



KENT AND MEDWAY COMMUNITY SAFETY PARTNERSHIPS MULTI-AGENCY LEARNING REVIEW EXECUTIVE SUMMARY

Report into the death of Faith November 2022

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Date of Final Version: May 2025**



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1. The Review Process

- 1.1. The Review Panel expresses its sympathy to the family and friends of Faith¹ (pseudonym provided by her family) for their loss and thanks them for their contributions to this process, which supported those involved in the review to see Faith as a real person.
 - 1.2. This summary outlines the process undertaken by Kent Community Safety Partnership in reviewing the death of Faith, who was a resident in their area. Faith was a woman aged in her early 30s, of White British ethnicity.
 - 1.3. The inquest returned the conclusion of suicide.
 - 1.4. Undertaking reviews in cases such as these is framed by the Home Office Domestic Homicide Review Statutory Guidance which 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. Reviews are not about who is culpable.”
 - 1.5. Once finalised by the Review Panel, the Executive Summary and Overview Report will be presented to the Kent CSP for approval and thereafter will be sent to the Home Office for quality assurance. A recommendation will be made to the CSP and the Home Office not to publish the Overview Report. This is to protect the identities of those connected with Faith.
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¹ Not their real name.

- 1.6. In accordance with Home Office guidance, all agencies and the family and friends of Faith are aware that the Overview Report will not be published, and that the Executive Summary will be published. IMRs and Short Reports will not be made publicly available.
- 1.7. Once agreed by the Home Office, the Executive Summary will be published on the website of the Kent and Medway CSPs.
- 1.8. Further dissemination will include:
 - The Kent and Medway DHR 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.
 - The Kent and Medway Safeguarding Adults Board.
 - The Kent Safeguarding Children Multi-Agency Partnership.
 - Additional agencies and professionals identified who would benefit from having the learning shared with them.
 - Surrey County Council for dissemination amongst relevant partners.
- 1.9. The recommendations will be owned by the Kent CSP, with the Kent and Medway DHR Steering Group being responsible for monitoring the recommendations and reporting on progress.

2. Contributors to the Review

- 2.1. This review has followed the 2016 statutory guidance for Domestic Homicide Reviews which was issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. Agencies were contacted to check for involvement with Faith. Ten agencies returned a nil contact.
- 2.2. At the first meeting, the Review Panel shared information about agency contact with Faith. The time period to be reviewed was established, to cover the time of Faith's significant contact with agencies. Agencies were asked to summarise any relevant prior contact with Faith. Key lines of enquiry were identified.
- 2.3. Four agencies submitted Independent Management Reviews (IMRs) and chronologies, and due to the brevity of their involvement two agencies submitted chronologies and Short Reports only, and two further agencies submitted chronologies only. The chronologies were combined, and a narrative chronology written by the Chair. The following agencies and their contributions to this review are:

Agency	Contribution
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District Council A	Chronology
Dover Counselling Centre (NHS Talking Therapies)	Short Report
East Kent Hospitals University NHS Foundation Trust (EKHUFT)	Short Report
Kent Community Health NHS Foundation Trust (KCHFT)	Chronology
Kent and Medway NHS and Social Care Partnership Trust (KMPT)	IMR
Kent Police	Short Report
Maidstone and Tunbridge Wells NHS Trust	IMR
NHS Surrey Heartlands Integrated Care Board	IMR
South East Coast Ambulance Service (SECAmb)	IMR

- 2.4. Review Panel meetings contained in-depth scrutiny of the chronology and IMRs/Short Reports. Lengthy discussions were held to which all panel members contributed openly, enabling appropriate challenge and understanding, to ensure all relevant learning was identified.
- 2.5. *Independence and Quality of IMRs:* All IMRs and Short Reports were written by authors independent of case management or delivery of the service concerned. All were comprehensive and enabled the Review Panel to analyse the contact with Faith, and to produce the learning for this review. Where necessary, further questions were sent to agencies and responses were received. In some cases, IMRs/Short Reports reported changes in practice and policies over time and four made single agency recommendations.
- 2.6. The Review Panel Members were:

Job Title	Agency
Regional Head of Supported Housing	Clarion
Adult Safeguarding Practitioner	East Kent Hospitals University NHS Foundation Trust
Head of Safeguarding	Kent and Medway NHS and Social Care Partnership Trust
Senior Project Officer	Kent and Medway Suicide Prevention Programme
Community Safety Practice Development Officer	Kent County Council
Serious Case Review	Kent Police
Detective Chief Inspector	Kent Police
Deputy Designate	NHS Kent and Medway ICB

Designate Safeguarding Adult Nurse	NHS Surrey Heartlands ICB
Specialist Safeguarding Practitioner	South East Coast Ambulance Service

- 2.7. *Independence and expertise*: Review Panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case.
- 2.8. The Review Panel met 3 times from 2023, to 2025 when the review concluded.
- 2.9. In addition to agencies, Faith's family were involved in the review and contributed their perspective on her life and experiences. They read and commented on the Overview Report and Executive Summary.
- 2.10. The Chair of the review wishes to thank everyone who contributed their time, patience and cooperation to this review.

3. Chair of the DHR and Author of the Overview Report.

- 3.1. From the start of the review until following the IMR Panel Meeting, the Chair of this review was Paula Harding, an associate of Standing Together. Following the IMR Panel Meeting, Paula was unable to continue due to a health issue. At that point, Althea Cribb, another associate of Standing Together was appointed to complete the review. Standing Together is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response (CCR).² Standing Together has been involved in the Domestic Homicide Review process from its inception, chairing over 100 reviews across England and Wales from 2013 until present day.
- 3.2. *Independence*: Neither Paula Harding nor Althea Cribb has any connection with the Kent CSP or any of the agencies involved in this case.

4. Summary of Chronology

- 4.1. In the terms of reference timeframe, Faith had contact with six agencies as a service user and as an employee with one agency.
- 4.2. Faith's contact with agencies as a service user related to her mental health. She shared experiences of trauma, loss and domestic abuse in her earlier adulthood (outside of the terms of reference timeframe) and ongoing challenges relating to her home situation, a recent relationship, and managing her workload.

² For more information, go to: <https://www.standingtogether.org.uk/ccr-network>.

- 4.3. Contact with other agencies, other than her employer, ended nine months before her death. In the month before her death, despite having a short period of absence due to her mental health, Faith presented to managers and colleagues as untroubled.

5. Information about Faith from those who knew her

- 5.1. Faith's family saw her as someone who was very capable, gifted and with many achievements. She was described as very warm, funny, and incredibly driven.
- 5.2. They shared that Faith:
- always cared for others before herself.
 - had enormous drive in all aspects of her life.
 - was committed to marine wildlife and Orcas and was an ardent campaigner.
 - had undertaken a master's degree in Marine Conservation.
 - had completed her training to be in the coastguard one week prior to her death.
 - was creative and accomplished in writing, guitar, singing, song writing and had written three dystopian novels and poetry.
 - had undertaken a secondment at the mental health and well-being Hub and had an article published in a Journal.
 - was applying to join the Joint Response Unit (Police/Ambulance) and had an interview scheduled for the week after her death.
 - was the union representative.
 - was very professional but was also great company and a good laugh: a shift with her would fly by.
 - always kept her personal life separate from her work life; and
 - was very funny and made them laugh all the time; they never saw a negative side to her.

6. Key Themes and Learning Identified

- 6.1. The review identified that there were times when Faith attended agencies accompanied by another person, whose details were not recorded. While it was not felt to have impacted on the care Faith received, it is good practice for professionals to understand who accompanies attendees at their services. A recommendation is made.
- 6.2. Research shows a significant overlap between women experiencing mental ill-health and experiencing domestic abuse from a partner/ex-partner. Given Faith's presentations to agencies were due to her mental health, there were missed opportunities to ask Faith about her relationships, including the possibility of domestic abuse in her life. We cannot know how

Faith saw her relationships or circumstances, or how she would have responded, but best practice would have been for this to be explored.

- 6.3. Since Faith's contact with them, each agency involved in this review has developed processes for enquiry on domestic abuse, either routine (asking all service users) or selective (asking service users due to their presenting issue prompt, such as mental health).
- 6.4. Additionally, the review heard that the Kent and Medway Domestic Abuse Partnership carries out awareness raising across the county, and on social media, which includes awareness of controlling and coercive behaviours. Activities have specifically addressed the links between experiences of domestic abuse and risk of suicide. Awareness raising covers information for family and friends and providing guidance on what to do if they are concerned for a loved one. Recommendations are made for the learning from this review to be shared with the partnership to support ongoing campaigns, events and awareness raising.

7. Recommendations

- 7.1. The following recommendations will be owned by the Kent and Medway Community Safety Partnership, with the Kent DHR Steering Group being responsible for monitoring the recommendations and reporting on progress.
- 7.2. *Recommendation 1:* Kent Police to identify actions that ensure families, and others, are offered referrals to Amparo when they are bereaved by suicide.
- 7.3. *Recommendation 2:* All partnership agencies to provide information about how they ensure information about those who accompany clients/service users/patients is gathered (with consent) and recorded
- 7.4. *Recommendation 3:* The learning from this review to be shared with the Kent County Council Public Health Suicide Prevention Team to support ongoing research and awareness raising.
- 7.5. *Recommendation 4:* The learning from this review, and the request from Faith's family, to be shared with Kent and Medway Domestic Abuse and Sexual Violence Executive Group to support the development of the Community Champions programme, and any other activities that support families, friends and communities.