CHELTENHAM BOROUGH COUNCIL

EXECUTIVE SUMMARY

DOMESTIC ABUSE RELATED DEATH REVIEW (DARDR)

Under s9 of the Domestic Violence Crime and Victims Act 2004

In respect of the death of Kelly, June 2019

Independent Chair
Professor Jane Monckton Smith

Final Draft
June 2022

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KELLY

I remember the day Kelly was born - a beautiful daughter born on a lovely spring morning in 1978.

Kelly was perfect in every way as she grew from baby and toddler to infancy.

Unfortunately, in time, my marriage to Kelly's mother didn't survive and they eventually moved to her family home in the North East. There Kelly's mother remarried and had two children; a brother and sister for Kelly.

Despite the distance between us I still had as much contact as possible which was mostly during school holidays. Without exaggeration this became my world and Kelly lit it up.

As the years passed, I met and married my second wife, and we had our own children – 3 sisters for Kelly. I tried to integrate Kelly into our family. Being from a broken home myself this was very important to me; I hope we succeeded - we certainly have many happy memories.

As Kelly grew up she had another change to cope with when her mother moved with her to London, leaving her siblings behind.

Possibly the upheaval wasn't helpful in her final years at school, and she left education a little sooner than I would have liked. However, what Kelly had in abundance was intelligence, personality, and an excellent work ethic; she put this to good use at her first job at a food import / export company based at Heathrow. She dealt with and no doubt charmed many of their Middle Eastern customers. Kelly's career over the next 10 years looked good, whilst also proving to me that you don't need a degree to do well.

It was towards the end of her time at the food import/export company that I realised that Kelly's life was not as perfect as I had hoped. I received a phone call from the director of the company telling me that Kelly was taking time off and that he was concerned about her well-being and if she might be drinking too much.

Trips and phone calls to and from London followed. Kelly's relationship with her mother broke down irretrievably to the extent where they never spoke again.

Kelly wanted a fresh start and in 2003 she moved to Cyprus, working as a hotel receptionist. Kelly found a lovely flat, she was so house proud, she loved the country and the climate. Whilst there she met and married a man from Pakistan.

They moved back to London, but Kelly struggled with culture differences. Her drinking increased and their marriage crumbled.

Not long after, Kelly went into 12 step rehab in Luton. The rehabilitation calls on faith to help people struggling with their addiction.

I have read all of Kelly's essays and projects from Luton and she certainly found the strength to confront many of her demons. However, the most poignant section was the good luck messages she received from everyone as she left. At Kelly's funeral I met two people from Luton, and they explained how grateful they were for the inspiration and guidance Kelly had given them to help them give up alcohol and rebuild their lives. Unfortunately, Kelly just couldn't do that for herself.

Kelly settled in Luton finding a flat and making it a home whilst working at an hotel where she progressed to duty manager.

The eventual crash was hard to take with Kelly's health deteriorating resulting in many periods of hospitalisation. She then entered The Nelson Trust rehabilitation in Stroud in 2013, again she worked so hard to turn her life around.

Kelly left The Nelson Trust for Cheltenham and with the help and support of services joined AA meetings, even taking a class in Aromatherapy.

In 2015 Kelly met and married Mark

In the final years of Kelly's life, it became apparent that she was reluctant for me to visit her, it wasn't that she didn't want to see me as much as she didn't want me to see her decline.

Looking back Kelly didn't want me to worry though in reality we spoke every day on the phone and I knew all was not well, unfortunately I didn't understand the full extent of Mark's physical abuse of Kelly until after her death.

Kelly never complained or blamed anyone for her illness, she would always do her best to find the funny side. Although laughter became a rare commodity, but it was what she wanted more than anything.

Kelly was the kindest of souls facing insurmountable difficulties, as a family we love and miss her so much.

Kelly's Father, Stepmother and Step-Sisters

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THE REVIEW PROCESS

Kelly's body was discovered at her home address in June 2019 by two probation officers. Her husband was also at the address but had not reported her death for some 4 or 5 days. He had recently been released from prison for offences relating to domestic abuse against Kelly and had post sentence conditions not to be at her home. Kelly was classified as being at high risk of serious harm or homicide from him by police and IDVA services.

Subsequent post-mortem and toxicology results indicated that Kelly had been deceased for some days prior to the discovery of her body but the cause of death was inconclusive. The police report received by Cheltenham CSP states that Kelly's husband may have been present at the time of her death, even though he should not have been present at her home due to an active restraining order.

A Domestic Abuse Related Death Review (DARDR) was commissioned to examine agency responses and support given to Kelly, prior to the point of her death in June 2019.

The DARDR followed the Home Office Multi-Agency Guidance for the Conduct of Domestic Homicide Reviews

In addition to agency involvement the review also examined the past to identify any relevant background or trail of abuse before her death, whether support was accessed within the community, and whether there were any barriers to accessing support.

By taking a holistic approach the review sought to identify appropriate solutions to make the future safer. The report summarises the circumstances that led to a DARDR being undertaken in this case.

The review considered agencies' contact and involvement with Kelly from January 2014 to June 2019 but additional information, specific to a history of domestic violence in her and her partner's lives provided by some agencies, has also been considered.

The key purpose for undertaking the DARDR was to enable lessons to be learned from Kelly's death particularly as there was the potential that domestic abuse was a relevant factor in her death.

For these lessons to be learned as widely and thoroughly as possible, professionals need to understand fully what happened and most importantly what needs to change to reduce the risk of such tragedies happening in the future.

CONTRIBUTORS TO THE REVIEW

Change Grow Live (CGL)
Cheltenham Borough Homes (CBH)
Gloucestershire County Council Adult Social Care (GASC)
Gloucestershire Clinical Commissioning Group (GCCG)
Gloucestershire Constabulary (GC)
Gloucestershire Domestic Abuse Support Service (GDASS)
Gloucestershire Health and Care NHS Trust (GHCNHSFT)
Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT)
Home Group (HG)
Kelly's Family
National Probation Service (NPS)
Southwestern Ambulance Service NHS Foundation Trust (SWASNHSFT)
Turning Point

THE REVIEW PANEL MEMBERS

Name	Agency
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Amanda Robinson Safeguarding Lead	South Western Ambulance Service NHS Foundation Trust

AUTHOR OF THE REPORT

Professor Jane Monckton-Smith was appointed by Cheltenham Borough Council as Independent Chair and Author of the Overview Report in November 2019. She has a substantive position as Professor of Public Protection at the University of Gloucestershire. She is a specialist in domestic homicide, coercive control and stalking. In addition to academic research and lecturing she maintains a wide portfolio of professional work training professionals in threat and risk, coercive control and stalking, as well as working with bereaved families and developing practical assessment tools.

Professor Monckton Smith has previously conducted a Domestic Homicide Review for Cheltenham CSP but has no involvement with any of the agencies involved in the DARDR into the death of Kelly.

TERMS OF REFERENCE

Background

On 10 October 2019, Cheltenham Borough Council (CBC) was notified about a death which required consideration as to whether a Domestic Homicide Review (DHR) should be undertaken.

The victim's body was discovered at her home address in June 2019 by two probation officers; she was classified as being at high risk of domestic abuse from her husband who was also at the address but had not reported her death. He had recently been released from prison where he had served a sentence for offences relating to domestic abuse against her and he had post sentence conditions not to be at her home.

In terms of whether the circumstances surrounding the victim's death gives rise to a DHR, CBC considered the national guidance for DHRs which has two key parts:

1. A DHR should be carried out after the death of a person aged 16 or over which has or appears to have resulted from violence abuse or neglect.
2. A DHR is a review of the circumstances held with a view to identifying the lessons to be learnt from the death.

In terms of the first element, although the evidence of cause of death has not been proven, it is CBC's opinion that the victim's death would appear to have resulted from neglect and would therefore meet the first element of the definition.

Secondly, in terms of identifying the lessons to be learnt from the death, the victim was a high-risk victim of domestic abuse from her partner and had multiple touch points to the safeguarding system, being well known to several agencies.

CBC is therefore interested to review the role of agencies in the run up to the victim's death with the aim of learning lessons about how other vulnerable high-risk victims of domestic abuse can be kept safe in the future.

As the cause of death was inconclusive CBC took the decision to call the review a Domestic Abuse Related Death Review (DARDR) rather than a Domestic Homicide Review (DHR).

Purpose of the Panel

To establish the facts about events leading up to and following the death of the victim in June 2019.

To establish the roles of the agencies involved in her case; the extent to which she had

involvement, with those agencies and the appropriateness of single agency and partnership responses to her case.

To establish whether there are lessons to be learnt from this case about the way in which organisations and partnerships carried out their responsibilities to safeguard her wellbeing.

To identify clearly what those lessons are how they will be acted upon and what is expected to change as a result.

To identify whether as a result there is a need for changes in organisational and/or partnership policy, procedures, or practice in Gloucestershire to improve our work to better safeguard victims of domestic abuse.

The scope of the panel review

To produce a chronology of events and actions in relation to the case of the victim from the period January 2014, which is when Kelly moved to Gloucestershire, until her death in June 2019. Agencies can go outside of these dates if they have information that is relevant to the review. January 2014 is when Kelly first sought accommodation in Cheltenham after being in residential care.
To review current roles, responsibilities, policies, and practices in relation to victims and perpetrators of domestic abuse with complex needs – to build a picture of what lessons can be learnt.
To review this against what happened, and to draw out the strengths and weaknesses.
To review national best practice in respect of protecting adults from domestic abuse.
To draw out conclusions about how organisations and partnerships can improve their working in the future to support victims of domestic abuse with complex needs.

Panel Membership

The panel will be made up of representatives of the agencies that had some involvement in the victim's life, those that have duties to care for adults at risk of domestic abuse and that will have local knowledge and insight. See 8.0 for names and roles of panel members.

Methodology

The decision to hold a review was taken by Cheltenham Borough Council in October 2019

The Multi-Agency Statutory Guidance for Conducting a Domestic Homicide Review was followed.

Professor Jane Monckton Smith was appointed as Independent Chair in December 2019.

The first panel meeting was held in February 2020.

All agencies were asked to search their records for any contact with Kelly and her husband either as a couple or individually.

Due to the circumstances of the case Gloucestershire Constabulary referred themselves for an IOPC investigation. The final report from the IOPC has been shared with the family and the independent chair.

The agencies identified as having significant contact with Kelly were asked to provide an IMR detailing the contact and analysing the way the contact was handled.

Agencies who provided IMRs were Gloucestershire Adult Social Care (GASC), Gloucestershire Clinical Commissioning Group (GCCG), Gloucestershire Domestic Abuse Support Services (GDASS), Gloucestershire Health & Care NHS Foundation Trust (GHCNHSFT), Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT), Gloucestershire Police (GP), Home Group (HG), National Probation Service (NPS) and South Western Ambulance Service NHS Foundation Trust(SWASNHSFT)

Each IMR author presented their report in person to the review panel.

The IMR authors were then available to answer questions from the panel about the contact they had.

All the information and data was circulated to the panel, and was discussed at panel meetings.

All panel members were asked to comment on the information and feed their comments to the Chair prior to the first draft of the Overview Report.

SUMMARY OF CHRONOLOGY

There is a significant amount of information in the chronology in this case, largely due to the health problems suffered by both Kelly and Mark. We accept that both were suffering the problems of alcohol misuse, and both had health conditions in addition. We think there is no need to document the various health appointments if these facts are accepted. We have therefore reduced the chronological information to that which we feel is relevant to establishing the events surrounding Kelly's death and identifying potential learning.

Kelly's body was discovered at her home address in June 2019 by two probation officers. Her husband was also at the address but had not reported her death. He had recently been released from prison for offences relating to domestic abuse against Kelly and had post sentence conditions not to be at her home. Kelly was classified as being at high risk of domestic abuse from him by the police and IDVA service. It was noted that Mark had facial injuries that he claimed were caused by Kelly prior to her death. This suggests there may have been a physical altercation involving them before she died.

Subsequent post-mortem and toxicology results indicated that Kelly had been deceased for a few days prior to the discovery of her body but the cause of death was inconclusive. The police report received by Cheltenham CSP states that Kelly's husband may have been present at the time of her death even though he should not have been present at her home.

Kelly was alcohol addicted and tried many times to give up alcohol; she was a very vulnerable and fragile woman. Kelly's degree of alcoholic liver disease is described consistently as 'decompensated', meaning it was serious and there was a fine balance to maintain her in a healthy condition; she had encephalopathy, meaning that her brain had been adversely affected by alcohol and she could become confused. She had oesphageal varices banded in 2013, meaning there was an ever-present risk that those would re-develop and she would exsanguinate to death if they burst open.

Decompensated liver disease is a medical emergency with a high mortality. It is defined as a patient with cirrhosis who presents with an acute deterioration in liver function that can manifest with the following symptoms:

- Jaundice (yellowing of the skin and whites of the eyes due to the liver not breaking down old blodd cells fully)
- Increasing ascites (fluid accumulation around the abdomen)
- Hepatic encephalopathy (gradual deterioration in the function of the brain due to 'poisoning' by accumulated waste products which the liver usually removes – this manifests predominantly as confusion)
- Renal impairment (failure of the kidneys)
- Gastrointestinal bleeding (bleeding from the gut, either in vomit or faeces)
- Signs of sepsis/hypovolaemia (difficult to distinguish from each other initially but consistently low blood pressures due to low circulating volumes of blood)
  There is frequently something that precipitates decompensation of cirrhosis. Common causes are:
  - Gastrointestinal bleeding
  - Infection/sepsis (often spontaneous rather than 'caught')
  - Alcoholic hepatitis (inflammation of the liver due to excess alcohol)
  - Acute portal vein thrombosis (a blood clot blocking the blood input to the liver)
  - Development of liver cancer
  - Taking drugs or starting to drink alcohol again
  - Dehydration
  - Constipation

Mark was also alcohol addicted and experienced a brain injury in 2012 that resulted in him suffering from epilepsy that was extremely difficult to control because he did not take his medication. It is not known whether the medication would have controlled the seizures. Following his brain injury Mark was assaulted and suffered a head injury. Thereafter his epilepsy became more difficult to control and he started having non-epileptic attacks. Mark led a chaotic life, drinking and smoking heavily; his mobility was impaired and the frequent seizures he experienced meant that he frequently attended hospital for both inpatient and outpatient services.

Alcoholism is a severe form of alcohol misuse and involves the inability to manage drinking habits. People who are alcohol addicted may feel they cannot function without alcohol.

Both Kelly and Mark were suffering serious health conditions as a result. There was likely some bonding over their alcoholism, and potentially an inter-dependence. However, Mark was also highly abusive and violent towards Kelly and there are serious assaults recorded against her, there was also evidence of controlling patterns and psychological abuse. Kelly was made to believe (through a process known as 'gaslighting') that she was suffering with a brain tumour. Mark shaved her head and convinced her she was suffering with cancer. Kelly's GP said in her statement to police that it was her belief that Mark's gaslighting and psychological abuse, coupled with the effects of prolonged alcohol abuse on her cognition, meant that Kelly's grasp on reality was severely affected and may have prevented her from making decisions that were in her own best interets.

Kelly had contact with many agencies locally, including various health services, housing services, domestic abuse services, social care services, police and ambulance visits and contact with probabtion services as a result of Mark's offending and licence conditions. There is no evidence to suggest that any agency failed badly in their contacts with Kelly, she received a good service from all agencies. There are however, learning opportunities when the broader picture is considered.

KEY ISSUES

There are two key issues that frame this analysis and any recommendations that result, and they are:

i) Kelly had complex needs.
ii) Kelly was subjected to wide ranging high-risk domestic abuse.

Both these issues create challenges, but together the challenges are significant for both Kelly, and the agencies involved.

Complex Needs

Kelly was a person with serious complex needs. She suffered with alcoholism, and was also suffering severe health implications because of that, she was in fact, considered to be terminally ill. She knew the seriousness of her situation and that continued alcohol misuse may result in her imminent death. This has implications for service delivery, for decision making, and potential responses to professionals by Kelly.

One of the impacts of Kelly's alcoholism and its effects on her body were that it impacted on her cognition and her perceptions of reality on occasion. She was as a result, especially vulnerable to psychological abuse and gaslighting, as much as the physical assaults on her body. This is important when thinking about her capacity and when she might be capable of making decisions in her own best interests. There is also the potential for a building co-dependency with Mark through their shared reliance on alcohol, to be able to function as they saw it. All these things present challenges for professionals who may or must assume competency and capacity.

A further consideration when responding to someone with complex needs is that they will likely be accessing support from numerous agencies. There is no doubt in this case that agencies were providing support to Kelly and there are many examples of good practice. What may be more at issue is the number of agencies involved. There are going to be challenges of information sharing and cross agency communication. It is also quite possible that the sheer number of different agencies could have created problems for someone like Kelly. It may have been difficult to keep track of different appointments, and coordinate in her mind what she needed, what she was required to do, when, and with whom.

ust her health care involved many different specialisms and medical interventions or supports, without adding in the social care needs she had, housing, domestic abuse etc. The CCG report states that Kelly had 149 contacts over the review period, and this represents ten times the average number of appointments, not including those she did not turn up for. This is significant and is in addition to other appointments with other agencies for her various needs. The ambulance service recorded 39 call outs, 30 for Mark and 9 for Kelly.

This of course also adds extra pressure on resources for her GP and health services, and similar pressures for other agencies.

There is also the issue for the victim of being overwhelmed by the numbers of appointments and actions and communications they must try to organize. Missed appointments are common in complex needs cases. If agencies do not know how many appointments, forms, phone calls, actions and travelling that the victim needs to do, they may not see how their agency fits into a wider and complex picture. Kelly could barely look after herself, so it is fair to imagine that she would not be able to manage a diary, recognize and evaluate her competing needs, and fulfil all the admin required by different agencies. The attention may become too difficult. When she was feeling unwell, and sometimes very unwell, the thought of appointments and admin may have overwhelmed her. It may even be that she could start to feel antagonistic towards those trying to help her.

A growing co-dependency between her and Mark may have at times, been easier to cope with than engaging with agencies. It is a part of chronic alcoholism that individuals sometimes feel that drinking makes it easier to function. This would have been a shared problem with Mark.

This is a difficult challenge for agencies, and for someone like Kelly, and there are no easy answers, but recognising complex needs as a particular status may give opportunities for formulating a more focused response. It may be considered, for example, that in those cases where there are complex needs, that a Single Point of Contact (SPOC) may be beneficial, or more importantly someone to act as an advocate for people suffering domestic abuse, especially with complex needs. This need not be someone from GDASS and other professionals can take this role in the context of their business, as has been found in recent research (Monckton Smith et al 2022).

Coercive Control

A public consultation completed by the Home Office in 2012 found that *Coercive Control* was the best framework for understanding and responding to Intimate Partner Abuse (IPA). Thus, Coercive Control as a pattern of behaviour was deemed to be a criminal offence under s.76 of the Serious Crimes Act of 2015 in England and Wales, and the offence carries up to 5 years imprisonment upon conviction. Coercive control is the most common form of IPA for which victims seek help or assistance. The law states it is:

'Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality'. Coercion encompasses psychological, physical, sexual, financial and emotional abuse. Controlling behaviour is defined as 'making 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 lives'.

Coercive Control perpetrators use a broad range of non-consensual tactics over an extended period to subjugate or dominate a partner, rather than merely to hurt them physically in isolated violent incidents (Stark 2009). Compliance is sought and achieved by making victims afraid and by denying basic rights, resources, choices and liberties without which they are unable to effectively refuse, resist or escape demands that are against their interests. This aspect to Coercive Control is relevant when thinking about Kelly's ability to make decisions in her own best interests. The *predicament of entrapment* in which victims of Coercive Control are often caught usually develops 'behind closed doors,' and its dynamics and consequences are rarely well documented or known in detail by outsiders. The major elements of coercive control include physical and/or sexual violence or coercion; threats, stalking, intimidation, gaslighting, isolation, degradation, and control. Many of the effects of Coercive Control make it difficult or near impossible to escape the entrapment.

There is ample evidence to establish that Kelly was subject to coercive control. There is evidence to suggest, violence, gaslighting, financial abuse, psychological abuse, persistent attention and harassment, isolation and sexual abuse.

The domestic abuse service, and health services have recorded injuries to Kelly, some of them serious and life threatening. For example, serious facial injuries, strangulation to the point of unconsciousness, and head injuries caused by a hammer.

She had been convinced by Mark that she was suffering with a brain tumour, and he apparently shaved off all her hair – this could be interpreted as gaslighting tactics. Hair shaving has been noted in other cases to humiliate victims and keep them from leaving the home. Kelly's GP considered that the gaslighting was severe and coupled with the effects of her alcohol misuse meant that her capacity to make decisions in her own best interests, and her perceptions of reality were affected.

Kelly also disclosed that she was having sexual relations with Mark when she did not want to, and there was significant bruising noted to her groin by health professionals. However, Kelly did not consider she had been raped when talking with the IDVA but had made allegations of anal rape to the police and health services.

Kelly told the police that she was frightened of Mark. This is one of the key high-risk markers for serious harm. Kelly would have known what Mark was capable of, she had experienced it. This was fuelling her fear of him.

There were allegations from Kelly that Mark took money from her, demanded money, and had an expectation that she would pay for things for him. This creates another form of abuse that can have wide ranging consequences for a victim. This is financial abuse, a sub-category of economic abuse that can take many forms. It is a legally recognised form of abuse and is defined in the Domestic Abuse Act (2021). It seems that Mark pressured Kelly to give him her money, and even threatened her. It is not known whether this was a co-ordinated pattern to make her more dependent on him or was simply

that he wanted money and abused her to get it. He certainly used her accommodation and resources as if they were his own.

The financial abuse continued after Kelly's death and her family have contacted an MP to challenge the way perpetrators of abuse can exploit a victim's finances after their death.

He had his own accommodation but kept turning up to her accommodation, he would hang around outside and made it very difficult for Kelly to resist his company.

When Mark was around, it is also the case that Kelly became more isolated. She would withdraw from agencies, and neighbours would report times when they wouldn't see her at all. This kind of isolation creates distance from help and Mark would become the only influence in her life. There are clear repercussions from this as there would be no witnesses to injuries, and alcohol consumption would likely increase.

Mark was known to use various tactics to make Kelly feel sorry for him and to make her feel guilty if she did not support him or if she called the police or asked him to leave her home. As noted, Mark had his own accommodation but persistently harassed Kelly even when there were no-contact orders.

The evidence therefore establishes that Kelly was suffering from serious and high-risk abuse, and this was also the assessment of all agencies involved. When this is coupled with Kelly's pre-existing difficulties with alcohol and the impact of her alcoholism the risk to Kelly escalated exponentially. It does seem as if her pre-existing issues were compounded with the abuse, and she found it very difficult to address those issues whilst Mark was around. Her GP also believed that the abuse coupled with her health and addiction issues affected her grasp on reality and her ability to make decisions in her own best interests.

The ambulance service recorded burn injuries to Mark's back that had not been attended to. There is no explanation available to this review around how this injury occurred. Mark did not make any allegations against Kelly but reported that he had laid on some tealights that were lit and on the floor.

Domestic Violence Prevention Orders (DVPO) were issued which Mark constantly breached, leading to multiple arrests and remands in custody and consequently a restraining order which was issued in October 2018. It was a breach of this restraining order which resulted in Mark being arrested again and being imprisoned. Mark could have been offered an accredited programme to address his abuse of Kelly such as Building Better Relationships (BBR) whilst he was in prison, but this may have been difficult to introduce due to the numerous short sentences he received and the length of time required to complete a programme. When not in prison, it is unlikely that Mark would have engaged with a voluntary programme held in the community as he would have been preoccupied with his fixation on Kelly and his alcoholism. Although he may have agreed initially to undertake a programme it is unlikely that he would have completed it as he was known to regularly miss appointments

He was also given sentences for breaching orders whilst in prison by contacting Kelly by letter. She said she wanted him to stop.

Mark had no intention of staying away from Kelly, and if court orders were not working, it seems likely that Kelly would have had little chance of deterring him.

The police did act when Kelly called, and Mark was prosecuted without her support. In the early arrests Mark was not incarcerated after conviction. Police even worked to change a charge so that Mark could be kept away from Kelly.

Kelly did engage with domestic abuse services, but she was not consistent and there was a point where she became angry with the domestic abuse service and her GP over a restraining order that she wanted lifted. The domestic abuse service, the GP and police acted in a way consistent with good practice. However, Kelly disengaged from the domestic abuse service because of this disagreement, though her engagement was always sporadic. Her GP kept contact even though it was difficult.

Kelly expressed on many occasions her desire to escape Mark, especially when he wasn't around or was incarcerated. When he was around Kelly would sometimes say she wanted to be with him. It is possible that coercive control was driving Kelly's changing opinion, her growing cognitive difficulties, and her increased alcohol consumption.

At a few points, Kelly expressed a desire to leave Cheltenham and live elsewhere, most notably to move to be close to her family and their support. There is no clear indication from the available documents that she was specifically helped with this request. Her family included her father, stepsisters and stepmother, all of whom were supportive of Kelly and were willing to help her. There was almost daily contact on the telephone between her and her father. A move would potentially have been difficult for Kelly to achieve on her own, and possibly a frightening and difficult move given her complex needs and need for ongoing health support. Not only would she need to arrange housing and benefits, but she would have to transfer her health care to a new area. It could be that whilst Mark was in prison that these things could have been furthered, and Kelly helped to move out of the area.

Given the framework discussed above, learning opportunities are identified in the context of the two key issues. A trawl through the chronology would not be the most effective way to draw out learning.

The following learning identified focuses on how we might respond to complex needs and domestic abuse together.

It appears that agencies did engage with Kelly and Mark. Kelly was in receipt of support for her varying needs. It does not seem there was any significant failure by any agency involved the problems arise from the context of dual complex issues.

The circumstances of Kelly's death remain unexplained. It is known however, that Mark knew she was deceased, and had lived with her dead body for around four days. No help was sought, and Kelly's body was not treated with dignity after her death.

She was naked when found and lying on the floor beneath rubbish.

Mark had some facial injuries which he claims were caused by Kelly, so it is possible there was an altercation before her death.

Kelly was found when two probation officers attended the address looking for him. He was not supposed to be there. The police had also attended twice during that week but had not managed to get an answer. It is not known whether Kelly was dead or alive at the time of the police calls.

Mark answered the door to the probation officers naked from the waist down. He asked the officers if they would like to see a dead body.

This is clearly a strange response, and it is likely that Mark was suffering the effects of alcoholism. He said he could not remember what happened.

Due to the lack of evidence and the length of time between the discovery of Kelly's body and examination of it, her advanced illness and precarious state of health, it is unlikely the circumstances of her death will ever be known.

CONCLUSIONS

An overall view of Kelly's situation reveals that her problems were most likely overwhelming for her. She was very unwell, she was suffering domestic abuse, and she was misusing alcohol. Her GP considered that her health problems coupled with the domestic abuse had affected her perceptions of reality and her ability to make decisions in her own best interests. Her husband was a determined and violent man who ignored court orders and was misusing alcohol himself. The records also show that Mark was suffering with epilepsy and often failed to take his medication leading to seizures. Mark was resistant to change, resistant to taking his medication, and resistant to following court orders or licence conditions.

The analysis has not focused on individual events from the chronology, and this was purposeful because the complex challenges created by the dual impacts of complex needs and domestic abuse render micro level focus almost irrelevant. I say this because the overriding impacts of the meso and macro level challenges are more likely to identify relevant learning. Overall, Kelly and Mark were receiving the services they needed, they were having above average levels of contact with some agencies, even if they did not always engage fully with them. Kelly's health was being monitored and her GP understood her competing problems; the police responded to calls for help and arrested Mark, prosecuting him. The problems arise from the complex needs and domestic abuse together.

This creates problems for Kelly.

This also creates problems for all agencies involved.

It does seem that Kelly's status as a high-risk victim of domestic abuse was sometimes in conflict with her status as an individual with complex needs. The extra resources and time needed for agencies to respond must also be considered.

Therefore, I conclude that the best way forward from all the information collected, is that we consider the recommendations made by agencies in their IMRs and place them in the context of complex needs and high-risk domestic abuse to identify relevant learning.

Learning Opportunities and Recommendations

Learning Opportunity 1: Responding to Complex Needs and SPOC

When considering complex needs it must be recognized that there are a lot of agencies involved: the scale of contact with Kelly was above average. Agencies should be aware of the

hierarchy of need to support engagement of those with complex needs in particular recognising that for some victims of domestic abuse it can be difficult for them to act in relation to domestic abuse when other needs are a priority - housing, food, clothing etc. These issues need to be addressed first, building trust, and supporting the victim to meaningfully engage in wider domestic abuse safeguarding activities. This presents challenges for agencies and for the victims of abuse. There are the challenges of information sharing and cross agency communication. There is also the issue for victims such as Kelly of being overwhelmed by the numbers of appointments and actions and communications they must try to organize. Missed appointments are common in complex needs cases. If agencies do not know the number of appointments, forms, phone calls, actions and travelling that the victim needs to do, they may not see how their agency fits into a wider and complex picture. Kelly could barely look after herself so it is fair to imagine that she would not be able to manage a diary, recognize and evaluate her competing needs and fulfil all the admin required by different agencies. The attention may become too difficult. When she was feeling unwell, and sometimes very unwell the thought of appointments and admin may have overwhelmed her. It may even be that she started to feel antagonistic. It may be of potential use for specified complex needs victims to have a Single Point of Contact (SPOC).

As noted above the challenges for domestic abuse victims with complex needs are numerous, and this means they are different in many ways. There should be a way of creating a marker for 'complex needs domestic abuse victim' so that a particular route to support can be considered that takes account of the issues for victims and agencies.

Gloucestershire County Council (GCC) are currently carrying out transformational work with respect to complex needs and individuals who are experiencing multiple disadvantages. GCC will be commissioning a consultant to carry out a piece of engagement work over the Summer of 2021 with senior colleagues across the system to gain insight into their views on this subject. It is hoped to secure engagement at senior level and use the insight gained from the work to inform workshops in the Autumn that will help drive this agenda forward

RECOMMENDATION 1a

Ensure the review into Gloucestershire's collective response to individuals experiencing multiple disadvantages considers the findings from this review. This will ensure that the countywide response to 'complex needs' considers the specific needs of victims of domestic abuse and supports future victim engagement in services/increased safety

RECOMMENDATION 1b

Ensure agencies are aware of the need to address immediate physical (shelter, food, clothing, emergency health care, sleep etc) needs (that may be caused by DA) first in complex cases to support victim engagement.

Learning Opportunity 2: Complex needs, domestic abuse and capacity

Kelly had sporadic contact with multiple agencies, often several agencies at the same time, though these agencies were not always aware of each other's involvement unless disclosed by Kelly or otherwise identified by agencies themselves. Kelly's GP said that she thought that Kelly's cognition was affected by Mark's abuse and coercive control, and by the effects of prolonged alcohol misuse and that subsequently Kelly was not making good decisions about her safety. This observation has been made by other agencies too at differing points of their contacts with Kelly, however there was an absence of opportunity for this opinion to be shared and acknowledged as a multi-agency group and in turn inform agency's "time and decision-specific" Mental Capacity Assessments. Consequently the approach taken by those undertaking these MCA Assessments, particularly in the hospital setting where full knowledge of the existence of these multiple factors or of their potential impact on Kelly's decision-making capacity may not have been known by those undertaking MCA assessments at the time in question, may have differed and this may also be a reflection of the tiered approach taken by agencies in delivering MCA training to their respective workforce with some staff having more advanced knowledge and skills than others. It may be good practice where the perpetrator is next of kin, to have an alternative name. Victims could be asked this when it is known they are victims, or they disclose.

RECOMMENDATION 2a

A small working group drawn from multi-agency partners, in conjunction with the Safeguarding Adults Board Workforce Development sub-group, be formed to review both the content and delivery of existing Mental Capacity Act Training, and Domestic Abuse training ensuring sufficient emphasis is given to the impact on decision-making capacity of long-term substance misuse, domestic abuse, and/or coercion and control.

RECOMMENDATION 2b

Multi-agency partners to review the Mandatory, or other status of such training to respective areas of the workforce involved in assessing and supporting people's decision-making.

<u>Learning Opportunity 3: Complex needs and domestic abuse – acting fast on requests</u>

Kelly was inconsistent in whether she wanted Mark around, and this made things challenging for agencies, notably the GP, the police and GDASS. Given this challenge, there may be some benefit in complex needs cases with domestic abuse that rapid action or focused action could be taken when a victim is in a position of asking for specific help.

RECOMMENDATION 3a

Ensure agencies are aware of the immediate safety measures that should be considered when responding to victims of domestic abuse to ensure safety planning is not delayed or linked to ongoing victim engagement

RECOMMENDATION 3b

For the Safeguarding adults board to ensure the findings from this review are considered alongside the 5 women SAR to ensure a joined up approach to the learning around 'ensuring agencies can respond effectively at the point when someone is ready to accept support' and the need to act fast in these situations to safeguard vulnerable people.

Learning Opportunity 4: Complex needs and domestic abuse - safe and well checks

A safe and well check by the police could have been more persistent given the complex needs and the serious violence and control recognising the restrictions placed on them by current legislation. It is possible that Kelly was dead when the calls were made. When Probation called they were more persistent and got an answer.

RECOMMENDATION 4

When agencies contact the police regarding safe and well checks, where possible, the information should be relayed directly (phone/face to face) in order to convey the risk associated with the individuals it concerns. This will support police in ensuring Safe and well checks are conducted appropriately, and victims are safeguarded.

Learning Opportunity 5: Complex needs and domestic abuse – self-care help

Kelly's ability to care for herself fluctuated, as did her engagement with support in this area when it was offered. At times Kelly said she needed help with self-care, at points Mark being identified as able and willing to provide this care (though this was accepted by professionals without them having any knowledge of any domestic abuse in the relationship at the time). At other points it was identified Kelly did not need help with self-care. Where there are such fluctuations in both the person's ability to self-care and remain engaged with external support, and in the known presence of domestic abuse, the absence of external support holds the potential to isolate the person further potentially increasing their vulnerability.

RECOMMENDATION 5 a

Domestic abuse training should explore the impact of domestic abuse on the person's ability to maintain self-care independently and how this area of a person's life may be used as a means to isolate them from an otherwise supportive network.

RECOMMENDATION 5b

When engaging with people who have complex needs and where domestic abuse may be known or suspected, all professionals should exercise professional curiosity when exploring with the person their ability to self-care and/or the appropriateness of their support network in relation to any arising needs for care and support.

Learning Opportunity 6: high risk domestic abuse and prison communications

It is known that there was contact between Mark and Kelly whilst Mark was in prison – letters and phone calls – and whilst an order was in place barring contact. Mark had two sentences

imposed for this. Is there opportunity for Mark to be prevented from contacting the primary victim of his abuse? Monitoring of contact? This would be an opportunity for the prison service.

RECOMMENDATION 6 (NATIONAL)

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HM Prison Service to review its policies and practice around communications from prison in cases of domestic abuse to ensure the ongoing safeguarding of victims.

Learning Opportunity 7: High risk domestic abuse grading and incarceration

There was an assumption that because Mark was in prison that the threat to Kelly was reduced significantly. This may be exactly the time to put in place safeguarding that separates the two permanently, particularly if that is what the victim wants. Also, there was communication between them so risk should be considered even when perpetrators are in prison. Control can be exerted from a distance.

RECOMMENDATION 7

All agencies to ensure DA training is clear on how professional should respond to immediate and long term risk; recognising the opportunity of perpetrator incarceration in engaging and safeguarding victims in the long term.

Learning Opportunity 8: domestic abuse perpetrators and noting a history in health records

There is a lack of consistent approach across health services currently around recording perpetrator information on records. Health providers are currently undertaking a project to integrate all the health-related safeguarding within the Integrated Care System (ICS). There is an opportunity both locally and nationally for consideration to be given to the Should a perpetrator of domestic abuse have this recorded somewhere on health records? There may be a relationship between control issues and abuse.

RECOMMENDATION 8a (NATIONAL)

All NHS Safeguarding integration projects provide a solution for how risks presented to and by a patient are documented within clinical records, so that NHS staff do not inadvertently increase their patient's risk of harm from or to others

RECOMMENDATION 8b (LOCAL)

Gloucestershire Safeguarding Integration Project to look to a solution for how risks presented to and by a patient are documented within clinical records in line with National practice and the National recommendation from this DARDR.