panel could know is that she did still have a significant sum in savings, as evidencing this to the housing team led to her exclusion from general needs housing options.

16.53 It was the Panel's view that Melissa should have been maintained as priority need for general needs housing, without the addition of any exclusionary criteria, as she was a victim of domestic abuse in line with the Domestic Abuse Act. The Panel continued to note that much of the housing team's activity was in line with the Homelessness Code of Guidance for Local Authorities whereby flexible and enabling behaviours were in place, but that inhibiting Melissa from accessing general needs housing through the local policies financial criteria presented a missed opportunity to enable her safety plan. The Panel also took the view that the Act is not securely worded enough to prevent this happening to future victims. Consequently, the housing team did not act outside of statute. The Panel were

[31] s.177 Housing Act 1996, as amended by s.78(2) Domestic Abuse Act 2021.

concerned that vital housing law, aimed at protecting victims of domestic abuse, could easily be undone by these grey areas.

16.54 In considering this change to Melissa's housing status, the Panel reflected on the multiple communications happening between practitioners following the MARAC meeting; these were an excellent example of the power of the coordinated community response with all participants focused on a solution to Melissa's housing need. The Panel acknowledged this as a dynamic risk-focussed approach. However, it was also acknowledged that this presented some issues in the work between the IDVA and the Housing Team. The Panel noted misunderstandings regarding Melissa being placed on auto-bid (although this was noted on the MARAC minutes), and the approach being shifted by the realisation that she had significant savings. Consequently, she lost access to a bungalow that she may have accepted.

16.55 Kent Housing Teams are undertaking Standing Together's DAHA (Domestic Abuse Housing Alliance) accreditation at the time of writing. The report author spoke with a former senior member of the DAHA team who advised that although the argument can be made that a housing duty was discharged through a reasonable offer of safe housing in Melissa's case (via the offer of the over-55's housing scheme); the DAHA accreditation process does expect to see housing teams acting flexibly to meet the needs of victim-survivors. However, they state the process itself cannot insist on this flexibility. It was the view of the panel that learning from this review could be used to support the development of housing officers' understanding of the importance of flexible approaches.

16.56 In busy, frenetic service delivery, agencies find themselves acting at speed and the chronology shows the commitment and responsiveness of this, but the Panel felt that it may in fact prove more effective to bring key people together, explore the problem at hand and then determine the way forward before course is changed. This could take place in a brief online professionals' meeting and has the potential to make the process more efficient. This is especially relevant in relation to the change of Melissa's housing status; as it occurred whilst her IDVA was on holiday, they returned to find the plan amended and were not able to advocate. The Panel observed that this change dramatically altered the course of Melissa's engagement and safety planning.

16.57 The Panel took the view that the moment at which a change in policy approach came into play, a brief meeting could have ensured that an agreement regarding the plan of action was made. Unfortunately, the housing plan shifted based on the new information and Melissa was then diverted into a housing approach that she was neither comfortable nor happy with. The Housing Team were also unaware that Melissa had dropped out of scope for the IDVA by this time, which left her without an advocate when her housing band was reduced following multiple property rejections.

Trauma-informed practice

16.58 It is clear from the information available that Melissa's life was blighted from childhood by abuse, leaving her with the impact of multiple and complex traumas.[32] In today's statutory definitional terms she was a victim of domestic abuse from childhood.

16.59 In G.P. records, as well as psychiatric and pain management assessments, Melissa was acknowledged as being burdened by significant psycho-social stressors, and it was known that suicidal ideation and attempts at suicide were a presenting feature throughout her life. The ICB IMR Author notes that her vulnerability/suicidality risk could have been flagged (using NHSE vulnerability codes - SNOMED) on the system to enable practitioner awareness of the issues that she faced.

16.60 Suicidality is a common feature of those who have experienced complex trauma, along with a range of other impacts that can disable a child from living a fully expressed adult life, leaving them with rage, shame, guilt, difficulty in forming and maintain relationships, in trusting others, in differentiating between an adult relationship and one which replicates the unhealthy dynamics of their childhood relationships, fear, anger and suicidality.[33]

16.61 On the previously cited website it states *'Survivors who deal with complex post-traumatic stress disorder often struggle with chronic suicidal ideation and have*

[32] Complex trauma events have been defined as chronic, interpersonal traumas that begin early in life (Cook, Blaustein, Spinazzola, & van der Kolk, 2003) (Wamser-Nanney & Vandenberg, 2013).

[33] https://cptsdfoundation.org/2021/09/20/the-link-between-complex-trauma-and-suicidal-ideation/ ACCESSED: 10.6.24

experienced repeated suicide attempts… Many people living with the after-effects of complex trauma will have periods of no suicidal ideation only to have it come back again later. Because of the tremendous pain involved with dealing with complex trauma, survivors must have a "way out" of the pain and may consider suicide a "safety net," a way of escape.'

16.62 Suicidality is subject to a gender paradox with men in the UK being significantly more likely to die by suicide than women; however, research also consistently shows that women are more likely to self-harm and make suicide attempts than men.[34]

16.63 Kent's Public Health Team have shown national leadership in developing understanding of domestic abuse and suicidality, and the Government's Suicide Prevention Strategy for England (2023-2028) references the need to develop our understanding of the links between suicide and domestic abuse, to ensure that bespoke support is available for certain priority groups, including children and young people and those in contact with mental health services.

16.64 Sadly, the impact of Melissa's entrapment in abuse and her lifelong mental health difficulties culminated in her death by suicide and the Panel were considerate of the impact of these abuses on her mental health resulting in this tragic outcome. In considering the lessons that could be learned to make the future safer for someone in Melissa's position, it was important to attend to the opportunities to intervene at stress points for Melissa who was known to be subject to multiple suicidality risk factors including domestic abuse, poor mental health and social isolation. The panel acknowledged the need for holistic services for those with complex, life-altering traumas.[35]

16.65 In the first and second instance, it is apparent that Melissa was a victim of domestic and sexual abuse and that this had a significant impact on her physical and emotional health. The MARAC referral documents state that Melissa described standing on a window ledge in 2022 with the intention of ending her life but decided that [Jerry] *'was not worth it'.* It was the Panel's view that awareness of suicidal thoughts and behaviours should form part of the multi-agency

[34] https://www.samaritans.org/about-samaritans/research-policy/gender-and-suicide/ ACCESSED: 11.6.24
[35] Department for Health & Social Care: Suicide prevention strategy for England: 2023 to 2028

processes safety planning considerations. In this example, her decision that he was not worth it appears to have been seen as a protective factor, whereas this should not have been the case. It may have inhibited her from jumping in this instance, but it was the Panel's view that this should have been considered in the context of ongoing abuse and entrapment.

16.66 The Panel were of the view that it is a priority that agencies recognise and understand the increased risk of suicidal ideation and attempts at suicide for those experiencing domestic abuse in the context of pre-existing complex trauma, and ongoing entrapment in abuse, including specialist domestic abuse services aiming to understand where these risks exist for those referred or self-referring to their services, and ensuring these are integral to safety planning.

16.67 Kent Domestic Abuse and ICB Health Commissioners introduced the requirement for commissioned services to undertake Suicide Prevention training in 2021 and many agencies now speak to 'trauma-informed practice' having undertaken short training courses. The Panel acknowledged the developments of awareness and understanding in these areas because of this type of training and the dissemination of learning from reviews.

16.68 Nevertheless, it was the Panel's view that, despite training being a good first step, agencies must ensure that their systems and processes are trauma-informed and suicide-aware. The Panel considered that the MARAC process and Domestic Abuse service providers in Kent should make a review of their suicidality and trauma-aware practice, specifically in relation to adequate safety planning for suicide risks. In the first instance, these agencies should ensure that the research and practice proposals produced by the Kent and Medway Suicide Prevention Team are embedded in their approaches.[36] This would include ensuring that agency partners were conversant with Professor Jane Monckton-Smith's Suicide Timeline[37] and reviewing internal systems to ensure that assessment and case review processes include the proposed implications for practice.[38]

[36] Kent & Medway Suicide Prevention team: Highlighting the link between domestic abuse and suicide
[37] Ibid. P10
[38] Ibid, P13-15

16.69 The Panel also noted that KMPT (Kent & Medway NHS & Social Care Partnership Trust) are recorded in the MARAC as stating that Melissa was not open to their service and consequently suggested that information was sought from the G.P. regarding current known risks. The Panel held the view that given Melissa's engagement with KMPT, they should have been in a position, as a health representative, to access the RIO database system and check Melissa's background. This could have enabled a greater appreciation of Melissa's overall vulnerability and tendency to suicidal thoughts and behaviours. However, the risk of suicide was not brought forward into the MARAC discussion and the Panel considered this a missed opportunity to recognise and act on this potential risk.

16.70 Engaging with considerations of the impact of trauma on the lives of those victimised by perpetrators of domestic abuse can be problematic. The Panel were of the view that these must be built into practice mechanisms in a way that does not support victim blaming but rather acknowledges the cumulative and debilitating impact of multiple traumas in someone's life. Gathering a picture of the individual's history in relation to suicidality is paramount and acts of suicidal ideation and attempts at suicide should not be considered historic. Especially where complex trauma is present, someone may return to these thoughts and actions during periods of stress and, for those with complex trauma, stress tolerance may be reduced because of their life experiences.

16.71 The third risk factor was her social isolation. Melissa herself described her socialising issues when she was assessed for the pain management programme. Childhood trauma can cause *'social thinning'* for children as they attempt to navigate relationships from a position of 'unsafe'[39] , making it difficult for them to be open and trusting in their interpersonal relationships in childhood and ultimately as adults.[40]

16.72 Social relationships are integral to mental health and wellbeing; a lack of access to these isolates the individual in their trauma, and the subsequent loneliness makes them vulnerable to abuse by others. Consequently, services must be conversant with the need to enable those who struggle socially to engage with

[39] The Body Keeps the Score, Bessel Van der Kolk, 2015 / Trauma and recovery, Judith Herman, 1992
[40] CHILDHOOD TRAUMA, THE BRAIN AND THE SOCIAL WORLD A short guide about the importance of social relationships for mental health. Professor Eamon McRory. ACCESSED 11.6.24

service provision. The Panel considered opportunities to reduce Melissa's social isolation at two key points.

16.73 The first related to her being offered a pain management programme and withdrawing because it was in the morning. The Panel felt that this programme should have been more flexible in its attempts to engage her and in offering alternative times for this programme, given her description of mornings being difficult because of her health needs. Melissa also did not join online pain management meetings due to 'IT issues' which were not explored. The Panel were of the view that enabling vulnerable individuals to gain access to services online could be a less threatening form of interaction and consequently create better circumstances for engagement.

16.74 The second is the form of services offered by domestic abuse organisations. The time-restricted, overburdened nature of the IDVA service did not enable Melissa to access a more holistic form of support which could have included the opportunity to build a trusting relationship in which she was enabled to have choice and control and consequently build hope for post-traumatic growth.[41] It was the Panel's view that Kent Domestic Abuse Commissioners should ensure, in commissioning domestic abuse services, that they have adequate resources to provide approaches that are trauma-informed and person-centred.

16.75 The Panel noted that Melissa had accessed CBT following a referral by a psychiatrist and had described this as helpful. They also noted that she had been assessed by the Mental Health Team sometime later and had not been considered in need of support. In both instances, there had been no continuity of service, and she had been left with the need to access community-based services on a self-referral basis. Given Melissa's descriptions of her social issues, the Panel found the concept of signposting to be problematic, feeling that services should have mechanisms that allow for a supported engagement into community-based services for those with difficulties in socialising.

16.76 Jerry was known to be a problematic drinker and although not featured extensively on the evidence gathered, drinking did seem to be a feature of

[41] SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, 2014

Melissa's life. For Melissa this could have been a coping strategy for the significant issues that she faced both historically and in day-to-day life. The national lockdowns are also now known to have triggered escalated alcohol use, with research showing nearly a third of people (29%) are reporting that they have drunk more alcohol than they normally would.[42] The Panel observed alcohol use being a common feature of those who have experienced complex trauma and noted that there was no exploration of Melissa's drinking or referrals for support acknowledged within the IMRs.

16.77 Kent and Medway have a Co-Occurring Conditions Policy (formerly known as Dual Diagnosis) that considers service provision in the context of both issues. The development of this policy was cross-agency in nature in 2021. The protocol is targeted at all staff of agencies providing services to those who may present with mental health and substance misuse issues in Kent and Medway, including in domestic abuse settings. The protocol notes *'NHS NICE and Public Health guidance states that without a clear improvement in the care and treatment of people who suffer both mental health and substance misuse disorders those people are at high risk of poorer outcomes and death. There are several points of learning from Kent and Medway Adult Safeguarding Reviews (SARS) that point to this. Effective joint working and care planning (parallel care) between all agencies is key to meeting the needs of those with co-occurring mental health and substance misuse disorders.'*[43]

16.78 The Panel acknowledged the complexity of working across service silos where individuals present with co-occurring needs. In Melissa's situation she had the addition of domestic abuse as a feature of her life, and it is not uncommon for those who are victimised in their relationships to experience mental health problems and/or use substances to cope. This is acknowledged in a side note within the policy, but the Panel held the view that this policy could be strengthened, given the prevalence of co-occurring conditions for those living with domestic abuse.

17 Conclusions

[42] Nearly a third of UK public drinking more alcohol than usual during the pandemic | King's College London (kcl.ac.uk): ACCESSED June 2024

[43] Kent and Medway joint working protocol for co-occurring mental health and substance misuse disorders, October 2021, Dual Diagnosis Strategy Group

17.1 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.

17.2 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.

17.3 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 and how services respond to these.

17.4 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.

17.5 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.

17.6 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.

18 Lessons to be Learned

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

18.1.1 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.

18.1.2 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.

18.1.3 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.

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

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

18.2.2 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.

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

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

18.3.1 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.

18.3.2 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.

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

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

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

18.4.2 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.

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

18.5 *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.*

18.5.1 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.

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

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

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

19 Recommendations

19.1 The Review Panel makes the following recommendations from this DARDR:

	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
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	KCC Integrated Commissioning Team

	Recommendation	Organisation
	practice frameworks in the delivery of IDVA services, preferably with a quality mark for those services.	
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
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

	Recommendation	Organisation
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
12.	Domestic Abuse service providers to ensure that they review suicidality practice internally and utilise the Kent and Medway Suicide Prevention Team's practice recommendations in doing so.	KCC Integrated Commissioning Team

20 Appendix A – Terms of Reference

Domestic Abuse Related Death Review - Terms of Reference

Kent & Medway - Domestic Abuse Related Death Review

Victim – Melissa

Terms of Reference - Part 1

Introduction

Following an agreement that the criteria for a Domestic Abuse Related Death Review (DARDR) has been met and the Independent Chair has been appointed, the first stage of a DARDR is the establishment of clear Terms of Reference (ToR). Guidance for setting DARDR ToR is provided in Section 4, Paragraphs 40-42 of the Home Office Statutory Guidance for the conduct of DHRs.

1. Background

1.1 In May 2023 police officers attended a property in Town X, Kent where Melissa had been found unresponsive by an ambulance crew – her death was caused by hanging in her home.

1.2 Jerry was arrested for murder but Major Crime Officers investigated the allegation and found there was no evidence to support this and he was refused charge. However, the couple had a history of domestic abuse which included episodes of non-fatal strangulation. Melissa also had a history of suicidal ideation.

1.3 In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Kent and Medway Domestic Abuse Related Death Review (DARDR) Core Panel meeting was held in July 2023. It confirmed that the criteria for a DARDR have been met because in 2016, deaths by suicide were brought into the scope of the review system where the victim had a history of domestic abuse.

1.4 That agreement has been ratified by the Chair of the Kent Community Safety Partnership (under a Kent & Medway CSP agreement to conduct DARDRs jointly) and the Home Office has been informed. In accordance with established procedure this review will be referred to as Melissa - May 2023.

2. The Purpose of a DARDR

2.1 The purpose of this review (as described in Section 2, paragraph 7 of the Home Office Guidance) is to:

a. establish what lessons are to be learned from the death 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.

3. The Focus of a DARDR

3.1 Sec 2, Para. 8: Reviews should illuminate the past to make the future safer and it follows therefore that reviews should be professionally curious, find the trail of abuse and identify which agencies had contact with the victim, perpetrator or family and which agencies were in contact with each other. From this position, appropriate solutions can be recommended to help recognise abuse and either signpost victims to suitable support or design safe interventions

3.2 Sec. 2. Para. 10: A successful DARDR should go beyond focusing on the conduct of individuals and whether procedure was followed to evaluate whether the procedure/policy was sound. Does it operate in the best interests of victims? Could an adjustment in policy or procedure have secured a better outcome for the victim? This investigative technique is sometimes referred to as professional curiosity. 3.3 Sec. 2, Para.12: The rationale for the review includes ensuring 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 violence. The review will also assess whether agencies have sufficient and robust procedures and protocols in place which were understood and adhered to by their staff.

4. DARDR Methodology - IMRs (See Sec. 7 and Appendix One of the Home Office Guidance in relation to IMRs)

4.1 Independent Management Reviews (IMRs) must be submitted using the templates current at the time of completion.

4.2 This review will be based on IMRs provided by the agencies that were notified of, or had contact with, Melissa and/or Jerry in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse, e.g. alcohol or substance misuse. Each IMR will be prepared by an appropriately skilled person who has not any direct involvement with Melissa and/or Jerry, and who is not an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR.

4.3 Each IMR will include a chronology, a genogram (if relevant), and analysis of the service provided by the agency submitting it. The IMR will highlight both good and poor practice, and will make recommendations for the individual agency and, where relevant, for multi-agency working. The IMR will include issues such as the resourcing/workload/supervision/support and training/experience of the professionals involved.

4.4 Each agency required to complete an IMR must include all information held about Melissa and/or Jerry from 1st of January 2016 to May 2023. If any information relating to Melissa as the victim(s), or Jerry as the perpetrator, or vice versa, of domestic abuse before 1st of January 2016 comes to light, that should also be included in the IMR.

4.5 Information held by an agency that has been required to complete an IMR, which is relevant to the homicide, must be included in full. This might include for example: previous incidents of violence (as a victim or perpetrator), alcohol/substance misuse, or mental health issues relating to Melissa and/or Jerry. If the information is not relevant to the circumstances or nature of the homicide, a brief précis of it will be sufficient (e.g. In 2010, X was cautioned for an offence of shoplifting).

4.6 Any issues relevant to equality, i.e age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation must be identified. If none are relevant, a statement to the effect that these have been considered must be included.

4.7 When each agency that has been required to submit an IMR does so in accordance with the agreed timescale, the IMRs will be considered at a meeting of the DARDR Panel and an overview report will then be drafted by the Chair of the panel. The draft overview report will be considered at a further meeting of the DARDR Panel and a final, agreed version will be submitted to the Chair of Kent CSP.

5. Specific Issues to be Addressed

5.1 Appendix One of the Home Office Guidance outlines the requirements for agencies' analysis of involvement. The following are given as examples of the areas that will need to be considered in agency IMRs, along with any further specific issues to the case. These can be edited and added to and will form the **Key Lines of Enquiry** expected to be addressed in the Analysis section of the Overview report (Page 37 – Home Office Guidance):

i. Were practitioners sensitive to the needs of Melissa and/or Jerry and 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. Document Control

6.1 The two parts of these Terms of Reference form one document, on which will be marked the version number, author and date of writing/amendment.

6.2 The document is subject to change as a result of new information coming to light during the review process, and as a result of decisions and agreements made by the DARDR Panel. Where changes are made to the document, the version number, date and author will be amended accordingly, and that version will be used subsequently.

6.3 A record of the version control is included in the appendix to the document.

END OF PART 1

GLOSSARY

Abbreviations and acronyms are listed alphabetically. The explanation of terms used in the main body of the Overview Report are listed in the order that they first appear.

Abbreviation/Acronym	Expansion
CMHT	Community Mental Health Team
CSP	Community Safety Partnership
DARA	Domestic Abuse Risk Assessment
DARDR	Domestic Abuse Related Death Review
DASH	Domestic Abuse, Stalking and Harassment (Risk Assessment)
DHR	Domestic Homicide Review
ELP	Evidence-led prosecution
GP	General Practitioner
IMR	Independent Management Report
KMPT	Kent & Medway NHS & Social Care Partnership Trust (Secondary Mental Health care provider)
KMDASG	Kent and Medway Domestic Abuse Steering Group
NHS	National Health Service
SPoA	Single Point of Access

Domestic Abuse Risk Assessment (DARA)

The Domestic Abuse Risk Assessment (DARA) is a risk tool for frontline police practitioners responding to domestic abuse. The DARA was developed by the College of Policing in consultation with survivors, frontline police officers, voluntary and charity sector support services, and leading academics. The DARA focuses on making it easier to identify coercive control so that responding officers can make better informed risk assessments. The DARA has been identified by the College Professional Committee and the National Police Chiefs' Council (NPCC) as the preferred risk tool for police first responders to domestic abuse. Further information about DARA can be found here: DARA

Domestic, Abuse, Stalking & Harassment (DASH) Risk Assessments

The DASH (2009) – Domestic Abuse, Stalking and Harassment and Honour-based Violence model is used by non-police agencies to assess the risk of harm faced by a victim of domestic abuse. A list of 27 pre-set questions will be asked, the answers to which are used to assist in determining the level of risk. The risk categories are as follows:

Standard	Current evidence does not indicate the likelihood of causing serious harm.
Medium	There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances.
High	There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious. Risk of serious harm is a risk which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible.

In addition, the DASH includes additional question, asking the victim if the perpetrator constantly texts, calls, contacts, follows, stalks or harasses them. If the answer to this question is yes, further questions are asked about the nature of this.
A copy of the DASH questionnaire can be viewed here.

Domestic Abuse (Definition)

Domestic Abuse Act 2021

(1)This section defines "domestic abuse" for the purposes of this Act.

(2)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.
(3)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 (see subsection (4));
(e)psychological, emotional or other abuse;
and it does not matter whether the behaviour consists of a single incident or a course of conduct.
(4)"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.
(5)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).
(6)References in this Act to being abusive towards another person are to be read in accordance with this section.
(7)For the meaning of "personally connected", see section 2.

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.*

Community Mental Health Team (CMHT)

CMHTs deliver mental health services to people with long term mental in the community health conditions, rather than at inpatient facilities. CMHTs in Kent and Medway cover geographical areas that are usually coterminous with NHS Clinical Commissioning Groups. More information about CMHTs can be viewed here.