Nottingham Community Safety Partnership

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SILP™ SIGNIFICANT INCIDENT LEARNING PROCESS

Overview Report into the death of RAA

April 2022

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Independent Domestic Homicide Review Chair and
Report Author
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The Nottingham Community Safety Partnership would like to express their sincere condolences to the surviving family members and especially to her children regarding the loss of RAA.

Pen Picture of RAA given by RAA's mother in conversation:

RAA was a kind, very giving person who put everybody first. She adored her children, her time with family was very precious. She came across as a very strong person, this was often a front, she told you what you wanted to know, and kept things back not to trouble you, she didn't like to burden anyone. She was close to her half-sister S and her two brothers. Her father was very supportive of her and although parents weren't together everything was amicable. She had a difficult time during her teenage years, as an adult her focus was on her children.

1. Introduction :

1.1 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004. This Domestic Homicide Review is commissioned by Nottingham Community Safety Partnership in response to the death of RAA at the age of 29. This DHR report examines agency responses and support given to RAA prior to her being found deceased in April 2022 by her ex-partner XY and mother at her ex-partner's property, having taken an apparent overdose of prescribed medication. An inquest has not currently been completed the cause of death to be confirmed by the coroner.

1.2 RAA had a history of mental health concerns documented from adolescence into adult hood. In addition to agency involvement, the DHR will also examine the past to identify any relevant background or trail of abuse before her death, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.3 There is clear evidence that RAA was experiencing domestic abuse with a number of police reported incidents. An investigation into coercive controlling behaviour has been undertaken by Derbyshire Police and this has now been concluded with no action taken.

1.4 The Nottingham Community Safety Partnership approved the circumstances of this case as fulfilling the criteria for a statutory domestic homicide review and initiated the DHR process on the 30th May 2022. The Significant Incident Learning Process (SILP) review model was the methodology used. This involves agencies producing timelines and analytical reports of their involvement and encourages learning to be identified by the staff involved in the case and as far as possible, aims to involve members of the families affected by the incidents. Staff who had been involved, and the agency report writers, were brought together at a learning event to discuss the reports and issues and themes emerging, focusing on key episodes identified from the reports. Recall

Days followed to discuss the draft of the Overview Report. The process was signed off by the Board on the 7/2/23.
The Panel met on the following dates: 12/10/22; 19/10/22; 12/12/22; 10/01/23; 18/01/23; 01/02/24.

1.5 The guidance states:
A Domestic Homicide Review (DHR) must be undertaken when 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 was related or with whom he was or had been in an intimate personal relationship, or
(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

The purpose of the DHR is to:
establish what lessons are to be learned from domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

Apply these lessons to service responses including changes to policies and procedures as appropriate; and

Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

Contribute to a better understanding of the nature of domestic violence and abuse; and

Highlight good practice.

Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016)

Confidentiality and Dissemination

1.6 The DHR was conducted in the spirit of openness and fairness that avoids hindsight bias and any bias toward any one agency or individual involved. The DHR was conducted in private. All documents and information used to inform the review were confidential. The findings of the review should remain confidential until the Nottingham Community Safety Partnership accepts the Overview Report, Executive Summary and Action Plan and it has been reviewed by the Home Office Quality Assurance Panel. To preserve confidentiality, and in accordance with the wishes of the surviving family members of the deceased, the following references have been used to represent the subjects of the review. This DHR has been anonymised in accordance with statutory guidance. The specific date of the death and the

sex of any children have been removed (with anonymity further enhanced by the children being referred to as child A, and child B identifying information about their primary school being removed). Only the Chair and Review Panel members are named.

RAA	deceased
XY	ex-partner
Child A	child
Child B	child
BC	RAA's mother
AZ	RAA's father

Dissemination List for the report:

The following individuals/organisations will receive a copy of this report:

- Relevant family members who wish to have a copy namely BC and AZ.
- Nottinghamshire Police and Crime Commissioner
- Domestic Abuse Commissioner
- HM Coroner
- The Chief Officer of all organisations engaged in the review
- Home Office Repository

2: The Review Process

2.1 The domestic homicide review process commenced with an initial meeting of the 13/10/22. An initial trawl for information identified 19 agencies who had significant contact with either RAA or her partner. Independent Management Reviews (IMR's) and chronologies of their contact with RAA and her partner were requested from these agencies addressing the agreed Terms of Reference and Project Plan, **(Appendix 1).** Initial contact was made with the family with information relating to the process as per Home Office guidance. The family were sent leaflets relating to support and advocacy services with a letter of introduction from the Independent Chair. An Interview was undertaken with RAA's mother and regular contact occurred throughout the process; the request to speak to RAA's work colleagues was declined; AZ was also contacted throughout the process communication was mainly via email. The Chair had a conversation in April just prior to the report submission in which AZ

indicated he would forward comments however these were not received. AZ has since been assisted by an advocate from AAFDA[1].

2.2 Independence and Quality of IMRs: The IMRs were written by authors independent of case management or delivery of the service concerned. The IMRs received were comprehensive and enabled the Review Panel to analyse the contact with RAA, XY, and their children, and to produce the learning for this DHR. The full List of Panel Members and the Agencies contributing to the review are listed below and in **Appendix 2:**

Agencies contributing to the review are listed below:

- Nottinghamshire and Derbyshire Police
- Juno Women's Aid
- Nottingham Muslim Women's Network
- East Midlands Ambulance Service
- Nottinghamshire Health Care Foundation NHS Trust
- NHS Nottingham ICB – Including GP information.
- Nottingham CityCare Partnership
- Nottingham City Council Children's Services
- Derbyshire Children's Services
- Housing Aid Nottingham City Council
- Derbyshire Community Health Services NHS Foundation Trust
- Elm Foundation Derbyshire
- The Arc Bolsover District Council Derbyshire
- Education – Schools in Derbyshire and Nottingham
- Nottingham Health Care Trust (NHCFT) & City Crisis Resolution and Home Treatment Team (CRHT)
- Neighbourhood Development
- NUH
- Adult Social Care
- Probation
- NHS 111 service
- Framework Clean Slate

[1] AAFDA provide emotional, practical and specialist peer support to those left behind after domestic homicide. For or more information, go to: https://aafda.org.uk.

- DWP
- Nottingham City Council Housing
- Erewash Borough Council

Panel Members

Review Panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case.

Name	Job Title	Agency
Paula Bishop	Domestic Violence & Abuse Policy Officer	Nottingham City Council Community Safety Partnership
John Matravers	Service Manager Safeguarding Partnerships	Nottingham City Council Children's Integrated Services
Karen Turton	Named Nurse Safeguarding	Nottingham CityCare Partnership
Darren Pope	Detective Chief Inspector, Domestic Abuse, Stalking & RASSO Lead, Public Protection	Derbyshire Police
Liz Cudmore	Child and Young Person Safeguarding Lead	East Midlands Ambulance Service (EMAS)
Debbie Richards	Service Manager	Nottingham City Council Housing Aid
Yasmin Rehman	Chief Executive Officer	Juno Women's Aid Specialist Agency
Nick Judge	Associate Designated Nurse for Safeguarding Adults	NHS Nottingham and Nottinghamshire Integrated Care Board
William Morritt	Head of Tenancy and Estate Management	Nottingham City Homes (NCH)
Helen Pritchett	Specialist Practitioner Domestic Abuse and Safeguarding	Nottingham Health Care Trust (NHCFT)
Maggie Westbury	Adult Safeguarding Lead	NUH
Zaynab Asghar	Expert panel member	Nottingham Muslim Women's Network
Mark Dickson	Detective Chief Inspector – Public Protection	Nottinghamshire Police (Public Protection)
Adrian Morgan	Regional Review Unit	Police – EMSOU Report Author (covered all Police forces info)
Lisa Adkins-Young	Deputy Head, Nottingham, and Nottinghamshire	Probation Service
Anon	Principal and DSL	Child A's primary school
Alison Boyce	Domestic Abuse Manager, Community Safety	Derbyshire County Council
Jennifer Calverley	Helpline & Community Team Service	The Elm Foundation

Kat Thornhill	Community Safety Manager	Erewash Borough Council
Adele Glover	Head of Child Protection and IROs	Derbyshire Children's Services
Claire McGonigle Kevin Howard	Head of SHEQ (Safety, Health, Environment & Quality	Framework - Nottingham Recovery Network (NRN) & Clean Slate
Julie Tomlinson	Lead Nurse – Adult Safeguarding	DHU Healthcare CIC

2.3 The Nottingham Community Safety Partnership appointed Vivien Bickham to Chair the review and to author the overview report. She has never previously worked in Nottinghamshire and is independent from all the agencies involved in this case, having never had any association with the agencies or organisations involved. She has been trained in the process prescribed by the Home Office to conduct Domestic Homicide Reviews, including three-day Chairs training by AAFDA and trained in the Significant Incident Learning Process[2]. She has written Internal Management Reports (IMRs) and led internal reviews of critical incidents in the Organisations she has worked for. She has worked in the domestic abuse field for over 40 years, in various leadership and strategic roles.

2.4 The Significant Incident Learning Process (SILP) is a learning model which engages practitioners in case reviews, focusing on why those involved acted in a certain way. It follows a systems methodology, SILP reviews also highlight what is working well and patterns of good practice.

2.5 **Family consultation:** Members of RAA's family were consulted as part of the review and shared their memories and observations of her. Her mother requested the use of initials in the report rather than a pseudonym. It was requested due to the ages of the children that details are anonymised. The family were given information on advocacy services and Home Office guidance about the process. RAA's mother BC and her father AZ were regularly updated on the process throughout by the Independent Chair and were given opportunities to contribute to the process throughout. BC was keen to read the draft version before publication to make comments on this report. BC was sent a draft copy of the Overview Report. BC and the Chair spoke about the draft, BC said that the report addressed the issues she had wanted to see considered and that she felt satisfied with the contents and the way that RAA was represented. AZ also had access to the report and seemed satisfied that certain things he had highlighted have been picked up in the report. AZ did indicate he would send in further comments after a conversation with the Chair on 18/4/23 prior to the report being submitted, however, these were not received. Both parents are aware of where and how the Final Overview and

[2] https://www.reviewconsulting.co.uk/silp-reviews/

Summary Report will be published once approved by the Home Office Quality Assurance Panel. AZ is currently being supported by an AAFDA advocate.

2.6 RAA's ex-partner at the time of her death, was approached through agencies working with him to participate in this review. No response was received. As a result, there is no information directly from XY in this DHR. Nor was it possible to identify any family or friends he might have suggested could be spoken to.

2.7 **Children:** There are no parallel reviews in relation to child A or B at the time of writing the report. At the first Review Panel meeting, it was noted that the ongoing care of the children was beyond the remit of the DHR as children were under the care of their biological father, and appropriate agencies were involved to offer support and safeguarding advice. A summary of the arrangements to date was provided to assure the Review Panel that appropriate steps had been taken in relation to their care. The Review Panel were informed that after RAA's death, direct work was undertaken with the children by their social worker. As the children are considered to be Children in Need at the time of writing, the Review Panel were reassured that a range of interventions had been put in place, including an allocated social worker and referrals for further additional support if required. The children's views were considered in contributing to the process however, it was agreed by Social Care and the Panel, as the children were being supported by specialist workers that it was inappropriate to add to their distress in the current circumstances. At the time of writing the report there are also contact issues currently in the family court between grandparents and the children's father and it was felt this would add additional pressure on the children due to their young age. Evidential research on the impact on children in domestic abuse situations will be included where relevant within the report.

2.8 The Review Panel met a total of five times, with the first meeting on the 12th Oct 2022. There were further meetings in October and December 2022 and with recall events to revise the draft report in January and February 2023. Thereafter, the Overview Report and Executive Summary were agreed electronically, with Review Panel members providing comment on a final draft and signing off the final report by the Safeguarding Board on the 7th February 2023. The Chair wishes to thank everyone who contributed their time, patience and cooperation.

2.9 The Review Panel expresses its sympathy to the family of RAA dealing with their loss in such tragic circumstances and thanks them for their contributions to this review.

3. Scope and Terms of Reference of Case Review:

Equality and Diversity

3.1 The nine protected characteristics identified in the Equality Act 2010[3] were assessed for relevance to the DHR. The characteristics of Age, Disability, Race, Religion or belief, and Sex, were discussed by the DHR, and the potential vulnerabilities of mental health and domestic abuse were recognised by agencies working with RAA.

3.2 At the first meeting of the Review Panel, it was identified that the protected characteristic of Sex required specific consideration. RAA was female, her partner male. An analysis of domestic abuse reveals gendered victimisation with females representing the majority of victims and males representing the majority of perpetrators[4].

3.3 The Review Panel also identified the following protected characteristics as requiring specific consideration:

- RAA's enduring mental health would meet the criteria for disability,
- Age (there was a 10 -year age gap between RAA and XY),
- Race (RAA was mixed heritage Asian other, and described being a victim of racism in her teens and XY was of Bangladeshi origin),
- Spiritual and cultural belief (RAA believed she was in an Islamic marriage which may have added cultural belief and pressure around honour-based abuse and marriage with XY believed to have been of the Muslim faith)

These issues are considered throughout this report and are analysed in Section 6 of this report.

3.4 Scope of the Review

The scope of the review was agreed from 27/01/2020 to date of death in April 2022 (This represents the period from when agencies became involved in reported RAA's deteriorating mental health). Additionally, at the start of the DHR, it was established that RAA had moved between the counties of Nottinghamshire and Derbyshire. The Domestic Abuse Manager for the Community Safety Partnership in Derbyshire was invited to join the Review Panel, as were specific agencies as required. There are 3 episodes identified within the review that will be analysed:

Episode 1 - 27/1/20 RAA and XY were known to have a history of domestic abuse with a previous high-risk referral to MARAC and Children's Services in 2015.

Episode 2 - 17/6/20 Incidents in relation to RAA's deteriorating mental health and refusal of XY to agree to a divorce. XY's alleged suicidal Ideation as an alleged manipulative tactic of coercion impacting on RAA's mental health.

[3] The Equality Act 2010 sets out nine protected characteristics and discrimination is recognised when at least one of these characteristics determines the way in which a person is treated. The nine characteristics that are protected are: Age, Disability, Gender reassignment, Marriage or Civil Partnership, Pregnancy and maternity, Race, Religion or belief, Sex and Sexual orientation.

[4] https://theconversation.com/why-gender-cant-be-ignored-when-dealing-with-domestic-violence-74137

Episode 3 - 5/11/21 Escalating deterioration in RAA's mental health exasperated by longstanding relationship breakdown and alleged concerns from 'family' if RAA left XY.

Key Lines of Inquiry addressed throughout the report: The Review Panel considered the statutory guidance and identified the following case specific issues:

- The communication, procedures, and discussions, which took place within and between agencies across county borders.
- The opportunity for agencies to identify and assess domestic abuse risk.
- RAA's access to specialist mental health agencies with an understanding of domestic abuse.
- Any evidence of help seeking, as well as considering what might have helped or hindered access to help and support.

The Review Panel benefited from the involvement of two organisations that specifically had contact with RAA around culture and honour-based abuse:

Juno Women's Aid

Nottingham Muslim Women's Network

The vital contribution of both agencies acted as a critical friend and provided comment and feedback on the report during drafting. The Chair and Review Panel are grateful for their time and input. Their contribution is a reminder of the importance of being able to access local community expertise and knowledge during a DHR.

3.5 In addition agencies were asked to provide a brief background of any significant events and safeguarding issues prior to the scoping period. This will include any significant event that falls outside the timeframe if agencies consider that it would add value and learning to the review.

3.6 **Specific terms of reference set for this review which agencies were required to address in their agency reports.**

3.6.1 Identify examples of good practice, both single and multi-agency.

3.6.2 Analyse the quality of risk assessments undertaken. Were links between mental health, domestic abuse and suicidal ideation identified at any risk assessment? Have there been changes in the service since 2020, particularly policies and training?

3.4.3 Whether risk was or was not identified, where can practitioners within your agency receive advice or support if they suspect domestic abuse? Was this taken up in this case? If this is available would the advice extend to consultation or referral across agencies?

3.4.4 Is there evidence of whether any identified risk had been assessed as reaching the threshold for inter-agency information sharing especially around suicidal ideation linked to Domestic Abuse?

3.4.5 What evidence is there of communication and information sharing between agencies? How could information sharing, and communication have been improved during the scoping period both within and between agencies? Did the cross-boundary context impact on information sharing and if so, how?

3.4.6 Were referral pathways followed according to local policies? If not, what was the reason this did not happen? Are these pathways different now?

3.4.7 What role if any, did the Covid pandemic and restrictions at the time impact on access to services for RAA and family members?

3.4.8 Were agencies aware of any complexities of family dynamics or circumstances that would impact on RAA or family members accessing support?

3.4.9 Was consideration given of the link between domestic abuse and suicide because of cultural practices, concepts of honour and shame, and/or community barriers that may have prevented RAA seeking help?

Engagement with family, friends and work colleagues.

3.3.10 A key element of SILP is engagement with family members, in order that their views can be sought and integrated into the Review and the learning. The Nottingham Community Safety Partnership had confirmed that the mother of RAA wishes to have contact and to be informed that this Review is being undertaken. The independent lead continued to seek the scope for any other family, friends or work colleagues who may have wished to engage in the review. Although approached no further information was provided.

4. Review Summary

4.1 Background Information

The victim will be referred to in this report as RAA. RAA at the time of her death was estranged from ex-partner who will be referred to as XY. She had 2 children, child A and child B. The eldest child A was a surviving twin, and the loss of the other twin is believed to have had an impact on RAA's mental health[5]. RAA was supported by her biological mother referred to as BC and her biological father referred to as AZ. Her biological parents were divorced however they have a good relationship, both having offered support as required throughout RAA's life. RAA also had close relationships with her half-sister and 2 biological brothers.

4.2 RAA is described as an adoring mother to her two children, kind, putting everybody first, family orientated. Although she came across as strong this was often a front as she didn't like to burden others. She is described that she often would only let you know what she wanted you to know and hold things back as she didn't want to burden her family. She would ask her mum and dad for assistance, including financial help, when necessary, although she is said to have not wanted anything. In information given by the family it is noted that RAA would also use cannabis as part of her self-medication for her situation.

4.3 She was known to Mental Health, Police, Children's Services and Domestic Abuse services with sporadic engagement at various crisis points. It is noted

[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8747442/

from information supplied reference to a traumatic event of an alleged rape and RAA's experience of going through the court process at 13 years of age. The rape occurred when RAA was aged 10, during this time there were concerns of some alcohol use and self-harming as part of her coping strategy with the traumatic events. Research evidences the impact of adverse childhood experiences[6] with almost half of children and young people living in the UK having experienced one or more forms of adversity. ACEs are shown to impact on a child's development, their relationships with others, and increase the risk of engaging in health-harming behaviours and experiencing poorer mental and physical health outcomes in adulthood. RAA's life experience would suggest from the examples given by family she was more than four times more likely to have concerns around mental health because of her life experience based on the research. RAA also would meet the criteria for an individual who has been exposed to complex trauma. This is defined as someone who has either experienced repeated instances of the same type of trauma (e.g. domestic abuse) over a period of time or experienced multiple types of trauma (van der Kolk, McFarlane, & Weisaeth, 1996). Expert consensus is that people who have complex trauma will typically require more intensive and extensive treatment as well as possible adaptations to standard treatment. It is significant that throughout reports there is no direct mention regarding the impact of rape trauma on RAA, minimal reference to loss of the other twin at birth with her pregnancy with child A, all with the potential impact of complex post-traumatic stress disorder[7]. It has been established that mental health conditions including enduring suicidality have an established patten with intimate partner violence.[8]

4.4 Her accommodation was primarily rented housing, both with her ex-partner and links to her family who lived close by. She is described as also spending time at a friend's property known as B in Nottingham. The Review Panel and Chair were unable to gain any further information from agencies or family about B. RAA did access safe temporary accommodation and was actively bidding for safe secure property away from her ex-partner and near to the support of her family during episode 2 & 3.

4.5 RAA is known to have had a close relationship with the GP who was very supportive and was aware of Domestic Abuse. Her GP had regular reviews and the surgery was aware of her situation with her file flagged for domestic abuse which is best practice. Her medication was in line with guidelines for her condition and the GP consulted with psychiatric services again best practice.

4.6 RAA is known to be XY's second wife. There is indication that XY had a history of domestic disturbances with his previous partner. Social Care records indicate XY was exposed to domestic abuse as a child. Witnessing domestic

[6] https://www.youngminds.org.uk/professional/resources/understanding-trauma-and-adversity/#:~:text=Trauma%20isn%E2%80%99t%20a%20mental%20health%20condition%20in%20itself%2C,compulsive%20disorder%20%28OCD%29%2C%20eating%20disorders%20and%20self-harming%20behaviours.

[7] https://enlivenarticles.com/ptsd-in-adults-from-childhood/

[8] https://doi.org/10.1136/bmj.o2890 (Published 01 December 2022)
Cite this as: BMJ 2022;379:o2890

abuse[9] as a child can have a long-term impact on intimate relationships in adult hood and is seen as an indication of an adverse childhood experience in itself. There was a ten-year age gap between RAA and XY, age differences[10] can indicate a 'power imbalance' in relationships, with the older person using their knowledge and life experience to influence the younger person with their values and beliefs. XY has a recorded history of criminality with his most recent conviction in 2021. Information given by RAA was that XY had connections with agencies which RAA felt made her unsafe. This would indicate the level of coercive control through 'gas lighting'[11] and 'power imbalance'[12] XY had over RAA and would influence her help seeking process. There was some intelligence to corroborate this perception.

5. Timeline of Significant Events

5.1 **Episode 1 27/1/20 – 16/6/20** RAA and XY were known to have a history of domestic abuse with a previous high-risk referral to MARAC[13] and Children's Services in 2015. Information supplied as part of the background to the relationship indicates the first report of domestic abuse between RAA and XY was in November 2015 with the incident referred to MARAC as high risk[14]. She was 5 months pregnant at the time of the incident with her second child and RAA described being punched to the face, kicked to the ground where XY placed his hands around her throat, when arrested for this assault XY denied the allegation. RAA disclosed to officers she was fearful of XY and his family and would not be able to obtain a divorce following a marriage in a Muslim ceremony until the children were of school age. RAA disclosed that there had been previous incidents of domestic abuse but there were concerns from officers that she was minimising the incidents and the likely effect on child A. It is apparent that there was a lack of understanding of the fear RAA was experiencing and the barriers to help seeking to those where there is added cultural belief and pressure around honour and marriage[15]. The outcome from CPS was no further action (NFA). Both children were made subject to a child protection plan in 2015, under the category of emotional harm following the incident of domestic abuse in which the father assaulted mother whilst she was pregnant (child B was put on a pre-birth plan). The plan closed in 2016, after father remained in the property and both completed work in relation to domestic abuse. There are no further reported incidents of domestic abuse to Notts Police till February 2020. It is of note that although there are no formal reported incidents of Domestic Abuse this does not mean domestic abuse

[9] https://safelives.org.uk/practice_blog/living-domestic-abuse-ace-adverse-childhood-experience

[10] https://www.brook.org.uk/your-life/power-imbalances-in-relationships/

[11] https://www.thehotline.org/resources/what-is-gaslighting/

[12] https://bmcwomenshealth.biomedcentral.com/articles/10.1186/s12905-018-0675-0Unequalpower relations and partner violence against women

[13] https://safelives.org.uk/sites/default/files/resources/MARAC%20FAQs%20General%20FINAL.pdf

[14] The DASH is a tool to provide a uniform understanding of risk across professions. There is a specific police version of the risk checklist, which is used by most police forces in England and Wales. For more information, go to: For http://www.safelives.org.uk/practice-support/resources-identifying-risk-victims-face.

[15] https://journals.sagepub.com/doi/full/10.1177/1077801220952168 Honor-Based Abuse in England and Wales: Who Does What to Whom?

wasn't present in the relationship, especially in terms of coercive control[16] which is one dynamic of domestic abuse. Less than 40 per cent of the women who experience domestic abuse seek help of any sort[17]. The last contact with Nottingham City Council Children's Services before the scoping period relevant to the report was in December 2019 when RAA reported to Police that XY may have taken an overdose after drinking alcohol after they had ended their relationship, and that RAA was worried about his whereabouts as they were unknown. This behaviour further illustrates XY's psychological manipulation of RAA. Information held by Nottingham Health Care Trust held outside of this scoping period however deemed relevant, highlights in 2019 a referral to Let's talk Wellbeing service due to issues with XY and reported thoughts to end her life although she denied that she would act on them at the time. In November 2019 RAA declines any further support when options were discussed, and she is discharged back to her G.P.

5.2 In the telephone assessment carried out by the Assistant Psychological Wellbeing practitioner in November 2019, RAA highlighted a history of multiple traumas and that she was currently off work and her partner had left three days earlier. There is no reference if the assessment took account of complex post-traumatic stress disorder as part the process and if specialist counselling had been accessed previously. There is a lack of professional curiosity shown to explore the context of his leaving and the impact on her mental state. Research from Women's Aid[18] highlights unfortunately, when survivors speak with healthcare professionals about domestic abuse and mental ill health, the response does not always meet the presenting need. Victim-blaming, disbelieving attitudes and inappropriate responses are significant barriers to accessing support. It is also important to understand the context of oppression (including multiple intersecting forms of inequality and discrimination) in which survivors are experiencing domestic abuse, and the barriers that structural sexism, racism and other forms of inequality create in accessing mental health support. In Thiara and Harrison's[19] report the authors note that access to mental health support is lowest amongst the most marginalised groups. They state that: "The ways in which racism perpetuates health inequalities is evident in how Black and minoritised groups access, or are deterred from accessing, forms of help and support, especially through statutory/mainstream mental health services…" When asked about domestic abuse she did not report any concerns. There is evidence of some healthcare professionals not feeling confident in addressing domestic abuse and sometimes treating survivors' mental health concerns as completely separate from their experiences of abuse. This leads healthcare professionals to focus solely on physical injuries or narrowly view a survivor's mental ill health as a medical problem or condition as is seen in RAA's experience, rather than understanding it as the result of being subjected to domestic abuse. It is important for practitioners to understand the help seeking process and barriers to disclosure in domestic

[16] https://www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship

[17] www.unwomen.org/en/what-we-do/ending-violence-against-women/facts-and-figures

[18] https://www.womensaid.org.uk/

[19] https://www.womensaid.org.uk/wp-content/uploads/2021/12/FINAL-Reframing-the-links.pdf

abuse[20] especially any factors which may include risks due to cultural or spiritual beliefs[21].The importance of early intervention as highlighted in trauma and domestic abuse research would suggest a further professional exploration into RAA's present and past circumstances to review any unresolved trauma may have assisted in enabling a tailored intervention.

5.2a In January 2020 RAA is assessed by the Department of Psychological medicine following a referral from Intensive Care Unit after RAA has taken an overdose of medication and alcohol. RAA is given an open appointment to contact them in event she feels she needs too – deemed as ongoing High Risk, discussed with crisis team and RAA is aware she can present at emergency department. Reason given for overdose the breakdown of her marriage and XY having an affair. RAA is encouraged to engage with Let's talk Wellbeing Service. She is discharged with a follow up appointment with the Department of Psychological medicine and encouraged to engage with Occupational health. A MARF[22] is completed and submitted to Social Care. Being subjected to domestic abuse can have devastating and long-term consequences for mental wellbeing and the perpetration of domestic abuse is a key driver of women's mental ill health. One study referenced in *Mental health and domestic abuse: A review of the literature*[23] describes the impact of domestic abuse as having "…psychological parallels with the trauma of being taken hostage and subjected to torture" (Howard et al., 2010). It is of note that it is unknown if the referral was for RAA or the children – there are no records from Adult Social Care that any referrals for RAA were made.

A referral on the 31/1/20 is made to the Crisis Resolution Home Treatment Team from the GP who had concerns re RAA's ambivalence[24] about her safety due to her recent overdose. Suicidal ambivalence is a predictor of suicidal behaviors, most people experiencing suicidal thoughts are ambivalent about dying but may be unable to imagine other potential solutions. RAA declined any intervention denying she had told GP she had wished the overdose had killed her and currently she felt alright. From a cultural perspective[25] RAA may have felt that from her previous experience support from outside agencies may bring a spotlight onto the family and put pressure on her around the stigma of her mental health and 'shame and dishonour' to the family. With the right support it is clear those in crisis can find their way through a suicidal crisis and recover. Crisis Team information was shared between relevant parties, and RAA was discharged back to her GP.

Nottingham Children's Social Care contacted RAA. Children's Social Services made relevant enquiries and RAA was offered the Targeted Family Support Service, however RAA advised that she no longer needed any support and that a robust support plan was in place. RAA's Asian cultural background with FA is based on the traditional collectivist principal that families value interdependence over independence. Consequently, the need to preserve

[20] https://avaproject.org.uk/wp/wp-content/uploads/2017/10/AVA-help-seeking-model-narrative-COLOUR.pdf

[21] https://safeguardinghub.co.uk/honour-based-abuse-the-facts/

[22] https://www.nottinghamcity.gov.uk/marf

[23] https://www.womensaid.org.uk/mental-health-and-domestic-abuse-a-review-of-the-literature/

[24] https://en.wikipedia.org/wiki/Suicidal_ambivalence#

[25] https://www.nami.org/Blogs/NAMI-Blog/July-2020/How-Asian-Shame-and-Stigma-Contribute-to-Suicide

and perpetuate collective honour (e.g. family, ethnicity, etc.) is held in the highest esteem. Failing to do so leads to where someone feels they have disgraced their family. By accepting assistance from outside agencies RAA may have felt the pressure of the extended family suggesting she has brought stigma and shame.

5.3 February 2020 Children's Social Care Targeted Family Support Team again made contact and were informed RAA had extensive family support describing support from her mother who lived on the same road, and she was receiving counselling. RAA stated she had also contacted her GP who was very supportive contact with Targeted Family support ended.

January 2020 The Crisis resolution home treatment team (part of NHCT[26]) made a follow up telephone consultation with RAA, she has now returned to work, no longer feeling suicidal lots of support from her mum and sister. RAA feeling positive and has good insight, she is going to attend counselling.
Nottingham CityCare Partnership planned a home visit after overdose incident in January by a Specialist Public Health Nurse (Health Visitor) and initially no access to home as unknown male answered door, informed RAA was at work. It would have been useful to ascertain the identity of the unknown male. A follow up phone call by Specialist Nurse is informed by RAA that she has been referred to Validium[27] and having support from her GP.

During the learning event it was identified the COVID-19 pandemic potentially exacerbated domestic abuse by further isolating RAA from family, friends, and support systems; and created even deeper economic and emotional hardship. At this point she would have been living with domestic abuse within the relationship for approximately 6 years. When accessing support RAA described abuse she had suffered from her husband and stated that she had been physically abused by XY. RAA described how they used to live opposite her mum and her mum would come to rescue her. Her mum described that one-day XY was hitting RAA so badly that she could hear RAA screaming from across the road and she had to come running to rescue her daughter. RAA had disclosed to one of the specialist agencies that she was expected to serve her husband, mother-in-law and brother-in-law as she was the eldest daughter-in-law, and it was her duty to do so. She had described that even though she had young children, she would have to wake up during the night to give her husband food, no matter what time of the night he came home. It was drilled into her that as a good wife she would have to fulfil all her husband's needs.[28] She said that they used to have rice and lentils nearly every day and she would have to mix the rice and lentils together with her hands and then serve it to the family. This behaviour illustrates the pressure of family control and 'imbalance of power' felt by RAA and examples of abuse[29] inflicted on RAA. With Covid

[26] https://www.nottinghamcitycare.nhs.uk/

[27] http://validium.org.uk/ Employee Assistance Programme Validium offers a compassionate service that includes: Telephone support or ad-hoc counselling available 24/7

[28] she is the visual symbol of an inherently misogynistic religion that deprives her of autonomy and self-realisation – she is always "constituted as a figure of subjugation, embedded and controlled by a community" (Crabtree and Husain, 2012:148).

[29] https://journals.sagepub.com/doi/full/10.1177/1077801220952168Honor-Based Abuse in England and Wales: Who Does What to Whom?

restrictions this meant she was confined to the same house. Families were not 'seen' in the same sense on home visits due to the Covid restrictions, which potentially limited opportunities for confidential disclosure or exploration by professionals. A known tactic by abusers at the time was to restrict access to a family by stating there is Covid within the household. It is not known if this was the case, however potentially it could have been a factor in RAA's help seeking. It is also of note that although Domestic Abuse was seen as a priority with specialist schemes set up Women's Aid and Refuge identified an epidemic beneath the pandemic.[30] The main barrier was victims were living with their abusers 24/7 limiting safe access to specialist services or space for action.[31]

Agencies had to adapt to changes in working practices with people deployed to working from home. This meant new arrangements for IT equipment linked to services for professionals. The impact of setting staff up remotely ultimately had to have had a delay in accessing systems remotely, all took time and may have impacted on some requests for information sharing. Statutory agencies were as much as possible responding to 'business as usual' and followed guidelines for assessments at the time. However, changes in work practices still had an impact on engagement and information gathering during this time. Some interviews were only done via online platform or doorstep contact, the usual observations of family interactions were limited. The hybrid working that has since followed has some positive outcomes as seen by the inclusion of the GP attending the meeting in Episode 3 where previously they would not have had capacity.

5.4 **Episode 2 - 17/6/20 – 5/11/21** Incidents in relation to RAA's deteriorating mental health and refusal of XY to agree to a divorce. XY's alleged suicidal Ideation as an alleged manipulative tactic of coercion impacting on RAA's mental health.

5.5 June 2020 There is an Incident with XY attempting self-harm, in front of RAA and child B. XY is deemed has having capacity and declined treatment reporting he would self-refer to his own GP to discuss low mood. There is no record of this. Professional expertise[32] identified as best practice suggests that one of the factors relating to the suspect associated with risk of abuse to a victim is threats or attempts at suicide by the suspect. This behaviour is further evidence of XY's coercive and psychological manipulation of RAA. XY then leaves the property with a friend. RAA informs attending police officers XY is her ex-partner although they are living at the same address, he was self-harming to sustain the relationship which included threats to take an overdose. RAA discloses to officers 'others' were blaming her for his self-harming; however, she was prioritising the welfare of their children. This highlights the pressure of factors associated with understanding risks and vulnerabilities in minoritised groups. Dash assessment was declined, and consent refused to share information with partner agencies. Officers deemed the incident as medium risk and a

[30] https://www.bbc.co.uk/news/uk-56491643

[31] https://projectmirabal.co.uk/

[32] https://www.college.police.uk/app/major-investigation-and-public-protection/domestic-abuse/understanding-risk-and-vulnerability-context-domestic-abuse#particular-issues-affecting-certain-groups-of-victims

safeguarding referral was made to Children's Social Care (CSC) and circumstances shared with Project Encompass[33], which is a Police and Education early information sharing partnership enabling schools to offer immediate support for children and young people experiencing domestic abuse. Information is shared by the Police with a school's trained Key Adult (DSL) prior to the start of the next school day after officers have attended a domestic abuse incident thus enabling appropriate support to be given, dependent upon the needs and wishes of the child, which is best practice.

5.6 Notts CSC responded to the Medium Dash Risk assessment by speaking with RAA to discuss concerns. RAA is staying with her parents with the children. RAA states that she does not believe XY is a risk to the children however contact was being supervised by her parents. XY is said to have been undertaking a spiritual healing programme. Did this have an impact on the belief for RAA that this would 'resolve' XY's issues? Or was this a reference to the 'others' putting pressure on her for XY's mood. Was this an opportunity to begin to link Intersectionality relevant to domestic abuse. RAA declines support and the case is closed 2/7/20. During the learning event the Review Panel began to see the fear of RAA engaging with services and the acceptance of agencies to withdraw without the professional curiosity of seeking what life was like for RAA on a daily basis. It appears that RAA told different people different things at different times, this is common in a victims help seeking process as they begin to build a picture of who it is safe to trust. This is evident in her disclosures to family members, and apparent in her contact with professionals. Putting the burden on RAA herself to disclose abuse or seek out mental health support, rather than services or healthcare professionals reaching out safely and sensitively enquiring is problematic throughout. The impact of domestic abuse often includes lowered self-esteem and feelings of shame, meaning that RAA did not feel able to seek out support, expecting her to do so was therefore often unrealistic. Survivors often fear that they will not be believed or taken seriously if they talk about abuse and/or mental health concerns, sometimes because of negative experiences in the past as had happened in RAA's case with services going back to her adolescent years. Additionally, while RAA did at times talk about her concerns about XY and the impact of his behaviour on her, including making disclosures of domestic abuse, at other times she said and behaved as if everything was fine. Research[34] involving survivors with children states they are often fearful that accessing mental health or domestic abuse support may mean that social services will get involved and they will be judged as "failing to protect" their children from abuse; or it will be used against them in any child contact or child protection legal proceedings. The Review Panel noted this as an example of the challenges that victims of domestic abuse can face in talking about their experiences, particularly when also trying to manage their safety. However, it is important to note that RAA did find ways to talk about what was happening to her, especially to her own family. It is difficult at this point to know exactly what may have helped or hindered RAA in resolving her fear of XY, and indeed services.

5.7 July 2020 RAA contacts GP. RAA's mental is deteriorating after the incident with XY. RAA requested assistance in managing anxiety symptoms, she was

[33] https://www.operationencompass.org/

[34] https://www.womensaid.org.uk/the-reality-of-the-barriers-to-mental-health-support/

continuing with counselling. RAA describes feeling positive about the future and no active suicidal ideation or thoughts. RAA is identified as a high priority and reminder re victim of domestic abuse.

5.8 Domestic Abuse Referral Team (DART) share information to 0-19 service and GP. This is in line with the pathway at the time. RAA continues to stay with family and states the marriage is over. It's noted by Notts Health Care Trust that there are no issues and RAA has good insight into any worsening mood and a good support network from family.

5.9 17/7/20 Domestic Incident reported by RAA stating she is being assaulted and held against her will by XY. Officers attended the address of RAA's father where they saw RAA who was living there at the time. RAA describes being coerced by XY into a situation and when she resists XY becomes aggressive again making threats of self-harm. RAA in the altercation receives visible injuries. XY then drops her off at her father's address. Tactics[35] suggested are typical of coercive control and manipulation by perpetrators of domestic abuse. RAA declined to make a formal complaint. Although she began to disclose information for the DASH risk assessment, RAA declined to comment further stating she was afraid of XY. Officers completed a medium risk DASH risk assessment. A learning opportunity here is given the previous recent incident and escalation plus 'fear factor' on Professional Judgement this could have been a MARAC referral or on escalation alone[36]. RAA declined consent to share information with partner agencies. Although children were not present referrals were made to CSC and Operation Encompass, and an honour-based PPN submitted with RAA identified as the victim. This is recognised best practice by the College of Policing[37] on honour-based abuse offering a Public Protection Tactical Menu of Options (PPTMO), referencing the one-chance-rule, thus practitioners may only have one chance to save a life. If the victim is allowed to walk out without support being offered that one chance could be lost.

5.10 18/7/20 CSC receive medium risk referral, there is an Operation Encompass email to child A's school on same day. Contact was made on 29/7/20 by a family support worker in Children's and Families Direct. Although concerns were raised in the information sharing around risk factors RAA advised that she had had a discussion with XY why the marriage had broken down which they had not done previously, and XY had agreed for a divorce. RAA states XY has regular contact with the children, and she doesn't believe he is a risk to them. Support was discussed however this was declined. Involvement ceased 29/7/20. A learning point here is that with the recent escalation in incidents there is no reference to the impact on the children[38] or the outcome of the referral of the Police honour-based assessment which should have considered the pressure and fear of engaging with services with an intersectional lens.

[35] https://www.goodreads.com/author/quotes/131380.Lundy_Bancroft

[36] https://safelives.org.uk/node/1264

[37] https://library.college.police.uk/docs/college-of-policing/Honour-based-abuse-practice-summary-2020.pdf

[38] https://www.freeva.org.uk/the-silent-victims-how-does-domestic-abuse-impact-children/#:~:text=Witnessing%20domestic%20violence%20can%20have%20profound%20and%20immediate,confusion%20as%20a%20result%20of%20their%20traumatic%20experiences.

Certain key features are regularly highlighted as making honour-based abuse distinctive, collectivity of perpetration (by multiple perpetrators, and/or evidence of premeditation or conspiracy), and the role of women in policing other women's behavior and carrying out punishments (Aplin, 2017; HMG, 2014; Idriss, 2017; Payton, 2014; Sen, 2005; Begikhani et al., 2015).

5.11 Notts CSC following a Safety Net Audit that was undertaken as part of a review, recommending that a children's assessment should be undertaken in respect of parental mental health and domestic abuse. Children were allocated a social worker on 13/10/20. On 15/10/20 a home visit is undertaken. RAA shared she had a 'rough patch' in her marriage which had led to contact with CSC. RAA states her family were not keen on XY due to the 10-year age gap and that they would be supportive if she wasn't with him. She stated that she was not frightened or worried about him. This would indicate her cognitive dissonance[39] regarding the impact of abuse from her previous statements which clearly evidences how fearful she was of him in previous recorded incidents. This illustrates that pressure, and the omnipresence of XY and others may have influenced her reluctance to engage with services for fear of further cultural pressure. Relevant to all these issues is how RAA's experiences of abuse were affected by the cultural environment in which she lived and the cultural issues that could have impacted her ability to ask for help. This is also relevant to her accessing help and support from her family and friends, as well as agencies. RAA states she is working at home which was better as she had time with her children. She stated she wasn't at risk or under any pressure and did not require any support. Children seen by social worker and described as having a good relationship with their mother and didn't share any worries with social worker. It is unlikely that given the alleged control 'from others' referred too previously that either RAA or the children would give a disclosure in a one-off meeting as mentioned due to the interdependence within the family and cultural pressure. The background of previous incidents, particularly as part of the early intervention assessment, was not explored.

5.14 16/11/20 RAA and XY make a claim together as a couple for Universal Credit (UC). It is of note that this is the around the same time as the second national lockdown due to Covid[40]. A joint claim means this is paid into one bank account as a family unit. This comes four months after RAA had informed CSC family worker about the breakup of her marriage and XY agreeing to a divorce. In context it may have indicated RAA was being coerced into a joint claim a feature of economic abuse which involves behaviours that interfere with an individual's ability to acquire, use, and maintain economic resources[41]. Coercive control does not always involve the use of physical violence, as we

[39] In the field of psychology, cognitive dissonance is the perception of contradictory information and the mental toll of it. Relevant items of information include a person's actions, feelings, ideas, beliefs, values, and things in the environment. Cognitive dissonance is typically experienced as psychological stress when persons participate in an action that goes against one or more of those things. According to this theory, when two actions or ideas are not psychologically consistent with each other, people do all in their power to change them until they become consistent. The discomfort is triggered by the person's belief clashing with new information perceived, wherein the individual tries to find a way to resolve the contradiction to reduce their discomfort. https://en.wikipedia.org/wiki/Cognitive_dissonance

[40] https://www.instituteforgovernment.org.uk/sites/default/files/2022-12/timeline-coronavirus-lockdown-december-2021.pdf

[41] https://survivingeconomicabuse.org/what-is-economic-abuse/

have seen in XY's behaviour previously, he has controlled RAA's choices and controlled her everyday actions, using threats to harm himself when demands were refused. This behaviour can make the individual economically dependent on the abuser, thereby limiting their ability to escape and access safety. It is designed to intimidate and isolate the victim. Economic abuse is included as a category of abuse in the Domestic Abuse Act 2021. Financial Abuse is also included as a form of abuse in Section 42 (3) of the Care Act (2014). It is of note that twelve months later RAA then makes a change in circumstances. In the recall event it is also noted that DWP also have specially trained staff to support applicants with suicidal ideation it is not known if this was accessed RAA's case. This is good practice.

5.15 A second social worker contacted RAA on 23/11/20 by phone. RAA stated she believed the previous social worker contact was a one off and didn't understand an assessment was going to be undertaken. RAA stated that things hadn't been explained by the previous social worker. RAA states she felt safe, and children were safe and had no concerns, RAA stated she did not want any support and knew how to access help if required. RAA did not want to participate in the assessment process. It is of note that RAA is currently in a joint claim with XY, it would have been a concern to RAA that if agencies became involved in the family, the pressure would be placed on her regarding the aspect of shame and 'dishonour'. Agencies should consider the risk posed to potential victims by family and community members in any risk assessment.

5.16 15/12/20 due to RAA's declining engagement with the assessment, involvement with CSC ends.

5.17 15/4/21 Referral to Notts CSC from RAA's GP requesting support for RAA specifically in respect of child B the youngest child. Contact was made by family support worker (FSW) on 26/4/21 in Children's and Families Direct Team. It was agreed a referral would be made to the parenting team. On contacting the school, the social worker was informed the family had a new address outside of the city boundary. RAA was sent contact details of how to access support in Derbyshire.

5.18 30/4/21GP makes referral to Nottingham CityCare Partnership Pediatric Dietetics Service due to concern re child B as he was eating little and was very thin. Child B was triaged the same day and a call made to RAA but no answer. Video appointment arranged following a further phone call made to RAA on 4/5/21, an appointment was made for 19/5/21. Could this behaviour have been related to the impact of domestic abuse that had occurred in the household, especially during the pandemic and further lockdown restrictions. Dr Emma Katz highlights the impact of coercive control and eating habits in children in a series of articles. [42] Children adapting their behaviours in order to control the situation as they see it.

5.19 15/7/21 Referral to Derbyshire Children's Services from child A's current primary school. Concern was raised about the mother daughter relationship. The details relate to child A disclosing at school that parents were fighting and were going to split up, it was noted that child A had also missed a number of health care appointments. RAA had stated she was concerned about the behaviour

[42] https://www.shera-research.com/team/dr-emma-katz

of child A towards child B also. School staff described concerns around RAA's negative language to child A during the conversation. This would support the fact that the domestic abuse was continuing and the pressure on RAA in managing the situation. From child A's perspective school could be seen as a place of safety and where they are able to share their concerns. Starting Point (SP) Derbyshire's front door service process the referral noting no previous referrals in Derbyshire. There is no professional curiosity of noting their recent move to the area and therefore having communication with the previous Social Services area which would have given a fuller picture of the background and context of the situation. Children's Services appear not to be trauma-informed in their response to child A, there isn't any exploration of the 'parental conflict' or consideration of referral to specialist domestic abuse support. The referral is triaged as a child in need[43]. Passed to locality team as RAA was requesting support. RAA has contact with a third social worker, (it is of note that this is the third social worker in a short space of time which must have had an impact on RAA's relationship with professionals) she shares concern re child A and gives consent for welfare enquiries with partner agencies. RAA blames herself for child A's presentation relating to the death of child A's twin at birth. The children are described as engaging and happy by the social worker on the visit. RAA's self-blame again would indicate unresolved trauma[44] and her unresolved loss which may have affected RAA's parenting capacity.

5.20 During the period July 2021 through to the end of August 2021 RAA's mental health deteriorates with episodes of suicidal ideation and increasing contact with Police, Children's Social Care, and a referral was made to the NHCT Crisis Resolution Home Treatment team (CRHT), but RAA did not engage with services. In an announced social work visit to the home, RAA became distressed. When the social worker was about to leave RAA wished to engage in conversation. XY was present and he presented as calm but felt that the visit (or anyone visiting) distressed RAA. His presence would have been a pressure on RAA, and his action can be perceived as 'controlling access' to RAA. The children engaged well with the social worker. This may be due to the 'unwritten rules' within the household of presenting to outside agencies all is well. RAA's Father was not happy about the situation and did not want any further visits. All were concerned about the impact of the visits on RAA's mental health. The need for an assessment was explained to the family but they were not informed that they could decline the assessment and the process that would take place should they take this position. Best practice would have suggested the social worker speak with RAA on her own, to give an opportunity to explore her concerns. RAA would have felt under pressure to withdraw due to the interdependence she relied on for family support. RAA describes the situation being triggered by the referral from child A's Primary school. RAA states during this time she feels disliked by the Police, Social Care and Mental Health professionals feeling that they judged her and thought she was a bad mother. It is apparent that RAA felt psychologically unsafe, as restrictions from the pandemic continue to be lifted, her space for action[45] is limited, what a victim

[43] This means a community or universal service (i.e. school, children's centre or health) would be identified to offer targeted support to a family and assess their strengths or needs. Given the ages of the children, the school or a local children's centre would have been identified to take the role of lead agency).

[44] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4018291/pdf/pone.0096606.pdf

[45] https://projectmirabal.co.uk/ space for action created by reducing the influence of the perpetrator

needs is a safe space to step into, at this point it appears RAA has a lot of external pressure and unresolved trauma to make any informed choice.

5.21 RAA continues to have extensive family support with family members, encouraging RAA to have support from her GP, who they are aware is a person she trusts. RAA's family describe that XY does not treat her well and this contributes to how she feels[46]. There is recognition by the World Health Organization [WHO], 2017[47] that interpersonal abuse is a public health concern that has been linked with long-term mental health consequences intrinsically linked to trauma, coercive control and suicidality. Her family explain RAA believes professionals are against her and the family present during this period as anxious, distrusting and distressed at involvement of professionals and concerned about the nature of the referral from school. Appropriate safeguarding referrals are made to agencies throughout this period, which is best practice.

5.22 RAA relates her breakdowns due to issues at school re child A's behaviour and concerns re care. RAA is having panic symptoms, not sleeping, or eating. RAA is linked to Notts Mental Health Services during this period. The allocated social worker is now supportive, RAA states she is now feeling very anxious triggering previous childhood traumatic events. Although RAA is linked to Notts Mental Health Services, RAA she did not become involved with mental health services, there was one phone call where she stated that she did not want input. Her medication is adjusted, and she is in contact with her GP. There is still a lack of professional curiosity around an informed approach in resolving her past trauma. Unprocessed trauma can have a negative impact on a person's psychological, emotional, and physical well-being as seen by RAA's physical and emotional symptoms. Many who have adverse experiences like RAA in their life, may not be consciously aware that their unhealed trauma can influence their thoughts, feelings, beliefs, and life choices. Research[48] illustrates patterns of unresolved trauma with RAA displaying some of the traits which affect her self-esteem and cognitive thinking to accept support.

5.23 Both the allocated social worker and GP shared concern with RAA's mental health and paranoia. RAA is supported at the surgery with her dad and GP so she can be assessed face-to-face, there is good liaison between the allocated social worker and the GP re RAA's mental Health and medication to manage her anxiety. RAA describes feeling utterly overwhelmed by involvement with social workers and school having stated that they had concerns with 'neglect' unable to get the phrase out of her head and feels devastated that this is the opinion that has been shared about her care of her children with social workers. She feels that everything has overwhelmed her since and that she feels as though she should just 'give up'. She is adamant that it is the action of authorities that is causing her distress. This response to a situation where it appears 'shame' is overwhelming as described by RAA, illustrates shame is a

[46] https://journals.sagepub.com/doi/epub/10.1177/15248380231162972 The Trauma and Mental Health Impacts of Coercive Control

[47] World Health Organization. (2017). Intimate partner and sexual violence against women: Fact sheet. https://www.who.int/news-room/fact-sheets/detail/violence-against-women

[48] https://www.psychologytoday.com/us/blog/understanding-ptsd/202308/10-common-patterns-seen-in-unresolved-relational-trauma

key emotional after effect of experiences of trauma, research[49] states that we 'have failed to see the obvious' by neglecting to acknowledge the influence of shame on post-trauma states. Shame becomes a barrier to successful engagement with services. In RAA's community and culture there is a lot of stigma around mental health which had an impact on her help seeking process. It is argued that a more effective approach to address this is through the concept and practice of shame-sensitivity. RAA gave consent for her dad, AZ for full disclosure to him by RAA about her situation and the GP and social worker can contact her dad if any concerns re her mental health or to discuss any aspect of her medical care.

5.24 It is of note that RAA's medication is administered during this period by XY as agreed, previously this had been administered by her father. This seems contradictory considering XY's previous mental health concerns and alleged coercive control. Although RAA stated she was happy with this situation at the time, was her compliance due to coercion and fear of repercussions if she didn't comply. There was an obvious power imbalance here of the person who has control of her welfare being the person it is documented has previously abused her in the past.

5.25 During this time RAA states that her natural default when things get difficult or stressful is to consider leaving her family and ending her life as she feels that her only thought is that everyone would be better if she were gone stating this is how she felt at the time of the overdose. Father and husband are aware of this, and she is able to share with them when she feels this way (more able to with dad than husband it is reported). This is certainly relevant to how RAA may have felt prior to ending her life in April 2022. Research paper by Bhavsar V, Kirkpatrick K, Calcia M, Howard LM. (Lockdown, domestic abuse perpetration, and mental health care: gaps in training, research, and policy. Lancet Psychiatry 2021; 8(3): 172–4) highlight 'the association between mental health conditions and interpersonal abuse, it has been proposed that health services which provide care for people with mental health conditions (including primary care and secondary mental health services) to present opportunities to strengthen identification and assessment. Understanding the distribution of psychiatric morbidity and mental health service use among people reporting abuse could shape policy by emphasising the role of mental health services as part of a national response and guide the development of interventions targeted at specific service settings.'

5.26 There continues to be ongoing stress at home with Social Services and Police involvement around domestic abuse. RAA blaming herself as she was the one who phoned social workers and disclosed historic events thinking that school had documented these events in their referral to safeguarding, this additional investigation appeared a direct consequence of RAA having disclosed information, she wishes she had not said anything as this was now a cause of conflict between her and her husband. Victims of domestic abuse suffering from complex trauma often blame themselves for abuse. It presents as a problem because they often do it when they objectively were not responsible for it. In RAA's circumstances the following quote describes the possible connection related to her response now agencies are involved "*Trauma leads*

[49] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7149881/ Social, cultural, and other diversity issues in the traumatic stress field

to shame. Trauma determines the content of shame. Shame pushes the body into a traumatic response. The more I learn about the two, the more I am convinced of their deep connection to one another." – Lucia Osborne-Crowley (Osborne-Crowley, 2020) This is described as a type of toxic self-blame and can happen to any victim of trauma. However, it's particularly prevalent for survivors of sexual and physical abuse. [50] There is limited information available to the Review Panel on the impact of these issues directly, although accounts by RAA's family have identified some of the impact of cultural expectations in RAA's life, including around her marriage. She was also isolated, with her main contact only with family but also because XY was controlling.

5.27 24/8/21 Email sent to duty screening at Nottingham City to view the files of historical assessments and involvement in relation to the family. The family provided consent to access this information. This is in line with good practice guidance to form a holistic view of a family's circumstances and to consider historical information to inform assessments, decisions, and any subsequent plans.

5.28 Good practice noted by Lancashire Police and cross border working when a Domestic Incident is reported from Out of Area to Derbyshire. Police were called out on another incident to an address where the Family were staying, Officers heard an argument despite no Police call out being made they intervened and although parental refusal to share details Officers did in the interest of safeguarding. This allowed the information to be shared with local agencies and was addressed as part of the assessment process. This also illustrates the ongoing conflict between RAA and XY. The children are present at the incident and officers note the inappropriate language witnessed by the children. It is unclear if or how the children were used by XY to abuse RAA psychologically. However, it is of note that her mother said that RAA was fearful that contact with services could lead to the loss of her children. Her mother thought RAA believed this based on what XY had told her. The impact on children[51] of living in a household where domestic abuse is well known. It is also possible that the health and emotional well-being concerns about child A, and child B, were linked to their own experience of domestic abuse[52].

5.29 September 2021 Derbyshire CSC make an Appendix B criminal information request sent to Derbyshire Police in relation to XY. This is in line with good practice guidance to ensure all available information is considered as part of the assessment process.

5.30 Derbyshire CSC receive a Subject Access Request (SAR) from RAA. RAA indicated she was happy with the current social workers support, however required written confirmation of the referral information shared by the school. RAA also requested written confirmation from the social worker that there were

[50] https://solaramentalhealth.com/understanding-self-blame/

[51] James, E. (2020). Not just Collateral Damage. The hidden impact of domestic abuse on children. Available at https://www.barnardos.org.uk/sites/default/files/uploads/%27Not%20just%20collateral%20damage%27%20Barnardo%27s%20Report_0.pdf

[52] CAADA (2014). In plain sight: The evidence from children exposed to domestic abuse. Available at: https://safelives.org.uk/sites/default/files/resources/In_plain_sight_the_evidence_from_children_exposed_to_domestic_abuse.pdf

no identified child protection concerns and confirmation social care's involvement related to support for child A only. Confirmation was also requested that information from the GP was also being taken into consideration as part of the assessment process. RAA indicated that until this information was provided, she did not wish to progress with interventions from social care.

5.31 RAA makes online self-referral to Let's talk Wellbeing Service (LTWB) referral states request to assist with anxiety, stress, pressure and guilt and management of mental health. No reference to social or domestic issues. She engages well with the assessment process, being open and honest about the trauma and abuse. However, RAA does not attend her initial face to face appointment.

5.32 17/9/21 – 19/11/21 Notts CSC receive requests from Derbyshire CSC – information is provided.

5.33 Derbyshire CSC - Single assessment completed. The single assessment did not raise any significant safeguarding concerns and parents did not wish for further support or intervention therefore no further action was taken. It is noted that XY's Police checks had not been returned at this point following the request made on the 1st September 2021. Information from Nottingham City Children's Services had also not been received at this point to inform the assessment. There was an opportunity here for the manager to make a formal escalation to both agencies. It was noted that a re-referral would be required should the police checks in relation to XY raise concern once received. This period of involvement would have benefitted from greater curiosity around mental health, domestic abuse and suicidal ideation with stronger links made with the GP to inform the assessment. There was missing information from Derbyshire Police and Nottingham City Children's Services that would have benefitted from being explored within the assessment and subsequent decision making. A targeted early intervention strategy approach would potentially have benefited RAA and the children at this point, with the potential for XY to be accountable for his actions.

5.34 The new school for child A and child B receive a confidential file from child A's previous school and this is shared with the DSL – school informed case closed to services.

5.35 A further request for Appendix B was sent to Derbyshire Police requesting information on XY.

5.36 RAA continues to have support from her GP and her medication is regularly reviewed she is feeling optimistic with the case closed to Social Care. RAA is able to look back over emotions that she had during the summer when undergoing investigation with social care and is surprised by how paranoid she felt. Reports she felt unable to trust anyone, even family, feels much better now and can see that this was paranoia and unfounded similar to how she had felt previously during stress related incidents.

5.37 28/10/21 Appointment letter for Step 3 counselling with LTWB via video link to RAA's email. Appointment made 29/10/21. RAA did not connect to the video

link for the session. 2/11/21 Further appointment letter sent from LTWB to RAA's email detailing a face-to-face counselling appointment on 11/11/21.

5.37.1 **Episode 3 6/11/21 – 25/4/22** Escalating deterioration in RAA's mental health exasperated by longstanding relationship breakdown and alleged concerns from 'family' if RAA left XY.

5.38 November 2021 Officers respond to a 999 call from RAA stating she would harm XY if he wasn't removed from the house. In the call she states she has been attempting to split up from him for 2 years, however, always goes back and this is affecting her mental health. Officers found her highly emotional and were concerned for her wellbeing, treating the episode as a mental health concern rather than a genuine threat of harm to XY. RAA was described by Police as petrified and fearful for her life, and he (XY) had threatened to harm her should she leave. Separation is high risk factor in domestic abuse cases[53]. This incident indicates RAA's trauma response to the situation as 'violent resistance' [54] (sometimes known as 'self-defence' or 'retaliatory abuse') it is when a domestic abuse victim, usually a female, perpetrates violence towards her coercive controlling and physically violent partner, Johnson (2002). An adult at risk PPN was submitted on behalf of RAA and the incident recorded as a medium risk domestic incident. Although a PPN is submitted re an Adult at Risk it appears no record of any assessment is made by adult safeguarding under the Care Act 2014 and domestic abuse. Where a person with care and support needs is suffering or is at risk of domestic abuse and requires an advocate there is a requirement upon the Local Authority to provide one[55]. The opportunity here to offer an (Independent Domestic Violence Advocate (IDVA) or Independent Mental Capacity Advocate (IMCA) is not pursued. Best Practice would have been a follow up on the Adult at Risk referral to record the outcome.

5.39 During this episode RAA is again supported by her GP and family in particular at this point by her mother. Her distress is exasperated by XY refusing to leave and she states the Police then treated her as the one with the problem and would not allow her access to her medication. RAA experienced stigma around being diagnosed as mentally ill from XY, and this is often used by perpetrators to discredit their victims of coercive control and domestic abuse. It is important to acknowledge RAA's experience is within a traumatising context of structural oppression (for example, racism and sexism) which also impacts survivors' responses. *(See Bradbury-Jones et al., 2011; Mantovani and Allen, 2017; Oram et al.,2017; Sweeney et al., 2019; Trevillion et al., 2014, 2016; Women's Aid et al., 2021.*) Analysis of in-depth survivor interviews about their experiences of justice and domestic abuse found that the language used to

[53] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/women-leave/
[54] https://www.dvact.org/post/violent-resistance-and-domestic-abuse
[55] https://safelives.org.uk/sites/default/files/resources/Briefing%20on%20the%20Care%20Act%202014.pdf

describe survivors' mental ill health (except sometimes by survivors in self-description) generally shows "very little and usually no understanding of mental illness as the result of trauma and a consequence of the perpetration of domestic abuse" (*Women's Aid et al., 2021:48*). Ongoing issues in her relationship with XY are described with detailed examples of controlling behaviour described by the GP stating to police officers that RAA was not suffering from a mental health diagnosis but was a suicide risk, her emotional state was due to the abuse she was suffering from her husband. He was making out that she was crazy, and that she was the problem (gas lighting) with the situation having a high impact on the children. She felt that there were cultural issues due to the Islamic marriage and she would be frowned upon for leaving. She feared that if she left XY, it would cause harm to herself and her family. This continues to highlight the impact of the dynamics around the potential honour-based abuse and the relationship of intersectionality due to her circumstances.

5.40 Details of specialist domestic abuse agencies were given. RAA also had access to the Mental Health Crisis Team who have a note of domestic abuse also. Her Mother also is given details of access to the NHCT CRHT.

5.41 Same day request to Derbyshire CSC from GA (school for both children) to Starting Point[56] asking for details as to reasons why the case had been closed as this was not shared previously. The school informed them they would not disclose as no consent from RAA.

5.42 During this episode the local commissioned domestic abuse service is contacted by Police with a referral for RAA and contact is attempted however no direct contact made.

5.43 8/11/21 Derbyshire Children's services receive a referral from Derbyshire Police following the incident on 5/11/21 due to a verbal argument between parents. The referral was triaged by Starting Point and a strategy meeting agreed.

5.44 11/11/21 Derbyshire CSC request an Information exchange to Derbyshire Police and Health service requesting the sharing of information for a strategy meeting. RAA was asking to be sectioned by the GP to avoid going home and in order that health services could say the children must stay with grandfather. RAA was deemed not in need of detaining under the Mental Health Act and her mental health needs were assessed to be as a result of the domestic abuse she was exposed to. Contact was made with Derbyshire Police requesting a response to the Appendix B information request previously made by the social worker. The family were re-allocated to a social worker and an allocation letter sent.

5.45 11/11/21 LTWB: RAA does not attend her planned counselling appointment.

[56] https://www.derbyshire.gov.uk/social-health/children-and-families/support-for-families/starting-point-referral-form/starting-point-contact-and-referral-service.aspx

5.46. After support from her GP and her father in attendance regarding the situation, her GP outlines the rational not to section her on her request with a plan for the Crisis team to offer assistance. Her father contacts the crisis team stating RAA in the interim has returned home to her husband who is perpetrating abuse and for this reason RAA and everyone around her are trying not to give the partner any inclination that she has been in touch with services for her own safety. He said phone calls from NHCT CRHT are not helping in keeping things quiet because some calls are coming in while he (XY) is present and requested no further contact until the MDT meeting tomorrow.

5.47 RAA had left two voice messages asking for NHCT CRHT to call her back. This was attempted but they were unable to make contact. RAA's father then made a further call to NHCT CRHT stating they were putting her at risk, he was hostile to the team and stated that any attempt to contact her should be through the GP or himself. NHCT CRHT plan to call the GP in the morning to inform them that they felt that the risk to RAA from her husband was greater than the risk from herself and they would withdraw interventions until the situation had stabilised. RAA had wanted to leave the home address with her children but was advised to return home pending the strategy meeting due to take place on the 12/11/21 when her and her children could leave in a co-ordinated way.

5.48 12/11/21 Strategy meeting held. There were concerns around what the children were witnessing and experiencing. RAA was in an abusive relationship where she thought if she left her father would be harmed, or her husband would kill himself as per previous threats. This is further evidence of examples of coercive control and domestic abuse combined with psychological manipulation. The meeting recognised the level of domestic abuse, the controlling elements, potential honour-based violence[57], and recognised this would all have an impact on the children. A multi-agency decision was taken to progress a Section 47 child protection investigation. This is seen as best practice with information known. RAA was provided with accommodation by the Local Borough Council. The children stayed with their maternal grandfather in line with RAA's request. The meeting was in-line with expectations and relevant information was shared to inform the threshold decision and safety planning. The strategy meeting would have benefited from the historical information from Nottingham City Children's Services and there was a further opportunity here for a formal escalation around the delay. A social work visit was completed to maternal grandfathers address to see the children. The children appeared well cared for by grandfather and his partner however the children were clearly missing RAA and were observed to become distressed when XY called. This

[57] https://www.whiteribbon.org.uk/news/2020/2/11/preventing-so-called-honour-based-violence#:~:text=So-called%20%E2%80%98honour%E2%80%99-based%20violence%20%28HBV%29%20is%20a%20form%20of,partner%20or%20close%20family%20member%29%20and%20their%20community.

would indicate the impact his presence had on them due to the ongoing conflict they have witnessed.

RAA was seen at a neutral venue by the social worker. RAA has the required phone numbers to access support from a variety of agencies. A request was made to the children's services out of hours service to contact RAA over the weekend to ensure she was suitably supported.

At Housing appointment RAA discloses domestic abuse. Accommodation is secured till 16/11/21 with a Housing Options appointment on Monday 15th to discuss options details emailed to social worker.

Concerns from the social worker with disclosures from RAA and her feeling the situation is having a high impact on the children are conveyed to Police. The GP had stated that she was not suffering from a mental health diagnosis but was a suicide risk, her emotional state was due to the abuse she was suffering from her husband. GP felt that there were cultural issues due to the Islamic marriage and she would be frowned upon for leaving. She feared that if she left XY, it would cause harm to herself and her family.

Following the strategy meeting, arrangements were made by Social Care and Housing for RAA to be temporarily housed. Arrangements were made for the 2 children to stay with RAA's father in Nottingham. All relevant agencies were informed of this including school attended by the children detailed on 16/11/21.

5.49 During this time agencies continue to liaise and follow up investigations as per single agency protocols. RAA builds a relationship with social worker and is happy to engage in plans. The social worker links with GP, again evidence of good practice to ensure continuity for RAA re her medications.

5.50 15/11/21 Derbyshire Social Care receive response in relation to Appendix B request to Police.

5.51 Information from services highlights RAA making reference numerous times to trusting nobody.[58] Trust plays a significant part in victims accessing the right service at the right time, the experience of services by RAA was that services had never addressed any of the presenting issues and each aspect was seen in isolation instead of a holistic perspective. Agencies were continuing to follow single agency protocols instead of a whole family/picture approach. RAA referred to having a letter in the bedside drawer at the temporary accommodation in case everything went wrong. This was linked to RAA

58

https://www.researchgate.net/publication/368785309_Barriers_to_help-seeking_the_gap_of_trust/link/63f969a40d98a97717b55189/download?_tp=eyJjb250ZXh0Ijp7ImZpcnN0UGFnZSI6InB1YmxpY2F0aW9uIiwicGFnZSI6InB1YmxpY2F0aW9uIn19

referencing suicide as the only way out if she was not going to be appropriately supported to progress her safety plan. Social care was concerned about RAA's mental health and that she had plans to kill herself if she felt professionals aren't listening to her. The social worker stressed that RAA was extremely high risk of suicide and a medical professional needed to assess and decide whether RAA required a mental health assessment. There appears no record of this being communicated to NHCT. The likelihood of having suicidal thoughts is 3.5 times greater for women who have experienced domestic violence than those who haven't[59].

Information from Local Housing Options Teams (HOT) documents exchanges between social worker and HOT in regard to extending the temporary accommodation. With the proposed plan to stay in temporary accommodation for a few weeks while she gets an injunction. Then she aims to move in with her children at her father's house. The social worker advises that RAA is at high risk of HBA and is very guarded due to the connections she believes XY has. Social worker states if RAA feels the EBC and CSC can't help her then she will have no option but to return to XY and therefore is at high risk of suicide. RAA would like to stay at the temporary accommodation until she can get security plans in place and move to an undisclosed address. This clearly highlights the fear RAA had of XY and his control over her life, along with the risk of HBA.

5.52 HOT case worker discusses the case with their manager and advised to extend the temporary accommodation till 22/11/21 while protective measures are put in place relating to injunction against XY. HOT call RAA and advised re extension. RAA described she was awaiting a call from solicitor, and she will provide further details later. Social worker is also updated re the extension.

5.53 During this time as assessments progress RAA describes feeling things are moving. Trusts her social worker and feels she is helping her; she does not feel suicidal at all now. Keeping in touch with dad, she wanted to speak with GP asking her to ring as she needed to run a few things by her. RAA said taking medication as prescribed and not overdosing. She is seen by GP with her dad present and asks for assistance re her abusive relationship, RAA believes the threats to her family are real she discloses multiple examples of abusive behaviour however does not want to pursue currently, for fear of XY hurting

[59] https://theconversation.com/how-domestic-violence-affects-womens-mental-health-104926#:~:text=Women%20who%20have%20experienced%20domestic%20violence%20or%20abuse,depression%2C%20anxiety%2C%20substance%20abuse%2C%20and%20thoughts%20of%20suicide.

himself as previously threatened. This illustrates further his coercive control, use of intimidation and his previous behaviour of psychological manipulation over RAA, by his omnipresence.

5.54 16/11/21 A further strategy meeting is held. It was agreed that the next step was a joint visit between Social Care and the Police. RAA and maternal grandfather, along with the children, needed to be spoken to so all services could fully assess in order to inform the level of risk and impact upon the children. A further health information exchange was received to inform the strategy meeting along with relevant police information.

5.55 Agencies continue to liaise and links with school are enhanced around hearing the child's voice in the process. The school DSL and Social worker work together with information shared re the welfare of the children. Social care is concerned that the current plan is unsafe. School agreed children to be collected by grandad this to be short term plan until school advised otherwise. Social worker will contact grandad to discuss this plan with him.

5.56 RAA's vision at this point appears that she wanted to be able to live in her father's home in Nottingham with safety measures in place. Based on the information shared by RAA and maternal grandfather there appeared to be a high level of risk to RAA. Options were discussed to minimise risk relating to HBA and domestic abuse. This joint agency visit between Police and Social Care was appropriate and is identified as good practice. There was ongoing oversight by Statutory Agencies and housing options with the added inclusion of specialist agencies informed about domestic and honour-based issues throughout this period.

The GP was satisfied she had no intent around suicide. RAA claimed to be taking medication appropriately. She informed the GP she was receiving support from specialist Women's Aid service. The GP felt confident RAA could manage her medication. The GP advised that based on her experience with RAA if she stated she intends to harm herself this should be taken as she had clear intent. RAA states her dad is helping with the injunction against XY and also getting added security at the address. HOT make a section 208 referral, this referral is made under Homeless Legislation making local Borough Council aware that a placement has been made temporarily into their area.

5.57 Support from specialist agencies was relevant to the information held and follow-up calls were in line with policies and practice. RAA was given options and information to inform any decisions with ongoing support and referral to awareness sessions. A high-risk referral to MARAC was created and an IDVA attempted to contact RAA, however the IDVA was unable to make contact. RAA, however, was receiving specialist support relevant to her situation with help from her father. The Review Panel felt this was positive. It was also

reassured by evidence that local services are accessible and sensitive to her cultural and spiritual needs.

5.58 18/11/21 Derbyshire CSC phone call to Nottingham City Children's Services requesting access to the family's information by the allocated social worker. Phone discussion between XY and the social worker, supported by the practice supervisor. XY recognises that he was not as available to the family as he would have wished and wanted to make changes to support RAA and the children returning to live with him. It is of note that currently RAA is in temporary accommodation and away from XY's influence. The report does not detail any exploration of XY accepting responsibility for his actions and contribution to RAA's psychological distress due to his behaviour. The new guidelines[60] recently published for social workers suggest this would be an opportunity to seek his motivation and establish if there is genuine motivation to change, or if this is disguised compliance to reassert his control. Clearly, the picture of domestic abuse presented here was not known to all agencies, nor known in full. However, different agencies knew about domestic abuse during their contact with RAA and XY, as well as the children. When working with the family, domestic abuse and cultural factors e.g. HBA was either not consistently responded to or was not the focus of intervention. While this is understandable in so far as the presenting issue for many agencies was RAA's mental health, there could and should have been a consideration as to the context (and possible cause) by agencies other than the GP. This would have enabled agencies to consider how to either support RAA or begin to address XY's behaviour. Sadly, this did not happen. This is important learning that should remind all agencies of the importance of professional curiosity and a wide-angled lens to early help assessment.

5.59 Her GP continues to support RAA along with specialist services. Her family continued to support and advocate for her during this time also. Late November RAA returns to the Nottingham area and there is confirmation of a MARAC to MARAC transfer from Derbyshire MARAC to Nottingham. She described wanting to 'survive in silence'. RAA still intended to reside with her father and the children and had agreed that if XY approaches the home the Police would be called immediately.

5.60 RAA is taking positive steps to move forward with her life at this point and separate from XY.

5.61 At the end of November Derbyshire CSC complete Section 47 child protection enquiry. The enquiry reflected upon the previous assessment, highlighting that the family were clear at that time that they did not want to be supported by social care. RAA had a clear plan for her, and the children and it was felt by

[60] https://new.basw.co.uk/articles/basw-england-releases-new-domestic-abuse-guidance-social-workers

the social worker that this was child focused. RAA was having support daily from her family and was not being left alone, she recognised she needed this whilst she built up her strength. RAA planned to live in her father's home with him and the children for a few months until they secured their own housing. At this point RAA had a specialist Women's Aid worker, who was supporting her with legal options. RAA was looking forward to having support around her experiences and did not want to reach a point again when she had taken an overdose. She did worry that if professionals did not listen to her and support her and the children in the way required that she would feel trapped. RAA was clear she wanted to live for her children. The outcome of the assessment was a child in need plan was recommended for coordinated support to the family to continue. RAA agreed for ongoing agency support and intervention. The social worker made further contact with MARAC to ensure an IDVA was in place which it was.

5.62 RAA is actively bidding for properties and states she feels safe, always has adults with her to support her and feels clarity being away from her husband and able to think clearly about what she wants. Supervised contact has taken place during this time, so XY has had contact with the children. Social care has been due to update her on their assessment with XY. RAA is engaging with IDVA although described at times distressed this is felt due to the circumstances and stressful situation and is a normal reaction for someone seeking help from domestic abuse. She is reassured that taking things forward with the Police is her choice.

5.63 1/12/21 Announced social work visits to maternal grandfather's home. The social worker used a strengths-based approach and reinforced numerous times how far RAA had come; how brave she had been and how positive it was that wider family were supporting with intense and long-term support. This was a considered visit which drew on the principles of strength-based practice in order to support long term change within the family a key principle of early intervention. The IDVA from Juno has contact and the MARAC process explained. RAA is currently on sick leave from work. XY is aware of RAA back living with her father and appropriate safety measures are in place. A referral to Let's talk Wellbeing Service for mental health support is made. She will consider moving the children's school once rehoused to reduce risk further but not while they are still at her father's.

5.64 2/12/21 Telephone discussion between the social worker and XY setting out social cares assessment and that it was felt the children would be at risk of harm if the parental relationship was to resume. There is no indication here if XY was given any actions to address his behaviour towards RAA or awareness of the impact of his behaviour on his children. There is a 'vacuum of responsibility' here with the appearance of XY and RAA 'policing' themselves, indicating to XY he still has an appearance of control over the relationship.

5.65 Social worker continues contact with children at School. No further info in school record till January 2022. Derbyshire CSC received information from Nottingham City Children's Services following a request to them for information held in relation to the children. The initial request for information was made on the 24th of August 2021. A summary of previous referrals, assessments and child protection processes was shared. A request was made to Derbyshire Police by the social worker for support for RAA to collect her belongings from XY, in particular the children's passports. There are no new incidents reported. The maternal family were offering a lot of support to RAA and sticking to what they had said they would do as part of the support plan. In the interim social workers have agreed her father can continue to facilitate safe contact between children and their father, which is working well for the moment.

5.66 15/12/21 MARAC Meeting[61]. Referral was an out of area MARAC transfer from Derbyshire. The family had previously been heard at MARAC in 2015. MARAC meeting takes place with a multi-agency approach to addressing risks identified. RAA is listed as the victim and XY as the perpetrator of domestic abuse. Agencies shared information known and actions created to reduce risk and increase safety and hold perpetrator to account. A standard action for all agencies is to tag / flag systems with a DV marker that the named people have been discussed at the MARAC. This enables where a repeat incident[62] takes place the case can also be returned to MARAC for discussion, alongside highlighting agencies the victim is at high risk of harm due to domestic abuse. 14 actions were created for this case by 7 agencies. Minutes were shared with Derbyshire MARAC, safety measures were put in place and discussed with RAA including support from specialist agencies relevant to HBA and domestic abuse. Individual actions from agencies will be covered in the IMR reports and in the learning and recommendation section.

5.67 Derbyshire Police confirmed to CSC they will be taking no further action in relation to the family as RAA did not want to participate in engaging with Police. December 23rd, 2021: telephone contact between the social worker and maternal grandfather. XY had allowed RAA to remove the items required from the home, she had everything she needed including the children's passports. It was agreed that the children's time with XY could be arranged between the family. Grandfather shared the proposed plans all of which seemed appropriate and well considered.

5.68 29/12/21 Face to face joint meetings between Nottingham Muslim Women's Network, RAA and RAA's mum and Juno Support worker. Juno Women's Aid support worker discussed MARAC actions with RAA. RAA did not wish to apply for a non-molestation order right now as she would like a smooth transition

[61] https://safelives.org.uk/sites/default/files/resources/MARAC%20FAQs%20General%20FINAL.pdf
[62] https://safelives.org.uk/definition-repeat-marac

away from her husband and feels a non-molestation order will trigger him. RAA is aware of this option and will apply should she feel the need to. RAA feels safe at her fathers as there is security in place. RAA will think about counselling and asks the support worker to liaise with Children's Social Care to discuss what support they could be offering the children. Help and further support were offered to RAA to deal with the domestic situation.

5.69 5/1/22: RAA is seen by GP in a face to face with her mum; she is doing well at the moment; living with children in property belonging to her dad; plans to return to work in mid Jan - manager at work fully aware of everything that happened and supportive. She states both children are doing well. Seem to be happy in new routine and RAA's father takes them to XY's for visits no signs of emotional abuse and RAA feels that it is positive contact; she feels safe and thinks that he has accepted that she has now left him for good. RAA has reduced her medication, is keen to try to take positive steps to help herself and has been accessing counselling through work.

5.70 9/1/22 Primary school email correspondence between social worker and DSL. To plan a visit to the children in school, a social worker is in the process of writing up the s47 assessment and will be recommending the children be supported on a child in need plan. There has been a clear expectation to both parents that this outcome is based on them separating permanently and should their relationship resume, CSC would be looking to have a further strategy meeting. As part of the plan CSC will be looking at supporting father to have unsupervised contact and monitoring this with the children. The social worker will be looking to organise an initial child in need meeting. Grandad contacted school he is concerned child A leaves the classroom to see a social worker whilst at school.

5.71 10/1/22 CIN[63] plan completed. This is outside expected timescales of 10 working days from the child in need decision taking place. Nottingham CityCare Partnership note address change for child A and child B within the City.

5.72 RAA continues to make plans independent from XY with family and agency support. Communication between the social worker and the school confirms the contact arrangements and expectations of the father in relation to the children and school. Both children were reported to be doing well.

Social worker has emailed school to advise that there is an arrangement for XY to collect on Tuesdays. RAA and maternal family have stated that they feel it

[63] https://www.brethertonlaw.co.uk/services/child-law/child-social-services-intervention-common-questions-answers/what-is-a-child-in-need-plan-social-services/

is appropriate for XY to have unsupervised contact. Should contact between the children and father go well with no issues there is not a plan for social care to remain open past February. School Staff advised children will be collected by XY every Tuesday.

JWA support worker makes a call to RAA. She confirmed she was safe and well. Discussed referring the children to our CATS[64] team for specialist support around DV. RAA would like to refer one of the children as she feels the other is younger and may not need it as much.

RAA is still seeking housing in her own right still bidding for properties. Some confusion over duty is clarified with support from the HOT team.

5.73 7/2/22 Multi-agency child in need meeting held via microsoft teams. This is within expected timescales. RAA had engaged in the child in need process and was keen to ensure that the children received the support they required. The children had been seen in XY's care and the interactions were positive. It was agreed that further support under children in need was not required. Clear expectations had been voiced to both parents that social care felt satisfied that there were no ongoing safeguarding concerns on the understanding that parents remain separated. They had both been advised that should they resume a relationship then a further social care assessment would be required. RAA had shared that she was feeling much better in herself and could think much more clearly and make rational decisions for herself and the children. The team manager agreed to no further action.

5.74 8/2/22 Final social work visit undertaken to XY's home; the children were present. All interactions between the children and XY were described as loving, warm, and positive, see previous reference to research from Emma Katz and coercive controlling parent. XY was not interactive overall but answered when questions were asked, various academics describe the concept of 'Responsible mothers and invisible men'[65] with the emphasis of finding that the focus of intervention in child protection cases tended to switch from the abusing father to the mother. XY knew the plan was for social care to close their involvement with the understanding and expectation that parents remain separated. The social worker emails Nottingham's Children's Services to advise them of the case closure and to advise that should they receive any future referrals they will need to link with Derbyshire Children's Services for information sharing purposes.

At this point RAA is currently doing parental courses with CAMHS and child A receiving support via JWA. The GP has also given her a list of crises numbers to contact if she has an emergency in terms of DV, mental health etc. RAA declined a referral to the Freedom Programme as she had returned to work

[64] https://junowomensaid.org.uk/under-18s-specialist-support/
[65] https://academic.oup.com/bjsw/article/43/6/1092/1653332?login=false

and had limited spare time. Could this referral have been done earlier when RAA was on sick leave? A specialist helpline number has been given to RAA in case she wants to be re-referred back in to service in the future, she has also been encouraged to report any new incidents to the Police. A review of the DASH is completed, outcome medium risk[66]. RAA is happy for case closure.

5.75 24/2/22 The NMWN worker contacted RAA on the 24th February (via the phone), to check on the progress of the statement. RAA states due to XY's previous marriage she no longer needed an Islamic divorce. As RAA did not require any support with the Islamic divorce[67], NMWN agreed to close her case as JWA were supporting her with the domestic abuse support.

5.76 2/3/22 GP Surgery: concern raised about hearing loss, RAA had grommets as a child and recent hearing test showed possible hearing impairment. A telephone consultation requesting audiology referral. RAA describes struggling at home with child A, RAA struggles with this as she feels guilty that child A has no one to talk to due to recent breakdown in relationship and also feels guilty about the things that child A witnessed at home between her and partner. She describes how she always gets it wrong with relationships with people and with instructions lots of self-loathing and self-blame, although no current suicidal ideation. GP Plan: no letter yet seen from audio assessor; GP to await this and then refer to audiology; RAA states that her dad has dropped this in, discussed restarting sertraline; whilst taking sertraline RAA seemed to have less self-blame and feel more able to control decisions that affect her discussed meeting with mental health practitioner initially as GP feels this may be more helpful to her than medication in longer term; has accessed talking therapy in past and this has helped but speaks to counsellor via work currently. Previously high risk for suicidal ideation; had significant overdose in past; no current ideation; aware of routes for help in event of this but does have good insight into when mood is real issue; children are a protective factor.

5.77 7/3/22 Derbyshire CSC: A case summary was added to the children's file as part of case closure activity. It was noted that social care supported RAA and the children to leave the relationship and XY understood this was an expectation set by social care to avoid child protection processes. The summary recognised concern for RAA's mental health however reported improvements once the relationship had ended and RAA and the children had settled into temporary accommodation. XY had been having unsupervised contact since the start of the year and all involved had no issues to raise. There was an expectation of professionals involved to ensure a referral was made to social care if there was a belief that parents had resumed their relationship.

[66] https://safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL.pdf

[67] https://islamqa.info/en/answers/307000/types-of-divorce-in-islam

5.78 16/3/22 GP Surgery: Referred by GP for in house counselling assessment. The assessment takes account of RAA's traumatic experiences as an adolescent which include sexual abuse and racism. Her experiences as a teenager at school led her to use alcohol, she returned to live in Nottingham when she was 18 and met her ex-partner, she experienced being pregnant with twins, one of them she miscarried and then later after having her 1st child she suffered an ectopic pregnancy. She describes working part time in a GP practice, says she enjoys spending time with her children and feels guilty that they are not a family with her ex-husband too. RAA does not disclose any domestic abuse to the counsellor at this point.

Second appointment: RAA missed appointment, stating she had forgotten about it. Practitioner observes RAA presents as visibly anxious, she is tearful throughout appointment, described feeling low, doesn't want antidepressant as tried them historically and didn't feel like they work. RAA described a routine currently that leaves no time for herself reported she feels suicidal most days and cries herself to sleep most nights. Has no plan to complete suicide although has previous history of overdose (2019 and crisis team support (Nov 21) children are a protective factor, current future planning with no plan or intent. RAA has insight into her issues and is aware that she will need counselling one day when she is ready, she does not wish to approach this route currently and feels she hasn't got time to do it. Practitioner Diagnosis: RAA does not wish to take medication currently; she does not wish to engage in any psychological therapy currently either. There are many negative life events that are impacting on her mood RAA is extremely anxious bordering on paranoid believing everyone she asks for help will believe she is bad, she is always trying to help others, so she doesn't feel they don't like her, she is not sleeping, and she has lost weight. No psychosis evident, very self-critical, worthless feeling denies suicidal plans/intent but is sad and cries most nights. The traits describe common thinking of a person with pre-conditions of suicide as identified by Dr Thomas Joiner (2010). RAA said she didn't want another appointment at that moment. Although the practitioner discussed her current mood and the benefits of medication jointly with counselling there is no mention of offering an A.B.C[68] or WRAP[69] plan both are individualised safety plans aimed at high-risk clients as highlighted in the report on high-risk suicide by people with mental illness by Appleby in 2019. At this point children are currently under Social Services following the MARAC in Nov 21 a known stress factor for RAA, information is sent to RAA for counselling and mindfulness along with the practitioner offering to do a few weeks of education not the therapies to encourage her however she doesn't feel this is the right time to commence this yet. The practitioner Informs the GP of the meeting, RAA has crisis numbers and said she would use them. RAA was to consider medication and to rebook if she

[68] ABC Plan Awareness Balance Connection

[69] WRAP = Wellness Recovery Action Plan

would like to. The work of Professor Keith Hawton notes the positive predictive rate of suicide assessment is only 5%, although Maria Michail (MH Birmingham) suggests having a personalised safety plan reduces risk of death by suicide by 43%.

5.79 17/3/22 A copy of the assessment and final child in need plan was posted to involved agencies and RAA. This set out the expectations that should parents resume their relationship a further assessment would be required. The expectations were shared with XY verbally by the social worker. This was within the expected timescales of 10 working days. Same day: Email from RAA to HOT advising that she authorises her father AZ to act on her behalf regarding her housing needs as she is not in the right mental place to understand housing procedures.

5.80 23/3/22 Offer of property is unsuitable so search for suitable accommodation areas widened. Police Information on 23/03/2022 Incident involving RAA causing damage to a female's property. RAA attended the police station on 02/04/2022 and interviewed about the incident. She denied the offence. This matter was still pending at the time of RAA's death. Was this incident an indication that the relationship had resumed with XY and as such as part of the exit strategy by agencies, should a referral back to social care have been made as Police would have been included in involved agencies as part of the child in need plan.

5.81 30/3/22 Notts Integrated services telephone call to RAA by the CAMHS practitioner. RAA described as being agitated she stated that too many people were phoning her, and it was getting too much. The CAMHS practitioner acknowledged that RAA was struggling with her own mental health, having tests undertaken due to weight loss and working full time, it was not the best time for RAA to implement strategies with child A consistently. It was agreed that CAMHS would end their involvement and RAA could re-refer in the future. Involvement ended on 31.03.2022. It is evident at this point RAA is under extreme stress from the situation, is this due to fear that agencies will become involved again if the couple have reconciled?

5.82 Beginning of April 2022 RAA bids on a property.

5.83 April 2022 EMAS crew attended XY's property, when RAA's mother found her unresponsive in the bedroom. History given RAA had been to collect children from husband on the previous day and was noted to be drowsy/stumbling. Husband let her stay at his property as she was noted to be not usual self, RAA stated she took tablets to help her sleep. The husband checked on her and had found her difficult to rouse so had called the patient's mother, initially RAA was observed and at 15.10pm found not breathing and called 999. Declared deceased at 17:44pm. Police informed.

5.84 Agencies informed of RAA's death. The Partnership informed at end of April 2022.

6. THEMES:

To give context to the Themes it was requested by the Panel to highlight the situation that for a considerable part of the scoping period, everyday life was very different for workers and service users alike due to the pandemic. Front line Services including schools were working in a different framework of safeguarding and public protection whilst keeping staff and services users safe from initially a potentially lethal virus. The role out of vaccines offering some reassurance didn't begin till much later in the scoping period. There are various vulnerabilities that RAA herself had to adapt to. In her various roles balancing considerations to do what she felt appropriate to protect herself and her family, whilst meeting the requirements of formal assessments, during times of her own crisis. Prof. Rory O'Connor talks about the burden and sense of hopelessness those who die by suicide carry, and cultural shame, all relevant to RAA's situation.

Following multi-agency discussions of the Key Episodes and Terms of Reference, the following themes have been identified for practice and organisational learning:

6.1 Intersectionality of domestic abuse and professional curiosity[70]

The term Intersectionality was first described by Kimberlé Crenshaw in 1989, intersectionality draws analytic attention to the fact that no social identity category exists in isolation of others. In the context of RAA's situation she was positioned within a system of multiple social categories including gender, disability and racialisation among others. In reviewing the extensive history of domestic abuse and mental health in RAA's case it is important to recognise that her lived experience had many facets and yet it is only in December 2021 do we see RAA engage with specialist agencies that relate to her cultural and belief system. It is apparent that they had a real understanding of her situation using DASH risk assessment to identify and corroborate high risk status. In terms of the DASH[71] assessment it highlights risk and on certain questions if identified e.g. HBA[72] or stalking[73] best practice is to ask further supplementary questions. In the standard 24 DASH tool question five asks 'Are you feeling depressed or having suicidal thoughts?' there is however no practice guidance to ask supplementary questions or consider risk around harm. It is noted that an action from the agency is to consider this in the future. RAA was assessed using various actuarial and clinical tools, yet the interconnectedness of her protected characteristics was seen in isolation rather than a whole system approach. In reading the reports the focus has been on the separation of risk and mental health concerns, isolating her social identity in the categories of cultural,

[70] Domestic Violence at the Intersections of Race, Class, and Gender Challenges and Contributions to Understanding Violence Against Marginalized Women in Diverse Communities NATALIE J. SOKOLOFF John Jay College of Criminal Justice IDA DUPONT Pace University

[71] https://www.dashriskchecklist.co.uk/

[72] https://www.dashriskchecklist.co.uk/honour-based-abuse/

[73] https://www.dashriskchecklist.co.uk/stalking/

ethnic, and disability rather than integrating a holistic trauma informed response[74]. It is important to consider the world of the lived experience of RAA and the impact of her complex life from her adolescent years brought into adulthood through unresolved traumatic experiences.

6.1a If practitioners isolate these identities there is risk of consciously or unconsciously oppressing individuals based on complex and an interlacing range of cultural, ethnic, biological, factors. Agencies working in the front line must be proactive with professional curiosity to promote early intervention and must actively acknowledge the multiple inequalities people experience as a result of oppressive behaviours of others especially in regard to domestic abuse. It's an area of practice close to Professor Claudia Bernard's heart, as Professor of Social Work at University of London, she is currently working on a book on the subject, entitled Intersectionality for social workers: Theory and Practice.

6.1b As mentioned, RAA was subject to a series of assessments within agency systems. Although there was evidence of escalation and issues within the family most incidents had been reviewed at medium risk level. This saw incidents in isolation rather than clusters[75] which would have escalated the domestic abuse she was experiencing to meet the MARAC threshold criteria on escalation and potentially give access to the specialist IDVA before December 2021. The Police made Adult at risk referrals, (via PPN) however there is no record of an assessment utilizing the element of domestic abuse within the Care Act by Adult Social Care to provide an IDVA or IMCA. Having an independent advocate to promote the elements of intersectionality may have supported the building of trust between RAA and agencies. There was evidence by Police to review the element of concern regarding HBA, however this was discounted yet further incidents are reported that would indicate some discord and family pressure. This isn't picked up again till the MARAC in December 2021 when we see a more intersectional lens with agencies openly sharing their concerns especially around the long history of domestic abuse and offer a culturally specific IDVA. At the point of referral when discussing couple relationships and parenting practices, it is important to consider that social status, religion, and experiences of racial discrimination all intersect with ethnicity.

6.1c Although the strategy meetings are a multi-agency arena there is no reference to specialist services offering professional expertise or joint visits other than with Police around the Domestic Abuse or cultural considerations. Although noted and there is evidence of a strength-based approach in the final assessment recorded, having insight into the intersectionality aspect of the situation does not appear to form any part of the whole family assessments that took place. The information explored in the learning event reflected there were opportunities to pursue further professional curiosity around the lived experience of RAA's situation which would have offered an early intervention approach to addressing the family's risk. RAA can be seen to not only feeling cultural shame but also a lack of trust and fear in services which is a common barrier that can prevent those affected by abuse from engaging with services. This in part was probably due to the lack of intervention of unresolved past

[74]https://socialworkwithadults.blog.gov.uk/2020/01/31/why-intersectionality-matters-for-social-work-practice-in-adult-services/

[75] https://www.ted.com/talks/dr_jane_monckton_smith_the_homicide_timeline

experiences, she had when as an adolescent she experienced significant trauma and racism which from reports indicated that it was never fully addressed by services. It was apparent she also had concerns about what services wanted to know or whether they would try to take her children away. These concerns could have been developed when professionals appear to have accepted the minimisation of the impact of the domestic abuse and combined mental health of RAA and the children with the outcome of assessments being at child in need. The focus was on RAA and her behaviour rather than the opportunity for an agency to address the behaviour of those causing harm within the legislative process which would have taken away the onerous burden off the victim of the one taking action against the abuser.[76]

6.1d As practitioners if we apply intersectionality in our assessments combined with professional curiosity, it offers us a framework that can be used to foster an understanding of how interlocking oppressions manifest in the lived experiences for the people who need services. Evidence from the Early Intervention Foundation[77] suggests that parents from minority ethnic groups experience poor mental health, economic stress, and substance and alcohol misuse which can influence interparental conflict. In RAA's case we have seen evidence of all these factors having an impact on the relationship. The Family Stress Model[78] illustrates how economic pressure affects parents' mental health and the quality of interparental relationships, which in turn impacts children's outcomes. The higher prevalence of risk factors among minority ethnic groups in the UK suggests that minority ethnic children might be at greater risk of exposure to parental conflict as was in this case with years of ongoing incidents of reported and un-reported incidents. Both child A and child B had behavioral and self-esteem concerns recorded which appear to have been secondary rather than the primary focus.

6.1e With specific reference to Equality and Diversity. At the outset of this DHR, the Review Panel identified the following protected characteristics of RAA and XY as requiring specific consideration for this case; enduring mental health as a Disability, Age, Race, Religion or Belief and Sex.

6.1f Enduring Mental Health: Research[79] evidence shows compared to women with no mental health disorders, measured over their adult life, women with depressive disorders were around 2.5 times more likely to have been victims of domestic violence (with a prevalence estimated at 45.8%). For women with anxiety disorders, this figure was over 3.5 times, with a prevalence estimate of 27.6%. Women with post-traumatic stress disorder (PTSD), the chances of having experienced domestic violence were 7 times more (prevalence estimate 61.0%) than women with no mental health problems. RAA as noted experienced symptoms of depression, anxiety, and post-traumatic stress disorder. Under the Care Act 2014 and the Care Programme Approach (CPA)[80] led by the NHS mental health and social work professionals need to be aware

[76] Marshalling the Evidence: Using Intersectionality in the Domestic Violence Frame: JENNIFER NIXON AND CATHY HUMPHREYS Social Politics 2010 Volume 17 Number 2

[77] https://www.eif.org.uk/resource/reducing-parental-conflict-outcomes-framework

[78] https://www.eif.org.uk/files/pdf/cg-rpc-2-2-family-stress-model.pdf

[79] https://www.medicalnewstoday.com/articles/254475#2

[80] https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/

of the link between domestic violence and mental health problems and ensure that their clients are safe from domestic violence and abuse and are treated for the mental health impact of such abuse. Their condition meets the threshold for disability[81] in this context. Professor Neil Websdale highlights that death by suicide can be somehow traced back to the experience of domestic abuse. The link may not be direct though it may include the cumulative effect and impact of domestic abuse in terms of the impact of mental health. This links to what we know about the impact of domestic abuse in terms of increased rates of suicidality and indeed death by suicide as highlighted in Aitken and Munroe Report[82].

6.1g Age: Although age was not identified by the Review Panel as having a particular impact in this case, RAA was in her late twenties at the time of her death. It is of note that there was a 10year age gap between RAA and XY; some research[83] suggests that a large gap can be a risk factor.

6.1h Race: RAA was of mixed race and XY was of Bangladeshi origin. Consequently, the Review Panel felt that RAA's experiences were directly or indirectly affected by race, due her experiences of racism and cultural issues, specifically expectations around her relationship. Additionally, XY may have experienced discrimination that is unknown to the Review Panel.

6.1i Religion or belief: Both RAA and XY were believed to follow Muslim faith and Islamic traditions. The Review Panel has not identified any information that both party's experiences were directly affected by their faith. However, as with the discussion concerning race, faith may have been a factor more generally.

6.1j Sex: Domestic abuse is a gendered crime which is deeply rooted in the societal inequality between men and women. RAA was female, the definition of discrimination includes gender-based violence, that is, violence that is directed against a woman because she is a woman or that affects women disproportionately.

6.2 Understanding Coercive Control and impact on Mental Health

Research undertaken in the UK and abroad demonstrates that there is a causal link between attempted or completed suicide and concurrent experience of domestic violence. In 2000, UK statistics showed that between 30 and 40 per cent. of female suicides were committed by those who had been subjected to domestic violence. In the United States, research has shown that there is a temporal connection between suicide attempts and hospital treatment for injuries resulting from domestic violence. Domestic violence and abuse is included in the Care Act 2014 as a specific category of harm/abuse[84]. The Care Act specifies that freedom from abuse and neglect is a key aspect of a person's wellbeing, and the statutory guidance outlines that abuse takes many forms, and local authorities should not be constrained in their view of what

[81] https://www.gov.uk/definition-of-disability-under-equality-act-2010

[82]https://www.semanticscholar.org/paper/Domestic-abuse-and-suicide-%3A-exploring-the-links-Aitken-Munro/5aef8b47a252fb183c7843498ba7123b1983d958

[83] Garcia, L., C. Soria, and E.L. Hurwitz. (2017) Homicides and Intimate Partner Violence: A Literature Review. Trauma, Violence, and Abuse 8(4), pp. 370–383.

[84] https://coercivecontrol.ripfa.org.uk/

constitutes abuse or neglect. 'Controlling behaviour' is a range of acts designed to make a person subordinate and/or dependent by isolating them. In RAA's case she had limited contact with anyone outside her family network. There is only one mention of a friend. She described having to cater for XY's family at all hours and having to cater to all his needs at any given time. He coerced her into getting into the car to talk about the divorce and then assaulted her, which he denied(gaslighting). He would 'love bomb' her with text messages and presented to agencies that he was calm and articulate, whilst his behaviour to RAA included physical and psychological abuse. There is a criminal offence under Section 76 of the Serious Crime Act 2015[85] in relation to coercive and controlling behaviour within the context of domestic abuse. This sets out the importance of recognising the harm and cumulative impact on the victim caused by these patterns of behaviour leading to psychological injury. On 22/11/21 RAA describes wanting to 'survive in silence' to Social Care and had also written in the note when staying in temporary accommodation 'suffer in silence, survive in silence' along with 'you don't need to suffer in silence, but you can be saved in silence', evidencing the impact of her not feeling she had a voice or power possibly of the situation and her best interest was to stay silent to survive. It highlights the complexity of her situation and the 'different hats' she had to manage, as a mother, a carer, a provider, a protector, each with different responsibilities in order to maintain the safety of herself and those she loved. Things weren't normal in the world at this time and added pressures of the pandemic put further strain on services and families.

6.2a RAA had suffered abuse over a sustained period, going back to the MARAC record in 2015. RAA had temporarily left her husband on a number of occasions because of the abuse; however, each time she returned. When RAA left and was temporarily accommodated RAA had left notes that she had kept, in which she harrowingly documented alleged physical and emotional abuse. Taken in isolation, the various reported domestic reported incidents over the 7-year period may not have appeared to be life threatening, combining the pattern of behaviours under the coercive control legislation over the same period of time RAA's pattern of psychological distress can be tracked. Someone who is regularly emotionally abused suffers psychological problems, and that psychological damage can ultimately be more harmful to the individual than isolated instances of physical abuse. It is recognised that the desire to exert power and control underpins the majority of domestic abuse which takes place, and that abuse is usually inflicted to achieve this end.

6.2b Both the Care Act around Mental Health and the CCB legislation link the impact of abuse on capacity[86]. In the case of DL v A Local authority 2012 it highlighted that there is a category of vulnerable adults due to their condition who are open to exploitation the ruling quotes "it is in part aimed at enhancing or liberating the autonomy of a vulnerable adult whose autonomy has been compromised by a reason other than mental incapacity because they are … (a) under constraint; or (b) subject to coercion or undue influence; or (c) for some other reason deprived of the capacity to make the relevant decision or

[85] https://www.legislation.gov.uk/ukpga/2015/9/section/76/enacted

[86] See DL vs A Local Authority and Others (2012), online at www.bailii.org/ew/cases/EWCA/Civ/2012/253.html
(accessed 22 October 2014)

disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent". (para 54). Further case law places a focus on public bodies to have a duty to consider vulnerability in a practical and contextual way as in s149 Equality Act 2010, (case law Hotak v LB Southwark 2015). Assessing capacity[87] can be particularly challenging in situations involving domestic abuse, especially in this case where the adult lives with a family member or intimate partner and is seen to be making decisions which put or keep themselves in danger. Any decision made by professionals on behalf of that adult where someone's capacity is compromised by coercion must be made in their best interests. People who do have family who are advocating as in RAA's case, are still entitled to have an IMCA/IDVA to support them in safeguarding procedures, if the decision-maker is satisfied that having an IMCA/IDVA will benefit the adult. This option does not appear to have been considered especially at the various crisis points or the link to coercive controlling behaviour by her partner[88] on her capacity to make a decision.

6.2c It is important that people who are experiencing domestic abuse are given accessible information about all the options available to them[89]. This should include specialist domestic abuse services as well as information on legal options such as restraining orders, and actions the police can take such as Domestic Violence Protection Orders. Although at points these were offered a DVPO was not considered and only after the second MARAC and her parents advocating does RAA have access to specialist services that meet her needs. It is of note the social worker who completed the assessments when RAA went into temporary accommodation was proactive and made links to local agencies to support RAA, using a strength-based approach this resulted in a trusting relationship between RAA and the social worker.

6.3 **Engaging with Services**

Within the scoping period it has to be acknowledged that for a significant proportion of time services and interactions had adapted to working within the restrictions of a pandemic. The impact of the pandemic, however small, can't be ignored as a factor in reducing access to help seeking for both her mental health and the impact of domestic abuse. Dr Saira Khan highlights with repeated PTSD that survivors feel "others do not understand them". In the learning event it was stated that many professionals were required to now work from home. Although there was a certain amount of flexibility of doing this, staff had to quickly adapt their home living spaces to the needs of multiple family members working from home whilst simultaneously attending to care needs of children and others who may have been shielding. Working from home came

[87] the Mental Capacity Act 2005. A lack of mental capacity could be due to:

- a stroke or brain injury
- **a mental health problem**
- dementia
- a learning disability
- confusion, drowsiness or unconsciousness because of an illness or the treatment for it
- substance misuse.

[88] https://www.communitycare.co.uk/2021/03/29/social-workers-can-identify-coercive-controlling-behaviour/

[89] https://www.adass.org.uk/adassmedia/stories/Adult%20safeguarding%20and%20domestic%20abuse%20April%202013.pdfmay

with an element of professional isolation. They were unsure of new working methods and missed the reassurance that working alongside more experienced colleagues and supervisors brought. For statutory agencies especially it was 'business as usual,' still potentially it was recognised this may have impacted on RAA's decision making. Work routines changed significantly. In the absence of some services not able to provide face-to-face work for both service users and colleagues, virtual communication platforms such as Zoom, and Microsoft Teams started to be utilised. At first, different sectors used different virtual platforms, which affected some inter-agency communications and not everyone had access to computer stations or all of the equipment that they needed. Those that did weren't always familiar with the communication tools, and they had to rapidly learn how to use them. Agencies still had to deal with the logistics of staff and access to systems, resources all would have had some consequence initially relevant to families accessing services and staff providing services.

6.3a RAA was reluctant to give formal statements, this may have been due to the fear of repercussions of disclosure, the responsibility of taking action whilst still living with her abuser, not knowing who or what options were available during lockdown, external pressures RAA refers to, and her enduring mental distress from historical and recent trauma. If we consider from her lived experiences, how could she trust others when she had experienced a betrayal from someone, she had placed her trust and care in, how could she easily trust other people? Survivors learn that this deception could be anyone and look for malicious intent and may try to understand the agenda behind every interaction. Dr Khan further describes survivors thinking 40-50% of people are untrustworthy because that has been their experience. It takes time to show survivors professionals are trustworthy, most interactions with RAA were at crisis point followed by formal assessments and in the learning event it was acknowledged that there were changes in staff that may have impacted on relationship building.

6.3b It is unknown if the pressure due to her fears of the impact of the pandemic on health of her family[90] (all-cause mortality rates for the entire period of the pandemic were higher for males and females in the Bangladeshi ethnic group) alongside keeping her children safe may have affected her engagement. It was recognised at the learning event that in order to feel safe a survivor needs to have a safe route out and place to go. For a considerable time, RAA would have lived with restrictions, then adapting to having to work from home as part of the new normal. Having previously had access to face-to-face support in private space, RAA is limited to access to others and yet it is seen as essential to have privacy when a victim is attempting to access specialist support for either the abuse or their mental health. Although RAA was accessing online services as we know, at times those services were contacting RAA at home whilst XY was present. Her father and mother advocated with RAA's consent that services approach RAA via them so as not to raise concerns with XY about her intentions.

[90]https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/updatingethniccontrastsindeathsinvolvingthecoronaviruscovid19englandandwales/10january2022to16february2022

6.3c RAA had a good relationship throughout with her GP who identified links with domestic abuse and her mental health. The GP liaised with secondary mental health services assisting in prescribed medication reviews and providing immediate response. One facet of the engagement with services is the control given to XY of her prescribed medication with agreement from some services. Some services were aware of the domestic abuse which included disclosed coercive control behaviour. Some services were aware of a known history of drug activity by XY. A recurrent theme within reviews is a distinction between an information exchange and effective communication. In many cases, important information is shared between agencies, however it is either not actioned or else its significance, particularly in terms of risk to the adult or child at risk, is not appreciated by other agencies. This appears to have occurred here. What message must RAA have taken from this agreement that her abuser had complete control again even with agencies aware of his documented activity and suicide threats also, does this not reinforce to RAA her powerlessness in the situation. It would not give her hope and make it feel that agencies weren't listening to her when she disclosed not being allowed food or money. Although RAA did not give consent to her information being shared as an Adult at risk, the guidelines from the suicide prevention strategy for England addresses this in the document consensus statement on information sharing[91] and the document recording and sharing information about domestic violence/abuse in the health service by Dr Sandi Dheensa.[92] The statement emphasises to practitioners that, they should use their professional judgement to determine what is in the person's best interest. It is important that the practitioner records their decision and justification about sharing information, section 115 of the Crime and Disorder Act could also be used. It is of note that the information is later shared with Children's Services which if shared earlier may have influenced how RAA engaged at that point.

6.3d The comprehensive counselling assessment in March 2022 highlights the traumatic background and enduring psychological distress. RAA describes 'wanting to survive in silence' and although offered interim support, counselling was declined, RAA felt unable to engage maybe due to the responsibility she felt in protecting her family including her mother, father and her children, her perception to be viewed by 'others' thinking she was crazy and not at that point having any time for herself, it was everyone else first.

6.4 **Understanding agency roles and Information sharing**

RAA had been in contact with a number of services across county lines. It is noted that with stronger information sharing of the history of vulnerabilities in the family there were potential opportunities to have a greater understanding of the context of RAA's distress to potential interventions from agencies. A key agency in her lived experience throughout were Health services and research highlights their role in identifying those who have been abused and providing

[91] Information sharing and suicide prevention Consensus statement Prepared by Mental Health, Equality and Disability Division

[92] https://research-information.bris.ac.uk/en/publications/recording-and-sharing-information-about-domestic-violenceabuse-in

mental health support[93]. There is clear direction around routine safe enquiry from the National Institute for Health and Care (NICE)[94] when indicators of domestic abuse are highlighted in women's services. Also, the British Medical Journal[95] published a review discussing how general practitioners and non-psychiatric specialists can assess suicide with specific guidelines on how to carry out assessments. This assessment of suicide risk may be lifesaving when it is coupled with clinical action such as a personalised Well Being Safety plan. In line with best practice there is evidence of safety plans with RAA by health services and her GP.

6.4a In practice, as mentioned assessment of suicide risk in an individual is not precise. Combinations of risk factors for suicide may be more important in determining an outcome than individual characteristics. In RAA 's case the risk factors for suicide and self-harm at crisis points changed rapidly over short periods (for example, from changing life events threats of harm from XY, moving into temporary accommodation, fluctuation in severity of mood,). Pressure was on RAA to separate away from the abuse, the survivor is then monitored to then monitor the abuser, whilst the abuser appears 'invisible'. Multi Agency arrangements included two strategy meetings and social care assessments, methods of contact were very different from pre-covid settings, staff time was limited, engagement was limited, access to resources for face-to-face work was limited. It was highlighted at the learning event that RAA felt there was no safe place. RAA appeared to carry the responsibility of the whole family. In the MARAC in 2015 seven agencies had known information with seven actions carried out by five agencies. Similarly in 2021 eight agencies had known information with fourteen actions being carried out by seven agencies. It is interesting that the new Perpetrator standards[96] highlight early intervention yet in six years there is no evidence of any significant interaction with XY to address his behaviour. It is of note actions related to RAA, the appropriate focus of MARAC[97], yet the highest risk to her was XY and no actions were identified to address or engage him. The usual response falls to statutory functions under enforcement however, without compliance from victims/survivor's actions are limited. There is a definite need for resources to engage those who display abusive behaviours to access early interventions through engagement rather than a 'shame' approach. Actions from MARAC are monitored and information is shared across borders, which is best practice.

6.4b The learning event did highlight delays in information sharing between agencies which may have impacted on agencies perception of risk and capacity to address these factors without the full history of abuse and links to mental health. This information may have assisted in responses to RAA, although this may not have changed her decision making, it could have influenced how agencies engaged with her with a better understanding of what her 'fears' related too.

[93]https://www.local.gov.uk/case-studies/kent-and-medway-highlighting-relationship-between-domestic-abuse-and-suicide

[94] https://www.nice.org.uk/guidance/ph50

[95] BMJ 2013;347:f4572 doi: 10.1136/bmj.f4572 (Published 25 July 2013)

[96] https://www.gov.uk/government/publications/standards-for-domestic-abuse-perpetrator-interventions

[97] https://safelives.org.uk/sites/default/files/resources/Perpetrator%20guidance%20for%20Maracs.pdf

6.4c The learning event considered connections between agencies and the liaison between key professionals. It was noted about staff turnover and sickness, impacting on consistency of contact with agencies. There had to be an impact on time dedicated to exploring issues too with new staff taking over cases and having time to gather the back story of complex family situations. This also highlighted cases of doorstep interviews, whilst some families also used the situation to hide behind the veil of the pandemic and be almost invisible to services. These highlighted opportunities could have been stronger at points, e.g. between Derbyshire CSC and the GP, however this did develop and by the second strategy meeting the GP was a strong advocate for RAA making it clear her chaotic presentation was driven by fear. Having meetings on Microsoft team's platform had meant the GP could attend, so it should be seen as positive that better engagement was enabled by professionals than prior to the new normal way of working. There appears to be some gaps in records being flagged linking the domestic abuse and mental health. It is not clear if the information was not documented correctly or shared fully in November 2021, it isn't clear if the crisis team would have been aware of the enduring domestic abuse and impact on RAA's mental health which may have impacted on their intervention strategy and safety plan.

6.4d It is highlighted that due to a delay in information sharing between cross border agencies Derbyshire CSC were not aware of the background to XY around a conviction for drugs. At the time of their involvement, he was administering RAA's medication. There were a number of agencies having contact with the family for very different reasons and it needs to be acknowledged that staff need a specific skill set to feel comfortable to challenge those who harm without increasing risk. Research[98] around the invisibility of perpetrators in assessments is highlighted as an area for development for front line services. In the coordinated community response, the focus of a whole family approach is enabling the abuser to be accountable for their actions, a fact which all agencies share the responsibility of calling out abusive behaviour in plain sight, enabling change in perpetrators and enhancing the safety of space for action of victim-survivors and their children[99]. From episode two to three we begin to see a fostering between agencies of professional and cultural curiosity and the need to ask more about the impact and influence across the whole family and their lived experience. Still within this there is minimal 'sight' or 'lens' on the abuser. It is important in partnership working with families to recognise who is best placed to have those conversations and who is best placed to have these behaviours challenged and then encourage engagement in relevant behaviour change work. David Mandel who leads on the Safe and Together[100] model highlights this in his direct work with families. That shared ownership by partners is really important.

7 Specific terms of reference were set for this review which agencies were required to address in their agency reports. The following section responds to the lines of enquiry as set out in the Terms of Reference.

[98] British Journal of Social Work (2013) 43, 1092–1110 doi:10.1093/bjsw/bcs049

[99] https://www.researchgate.net/publication/275158728_Why_Extending_Measurements_of_%27Success%27_in_Domestic_Violence_Perpetrator_Programmes_Matters_for_Social_Work

[100] https://safeandtogetherinstitute.com/the-sti-model/those-we-serve/mens-behavior-change/

7.1 Identify examples of good practice, both single and multi-agency.

During discussion and within records, there is evidence of much good practice within several agencies who supported RAA and it is equally important to develop learning from this good practice as it is from any shortcomings.

The police officer who attended when RAA was in crisis and supported access to her GP. The police officer and social worker in episode 2 who were very experienced in the field of domestic abuse investigation and spoke in depth to RAA. Despite no criminal offences being disclosed, markers were still put on the address to alert call handlers to the background information and provide a rapid response.

The Housing officers who supported RAA's applications and ensured she was in the right band and had the current information.

The specialist advocates in episode 3 who were diligent in their assessments and followed up on actions. Supporting RAA to access support for child A. Their expertise around cultural barriers and flexibility in their approach to support RAA. NMWN and JWA have also introduced completing their own DASH RIC and empowerment form with the client to capture a fuller history of the abuse and any concerns regarding mental health.

The GP was a strong advocate and support for RAA. The GP was a key figure in the strategy meeting held post MARAC, sharing relevant information as to RAA's concerns.

The practice of the primary schools DSL in being proactive around concerns and their liaison with CSC. Their focus being the voice of the children. Operation Encompass link was also key in communicating incidents alerting the school to the impact on children.

The social worker in episode 2 enabled RAA to access temporary accommodation and built trust and rapport with her. The links that were developed with the GP which identified and linked domestic abuse and mental health along with the cultural aspect. Strong multi agency practice with plans being informed by RAA's wishes.

7.2 Analyse the quality of risk assessments undertaken. Were links between Mental Health, Domestic Abuse and suicidal ideation identified at any risk assessment? Have there been changes in the service since 2020, particularly policies and training?

This DHR aimed to identify the learning from this case, and for action to be taken in response to that learning: with a view to prevention of harm in the future and ensuring that individuals and families are better supported. For each agency that had contact with Parents, or the children, internal and external communication and cooperation have been explored in the report. Taken together, broadly, certain themes have emerged.

7.2.1 Apart from the DASH risk assessment completed by the Police recorded as medium risk and the specialist agencies, no other agencies appear to have completed any assessment of domestic abuse risk linking this to RAA's mental health. The disclosures made to different agencies e.g. Social Care could have triggered more robust consideration of the risks as well as her needs and those

of the children. Additionally, as noted below, XY was often largely 'absent' from view, with consideration of key issues – including his suicidal ideation and previous drug convictions, as disclosed by RAA – going unaddressed. The reality of RAA's experience of domestic abuse, suicidal ideation, and her mental health was not grasped by most agencies who were aware of it.

7.2.2 Firstly, communication between agencies was often extensive but sometimes had little effect in regard to coordinating risk around her mental health and domestic abuse. In general, that seems to have been due to an overreliance on email, rather than direct conversations between agencies. This may have been due to restrictions due to the pandemic and a different working environment for professionals at the time. More immediate communication may have enabled clarification of issues including whether a referral had been made or taken up (e.g. with IDVA in Derbyshire), or indeed the family's residence (e.g. between Children's Social Care and Early Help Service and Housing Options).

7.2.3 Additionally, to some extent, communication was sometimes along the lines of 'fire and forget', with referrals being made but not followed up within time frames (particularly to Police HBA unit no outcome noted) or outstanding queries abandoned or significantly delayed as in the case of the request from Derbyshire Social Care to Nottingham Integrated Children Services which took over 2 months and similarly with the request for Police information on XY. Conversely, some agencies do not seem to have been notified at all, including the GP.

7.2.4 Secondly, in Nottingham the responses were to provide individual and parenting interventions, strategies with RAA to assist the emotional crisis of child A self-harming and CAMHS focused on their behaviour without a deeper consideration of what may have been occurring within the family home. Different information and recording systems used by health, education, social care and external agencies also limited the ability of agencies to triangulate what interventions, referrals or support were being offered to the family.

7.2.5 Thirdly, there were different opportunities to identify that RAA had moved between Nottingham and Derbyshire. What was known varied considerably and was the cause of confusion as to which agency was supporting her or the children. The Review Panel felt that, while the issue of residence was important, the underlying factor was the communication between agencies. The Review Panel noted that some of this learning is not new – it has been a feature of different reviews into serious incidents and homicides involving adults as well as children that move between county boundaries.

7.2.6 Changes evidenced in agency action plans include Nottingham Muslim Women's Network are enabling all supporting staff to attend suicide awareness training by Harmless. They are instigating improved interprofessional communication with Juno by regular information sharing meetings. Two additional staff members to attend IDVA training.

7.3 Whether risk was or was not identified, where can practitioners within your agency receive advice or support if they suspect domestic abuse? Was this taken up in this case? If this is available would the advice extend to consultation or referral across agencies?

7.3.1 Agencies had appropriate line management and support structures in place for practitioners in line with their statutory duties and responsibilities. From Agency reports it is evident that the opportunity to consult was followed e.g. with the Police example regarding the referral of the incident to their HBA unit. However, there was evidence of agencies at times relying on the actions of other agencies as a proxy for their own assessment, e.g. mental health, relying on Social Services or Police to intervene. This could have been managed in a more coordinated process e.g. with a focus on early help provision to assist the children in dealing with their trauma or given each agency should take responsibility for its own response.

7.4 Is there evidence of whether any identified risk had been assessed as reaching the threshold for inter-agency information sharing especially around suicidal ideation linked to Domestic Abuse?

7.4.1 This is detailed in section 6.4 above. At the time DASH RIC's were received by agencies the correct process was followed in terms of information sharing with partner agencies. Where RAA was spoken to, and the information contained in the DASH RIC's was discussed her wishes were taken into account so as not to exacerbate her mental health. In line with the information sharing process information was shared with the respective school via Operation Encompass.

7.5 What evidence is there of communication and information sharing between agencies? How could information sharing, and communication have been improved during the scoping period both within and between agencies? Did the cross-boundary context impact on information sharing and if so, how?

7.5.1 There were examples of good interagency working, including an awareness of the importance of sharing information or making referrals where necessary. However, all too often communication took the form of 'fire and forget', as mentioned in detail above, with agencies failing to follow up correspondence, or enquire about outcomes, or respond promptly. There was also a reliance on indirect communication (particularly email) rather than speaking directly to another professional, which may have more readily resolved the issues causing confusion or concern.

7.5.2 During the timeframe covered by this DHR, RAA, had been resident in both Nottingham and Derbyshire. It is important to note one fact: this was not necessarily her choice. She had come to live in Derbyshire as a result of being placed in temporary accommodation by Social Services. Other services there were also in communication with RAA. This caused confusion, affecting decisions both on what services were offered but also meaning agencies did not always have a complete picture of the RAA's risks and needs. This was exacerbated by the issues with interagency communication as summarised above, but also on occasion the failure of agencies to undertake enquiries with their counterparts in neighboring counties in a proactive manner.

7.5.3 Individual agencies have made recommendations in relation to both interagency communication and cross-border working. While it is impossible to say what the effect of resolving these issues may have been, the importance of prompt and clear communication, as well as the speedy resolution of areas of confusion, is important learning from this DHR.

7.6 Were referral pathways followed according to local policies? If not, what was the reason this did not happen? Are these pathways different now?

7.6.1 The Review Panel felt the referral pathways according to local policies were positive. It was also reassured by evidence that local services are accessible and meet local demographic needs. The Review Panel was especially thankful for the contribution of the specialist agencies in the review and their part as critical friends in learnings from the review.

7.7 What role if any, did the Covid pandemic and restrictions at the time impact on access to services for RAA and family members?

7.7.1 This is discussed extensively throughout the report and highlighted in section 6.3 above. There is evidence that the restrictions may have played a significant part in the isolation and access to early help services at the beginning of the scoping period due to changes in working practices. This would have an impact on recovery pathways for the children and the parents in dealing with the ongoing domestic abuse.

7.8 Were agencies aware of any complexities of family dynamics or circumstances that would impact on RAA or family members accessing support?

7.8.1 It is evident from reports that the Police and Social Services were aware of complexities. Despite RAA's fears for her family and children, as well as isolation and challenges regarding her mental health and potentially the impact of cultural norms and expectations, she did disclose her experiences of domestic abuse, usually with the support of her family. The responses to these disclosures were mixed, with examples of risk being downgraded or not recognised. Critically, the issues identified around interagency communication above meant there were attempts to involve agencies without success. While RAA would have needed to accept any offer, and that agencies were often unaware that referrals had not been successfully taken up, so could not consider what if anything else they could do to support RAA. Other areas of learning include issues around risk identification and assessment of impact of the situation on the children; as well as the response to other issues in this context like suicidal ideation and coercive control; and policy and practice that would encourage agencies to raise awareness of and identify domestic abuse. Individual agencies have made recommendations in response to these issues, while multi agency recommendations have also been made.

7.9 Was consideration given of the link between domestic abuse and suicide because of cultural practices, concepts of honour and shame, and/or community barriers that may have prevented RAA seeking help?

7.9.1 The link between domestic abuse and suicide in the context of RAA's circumstances was either not consistently responded to or was not the focus of any intervention. There is reference to HBA by Police however this appears to be discounted. It is only when RAA receives specialist support from NMWN and JWA the two specialist agencies do we see evidence of the link between her situation around the ending of her relationship with XY and concepts of honour and shame with references to family pressure. Their support provided access to appropriate information that empowered RAA to make informed choices and created a 'space for action'. It is acknowledged that the DASH RIC did not capture the extent of RAA's suicidality and background around her

deteriorating mental health due to the breakdown of her relationship. Agencies have as part of their action plans addressed this.

8. Conclusions:

The impact of a client in considering suicide can be terrifying for practitioners. Suicide refocuses practitioners' attention, restructuring the way they were thinking and communicating at the time to justify their decision making. For many domestic abuse professionals this can be a good thing from a practice perspective. The consequences of suicidal ideation in domestic abuse cases can be devastating as we have seen in RAA's case. On the other hand, this is precisely why abusers weaponise suicide threats to control victims. Yet engagement with XY was recognised as being at a basic level. There are areas around professional curiosity that can be developed to enhance best practice and offer early intervention strategies to address a perpetrator's use of abuse.

Research by the National Vulnerability Knowledge and Practice programme identify suspected victim suicide is strongly characterised by intimate partner domestic abuse, it is heavily gendered to female victims, and victims are most commonly in their mid-20s to mid-40s the age group RAA was in. Services need to work to and be cognisant of local partnership safeguarding requirements and referral processes, to help safeguard domestic abuse victims with mental health concerns. One of the key findings was most commonly deaths occurred by hanging, poison or drugs again RAA falls into this cohort. Moving towards prevention, a case of best practice highlighted a Police Force that has implemented a process whereby an attempted suicide of a domestic abuse victim is reported to the local Independent Domestic Violence Advocate (IDVA) service, who contacts that individual to provide additional support.

It is known that family involvement and engagement can be key to recovery for individuals diagnosed with mental illness. Previous studies have found that people using mental health services are more likely to stick to their treatment plans and have better outcomes when they have supportive family members involved in their care. Most government policies and mental health guidelines suggest that staff members should involve carers in patients' treatment. It is evident that RAA had supportive family members who advocated for her, however her main carer her partner, in part as RAA highlighted, had a significant impact on her mental state and having access to an IMCA or IDVA may have assisted agencies understanding the role XY's behaviour played in disenabling RAA's trust in services by informing RAA he had connections in agencies and would know her plans. Professionals need to be clear as to the question being asked of the victim and recognise that individuals may be able to make decisions with capacity in response to certain questions and may not in others due to fear. Assessing capacity can be particularly challenging in domestic abuse situations, where the person is cared for by their intimate partner and is seen to be making decisions which put or keep themselves in danger. For example, a decision to continue to live with an abusive partner might be a free and informed decision based on a full understanding and appreciation of the risks and the alternative courses of action, including support available. A decision not to leave may also be based on a realistic fear of the behaviour the perpetrator has threatened if the victim were to disclose abuse or try to leave the relationship. Research shows that women are at most risk of serious harm from the perpetrator when they are leaving the abusive

relationship. Case law has clarified that there is scope for local authorities (using the principle of inherent jurisdiction) to commence proceedings in the High Court to safeguard people who do not lack capacity, but whose ability to make decisions has been compromised because of constraints in their circumstances, coercion or undue influence. A principle of the Mental Capacity Act is that a person only has full capacity if they have access to all the relevant information about the decision they are making. If, after considering the options carefully, you believe they are not free to make decisions then it is time to make a defensible decision about the next steps. This information is taken from Adult Safeguarding and Domestic Abuse — A guide to support practitioners and manager (second edition, 2015).

9. Lessons Identified

This part of the report will summarise what lessons are to be drawn from the case and
how those lessons should be translated into recommendations for action.
Early learning identified during the review process and whether this has already been acted upon is captured in Single Agency Actions Appendix 3.

9.1 It is acknowledged that there was some impact of the pandemic on how agencies and services interacted with RAA in the early scoping period. The pressures on RAA to manage the home, keeping her children and family safe played a role in her help seeking process. RAA was working out which was the safest way to exit her marriage, whilst meeting the requirements of various assessments by agencies to appease XY. Someone experiencing domestic abuse needs to feel safe and have a safe place to go to. Meetings with Derbyshire Social Services as restrictions were lifted were held virtually with RAA with her agreement. Although it was considered not having face-to-face meetings had an impact it cannot be discounted either the lack of personal connection with services. The added complication in RAA's situation was the concept of her being responsible for "upholding family ties" too. In cases where cultural dynamics play a role it is considered dishonourable to leave a marriage. The suggestion is to apply a holistic approach using a professional curiosity lens of how the intersectionality of life links together for anyone in the future e.g. using a culture gram may assist in building rapport in the future.

9.2 It is also acknowledged that engagement with XY the person identified as causing harm in the safeguarding context, was at a basic level. It was of concern that XY was controlling RAA's medication at one point, yet the apparent control and risk factors were not seemingly considered in the assessment partly due to a gap in information sharing. His conviction background wasn't fully known until much later, David Mandel from Safe and Together describes this as 'asking that the issue with car drivers running stop signs, is to educate the car passengers about the dangers of failing to stop when legally required'. The onus of fixing the problem remains with the victim whilst the abuser remains invisible, yet in plain sight, her options are closed down with agencies appearing to inadvertently collude with the abuser. Training named ENGAGE[101] is available for professionals who are less familiar

[101] ENGAGE | WWP European Network (work-with-perpetrators.eu)

on approaches to interviewing those who harm in domestic abuse cases. It outlines a roadmap of options highlighting high risk factors and promoting safe enquiry to support engagement from a holistic perspective. Recently the Government have published the new national standards [102] for engaging perpetrators looking at early intervention. In this case there was also substantial family support and using a family group meetings approach is an option to consider in the future [103] , which would also potentially capture the intersectionality of factors within cases.

9.3 In episode 2 August 2021 Derbyshire Social Services made a request to Nottingham Team for information on previous assessments, this information wasn't received until Dec 2021. Also, a request was made to Derbyshire Police in September 2021 and was received prior to the strategy meeting in December 2021. It is of note that if information on the history of vulnerabilities within the family had been shared earlier this may have informed professionals to understand the distress to the interventions by the family due to the dynamics of domestic abuse and cultural pressures evident between the parents alongside RAA's mental vulnerability. A point noted was the connectivity between professional curiosity and the child's voice, with professionals asking the right questions at the right time. Having that curiosity to explore families and individual's cultures and what that means on impact on risk and children. It is acknowledged as a learning point that an earlier escalation to Nottingham Children's Services for the information would have benefited the Strategy meeting.

9.4 A significant relationship in RAA's life was with her GP who had a clear understanding of the lived experience of domestic abuse and the impact on her mental health and wellbeing. The 'new normal' was virtual meetings and this gave an opportunity for the GP to attend whereas previously this would have not been possible. Having the GP input at the strategy meeting with her knowledge of the links between mental health, suicide ideation and domestic abuse was invaluable. It enabled the strategy meetings to fully appreciate the risks posed and enabled professionals to enact appropriate safety plans based on known risks. It was evident suicidal ideation was a known risk in RAA's case and the GP advocated strongly on RAA's behalf to ensure professionals were aware of the risk.

9.5 DASH- RIC Risk assessment was used to identify the level of harm by Police and specialist domestic services. It is dependent on the information provided primarily by the identified victim with limited opportunity to verify details. This is a strength in that a first-hand account of an incident is captured from source, however the flaw is that it can also be a deficit because traumatised victims may minimise, confuse incidents leading to an inaccurate impression of the level of risk. RAA was subsequently assessed as medium risk. It is in November 2021 after further incidents and the separation from XY that her risk is identified as high and a MARAC-to-MARAC transfer is arranged from Derbyshire to Nottingham. The DASH-RIC has an option for "professional judgement" to be included as part of the assessment. It appears in the reports supplied that there

[102] https://www.gov.uk/government/publications/standards-for-domestic-abuse-perpetrator-interventions

[103] https://whatworks-csc.org.uk/evidence/evidence-store/intervention/family-group-conferencing/

was a reliance to reach the threshold for MARAC on the numerical threshold of 14 and above, rather than using professional judgment or escalation of risk that would have included RAA's vulnerabilities and meet the MARAC threshold perhaps earlier in time.

9.6 It is acknowledged that the two DASH RIC assessments completed by specialist agencies at the time do not reflect the actual extent of RAA's mental health history. Case notes however acknowledge RAA's psychological distress. A resource to support mental health professionals identify and respond to Domestic Violence and Abuse is available. [104] The DASH RIC has no practice guidance on exploring the suicidal risk with the client which is a gap when working with a traumatised victim. The risk assessments did not link the domestic abuse to her suicidal ideation. Subsequently the agencies have attended suicide awareness training from Harmless and have a suicide policy for staff to refer to. Additionally, it is proposed from the MARAC review to have additional questions at that point to illicit a fuller background history of their suicidal ideation using professional curiosity rather than a closed question approach. It is also noted the area's best practice of being part of the Real Time Surveillance for suicide prevention sharing learnings from DHR's with the City and County suicide prevention agenda. This includes additional training on suicide prevention for front line services as part of previous learning currently being implemented.

9.7 The MARAC provides an effective way for agencies to share information, identify,
patterns of abuse and put plans in place to mitigate risk to protect victims and hold the perpetrator to account. The MARAC assesses risk to the identified victim and in RAA's case where she feared for her father especially, he could also be included alongside any other family members or associates who may be at risk.
The MARAC in December 2021 enabled RAA to access specialist support from domestic abuse services. As a forum for exchanging information to produce a comprehensive assessment of risk it was effective.

9.8 There was a reluctance for RAA to disclose information due to fear of repercussions. Some agencies were aware of the potential risk to RAA and other members of the family from information she disclosed. It is apparent there were a number of staff changes during the scoping periods and new staff taking over mid-way through assessments who may not have been aware of the MARAC without consent form thus facilitating an earlier referral to MARAC based on escalation or professional judgment. It is possible to still make a referral without the consent of the victim for high-risk referrals to MARAC. It must be clear what legal justifications are being used in the information sharing without consent form, which provides these grounds and a lesson learned is to recirculate the guidance to MARAC partners because of the review.

9.9 RAA had identified needs especially around her mental ill health and although an adult at risk PPN was submitted it appears no adult safeguarding assessment

[104] https://www.kcl.ac.uk/mental-health-and-psychological-sciences/research/lara-vp-download

was carried out. Under the Care Act RAA should have met the threshold for assessment and a learning point is to track referrals and follow up to request the rational for non-acceptance by the referring agency. There potentially was a missed opportunity for her to have access to an independent advocate that again may have assisted in her engaging with services. In Derbyshire a development is the DART team will review all incidents and PPN assessments to establish patterns of behaviour and potential risk factors allocating cases to the relevant departments and ensuring information is shared with partners in a timely manner.

9.10 RAA felt she couldn't trust the Police as there had been an incident where she was allegedly threatened, and her father attended the scene before the Police. There was also information shared by her father that details about RAA had been shared inappropriately and this reinforced her reluctance to give statements. It is acknowledged that RAA's decisions not to support prosecutions could have been influenced by her own self-preservation for fear of repercussions and her own way of managing her risk. It is stated evidence led prosecutions were considered. An option from the learning would have been to consider a DVPO/N[105] allowing RAA some time to consider space for action or a DVD[106] disclosure as although she had lived with her partner for a number of years, she may not have been aware of his extensive history with the Police. The Police in Nottingham have commenced a Pilot scheme to assist victims of domestic abuse. The pilot is a multi-agency approach enabling access to alarms for an immediate Police response. They have also included access to a suicide prevention application called 'Staying Alive', the app provides resources and strategies. It is clear both Police forces are committed to promoting awareness of domestic abuse and providing tools to officers such as body worn cameras to enhance evidence gathering.

9.11 Throughout the scoping period there are references to coercive controlling behaviours which impacted on RAA's everyday life. From the initial disclosure in 2015 when XY denies all allegations of the assault, the message to RAA he is in control. The use of Non-Fatal Strangulation (NFS) which wasn't a standalone offence at the time, is used by perpetrators as a tactic to exert their control over their victim giving a message that the abuser has control of whether the victim lives or dies. Evan Stark and Professor Jane Monckton Smith both speak about NFS as part and parcel of coercive control behaviour. It instils fear of the consequences of non-compliance and the victim's own fragility of being unable to protect themselves, bearing in mind this act was whilst RAA was pregnant[107] with child B, when we often see an escalation of domestic abuse. A former United States Police Officer Joe Bianco states "more than two decades of research have revealed that strangulation is the calling card of manipulative controlling dangerous men, this is because strangulation

[105] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/506148/2016-03-08_DVPO_report_for_publication.pdf#:~:text=A%20DVPN%20is%20an%20emergency%20non-molestation%20and%20eviction,immediate%20support%20they%20require%20in%20such%20a%20situation.

[106] https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/domestic-violence-disclosure-scheme-factsheet

[107] https://www.nhs.uk/pregnancy/support/domestic-abuse-in-pregnancy/

indicates the dynamic of Coercive Control". Coercive control legislation has been on the statute since 2015 and although there is a substantial amount of reports the conviction rate is still relatively low. A challenge is evidence gathering in such cases and the prosecutions rely on statements from those affected as well as other corroborative material. The Police have invested in additional training for Front Line staff including College of Policing training DA Matters to assist officers to gather other material to aid future victimless prosecutions.

9.12 A key point raised was about using professional curiosity much earlier as part of an early intervention strategy, in looking at the motivation behind certain actions when there was clearly a history of ongoing domestic abuse. In the Deserve to be Heard campaign[108] the report found that black and minoritised women survivors have to confront heightened barriers including discriminatory responses and a lack of understanding of cultural issues when seeking help from mainstream services resulting in their exclusion from support services and potential further traumatisation (Thiara and Harrison 2021). The family was subject to statutory child protection and child in need plans, there is evidence suggesting that when parental conflict is frequent, intense, and poorly resolved it can put children's mental health and long-term outcomes at risk. In the information given to Social Services both children developed physical symptoms of distress. In reports their voice appears limited with the focus on actions by parents rather than supportive interventions for the children. Early intervention programs[109] that were completed in 2015 as part of the child protection plan may have raised awareness at the time however, in later assessments the option of revisiting specialised work does not appear to have been considered. On one hand there is a presentation that everything is 'fine' as in the instance of the joint claim in November 2020, this occurs during covid restrictions with a phone consultation with RAA. This allows both parties access to see each other's information including messaging between customers and DWP staff. For a victim of domestic abuse, it would be difficult therefore to make any disclosure without fear of reprisals. In this case it is circumstantial as to whether the coercive control was being escalated to include financial control and thereby making it more difficult for RAA to leave as she was now intrinsically linked financially with limited access to money without her partner knowing. BC describes RAA asking for money for the children on occasions which would indicate that XY monitored the finances and RAA was restricted in accessing monies, a further suggestion that he was coercively controlling her access to finances. It is of note this claim occurs only eleven months after the significant suicide attempt and following the serious incident in June when Police attended when XY had self-harmed, then a subsequent incident of alleged assault and a family dispute recorded in the September suggesting domestic abuse was continuing in the relationship. RAA was still experiencing episodes of psychological distress so had added vulnerability and possibly open to manipulation from her abuser. It is difficult to determine if there was any coercion in applying for a joint claim. A practice point is to consider a more holistic assessment with safe routine enquiry regarding domestic situations and

[108] https://www.womensaid.org.uk/wp-content/uploads/2023/08/DTBH-Impact-Report.pdf
[109] https://www.eif.org.uk/resources

separate individual access to maintain confidentiality and offer an opportunity for disclosure.

10 Recommendations

The review would like to thank agencies for their single agency learning not all agencies made individual recommendations for their agency, however the following specific recommendations have been noted which are included in **Appendix 3**

The review would ask that NCSP monitor action plans and that outcomes are impact assessed within the organisations. The following **multi-agency recommendations** are made to NCSP:

Recommendation 1: To improve assessments to offer early intervention[110] to inform a fuller picture of the context and mapping of abuse by taking account of historical dynamics of abuse incidents, not just the current incident, using professional curiosity to inform their actions as required.

Agencies screening and/or making assessments[111] of domestic abuse cases look at the clusters of incidents taking account of historical dynamics of abuse not just the current incident as recommended by Prof Jane Monkton Smith in the Homicide Timeline model. Consent is acknowledged and professionals consider making an informed decision using appropriate legislation on a case-by-case basis, to make a justifiable rationale to gather further information, when necessary, from partner agencies if consent is withheld using the recognised without consent form. A briefing guidance has already been compiled by NCSP to ensure current workforce staff are aware.

Recommendation 2: To improve holding perpetrators to be accountable for their actions and understanding the impacts on those affected

To develop meaningful engagement of those who harm by including a diverse approach to address the lived experiences of all parties and other intersectionality's in those experiencing abusive behaviours that are controlling and harmful. A whole family approach would contribute to reducing risk of misinterpreting motivation and behaviours in the context of coercive controlling abuse by abusers[112]. As mentioned, using a training package such as the ENGAGE[113] model for those less familiar with interviewing those who harm would be of benefit. Early intervention in addressing harmful behaviours would follow recent Government recommendations.

Recommendation 3: Improve communications, information sharing and risk

[110] file://early-intervention-in-domestic-violence-and-abuse-full-report.pdf

[111] https://new.basw.co.uk/sites/default/files/resources/181181_basw_england_domestic_abuse_guidance.pdf

[112] https://www.gov.uk/government/publications/standards-for-domestic-abuse-perpetrator interventions/standards-for-domestic-abuse-perpetrator-interventions-accessible

[113] ENGAGE | WWP European Network (work-with-perpetrators.eu)

management when multiagency working across authorities and geographical boundaries. Agreeing a purposeful communication strategy for all concerned assisting in building on the strengths of all parties involved in proceedings.

At the initial cross boundary meeting It is agreed that the partnership have a multi-agency consultation around the impact and influence they will have in the family's life, mapping out the contact points of the family with agencies, what is the best way to communicate timely updates and information, (including to confirm if there is no update) robustly enabling all agencies to remain fully informed. This ensures a holistic picture of circumstances and context of risk is maintained. Identification of the single point of contact for the family enabling a strength-based approach and recognising that relationships with families due to the process may increase communication barriers. Agreeing a purposeful communication strategy for all concerned would assist in building on the strengths of all parties involved in proceedings.

Recommendation 4: Consider each case individually where domestic abuse is a factor and that due to domestic abuse a person's ability to make an autonomous decision is impacted due to coercion, fear or threat of harm and those factors need to be considered when assessing capacity.

In considering how adults at risk maybe supported a lesson taken from the review is that although one adult safeguarding referral was made by Derbyshire Police it was not submitted to the Adult Social Care, due to their understanding the victim had capacity and at the time was refusing any referrals to support services. A child concern was instead submitted to Derbyshire Children's Services as children were present. There were also other opportunities for other agencies to refer into safeguarding, however, these opportunities again do not appear to have been taken at significant points. As Adult safeguarding did not receive a referral, they could not offer support under the Care Act that may have been available to RAA. As best practice it is suggested that Police, Nottingham City Council / Derbyshire County Council Adult Duty Workers who are responding to DART / Domestic Abuse referrals ensure they review the history of the case and do not respond to referrals in isolation, irrespective of risk rating to ensure adults at risk in domestic abuse cases are assessed under the Care Act 2014 where they meet the threshold for assessment under Sec. 42 reason to suspect abuse. Where Coercive Control is identified links to the Serious Crimes Act 2015 part 5 Section 76 are made in conjunction with Police to determine capacity around coercion as in Case Law DL v A Local Authority 2012[114] … is in part aimed at enhancing or liberating the autonomy of a vulnerable adult whose autonomy has been compromised by a reason other than mental incapacity because they are … (a) under constraint; or (b) subject to coercion or undue influence; or (c) for some other reason deprived of the capacity to make the relevant decision or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent". (para 54). If an adult decides to refuse an assessment, it must nevertheless still be carried out if (for example) the adult is experiencing, or is at risk of, abuse or neglect, including self-neglect (section 11 of the Care Act). Whether the adult's decision to refuse is unwise or not is not a relevant consideration. Their

[114] https://www.39essex.com/information-hub/case/dl-v-local-authority-others

decision to refuse must be reviewed in the context that due to the domestic abuse situation the DA Act 2021 that a person cannot consent to the infliction of serious harm and therefore the decision to remain is not an autonomous decision due to fear or threat of harm , in the sense that the assessment must be carried out and the adult's eligible needs must be met, again provided that the ordinary residence rules and costs and charging criteria are met. A human rights-based approach to safeguarding and risk assessment needs to support people to understand their legal rights, identify coercive or exploitative behaviours, make informed decisions about risk based on potentially differing viewpoints and manage risk from a person centered, strength-based perspective. Public bodies have a duty to consider vulnerability in a practical and contextual way (s149 Equality Act 2010 and Hotak v LB Southwark [2015]). Assessment and safeguarding duties are triggered on deliberately low thresholds[115]- namely, the appearance of need and continues, despite capacitated refusal by an adult, if the local authority has concerns there is a risk of abuse or neglect (s11(2) Care Act 2014 and South-end on Sea Council v Meyers [2019]).
Also, carers are assessed where domestic abuse is suspected in line with best practice. Best practice requires inquisitive enquiry, so all safeguarding issues are understood in context, as in the duty of safeguarding s42 of the Care Act. Where identified those at risk have access to an IMCA/IDVA especially where coercive controlling behaviour is identified in the context of domestic abuse to ensure their capacity to make informed choices is not compromised.[116]

Recommendation 5: Embed mapping incidents, understanding abusive patterns and use of the 8 stage of homicide / suicide timeline.

NCSP to highlight to all partner agencies Prof Jane Monckton Smith's eight-stage domestic homicide and Suicide Timeline pattern models and ensure that they are aware of the benefits of incorporating them practically in assessments. This is currently being addressed with a local seminar organised later this year 2023.

Recommendation 6: Improve identification and understanding of the links between domestic abuse and suicide. Understand the local and national referral pathways for support at crisis point using a trauma informed approach.

Nottingham CityCare Partnership, Notts Health Care Trust, and Primary Care, to share with health practitioners the recent new NICE quality standards regarding clinical indicators of domestic abuse and NICE[117] guidelines on Self-harm: assessment, management and preventing recurrence 2022. Also consider guidelines and training around developing mental health risk assessment to consider formulations which link domestic abuse and suicide risk where appropriate. Using individual mental health safety plans which consider the risk posed by domestic abuse and risk of suicide. This is also to be considered across the border for Derbyshire services building on the work currently being undertaken by the Elm Foundation in conjunction with the ICB in Derbyshire.

[115] https://www.scie.org.uk/safeguarding/adults/practice/sharing-information
[116] DL v A local authority (2012) – category of vulnerable adults who are open to exploitation due to coercion
[117] https://www.nice.org.uk/guidance/NG225

Recommendation 7: To Improve understanding of the impacts of trauma on those affected by domestic abuse and linked to their risk around suicidal ideation.

The need for trauma informed approaches to practice, for clients and for the workforce were identified in both areas. Services, that respond with compassionate understanding to their 'cry of pain'[118] are essential to prevent suicide or further acts of self-harm. Trauma focused professionals who ask victims 'what happened to you?' rather than 'what is wrong with you?' recognise the relevance of the abuse within a victim's relationship and the broader social context in which they find themselves, are key. Additional complexity in terms of cultural abuses, such as so-called 'honour' based violence are addressed, once again with understanding and compassion. This can be achieved by offering victims/survivors trauma cards[119] to produce to services so services are aware their response may be affected by their lived experience and should be considered when requesting statements or engagement with professionals.

Recommendation 8: NCSP with all partners promote awareness around suicide prevention in line with the National Suicide Prevention Alliance best practice guidance.

NCSP with all partners promote awareness around suicide prevention[120] in line with the National Suicide Prevention Alliance best practice guidance. Consider domestic abuse in local and national suicide prevention strategies. It is noted that NCSP are part of the real time surveillance for suicide which is best practice and link reviews to their strategic suicide prevention oversight group.

National Recommendations: [121]

Recommendation 9:

The Police and partner agencies involved in Domestic Abuse cases should be made aware of an elevated risk of both intimate partner homicide and of victim suicide where coercive or controlling behaviour (CCB) is present. Frontline and supervisory personnel within safeguarding victim units should consider referrals to suicide prevention interventions in setting safeguarding actions when CCB is identified.

Recommendation 10:

There should be a continued push within policing to identify, record and take positive action where coercive or controlling behaviour (CCB) is identified. The number of convictions around CCB is disproportionate to the number of reports, with only a small number of cases where the specific offence of controlling or coercive behaviour is recorded or charged. The nature and extent of prior coercive control is severe in situations which culminate in a victim dying by suicide, which reinforces the importance of identifying, recording and

[118] Williams, J.M.G. (2014) Cry of Pain: Understanding Suicide and the Suicidal Mind; Piatkus

[119] https://healthwatchessex.org.uk/2022/11/healthwatch-essex-launch-trauma-card-to-empower-trauma-survivors/

[120] https://www.gov.uk/government/collections/suicide-prevention-resources-and-guidance

[121] www.vkpp.org.uk/assets/Files/Domestic-Homicide-Project-Year-2-Report-December-2022.pdf

charging for controlling or coercive behaviour in a timely and accurate manner.

Recommendation 11:

It is recommended that the College of Policing, in consultation with the Home Office and NPCC develop training to directly address the evidential issues experienced in domestic abuse cases where suicide and/or coercive or controlling behaviour is identified to enable abusers to made accountable. The College of Policing has developed a DA Matters Investigators' Immersive Learning Hydra programme to give officers a better understanding of how to evidence coercive and controlling behaviour, how to progress 'course of conduct' investigations and develop effective case files. This training is for those officers who investigate and progress domestic abuse cases and is a two-day Hydra programme to be delivered in-force by trained trainers.

Feedback from Family:

Although members of the family were consulted throughout the process, the feedback on the report has been given by RAA's mother.

I have read the report and I'm happy with it. Thank you for making RAA's voice heard. Hope this helps others in the future to speak out and professionals to get more training and support in a better way. It was upsetting to read as I can't change what has happened. Hope this is a learning point. Kindest regards to all the panel and thank you all from the bottom of my heart.

It is to be noted AZ was contacted throughout the process however wishes it to be recorded their voice is not represented. The Independent Chair has suggested that he may wish to provide written feedback on the report which he has had sight of where he feels the issues aren't representative of his viewpoint. The last contact by the Chair was by phone with AZ was April 2023. Contact was made with his advocate, in the same month, however, to date he has not made any further comment.

APPENDICES

Appendix 1 Terms of Reference

1. Introduction:

1.1 This Domestic Homicide Review is commissioned by Nottingham Community Safety Partnership in response to the death of RAA.

RAA the victim was found deceased by her ex-partner XY and mother at her ex-partner's property, having taken an apparent overdose of prescribed medication. Paramedics attained a call from the East Midlands Ambulance Service to say that they had attended an address to a deceased female after receiving a call from her ex-partner.

RAA was estranged from XY, although she had attended XY's property with their two children. Derbyshire Police commenced an investigation into the death, and as part of this a search was made of RAA's address. The address was secure and tidy, but inside officers found a lengthy note that suggested that RAA had been depressed for a long time and that she felt that ending her life was the only way to make things better. There was no explicit mention of domestic abuse within the note. On top of the note were three packets of medication, all pain and sleeping medication, with all the blister packs empty.

Initial enquiries with a Forensic Pathologist have suggested that the types and quantities of the medication that appear to have been taken by RAA would be consistent with the description of her condition, and the slow deterioration leading to death.

1.2 RAA had a history of mental health concerns.

1.3 There is clear evidence that RAA was experiencing domestic abuse, and this is flagged within her GP records including a DASH-RIC attached to her records. The GP practice liaised with agency partners from the local authority in Nottingham city, Notts Police and specialist mental health services to ensure appropriate support was offered to RAA.

1.4 The Nottingham Community Safety Partnership is keen to establish lessons from agencies that may have worked individually and together to safeguard RAA. It wants to explore whether there were missed opportunities to have engaged with the family to offer any relevant support. The review will explore whether the risk to RAA was recognised and whether there were any barriers to RAA accessing services that may have offered support to reduce risk around suicide. If so, what can be done to raise awareness of domestic abuse linked to those who experience suicidal ideation in such circumstances and of the services available to victims of domestic violence and abuse in this context.

2. Legal Framework:

2.1 A Domestic Homicide Review (DHR) must be undertaken when 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 was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

2.2 The purpose of the DHR is to:

a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

c) apply these lessons to service responses including changes to policies and procedures as appropriate; and

d) prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

e) contribute to a better understanding of the nature of domestic violence and abuse; and

f) highlight good practice.

Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016)

3. Methodology:

3.1 This Domestic Homicide Review will be conducted using the Significant Incident Learning Process (SILP) methodology, which reflects on multi-agency work systemically and aims to answer the question why things happened. Importantly it recognises good practice and strengths that can be built on, as well as things that need to be done differently to encourage improvements. The SILP learning model engages frontline practitioners and their managers in the review of the case, focusing on why those involved acted in a certain way at that time. It is a collaborative and analytical process which combines written Agency Reports with Learning Events.

3.2 This model is based on the expectation that Case Reviews are conducted in a way that recognises the complex circumstances in which professionals work together and seeks to understand practice from the viewpoint of the individuals and organisations involved at the time, rather than using hindsight.

3.3 The SILP model of review adheres to the principles of:

- Proportionality
- Learning from good practice
- Active engagement of practitioners
- Engagement with families
- Systems methodology

4. Scope of Case Review:

4.1 Subject RAA:

4.2 Scoping period: From 27/01/2020 to her death in April 2022 (This represents the period from when agencies became involved and reported RAA's deteriorating mental health)

4.3 In addition agencies are asked to provide a brief background of any significant events and safeguarding issues prior to the scoping period. This will include any significant event that falls outside the timeframe if agencies consider that it would add value and learning to the review.

5. Agency Reports:

5.1 Agency Reports will be requested from:

- Nottinghamshire and Derbyshire Police as one report
- Juno Women's Aid
- Nottingham Muslim Women's Network
- East Midlands Ambulance Service
- Nottinghamshire Health Care Foundation NHS Trust
- NHS Nottingham ICB – Including GP information
- Nottingham Citycare Partnership – Employer
- Nottingham City Council Children's Services
- Derbyshire Children's Services
- Housing Aid Nottingham City Council
- Derbyshire Community Health Services NHS Foundation Trust
- ELM Foundation Derbyshire
- The Arc Bolsover District Council Derbyshire
- Education – Schools in Derbyshire and Nottingham

- NHCFT & City Crisis Resolution and Home Treatment Team (CRHT)
- Neighbourhood Development
- Nottingham Trent University
- NUH – will be submitted late
- SARC – Topaz Centre

5.2 Agencies are requested to use the attached Report Template.

5.3 Summary reports are requested from:

- Adult Social Care – to offer an account of barriers to accessing statutory services including thresholds due to her support needs around her mental health.
- Probation
- NHS 111 service
- Framework Clean Slate
- DWP
- Nottingham City Council Housing

6. Areas for consideration:

6.1 Identify examples of good practice, both single and multi-agency.

6.2 Please analyse the quality of risk assessments undertaken. Were links between Mental Health, Domestic Abuse and suicidal ideation identified at any risk assessment? Have there been changes in the service since 2020, particularly policies and training?

6.3 Whether risk was or was not identified, where can practitioners within your agency receive advice or support if they suspect domestic abuse? Was this taken up in this case? If this is available would the advice extend to consultation or referral across agencies?

6.4 Is there evidence of whether any identified risk had been assessed as reaching the threshold for inter-agency information sharing especially around suicidal ideation linked to Domestic Abuse?

6.5 What evidence is there of communication and information sharing between agencies? How could information sharing, and communication have been improved during the scoping period both within and between agencies? Did the cross-boundary context impact on information sharing and if so, how?

6.6 Were referral pathways followed according to local policies? If not, what was the reason this did not happen? Are these pathways different now?

6.7 What role if any, did the Covid pandemic and restrictions at the time impact on access to services for RAA and family members?

6.8 Were agencies aware of any complexities of family dynamics or circumstances that would impact on RAA or family members accessing support?

6.9 Was consideration given of the link between domestic abuse and suicide because of cultural practices, concepts of honour and shame, and/or community barriers that may have prevented RAA seeking help?

7. Engagement with the family

7.1 A key element of SILP is engagement with family members, in order that their views can be sought and integrated into the Review and the learning. The Community Safety Partnership has confirmed that the mother of RAA wishes to have contact and to be informed that this Review is being undertaken. The independent lead will seek to assess the scope for any other family member who may be appropriate to engage in the review.

7.2 Further contact will be made to invite participation in the form of a telephone or virtual face to face conversation prior to the Learning Event. Relevant contributions will be woven into the text of the Overview Report and contributors will be given feedback at the end of the process.

8. Timetable for Review:

Scoping Meeting	12/10/22
Letters to Agencies	w/c 17/10/22
Agency Report Authors' Briefing	19th Oct 10am – 11.15am 2022
Engagement with family	October 2022
Agency Reports submitted to NCSP	28/11/2022
Agency Reports quality assured by Chair	5/12/2022
Agency Reports distributed	6/12/2022
Learning Event	12/12/2022 pm
First draft of Overview Report to NCSP	10/1/2023
Recall Event	18/1/2023 pm
Second draft of Overview Report available	25/1 2023
Presentation to DHR Steering Group	7/2/2023

Appendix 2 DHR Panel members and IMR authors

Agency	Initial information only	Panel member	Agency Report Author
CSP		Paula Bishop (Domestic Violence & Abuse Policy Officer)	Report for MARAC
Nottingham City Council Adult Social Care	Julie Sanderson Head of Adult Safeguarding and Quality Assurance Oliver Bolam Head of Mental Health & Whole Life Disability	Julie Sanderson Head of Adult Safeguarding and Quality Assurance **If required**	
Nottingham City Council Children's Integrated Services		John Matravers (Service Manager Safeguarding Partnerships) Jesse Keene Children's Safeguarding Board officer (when John is unable to attend)	Samantha Danyluk Head of First Response
Nottingham CityCare Partnership		Karen Turton (Named Nurse Safeguarding) Katy Swanwick (Safeguarding service manager) When Karen is unable to attend	Joanna Williams Named Nurse Safeguarding, and Katy Swanwick (Safeguarding service manager)
Derbyshire Police		Darren Pope (Detective Chief Inspector, Domestic Abuse, Stalking & RASSO	

Agency	Initial information only	Panel member	Agency Report Author
		Lead, Public Protection)	
East Midlands Ambulance Service (EMAS)		Liz Cudmore (Child and Young Person Safeguarding Lead)	Liz Cudmore Child and Young Person Safeguarding Lead
Nottingham City Council Housing Aid		Debbie Richards (Service Manager)	Debbie Richards (Service Manager)
Juno Women's Aid		Yasmin Rehman (Chief Executive Officer) Sam Bennett Head of Quality, Compliance & Performance	Sam Bennett Head of Quality, Compliance & Performance
NHS Nottingham and Nottinghamshire Integrated Care Board		Nick Judge (Associate Designated Nurse for Safeguarding Adults) Ishbel Macleod (Designated professional for Safeguarding Adults) – attends when Nick is unable to.	Nick Judge (Associate Designated Nurse for Safeguarding Adults)
Nottingham City Homes (NCH)		William Morritt (Head of Tenancy and Estate Management)	William Morritt (Head of Tenancy and Estate Management)
Nottingham Health Care Trust (NHCFT)		Helen Pritchett (Specialist Practitioner Domestic Abuse and Safeguarding) Replaces Hayley Frame (Senior	Sam Roberts Safeguarding Lead

Agency	Initial information only	Panel member	Agency Report Author
		Safeguarding Lead) who is leaving	
NUH		Maggie Westbury Adult Safeguarding Lead	Maggie Westbury Adult Safeguarding Lead
Nottingham Muslim Women's Network		Zaynab Asghar – also expert panel member	Zaynab Asghar
Nottinghamshire Police (Public Protection)		Mark Dickson (Detective Chief Inspector – Public Protection) Luke Waller, Detective Inspector (when Mark is unable to attend)	
Police – EMSOU			Adrian Morgan Regional Review Unit (covered all police forces info).
Probation Service		Lisa Adkins-Young Deputy Head, Nottingham and Nottinghamshire	Karen Middleton MAPPA Coordinator
Child A Primary School		TS Principal J S (DSL) - (attended meetings for Principal)	J S T S
Derbyshire County Council		Alison Boyce (Domestic Abuse Manager, Community Safety)	
The Elm Foundation		Jennifer Calverley	Jadah Shah

Agency	Initial information only	Panel member	Agency Report Author
			Derbyshire Domestic Abuse Helpline & Community Team Service Manager
Erewash Borough Council		Kat Thornhill (Community Safety Manager)	Leah Taylor Housing Options Team Leader
Derbyshire Children's Services		Adele Glover (Head of Child Protection and IROs)	Paula Livesey Head of service
Derbyshire Community Health Services NHS Foundation Trust	Jane Graham Safeguarding Specialist Practitioner Adults Sarah Fitzgerald Safeguarding Specialist Practitioner		
Framework - Nottingham Recovery Network (NRN) & Clean Slate		Claire McGonigle Kevin Howard Head of SHEQ (Safety, Health, Environment & Quality)	Jez Wilson Services Manager Criminal Justice Substance Misuse Service & Alcohol Recovery
DHU Healthcare CIC		Julie Tomlinson Lead Nurse – Adult Safeguarding	Julie Tomlinson Lead Nurse – Adult Safeguarding
Bolsover District Council – The Arc	Deborah Whallett **Nothing Further to contribute to the review**		Sharon Ryan Job title: Domestic Violence Officer / IDVA

Agency	Initial information only	Panel member	Agency Report Author
Department of Working Pensions (DWP)	Kerry Jackson **Nothing Further to contribute to the review**		

Appendix 3 - GLOSSARY:

Abbreviation / Stands for

AAFDA Advocacy After Fatal Domestic Abuse

ACE's Adverse Childhood Experiences

ASG Adult Safeguarding

CAADA Co-ordinated Action Against Domestic Abuse

CAMHS Children and Adolescent Mental Health Services

CATS Juno Women's Aid Children And Teens Service

CBT Cognitive Behaviour Therapy

CCG Clinical Commissioning Group

CHISVA Children's ISVA

CRHT City Crisis Resolution and Home Treatment Team

CIN Child in Need

CMHT Community Mental Health Team

CPS Crown Prosecution Service

CSC Children's Social Care

CSP Community Safety Partnership

CYP Children & Young People

CYPFS Children, Young People's and Families' Service

DA Domestic Abuse (DV Domestic Violence)

DASH Domestic Abuse, Stalking and Honour-based violence risk assessment

DHR Domestic Homicide Review

DSL Designated Safeguarding Lead

DVSA Domestic and Sexual Violence and Abuse

EDI Equality, Diversity & Inclusion

EMAS East Midlands Ambulance Service

GP General Practitioner

HBA Honour Based Abuse

HOT Housing Options Team

IMR Individual Management Review

IOM Integrated Offender Management scheme

ISVA Independent Sexual Violence Adviser

MARAC Multi Agency Risk Assessment Conference

MARF Multi Agency Request for services form

NCSP Nottingham Community Safety Partnership

NFA – No Further Action

NHCFT Nottingham Health Care Trust

NHS National Health Service

NMWN Nottingham Muslim Women's Network

OFSTED Office for Standards in Education

PPN Public Protection Notice

PTSD Post-Traumatic Stress Disorder (CPTSD Complex post- traumatic stress disorder)

SARC Sexual Assault Referral Centre

SDVC Specialist Domestic Violence Court

SILP Serious Incident Learning Process

SIO Senior Investigating Officer

SV Sexual Violence

SW Social Worker (e.g. SW1)

Appendix 4 – Action Plans

DHR Stonefox Final Recommendations Action Plan – August 2024

This action plan is a live document and subject to change as outcomes are delivered.

	Recommendation	Rationale	Scope of Recommendation - Local or National	Action to take	Lead Agency	Date of Completion	Evidence: • Key milestones achieved in enacting recommendation • Outcome Have there been key steps that have allowed the recommendation to be enacted? List the evidence for outcomes being achieved What does outcome look like? What is the overall change or improvement to be achieved by this recommendation?	RAG
1	To improve assessments to inform a fuller picture of the context and mapping of abuse by taking account of historical dynamics of abuse incidents not just the current	Agencies screening and/or making assessments of domestic abuse cases look at the clusters of incidents taking account of historical dynamics of abuse not just the current incident as	Local	Agencies involved in assessments to ensure they include: - The full background history wherever possible and pattern of incidents in order to provide a holistic assessment. - To utilise multi-	CSP – **Nottingham Agencies** • Nottingham City Council Adult Social Care, • Nottingham City Council Childrens and integrated Families, • NHS Nottingham and		PDF Honour-based-abuse -practice-summary-2(Best Practice Guidance when HBA is highlighted The importance of information sharing guidance was circulated 29/9/21 PDF Guidance on Multiagency data shar https://nspa.org.uk/wp-content/uploads/2023/04/Sarah-Dangar-Learning-Legacies-bringing-visibility-to-domestic-abuse1.pdf	

Appendix 4 – Action Plans

DHR Stonefox Final Recommendations Action Plan – August 2024

This action plan is a live document and subject to change as outcomes are delivered.

	incident using professional curiosity to inform their actions as required.	recommended by Prof Jane Monkton Smith in the Homicide Timeline model. Consent is acknowledged and professionals consider making an informed decision using appropriate legislation on a case-by-case basis, to make a justifiable rationale to gather further information, when necessary, from partner agencies if		agency working and safeguarding arrangements to consider legal grounds for information sharing without consent - To take account of cultural considerations and links to mental health where suicidal ideation is identified.	Nottinghamshire ICB, • NHCFT, • Nottinghamshire Police, • Probation Service, **Derbyshire Agencies Actions co-ordinated and Reviewed by Alison Boyce Domestic Abuse Manager, Community Safety** • Derbyshire Police • Derbyshire Children's Services • Derbyshire Community Health		Vulnerability Knowledge and Practice Programme (VKPP) Domestic Homicides and Suspected Victim Suicides During the Covid-19 Pandemic 2020-2021 Domestic_homicides_and_suspected_victim	

Appendix 4 – Action Plans

DHR Stonefox Final Recommendations Action Plan – August 2024

This action plan is a live document and subject to change as outcomes are delivered.

		consent is withheld using the recognised information sharing without consent form. A briefing guidance has already been compiled by NCSP to ensure current workforce staff are aware.			Services NHS Foundation Trust			
2	To improve holding perpetrators to be accountable for their actions and understanding the impacts on those affected.	Early intervention in addressing harmful behaviours would follow recent Government recommendations in addressing	Local	When working with perpetrators of domestic abuse to consider different approaches to understand the different experiences and	CSP – **Nottingham Agencies** • Nottingham City Council Adult Social Care, • Nottingham City Council		https://www.gov.uk/government/publications/standards-for-domestic-abuse-perpetrator-interventions Domestic Abuse Practice Guidance for both Children and Family/ Adult Social Workers	

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		perpetrators behaviours. To develop meaningful engagement of those who harm by including a diverse approach to address the lived experiences of all parties and other intersectionality's in those experiencing abusive behaviours that are controlling and harmful. A whole family approach would contribute to reducing risk of misinterpreting		intersectionality of individual perpetrators and survivors of abuse, using a whole family approach. To utilise professional curiosity to explore the dynamics of relationships in context of domestic abuse. To access training and tools to assist working with perpetrators and early intervention methods such as the Engage Toolkit, local training and resources (Equation), referrals to	Childrens and integrated Families, • NHS Nottingham and Nottinghamshire ICB, • Nottinghamshire Police, • Probation Service, • Nottingham Muslims Women's Network • Juno Women's Aid **Derbyshire Agencies Actions co-ordinated and Reviewed by Alison Boyce**		181181_basw_england_domestic_abuse_g	

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		motivation and behaviours in the context of coercive controlling abuse by abusers. As mentioned, using a training package such as the ENGAGE model for those less familiar with interviewing those who harm would be of benefit.		Your Choice perpetrator programme (where relevant).	**Domestic Abuse Manager, Community Safety** • Derbyshire Police • Derbyshire Children's Services • Derbyshire Community Health Services NHS Foundation Trust			
3	Improve communications, information sharing and risk management when multiagency	At the initial cross boundary meeting It is agreed that the partnership have a multi-agency	Local	To develop a purposeful communication strategy for all parties involved in proceedings detailing in	• Nottingham City Council Childrens and integrated Families,			

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	working across authorities and geographical boundaries. Agreeing a purposeful communication strategy for all concerned assisting in building on the strengths of all parties involved in proceedings.	consultation around the impact and influence they will have in the family's life, mapping out the contact points of the family with agencies, what is the best way to communicate timely updates and information, (including to confirm if there is no update) robustly enabling all agencies to remain fully informed. This ensures a holistic picture of circumstances and		Multi-agency action / safety plans - who is lead - what the impact and outcomes will be for family members - timelines - scheduled updates - communication strategies.	**Derbyshire Agencies Actions co-ordinated and Reviewed by Alison Boyce Domestic Abuse Manager, Community Safety** • Derbyshire Children's Services			

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		context of risk is maintained. Identification of the single point of contact for the family enabling a strength-based approach and recognising that relationships with families due to the process may increase communication barriers.						
4	Consider each case individually where domestic abuse is a factor and that due to domestic	In considering how adults at risk maybe supported a lesson taken from the review is	Local	Improve understanding of the impacts of control and coercion upon a person's capacity by skilling the workforce in	Nottingham City Council Adult Social Care **Derbyshire Agencies Actions co-**		https://www.local.gov.uk/topics/community-safety/domestic-violence-and-abuse	

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	abuse a person's ability to make an autonomous decision is impacted due to coercion, fear or threat of harm and those factors need to be considered when assessing capacity.	that although one adult safeguarding referral was made by Derbyshire Police it was not submitted to the Adult Social Care, due to the victim having capacity and refusing any referrals to support services. It was instead submitted to Derbyshire Children's Services as children were present. There were also other opportunities for other agencies to refer in too,		linking the legislation of coercive control Serious Crimes Act sec 76 part 5; DA Bill 2020 and domestic abuse procedure within the Care Act 2014 sec 11 sec 14.24 and sec 68 By the inclusion of training for frontline staff and provision of an operating procedure/manual	**ordinated and Reviewed by Alison Boyce Domestic Abuse Manager, Community Safety** Derbyshire County Council Adult Social Care			

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		however, these opportunities again do not appear to have been taken at significant points. Nottingham City Council / Derbyshire County Council Adult Duty Workers who are responding to DART / Domestic Abuse referrals should ensure they review the history of the case and do not respond to referrals in isolation, irrespective of risk rating						

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		to ensure adults at risk in domestic abuse cases are assessed under the Care Act 2014 where they meet the threshold for assessment under Sec. 42 reason to suspect abuse. Where Coercive Control is identified links to the Serious Crimes Act 2015 part 5 Section 76 are made in conjunction with Police to determine capacity around						

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		coercion as in Case Law DL v A Local Authority 2012 … is in part aimed at enhancing or liberating the autonomy of a vulnerable adult whose autonomy has been compromised by a reason other than mental incapacity because they are … (a) under constraint; or (b) subject to coercion or undue influence; or (c) for some other reason deprived of the capacity to make the						

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		relevant decision or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent". (para 54). If an adult decides to refuse an assessment, it must nevertheless still be carried out if (for example) the adult is experiencing, or is at risk of, abuse or neglect, including self-neglect						

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		(section 11 of the Care Act). Whether the adult's decision to refuse is unwise or not is not a relevant consideratio n. Their decision to refuse must be reviewed in the context that due to the domestic abuse situation the DA Act 2021 that a person cannot consent to the infliction of serious harm and therefore the decision to remain is not						

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		an autonomous decision due to fear or threat of harm , in the sense that the assessment must be carried out and the adult's eligible needs must be met, again provided that the ordinary residence rules and costs and charging criteria are met. A human rights-based approach to safeguarding and risk assessment needs to						

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		support people to understand their legal rights, identify coercive or exploitative behaviours, make informed decisions about risk based on potentially differing viewpoints and manage risk from a person centered, strength-based perspective. Public bodies have a duty to consider vulnerability in a practical and contextual						

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		way (s149 Equality Act 2010 and Hotak v LB Southwark [2015]). Assessment and safeguarding duties are triggered on deliberately low thresholds- namely, the appearance of need and continues, despite capacitated refusal by an adult, if the local authority has concerns there is a risk of abuse or neglect (s11(2) Care Act 2014 and South-end on Sea						

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		Council v Meyers [2019]). Also, carers are assessed where domestic abuse is suspected in line with best practice. Best practice requires inquisitive enquiry, so all safeguarding issues are understood in context, as in the duty of safeguarding s42 of the Care Act. Where identified those at risk under sec 68 have access to an						

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		IMCA/IDVA especially where coercive controlling behaviour is identified in the context of domestic abuse to ensure their capacity to make informed choices is not compromised.						
5	Embed mapping incidents, understanding abusive patterns and use of the 8 stage of homicide / suicide timeline.	NCSP to highlight to all partner agencies Prof Jane Monckton Smith's eight-stage domestic homicide and Suicide Timeline pattern	Local	CSP to share Jane Monkton-Smith 8 stages of homicide	CSP		Seminar on 18th April 2023 8 Stages of homicide is on Equations Website and incorporated into Training.	

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		models and ensure that they are aware of the benefits of incorporating them practically in assessments. This is currently being addressed with a local seminar organised later this year 2023.						
6	Improve identification and understanding of the links between domestic abuse and suicide. Understand the local and national referral pathways for	Nottingham CityCare Partnership, Notts Health Care Trust, and Primary Care, to share with health practitioners the recent new NICE quality standards	Local	Elevation of referral pathways in regard to reducing suicide risk as part of National Strategy which includes Domestic Abuse share the following:	CSP – **Nottingham Agencies** • NHS Nottingham and Nottinghamshire ICB, • NHCFT, • NUH		https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028 Self-harm: assessment, management and preventing recurrence https://www.nice.org.uk/guidance/ng225	

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	support at crisis point using a trauma informed approach.	regarding clinical indicators of domestic abuse and NICE guidelines on Self-harm: assessment, management and preventing recurrence 2022. Also consider guidelines and training around developing mental health risk assessment to consider formulations which link domestic abuse and suicide risk where appropriate. Using		- Best Practice NICE quality standards regarding clinical indicators of domestic abuse - NICE guidelines on Self-harm: assessment, management and preventing recurrence 2022. - Guidelines and training around developing mental health risk assessment to consider	**Derbyshire Agencies Actions co-ordinated and Reviewed by Alison Boyce Domestic Abuse Manager, Community Safety** **Derbyshire Agencies** • Derbyshire Community Health Services NHS Foundation Trust			

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		individual mental health safety plans which consider risk posed by domestic abuse and risk of suicide. This also to be considered across border for Derbyshire services building on the work currently being undertaken by the Elm Foundation in conjunction with the ICB in Derbyshire. .		formulations which link domestic abuse and suicide risk where appropriate - Use individual mental health safety plans which consider risk posed by domestic abuse and risk of suicide.				
7	To Improve understanding of the	The need for trauma informed	Local	- Use trauma informed	**Nottingham Agencies**		https://www.gov.uk/government/publications/working-definition-of-trauma-	

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	impacts of trauma on those affected by domestic abuse and linked to their risk around suicidal ideation.	approaches to practice, for clients and for the workforce were identified in both areas. Services, that respond with compassionate understanding to their 'cry of pain' are essential to prevent suicide or further acts of self-harm. Trauma focused professionals who ask victims 'what happened to you?' rather than 'what is wrong with you?' recognise		- approaches to support survivors and staff - Offer victims/survivors trauma cards to produce to services so services are aware their response may be affected by their lived experience and should be considered when requesting statements or engagement with professionals.	• Nottingham City Council Adult Social Care, • Nottingham City Council Childrens and integrated Families, • Nottinghamshire Police, • Probation Service, **Derbyshire Agencies Actions co-ordinated and Reviewed by Alison Boyce Domestic Abuse Manager,**		informed-practice/working-definition-of-trauma-informed-practice Suicide risk in people with post-traumatic stress disorder: https://www.ucl.ac.uk/news/2020/nov/ptsd-contributes-suicide-risk-particularly-women	

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		the relevance of the abuse within a victim's relationship and the broader social context in which they find themselves, are key. Additional complexity in terms of cultural abuses, such as so-called 'honour' based violence are addressed, once again with understanding and compassion. This can be achieved by		- Embed Trauma Informed practice in policy and procedures of agencies dealing with Domestic Abuse victims and perpetrators - Provision of trauma informed training for front line staff who will interact with survivors where training isn't provided as part of their	**Community Safety Derbyshire Agencies** • Derbyshire Police • Erewash BC – Housing Options • Derbyshire Children's Services • Derbyshire Community Health Services NHS Foundation Trust			

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		offering victims/survivors trauma cards to produce to services so services are aware their response may be affected by their lived experience and should be considered when requesting statements or engagement with professionals.		agency training and development programme.				
8	NCSP with all partners promote awareness around suicide prevention in line with the	This will improve practice by considering domestic abuse in the context of local and	Local	To embed the Suicide Timeline risk training by Prof Jane Monkton Smith in agencies as	CSP – **Nottingham Agencies** • Nottingham City Council		DHR where there has been a suicide and the learning is shared with the local Suicide RTS group https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028	

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	National Suicide Prevention Alliance best practice guidance.	national suicide prevention strategies. It is noted that NCSP are part of the real time surveillance for suicide which is best practice and link reviews to their strategic suicide prevention oversight group		part of the continued commitment to share DHRs and learning where there has been a suicide with the local suicide prevention group. Work with suicide prevention group to support promoting awareness of risk factors between suicide and domestic abuse.	Adult Social Care, • Nottingham City Council Childrens and integrated Families, • Nottingham CityCare Partnership , • Nottingham City Council Housing Solutions , • Juno Women's Aid, • NHS Nottingham and Nottinghamshire ICB, • Nottingham City Council Housing service, • NHCFT,			

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					• NUH, • Nottingham Muslim Women's Network, • Nottingham shire Police, • Probation Service, • Framework - Nottingham Recovery Network (NRN) & Clean Slate **Derbyshire Agencies Actions co-ordinated and Reviewed by Alison Boyce Domestic Abuse Manager,**			

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					Community Safety Derbyshire Agencies • Derbyshire Police • The Elm Foundation • Erewash BC – Housing Options • Derbyshire Children's Services • Derbyshire Community Health Services NHS Foundation Trust			
9	The police and partner agencies involved in Domestic Abuse cases should be made aware of an elevated risk	Improve practice and potential outcomes by elevating access to appropriate interventions to safeguard those at risk	National	Work with suicide prevention group to support promoting awareness of risk factors between suicide and	Police		College of Policing www.vkpp.org.uk/assets/Files/Domestic-Homicide-Project-Year-2-Report-December-2022.pdf	

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	of both intimate partner homicide and of victim suicide where coercive or controlling behaviour (CCB) is present. Frontline and supervisory personnel within safeguarding victim units should consider referrals to suicide prevention interventions in setting safeguarding actions when CCB is identified.			domestic abuse.				
10	There should be a continued	Improve evidence gathering to		Work with suicide prevention	Police		College of Policing	

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	push within policing to identify, record and take positive action where coercive or controlling behaviour (CCB) is identified. The number of convictions around CCB is disproportionate to the number of reports, with only a small number of cases where the specific offence of controlling or coercive behaviour is recorded or charged. The nature and extent of prior coercive	enable positive CCB outcomes and increase numbers of convictions	National	group to support promoting awareness of risk factors between suicide and domestic abuse.			www.vkpp.org.uk/assets/Files/Domestic-Homicide-Project-Year-2-Report-December-2022.pdf	

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	control is severe in situations which culminate in a victim dying by suicide, which reinforces the importance of identifying, recording and charging for controlling or coercive behaviour in a timely and accurate manner.							
11	It is recommended that the College of Policing, in consultation with the Home Office and NPCC develop training to directly	Improve training on gathering evidence from reliable sources to improve outcomes in convictions	National	Work with suicide prevention group to support promoting awareness of risk factors between suicide and domestic abuse.	Police		College of Policing www.vkpp.org.uk/assets/Files/Domestic-Homicide-Project-Year-2-Report-December-2022.pdf	

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	address the evidential issues experienced in domestic abuse cases where suicide and/or coercive or controlling behaviour is identified to enable abusers to made accountable.							

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	Recommendation	Rationale	Action to take	Target Date	Date of Completion	Evidence • Key milestones achieved in enacting recommendation • Outcome	RAG
Nottingham CityCare Partnership							
1.1	Records are reviewed alongside strategy meeting minutes to ensure an accurate understanding of any potential public health need	To ensure Historical information is considered as part of any risk assessment and action plan	Include within the record keeping training and to be discussed as a safeguarding update at supervision and team meetings.	31st January 2023	February 2023	This will be audited by Record Keeping Audit via management supervision. 23/1/23 Discussion with the Clinical Educator and record keeping lead, they have agreed to update the record keeping training to embed the learning. The training will be updated and rolled out by mid Feb. PDF Safeguarding Update Children's Services st The information has been disseminated in the safeguarding updates for Q4, which are shared across the workforce. The safeguarding updates are also discussed at:	

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						• safeguarding supervision • quarterly 0-19 team meetings, attended by the Safeguarding Team	
1.2	There should be clarity on the dates of any significant safeguarding event to reduce risk of duplication and improve communication and record keeping in relation to safeguarding events.	To provide Clarity and accurate recording of meetings and avoidance of duplication	When reviewing minutes from safeguarding meetings, the reviewer to document the date of the meeting.		March 2023	This is also reviewed in management supervision by Clinical Service Managers. The learning has been disseminated in the safeguarding updates for Q4 2022/23, which are shared across the children's workforce. The safeguarding updates are also discussed at: • safeguarding supervision • quarterly 0-19 team meetings which are attended by the Safeguarding Team	
1.3	At RCPC where there is consideration of closure to child protection plans,		Further training to be given to staff around the	28th February 2023	January 2023		

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	ensure consideration is given to the original reasons for ICPC and whether the original recommendations have been met and consideration given to factors that can influence people to retract disclosures of abuse		difficulties in disclosing abuse and the reasons for retractions and the need to remain professionally curious and sensitively challenge.			This learning will be monitored by the Childrens Public Health 0-19 Record Keeping Audit Nottingham CityCare Partnership mandatory Domestic Abuse training has been updated, (Jan 2023). Additional slides have been added which highlight the reasons why survivors may retract disclosures. The training identifies what steps practitioners should take when working with survivors who have made retractions. This information has also been added to the Domestic Abuse Resource Booklet which is disseminated to staff at induction and is available on our intranet pages and so accessible to all Nottingham CityCare Partnership staff. The reasons why DA survivors retract disclosures was also discussed at the Champions Safeguarding	

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						meeting held on the 19th Jan 23. Safeguarding Champions January 2	
Derbyshire County Council Children's Services							
2.1	To establish a stronger understanding across the workforce around the parental right to refuse a Section 17 Single Assessment and the actions to take in such circumstances.	To ensure a consistent application of practice to seeking consent and explaining the nature of the consent to enable informed decision making by parents. To enable Growth in social work confidence	A 'practice matters' briefing to be circulated across the Derbyshire safeguarding service outlining the statutory expectations along with good practice guidance.	31st January 2023	29th March 2023	Audit will be completed through the regular reflective case review process supported by quality assurance managers. 20/1/23 - This is on track to update / produce practice matters / practice standards as appropriate to include this learning. **29/3/23 –** completed.	

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2.2	Cultural considerations to be further supported and encouraged in assessment and intervention across the workforce.	To ensure Practitioners to feel confident in seeking out the necessary skills, knowledge and support in order to enhance the delivery of service to people with varying cultural experiences.	Training in relation to cultural competence will be delivered to key individuals who can share this learning back into their service area and as such support practice across the whole workforce within early help and safeguarding services.	28th February 2023		This will be evidenced through Reflective team supervision to explore and support continued learning around cultural considerations in assessment and intervention and to gain an overview of the impact of this workforce development. 20/1/23 - Initial training session has taken place (by Research in practice) – including 3 members of our L&D training team – Plan / timeframe for wider roll out still needs to be agreed 29/3/23 - liaising with Learning & development partner as some work on this also being undertaken corporately to roll out across the council (some roll out has already taken place) – so we can combine / avoid duplication. On track for completion. **12/02/2024 – CON has asked for further update.** On 17th January 2023 Research in Practice delivered a day's	

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						virtual facilitated seminars on **An Introduction to Cultural Competency** following participants watching 4 short pre-recorded films and completing exercised as prompted within those films. This package of learning was delivered to 28 participants from across our teams and explored what we mean by the term 'cultural competence'. It considers inclusive workspaces, direct work with children and adults, and intersectionality – all supporting the various ways in which we can use cultural identity positively and effectively. 2 L&D Trainers were part of this to support the wider roll out of this learning. That roll out was paused because Corporate Services had developed a plan to roll out a programme of training around Equality,	

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						Diversity & Inclusion to all DCC workforce - the first part of this (Induction) has been developed and is being rolled out as mandatory (to date 70% of the DCC workforce has completed this). In June 2023 a Development day for Early Help and Safeguarding managers / supervisors took place focussed on Leading in Colour - facilitated by The Staff College (over 100 attended) . Some of these issues are also embedded in the Aspiring Leaders programme being rolled out to all DCC leaders The week beginning July 17th 2023 was Derbyshire's first Practice week – the theme of which was 'equality and diversity'. Every day appreciative enquiries were facilitated on cases drawing out good practice in this area that had a positive impact on children and their	

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						families. Each service area also completed practice observations to add to the learning from practice in this area. 21/02/3034 – These actions are now closed	
2.3	Information sharing protocols to be strengthened	Information sharing to be timely in order that assessments and interventions with families can be fully informed	Information sharing protocols to be strengthened to include period by which responses should be provided.	31st March 2023	29th March 2023	Audit process - Information sharing is routinely sampled during reflective case review activity within children's services 20/1/23 - Information sharing protocols between children's services department and the police are currently in the process of review, it is anticipated that the work will be completed by the end of January 2023 and this recommendation has been included therein. The east midlands regional protocol has been strengthened to ensure that escalation pathways across	

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						the region are clear to support timely sharing of information regionally. The Local Authority has strengthened the children's services transfer protocol which now includes timeframes for which responses to information should be provided. 29/3/23 – this action is closed, all relevant information sharing protocols have been reviewed and updated.	
2.4	The use of domestic abuse assessment tools to be utilised, as appropriate, within assessment and interventions with families.	To ensure Practitioner confidence in the use of such tools will increase. Assessments will be stronger in quality by the use of appropriate tools and assessments will	A 'practice matters' briefing to be circulated across the Derbyshire safeguarding and early help service outlining the available tools along with good practice guidance.	31st May 2023		Audit will be completed thought the regular reflective case review process supported by quality assurance managers. **20/1/23 -** A task and finish group has been established by the local safeguarding children's partnership to commission a new domestic abuse risk assessment	

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		be utilised as an opportunity for intervention.	The multi-agency partnership will be introducing new domestic abuse risk assessment for children in 2023, this will be supported by new practice tools and guidance and will be launched in a workforce development programm			framework for children, this work includes amendments to policy and procedure and supporting workforce development from a partnership perspective. **29/3/23** - the briefing has been completed and the first look at the tool is being shared with the partnership (DDSCB) on 25/04/23 – a further meeting is planned on 26/04/23 for DCC to consider any training needs / actions we may need to action to be able to embed / utilise this tool. On track for completion. **12/02/2024 – CON has asked for further update.** On 2nd March 2023 Research in Practice delivered a day's virtual training on **responding to families in which a parent / carer is using domestic abusive behaviours.** 2 L&D Trainers attended and participated in that session to enable wider roll out. The	

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						DDCSB were leading on jointly agreeing / procuring a domestic abuse assessment tool(s) to be used across the partnership (including LAs). The DDSCB are still in the process of agreeing a toolkit. Once that toolkit is agreed – a L&D programme will be developed (including the development of guidance & Practice Matters) to launch the tool kit and embed it into the organisation 21/02/2024 - This action is now closed.	
2.5	Further strengthening of information sharing, the use of historical data and	To ensure The policy will be utilised	The partnership are undertaking a review to raise	31st March 2023	23rd March 2023	Audit will be completed through the regular reflective case review process	

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	embed the use of the formal escalation policy	appropriately and confidently.	awareness and confidence in the use of the policy			supported by quality assurance managers 20/1/23 - The local children's partnership are currently reviewing and strengthening the pre-dispute and escalation pathway to support timely information exchange and dispute resolution through the local partnership. An annual programme of reflective case reviews is established and this will capture the appropriate use of the pre-dispute and escalation procedure. The learning arising from this work will inform future workforce development activities to drive impact. 23/3/23 – This action is complete and closed. The DDSCP have reviewed escalation pathways and the policy and procedure group sighted on the outcome. This activity provided assurance in relation to confidence in the sue of the policy.	

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Children's School							
3.1	Agreed policy on how to respond if parent in future was to express suicidal ideation.	All DSLs have clarity on steps to taken when parent/ carer presents with suicidal ideation.	Script to follow for all DSLs if parent/ carer presents with suicidal ideation	31st March 2023		**12/02/2024 – CON emailed copy of IMR pwp. Awaiting feedback.**	
Juno Women's Aid							
4.1	Review Risk assessments to link domestic abuse and suicidal ideation	Risk assessments did not link the domestic abuse with suicidal ideation.	Update risk assessments accordingly			**27/02/2024 -** Juno Case Management Policy. Procedure's manual inc suicide risk checklist. 5. Suicide checklist.docx Juno Safeguarding Policy.	
Nottingham City Council Children's Integrated Services							
5.1	Review current training delivered	All staff who work within the service have	Review training delivered to colleagues to	28th February 2023		**12/02/2024 - CON emailed IMR. Awaiting feedback.**	

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	within Children's Integrated Services in respect of domestic abuse and working with perpetrators	an awareness of the impact and links around mental health and suicidal ideation linked to domestic abuse to aid intervention and assessment. In addition to this that all staff have an understanding of the barriers that survivors may face when accessing support linked to cultural practices and feelings of shame and stigma.	ensure that it adequately covers links with mental health and suicidal ideation, barriers to access supporting linked to cultural practices, stigma and shame. Review current training available to support practitioners in the MASH around engaging with perpetrators of domestic abuse.				

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		To ensure that all staff within the MASH have access to training around engaging with perpetrators of domestic abuse to aid their confidence when undertaking enquiries					
5.2	Briefing to be shared at service level learning meetings around the importance of engaging with non-resident parents.	All staff within the service understand the need to contact non-resident parents to ensure holistic decision making, assessments and intervention.	Full briefing to be developed alongside the principal social worker and the quality assurance team to be shared service wide as part of the ongoing practice developments.	27th January 2023		**12/02/2024 - CON emailed IMR. Awaiting feedback.**	

Appendix 4 – Action Plans

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	Nottingham City Homes						
6.1	Remind tenants to ensure household details are updated regularly	Have detailed knowledge of who is resident in our properties	Reminder provided at point of sign up to new tenancy. Reminder provided on website with link to provide information	30th April 2023	1st March 2023	Tenants are reminded of the need to keep household details updated at point of sign up to new tenancy. Reminder provided on website with link to provide information (page 9 Appendix 3) https://www.nottinghamcityhomes.org.uk/repairs/	
	Notts HealthCare Foundation Trust						
7.1	The use of Routine Enquiry to continue to be promoted across all Nottinghamshir	Identify domestic abuse	See evidence section		1st February 2023	Actions completed 1.Domestic Abuse E learning is to be a mandatory requirement of all Notts HC staff. This in addition to other mandatory Safeguarding training. 2.Safeguarding Roadshows have been undertaken during 16 days of activism promoting routine enquiry at locations across the Trust.	

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	e Healthcare trust Services.					3. Specific training can be accessed by teams relating to routine enquiry and completion of DASH. 4. Routine Enquiry continues to be promoted through the SPOC. 5. Agreed for routine enquiry to be an ongoing Trustwide workstream within DSVA Subgroup.	
7.2	Trust Safeguarding team to ensure that Marac minutes are shared with all teams that are currently working with relevant parties.	To ensure that minutes are shared appropriately with all involved services for risk assessment purposes.	To be raised in team meeting	31st January 2023	1st February 2023	This has been raised within Safeguarding Team Meeting 01.02.2023. Minutes are available if needed. MARAC Actions Process resent to the Team 01.02.23 to ensure all received this.	
	Probation Service						
8.1	Prior to completing a risk assessment,	Risk assessments will improve in ensuring	All staff will be informed that they have to routinely	31st January 2023		**Audit -** Offender management Senior Probation Officers with the lead area for MARAC in Nottingham City and Nottingham County will 5 cases that have been heard at MARAC to check if the key information in the	

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	probation practitioners should check if there are any historical records in the OASys INTBD	historic information is considered within the context of a new assessment. As noted within this report the practice is now ended.	check the INTBD section of OASys (prior to completing a review assessment) and incorporate any relevant information in their risk assessment			minutes have been incorporated into the risk assessment. **12/02/2024 - CON emailed IMR. Awaiting feedback in next 7 days.** MARAC Audits were conducted in August of 2023 by the City and County manager point of contact for MARAC (at that time). The audits for both probation delivery units identified a number of issues around the recording of information, which related to our case recording system (Delius). In the DHR the concern had been that the MARAC information was on the assessment system in non-disclosed information (OASYS NTBD), since that time there had already been a practice chance to ensure this information is recorded sensitively on the main record (Delius) and not on the assessment system (Oasys) which is less frequently viewed. Nonetheless, when the audit happened last August, there was differing practice in relation to the correct Delius contact being used and also a lack of consistency about the information from the minutes (relating to our case) being shared with the probation practitioner via the Delius contact). Following on from this audit there was a joint City and County review of the process and the process	

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						map for staff and case admin was updated to capture these errors. Alongside the audit we have also shared the issues around recording with our senior probation officers who have discussed this with individual teams. Therefore, that action is completed.	