



North Somerset Safer Communities
DRAFT 1
Victim: Kathryn (DHRS8)
Year of Death: August 2023.

Author: Paul Northcott

Date the review report was completed: 13th January 2025

Contents

Contents	2
Preface	3
1.0 Introduction	4
2.0 Timescales	4
3.0 Confidentiality	5
4.0 Methodology	5
5.0 Involvement of family, friends, neighbours and the wider community	8
6.0 Contributors to the Review	8
7.0 The Review Panel Members	9
8.0 Author of the Overview Report	10
9.0 Parallel Reviews	11
10.0 Equality and Diversity	11
11.0 Dissemination	13
12.0 Background Information (The Facts)	14
13.0 Chronology	16
14.0 Overview	27
15.0 Analysis	32
16.0 Conclusions	57
17.0 Learning	59
18.0 Recommendations	61
Glossary	63
Bibliography	64

Preface

As the Independent Chair and author of this report I would like to thank all the agencies for their active involvement in this review and in assistance with its findings. I would also like to thank Kathryn's best friend who was invaluable in providing an insight into her life which we would not have had otherwise. The below paragraphs are Annika's reflection on Kathryn's life experiences.

Kathryn was an intelligent and empathetic woman. She hated being labelled as vulnerable or being considered as a victim, no matter what she suffered. Kathryn experienced the loss of her mother when she was 6 years old, she suffered emotional abuse in childhood, and tackled drug addiction and street homelessness as a young adult. Kathryn was resilient and determined in many ways. When Kathryn fought, she fought with all her might. Kathryn's trauma meant that when she loved, she loved unconditionally and without boundaries. She forgave all trespasses and could not tolerate being alone. She wanted to feel loved and appreciated.

Kathryn was fearful of agencies after her daughter was born, worried she would lose her child. Her daughter was the most important person to her and she loved her more than anything else. Kathryn wanted Nyota to have a safe and stable home, but she couldn't build one alone.

DRAFT 1

1.0 Introduction

- 1.1 This report was commissioned by North Somerset Safer Communities Partnership and examines the interaction that local agencies had with Kathryn prior to her death in August 2023. The key purpose for undertaking a Domestic Homicide Review (DHR) is to enable learning from those deaths where a person has died and where domestic abuse was or could have been a factor.
- 1.2 In this case North Somerset Safer Communities Partnership wanted to review the death of Kathryn to establish if there had been effective intervention by agencies, and whether she had been a victim of abuse prior to her taking her own life. The report will examine the past to identify any relevant background or trail of abuse, and through a holistic approach identify appropriate solutions to make the future safer.
- 1.3 This report will consider the contact and involvement that agencies had with Kathryn between the dates of 1st September 2016 and August 2023. The reason that members of the Panel chose these dates is that they provide a time frame during which agencies had the greatest amount of contact with Kathryn whilst she was in a relationship with Brent and her previous partner William. Members of the Panel wanted to understand and learn from Kathryn's experience of service contact, and the support that was provided to her.
- 1.4 Every effort has been made to conduct this review process with an open mindset and to avoid hindsight bias. Those leading the review have made every attempt to manage the process with compassion and sensitivity.

2.0 Timescales

- 2.1 The decision to commission a review was taken by the Chair of the North Somerset DHR Advisory Panel on the 21/09/2023. The Home Office were informed of the decision to undertake a review on the 07/11/2023. The review was conducted in accordance with the Home Office Multi Agency Statutory Guidance for the conduct of Domestic Homicide Reviews (2016).
- 2.2 This review began on the 12/12/2023. There was a delay between commissioning the report and starting the process due to initial scoping inquiries and appointing a suitable Chair. Further delays occurred because of the need to contact organisations outside of the North Somerset area. Obtaining information from these organisations proved difficult despite repeated efforts by the CSP.
- 2.3 The Home Office Statutory Guidance advises that where practically possible the review should be completed within six months of the decision made to proceed with the process. For this reason, an initial timetable was drawn up to ensure that agencies complied with this request. The review was unable to be completed in the six-month time frame due to;
- Initial scoping inquiries (a large amount of information that was held by agencies and this impacted negatively on the completion of the IMRs) and appointing a suitable Chair.

- The need to contact organisations outside of the North Somerset area. Obtaining information from these organisations proved difficult despite repeated efforts by the CSP.

2.4 The first panel meeting was held in December 2023. Following this meeting, the draft terms of reference were drawn up and circulated to the members of the DHR Panel. The Panel agreed upon their content and reviewed them at subsequent meetings.

2.5 The review concluded on the 13th January 2025 after a final meeting with Annika who was a close friend of Kathryn's and her advocate. The North Somerset Safer Communities Partnership actively oversaw the progress of the review throughout the process.

3.0 Confidentiality

3.1 The findings of this review are confidential. The Information obtained as part of the review process has only been made available to participating professionals, and their line managers.

3.2 Before the report is published the North Somerset Safer Communities Partnership will circulate the final version to all members of the review panel, the Chief Executives of their agencies, and the family members (should they want to see the report). The family will be notified of the publication date. The family will be consulted about key dates to avoid for publication and the CSP will provide appropriate support for them should there be media interest.

3.3 The content of the overview report has been anonymised to protect the identity of Kathryn, relevant family members, and all others involved in this review. As Kathryn's family had declined involvement in the review her closest friend was consulted about the pseudonym/s used in this review and the following were agreed;

Family composition and pseudonyms used.

- Kathryn - Deceased female.
- Brent – Deceased females' partner (although they had separated prior to her death).
- William– Deceased females' previous partner.
- Nyota – Deceased females' child.
- Annika – Kathryn's close friend.

3.4 Kathryn was aged thirty-four at the time of her death and in terms of ethnicity she was a white European. Brent was thirty-three at that time and in terms of ethnicity he was a white European.

4.0 Methodology

4.1 Domestic Homicide Reviews were established on a statutory basis under section 9 of the Domestic Abuse, Crime and Victims Act (2004). The Act, which came into force on

the 13th of April 2011, states that a DHR should be a review 'of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by:

- a. A person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship or.
- b. A member of the same household as him/herself; held with a view to identifying the lessons to be learnt from the death¹.

4.2 The methods for conducting DHR's are prescribed by the Home Office guidelines¹. These guidelines state;

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

In addition to the above North Somerset Safer Communities Partnership also agreed that the review should;

- To 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.

¹ Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews; Home Office: Dec 2016

- 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.

4.3 In order to ensure that the review was comprehensive the North Somerset Safer Communities Partnership contacted twenty-three agencies to see if they had contact with the family.

4.4 All those agencies who were identified as having contact with the family were asked to secure relevant documents, and appropriate professionals were invited to become members of the DHR panel. Relevant agencies were then asked to complete

chronologies and where appropriate Individual Management Reviews (IMR's) were requested (these are specified in Section 6).

- 4.5 Numerous attempts were made by the CSP to obtain additional information from a refuge in Gloucestershire. Despite escalation and repeated requests that information was not provided. Whilst not pivotal to the review this information would have assisted in providing additional information about the support that was provided to Kathryn.
- 4.6 Additional information was also reviewed by the Chair of the Panel and this included reading local and national DHR's and reviewing policies and procedures. The North Somerset Suicide Prevention and Self-Harm action plan was also reviewed due to the circumstances of this case.
- 4.7 Body worn video (BVW) footage was also reviewed by the A&S Police IMR writer.

5.0 Involvement of family, friends, neighbours, and the wider community

- 5.1 Kathryn's father was approached by the CSP and asked if he wanted to take part in the review process but he declined. He had been provided with a letter summarising the rationale behind the review and he was sent the leaflet prepared by the Home Office about the DHR process. He declined to see the terms of reference.
- 5.2 Kathryn's closest friend, Annika attended one of the Panel meetings to provide an overview of Kathryn's life, and to articulate the issues that she had raised in conversations with her about the way that professionals and services responded the reports of abuse. Annika was supported by a representative from AAFDA. Annika was provided with the terms of reference for the review and she and her advocate were updated on a regular basis. Annika was also provided with a copy of the report prior to finalization to ensure that it accurately reflected Kathryn's life experiences. Annika had the opportunity and time to make amendments to the report and agreed on the final version on the 13th January 2025.
- 5.3 One of Kathryn's previous partners (their relationship occurred between 2015-2017) also contributed to the review process. Their relationship was brief and not abusive. Whilst this partner had maintained contact with Kathryn, they were unaware of the abuse that she had endured in her other relationships.
- 5.4 Two of Kathryn's employers were contacted for relevant information, and neither were able to provide any further details that could assist the review process.
- 5.5 Brent was sent a letter and asked if he wanted to take part in the review process, but the CSP received no response from him.

6.0 Contributors to the Review

- 6.1 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 - Information²
- 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
- South Wales Police - Information

- 6.2 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.
- 6.3 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.

7.0 The Review Panel Members

- 7.1 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)

² GP where Kathryn was registered whilst at a mother and baby unit.

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)
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

- 7.2 The North Somerset Safer Communities Partnership ensured that there was scrutiny and accountability throughout the DHR process particularly in respect of independence and impartiality. All the panel members were independent. None of the panel members knew the individuals involved, had direct involvement in the case, or had line management responsibility for any of those involved. This was confirmed by agencies at the initial panel meeting.
- 7.3 Responsibilities directly relating to the commissioning body, namely any changes to the terms of reference and the agreement and implementation of an action plan to take forward the recommendations in this report are held by the North Somerset Safer Communities Partnership.
- 7.4 The Panel met formally on five occasions. Contact was made with Panel members on a regular basis to clarify issues and matters of accuracy about their agency's involvement with the family. Documents including draft reports were circulated electronically to members and discussed on an individual basis, as were the themes identified from the review process.

8.0 Author of the Overview Report

- 8.1 The North Somerset Safer Communities Partnership appointed Paul Northcott as Independent Chair and author of the overview report in December 2023.
- 8.2 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.
- 8.3 Paul retired from the police service in February 2017. Prior to this date Paul had worked in London for three years on a National Programme of work.
- 8.4 North Somerset Safer Communities Partnership is aware of the Home Office's requirements around commissioning an independent Chair and report writer and that Paul had the requisite skills and experience to undertake this case. Paul has not previously worked for the Police Force, nor any of the agencies involved in this review.
- 8.5 Paul has been trained as a DHR Chair, is a member of the DHR network and has attended AAFDA³ webinars.

9.0 Parallel Reviews

- 9.1 Following the police investigation the death of Kathryn was referred to the HM Coroner's office. The CSP lead and the Independent Chair met with a representative from the Coroner's office prior to inquest to ensure that relevant information from the review was shared with them.
- 9.2 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.
- 9.3 There were no other reviews or investigations taking place at the time that this report was submitted to the Home Office.

10.0 Equality and Diversity

- 10.1 The review adheres to the Equality Act 2010 and all nine protected characteristics (age, disability, gender re-assignment, marriage and civil partnerships, pregnancy and maternity, race, religion and belief, sex, or sexual orientation) were considered by the Panel as part of the terms of reference and throughout the review process.
- 10.2 Kathryn and her ex-partner were white English nationals and from the information that was available he was heterosexual and she was bisexual. Kathryn was aged thirty-four when she took her own life. Brent was also aged thirty-three at that time.

³ Advocacy After Fatal Domestic Abuse.

- 10.3 Domestic abuse perpetrated towards women by men is a form of violence against women and girls (VAWG) and it is often linked in research to wider gender inequality, misogyny, and perceptions around harmful gender norms.⁴ While interpersonal violence and abuse (IPVA) affects a significant number of individuals, families, and communities⁵, it is disproportionately experienced by women and perpetrated by men⁶. The Crime Survey for England and Wales estimated that 5.0% of adults aged 16 years and over experienced domestic abuse in the year ending March 2022; this equates to an estimated 2.4 million adults (1.7 million women and 699,000 men).
- 10.4 Research has identified that women are more likely to encounter, repeated, systematic and more severe Interpersonal Violence and abuse (IPVA), resulting in injury and/or death⁷. Statistics⁸ also show that almost all perpetrators convicted for controlling and coercive behaviour in England and Wales in the year ending Dec 2020 were male (97%).
- 10.5 There is also a corresponding impact in terms of Domestic Violence and Abuse (DVA) impacting on the mental health of female victims leading to victims taking their own lives and suicidal ideation⁹. This research has shown that women who have experienced IPVA are also three times more likely than those who have not experienced abuse to have attempted to take their own lives in the past year. In those cases which involve sexual abuse women are seven times more likely than those who had not experienced sexual IPV to have attempted to take their own lives in the past year. IPVA involving sexual violence is ten times more common in women than in men¹⁰. In this case Kathryn had initially been diagnosed with an emotional intensity type disorder and later a borderline personality disorder. This had a significant impact on her ability to cope with daily life. Mental health problems can be considered a disability and therefore relevant when considering equality.
- 10.6 There is a complex interplay between domestic abuse and alcohol and drug dependency. Evidence of substance misuse in a victim's life should be understood not as a "causal factor for domestic abuse" but rather as a "symptom" of that abuse. A recent analysis of data¹¹ on people's experiences of four domains of disadvantage – homelessness, substance misuse, poor mental health, and violence and abuse – identifies a cluster of 17,000 people in the UK experiencing all four domains, of whom 70 per cent are women. Of a larger group of 336,000 adults experiencing three or four of these domains, approximately half were women¹².
- 10.7 International evidence identifies that it is predominantly men who tend to perpetrate more assaults when they have been drinking¹³ and women are more vulnerable to

⁴ Guedes et al 2016

⁵ Baker et al, 2013; Ali et al, 2016

⁶ Stark, 2007; Hester, 2013; Walby et al, 2017

⁷ Long et al, 2021; Monkton et al, 2014

⁸ Women's Aid 2021

⁹ Women's Aid 2021

¹⁰ Agenda Alliance (2023)

¹¹ Sosenko et al. 2020

¹² Department for Levelling Up, Housing and Communities 2024

¹³ Graham et al., 2011; Reno et al., 2010

being victimised when they have become intoxicated¹⁴ through alcohol. Such research also shows that the use of alcohol and/or illicit drugs is a form of “self-medication”¹⁵ and a way for some victims to escape their life experiences and the abuse that is occurring in their relationships.

- 10.8 Substance misuse also features in around half of all UK domestic homicides. Since 2011, substance use has been detected among domestic homicide perpetrators more than four times as often as it has among those killed by them^{16/17}. Whilst similar data is not readily available in terms of suicides linked to abuse, it is thought to be similar.
- 10.9 Age is an important factor in this review. Research has shown that young people (18–25) are at particular risk of intimate partner violence and abuse (IPVA) by a current or former partner¹⁸. National UK crime surveys consistently report young women to be at greater risk of victimisation than those over 25 (ONS, 2021). Rates in adolescents and young people are high with a reported prevalence of up to 97% for emotional and psychological violence. In the latest figures from the Office of National Statistics for England and Wales (2022), the prevalence of IPVA is highest in the 20–24 years group (6.3%) as compared to the age 35–44 group with the next highest prevalence (4.2%)¹⁹. In this case the abuse reported by Kathryn started when she was within these age ranges, and this will be discussed further in the analysis section of this report.
- 10.10 'Disability' has a special legal meaning under the Equality Act, which is broader than the usual interpretation. The Equality Act states that you have a disability if you 'have a physical or mental impairment that has a substantial, adverse, and long-term effect on your ability to carry out normal day to day activities'²⁰. Whilst a dependency on drugs and alcohol isn't classed as a disability, it could become so if the addiction causes an impairment. In Kathryn's case her impairment, in terms of her suffering from mental anxiety, was long term (longer than twelve months) and the combination of her symptoms linked to alcohol and drug use coupled with mental anxiety meant that her ability to cope with day-to-day life was impaired. Arguably Kathryn would have also met the Care Act (2014) definition of being an adult at risk because she had care and support needs and was experiencing abuse. This will be explored further in the analysis section of this document.
- 10.11 On considering all the factors in this case it was concluded that there was no evidence to indicate that Kathryn or Brent were directly or indirectly discriminated against by services or individuals with whom they came into contact in terms of the nine characteristics. Nor was there any evidence of intersectional discrimination.

11.0 Dissemination

¹⁴ Iverson et al., 2013

¹⁵ AFFDA (2022)

¹⁶ Home Office, 2016

¹⁷ Graham et al 2011

¹⁸ Stonard et al., 2014

¹⁹ Barnes et al 2023

²⁰ MIND (2022)

11.1 Following approval from by the Home Office the final report will be disseminated to the following organisations/partnerships;

- North Somerset Safer Communities Partnership
- Police and Crime Commissioner – Dorset and A&S Police
- Avon and Somerset Police (A&S Police)
- North Somerset Substance Misuse Commissioning Team
- Public Health Nursing Services – Health Visiting Service Sirona Care& Health
- Housing Association
- Homeless Prevention Team
- North Somerset Adult Social Care
- NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board
- North Somerset Public Health
- Avon & Wiltshire Mental Health Partnership
- Nextlink Domestic Abuse Support Services
- North Somerset Children’s Service
- Birmingham Children’s Trust
- Birmingham Children’s Partnership
- DA Commissioners Office
- North Somerset Adults Partnership
- Primary Care support England

11.2 In accordance with Home Office guidance all agencies and Kathryn’s family are aware that the final overview report will be published. Although key issues have been shared with specific organisations the overview report will not be disseminated until clearance has been received from the Home Office Quality Assurance Group.

12.0 Background Information (The Facts)

12.1 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.

12.2 Kathryn felt unwanted and she later described to health professionals that her childhood was “unhappy and horrible”. Her sense was that her father wanted her out of the way and “did not care” about her. These events had a significant impact on her life circumstances, mental health and would appear to have contributed to her becoming drug dependant.

12.3 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.

12.4 Kathryn was well educated and had aspired to attend University to undertake a clinical degree. The complexity of her life (drug dependency and mental health) continually

disrupted her education, and this meant that she didn't reach the goals that she had set for herself or which she could have achieved. Kathryn had felt no option but to drop out of college at the age of seventeen due to her mental health and the instability of her life.

- 12.5 Kathryn left her family home at the age of eighteen and had minimal contact with her family after that time.
- 12.6 In her teenage years Kathryn had been employed on a part time basis as pharmaceutical counter assistant. Kathryn later worked full time in this role before training as a pharmaceutical dispenser and was later promoted to that role on qualification. Kathryn eventually became a pharmaceutical technician but had to leave her employment due to suffering from anxiety and depression.
- 12.7 In 2015 Kathryn was able to secure employment as a dementia carer and she went back to college. The struggles with her mental health continued and in February 2017 she lost her job. Kathryn later secured a job working as a peer mentor with a local charity, but this only lasted for a few months.
- 12.8 Kathryn struggled to control her dependency with illegal drugs, and this 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 her the target of abusive men, who were physically, sexually, and emotional abusive to her. Most of these males were not known to agencies.
- 12.9 Kathryn had met William in 2010 whilst in Newport Wales when she was living with Annika. William subjected Kathryn to several violent assaults, the first reported one occurring in May 2017. Further reported incidents occurred in 2018 resulting in a Multi-Agency Risk Assessment Conference (MARAC). At that time Kathryn was street homeless and at one stage she had been living with William in a tent. Due to the pressures in her life Kathryn had also become a street worker as she had little access to money, other than state benefits which were often taken from her by the people that she encountered.
- 12.10 In this period of her life Kathryn was in debt, having mental health issues (self-reported diagnosed with personality disorder and anxiety) suffering from depression, had a history of self-harm and suicide ideation and was self-neglecting (low weight and loss of teeth). Kathryn was also using illicit drugs on top of her prescription medication. Kathryn had been diagnosed at that time with emotionally unstable personality disorder.
- 12.11 Kathryn and Brent started their relationship in July/August 2020 and the two of them lived in the North Somerset area. It is reported that Kathryn had met Brent at one of the lowest points in her life and this was when she felt no option but to work on the streets due to her financial position and mental health. Their relationship developed after Brent had been released from prison. Brent had a history of criminality including

being involved in illicit drugs but was not known for domestic abuse or other forms of violence prior to the reported incidents involving Kathryn.

- 12.12 Nyota was born in October 2020 and was seen by professionals as a stabilising factor in Kathryn's life. Professionals did not know the identity of Nyota's biological father as Kathryn only had a brief relationship with him and he chose not to have any contact with the child.
- 12.13 Throughout her adult life Kathryn had received help and support from Annika and others including a former partner, and it is evident that they had provided substantial assistance at her times of need. Annika provided financial, emotional and welfare support for Kathryn, whilst her former partner and their family members assisted her with toys and clothes for Nyota.
- 12.14 Kathryn's mental health was poor, she would suffer from bouts of depression for months and this would prevent her from leaving her home address. Annika has described how Kathryn would avoid "*emotional harm through using drugs and alcohol*".
- 12.15 At the time of death Kathryn had been living in social housing provided accommodation together with her two-year-old daughter, Nyota. Following several altercations and a break down in their relationship Brent had moved out of the address and had gone to live with his own family. From the records held by agencies and from the information received from Annika the two of them had continued to see each other.
- 12.16 In August 2023 Police attended Kathryn's home address (in the North Somerset area), after receiving a report from her partner Brent that he had entered the house (as he had a key) and found her hanging. Kathryn's daughter had been asleep upstairs. On that occasion Brent had returned to Kathryn's home address to see Nyota. Brent admitted to officers that he had had an argument with Kathryn in the early hours of the previous day and left soon after. According to Brent, the argument was about her "*insecurities and believing things that aren't true.*"²¹
- 12.17 Police records identified that there had been numerous reports of both verbal and physical abuse in the relationship between Kathryn and Brent and that her case had been discussed at MARAC.
- 12.18 A forensic post-mortem was carried out as Kathryn's death had initially been treated as unexplained. The post-mortem revealed that Kathryn's neck injuries were consistent with hanging.

13.0 Chronology

²¹ Brent would continuously use gaslighting techniques to deflect professionals from the abuse that Kathryn was being subjected too- see analysis section of this report.

- 13.1 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.
- 13.2 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. Where relevant these have also been included in this report as they add additional context about Kathryn's life. Only specific issues of relevance that relate to the content of this report have been included in this section.

Date	Comment
September 2010 ²²	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 ' <i>a prostitute who sold her belongings for drugs</i> '. Kathryn had felt the police were unprofessional and inappropriate in their response and immediately after this contact took an overdose. Due to the poor response Annika made a complaint to the police. The police closed this complaint as there was no evidence available to verify the details that had been reported.
14 th 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.
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. She told Annika that that someone had phoned the police when William had stamped on her throat, and the police arrested him but dropped him back at the property where she was staying when he was released. Annika spent the next day calling refuges and secured a place in one of them. In her conversations with Annika, Kathryn had recounted multiple examples of violence, and it is believed that she was also referring to the incident in May 2017. Kathryn had also explained that she could not rely on services like the police to keep her safe.
11 th 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

²² Some dates that have been included in this chronology are not specific as they were not fully recorded by Kathryn's friend Annika.

	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.
13 th May 2018	The police received a 3 rd party report of a domestic incident. On attendance, officers could still hear shouting within the address. Kathryn and William had had an argument about drugs. It was reported that Kathryn had been throwing things at him and he'd tried to stop her, by grabbing her by the throat. Neither wanted to engage with police or complete a DASH. Both were spoken to separately and an officer perceived DASH for Kathryn was rated standard. Officers could not be certain who was the aggressor at that time. Kathryn stated that she would leave the address, and the case was filed with no further action.
22 nd 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 noted that William had recently strangled her until she became unconscious and was exhibiting controlling/coercive behaviour. The referral was accompanied by a DASH rated high. The case was accepted for MARAC in June 2018. Kathryn had reported she did not want police contact at this time, and the referring practitioner thought that police contact may make matters worse. Kathryn was engaging with an IDVA and with Addaction.
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.
16 th July 2018	The Substance Misuse Commissioning Team received a notification of a safeguarding referral due to concerns for welfare. Those on the team were trying to encourage Kathryn to attend appointments weekly and to motivate her to work towards accessing residential treatment (working on CCA). Referrals were made to an emergency accommodation provider and MARAC, in addition to adult safeguarding.
24 th September 2018	Kathryn started detox at a specialist hospital.
9 th October 2018	Kathryn self-discharged from the specialist hospital and returned to live with William.
12 th August 2019	Homeless Prevention Team records show that they had a call from Night Assessment Centre (NAC). Kathryn had lost her accommodation at the centre due to not staying there. Concerns were

	raised that she was being exploited and a safeguarding report was raised.
20 th February 2020	Kathryn was discharged from a drug treatment centre for reportedly concealing prescription medicine (diazepam), which had been prescribed by a local GP against the centres policy. Kathryn also hadn't been participating in the groups. Addaction's clinical lead highlighted that Kathryn was not responsible for the GP prescribing error and asked if Kathryn could remain. This was refused. Addaction spoke to Kathryn who admitted she had messed up and she asked if she could go back to local rehab – unfortunately they were full. Arrangements were made for Kathryn to return and report to Housing in North Somerset. Unfortunately, she missed her train and Housing was closed. The drug treatment centre staff agreed to provide Kathryn with the emergency team number. On contacting Kathryn the next day, she stated that the non-medical prescriber ²³ hadn't contacted her. Kathryn reported that she hadn't been provided with emergency number and had spent the night on the streets. Emergency housing was found; and the local rehabilitation centre agreed to take her back when they had a vacancy if she can remain abstinent.
27 th February 2020	Kathryn was referred to the Primary Care Liaison Service ²⁴ by her GP for mental health support. She was described as having challenges with anxiety and suicidal thinking. Kathryn was discharged in May 2020 after there had been five failed attempts to contact her (phone, texts and letter).
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.
June/July 2020	Kathryn informed Annika that she had received a pre-proceedings letter from children's services and was really scared and overwhelmed.
15 th – 17 th 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 " <i>my little whore</i> " to his friends. He would constantly demean her and refer to the time that they met when, due to her life experiences, she had no choice but to work as a street worker.
26 th August 2020	Kathryn text Annika to apologise for not responding to her calls and stated that there had been " <i>an incident</i> " 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 to her was rape. Annika tried to speak to her about getting support and leaving

²³ A non-medical prescriber is a healthcare professional other than a doctor who can prescribe medicinal drugs.

²⁴ The Primary Care Liaison Service (PCLS) provides a first point of contact to access mental health services in North Somerset.

	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.
8 th September 2020	Specialist Community Perinatal Mental Health Service (SCPNS) assessment with Kathryn. Those present identified the risks associated with her drug misuse and the impact on her pregnancy. They also identified that she was using impulsive self-harm as a coping mechanism for difficult emotions. Kathryn's trauma history was discussed but there were no disclosures of domestic abuse by Brent at that time.
18 th September 2020	A SCPNS Consultant Psychiatrist called Kathryn for a review. The risk of further deterioration of her mental state was assessed as moderate. Kathryn was deemed to have capacity.
22 nd 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.
29 th September 2020	SCPNS referred Kathryn to the West Devon Perinatal Mental Health Team (WDPMHT). Five days later the referral was declined as the primary issue was drug misuse and did not meet their commissioned criteria.
12 th October 2020	Kathryn's daughter was born and approximately a week later they were moved to a baby rehabilitation unit for residential assessment.
30 th December 2020	A diagnostic and medication review was conducted at the baby rehab unit. Kathryn was diagnosed with emotionally unstable personality disorder (EUPD). Kathryn was given information about the disorder and informed of treatment options.
January 2021	A strategy discussion was held by CSC about Kathryn and Nyota's imminent discharge from the mother and baby unit, having no onward accommodation and the risks around Kathryn relapsing. It was agreed that Nyota would go on to a Child Protection Plan (CPP).
6 th January 2021	Housing were notified that Kathryn was due to be discharged from the mother and baby rehab unit. She was provided with emergency accommodation and signed up for social housing.

22 nd January 2021	Kathryn's social worker was updated by SCPNS that there were significant concerns raised about her ability to care for Nyota. Kathryn at that time was described as overly sedated and had declined to detox from drugs (although the reasons why were not clear). Kathryn was assessed as of high risk of relapse due to poor family support, being involved in abusive relationships and her deteriorating mental state. SCPNS supported Nyota being placed on a plan. Kathryn had not been discharged in line with normal practice due to these concerns (good practice).
25 th January 2021	Kathryn was referred to the North Somerset Recovery Team following her discharge from SCPNS. SCPNS spoke to Kathryn and clearly outlined their concerns. Kathryn engaged in the discussion and was keen to receive support.
27 th January 2021	Nyota became the subject of a child protection plan under the category of neglect.
23 rd February 2021	Kathryn left the mother and baby rehab unit and was temporarily housed by the homeless persons unit. She was in contact with SCPNS, social care and We Are With You (WAWY).
29 th February 2021	A health visitor and a Community Nurse (CN) visited Kathryn. They saw Kathryn and Brent with Nyota and completed a thorough health needs assessment which identified the previous concerns and risks raised.
10 th March 2021	A core group ²⁵ was held. Kathryn met with her care coordinator and SCPNS. She had attended a women's support group with WAWY the day before. SCPNS requested funded childcare from Children's services to support Kathryn attending appointments. No risk issues were raised. SCPNS were to discharge Kathryn following a child protection conference and arrangements were made for her to attend Structural Clinical Management (SCM) ²⁶ .
24 th March 2021	Notes from SCPNS attendance at Child Protection conference – <i>'Brent, staying at Kathryn's home regularly. Kathryn in temporary accommodation, needs to secure permanent accommodation. One visit every other day by social services, reduced from 3 times a day over time as no concerns raised. Kathryn has been available to all professionals, needs have been met for baby by Kathryn.'</i> <i>'Partner has been assessed by social care, no concerns. This would change if he relapsed to illicit drug use.'</i> <i>'Kathryn engaged well with support from WAWY. All medical</i>

²⁵ The core group is responsible for developing and maintaining the child protection plan as well as determining whether the plan is working or not.

²⁶ SCM provides generalist mental staff with a coherent systematic approach to working with people with borderline personality disorder.

	<i>appointments attended for Kathryn and baby. To remain on child protection plan’.</i>
15 th - 20 th July 2021	Annika went to visit Kathryn. Kathryn stated that she felt overwhelmed by professionals. Kathryn stated that pre-proceedings had ended and she refused a Child in Need plan. Kathryn found the involvement of professionals extremely distressing and was fearful that Nyota would be removed if she made any mistake or did not follow advice. Kathryn explained that this was why she had refused a Child in Need plan and would not entertain Annika’s efforts to persuade her to agree one and accept ongoing support.
3 rd August 2021	A case conference was held, and Nyota was stepped down from a child protection plan to a child in need (CIN) plan.
3 rd November 2021	The recovery team consultant psychiatrist called Kathryn. She was described as having mixed anxiety and low mood. She had panic symptoms, poor motivation and focus. Her anxiety was described as social anxiety and she would not go out alone.
December 2021	Kathryn informed Annika that she had been suffering from increasing bouts of depression and was self-harming. She stated that Brent worked away for long periods of time and that she was struggling financially. Kathryn stated that her depression had been so bad that she had gone “months” barely saying a word to Nyota and that she was self-harming. Annika tried to persuade Kathryn to get support, but she was adamant she would not get help for fear of children’s services removing her child. Annika made a safeguarding referral to Children’s Social Care. Annika explicitly informed them that Kathryn had made multiple attempts to take her own life, including an overdose, in the days before she contacted her. She had also lost consciousness on the bathroom floor when only Nyota was in the house. Annika explained Kathryn’s mental health history and stated that she was concerned as she thought that she was a high risk of suicide. Annika also stated that she was concerned that Nyota was at risk of dying if Kathryn was successful in taking her own life, as it was likely that no one would come across them for days. Children’s Social Care attempted to visit and contact Kathryn without success.
17 th December 2021	The police received an email request from a social worker (SW) who had received a referral from Annika. The SW had attended Kathryn’s address but got no response. The SW wanted police to undertake a welfare visit. Officers attended on 20/12/2021 in line with THR ²⁷ Matrix due to high demand. Initially there was no answer, but Kathryn and Nyota were then seen safe and well. The log notes they ‘have no

²⁷ Threat Harm Risk matrix is used by control room to determine and prioritise police response

	issues and no financial issues'. Background checks were completed on both Kathryn and Brent.
11 th January 2022	The recovery team consultant psychiatrist called Kathryn. She gave superficial, non-specific responses and stated that her social anxiety was persisting. She stated that Brent did all the shopping.
13 th January 2022	A home visit was carried out by a Health Visitor and Kathryn reported that her long-term mental health issues led to her being socially isolated. Kathryn identified Brent as a good support, and he helped her with getting out and about when he was around. Kathryn was signposted to support services.
20 th January 2022	Kathryn attended her first SCM appointment. She presented as anxious initially and struggling to concentrate. She talked about her difficulties with her identity and feeling "useless, inadequate and unable to do normal things". She also reported as struggling with maintaining relationships and talking to people. No risks were noted and it was identified that Kathryn knew who to contact for support.
8 th 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 ' <i>to protect her and her neighbours</i> ', 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. When booked in at the custody centre Kathryn had stated that she didn't have any injuries. Despite multiple attempts she would not provide any further information and was later released without being charged. There was no evidence of visible injury. On release Kathryn was taken home by officers.
8 th 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.

	<p>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). EDT and Nextlink were contacted and a MARAC referral was made. A CSC referral was also made.</p> <p>Kathryn felt unable to support a complaint at that time. The officer documented consideration of a DVPN but noted that Kathryn was now out of area with no intention of returning so this would have little or no effect. Kathryn was offered a safehouse space but declined it.</p>
8 th December 2022	<p>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: <i>“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.”</i> On that occasion the Triage Team explained that they did not have availability for an on the day placement into a safehouse and advised the police of the Pathway for emergency accommodation during working hours and out of hours.</p>
8 ^h December 2022	<p>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.</p>
9 th December 2022	<p>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.</p>
9 th December 2022	<p>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.</p> <p>When later describing the attack on her she reported that Brent had told her that she had to <i>“take it”</i>, <i>“learn to take it”</i>, and that she is a <i>“big girl”</i> who needs to <i>“take her punishment”</i>. Kathryn interpreted this to mean she had to take her beating and gang rape as punishment for allegedly cheating on him.</p> <p>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.</p>

She informed Annika that she asked to go with them so the police arrested her for damaging the window.

When Annika asked her whether the police had protected Nyota, she explained that the police asked her if she thought her partner would harm her daughter. Kathryn said he would not hurt a child so Nyota was left in the property with Brent.

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.

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.

When Kathryn arrived in Birmingham, she informed Annika that she had had no money because Brent took her Universal Credit payments each month. She was also worried that she had been locked out of her bank account and that he had access to her bank card and so could continue to take her money.

Annika asked Kathryn about her mental health and if she was getting support. Kathryn explained she had been offered Dialectical Behaviour Therapy, but she alleged her partner prevented her from attending so she was discharged. Kathryn said her partner viewed mental ill health as weakness and she simply needed to "*get on with it.*"

Kathryn described her daily lived experience of caring for Nyota and allegedly waiting on her partner. She reported that she cooked his dinner daily, brought him drinks, and even went as far as dressing him. Kathryn said she felt like she had to obey him. She alleged that if her partner wanted to have sex with her, Kathryn had to have sex with him. She further reported that Brent also pressured her to take drugs. Kathryn reported that, a couple of weeks before the incident above, her partner had attacked her and strangled her. Kathryn informed Annika that Nyota was present throughout these incidents. She also alleged he controlled what she wore and her diet.

Kathryn alleged his behaviour had deteriorated over the six months prior and, from her descriptions, it sounded like Brent had become increasingly paranoid. According to Kathryn, Brent had stopped working and was smoking increasing amounts of crack-cocaine He was also involved in theft.

	<p>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.</p> <p>Kathryn admitted that the years of emotional abuse and being “ground down,” leading her to feel reliant on him and unable to trust herself. Kathryn reported that he continued to refer to her as “my little whore,” made her feel stupid, and told her that she was “stupid and ugly.” He would also belittle and degrade her by stating that he “had her for a fiver”.</p> <p>Annika felt that Kathryn was only able to demonstrate limited insight into the consequences of Brent’s actions and recognise it as domestic abuse, albeit she minimised the abuse. Disturbingly, Kathryn said if it had just been her partner attacking her, she “would have taken it,” because it is “better for Nyota to have a father”. She said she “could take it”.</p>
9 th December 2022	<p>Kathryn was assessed by a worker from the South Glos Safehouse Team, for a safehouse space, however both she and the worker felt the geographic area was not safe due to Brent’s local connections. Kathryn stated she would prefer to find accommodation/refuge in Birmingham as Annika (who she was currently staying with) was her only support network. The Social Worker made contact to refer Kathryn for Safehouse accommodation. The Social worker later updated records advising that Kathryn had decided to stay in Birmingham for the time being.</p>
13 th December 2022	<p>CSC were informed by EDT and the police report that Kathryn had been physically assaulted by Brent. CSC formed a plan to support Kathryn.</p>
14 th December 2022	<p>Following a self-referral Kathryn went to a domestic abuse refuge. After a few days Kathryn left the premise as she was unhappy that it was shared accommodation. Kathryn went to stay with her friend Annika.</p>
22 nd December 2022	<p>North Somerset referred Kathryn’s case to Birmingham Children’s Trust as she was residing in that area.</p>
28 th December 2022	<p>A Health visitor contacted Birmingham Children’s Trust to state that she had spoken to Annika and that Kathryn had left and moved to a refuge with no forwarding address. Health visitors were unable to complete a new assessment. The Children’s Trust were asked to confirm her current whereabouts.</p>

4 th 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.
24 th January 2023	A Health Visitor contacted Birmingham Children's Trust and raised concerns about the safety and well-being of both Kathryn and her daughter. She was told that the case had been previously closed after no additional concerns had been raised in December 2022. Records show that the case notes were finalised as ' <i>complete</i> '.
2 nd February 2023	A Health Visitor completed a home visit. Kathryn reported that they had moved back to the area as they did not like the refuge. Kathryn stated that Brent had moved out of area and that she was not in contact with him. She stated that she felt emotionally well and that she was feeling supported by her father and some friends. The Health Visitor did discuss the impact of domestic abuse on children.
21 st March 2023	Annika made a safeguarding referral stating that Kathryn had left her address on the 14 th December 2022 and was believed to have returned to live with Brent. CSC made a referral to the Multi- Agency Safeguarding Hub (MASH).
28 th March 2023	The MASH outcome was that professionals had spoken to Kathryn and that ' <i>there is no clear evidence that Kathryn is either using drugs or back in a relationship with Brent</i> '.
6 th April 2023	Police received a report from a member of the public who had witnessed a couple screaming at each other in a vehicle, then the female got out and tried to get a pram out of the car, but the male grabbed her and made her get back in car. The police identified that the car was linked with Brent and noted that he was flagged as a MARAC perpetrator of domestic abuse. Officers attended various addresses but were unable to get an answer. After several attempts to speak to both parties in person, the officer spoke separately to both on the phone a week later. Neither could remember the incident. At that time, they were living separately but were still seeing each other. A few days later, officers attended Kathryn's address to follow up with her in person. Kathryn denied any assault and said the relationship was fine. Officers noted that Nyota seemed well cared for. Kathryn refused to complete a DASH and the officer completed one rating it standard as there were no concerns identified at that time, and the parties were living apart.
August 2023	Kathryn's death is reported.

14.0 Overview -

14.1 This overview will summarise what information that was known to the agencies and professionals who were involved with Kathryn and her family.

Avon and Somerset Police

- 14.2 Kathryn's first recorded contact with the police was in 2007 when she was a victim of theft. Police records indicated that she had been vulnerable from drug addiction since 2010.
- 14.3 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 abuse that was reported to the police involved both Brent and William. Police became aware that Kathryn was associating with Brent in March 2019 and that they started a relationship in July/August of 2020. There were eleven contacts in this period until her death.
- 14.4 The police were aware of Kathryn's vulnerability including her declining mental health, drug misuse and her being the repeat victim of domestic abuse.

Primary Care

- 14.5 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.
- 14.6 Due to COVID restrictions contacts with the practice were primarily online and appointments with clinicians would have been primarily via the telephone. In the period that Kathryn was registered at the Practice she had ten appointments and several contacts relating to personal medical matters including her mental health.
- 14.7 In records there was evidence of communication with her GP and mental health services but those at the practice were unaware of any domestic violence history and they state that the '*few mentions of her relationship with her partner suggest he is supportive*'.
- 14.8 The Health Visiting team had shared police information with the GP practice which had indicated that Kathryn had been the victim of domestic abuse in December 2022 and April 2023. There was also additional information shared with the practice notifying them that Kathryn had been the subject of the MARAC process in December 2022 and January 2023.

AWP

- 14.9 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.

- 14.10 In 2017 Kathryn had disclosed to staff working in an Intensive Treatment Unit that she had suffered abuse from an ex-partner, although the extent of that abuse is unclear. The identity of the abuser was also not known.
- 14.11 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*” and there were other subtle comments about what it was like living with him. Unfortunately, her home life was never fully explored by those treating her and this will be discussed later in this report.

The Health Visiting Service

- 14.12 The health visiting service across Bristol, North Somerset and South Gloucestershire (BNSSG) is made up of Health Visitors, Public Health Nurses, Community Nursery Nurses and Administrators who work in local communities with children and families from the antenatal period until they go to school. The service is commissioned by the three local authority areas within BNSSG. The service in North Somerset and Bristol has been run by Sirona Care and Health since April 2020. The commissioned service is based on the requirements of the Health Child Programme (2021). Services are provided universally, and they are based on five mandated touch points. This contact starts for the parent antenatally, when the child is newborn, at 6-8 weeks, 9-12 months, and 2 years. The service delivered depends on assessments of need and level of support required by individuals referred to the service.
- 14.13 Kathryn first came to notice of the service in 2020 because of her pregnancy. Records show that health staff working in the service were aware of Kathryn’s complex needs including;

- Drug use
- Previous homeless state
- Being a street worker
- Trauma and neglect in her own childhood, including the death of her mother when she was young
- Long term mental health issues

- 14.14 Health visiting professionals were aware that Kathryn was the victim of domestic abuse, and that Brent was the perpetrator of that abuse.

SWAST

- 14.15 SWAST attended four incidents involving Kathryn. They were aware that she had complex needs including drug dependency, but they only became aware of her domestic abuse history following her death.

Housing Association

- 14.16 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.
- 14.17 There were numerous contacts with the housing provider between 2019 and 2022. In that period Kathryn had also come to their attention when she was pregnant in 2020 and at that time she was again classed as street homeless.
- 14.18 The Homeless Prevention Team became aware of Kathryn and Nyota in December 2022 following contact from the police who had advised her to register for accommodation after she had been released from custody following an arrest for criminal damage. At that time Kathryn was living in rented accommodation with Brent.
- 14.19 The Homeless Prevention Team had completed a DASH risk assessment and after an initial assessment had worked with Kathryn to find her emergency accommodation. This DASH assessment had highlighted the physical abuse in her relationship with Brent.

Substance Abuse Commissioning Team

- 14.20 This team had no direct contact with Kathryn, but they had knowledge of her through their treatment provider and through their residential treatment panel (finished in 2019). Kathryn had first come to their notice in 2018 through the applications for residential treatment.
- 14.21 The team were aware the Kathryn was extremely vulnerable and that she was in a domestic abuse relationship with both William and Brent.

We Are With You (formerly Addaction)

- 14.22 We Are with You is a charity providing free, confidential support to people experiencing issues with drugs, alcohol or mental health. We Are with You is not a crisis service, but offer planned detoxifications, access to residential treatment, opiate substitute medication and groups and key working for clients using evidence-based interventions.
- 14.23 The charity had a comprehensive overview of Kathryn's background and welfare needs. They were aware of the trauma in her past and the abuse that had occurred in her relationships with both William and Brent.
- 14.24 Kathryn had six treatment episodes delivered through We Are With You from 12th February 2013 to 17th January 2022. When Kathryn first presented to the service she was assessed as high risk, vulnerable, traumatised, exploited and abused. Kathryn had reported a mental health diagnosis of borderline personality disorder, anxiety and depression.

North Somerset Children's Social Care

14.25 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.

Birmingham's Children's Trust

14.26 Birmingham's Children's Trust were notified in December 2022 that Kathryn and her daughter had moved into their area and were staying with a friend. They were aware that she had moved there in response to domestic abuse. They were aware that Nyota was not an open case at that time but that she had been on a child protection plan in the past.

Next Link Services

14.27 Next Link North Somerset provide support services for anyone who has been a victim of domestic abuse. Kathryn first came to the notice of the service in December 2022 after she had been arrested by the police²⁸. They were aware from the referral that Kathryn felt '*absolutely terrified*' of her partner and his friends and that she did not feel safe to go home.

14.28 On further contact with Kathryn professionals in the service identified that Kathryn had suffered emotional, sexual, physical, verbal, economic and psychological abuse from Brent.

14.29 Kathryn was known to Next Link for a period of twenty-seven days from the first referral to the date of the MARAC meeting relating to her case.

Domestic Abuse refuge

14.30 The refuge had limited interaction with Kathryn. Following a disclosure to a support worker they were aware that Kathryn was in an abusive relationship with Brent and that he had been physically and sexually violent to her. They were also aware that he had control over her bank account and mobile phone account.

Adult Social Care

14.31 Adult Social Care had limited involvement with Kathryn. One safeguarding contact (20th of July 2018) referred to Kathryn experiencing domestic abuse.

²⁸ There were no records of contact with Kathryn prior to this date due to changes in service provision and some records not being retained due to policy and practices at that time.

15.0 Analysis

- 15.1 This part of the overview report will examine how and why events occurred and seeks to address the terms of reference and the key lines of enquiry within them. It is also where any examples of good practice are highlighted. Much of Kathryn's story has had to be told through the details provided by Annika as Kathryn had disclosed the full extent of the abuse to her.
- 15.2 Previous local DHR's were considered when completing this section. This was completed to identify if the themes and learning from other similar tragic events had been embedded into frontline practice. There were no specific recommendations or areas of learning identified that were relevant to this review.
- 15.3 According to Annika the early interactions that Kathryn had with some services and her perception of how she was treated by them had led to barriers to her disclosing the abuse that was occurring to her, and to her trusting professionals. This included her interactions with Children's Services and the reported burglary in 2010 where Kathryn had confided in her friend Annika, that the police response had left her feeling distressed and gave her little confidence in the support that they would provide to her. This was due to Kathryn believing that there was a lack of professionalism at the time that the incident was reported. After a complaint was made by Annika about the police response and despite Kathryn being in hospital she was constantly contacted with requests for more information. This had, according to Annika, led to increased anxiety, hindered her recovery and led to an increased mistrust of the police. Ultimately it was these experiences, together with the abuse, coercion and control in her relationship which had led to her declining to report incidents.
- 15.4 The impact of Kathryn's experiences of services and her later reluctance to report abuse will be discussed further in this section of the report.

15.5 Domestic Abuse

- 15.5.1 The first area for analysis is to determine the extent that Kathryn was subjected to abusive, coercive, or controlling behaviour in her relationship with both William and Brent.
- 15.5.2 The review has been unable to identify whether Brent had been exposed to domestic abuse whilst growing up or whether his own life experiences had impacted on his behaviour in adulthood.
- 15.5.3 There is nothing held in agency records that would indicate that Kathryn had witnessed domestic abuse as a child, but she had, according to Annika, been subjected to emotional abuse and neglect whilst growing up with her father, which was not reported to the police. According to Annika the impact of this abuse had led Kathryn to trust any person who showed her affection, and she would then fail to see the risks that they presented as she simply sought affection and love in her life.

15.5.4 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 who had encouraged her to take crack cocaine in 2006 which led to her continued dependency in the years that were to follow. The cycle of reoccurring abusive relationships has been identified as a strong indicator that leads to the deterioration of mental health and subsequent suicidal ideation for victims²⁹, and these factors were evident in Kathryn's life.

15.5.5 From the records held by agencies Kathryn had an intermittent relationship with William between 2010 and 2020. Annika has stated that this male was physically and emotionally abusive towards her. There were also reported incidents to the police of physical assaults including strangulation.

15.5.6 In 2022 Kathryn commenced a relationship with Brent. Kathryn described Brent to Annika as a misogynist who considered women to be inferior to men. The chronology shows that he 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 it³⁰
- reportedly accessed her online social media accounts³¹
- 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

15.5.7 Controlling or coercive behaviour does not relate to a single incident, it is a purposeful pattern of behaviour which takes place over time for one individual to exert power, control or coercion over another. The Cross-Government definition of domestic abuse³² outlines controlling or coercive behaviour as follows;

'Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour'.

15.5.8 Controlling or coercive behaviour is a major risk factor in domestic homicides, particularly for female victims of intimate partner homicide and a significant pre-cursor

²⁹ Domestic Abuse and Suicidality: What you need to know (2022)

³⁰ This was never corroborated by the Police or other agencies.

³¹ As above.

³² Domestic abuse; Home Office (2016)

for suicides^{33 34}. 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 Annika.

15.5.9 Annika has stated that Brent had gained access to Kathryn's Facebook/ Google/ Gmail accounts and had set his email address as a backup which prevented her from re-gaining access. Using Facebook, Brent would reportedly look at location services and Kathryn's messages to see where she had been and who she was in contact with. Kathryn's Gmail account was also reportedly linked to her Universal Credit account so Brent would access it by re-setting the necessary passwords. This made Kathryn more reliant upon him for financial support particularly as she was constantly forgetting important things such as passwords for accounts. Brent had according to Kathryn's disclosures to Annika manipulated himself into a position of dominance in the relationship and had used economic abuse to exert his control.

15.5.10 Brent had considerable control over Kathryn's bank account as she had once given him her PIN code. Kathryn had reportedly granted Brent access as she had been too anxious to leave the house. It was quite common for Kathryn to rely on others to use her card to buy items because of her anxiety, and this made her even more vulnerable to being financially and economically exploited. Kathryn would often find that those she trusted had taken all her money. Brent had economically³⁵ 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 ideation³⁶.

15.5.11 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 she didn't have the additional identification documents that she needed to secure access. Her bank refused to speak to Annika who was trying to assist her at that time. The fact that it was an international call centre made communication difficult. Whilst considerable work has taken place involving the charity Surviving Economic Abuse (SEA), the HSBC banking group³⁷ and the Financial Abuse Code (2021)³⁸, the review has identified that further work needs to take place at a national level (**Recommendation 1**).

15.5.12 Kathryn had disclosed to Annika that Brent would constantly "*upset and embarrass her*". This included his nickname for her ("*my little whore*") and he would often brag to his friends that he "*had her for a fiver*". She was made to feel worthless, and he would often manipulate and psychologically control her. Kathryn admitted that she

³³ Welford-C, Kathrynnger. C et al (2017)

³⁴ In 2020 the Domestic Homicides Project was established by police and government in England and Wales to collect, review, and share quick-time learning from all police-recorded domestic homicides and from suspected suicides of individuals with a history of domestic abuse victimisation in the wake of the Covid-19 pandemic and restrictions.

³⁵ 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.

³⁶ Johnson et al (2022)

³⁷ [How banks can help - Surviving Economic Abuse](#)

³⁸ [Financial Abuse Code](#)

was “ground down”, leading her to feel reliant on him and unable to trust herself. Brent would call her “stupid” and an idiot” and she had come to believe him. His behaviour which can be seen as gaslighting³⁹ caused Kathryn to doubt herself and the agencies that were there to support her. Brent also reportedly had intimate images of Kathryn and she was concerned that he might use these against her.

15.5.13 Kathryn would often minimise, or not accept, or admit to the abuse that was occurring in her relationship with Brent. An example being when she reported to Annika that Brent had forced her to have sexual intercourse against her will. On this occasion Annika had to explain to her that as she had not consented to the intercourse taking place then this amounted to rape in criminal law. This type of reaction can be common amongst victims and is often a coping mechanism which helps them to deal with the trauma in their lives. Research⁴⁰ has shown that women utilise a diverse range of protective strategies to make decisions based on their knowledge and experience of how their actions may increase or decrease danger. In this case 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 be 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.

15.5.14 Kathryn also felt that the police would be unable to protect her. Brent had a substantial criminal history, and he had a history of breaching his bail conditions. Kathryn felt that Brent did not fear the consequences of any police action. Kathryn’s scepticism about the ability of agencies to protect her was further compounded by her views on the reality of court delays and the fact that Brent was likely to get a short sentence. Kathryn also felt that due to Brent having access to her mobile phone and bank accounts that no matter where she lived Brent would be able to track her.

15.5.15 Annika has also stated that Kathryn’s own personality created a barrier to her recognising and reporting abuse as she had an ‘endless capacity for empathy and love’ and this made her vulnerable as she was willing to constantly forgive the abuse that was occurring to her. These vulnerabilities were preyed upon by her abusers, including Brent, and they also presented significant barriers to Kathryn recognising and reporting the abuse.

15.5.16 Kathryn had been made aware of the options for support that were available in the locality and she had been signposted by all the agencies that she had contact with. Annika was also in a unique position to provide Kathryn with advice due to her professional background. Despite the support that was offered 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. Annika stated that what may seem as simple tasks or decisions for most people were seen as almost insurmountable by Kathryn due to the decline in her mental health. This burden had weighed heavily on

³⁹ Gaslighting is an insidious form of manipulation and psychological control. Victims of gaslighting are deliberately and systematically fed false information that leads them to question what they know to be true, often about themselves. They may end up doubting their memory, their perception, and even their sanity (Psychological Today 2022).

⁴⁰ Irving, L (2020)

her and had meant that she had felt no other option but to remain in her relationship with Brent.

15.5.17 From the information available from agencies and Annika, Kathryn did not see Brent as a threat to Nyota and believed that he would not harm her (although Nyota was reportedly present in the same room on several occasions when the abuse occurred). Kathryn had not reported any concerns to agencies and had on one occasion informed the police that he was a suitable person to look after Nyota. It is unclear whether this response was driven by a genuine belief that he was not a risk to Nyota or due to the fear of further abuse and Social Care intervention if he were to be declared as abusive.

15.5.18 The main agency responses to domestic abuse are explored further in this section of the report.

Police Response

15.5.19 The first recorded episode of domestic abuse in the period for the chronology was in May 2017 and involved William. Kathryn only reported one incident involving Brent, with two other reports being made by third parties.

15.5.20 The first reported incident with William was in May 2017. On this occasion there was evidence of effective and positive action being taken and William was arrested. The case was presented to the CPS whilst William was in custody, but Kathryn felt unable to support a prosecution at that time. In cases of domestic abuse, it is not uncommon for victims to feel powerless and unable to report incidents to professionals⁴¹ or support prosecutions. This can be for a variety of reasons including shame, embarrassment, denial, trauma, and low confidence⁴². All these factors were evident in this case.

15.5.21 On this occasion the police and the CPS considered the viability of an evidence led prosecution but decided that without Kathryn's statement there was insufficient evidence to charge. Safeguarding considerations for Kathryn were given prior to William's release. The Lighthouse Safeguarding Unit⁴³ (LSU) tried to complete a common needs assessment with Kathryn but she felt unable to engage and said that she didn't need any additional support. The decisions made would appear to have been proportionate on what evidence was available at that time.

15.5.22 In September 2020 Brent assaulted another victim who he had found with Kathryn. The male victim reported that Brent had previously raped and assaulted Kathryn. On review the police IMR writer found that the response to this incident had been

⁴¹ On average victim's experience fifty incidents of abuse before getting effective help (Safe Lives ;2019)

⁴² Women's Aid website, 2024.

⁴³ LSU have a joint function of supporting victims and witnesses of crime (including onward referral to other agencies and, where appropriate, being a point of contact during a Criminal Justice System processes) alongside safeguarding overview. The development of this joint team provides a more streamlined approach to supporting individuals by improved ways of working with partners to safeguard the most vulnerable. The team offers an enhanced service to vulnerable, intimidated or persistently targeted victims of crime and anti-social behaviour as well as to victims of serious crime.

comprehensive: Officers completed house to house enquiries, photos of Kathryn's injuries were taken, and medical records for the injured male were obtained. Ambulance CCTV was also secured. Clothing and hand swabs were taken from Brent. On that occasion Kathryn felt unable to confirm that an assault had occurred, and Brent had denied the allegation of rape. Kathryn was offered LSU support, but she felt unable to support a prosecution at that time, and she declined a DASH. As detailed in the above paragraph this behaviour is common amongst victims who have been abused. Referrals to Children's Social Care (CSC) and Health were made which should be seen as good practice. For some unknown reason there had been a delay in the submission of the DASH after this incident. The Police IMR writer was unable to find a documented reason as to why this had occurred. This has not resulted in a recommendation as existing practices exist to cover this process.

15.5.23 In addition to the reported rape there was a thorough response to the report of assault with all available lines of enquiry made, and there was documented consideration to an evidence-led prosecution. A BRAG for Kathryn and Nyota (unborn at that time) should have been submitted after the initial attendance but this had not been completed. There are existing processes in place regarding the submissions of these documents and the appropriate referrals were made anyway without the BRAG, so this has not resulted in a recommendation.

15.5.24 Kathryn had made disclosures to Annika about the police response to the report of criminal damage in December 2022. Kathryn stated to her friend that the response had left her feeling further isolated and victimised. 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. On review officers were seen on body worn video (BWV) to be empathetic with Kathryn and they had asked her if she required additional support. Kathryn stated that she had felt unable to accept any of the offered support at that time. The action that officers had taken was found to be proportionate and in line with the evidence that was available to them. Annika has stated that due to the impact of Kathryn's drug use, her medication and the domestic abuse this type of behaviour was particularly prevalent at this time. Kathryn felt overwhelmed, was unable to focus and she would question every decision that she made which was a barrier to her informing officers of what had happened.

15.5.25 The second response on that night was reviewed in the light of this information from Annika. Officers attended (after a neighbour had reported that Kathryn had smashed one of their windows) and spoke to Kathryn alone. At that time, there was nothing recorded on police records regarding visible injuries and a review of the BWV footage has also confirmed this⁴⁴. 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

⁴⁴ Whilst there were no visible injuries at that time when Kathryn reported to a police station the following day she had photographs taken of minor bruising/injuries to her arm and face.

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.

15.5.26 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.

15.5.27 Prior to leaving the scene it was apparent that the officers had considered the risks to Nyota (they were aware of Brent’s criminal history). They had confirmed with Kathryn that she was happy for Nyota to be left with Brent. There were insufficient concerns at that time, without further evidence from Kathryn, to suggest that Brent was a particular risk to Nyota. When officers spoke to Brent he was coherent and rationale.

15.5.28 When in police custody Kathryn was referred to the Advice, Support, Custody and Courts Service (ASCC)⁴⁵. Whilst there Kathryn stated that she did not want to go home “*as it wasn’t safe*” but she felt unable to expand on this statement. When assessed by the ASCC recovery worker she repeated her concerns and stated that she didn’t want her partner arrested as “*that would be the end for her*”. She further stated that he has friends who would “*get her*”. 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. Additional referrals were made to CSC and Health. The ASCC worker also emailed Nextlink to see if refuge could be arranged. The level of signposting and support from those in custody should be seen as good practice.

15.5.29 The following day Kathryn had attended a police station to report a different version of the events that had occurred the previous night. She described how she had been physically assaulted by Brent and believed that she was going to be kidnapped by his friends. Kathryn stated that Brent had tracking software on her phone and that she felt unable to provide a statement at that time. The police were sympathetic and supportive towards Kathryn. Officers attended her home address with Kathryn to enable her to retrieve some belongings and ensured that she was going to a safe

⁴⁵ Advice, Support, Custody and Courts Service (ASCC) – a specialist team providing assessment and advice for people in police custody or appearing in the criminal courts where there are concerns or issues around mental health. This service is provided by Avon and Wiltshire Mental Health Partnership Trust (AWP).

place. Officers completed a DASH (rated as high risk) and appropriate referrals were made to agencies. A referral was also made to MARAC. Kathryn was contacted the following day and again she felt unable to make a complaint at that time, saying that would make things worse. The officer documented consideration of a DVPN but noted that Kathryn was now out of the area with no intention of returning so would have little or no effect. Further inquiries were made with neighbours and a comprehensive review conducted by an Inspector before the case was closed pending further evidence coming to light. From records no further inquiries were made about tracking software. A DVPN could have been considered in these circumstances and may have been effective in helping Kathryn to live in safety.

15.5.30 The police identified that Kathryn's concerns about tracking software on her phone were not addressed. The police have since introduced a system for detecting tracking software which has been widely publicised in the Force. This improvement should be seen as good practice.

15.5.31 When police attended and spoke to Kathryn a few days after the incident that was reported on the 6th April 2023 she stated that she was "ok". Kathryn declined to report any assault and she stated that her relationship with Brent was fine. Officers noted that Nyota was well cared for and happy. Kathryn declined to complete a DASH risk assessment so the officer completed one rating it as standard. A referral was made to Health as is the standard practice in reported domestic abuse incidents involving children. On this occasion a BRAG was not completed and should have been considered.

15.5.32 The immediate police response for all incidents relevant to this DHR were considered to have been timely and mostly appropriate. The A&S Police IMR writer has confirmed that relevant local and national policies and procedures have been considered when analysing police contact within the timeframe of the review. The author and subsequently the Panel were satisfied that policy and procedure had, in the main, been followed by the police when they had dealt with Kathryn. They also identified that evidence-led prosecution had been consistently considered when it was appropriate and there were no missed opportunities to prosecute Brent in relation to domestic abuse offences.

15.5.33 DASH assessments were completed by A&S police officers for Kathryn in all reported incidents, including the three occasions involving Brent. Two of these were 'officer perceived'⁴⁶ due to Kathryn not feeling able to engage with the service. Both officer perceived DASH assessments were rated as standard. The Panel considered whether there was sufficient information on any of these occasions for officers to have applied a higher rating and confirmed that they are satisfied that the assessments were appropriate based on the information the officer had at the time.

15.5.34 Many areas of good practice were identified as part of the police's review of their practices, including officers dealing empathetically with Kathryn (as witnessed on

⁴⁶ Officers complete the DASH on what they have been able to ascertain from the initial investigation that they have completed.

BWV's) and there was evidence of comprehensive record keeping. The officers considered all available options to safeguard Kathryn, including signposting, onward referrals and DVPN/DVPO and documenting rationale for what actions were or were not taken. Officers also followed up other lines of inquiry including seeking out witnesses.

15.5.35 When working with vulnerable victims of abuse it is recognised that there is a balance that professionals must strike between being professionally curious and being invasive and intrusive. Kathryn had already felt overwhelmed by services and the additional pressure exerted by continually asking her questions about her relationship with Brent and family circumstances could, if not managed correctly, have contributed to her ongoing anxiety, self-harm, and declining mental health. This was recognised by those dealing with her.

15.5.36 Officers also recognised the risks to Nyota of witnessing domestic abuse (the impact of which will be discussed further in section 15.7) and safeguarding referrals were completed on all appropriate occasions. This should be seen as good practice.

Primary Care

15.5.37 Approaching GP's or other Health professionals for help can often be difficult for young people and they rarely feel comfortable with speaking to professionals about their problems⁴⁷. There is a recognised need for continuity in the Health Care of individuals, particularly young people such as Kathryn, to ensure that they feel confident in discussing abuse. National Guidance for professionals⁴⁸ identifies mental health as a potential indicator for domestic abuse with a low threshold for domestic violence enquiry suggested within the guidance.

15.5.38 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 has been identified that there were some missed opportunities to demonstrate increased professional curiosity and ask Kathryn routine questions about domestic abuse. It is recognised that without any disclosures by Kathryn, there would not have been any an increased threshold for professional curiosity and further inquiry. The review has 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**).

15.5.39 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, and it was noted that her "*mood is good*". As part of this consultation there was no mention of relationships or domestic abuse. The GP's impression at that time

⁴⁷ Barnes et al (2023)

⁴⁸ [Recognizing domestic violence and abuse | Recognition | Domestic violence and abuse | CKS | NICE](#)

was that Kathryn was '*in a good place*'. 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**).

15.5.40 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**).

15.5.41 Kathryn attended a routine smear test appointment face-to-face with the practice nurse in March 2021, when Covid restrictions and telephone appointments were still the default. On discussion with the practice, it was considered that this could have been a further opportunity to have included 'routine inquiry' about domestic abuse and if Kathryn felt safe at home. Experience has shown that most women attend smear tests alone and have a longer appointment with a nurse for this, so it would have been a good time for the routine inquiry to take place and for them to inform the GP, signpost to services and arrange appropriate follow up. The IMR writer and practice acknowledge that training for practice nurses would be required if DV screening were expected at smear appointments.

15.5.42 Kathryn had a further GP telephone appointment in October 2021 (due to covid restrictions) where she was signposted to a clinic for management of symptoms of an intimate nature. There was no inquiry/discussion about social context for this presentation although professionals generally believe that this would have taken place at the clinic (the review has identified that routine inquiry does take place at the clinic). Kathryn called her GP practice again on the same day as she couldn't get an appointment in the clinic in a timely manner. At that point the Nurse could have asked further questions about social history and relationships and this might have been an opportunity for Kathryn to disclose information about domestic abuse.

15.5.43 In August 2021 Kathryn reported a wound infection and this was booked into a telephone appointment with a nurse. The consultation led to an antibiotic prescription; however, no photo was requested/no examination took place. The mechanism of injury was reported as 'cut leg on glass'⁴⁹, but no further details were documented. The case was not discussed with a GP and on review it was felt that it was unusual for such an injury not to have been assessed at a face to face for examination. It is not possible to comment on whether this injury may have been connected to a domestic abuse incident, but it was a further missed opportunity to exercise professional curiosity and ask the relevant questions about the cause of the injuries.

⁴⁹ Kathryn self-harmed mainly by cutting her thighs, upper arms and stomach.

- 15.5.44 In September 2021 Kathryn contacted the practice and spoke to a receptionist. As a result of this conversation an SMS text message was sent to Kathryn signposting her to the 'MSI Choices' link. MSI choices is an NHS funded service providing abortion care. There was no consultation or administrative note for this event, so it isn't known if this case was discussed with a clinician or not. However, the outcome of this contact with Kathryn was that she was signposted to a specialist service for further assessment and management of the condition that she presented with (unplanned pregnancy).
- 15.5.45 On discussion with the Practice, it was considered that in cases where a specialist service is available to patients on a self-referral basis it would be reasonable for non-clinical but trained 'care navigators' at the 'front door' of primary care, to signpost patients appropriately. Using care navigators may avoid 'unnecessary' GP consultations but there is a risk that there may be missed opportunities to exercise professional curiosity and engage in a holistic assessment. It was recognised that when a patient is seeking an abortion, there is an increased risk that there may be safeguarding concerns at that time and therefore such questions should be asked. In healthcare settings, the evidence shows that routine or universal screening results in higher identification rates of DA than selective screening⁵⁰. Given associations between DA and sexual and reproductive health (SRH), SRH clinics have been identified as settings where routine DA enquiry should be considered best practice in the UK⁵¹. The Primary Care IMR writer identified that the processing of requests (MED3⁵²) must be considered, with training (see paragraph 15.5.46) 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**).
- 15.5.46 Both the sexual health and abortion clinics attended by Kathryn use routine enquiry but there is no record of whether disclosures were made. The Panel have confirmed that both services have established practices where they will refer victims to hospital IDVA's if appropriate. This should be seen as good practice.
- 15.5.47 On 12/07/23 Kathryn was seen in a face-to-face GP appointment for a chest infection. Given Kathryn's history and reported domestic abuse, an opportunistic review of current mental health and a question about domestic abuse might have been appropriate. This could have led to an offer of additional support. On discussion with the GP Practice, it was noted that Kathryn's last entry in the clinical records prior to this appointment was the MARAC / police reports entry, so the GP at this time would likely have seen this on the screen and it was therefore a further missed opportunity to engage in increased professional curiosity.
- 15.5.48 Professionals at the Practice have worked constructively with the review process and have recognised that there are further opportunities to raise awareness about

⁵⁰ Ahmad et al (2022)

⁵¹ NICE *Domestic violence and abuse: multi-agency working*. Public health guideline [PH50] Published: 26 February 2014

⁵² Doctors medical certificate (fit to work).

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**).

15.5.49 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**).

15.5.50 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**).

AWP

15.5.51 Health professionals at an Intensive Treatment Unit were aware that Kathryn had suffered abuse in previous relationships, as she had disclosed in May 2017 that her ex-partner had assaulted her. At that time there was no indication in their records who the ex-partner was. There was also no documented information that safeguarding had been considered, or whether appropriate risk assessments were carried out. The lack of action at that time has been reviewed as part of this DHR process and it has been identified that practices have since been improved. There are now established expectations in current practice that such issues would be further explored, escalated and that record keeping would detail the safeguarding follow up plan.

15.5.52 The AWP IMR writers have identified that Kathryn was not recognised to be at risk of domestic abuse or coercive control in her relationship with Brent. There were potential subtle indicators identified within consultations with professionals, which would have benefited from further exploration and clarification. It may have been that these indicators were discussed, however if this was the case they were not documented in Kathryn's records. AWP have acknowledged that had Kathryn been considered at risk of domestic abuse or coercive control this may have allowed her access to additional support and prevented her discharge from their care. The current AWP Domestic abuse procedure states that "*direct questioning about concerns should be had with service users, if safe to do so, if there are indicators of domestic abuse. Those experiencing domestic abuse may not disclose to the first person who asks them so it is important to include enquiries at every assessment.*"

15.5.53 Senior managers within AWP have provided assurance that if such concerns existed or were to be disclosed direct to staff, then there are clear expectations that they would support the individual concerned and escalate the matter. There are quality assurance practices in place to ensure that this takes place. Further to this there is now an established Next Link domestic abuse worker in the Emergency Department at the hospital who can deal with victims on presentation. This should be seen as good practice.

Health Visitor

15.5.54 Within Health Visiting Services there are established practices where questions about the relationship between parents and routine inquiry is carried out at an antenatal or a new birth visit. In February 2021 a Health Visitor (HV) and a Community Nurse (CN) saw Kathryn at her home address together with Brent and Nyota. During this appointment they completed a thorough health needs assessment. This assessment identified the previous concerns known to services and the risks that had been raised. There are established practices where the HV would normally ask questions about the relationship and conduct a routine enquiry around domestic abuse at this point. The HV recorded that these questions were not asked as Brent was present during the visit and they didn't want to increase any risks.

15.5.55 In Kathryn's case the antenatal visit was carried out via the telephone (due to Covid restrictions and in line with the guidance issued by NHS England). There were concerns in relation to making these routine enquiries over the telephone at that time when the HV would not have known who else was around when the call took place, and them not wanting to put Kathryn at risk.

15.5.56 Whilst the two approaches were sensitive to increasing the risks of domestic abuse there would appear to have been no subsequent follow up and this was a missed opportunity to identify any ongoing risks in the relationship and/or threat to Nyota. From what is known in this case Kathryn was reluctant to disclose the abuse (because of the reasons that have already been covered earlier on in this report), and therefore had the direct questions been asked they may have elicited further information that could have informed assessments.

15.5.57 The health visiting IMR writer identified that the concerns about domestic abuse were not a strong feature in their records and Brent was often seen as a support for Kathryn, who was socially isolated and did not have a strong and supportive network of family or friends.

15.5.58 From the records held there were no recorded disclosures of domestic abuse by Kathryn to her Health visitors and they had not witnessed any injuries. The health visiting service was made aware of the domestic abuse when they received the police incident report on the 12/12/2022. At that time, and following the receipt of the information, the HV was proactive in contacting the Lighthouse service to try and ascertain the whereabouts of Kathryn and to establish safe contact. This should be seen as good practice.

Housing Association

15.5.59 Kathryn had reportedly been given inaccurate advice from her housing association when she had to leave her home address. Annika has stated that Kathryn had been informed that as the tenant 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 challenged by Annika as it had led to unnecessary stress for Kathryn (**Recommendation 9**).

Homeless Prevention Team

15.5.60 When the Homeless Prevention Team were contacted in December 2022 by the Police there were persistent attempts to contact Kathryn. Emergency accommodation was immediately offered to her in Bristol as there wasn't any suitable accommodation available in the North Somerset area.

15.5.61 After that initial contact a housing officer saw Kathryn and completed a DASH risk assessment and this should be seen as good practice. There was evidence of safety planning and recognition of risk in housing records.

15.5.62 The most recent Annual progress report from the Domestic Abuse Safe Accommodation National Expert Steering Group⁵³ shows that from April 2022 to March 2023, local authorities in England reported 24,580 instances where a household was referred to a safe accommodation service, but the service did not support that household. This is 19% higher than the previous year. The most common reason a victim was unable to access support was due to capacity constraints, where the service did not have sufficient space to house the survivor.

15.5.63 The Panel have sought assurance from those commissioning services that there is adequate provision in place in the county. Since this case they have increased capacity and staffing which has increased their ability to accommodate those with complex needs. They are also attempting to source emergency short term housing to ease current pressures on refuge space. This project is being overseen as part of the Domestic Abuse Strategy for the area and there is no requirement to duplicate a recommendation.

Domestic abuse refuge

15.5.64 Kathryn had stayed at a refuge for only one night leaving it due to it being shared accommodation. On that occasion Kathryn had been signposted to support services and other refuges in the area. From the conversations that Annika had with Kathryn,

⁵³Department of Levelling Up, Housing, and Communities. *Annual progress report from the Domestic Abuse Safe Accommodation National Expert Steering Group 2022 to 2023*. Published 20 February 2024.

those dealing with her at the refuge 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**).

Next Link

15.5.65 Following a referral from the police in December 2022 the Triage Team responded in a timely manner, providing all available options to professionals and to Kathryn. Safety Planning was completed, including safe accommodation, physical safety/online safety and Kathryn stated that she was confident she would call the police if needed. Kathryn had Next Link contact details including their out of hours phone number should she require additional help and support.

15.5.66 The Safehouse team completed the assessment in a timely manner and explored all available options with Kathryn. Onward referrals to IDVA support were not progressed as Kathryn decided to remain out of area. Next Link provided Kathryn with their contact details again should she return to the locality. Different support options were considered and had been discussed with Kathryn in line with their policy and practices. The Next Link teams liaised with professionals including the police and Kathryn's social worker. This was a proportionate response at that time.

15.5.67 Next Link had become aware, from other professionals, that Kathryn may have moved back into their area and was living with Brent. Following an assessment, it was not thought to be safe for Next Link to attempt to contact Kathryn to offer support. Kathryn was known to have contact details for Next Link and had expressed a willingness to contact them should she need their services. This was a proportionate response at that time and there was an appropriate consideration of risk.

Children's Services

15.5.68 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. At that time the main risks that were identified related to Kathryn's mental health and drug use, and their impact on her ability to cope for Nyota.

15.5.69 Children's Services have confirmed that those dealing with her were aware of the risks of domestic abuse and these were monitored as part of the Child Protection Plan. At that time Brent was seen as supportive and a stable factor in her life as he was providing "*emotional support*". The 'no concerns' decision related to the risk to Nyota. Those concerns further diminished in the later stages of their relationship,

despite the knowledge of abuse, as the two of them had separated and Brent was living elsewhere.

- 15.5.70 The assessment by Children's Services appears to have provided agencies with a false sense of security and prevented further professional curiosity about the risks in the relationship, and this was identified in the AWP and HV IMR. 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. Annika has also stated that the outcome of the assessment may have been a barrier to Kathryn making further disclosures, as she would not have cast him in a negative light and risk this impacting on her ability to keep Nyota.
- 15.5.71 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 agencies should complete their own risk assessments as it is likely that victims and alleged perpetrators may reveal different information to the professionals that deal with them. All professionals need to remain vigilant and professionally curious and conduct or review assessments at every contact⁵⁴. (**Recommendation 11**).

Adult Social Care (ASC)

- 15.5.72 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. Her mental ill health could also have met the criteria as a protected characteristic under the Equality Act 2010. 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.
- 15.5.73 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. On review the referral in July 2018 could have contained better information in connection with what was being asked of adult social care. 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

⁵⁴ This is a practice routinely conducted by the police and NextLink.

taken. The IMR writers suggest that the form should be continually promoted across all agencies (**Recommendation: 12**).

15.5.74 The nature and degree of domestic violence was not explored at the time of the original referrals by ASC and it was therefore difficult for the IMR writer to evidence whether the response from the local authority was proportionate to the level of risk. There was an attempt to contact Kathryn by phone which was unsuccessful but no further attempts were made to engage with her. The Care & Support Statutory Guidance (DH 2023) states: *“14.15 Making safeguarding personal means it should be person-led and outcome-focused. It engages the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.”* This wasn't achieved, and it appears that the decision not to take further action was made before contact with Kathryn.

15.5.75 Adult safeguarding processes have changed significantly in North Somerset since 2019 and they were able to provide examples of good practice. Safeguarding decision making has been 'centralised' with the objective of achieving greater consistency of process (including making use of safeguarding personal principles) and improving legal literacy. This means that care is more centred around an individual's specific needs and that staff are aware of their legal responsibilities as stated within the Care Act 2014. All concerns that meet the three statutory criteria with S.42(1) of that Act now receive a S.42(2) response including those cases where there are support needs around addiction and substance misuse. This is seen as a positive and progressive move by the service.

15.5.76 These changes are evident in later practice. In July 2019 following a referral from a night shelter the Single Point of Access Team within ASC responded appropriately by contacting Addaction (now With you) and confirming that a multi-disciplinary meeting was planned and that all relevant support was in place. Whilst this should be seen as good practice it was evident that Kathryn's voice was not represented either in the referral or in the response by ASC. The care and support statutory guidance advocates that the adult at risk should be consulted at as early a stage as possible and is the primary consideration in safeguarding decision making. 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**).

15.6 Mental Health Support for Kathryn

15.6.1 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. Childhood adversity such as this can have lasting negative

effects on physical and mental health⁵⁵ and can have poor psychosocial/behavioural outcomes, such as alcohol problems, risky sexual behaviour, depressed mood, suicidal ideation, and anxiety problems. Trauma exposed young people have been found to be twice as likely to develop a mental health condition compared to non-trauma exposed young people and they have an increased risk of taking their own lives.⁵⁶

- 15.6.2 Over the years there is evidence to indicate that Kathryn's mental anxiety had increased, and this had a detrimental impact on her life experiences. According to Annika, Kathryn had started to self-harm in 2003/2004 and she described how the severity of her mental health issues had only become apparent to her in the summer of 2006. At that time Kathryn was cutting herself with razor blades and was described as acting in an "*impulsive and self-destructive way*".
- 15.6.3 In 2009 Kathryn had access to counselling which, according to Annika, she found very traumatic. After that period Kathryn made several attempts to take her own life and became increasingly addicted to illegal drugs. During this period Annika described how Kathryn's periods of anxiety and depression increased, and she has acknowledged that this made Kathryn's engagement with agencies difficult.
- 15.6.4 Although Kathryn had never requested a specific consultation with her last GP for mental health, they were aware that she was involved with specialist services and had confirmed that she was being supported by a recovery team based at the specialist resource centre. This was good practice.
- 15.6.5 Kathryn had received support from community mental health services and had a care co-ordinator. In 2021/22, Structured Clinical Management (SCM) sought to complete a detailed assessment and formulation to explore how the past trauma had impacted on Kathryn's life, and how this could inform current difficulties to support the goals and the treatment phase interventions. 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.
- 15.6.6 Kathryn's capacity to make decisions about her own welfare and support would appear, on occasions, to be impaired by the level of coercion and control that both Brent and formally William exerted. Brent used to dissuade Kathryn from attending appointments and he had convinced her that that attendance at counselling was a sign of weakness. He would also refuse to look after Nyota during appointments, hence her non-attendance.
- 15.6.7 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. On many occasions this

⁵⁵ Knipschild R et al (2024).

⁵⁶ Rogerson et al (2024)

was likely due to them being unaware of her circumstances as Kathryn had felt unable to disclose the abuse she was experiencing. As Kathryn's mental anxiety and alcohol/illicit drug misuse intake increased her ability to make rational decisions would also fluctuate.

- 15.6.8 The Mental Capacity Act 2005 (MCA) clearly states that professionals should always assume that clients have capacity⁵⁷ unless they are able to establish otherwise. Under the MCA health and social work professionals are required to assess an individual's capacity before carrying out any care or treatment if they have reasonable belief that they lack that capacity. Principle 2 of the Act states that people should be supported to make their own decisions. This should occur before any assessment of their ability to make the decision is carried out. If there were concerns that Kathryn was experiencing coercion and control, which was influencing their ability to make their own decisions, then work should have been completed to remove the impact of this abuse and to support her to make appropriate decisions.
- 15.6.9 The balance between meeting someone's needs, particularly when they are deemed to have the capacity to make decisions for themselves and the need to intervene with treatment and care can often be difficult for professionals to judge. Often resource capacity, limited time, lack of training, awareness and legal literacy hinder professionals from considering the wider implications of coercion, control, and the mental impact of abuse on an individual's ability to make rational decisions, including the ability to engage.
- 15.6.10 Despite Kathryn's mental state and her diagnosis of borderline personality disorder she was deemed to have capacity by those that were treating her. In their discussions with Kathryn, she had demonstrated that she was able to make her own decisions (albeit this could fluctuate) and it is unlikely that an assessment would have demonstrated otherwise, and in turn have led to more restrictive interventions. This would appear to have been a proportionate response in these circumstances.
- 15.6.11 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. An example of this was demonstrated in the Autumn/Winter of 2016 when Kathryn was under the care of a CMHT and a social worker was allocated to her case. On this occasion Kathryn had apparently struggled to engage with the psychiatrist, psychologist, and social worker due to her anxiety. On the 22nd of December 2016 Kathryn met with the psychologist to see if she met the criteria for therapy and was warned that she would be discharged from all services if she did not attend her appointments. Annika has stated that Kathryn felt overwhelmed by agency contact (although it is unclear as to whether Kathryn had confided in mental health professionals that she felt this way) 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.

⁵⁷ Having mental capacity means being able to make and communicate your own decisions.

- 15.6.12 In 2020 professionals working with Kathryn felt that she was not appropriate for referral to AWP mental therapeutic intervention until she had addressed her substance misuse. She was signposted to community mental health services and discharged to her GP. Health records show that her midwife had concerns that primary services were unable to deal with escalating issues of self-harm without specialist mental health support.
- 15.6.13 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.
- 15.6.14 The review Panel have discussed the current waiting times for GP therapeutic services, particularly for those individuals who may be suffering from domestic abuse. There was an acknowledgement 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.
- 15.6.15 A recent report by the Department for Levelling Up, Housing and Communities (2024) identified that domestic abuse services in the UK report cannot meet current demands. Within this context, there is evidence that it is particularly difficult for women experiencing multiple disadvantages to access support. The lack of integration of domestic abuse services with other services for co-occurring needs has also been identified as a barrier to engagement. The siloed nature of services limits their ability to deal with co-occurring issues.
- 15.6.16 In Kathryn's case the GP practice demonstrated thorough and safe medical practice regarding the long-term prescribing of controlled drugs / mental health medication, in a shared care mechanism with MH services. Each time a clinical letter was received from the MH team regarding a change in medication it was processed in a timely fashion and Kathryn was informed via SMS text message of the update. Kathryn was also reminded (via SMS) to book appointments for medication reviews on a regular basis. Discussions and updated prescriptions were arranged with both the GP and clinical pharmacists over the review period. When Kathryn requested controlled drugs at an unexpected time (too soon according to prescription length), this triggered a review with clinical staff. This level of co-ordination and flexibility should be seen as good practice.

15.7 **Safeguarding/Welfare - Support for Kathryn and Nyota**

- 15.7.1 Kathryn's life experiences would appear to have had a profound impact on her mental wellbeing. As described in previous sections of this report she had suffered from increasing bouts of anxiety and depression, and she was dependant on illegal drugs. Agencies had worked with Kathryn when she was pregnant to inform her of the consequences of this addiction on her daughter. There was clear evidence of her GP and midwife services working together to control her use of medication and they had

been honest with her about their concerns. They had also tried to support her to change her behaviour. 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. At that time there was also evidence of good liaison between drug services and children's Social Care.

- 15.7.2 The concern shown by agencies and the possibility of losing her daughter had led to Kathryn fearing services and being overwhelmed by professionals. Midwives raised concerns that the uncertainty about the plans from a social care perspective appeared to be escalating Kathryn's risks of self-harm. Her behaviour to professionals was at that time driven by the fact that she was fearful that Nyota would be removed if she made any mistake or did not follow advice. These concerns have been evident in several DHR's linked to victims taking their own lives⁵⁸ where researchers have '*acknowledged the complex dynamics at stake with ...the impact that fear of losing custody may have on victims' disclosure and engagement, and the appropriateness of interventions in the name of child protection*'.
- 15.7.3 In response to a referral by We Are With You in June 2020, which had raised concerns about Kathryn's wellbeing to the Local Authority (Children's Social Care), they had no option but to initiate pre-proceedings with a plan for Kathryn to move with Nyota to a mother and baby rehabilitation unit. The response was immediate in line with policy and practice and was progressed as a way of supporting Kathryn and her child. CSC have stated that they were aware that Kathryn was concerned about losing the care of Nyota but they had reassured her on several occasions. Kathryn had also reported that she felt reassured by what professionals had told her, although the review was unable to confirm whether this was what she was truly thinking. Kathryn was also described as having a good relationship with her social worker.
- 15.7.4 Kathryn successfully completed the programme of support and returned to Weston-Super-Mare in February 2021. Nyota was then monitored on a Child Protection plan (27/01/2021 – 03/08/2021) and throughout that period CSC have confirmed that risk assessments were completed and updated in line with their policy. Kathryn was described as working well with the community plan, which gradually decreased the level of support and visits. Again, this level of support and oversight was in line with practice.
- 15.7.5 At the time when Nyota was on a Child In Need Plan. Children's Social Care had raised continual concerns that they felt that the Child Protection Plan would not ensure Nyota's safety. Social Care professionals believed that the plan would not add anything further to the intervention that was already in place, and this had failed to curtail Kathryn's drug dependency in the past. This was a difficult time for all agencies involved and it is apparent that the primary and overriding concern at that time was the safety and welfare of Nyota. During this time there was evidence of good

⁵⁸ Dangar et al (2022)

communication between SCPN's, midwives and Kathryn's social worker. All agencies followed their statutory duties (section 11 of the Children's Act, 2004).

- 15.7.6 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 (e.g. SCPNS) with regards to the child safeguarding process had also failed to fully appreciate any adult safeguarding considerations for Kathryn (**Recommendation: 14**).
- 15.7.7 A parenting assessment was completed in April 2021 which was positive, and it was agreed that the pre-proceedings process would end. Kathryn's case was closed in September 2021 and CSC have confirmed that the relevant risks had been consistently reviewed. Following which Kathryn withdrew her consent for CSC involvement.
- 15.7.8 Following the referral from Annika in December 2021 CSC made attempts to contact Kathryn without success. CSC requested that a police welfare check was undertaken, but no concerns were identified at that time. Annika has stated that this visit had heightened the risks, but in the circumstances, CSC felt that they had no other option as they wanted to ensure that Kathryn and her daughter were safe. Kathryn had told Annika that her partner was angry about the police turning up (given his history) and she lied to them about the situation. On this occasion agencies were following correct procedures as the safety of the child is paramount and CSC confirmed that the relevant risks had been considered. Research has shown that living in a home where there is domestic abuse can seriously impact on a child's development, physical and mental health. The subsequent impact on their later life experiences is also substantial with associated problems in education, forming relationships and being driven towards social deprivation and criminality⁵⁹.
- 15.7.9 On that occasion CSC also conducted checks with Kathryn's MH worker and again no concerns were raised. The CSC worker felt that Kathryn would benefit from some additional support however she declined. The CSC worker concluded that as Kathryn was receiving MH support and was being visited in January 2022 by a HV concerns could be raised by them. Annika claims that the return call from the CSC worker was hostile and that they refused to help address her concerns. CSC have a written record of the call and have stated that there is no evidence that the CSC worker was hostile and that they could not discuss the case as Kathryn had not given consent to do so.
- 15.7.10 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. CSC records document that if Kathryn and Nyota were to return to Somerset then they would consider whether an assessment was

⁵⁹ Taylor, J et al.

necessary *“to ensure Nyota is not being exposed to frightening behaviours or drug use”*.

15.7.11 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. The review has also highlighted that there was poor information exchange between Birmingham Children’s Services and North Somerset’s Children’s Services (**Recommendation: 15**).

15.7.12 In March 2023 following a report from Annika that she was concerned for Kathryn’s welfare, and that she believed that she was living with Brent CSC made a referral to the MASH. Professionals in the MASH conducted checks with agencies and spoke to Kathryn who insisted that she wasn’t living with Brent. Those conducting the call stated that whilst they remained *“worried that this situation may change or that Kathryn may not be honest with us about the current situation, however at present there is no evidence to the contrary and no concerns are being raised that she is dishonest”*. On what was known at that time CSC did not consider that a further assessment was needed and they reminded Kathryn of the support options that were available to her including Next Link and closed the referral. On the information known at that time this was a proportionate response. This was in line with their policy and practices and would seem proportionate in the circumstances.

15.7.13 Health visiting service records document that they had established a good working relationship with Kathryn and that they were attempting to work with her to meet the needs of her daughter. HV’s ensured that their approach was inclusive, trauma informed and they had explored with Kathryn whether she had an issue with accessing and reading information before sending written resources via email. This was particularly important as face-to-face services were limited due to COVID restrictions. This approach should be seen as good practice and there was evidence that the HV had tried to be flexible in the delivery of the services that they offered to meet Kathryn’s needs (HV asking the SW to co-ordinate contact with Kathryn) whilst she was caring for Nyota. This was particularly important as she felt overwhelmed by agency contact.

15.7.14 There was also evidence of effective communication between agencies during the period that Kathryn was pregnant and following the birth of Nyota. There was evidence that professionals (police, HV, GP) had repeatedly signposted Kathryn to additional support services. Kathryn's HV was particularly proactive in seeking out and sign posting her to some support groups and activities that she could take part in within the community, and she referred Kathryn into a Mum in Minds Toddler group with her consent. The police had also submitted BRAG⁶⁰ assessments for both Kathryn and/or Nyota during their periods of contact.

15.8 **Risk Management**

15.8.1 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.

15.8.2 The risks that were identified in this case were balanced against the protective factors in Kathryn's life, which included the birth of her daughter, the friendship of Annika and Brent being present to support her, although as previously stated in the report this belief was misguided. There was clear evidence that support mechanisms were discussed on numerous occasions and signposting offered. When assessments took place there was no immediate risks identified and Kathryn had not made any direct disclosures about abuse, other than those to the police. This makes professional decision making difficult in terms of managing these risks.

15.8.3 The agencies involved with Kathryn have established risk management processes in place. Whilst each agency was looking at risks factors that were pertinent to their own organisation there was also, on most occasions, a collective understanding of the issues that Kathryn was facing, albeit the review has found some gaps in agency record keeping.

15.8.4 Studies⁶¹ have found that domestic abuse survivors have higher than average rates of suicidal thoughts, with as many as twenty three percent of them having attempted to take their own lives compared with three percent among populations with no prior domestic abuse exposure. 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

⁶⁰ The purpose of a BRAG assessment is to help officers more objectively assess and articulate vulnerability. This helps them determine the right course of action and facilitates signposting / onward referrals to partner agencies.

⁶¹ Aitken, R & Munro, V. E (2018), DomesticShelter.Org (2016).

probably due to the low numbers that have been identified there needs to be a greater acknowledgement of the impact of abuse (**Recommendation:16**).

15.9 **The impact of COVID**

15.9.1 During the COVID period Annika and her daughter were the only real protective factors in Kathryn's life. Her inability to socialise together with the coercion and control in her relationship with Brent undoubtedly increased her vulnerability during this period in her life. Contact by several of the services that were supporting her (GP/Health visitors) were carried out online or via the telephone which reduced the opportunities for interaction and disclosure.

15.9.2 The true impact of COVID on Kathryn's mental health has been difficult to determine. From the records that are held, and from the disclosures made by Kathryn and Annika, she felt isolated and struggled to mentally cope with her life experiences.

15.9.3 The consequences of COVID are only just starting to emerge on a national basis post pandemic^{62/63} but the evidence would appear to indicate that abuse and mental health anxiety proliferated in this period, and this is reflected in Kathryn's own life story. There has been nothing specifically found during the review process that would require additional recommendations for agencies about their response during this period.

15.10 **Operational Practice, Policy, and Procedure**

15.10.1 As part of the review process the IMR writers and Panel members have confirmed that their domestic abuse policies and practices are current and have been reviewed in line with their organisational guidelines. The review has however identified that some of these policies require further review to ensure that they meet national best practice. These findings have resulted in two recommendations (9 and 12) to ensure that this work takes place.

15.10.2 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. 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. 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. This

⁶² The Office of National Statistics reported that domestic abuse rose by 7% in the period of March to June 2020, compared to 2019 and by 18% comparatively from 2018, with a month on month increase of 9% being reported between April and May 2020 (Domestic Abuse during the coronavirus pandemic, England and Wales: November 2020 www.ons.gov.uk).

⁶³ Local Government Association (2021)

can be done with support from PCSE (Primary Care Support England) but remains a National issue (**Recommendation:17**).

15.10.3 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 there was an acceptance it can often be difficult to establish a comprehensive approach when agencies lack all the information, particularly when those who use services are reluctant to share that information. In this case there was some understanding amongst agencies of the trauma in Kathryn's background, but this wasn't shared. Agencies acknowledged that having the time and resource to adopt this approach effectively can be problematic. 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.

15.11 **Training**

15.11.1 Representatives of the agencies involved in this review have confirmed that training and awareness in relation to domestic abuse and coercion and control continues to be delivered to all staff to promote greater knowledge and understanding. Changes have been implemented to ensure that there is a comprehensive multi-agency package of training in North Somerset that covers all areas of domestic abuse including risk led response and coercion and control. This training is being delivered by NextLink. There is also an online package for non-statutory organisations and this should be seen as good practice.

15.11.2 The report has highlighted the need for the ICB to ensure that appropriate Primary Care staff are trained in domestic abuse and coercive and controlling behaviour.

16.0 Conclusions

- 16.1. 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.
- 16.2. 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.
- 16.3. 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.

- 16.4. 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.
- 16.5. 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.
- 16.6. 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.
- 16.7. 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.
- 16.8. 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.
- 16.9. 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.
- 16.10. There were also occasions when Kathryn's voice was lost in the systems and processes that were followed by agencies.
- 16.11. 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.
- 16.12. 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.

- 16.13. 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.

17.0 Learning

- 17.1 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 its 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.

18.0 Recommendations

- 18.1 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 ASC⁶⁴ 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.

⁶⁴ 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

Bibliography

Agenda Alliance (2023) Under examined and under reported. Briefing by Agenda Alliance.

Ahmad I, Ali PA, Rehman S, Talpur A, Dhingra K. *Intimate partner violence screening in emergency department: a rapid review of the literature*. J Clin Nurs. 2017 Nov;26(21-22):3271-3285. doi: 10.1111/jocn.13706. Epub 2017 Mar 22. PMID: 28029719

Aitken R, Munro V (2018) Domestic Abuse and Suicide: Exploring the Links with Refuge's Client Base and Work Force. London: REFUGE.

Ali, P.A., Dhingra, K. and McGarry, J. (2016) A literature review of intimate partner violence and its classifications, *Aggression and Violent Behaviour*, 31(6): 16–25. doi: 10.1016/j.avb.2016.06.008

Barnes M, Barter C, Herbert A, Heron J, Feder G, Szilassy E. Young People and Intimate Partner Violence: Experiences of Institutional Support and Services in England. J Fam Violence. 2023 Jun 13:1-13. doi: 10.1007/s10896-023-00591-x. Epub ahead of print. PMID: 37358971; PMCID: PMC10264091.

Bates L , Hoeger K , Stoneman MJ , Whitaker A (2022) Home Office, Vulnerability and Knowledge Programme, NPCC, College of Policing (2021) Vulnerability Knowledge and Practice Programme (VKPP): Domestic Homicides and Suspected Victim Suicides During the Covid-19 Pandemic 2020-2021.

Baker, N., Buick, J.D., Kim, S.R., Moniz, S. and Nava, K.L. (2013) Lessons from Examining Same-sex IPV, Sex Roles, 69(3-4): 182–92. doi: 10.1007/s11199-012-0218-3

Care and Support Statutory Guidance: DH 2023 (Chapter 14)

Care and support statutory guidance - GOV.UK (www.gov.uk)

Danger, S., Munro, V., Andrade, L. (2022) "Learning Legacies: An analysis of Domestic Homicide Reviews in Cases of Domestic Abuse Suicide. Warwick University.

Department of Levelling Up, Housing, and Communities. *Annual progress report from the Domestic Abuse Safe Accommodation National Expert Steering Group 2022 to 2023*. Published 20 February 2024.

Domestic Violence and Abuse: Multi Agency Working; Public Health (NICE) Guideline [PH50]; 2018

Guedes. A, Bott. S, Garcia-Moreno. C, Colombini. M. (2016) Bridging the gaps: a global review of intersections of violence against women and violence against children.

Graham K, Bernards S, Wilsnack SC, Gmel G. Alcohol may not cause partner violence, but it seems to make it worse: a cross-national comparison of the relationship between alcohol and

sKathrynarity of partner violence. *J Interpers Violence*. 2011 May;26(8):1503-23. doi: 10.1177/0886260510370596. Epub 2010 Jun 3. PMID: 20522883; PMCID: PMC3142677.

Graham K. Bernards S., Wilsnack, and Gmel, G. (2011), 'Alcohol May Not Cause Partner Violence but It Seems to Make It Worse' *Journal of Interpersonal Violence*, 26:1503–23

Hester, M. (2013) Who does what to whom? Gender and domestic violence perpetrators in English Police Records, *European Journal of Criminology*, 10(5): 623–37. doi: 10.1177/1477370813479078

Home Office. (2015) Controlling or Coercive Behaviour in Intimate or Family Relationship Statutory Guidance Framework; Dec 2015; London. Home Office.

Home Office (2016) Domestic abuse and Abuse guidance; London. Home Office

Home Office. (2016) Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews; December 2016; London. Home Office.

Home Office (2020) Domestic Abuse during the coronavirus pandemic, England and Wales: November 2020 www.ons.gov.uk

Home Office (2022) Controlling or Coercive Behaviour; Statutory Guidance Framework - [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1072673/MASTER ENGLISH - Draft Controlling or Coercive Behaviour Statutory Guidance.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1072673/MASTER_ENGLISH_-_Draft_Controlling_or_Coercive_Behaviour_Statutory_Guidance.pdf).

Intercollegiate Document: Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019).

Irving L, Liu BC. Beaten Into Submissiveness? An Investigation Into the Protective Strategies Used by Survivors of Domestic Abuse. *J Interpers Violence*. 2020 Jan;35(1-2):294-318. doi: 10.1177/0886260516682520. Epub 2016 Dec 14. PMID: 29294623.

Iverson, K.M., Litwack, S.D., Pineles, S.L., Suvak, M.K., Vaughn, R.A. and Resick, P.A., 2013. Predictors of intimate partner violence revictimization: The relative impact of distinct PTSD symptoms, dissociation, and coping strategies. *Journal of traumatic stress*, 26(1), pp.102-110.

Kertesz, Margaret, Larissa Fogden, and Cathy Humphreys. "Domestic violence and the impact on children." *The Routledge International Handbook of Domestic Violence and Abuse*. Routledge, 2021. 128-140.

Johnson, L., Chen, Y., Stylianou, A. and Arnold, A., 2022. Examining the impact of economic abuse on survivors of intimate partner violence: a scoping review. *BMC public health*, 22(1), p.1014

Knipschild R, Hein I, Pieters S, Lindauer R, Bicanic IAE, Staal W, de Jongh A, Klip H. Childhood adversity in a youth psychiatric population: prevalence and associated mental

health problems. *Eur J Psychotraumatol.* 2024;15(1):2330880. doi: 10.1080/20008066.2024.2330880. Epub 2024 Mar 26. PMID: 38530708; PMCID: PMC10967663.

NICE (2014) *Domestic violence and abuse: multi-agency working*. Public health guideline [PH50] Published: 26 February 2014

NICE (2016) *Recognising and Responding to Domestic Violence and abuse*

Rogerson, O , O'Connor, R, O'Connor D (2024) "The effects of childhood trauma on stress-related vulnerability factors and indicators of suicide risk: An ecological momentary assessment study" *Journal of Affective Disorders* <https://doi.org/10.1016/j.jad.2024.02.029>

Local Government Association (2021). *COVID-19 Adult Safeguarding Insight Project Second Report*. Local Government Association.

Long, J., Harvey, H., Wertans, E., Allen, R., Harper, K. and Deirdre, K.E. (2021) *UK Femicides 2009–2018*, London: Femicide Census

Reno, J., Marcus, D., Leary, M.L. and Samuels, J.E., 2010. Full report of the prevalence, incidence, and consequences of violence against women. Department of Justice. Available online at: <https://www.ncjrs.gov/pdffiles1/nij/183781.pdf>.

Sosenko, F., Bramley, G., and Johnsen, S. (2020) *Gender matters: gendered patterns of severe and multiple disadvantage in England*. Heriot-Watt University and DMSS Research.
Stark, E. (2007) *Coercive Control: How Men Entrap Women in Personal Life*, Oxford: Oxford University Press.

Stonard, K. E., Bowen, E., Lawrence, T. R., Price, S. A. (2014). The relevance of technology to the nature, prevalence and impact of adolescent dating violence and abuse: A research synthesis. *Aggression and Violent Behavior*, 19(4), 390–417. <https://doi.org/10.1016/j.avb.2014.06.005>

Taylor, J, Bates, E (2023) *Children and Adolescent's Experiences of Violence and Abuse at Home*. Taylor and Francis.

UK Finance (2021) *Financial Abuse Code*

Walby, S., Towers, J., Balderston, S., Corradi, C., Francis, B., Heiskanen, M., Helweg-Larsen, K., Mergaert, L., Olive, P., Palmer, E. et al. (2017) *The Concept and Measurement of Violence Against Women and Men*, Bristol: Policy Press.

Wolford-C, IKathrynnger. C et al (2017) Associations of Emotional Abuse Types with Suicide Ideation among Dating Couples, *Journal of Aggression, Maltreatment & Trauma*, Volume 26, Issue 9, p.1042-1054

Women's Aid (2019) *The domestic abuse report 2019: The Economics of abuse*. Bristol Women's Aid.

Women's Aid. (2021) Mental health and domestic abuse: A review of the literature. Bristol: Women's Aid.

Women's Aid (2023) The Domestic Abuse report 2023; The Annual Audit

DRAFT 1