North Somerset Safer Communities

# Victim: Kathryn (DHRS8)

# Executive Summary

Year of Death: August 2023.

Author: Paul Northcott

Date the review report was completed: 13th Januaury2025

## 1.0 The Review Process

1.1 This summary outlines the process undertaken by North Somerset Safer Communities Partnership in reviewing the death of Kathryn in August 2023, who was a resident in their area. Kathryn was described by her close friend as an intelligent and empathetic women who had suffered physical, emotional and psychological abuse over many years, and this had shaped her life experiences and interactions with agencies. Kathryn was fearful that she would lose her daughter due to her circumstances and Nyota was the most important person in her life.

1.2 Kathryn sadly took her own life in August 2023. There were no criminal proceedings in this case.

1.3 The following pseudonyms have been in used in this review for the victim and other parties as appropriate to protect their identities and those of their family members:

- Kathryn – Deceased female. Kathryn was a white European and aged thirty four at the time of her death.
- Brent – Deceased females' partner (although they had separated prior to her death). Brent was a white European and aged thirty-three at the time of Kathryn's death.
- William– Deceased females' previous partner. William who was a white European had passed away prior to Kathryn's death.
- Nyota – Deceased females' child. Nyota was aged two at the time of her mother's death.
- Annika- Close friend of Kathryn.

1.4 The death of Kathryn was referred to the HM Coroner's office. An inquest has yet to be held in respect of this case and the date had not been set at the time when the report was submitted.

1.5 The process began with an initial meeting of the Community Safety Partnership on 21/09/2023 when the decision to hold a domestic homicide review was agreed. All agencies that potentially had contact with Kathryn prior to the point of death were contacted and asked to confirm whether they had involvement with them.

1.6 Seventeen of the twenty-three agencies contacted confirmed contact with the victim and/or perpetrator and children involved (if relevant) and were asked to secure their files.

## 2.0 Contributors to the Review

2.1 The contributors to the DHR were;

- Avon and Somerset Police (A&S Police)- IMR
- North Somerset Substance Misuse Commissioning Team - IMR
- Adult Social Care (NSC)- IMR
- Sirona Care & Health – Health Visiting Service – IMR

- Homeless Prevention Unit- IMR
- Housing Association - Information
- Primary Care – IMR
- Primary Care - Information[1]
- North Somerset Children's Services – IMR
- Birmingham Children's Trust - Information
- Southwest Ambulance Service NHS Foundation Trust (SWAST)- IMR
- Mother and Baby Recovery Unit – Information
- NextLink - IMR
- WithYou – IMR
- Social Home - Information
- Community Safety- Information
- Probation - Information

2.2 Specialist domestic abuse advice and scrutiny was provided by the senior service manager from the Nextlink Domestic Abuse Support Services. Nextlink are a charity that provides specialist support to those who have been affected by domestic abuse and sexual violence.

2.3 All of the IMR writers were independent. None of the writers knew the individuals involved, had direct involvement in the case, or had line management responsibility for any of those involved.

## 3.0 The Review Panel Members

3.1 The Panel for this review were made up of the following representatives, all of which were independent and had no direct involvement in the case.

| | | |
|---|---|---|
| Paul Northcott | Independent Chair. | |
| Hannah Gray | Domestic Abuse & VAWG Lead (NSC) | North Somerset Safer Communities Partnership |
| Dave Marchant | Detective Inspector Major Statutory Crime Review Team - Police | Avon & Somerset (A&S) Police |
| Naomi MacMeekin | Snr Safeguarding Adults Officer | Adult Social Care (NSC) |
| Lucy Austin | Deputy Designated Nurse (all age safeguarding) | NHS Bristol, North Somerset, and South Gloucestershire Integrated Care Board (ICB) - 15C |
| Fiona Dixon | Substance Use Commissioning Manager | Public Health (NSC) |

[1] GP where Kathryn was registered whilst at a mother and baby unit.

| | | |
|---|---|---|
| Jenny Thompson | Deputy Head of Safeguarding, | UHBWNHST |
| Alex Morgan | Designated Named Professional | NHS Bristol, North Somerset and South Gloucestershire ICB - 15C |
| Debbie Howitt | Mental Health Specialist | Public Health (NSC) |
| Vanessa Colman | Interim Des Nurse Safeguarding Adults | NHS Bristol, North Somerset and South Gloucestershire ICB - 15C |
| Dani Rowan | DA Lead, | Avon & Wiltshire Mental Health Partnership |
| Sian Scholes | Senior Service Manager, | Nextlink Domestic Abuse Support Services |
| Sharon Doran | Named Lead for safeguarding Children | Sirona Care & Health |

3.2 The North Somerset Safer Communities Partnership ensured that there was scrutiny and accountability throughout the DHR process particularly in respect of independence and impartiality. The Panel met formally on five occasions. All the panel members were independent.

## 4.0 Author of the Overview Report

4.1 The North Somerset Safer Communities Partnership appointed Paul Northcott as Independent Chair and author of the overview report in December 2023.

4.2 Paul is a safeguarding consultant specialising in undertaking reviews and currently delivers training in all aspects of safeguarding, including domestic abuse. Paul was a serving police officer and had thirty-one years' experience. During that time, he was the Head of Public Protection, working with partner agencies, including those working to deliver policy and practice in relation to domestic abuse. He has also previously been the senior investigating officer for domestic homicides. Paul has not previously worked for the Police Force, nor for any of the other agencies involved in this review.

4.3 Paul has been trained as a DHR Chair, is a member of the DHR network and has attended AAFDA[2] webinars.

## 4.0 Terms of Reference for the Review

4.1 The North Somerset Safer Communities Partnership agreed the following terms of reference.

[2] Advocacy After Fatal Domestic Abuse.

The review should;

- Provide an overview report that articulates Kathryn's life through her eyes, and those around her, including professionals.
- Establish the sequence of agency contact with Kathryn/Brent, and the members of their household (between the dates of 1st September 2016 and August 2023); and constructively review the actions of those agencies or individuals involved. Agencies should summarise any additional contact and outcomes prior to that date which specifically relate to domestic abuse or trauma in Kathryn's life.
- Provide an assessment of whether the death of Kathryn was an isolated incident or whether there were any warning signs that would indicate that there was any previous history of abusive behaviour towards Kathryn and whether this was known to any agencies.
- Seek to establish whether Kathryn or Brent were exposed to domestic abuse prior to adulthood and impact that this may have had on the individuals concerned.
- Establish whether family or friends want to participate in the review and meet the review panel.
- Provide an assessment of whether family, friends, neighbours, key workers (if appropriate) were aware of any abusive or concerning behaviour in relation to the victim (or other persons).
- Review any barriers experienced by Kathryn or her family/friends in reporting any abuse or concerns in Somerset or elsewhere, including whether they knew how to report domestic abuse.
- Assess whether there were opportunities for professionals to enquire or raise concerns about domestic abuse in the relationship.
- To review current roles, responsibilities, policies, and practices in relation to those affected by domestic abuse – to build up a picture of what should have happened.
- To review national best practice in respect of protecting those affected by domestic abuse and their families.
- Evaluate any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services in North Somerset.
- Identify whether the work undertaken by the services in this case was consistent with their own: professional standards, compliant with their own protocols, guidelines, policies, and procedures.
- Establish whether thresholds for intervention were appropriate and whether they were applied correctly in this case.
- Explore whether those dealing with Kathryn were sufficiently professionally curious and tenacious in identifying domestic abuse and considering its links and risks to individuals taking their own lives.
- To consider whether practice was trauma informed.
- Consider any equality and diversity issues that appear pertinent to the Kathryn or family members e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual

orientation.

- To consider the impact of drug dependency, street working and other complex medical and social issues in relation to how victims are treated when they present to services.
- To clearly identify learning and draw out conclusions about how organisations and partnerships can improve their working in the future to support those affected by domestic abuse.
- To clearly articulate how learning 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 North Somerset to improve our work to better safeguard those affected by domestic abuse and their families.
- To identify good practice.
- To review any other information that is found to be relevant.
- The review excludes consideration of how Kathryn died.

## 5.0 Summary Chronology

5.1 Due to the considerable contact that had occurred with some agencies the chronology dates set for this review was from 1st May 2020 to until the date of Kathryn's death**.** These dates were chosen as they provide a sufficient time span that capture the deterioration in Kathryn's health and the allegations of domestic abuse that were reported to agencies.

5.2 Whilst they were reviewing their records agencies were also asked to consider any other relevant incidents or contact that they had with Kathryn relating to trauma or domestic abuse between the 1st of September 2016 and the 1st of May 2020. This request ensured that all relevant information was considered as part of the review.

| Date | Comment |
|---|---|
| September 2010[3] | Kathryn reported a burglary to North Somerset police. Following an initial investigation Kathryn reportedly stated that they believe she had lied and that she was '*a prostitute who sold her belongings for drugs*'. Kathryn had felt the police were unprofessional and inappropriate in their response and immediately after this contact took an overdose. |
| 14th May 2017 | Police received a 999 call from Kathryn to report that William had pushed her to the floor, stood on her throat and tried to strangle her. Officers arrested William. A DASH was completed with Kathryn, and she was assessed as medium risk. |
| May 2017 | Kathryn attended an Intensive Treatment Unit following an overdose and was accompanied by William. During that visit Kathryn stated that she had been assaulted by an ex-partner. |

[3] Some dates that have been included in this chronology are not specific as they were not fully recorded by Kathryn's friend Annika.

| | |
|---|---|
| December 2017 | Kathryn contacted Annika stating that she had been assaulted by William. William had reportedly strangled her and stamped on her William had lost his temper with her and punched her. |
| 11th February 2018 | Police received a 999 call from Kathryn reporting that she'd been punched and kicked by William. Officers were unable to establish what had happened and removed William from the house. A DASH (officer perceived) was completed and rated as medium risk. Kathryn felt unable to make a statement but did agree to present as homeless to the council the following day and to attend drug treatment services. After investigation the case was filed. Attempts were made to engage with Kathryn without success. |
| 22nd May 2018 | The police received a MARAC referral from Addaction after Kathryn disclosed that the domestic violence in her relationship with William was escalating in nature and frequency. The referral was accompanied by a DASH rated high. |
| June/July 2018 | Kathryn sought advice from Annika as she was approaching the local authority for housing. Kathryn stated that she was originally disbelieved that she had been a victim of domestic violence, then turned away. They stated that she had been told that she needed to approach a refuge first. |
| May 2020 | Death of William. Kathryn spoke to Annika and informed her she had been living in a tent with William and that she was pregnant. Kathryn said that she was scared that children's services will get involved and that they would take her baby away. |
| 15th – 17th August 2020 | Annika visited Kathryn at her home address. Kathryn informed Annika that she had a partner (Brent). Kathryn described him as being a "massive misogynist" and that he had emotionally abused her including calling her "*my little whore*" to his friends. |
| 26th August 2020 | Kathryn text Annika to apologise for not responding to her calls and stated that there had been "*an incident"* involving Brent. A few days later she called Annika and described what had happened to her. Annika explained to Kathryn that what she was describing was rape. Annika tried to speak to her about getting support and leaving Brent to safeguard herself and Nyota, but she was fearful, especially of children's services. Kathryn informed Annika that one of the social workers had commented that he was a "protective factor." She did not think children's services would believe her and thought they would remove her baby. |
| 22nd September 2020 | Police were contacted by the Ambulance Service reporting a male had been assaulted by Brent. The ambulance crew were concerned about Kathryn's welfare (who was 37 weeks pregnant) whilst the other male was in hospital as the male alleged that Brent had previously assaulted and raped Kathryn. The assault victim also called police expressing concerns for Kathryn's safety, after which officers were dispatched. Brent was arrested on suspicion of rape and GBH. Kathryn felt unable to continue to support the investigation at that time |

| | |
|---|---|
| | and declined to complete a DASH. An officer perceived DASH was completed a week later and rated standard. Referrals to CSC and health were made. |
| October 2020 | Kathryn's' daughter was born. |
| 8th December 2022 (00.57hrs) | Police received a 999 call from Kathryn's next-door neighbour to report that Kathryn was banging on the door/window saying she was frightened and needed help. Officers arrived ten minutes later by which time Kathryn had calmed down. Officers determined that she'd had a mental health episode and left her in the company of Brent. The neighbour called back about ten minutes after officers left to report that Kathryn had come back again and was screaming, banging on the door, and had smashed their window. The neighbour said Kathryn appeared terrified of Brent. Officers attended and spoke to Kathryn (shown on Body Worn Video) and Brent. After speaking with the neighbour, the officer arrested Kathryn for criminal damage '*to protect her and her neighbours*', noting that she was acting strangely as if she wanted to be arrested. When in custody Kathryn said that she wanted to speak with a female officer and that she didn't want to go home as it wasn't safe. Despite multiple attempts she would not provide any further information and was later released without being charged. There was no evidence of visible injury. |
| 8th December 2022 | Kathryn attended a police station with Nyota to report a different version of events from the previous night. She said Brent had attacked her, pinning her down and punching her in head when she put the outside light on and locked the doors. This was when she ran to the neighbour's house and smashed the window due to her fear and desperation. Kathryn did not want Brent to be arrested for fear of him becoming more aggressive and killing her. She was concerned that he had tracking software on her phone. Kathryn said that she thought she would be kidnapped. She declined to provide a statement and wouldn't talk to officers.<br><br>Kathryn was taken home to get some belongings and then brought back to the police station for safeguarding. A DASH was completed (rated high risk) and a BRAG (rated red). |
| 8th December 2022 | Next Link received a referral from the police for Kathryn. At that time Kathryn was in police custody and was seeking emergency accommodation. The referrer from the police stated: "*When I spoke with her about why she felt it was unsafe to go home, she opened up but then told me I couldn't share any of this information as if her partner is arrested, she stated "That would be the end for her". She is absolutely terrified of him and friends of his that live opposite her accommodation."* On that occasion the Triage Team explained that they did not have availability for an on the day placement into |

| | |
|---|---|
| | safehouse and advised the police of the Pathway for emergency accommodation during working hours and out of hours. |
| 8h December 2022 | The lettings team manager (Homeless Prevention Team) received a referral from their customer services following contact from the police. The manager advised the police that they could provide overnight accommodation for Kathryn and Nyota in Bristol as North Somerset had no emergency housing. Kathryn and Nyota were accommodated in a local bed and breakfast. The team explained that they would work with Kathryn to find permanent residency in Somerset. |
| 9th December 2022 | A Housing Officer from the Homeless Prevention Team saw Kathryn following the police referral. A DASH risk assessment was completed. An emergency accommodation offer was made for the Bristol area but Kathryn stated she would stay with a friend as she thought this would be safer. |
| 9th December 2022 | Kathryn contacted Annika in distress and described how Brent had attacked her along with others. Kathryn informed her that she was with a children's social worker, that the council had housed her in a B&B in the area, and the social worker had called a safe house.<br><br>When later describing the attack on her she reported that Brent had told her that she had to "*take it*", "*learn to take it*", and that she is a "*big girl*" who needs to "*take her punishment*". Kathryn interpreted this to mean she had to take her beating and gang rape as punishment for allegedly cheating on him.<br><br>When the police arrived, Kathryn said she was too scared to tell them what had happened. Kathryn told Annika the police gave her the option of staying there or going with them because she looked terrified. She informed Annika that she asked to go with them so the police arrested her for damaging the window.<br><br>Kathryn told Annika that she was scared that Brent would pay someone to kill her if she pursued a complaint. She did not think any bail conditions would be sufficient because she believed that he would pay others to carry it out.<br><br>Kathryn then informed Annika of other domestic abuse that she had suffered during her relationship with her partner over the past 2-3 years. This included emotional abuse, controlling and coercive behaviour, physical abuse, sexual abuse, and financial abuse.<br><br>Kathryn alleged his behaviour had deteriorated over the six months prior and, from her descriptions, it sounded like Brent had become increasingly paranoid. |

| | |
|---|---|
| | Kathryn also reported that Brent and his friends had accessed her online accounts, including Facebook and email, but he had convinced Kathryn she was "*crazy*" for thinking that they had. Even when Kathryn checked location services and saw someone had accessed her account from another town, Kathryn said she was still inclined to believe her partner.<br><br>Kathryn admitted that the years of emotional abuse and being "*ground down,"* leading her to feel reliant on him and unable to trust herself. |
| 4th January 2023 | MARAC meeting held in North Somerset. The outcome of the meeting was for Housing to discuss with Kathryn NextLink engagement. There was also an additional action for both Housing and the HV service to consider a referral to children's service post visit. |
| August 2023 | Kathryn's death is reported. |

## 6.0 Key Issues Arising from the Review

6.1 Kathryn had several traumatic events in her childhood which included the death of her mother from cancer when she was aged six. Kathryn had also been subjected to emotional abuse and neglect by her father and stepmother.

6.2 Due to her life experiences Kathryn had started to self-harm at the age of twelve and she had taken her first overdose at the age of fifteen. In the years that followed Kathryn made several attempts to take her own life and at the age of sixteen she had started to use illicit drugs.

6.3 Kathryn was extremely vulnerable both mentally and physically, and she struggled to control her dependency with illegal drugs. This dependency had led to erratic behaviour and an inability to maintain stable relationships. According to Annika, Kathryn would instantly fall in love with anyone who showed her kindness and affection. This made Kathryn the target of abusive men who were physically, sexually, and emotional abusive to her. Most of these males were not known to agencies.

### 6.4 <u>Domestic Abuse</u>

6.4.1 During her life Kathryn had several relationships where her partners had taken advantage of her vulnerability, and this had a significant impact on her physical and mental health. This included a relationship with a male in 2006.

6.4.2 From the records held by agencies Kathryn had an intermittent relationship with William between 2010 and 2020. William was physically and emotionally abusive towards her including reports of strangulation.

6.4.3 In 2022 Kathryn commenced a relationship with Brent. The chronology shows that Brent was physically, mentally, sexually, financially and economically abusive towards Kathryn. Brent was also coercive and controlling in that he;

- controlled who Kathryn could see
- constantly monitored where she was
- reportedly had access to Kathryn's mobile phone and had tracking software downloaded on it[4]
- reportedly accessed her online social media accounts[5]
- would threaten Kathryn that he would get others (his friends) to sexually abuse her if she failed to comply with what he wanted
- would make her dress and undress him
- had control of her bank account

6.4.4 Up until her death Brent had economically[6] and financially exploited Kathryn by ensuring that she was reliant upon him for all her needs. This limited Kathryn's ability to leave the relationship and to live independently. The impact of this type of abuse on an individual's mental and physical health can be substantial and in Kathryn's case had led to depression and suicidal ideation.

6.4.5 Kathryn had wanted to make her own financial decisions but had found additional barriers when trying to establish her own financial security. Whilst considerable work has taken place involving the charity Surviving Economic Abuse (SEA), the HSBC banking group[7] and the Financial Abuse Code (2021)[8], the review has identified that further work needs to take place at a national level to support victims and survivors of abuse (**Recommendation 1**).

6.4.6 Records show that police contact with Kathryn increased significantly from 2017. Between 2017 and May 2020, there are fifty-four records for (or linked to) Kathryn ranging from intelligence logs to her being assaulted (two of which were sexual assaults). The police response to the incidents that were reported were found to be largely proportionate and in line with their policies. Arrests were made where there was supporting evidence with all available lines of enquiry being completed. There was also documented consideration of an evidence-led prosecution where appropriate and DASH risk assessments were completed. Despite these interventions Kathryn had felt isolated and further victimised by the responses that were made. An example of this was in December 2022 when the police attended a reported incident at Kathryn's home address. Whilst the action that officers had taken was found to be proportionate and in line with the evidence that was available to them Kathryn had confided to her friend that it had left her feeling unsupported. On review the initial response had led officers to believe that Kathryn's behaviour had been driven by her mental health as she was very erratic.

[4] This was never corroborated by the Police or other agencies.
[5] As above.
[6] Economic abuse encompasses behaviours that control a survivor's "ability to acquire, use, and maintain resources thus threatening [their] economic security and potential for self-sufficiency". BMC Public Health 2022.
[7] How banks can help - Surviving Economic Abuse
[8] Financial Abuse Code

6.4.7 The second response on that night which was to a neighbour's house was reviewed in the light of this information from Annika. Officers attended (after a neighbour had reported that Kathryn had smashed one if their windows) and spoke to Kathryn alone. BWV footage shows that the officer spent time in building a rapport with her to understand what had happened. The officer also offered to refer her to the mental health crisis team and specifically asked if Brent had hurt her. From her demeanour the officer felt that Kathryn wanted to be arrested. As there was a formal complaint the officer had to take positive action and they felt that by arresting her would also "*protect her"*. From the records held it is not clear whether the officer had taken into consideration the previous reported incidents of abuse between the Kathryn and Brent, but they felt as though they were acting in her best interests on the limited information that they had at that time.

6.4.8 Whilst some may conclude that the decision that was made by the officer was not in line with best practice for dealing with victims and was misguided (particularly as they would appear to have not considered all of the previous reported incidents and intelligence) it would appear to have been made with the best intentions of trying to take Kathryn away from the situation and giving her an opportunity to disclose any concerns about her welfare. On what they knew at that time they would have been unable to take positive action against Brent. We now know that whilst this action was well intentioned by the officer concerned it had a profound and negative effect on Kathryn's confidence in services, particularly the police. Kathryn had a previous experience in 2010 where she felt that the police had not believed her or supported her when she felt particularly vulnerable. The culmination of these two incidents left her with little faith that the police were there to support her.

6.4.9 On each of the occasions when Kathryn was in police custody she was signposted to support services. Those in custody made sustained attempts to get Kathryn to engage with them about her circumstances but she continued to feel that she could not discuss her concerns with them.

6.4.10 In this case agencies were aware of the risks to Kathryn through the DASH risk assessment, although the true extent of the abuse was unknown to agencies, as Kathryn felt that she could only confide in her friend called Annika. Kathryn appears to have minimised the abuse in her relationship with Brent as she didn't want him to be arrested. Kathryn feared that the consequence of his arrest would result in an increase in violence and that her daughter may have been taken away from her if she was seen as unable to protect herself and Nyota. Kathryn also felt that the police would be unable to protect her. Trauma, anxiety and low confidence also played a significant part in her ability to make decisions.

6.4.11 Kathryn felt totally overwhelmed by the amount of additional work that she would have to undertake for her to access the services that she needed. This burden had weighed heavily on her and had meant that she had felt no other option but to remain in her relationship with Brent.

6.4.12 Kathryn registered with her last GP in February 2021. At the time of registration there was nothing highlighted in Kathryn's prior medical records suggesting a known history of trauma or abuse in her life. Kathryn had also not reported her experiences of domestic abuse or violence to her GP practice either at the time of registration or at her first GP appointment.

6.4.13 Overall, Kathryn's GP Practice (final Practice) did deal promptly with any requests for appointments or advice and signposting. Kathryn was dealt with in a sensitive and inclusive manner by all the staff at the practice. Within the Primary Care IMR it was identified that there were some missed opportunities to demonstrate increased professional curiosity and ask Kathryn routine questions about domestic abuse. The review however highlighted the need for the national standardisation of coding in primary care records to ensure that victims and survivors are easily identifiable and in addition this would assist in prompting professional curiosity (**Recommendation 2**).

6.4.14 Kathryn booked a GP appointment as a new patient the day after registration for review of medications and ongoing long-term prescriptions. During this telephone appointment, which was standard practice at the time, her mental health was discussed, but there was no mention of relationships or domestic abuse. The Primary Care IMR writer noted that it would normally be good practice to enquire about patient's home life and lifestyle risk factors during such a review, but this did not take place (**Recommendation 3**).

6.4.15 At the time that Kathryn was having contact with her GP Practice a new IT system had been implemented for the triaging of online requests (e-consult). Kathryn had previously submitted a request for sick note online and the automated data-gathering did not include any screening questions for difficulties at home therefore was again a missed opportunity for routine inquiry. This was discussed with the practice, and it was felt that services could be improved if an online form was introduced with simple tick box screening question that would be an opportunity for risk assessment. (**Recommendation 4**).

6.4.16 The Primary Care IMR writer also identified that when processing requests for (MED3[9]) fit to work certificates there needs to be appropriate training and support for staff to initiate a clinical contact where there is mental health or safeguarding concerns. The online tool (e-consult) should be reviewed to ensure that its algorithms consider incorporating safeguarding screening questions to assist and support patients to make a disclosure (**Recommendation 5**).

6.4.17 Professionals at the Practice have worked constructively with the review process and have recognised that there are further opportunities to raise awareness about domestic abuse in all areas of Primary Care, through the effective training of key staff. There are current training programmes already in existence within North Somerset that should be further promoted by the ICB (**Recommendation 6**).

[9] Doctors medical certificate (fit to work).

6.4.18 The Primary Care IMR writer has identified that there was not a holistic overview of Kathryn's case and that those dealing with her had not fully considered her family circumstances. The IMR writer identified that staff within the health sector need to utilise a "Think Family" approach where there are concerns about domestic abuse and mental health. This was particularly important in Kathryn's case due to the birth of Nyota. The Primary Care IMR writer also identified that within Primary Care it would have been gold standard practice to have enquired about Kathryn's social history, relationships and family dynamics at pivotal points in her care including when her mental health and controlled drug medications were reviewed. This would have also allowed for the 'linking' of family members' records. (**Recommendation 7**).

6.4.19 The Primary Care IMR writer identified that there were gaps in information flow between health services using clinic letters. They recommended that the processing of clinical letters must be considered, with training and support being given for admin staff to implement practice policies for mental health and safeguarding. Coding should be prioritised and utilised, to raise the threshold for professional curiosity and further inquiry at each clinical contact (**Recommendation 8**).

6.4.20 Kathryn had first come to the notice of the most recent housing provider in 2018 when she had been evicted from emergency accommodation and then again in 2019 when she was homeless. This housing provider had been aware of Kathryn's complex needs including the fact that she had been involved in an abusive relationship with Brent. They were also aware that she had specific mental health needs and was vulnerable through drug dependency.

6.4.21 Kathryn had reportedly been given inaccurate advice from her housing association when she had to leave her home address. Kathryn had reportedly been informed that it was her responsibility to secure her property, despite her being a victim of abuse, and that she would be liable for any damage caused by Brent. This had been contrary to their domestic abuse policy and was poor practice (**Recommendation 9**).

6.4.22 Kathryn had stayed at a local refuge which according from the conversations that Annika had with Kathryn had failed to acknowledge the risks associated with IT surveillance. They had asked Kathryn to turn on her phone whilst at the refuge so that she could log on and prove that she was able to pay rent. This was despite the police advising Kathryn not to do so as Brent may have been able to track her. Kathryn told Annika that she had been told that she had to do this or she would not be able to stay there. Kathryn also stated that they were unable to provide her with any advice or assistance to obtain identity documents, seek financial assistance or secure her financial accounts. This was poor practice (**Recommendation 10**).

6.4.23 Children's Social Care became involved in Kathryn's case following a referral from We are With You. They were aware of concerns about her drug use, mental health, limited support network and lack of permanent housing. Following an initial assessment of the information about her life experiences, and the risk to Nyota, they were aware that Kathryn was in an abusive relationship with Brent.

6.4.24 Children's Services had assessed Brent in May 2021 and had stated that they had "no concerns" about him. Children's Services have confirmed that the risk assessment had included the consideration of the information provided by the police, including the domestic abuse. At that time Brent was seen as supportive and a stable factor in her life as he was providing "*emotional support*". This assessment appears to have provided agencies with a false sense of security and prevented further professional curiosity about the risks in the relationship. The primary focus for all agencies on mental health and drug dependency could also account for why some failed to be professionally curious about the relationship itself. risk this impacting on her ability to keep Nyota.

6.4.25 The review has highlighted the need for professionals to be constantly aware of changing circumstances within relationships and family life, and therefore there continues to be a need for ongoing assessments of risk and the awareness of the impact of the decisions that are made in such circumstances. All professionals need to remain vigilant and professionally curious and conduct or review assessments at every contact[10]. (**Recommendation 11**).

6.4.26 It could be argued that Kathryn would have met the Care Act 2014's definition of an adult at risk because she was accessing mental health services and was dependant on drugs and alcohol. As a result of these complex needs Kathryn had care and support needs, and due to the coercive control in her relationship with Brent, it was probable that she was unable to protect herself from abuse and neglect. In July 2018 the local drug and alcohol support service raise a safeguarding adults concern with the council. The ASC IMR writer found that the referral contained a lot of information but was not clear about what was being asked of the service. The contact did not correctly record that there were safeguarding concerns. This was despite Kathryn being homeless (at the time Kathryn was living in a tent with a person with a person who was reportedly abusive to her), she had various mental health diagnoses, was reported as underweight and she was in significant debt.

6.4.27 At that time consideration was given to the statutory criteria (Care Act S.42(1)) for referrals and the conclusion was reached that there was "*No evidence of care and support needs…".* This was a poor assessment of the information and requirement to act at that time. Since this time, the North Somerset 'Raise a Safeguarding Adults Concern Form' has been updated and asks professionals to be explicit about what action they feel needs to be taken. The IMR writers suggest that the form should be continually promoted across all agencies (**Recommendation: 12**).

6.4.28 In this case Kathryn's voice was not represented either in the referral or in the response by ASC. Processes have since been adjusted to ensure improved application of procedures, such as involving the adult at risk at all stages, but the ASC IMR writer identified that further assurance work was required to demonstrate that this practice is fully embedded in frontline procedures (**Recommendation: 13**).

[10] This is a practice routinely conducted by the police and NextLink.

## 6.5 Mental Health Support for Kathryn

6.5.1 Kathryn's mental health and life experiences had been significantly impacted by her exposure to trauma in her childhood. This trauma included emotional abuse and neglect by her father and stepmother, and she had also been severely traumatised by the death of her mother.

6.5.2 Over the years there is evidence to indicate that Kathryn's mental anxiety had increased, and on occasions this would have had an impact on her ability to make rational decisions.

6.5.3 Health professionals working for AWP were aware that Kathryn had been diagnosed with mental health concerns, was vulnerable to drug misuse, and latterly through information sharing with partner agencies that she had been the victim of abuse. Kathryn had not made any specific disclosures of abuse by Brent although she had indicated to Health professionals that her "*partner did not understand her illness*".

6.5.4 Kathryn had received support from community mental health services and had a care co-ordinator. Kathryn was unfortunately unable to sustain engagement which resulted in the formulation work being incomplete and the treatment phase not commencing. Despite repeated attempts to engage with her these were unsuccessful, and this resulted in a therapeutic discharge in 2022.

6.5.5 Despite Kathryn's mental state and her diagnosis of borderline personality disorder she was deemed to have capacity by those that were treating her. Kathryn's capacity however would appear, on occasions, to be impaired by the level of coercion and control that both Brent and formally William exerted. The impact that this abuse was having on Kathryn's ability to make rational decisions does not appear to have been considered by those professionals who were trying to assist her. If it was considered, then it was not documented.

6.5.6 Annika has stated that due to her mental health diagnosis and the pressures that Kathryn was experiencing agencies needed greater flexibility in the services and support that they were offering. Annika has stated that Kathryn felt overwhelmed by agency contact and such approaches simply alienated her further from services. When Kathryn did attend the initial appointment, she was informed that there was a two-year waiting list for therapy which again impacted on her confidence in services[11]. This was discussed at Panel, and it was acknowledged that there are difficulties for individuals to access the correct therapy when they have co-occurring complex needs. North Somerset Public Health are currently working on a Dual Diagnosis Strategy that will address this issue.

## 6.6 Safeguarding/Welfare - Support for Kathryn and Nyota

[11] The review identified that whilst current commissioned services are effective the demand for such intervention far outweighs the resources and funding that is available. This is regularly reviewed by those commissioning the services.

6.6.1 Kathryn's life experiences would appear to have had a profound impact on her mental wellbeing. Agencies had worked with Kathryn when she was pregnant to inform her of the consequences of this addiction on her daughter. Kathryn was aware that unless she could change her daughter could be taken from her as she was perceived as at risk from her mother's addiction. The concern shown by agencies and the possibility of losing her daughter had led to Kathryn fearing services and being overwhelmed by professionals.

6.6.2 Whilst CSC professionals had tried to support Kathryn at this time it is not clear that they fully understood or were aware of the pressures that Kathryn felt and consequently had failed to reassure her that they would support her to keep Nyota. On occasions the assessments whilst appropriate and timely with regards to the child safeguarding process had also failed to fully appreciate any adult safeguarding considerations for Kathryn (**Recommendation: 14**).

6.6.3 In December 2022 CSC were notified that Kathryn had been physically assaulted by Brent. CSC formed a plan for her to stay with Annika for the weekend as Kathryn had stated that she was feeling unsafe in Weston Super Mare. CSC supported Kathryn to take Nyota to another area.

6.6.4 North Somerset CSC notified Birmingham's Children's Trust that Kathryn and her daughter had moved to their area. The referral highlighted that Kathryn was a victim of domestic abuse and that Nyota had been on a child protection plan in the past due to concerns over Kathryn's drug use. Whilst this referral was received it was not acted on until a Health Visitor in that area raised concerns in January 2023 that she was unable to locate Kathryn and that Kathryn had left Annika's address to go to a refuge. The Health Visitors concerns related to Kathryn's poor state of mental health and previous drug use. The Health Visitor had been told that the case was closed as there were no immediate concerns raised at the time of referral. From the records held the concerns that were raised at that time by the Health Visitor were not acted upon and/or followed up. This is poor practice as enquiries should have been made to establish her whereabouts and the safety of Nyota. Further contact should also have been made with North Somerset CSC so that both services could work together to ensure that both Kathryn and Nyota were safe and well (**Recommendation: 15**).

## 6.7 Risk Management

6.7.1 On each of the occasions when Kathryn was seen by Health Professionals she was appropriately assessed in terms of her immediate needs and support was initiated to address the risk factors that had been identified. On many occasions professionals used Kathryn's case history and multi-agency information to inform the process and this demonstrated a trauma informed approach. The risks of her self-harming and the possibility of Kathryn taking her own life were considered, and the decisions that were made were based on her presentation and her perceived capacity to rationalise her behaviour. These risks were reviewed from the perspective of her mental health and not necessarily from a perspective of domestic abuse.

6.7.2 The current North Somerset Suicide Prevention and Self Harm Plan acknowledges that those with complex mental health needs, and who have a self-harm history, are more likely to take their own lives, but there is no specific mention of the link between deaths by suicide and domestic abuse. Whilst this is probably due to the low numbers that have been identified there needs to be a greater acknowledgement of the impact of abuse (**Recommendation:16**).

6.8 **Operational Practice, Policy, and Procedure**

6.8.1 The review of Kathryn's medical GP records showed that they were incomplete. It is possible that GPs looking after Kathryn at the time when her records are missing may have offered more support and/or coded these risks into her records for future reference but this data was missing from the records. It is important to make reasonable attempts to recover missing data and close these gaps in patient records where possible. This can be done with support from PCSE (Primary Care Support England) but remains a National issue (**Recommendation:17**).

6.8.2 Whilst there were some good examples of trauma informed practice by agencies (e.g. We Are With You) in building up relationship/trust with Kathryn the information that was held was not shared effectively across the relevant agencies. There was wide acceptance that the trauma informed approach needs to be further embedded in North Somerset. North Somerset Council have now employed a consultant to embed trauma informed practices across the organisation and they will also look at wider systems change. This should be seen as good practice and address the issues identified in this review.

## 7.0 Conclusions

7.1 At the time that Kathryn took her own life she had a history of self-harming and she was suffering from increasing bouts of anxiety.

7.2 Over the years and prior to her death, there is evidence within records indicating that Kathryn's mental health had deteriorated. This deterioration would appear to have been partly attributable to her early life experiences and the trauma that she suffered during her formative years.

7.3 During that deterioration in Kathryn's mental health, she had been offered several therapeutic and counselling services and she was being treated by community services. Kathryn also came into regular contact with other statutory and domestic support services. Despite these interventions no single professional had a clear understanding of the coercion, control and abuse in her life as Kathryn felt unable to disclose it.

7.4 From the facts presented Kathryn had suffered domestic abuse throughout her adult life, and during her relationships with both Brent and William. This abuse had been psychological, physical, sexual, emotional, financial and economical.

7.5 When Kathryn presented in crisis to health professionals, they had made appropriate assessments, and she was encouraged to consent to referrals to other areas of specialist support. Where possible referrals were made for additional help and support, and this was provided when Kathryn consented and felt that she was able to engage.

7.6 There were several occasions where Kathryn felt unable to engage with services or make any formal report against Brent. Kathryn's reactions were largely driven by the coercive controlling behaviour of Brent, by the fear that Nyota would be taken away from her and because she felt that services didn't believe her. These factors in her life clearly presented barriers to disclosure and were not widely understood by the professionals who interacted with her.

7.7 Despite Kathryn feeling unable to engage with services, and often feeling overwhelmed by agency interaction, there was evidence in records that she had been encouraged to do so and for her to seek out support. Kathryn was signposted to several agencies including specialist domestic abuse workers by agencies and by her close friend.

7.8 There has been nothing identified in this review that would indicate that Kathryn was unfairly disadvantaged by agencies because of her life experiences but agencies have identified that there were opportunities where a greater degree of professional curiosity could have been shown.

7.9 Information sharing and record accuracy across agencies was variable. There were gaps in the records held by Primary Care Services and their processing of important information was often lost in the IT systems that were used. According to Annika Kathryn was frustrated by the quality of the information that she had received by all agencies and the inability to get her own life back on track by a system that requires inordinate amounts of identity. This was particularly evident when contacting her bank for assistance to break the cycle of economic abuse that she found herself in.

7.10 There were also occasions when Kathryn's voice was lost in the systems and processes that were followed by agencies.

7.11 Whilst opportunities were missed there were also many occasions where agencies submitted the relevant referrals to each other and they had discussed Kathryn's case.

7.12 The agencies in this case have confirmed that their policies, practices and training have all developed in the intervening period since Kathryn took her own life, and that their expected response to domestic abuse is clearly stipulated. Agencies do monitor their responses to domestic abuse but they must continue to robustly and continually quality assure practice if tragic cases like this are to be prevented in the future.

7.13 There have been several areas of learning that have been identified because of this review. The recommendations that have been made will seek to further improve and strengthen current policy and practices in the North Somerset area.

## 8.0 Lessons to be Learned

8.1 The learning from this review is detailed below;

**Learning point 1:** Kathryn had wanted to make her own financial decisions but had found additional barriers when trying to establish her own financial security. Kathryn had contacted her bank for support but found it difficult to obtain the additional identification documents that she needed to secure access. Her bank had also refused to speak to Annika who was trying to assist her at that time, and the fact that it was an international call centre made communication difficult.

**Learning Point 2:** The review has identified that the coding of domestic abuse in Primary Care services varies across individual practice. This is a national issue and needs to be resolved for practitioners to easily recognise patients at risk of DA.

**Learning Point 3:** Within Primary Care the registration of new patients could be considered an opportunity to screen for safeguarding risks and prior history of domestic abuse. This would allow for increased information sharing, opportunity for disclosure and increasing threshold for professional curiosity.

**Learning Point 4:** A new IT system had been implemented at Kathryn's GP practice for the triaging of online requests (e-consult). The automated data-gathering did not include any screening questions for difficulties at home. There is a need to review how safeguarding data is gathered and triaged to improve the outcomes for those people who may be at risk.

**Learning Point 5:** The Primary Care IMR writer identified that internal processes and IT need to be updated to improve data collection, documentation and coding which will assist in identifying and promoting effective safeguarding and the management of identified risks.

**Learning point 6:** The importance of promoting current DA and safeguarding training for Primary Care staff working within North Somerset has been demonstrated throughout this review process to ensure that they recognise domestic abuse and embed professional curiosity into practice.

**Learning point 7:** There is a need to ensure that patient records are linked to include all family members and partners. This would allow those in Primary Care to adopt a "Think Family Approach."

**Learning point 8:** The review identified that there was a safeguarding training need for Primary Care administrative staff to ensure that they can accurately code safeguarding information and escalate concerns to GP's.

**Learning point 9:** Kathryn had reportedly been given inaccurate advice from her housing association when she had to leave her home address. All members of staff

need to be conversant with the associations domestic abuse policy and be sufficiently trained to provide effective advice and guidance.

**Learning point 10:** Kathryn had reportedly been given inaccurate advice by refuge staff when she relocated there and this had left her feeling vulnerable and at risk. The advice was contrary to what the police had asked Kathryn to do about using her mobile phone. Kathryn also felt that the staff members that she had spoken to provide had failed to provide her with effective financial support advice and guidance.

**Learning point 11:** Where agencies conduct risk assessments in any relationship there is a requirement to dynamically update them at the point of each contact and /or when new information comes to light that impacts on its accuracy.

**Learning point 12:** There were missed opportunities to hear Kathryn's voice within ASC. Processes have since been adjusted to ensure improved application of procedures, such as involving the adult at risk at all stages but this requires further monitoring to ensure that changes have been embedded into practice.

**Learning point 13:** The referral in July 2018 should have contained comprehensive information about what was being asked of adult social care. Whilst the North Somerset 'Raise a Safeguarding Adults Concern' form has been updated the Adult Social Care needs to provide evidence that it's improved the quality of referrals.

**Learning point 14:** Assessments conducted as part of child safeguarding need to fully consider and document the needs and risks identified for parents and carers.

**Learning point 15:** In this case concerns were raised by a Health Visitor who was unable to verify the whereabouts of Kathryn and Nyota. Birmingham Children's Trust need to ensure that where concerns are raised by any person then there are quality assurance processes in place to check that all available enquiries have been conducted.

**Learning point 16:** The current North Somerset Suicide Prevention and Self Harm Plan acknowledges that those with complex mental health needs, and who have a self-harm history, are more likely to take their own lives but there is no specific mention of the link with domestic abuse. Whilst this is probably due to the low numbers that have been identified there needs to be a greater acknowledgement of the impact of domestic abuse.

**Learning point 17:** The review of Kathryn's medical GP records showed that they were incomplete, they begin in 2007 (when Kathryn was aged 17) and there are other gaps in the health records prior to 2021. On review it was believed that her last practice may not have had access to her whole history. The Primary Care IMR identified that Health record gaps can occur for a variety of reasons including IT / technical problems at the time of deregistration and registration between practices etc. It is important to make reasonable attempts to recover missing data and close these gaps in patient records where possible, particularly for victims of abuse.

## 9.0 Recommendations from the Review

9.1 The learning opportunities identified in this case that have resulted in the recommendations that are listed below. The progress made by all the agencies against their recommendations will be monitored by a scrutiny group which has now been established in North Somerset.

**Recommendation 1 (National)**: North Somerset CSP to write to the DA Commissioner to highlight the specific learning from this case about the need for additional support for victims and their advocates when dealing with the banking sector. The letter should also identify the need for banks to be clearer about their support offer to victim-survivors of domestic abuse and how to access the specialist teams that exist.

**Recommendation 2**: North Somerset CSP to write to NHS England and the National Network of Named GPs to highlight the need for standardisation of coding for DA risks across Primary Care Services.

**Recommendation 3**: ICB to work with One Care to develop a supplementary registration information form for use across BNSSG, which includes safeguarding questions and risk assessment.

**Recommendation 4**: The ICB to write to e-consult to share the findings from the statutory review and request that they review how safeguarding data is gathered and triaged.

**Recommendation 5**: ICB to work with GPCB to update the Safeguarding elements of Emis Templates, to improve safeguarding data collection, documentation and coding.

**Recommendation 6:** The ICB to promote and deliver safeguarding training to primary care staff, to familiarise them with the signs and symptoms of domestic abuse and embed professional curiosity in practice.

**Recommendation 7**: ICB to work with GPCB on implementing the "Think Family Approach" to safeguarding by developing Emis guidance for Primary Care on how to link patient records for patients who are related or in a relationship.

**Recommendation 8:** ICB to undertake safeguarding training for Primary Care Admin staff, to promote accurate escalation and coding of safeguarding information to GPs.

**Recommendation 9:** The Housing association to ensure that all its staff are trained in domestic abuse and that their policies and practices adhere to the standards laid down by the Domestic Abuse Housing Alliance.

**Recommendation 10:** The refuge to ensure that all its staff are trained in the risks around IT surveillance and are sufficiently informed to provide comprehensive advice to victims/survivors about how they obtain identity documents, seek financial assistance or secure their financial accounts.

**Recommendation 11:** CSC, Public Health Services, Housing association, Homeless Prevention Team, WithYou, UHBWNNHST, AWP and ASC[12] to review their policies and current risk assessment guidance to ensure that routine questions are asked about ongoing safeguarding concerns and domestic abuse at each point of contact with clients.

**Recommendation 12**: ASC to publicise and promote use of SA referral form to all external agencies and ensure that a quality assurance process is in place to monitor referrals and conversion rates from concerns to enquiries in domestic abuse related cases.

**Recommendation 13**: North Somerset Adults Board to assure itself that SA policy and processes in the County have a clear expectation and application of hearing the individual's voice across the partnership.

**Recommendation 14:** CSC to review and update their risk assessments to ensure that all known risks including those to parents and carers are documented, assessed and where appropriate reported to ASC.

**Recommendation 15:** Birmingham's Children's partnership to assure itself that there are quality assurance processes in place to check that all available lines of enquiry have been conducted and information shared to appropriate agencies before cases are finalised.

**Recommendation 16:** North Somerset Public Health to ensure that the links between self-harm, deaths by suicide and domestic abuse are detailed within the Suicide Prevention Strategy and considered in any preventative work conducted in the area.

**Recommendation 17: (National):** North Somerset CSP to write to Primary Care Support England to highlight the need for a review of current Primary Care IT systems to ensure that missing data in patient records, specifically relating to domestic abuse, is remedied at the earliest opportunity.

[12] Within Primary Care this will be achieved through recommendation 5.

## Glossary

| | |
|---|---|
| A&S | Avon and Somerset |
| ACE's | Adverse Childhood Experiences |
| AFFDA | Advocacy After Fatal Domestic Abuse |
| A&S Police | Avon and Somerset Police |
| AMHP | Approved Mental Health Professional |
| ASC | Adult Social Care |
| BNSSG | NHS Bristol, North Somerset and South Gloucestershire |
| BWV | Body Worn Video |
| CCB | Controlling and coercive behaviours. |
| CMHT | Community Mental Health Team |
| CN | Community Nurse |
| DA | Domestic Abuse |
| DASH | Domestic Abuse, Stalking and Honour Based Violence |
| DH | Domestic Homicide |
| DHR | Domestic Homicide Review |
| DVA | Domestic Violence & Abuse |
| ED | Emergency Department |
| EDS | Emergency Duty Service |
| GP | General Practitioner |
| HO | Home Office |
| HV | Health Visitor |
| ICB | Integrated Care Board |
| IMR | Independent Management Review. |
| IPVA | Interpersonal Violence and Abuse |
| MCA | Mental Capacity Act. |
| MH | Mental Health |
| MHAA | Mental Health Act Assessment |
| NHS | National Health Service |
| NHSE | National Health Service England |
| NS | North Somerset |
| NSC | North Somerset Council |
| UHBWNHST | University Hospitals and Western NHS Foundation Trust |
| RE | Routine enquiry. |
| SEA | Surviving Economical Abuse Charity |
| SWAST | The South Western Ambulance Service NHS Foundation Trust |
| VAWG | Violence Against Women and Girls |