Domestic Homicide Review

Diana

2020

Executive summary

Independent Report Writer: Elizabeth Hanlon

Commissioned by:

Kent Community Safety Partnership

Medway Community Safety Partnership

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1 Diana

1.1 Diana is described as being 'popular, loud and loved being the centre of attention'. She had bundles of life and liked to be the life and soul of the party. Diana was rarely happier than when she was on the dance floor with her friends and sister. She was the loving mother of two children and was described by her family as having loved being a mother. Diana was the person that many people turned to if they had problems, she was always there for her family and friends and no matter what people were going through she always put it aside and dealt with the people that needed her. She will be sadly missed. Diana's mum explained that the funeral for Diana was held in a 'Ascot racing' style because Diana had loved to go to ladies' day at Ascot. She said that everyone who attended the funeral had come dressed in bright Ascot clothes and that it was a funeral that celebrated Diana's life and was very 'fitting for her'.

2 The Review Process

2.1 This overview report has been commissioned by the Kent Community Safety Partnership (on behalf of the local CSPs including the Medway Community Safety Partnership) concerning the death of Diana which occurred in 2020.

2.2 It is important to understand what happened in this case at the time, to examine the professionals' perspective at that time, although it is likely as a consequence that hindsight will be encountered. This will be rationalised by taking key matters forward in order to broaden professionals' awareness both for the future and to ensure that best and current practice is embedded and that any learning is maximised both locally and nationally.

2.3 Family members were contacted and asked whether they would like to see a copy of the Terms of Reference and invited to contribute to the review and comment. The family stated that they were too distressed at the death of Diana to contribute to the review although Diana's sister later contacted the chair of the review and said that she would like to speak about Diana. Diana's sister was spoken to and described Diana and her relationship with Nathan. Diana's sister described Diana as being a very loving and caring person who had a bubbly personality. She said that Diana was always the life and soul of

any party, was loveable and had a big caring heart. She said that she is greatly missed by all the family and was a big part of their lives.

2.4 At the conclusion of the review process, Diana's family were contacted regarding reviewing the overview report and its recommendations and speaking to the chair.

2.5 The panel wish to send their condolences to the family and friends of Diana. Pseudonyms for both Diana and her ex-partner, Nathan, have been used throughout this report to maintain anonymity. These pseudonyms were shared with the family by the Independent Chair and report writer.

2.6 The Home Office were notified by the Community Safety Partnership (CSP) of their intention to carry out a Domestic Homicide Review (DHR). The Coroner was also notified that a Domestic Homicide Review was taking place.

2.7 The DHR was started in December 2020 when the first meeting took place and concluded in August 2022. The panel met on four occasions, where they identified the key learnings, set the terms of reference, examined IMRs and agency information, and scrutinised the overview report and its recommendations. The review process was delayed due to the pandemic and the additional pressure placed upon agencies. This meant that agencies were given additional time to complete their IMRs and the panel meetings were also put on hold as a consequence. An action plan was developed and populated by panel members prior to Home Office submission.

2.8 The inquest into Diana's death took place with the verdict being recorded as suicide.

3 Contributors to the Review

3.1 The Independent Management Reviews (IMRs) were written by a member of staff from the organisation to which it relates. Each of the agency authors is independent of any involvement in the case including management or supervisory responsibility for the practitioners involved. The IMRs were quality assured by supervisors and were signed off by management prior to being presented to the panel.

3.2 Each of the following organisations contributed to the review:

Agency/Contributor	Nature of Contribution
Kent Police	Independent Management Review
Domestic Abuse Service A	Independent Management Review
Clarion Housing Association	Summary Report
Kent County Council, Integrated Children's Services	Independent Management Review
The Education People, Education Safeguarding	Independent Management Review
Borough Council A, Housing	Independent Management Review
Housing Provider A	Summary Report
Kent and Medway Clinical Commissioning Group, representing Primary Care, including Out of Area CCG	Independent Management Review
London Community Rehabilitation Company	Independent Management Review
NHS Trust A	Independent Management Review
Victim Support	Independent Management Review
HM Prison Service	Summary Report
Crown Prosecution Service	Summary Report

4 Review Panel Members

Name	Organisation	Job Role
Elizabeth Hanlon		Independent Chair and Report Writer
Kathleen Dardry	Kent County Council, Community Safety	Practice Development Officer
Sophie Scott	Kent Police	Domestic Abuse and Stalking Manager

Jackie Hyland	Domestic Abuse Service A	Operations Manager
Leigh Joyce	Clarion Housing Association	Locality Business Manager (Southern Region)
Sophie Baker	Kent County Council, Integrated Children's Services	Practice Development Manager
Claire Ray	The Education People, Education Safeguarding	Head of Service, Education Safeguarding
Toni Carter	Borough Council A, Housing	Housing Solutions and Private Sector Manager
Colin Lydon	Housing Provider A	Head of Community Safety
Zoe Baird	Kent and Medway Clinical Commissioning Group, representing Primary Care, including Out of Area CCG	Designated Nurse for Safeguarding Adults
Lucien Spencer	London Community Rehabilitation Company	Head of Service (PDU) (Job Title prior to probation merge: Area Manager - London South East Area)
Gina Tomlin	NHS Trust A	Safeguarding Adults Lead
Catherine Collins	Kent County Council, Adult Social Care	Strategic Safeguarding Manager
David Naylor	Victim Support	Area Manger
Simone Clarke	HM Prison Service	Custody Senior Probation Officer
Tim Woodhouse	Kent County Council, Suicide Prevention *(Suicide Expert Opinion)*	STP Suicide Prevention Programme Manager
Celia Dunn	Kent and Medway NHS and Social Care Partnership Trust *(Mental Health Expert Opinion)*	Principle Lead Social Worker / Approved Mental Health Professional

5 Chair and Overview Report Writer

5.1 The Independent Chair and report writer for this review is Elizabeth Hanlon, who is independent of the Community Safety Partnership and all agencies associated with this overview report. She is a former (retired) senior police detective from Hertfordshire Constabulary, having retired seven years ago, who has several years' experience of partnership working and involvement with several previous Domestic Homicide Reviews, Partnership Reviews and Serious Case Reviews. She has written several Domestic Homicide Reviews for Hertfordshire, Cambridgeshire, and Essex County Council.

5.2 The Chair has received training in the writing of DHRs and has completed the Home Office online training and online seminars. She also attends the yearly Domestic Abuse conferences held in Hertfordshire and holds regular meetings with the Chair of the Domestic Abuse Partnership Board in Hertfordshire to share learnings across boards. She is also the current Independent Chair for the Hertfordshire Safeguarding Adults Board.

6 Terms of Reference

The critical dates for this review have been designated by the panel as 1st July 2016 to the date of Diana's death; however, the panel Chair also asked the agencies providing IMRs to be cognisant of any issues of relevance outside of those parameters which will add context and value to the report. These dates were felt to be the most relevant in the life of Diana as it was during this time that the domestic abuse, her health and wellbeing was most evident. The timescales were again reviewed by the panel meeting and were still felt to be appropriate.

6.1 The Focus of the DHR

6.1.1 In conducting the Domestic Homicide Review into the death of Diana, the Panel had regard to the following:

6.1.1.1 The review will establish whether any agencies have identified possible and/or actual domestic abuse that may have been relevant to the death of Diana.

6.1.1.2 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.

6.1.1.3 If domestic abuse was identified, this DHR 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.

6.1.1.4 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.

6.2 Specific Issues to be Addressed

6.2.1 Specific issues that must be considered, and if relevant, addressed by each agency in their IMR were:

6.2.1.1 Were practitioner's sensitive to the needs of Diana and her children, knowledgeable about potential indicators of domestic violence and 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?

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

6.2.1.3 Did the agency comply with domestic violence and abuse protocols agreed with other agencies, including any information-sharing protocols?

6.2.1.4 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?

6.2.1.5 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?

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

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

6.2.1.8 Had Diana disclosed to any practitioners or professionals and, if so, was the response appropriate?

6.2.1.9 Was this information recorded and shared, where appropriate?

6.2.1.10 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?

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

6.2.1.12 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?

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

6.2.1.14 Are there lessons to be learned from this case relating to the way in which this agency works to safeguard Diana, her children and promote their welfare, or the way it identifies, assesses and manages the risks posed by Nathan? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources? Was the right level of support offered to Diana surrounding her impending court case and the impact this might have had on her? Were any stress indicators identified or reacted to regarding the impending court case?

6.2.1.15 Did any staff make use of available training?

6.2.1.16 Did any restructuring take place during the period under review likely to have had an impact on the quality of the service delivered?

6.2.1.17 How accessible were the services for Diana? Were there any issues regarding non-engagement of agencies either within Kent and Medway or across borders?

6.2.1.18 Were previous decisions not to investigate DA within Diana's and Nathan's relationship the right decision?

6.2.1.19 What impact did the incidents of DA have on Diana's children and were these considered?

6.2.1.20 Were Child Protection investigations relevant to DA concerns and what impact did these have on Diana and her family? Were there any instances or considerations surrounding stalking and harassment or coercion and control?

6.2.1.21 Were there any issues surrounding substance abuse in relation to either Diana or Nathan and did this impact on their relationship?

6.2.1.22 Were there any mental health considerations surrounding Diana and any previously identified suicidal ideation?

6.2.1.23 Was any good practice identified within agencies to help develop future practice?

7 Summary Chronology

7.1 Diana was born locally and had two children from a previous relationship. The two children lived with Diana the majority of the time but used to go and stay with their father on occasions. On the night of Diana's death, the youngest child, child B, was due to go and stay with their father but this appears not to have happened. Child A had a friend to stay the night at their house. On the night of Diana's death, she had spoken to her father and a male friend earlier on in the evening and there appears to be no indication that Diana was considering taking her own life. Diana's sister received a text from Diana stating, "I never want to see my child's heart break like that again." This appears to relate to the fact that the child's father had not picked them up for the weekend as arranged.

7.2 Diana had been in a relationship with Nathan for several years, during which time she was a victim of his abuse, there are incidents of recorded assault upon Diana by Nathan. The first reported incident of domestic abuse was in July 2018 when Diana called the police to report that she had argued with Nathan and that he had put his hands on her. A further assault took place on Diana by Nathan in December 2018 where extensive damage was also caused to the flat. Nathan was arrested for common assault on Diana and criminal damage and was given conditional bail. It appears that the appropriate processes were followed and security measures were put in place. Referrals were made to Kent Integrated Children's Services (ICS) and the children were allocated a social worker. ICS had involvement with Diana and her children throughout this time. Numerous agencies were involved with Diana in relation to the domestic abuse incidents and domestic support services also provided support to Diana. Diana was discussed at MARAC meetings and the appropriate IDVA support was provided.

7.3 In February 2019 Nathan was found guilty of the assault and criminal damage relating to Diana and was given a Restraining Protection Order, a Community Order and an Unpaid Work Requirement. Good contact continued between Diana and the IDVA Service. During this time Nathan breached his order and reappeared at court for the breach and was issued a fine.

7.4 In November 2019 Nathan attended Diana's home address and persuaded her to allow him to sleep on her settee. Diana however, then left the address to go and stay with a friend. Upon her return to her home the next day, Nathan committed a serious assault on Diana at her home address resulting in several injuries including a broken nose and broken cheekbone. Nathan was arrested and charged with an offence of Grievous Bodily Harm, S18. At the time of Diana's death in 2020, Nathan was still on remand in prison having been charged with the serious assault, Grievous Bodily Harm, on Diana. The Witness Care Unit maintained contact with Diana throughout the court process and kept her updated regarding court delays.

7.5 A referral was made to ICS following a further assault on Diana. A strategy discussion took place and a S47 enquiry was completed whilst the children stayed with their biological father. The children were considered Children in Need. Support was provided to Diana throughout this period and continued through the COVID-19 restrictions.

7.6 There are no records of Diana suffering from domestic abuse or the injuries she sustained within her GP records. Diana's records showed detailed enquires as to her physical and mental health, along with the safeguarding measures undertaken by domestic abuse support services, although there had been no communication to the GP from the services themselves. The GP appeared to rely solely upon gleaning information from Diana.

7.7 In the early hours of the morning, Diana was found hanging by child A. The ambulance was called, and Diana was taken to hospital where she was ventilated in the Intensive Treatment Unit. Later that evening Diana was sadly declared life extinct. A police investigation took place into Diana's death and the investigation concluded that there is no indication of any suspicious circumstances, or third party being involved in the sudden death of Diana. Diana had communicated to the ICS social worker that she was feeling low

and was worried about the impending court case, and a referral had been made to Victim Support on Diana's behalf and although accepted, only initial contact was made with no follow-up.

8 Key Issues Arising from the Review

8.1 Suicide

8.1.1 On average, two women are killed by a partner or former partner every week in England and Wales. What remains far more hidden, however, is the stark number of women who take their own life as a direct result of experiencing domestic abuse.

8.1.2 Data from Professor Sylvia Walby's research[1] estimates that approximately one in eight of all female suicides and suicide attempts in the UK are due to domestic violence and abuse. This equates to 200 women taking their own lives and 10,000 attempting to do so due to domestic abuse every year in the UK. That is nearly 30 women attempting to complete suicide every single day[2].

8.1.3 The report 'Domestic abuse and Suicide Exploring the Links with Refuge's Client Base and Work Force' by Ruth Aitken and Vanessa E. Munro[3] on behalf Warwick Law school and Refuge identifies:

> 'Domestic abuse is a high-risk situation, whether this refers to the immediate risk of serious, physical harm from the perpetrator, or to the longer-term risk to the victim's psychological well-being, to their life chances in terms of lost opportunities and potential, or significant damage to 'the self'. Domestic abuse is also a risk to life, either through homicide or suicide of the victim. Although domestic abuse is mentioned as a risk factor within the national suicide strategy, neither suicide nor suicidality are mentioned within the Government's most recent violence against women and girls (VAWG) or domestic abuse strategy, it seems clear that any meaningful integration of policy or practice across both spheres is lacking.'

[1] Professor Sylvia Walby (University of Leeds) *"The Cost of Domestic Violence September 2004"*
[2] Hesita, Celebration 50 years of life beyond crisis.
[3] Ruth Aitken and Vanessa E. Munro, Domestic abuse and suicide exploring the links with Refuge's client base and work force. © Refuge and Warwick Law School 2018

The new Domestic Abuse Plan 'Tackling Domestic Abuse Plan' strongly links domestic abuse with suicide[4].

8.1.4 In suspected victim suicides, as with intimate partner homicides, the most common risk factors for suspects were previous perpetration of domestic abuse and coercive and controlling behaviour. In relation to Nathan, he had a previous conviction of assault against Diana, and it was known to agencies that he was again in contact with her in breach of his Restraining Order. He had made numerous attempts to contact her and had turned up at a previous address trying to find her. There is also information that Nathan had been contacting Diana whilst in prison on remand.

8.1.5 On 21st December 2018, Nathan assaulted Diana and caused extensive damage to her flat. Seven days later Diana contacted the police stating that Nathan had been constantly contacting her for over an hour and that he was outside her new address. Although this is recorded by the police, as it was a different area, it does not appear to have been given the right level of consideration. This was prior to Nathan's arrest for the assault on Diana and therefore was not in violation of bail conditions or any Orders.

8.1.6 It is recorded that on 3rd January 2019 Diana attended the school of child A to explain that child A would be moving schools as they were fleeing domestic violence and that she was worried that the perpetrator would follow them home from school to their new safe address.

8.1.7 On the 8th of January 2019 Nathan was arrested by the police for the assault. He was charged with the offence and bailed. There is no evidence that the police considered an additional charge of harassment at this point.

8.1.8 Within a year of Nathan's first arrest and conviction for assault on Diana, Nathan attended Diana's home address on two occasions and persuaded her to allow him into the family home. The first incident resulted in Nathan

[4] Tackling Domestic Abuse Plan - GOV.UK (www.gov.uk)

fraudulently accessing Diana's bank accounts and stealing money from her. On the second occasion, Nathan claimed that he was homeless and had nowhere to sleep and was therefore 'allowed' to sleep on her sofa. Subsequently Nathan carried out a further serious assault on Diana. There is a recorded history of assault on Diana perpetrated by Nathan, harassment, coercive control and ultimately another assault. Although it does appear that all agencies dealt with Diana in a timely and considerate manner regarding the assaults, agencies do not appear to have considered the impact that the assaults, harassment and coercive controlling behaviour might have had on Diana, perhaps apart from her personal safety. There is no indication that Diana was spoken to regarding the contact that Nathan was making from prison and the pressure this must have put on her regarding the court case. There were no discussions regarding her mental health or the impact that the assault and court case was having on her. There is also no reference to any agencies having considered the link between domestic abuse and possible suicide. The Kent and Medway Suicide Prevention Network identified a lack of evidence and wider understanding about the relationship between suicide and domestic abuse and sought to address it locally. This is now contained within their prevention strategy.

8.2 Coercive and Controlling Behaviour

8.2.1 Coercive control is a wide-reaching form of abuse and, as control is at the heart of all domestic abuse, it overlaps with many other categories, especially sexual abuse and financial abuse. Control is established using threats to harm the woman if she does not comply or making the atmosphere at home unbearable.

8.2.2 Suspects in cases of suspected victim suicide were three times as likely to have engaged in coercive and controlling behaviour than suspects of intimate partner homicide (95%). National suicide statistics show that strangulation/hanging is the most common method of suicide for females in the general population, accounting for 47% of cases.

8.2.3 Findings within this review identified that even though Nathan was remanded in custody for the serious assault on Diana, contact was made from prison to Diana. This was identified by an agency and the Prison

were informed however, although investigated they were unable to find any means of which Nathan was contacting Diana. There does not appear to have been any consideration by agencies that Nathan could be contacting Diana and the likelihood that he would be using this contact to continue controlling her from prison. There is also no indication that Diana was spoken to regarding these calls, or any additional support put in place regarding them. This should have been dealt with in relation to witness intimidated or at least harassment. The panel were unable to find any additional information surrounding the calls or who made the referral to the Prison Service.

8.2.4 Agencies were aware of the controlling nature of Nathan. Following the first recorded and convicted assault Nathan was able to find out where Diana was living and subsequently attended her home address and accessed her online banking, stealing from her. He further managed to persuade her to allow him to stay on her sofa. This contact ultimately led to a further, more serious assault occurring.

8.2.5 The language used by ICS and subsequently the police, within their IMR, has been acknowledged as inappropriate as they appeared to have put the blame on Diana for allowing Nathan to stay with her. It does not appear to have been considered that perhaps Diana did not have any say in the matter and that she may have felt that she had no choice over letting him stay. Considerable training has taken place within ICS regarding domestic abuse and coercive, controlling behaviour however, it was identified that all agencies could benefit from further training regarding 'victim blaming' to improve the language sometimes used by services.

8.2.6 The impact that Nathan had on Diana and her children was underestimated. Agencies were aware that Nathan was a physical risk to Diana and considerable effort and joined up working was put in place to help and support Diana and the children. However, the emotional impact was underestimated. The children had formed a strong bond with Nathan, as he and Diana had been in a relationship for several years with the children viewing him as a father figure. Agencies do not appear to have considered the guilt that Diana must have felt when ending the

relationship, due to the assault, as she could see the impact of Nathan not being present on the children.

8.2.7 Diana's family were aware of the instances of assault taking place on her by Nathan and the fact that he was controlling her behaviour. It was identified that the family felt helpless regarding the support they could offer Diana and would have benefitted from knowing what support was available and how they could have gained that support or signposted Diana in gaining that support. Advocacy After Fatal Domestic Abuse (AAFDA) and Wearside Women in Need (WWIN) are currently working on a new initiative with the aim of enabling family, friends and communities to better support the people close to them who are subjected to domestic abuse. There is also the J9 project,[5] which is an initiative named in memory of Janine Mundy, who was killed by her estranged husband whilst he was on police bail. The project was established with the primary aim to raise awareness of domestic abuse amongst local businesses and services in order to gain timely help, support and access to services in a safe way.

8.3 Economic Abuse

8.3.1 Economic abuse is an aspect of 'coercive control'- a pattern of controlling, threatening and degrading behaviour that restricts a victims' freedom. It is important to understand that economic abuse seldom happens in isolation: in most cases perpetrators use other abusive behaviour to threaten and reinforce the financial abuse. It was identified that Nathan accessed Diana's bank accounts when he returned to the home address and stole money from her. This was dealt with by the police and Nathan was arrested for the theft however, it does not appear to have been formally recognised as a build-up of coercive and controlling behaviour. There is also no record of this escalation being discussed at the MARAC.

8.3.2 Economic abuse has been formally recognised and defined in the in the new Domestic Abuse Act, however, this form of abuse is still not widely

[5] https://www.hertssunflower.org/media/documents/herts-sunflower-j9-resource-and-information-pack.pdf

understood, and many girls and women do not recognise the early signs of controlling behaviour by an abuser[6]

8.4 Chronic Pain and Suicide

8.4.1 Significantly, chronic pain has been associated with higher rates of suicidal ideation, suicide attempts, and completed suicides. The prevalence of suicidal ideation in chronic pain patients is about three times as great as among those who do not suffer from chronic pain.

8.4.2 Throughout 2017 it is recorded that Diana was seen by her GP on numerous occasions regarding pain relief for her back. Throughout this time Diana was prescribed liquid morphine, Co-Codamol and often the sleeping tablet, Zopiclone. It was not until later in the year that the GP initiated a weaning regime for the Oramorph and Co-Codamol. This appeared to continue over the following months although it is recorded that in March 2018 Diana was still receiving the same amount of medication through repeat prescriptions. There appears to have been some identified issues where the GP surgery was trying to wean Diana off the addictive medication by instigating a weaning regime however the drug continued to be issued on a repeat basis by the ancillary staff noting "weaning regime" next to the identical quantities for extended periods. These periods should have been monitored more closely by the GP.

8.4.3 There is no recognition by the primary trust regarding the impact Diana's chronic pain was having on her life and her ability to care for herself and her children. The GP identified that they were aware of Diana's domestic abuse situation and the assault inflicted upon her by Nathan, but these were all self-reported to the GP rather than information shared from other agencies. This information was of significant importance in how GPs care for and support their patients and are unable to provide the appropriate support if they are unaware of the full history. There is no evidence of any agency making referrals to the GP regarding Diana and the domestic abuse taking place within her relationship.

[6] https://survivingeconomicabuse.org/controlling-your-financial-future-new-guide-helps-women-to-recognise-economic-abuse-across-their-life-span/

8.4.4 The assault that took place in June 2018 is recorded as having taken place as Nathan accused Diana of taking prescription drugs and not looking after her children. Again, the GP was not provided this information which would have been another avenue to speak to Diana regarding the medication that she was being prescribed and any weaning regime that was in place to provide additional support.

8.5 COVID-19

8.5.1 The police identified the impact of COVID-19 on delays with court cases and the effect this had on witnesses and victims. Kent Police implemented a specific operation to manage delayed court trials however, this operation did not look at the impact the delays may have had on the victims' and witness' mental health.

8.5.2 The Vulnerability Knowledge and Practice Programme (VKPP) report on Domestic Homicides and Suspected Victim Suicides During the COVID-19 Pandemic 2020-2021 asked police domestic abuse leads via survey and interviews about any perceived impact of the pandemic on domestic abuse and domestic homicide.

8.5.3 Around 1 in 7 (14%) submissions from police identified a specific impact of COVID-19 on the circumstances of the homicide or suicide, either relating to the victim or perpetrator. In addition, for 30% of victims and 33% of suspects this was recorded as 'Not Known'. So, it is possible that COVID-19 had an impact in more than the 14% of cases where it was positively identified, but that the impact was not visible to or reported to by police. Suspected victim suicides had the greatest proportion of COVID-19 impact recorded, with submissions recording that nearly a quarter of those victims were affected by lockdown restrictions.

8.5.4 The court case against Nathan was postponed on three occasions due to COVID-19 and as a result the day before Diana's death the defence gave notification of their intention of applying for bail for Nathan as he had been in custody for seven months. The review was unable to identify whether Diana had been notified of this bail application.

8.5.5 In suspected victim suicide cases, COVID-19 may have reduced the victim's zone of safety or freedom and led to them feeling desperate. Increase in victim anxiety and depression was particularly reported in these cases, as was concern that the perpetrator might be released from prison or remand due to COVID-19 or court cases being further delayed.

8.5.6 Serious concerns have been highlighted by all four of Her Majesty's Justice Chief Inspectors who have united to express "grave concerns" about the potential long-term impact of COVID-19-related court backlogs on the criminal justice system across England and Wales.

9 Conclusion

9.1 This review is different from the expected context of domestic homicide reviews. Diana did not die in an act of murder directly at the hands of her intimate partner, but rather the domestic abuse she suffered appears to have contributed to her taking her own life.

9.2 There were clear examples of domestic abuse, intimidating behaviour, harassment, stalking and coercive and controlling behaviour on Diana by Nathan throughout their relationship. The psychological long-term impact of this was underestimated by agencies. The physical aspects of dealing with the acts of domestic abuse appear to have been dealt with well by agencies however, as identified, the impact of these acts of domestic abuse on Diana's mental health were either not considered or were not highlighted as a serious concern.

9.3 Professionals were trained in domestic abuse and recognising the signs of this however, they are not trained to look at the psychological impact of domestic abuse on victims. The difficult questions were not asked of Diana even though she identified to several agencies her level of stress and concern regarding the impact the domestic abuse was having on her and her children. Stigma surrounding suicide creates silence, and silence kills. No one should have to struggle alone with suicidal thoughts, talking through the taboo helps break the silence[7].

[7] https://www.papyrus-uk.org/talk-about-suicide-safely/

9.4 Professionals need to be aware of the impact of domestic abuse and suicide and ask the difficult questions. It is a myth that talking about suicide puts the idea in someone's head. Mentioning suicide does not increase the risk. The risk is not mentioning it at all. Being confident and reaching out to someone can make a huge difference. The evidence surrounding the high levels of suicides in women subjected to domestic abuse is frightening and as such professionals must learn to identify this risk and ask the appropriate questions.

9.5 There was clearly coercive controlling behaviour on the part of Nathan. Nathan had a strong hold over Diana which was not always recognised by agencies, in fact victim blaming was still evident within the review. Protection plans were put in place for Diana and support was provided regarding her and the children's physical welfare however, the impact that Nathan had on Diana was not identified by agencies. Following a previous DHR in Kent and Medway, Mary 2018, Witness Care have received training in suicide prevention and noted within their records that Diana showed no signs of suicide ideation. It is felt this is not strong enough. Professionals must ask the questions directly and signpost to the most appropriate agency for support.

9.6 Identified within the review was the fact that Nathan managed to contact and resume a relationship with Diana even though he was either on bail or in breach of orders preventing him contacting Diana. These do not appear to have been dealt with in a robust manner even when there were clear signs of coercive controlling behaviour. Agencies were naive regarding their thoughts that when remanded to prison, Nathan would not be able to contact Diana. It is well documented in several areas that those in prison are often able to access mobile phones and use them to contact the outside. This needs to be considered in risk assessments that agencies complete.

9.7 It is worth commenting that there are perpetrator support programmes available across Kent and Medway for DA and Stalking perpetrators. This is offered as one to one and group sessions by Interventions Alliance. The programmes are funded by the Home Office and commissioned by the OPCC. The identified issue is that this is a community programme and those offenders who are under Probation management or custody, or have a court case approaching, cannot access it as they will likely have access to mandated national programmes. In line with the Kent and Medway Domestic Abuse

Strategy and action plan, work is underway to review services available to those who perpetrate abuse to promote information and referral pathway sharing with all agencies in Kent. This will allow gaps in provision to be identified, inform commissioning decisions and support funding bids to ensure that quality, coordinated responses from the statutory and voluntary sectors are consistently available across Kent to address perpetrators' behaviour effectively. The Domestic Abuse Act 2021 stipulates that a National Perpetrator Strategy is to be developed and it was announced in the 2021 Budget. The lack of perpetrator programmes was identified within the DHR 'Patrick' 2018[8]. Perpetrator programmes are also delivered by Probation as a part of their current contract, these programmes are in place to deliver risk reduction work as part of a sentence. This work includes 121 interventions and group work programmes to address domestic abuse.

9.8 There are only two mentions within the review of Nathan suffering from PTSD. One is where the court case was adjourned citing Nathan's mental health due to PTSD and the other where Diana spoke to her DVAP believing that Nathan would try and use this as a defence for assaulting her. This is a missed opportunity for agencies to have looked at the mental health of Nathan and the impact this might have had in how he reacted to Diana and any additional support that could have been put in place. This does not appear to have been recorded in any risk assessments and is not identified in any MARAC meetings.

9.9 Diana was discussed at MARAC on two occasions and in neither of the occasions was the link between domestic abuse and suicide identified. Other identified links with suicide including chronic pain were also not taken into consideration. This should be a routine practice and should become an embedded part of the MARAC process. There are also records within the agencies' IMRs of Diana stating that she was abusing drugs (cannabis) and alcohol as a coping mechanism. These were written within her contact reports however, there are no records of agencies highlighting these issues as possible concerns regarding Diana herself and her children. It appears that the usage of alcohol and drugs were accepted as the norm. These self-

[8] https://www.kent.gov.uk/__data/assets/pdf_file/0018/126081/Patrick-2018-Overview-Report.pdf

reported coping mechanisms should have highlighted concerns with agencies working with Diana.

10 Learning Points and Recommendations

10.1 Suicide Prevention

10.1.1 Knowledge of domestic abuse is required in services that work in suicide prevention. This prevention must be owned by all agencies and not just Public Health. Although the Suicide Prevention Strategy highlights the risk of domestic abuse on suicide this requires additional training for professionals in relation to completing risk assessments and asking those difficult questions.

10.1.2 Agencies need to be aware of the significant impact that domestic abuse can have on a person's mental health and the high risk that this poses. The heightened risk that there is to the victim at the time of or immediately following separation should be considered. This should also cover the risk of physical harm, from the perpetrator of the DA, but also note the risk of self-harm through suicide as in this case, where the combination of risks for the victim was high.

10.1.3 In June 2022 the then Secretary of State Sajid Javid identified the direct correlation between domestic abuse and suicide in a speech announcing the Government's Suicide Prevention Plan. The new plan will include a section on domestic abuse for the first time. Highlighted within the speech is the excellent work taking place within Kent which found that 30% of all suspected suicides in a two-year period were linked to domestic abuse.

10.1.4 All agencies highlighted specific recommendations within their own IMRs. The CRC identified within their IMR the changes within their service and the fact that they were being amalgamated into the Probation Service. As such the recommendations require acceptance and ownership by the Probation Service.

	Recommendations Suicide Prevention	Organisation
1a.	Public Health Suicide Prevention Programme to develop and distribute briefing materials, in a variety of formats, highlighting the link between domestic abuse and suicide that can be used to raise awareness amongst agencies and professionals. To highlight the usage of the DA website as a means to promote training and signposting for support.	Kent and Medway Suicide Prevention Panel
1b.	All agencies to incorporate the above training within their pre-existing domestic abuse training.	**All agencies,** Kent and Medway Safeguarding Adult's Board and the Kent and Medway Children's Multi agency Partnership. Kent Coroner's service.
2	To write to the National Suicide Prevention team in the Department of Health to make them aware about the growing number of deaths by suicide that are happening very close to court cases relating to domestic abuse.	Domestic Abuse Commissioner's Office
3a.	To highlight to the Government the huge gap regarding the link between suicide and domestic abuse.	Domestic Abuse Commissioner's Office.
3b.	Although domestic abuse is mentioned as a risk factor within the national suicide strategy, neither suicide nor suicidality are mentioned within the Government's most recent violence against women and girls (VAWG) or domestic abuse strategy. It seems clear that any meaningful integration of policy or practice across both spheres is lacking.	Home Office
4	The MARAC process should consider the risk of victim suicide following domestic abuse alongside the risk of homicide, where risk factors which indicate coercive controlling abuse, harassment and attempts to separate are present.	Kent and Medway MARAC steering group
5	Kent Integrated Children's Services is developing a 'spotlight on domestic abuse' series which is a development programme which will look to develop knowledge in many aspects of domestic abuse, including coercive and controlling behaviour. It is recommended that this training programme is extended to include the link between domestic abuse and suicide.	Kent County Council, Integrated Children's Services

10.2 Multi-Agency Working and Information Sharing

10.2.1 Although there is some good evidence within the review regarding the sharing of information by agencies, there unfortunately are also some examples where this did not happen. Agencies appeared to communicate well where their involvement with Diana was as a result of the children. ICS were contacted on several occasions and referrals were made regarding Diana being subjected to domestic abuse. There were also good examples of Diana received a good level of care and support for the impending court case. However, although identified to agencies by Diana on a few occasions that her mental health was suffering because of the case, this did not appear to have been shared with other agencies. There is no indication within Diana's GP records that she was awaiting a court case and that she was feeling depressed and had had suicidal thoughts.

10.2.2 There is no indication that the GP provided information to the MARAC process or the Child in Need process. Consent would have been needed from Diana to have informed the GP that her children were subjected to the CiN process however, this does not appear to have been sought. Several agencies were aware that Diana was using alcohol and drugs as a coping mechanism but again this was not shared with other professionals, and it also appears that this information was not considered to be overly relevant. The impact on Diana's decision making whilst under the influence of drink and drugs was not considered. These substances could have altered her thinking. Professionals would also not have been aware of the high level of pain controlling medication Diana was on and what impact these might have had on her taking drink and drugs.

10.2.3 The lack of GP attendance and information sharing at MARACs has already been highlighted in a previous Kent and Medway DHR and as such that recommendation will be reinforced within this review. This review has highlighted the lack of other agencies being invited to, and attending, the MARAC. The Kent CRC and National Probation Service (NPS) were invited to the MARAC and did attend however, information from the London CRC who were managing Nathan was not supplied to the conference.

10.2.4 The information surrounding Nathan's PTSD was not shared with other agencies. This could have changed the way other professionals dealt with Nathan especially during the MARAC and CiN processes where this information might have impacted on the support offered to Diana.

	Recommendations regarding Information sharing	Organisation
6	Kent and Medway CCG to continue to develop the work with GPs surrounding attendance at MARACs and the importance of information sharing. Consideration to be given to the creation of the role of a MARAC liaison nurse's role for general practice to allow for a more informed and effective decision making and safety planning process to take place.	Kent and Medway CCG
7	Upon completion and review/audit of the IRIS project, dependent of the findings, consideration is to be given to the rolling out IRIS within other parts of Kent and Medway.	Kent and Medway CCG
8	The MARAC process needs to consider that hearing current information surrounding the perpetrator, his background and mindset, can be beneficial as it can establish risk and dynamics. Nathan had a restraining order against him; it would have been beneficial to the meeting to understand Nathan's comments surrounding this and whether he is victim blaming. The information regarding his mental health and drug misuse would have also been beneficial to the meeting.	Kent Police and the Probation service
9	The MARAC process requires a review to make sure that it is more meaningful. Evidence has shown that because numerous victims are discussed within the one meeting there are often times when individual agencies who are relevant are not identified and invited. A more robust process needs to take place where a victim is treated as an individual and that the circumstances are looked at on an individual basis. The minute taking and actions review also requires a review to make sure that they are SMART and meaningful.	Kent and Medway MARAC Steering Group

10.3 Coercion and Control

10.3.1 The level of coercion and control exercised by Nathan over Diana was not identified strongly enough by some agencies. This behaviour was not always identified in agencies' risk assessments, nor was Diana's ability to cope with his behaviour. As identified previously, Diana felt frustrated that her social worker was blaming her for letting Nathan in her house and that the level of control exerted by him was not recognised.

10.3.2 As identified within the review professionals were naive regarding the fact that Nathan was remanded in prison and the belief that Diana was safe because of this. Risk assessments must always consider the whereabouts of the perpetrator and any previous history of harassment and coercion and control. Nathan had a long history of continuing to contact Diana even though he was subject to Restraining Orders. He had also managed to persuade Diana to let him back in the house even though he had assaulted her previously. This appears to have been underplayed by agencies. Diana identified that the children were traumatised and that she felt guilty about that and the removal of Nathan from their lives.

10.3.3 Although it has been identified within this review that Diana's home address does not appear to have been read out during court appearances, it has been recognised by the police that there are no current systems in place to stop this from happening in the future and that this is an area for development.

	Recommendations regarding Coercive and Controlling behaviour	**Organisation**
10	All agencies' domestic abuse training is to be reviewed to ensure that coercive and controlling behaviour is highlighted to enforce the fact that the stretch of a perpetrator is far reaching to include the impact of economic abuse and where the offenders are in prison or subject to orders.	**All agencies**, Kent and Medway Safeguarding Adult's Board and the Kent and Medway Children's Multi agency Partnership.
11	The Probation Service to consider the findings from the three DHRs within Kent and Medway (Ann, Connie and Diana) which have raised significant concerns surrounding the identified lack of challenge by Responsible Officers and a practice of passive risk management and over reliance on the accounts provided by the perpetrator.	The Probation Service
12	The Criminal Justice Team within Kent Police to identify a means of highlighting the fact that the current address for a victim of domestic abuse is not to be placed on the documentation for the CPS and therefore inadvertently read out in court proceedings.	Criminal Justice Team, Kent Police

10.4 Training

	Recommendations regarding Training	Organisation
13	All agencies are to provide guidance to staff regarding the use of 'victim blaming' language within their interaction with victims and also within their written documentation.	All agencies
14	Training to take place with Coroners to identify the linkage with domestic abuse and potential suicide cases.	Chief Coroner
15	The DASVEG to review and consider the implementation of the J9 project or to liaise with Advocacy After Fatal Domestic Abuse (AAFDA) and Wearside Women in Need (WWIN) who are currently working on a new initiative with the aim of enabling family, friends and communities to better support the people close to them who are subjected to domestic abuse.	Kent and Medway Domestic Abuse and Sexual Violence Executive Group

10.5 The Education People, Education Safeguarding

	Recommendation for Education	
16	The Head of Education Safeguarding to write to the schools within their area identifying the importance of good record keeping and the role of the Safeguarding Lead within their school.	Head of Educational Safeguarding

10.6 Pain Management

	Recommendation for CCGs	
17	The NICE guidance regarding pain management is to be circulated to GPs within Kent and Medway with a request that they review their patients in light of the new guidance. This recommendation links into the Kent and Medway SAR David (2021) which also made a recommendation regarding the new NICE guidance.	Kent & Medway CCG