Working together for a safer county
SAFERNORTHUMBERLAND

Domestic Abuse Related Death review of the death of Martha in October 2022.

Overview Report

Author: Chris Hogben

Commissioned by:

Safer Northumberland Partnership.

Date. 15 November 2024.

Sensitive and confidential.

Working together for a safer county
SAFERNORTHUMBERLAND

Contents.

1. Introduction

1.11 The Chair of the Safer Northumberland Partnership, (SNP), has commissioned this Domestic Abuse Related Death Review, (DARDR)[1], in response to the death of Martha. Martha's death appears to have been a suicide but the Coroner's inquest has yet to be concluded. The death falls within the statutory parameters for a DARDR as Martha was believed to have been in an abusive relationship with her husband and there were grounds to believe that domestic abuse was a causal factor in her death.

1.12 Martha was 51 years of age at the time of her death. She was married to Malcolm and they had two adult children; a daughter, Melissa, who was 29 years old when Martha died and a son, Mark, who was 32 years old. Both adult children lived at separate addresses to their parents.

1.13 Martha and her husband Malcolm were known to services, including in relation to allegations of domestic abuse. Malcolm had a previous caution for an offence of domestic assault with Martha as the victim.

1.14 On a date in mid-October 2022, Martha was taken to the Northumbria Specialist Emergency Care Hospital, (NSECH), where sadly, she died two days after her admission. At the time of her admission to the NSECH, Martha made disclosures about her husband Malcolm being verbally and physically abusive towards her. She stated that she had taken an overdose as she did not want to live anymore, providing a clear causal link between domestic abuse and her death.

1.15 The SNP was informed of Martha's death on 21 October 2022. A senior SNP management meeting, held on 9 December 2022, determined that this case met the criteria for a DARDR, in accordance with section 9 of the Domestic Violence, Crime and Victims Act 2004. This decision, was subsequently ratified by the SNP Chair. There were some challenges experienced in recruiting an independent chair for the review. This resulted in the Independent Chair being recruited and commencing the review in July 2023.

1.16 The Home office was informed of the intention to commission the DARDR on 9 December 2022.

[1] In line with the Home Office guidance issued in 2024, the review will be described as a Domestic Abuse Related Death Review, (DARDR).

1.17 The review panel would like to express its sympathy to Martha's family and friends for their sad loss.

1.2 Purpose of the Domestic Abuse Related Death Review (DARDR)

The purpose of the review is to;

i. to establish the facts that led to Martha's death in October 2022, and produce a comprehensive and balanced analysis of the information to inform organisational learning and influence change.
ii. establish what lessons are to be learned from Martha's death with regard to the way in which local professionals and organisations work individually and together, to safeguard victims;
iii. 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;
iv. apply these lessons to service responses, including changes to inform national and local policies and procedures as appropriate;
v. prevent domestic violence, homicide and improve service responses for all domestic 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;
vi. identify potential gaps in services provision and/or potential barriers to accessing services;
vii. contribute to a better understanding of the nature of domestic violence and abuse;
viii. highlight good practice.
ix. the key reason for undertaking a DARDR where a person has died through suicide because of domestic abuse, is to enable lessons to be learned through professionals being able to understand what happened and most importantly, what needs to change, to reduce the risk of similar tragedies happening in the future. The DARDR is not an enquiry into how a victim of abuse died or who may be responsible.

1.3 Scope

1.31 This DARDR examines the contact and involvement that organisations had with Martha between 1 August 2017 to Martha's death in October 2022.

1.32 In order to meet its purpose, the review also examines the contact and involvement that organisations had with Martha's husband, Malcolm during the same period.

1.33 The reason why the panel determined that it would examine the period 1 August 2017 through to the tragic death of Martha in October 2022, was to enable the review to consider the contact that Martha had with her GP during late 2017 and early 2018. This included Martha reporting mental ill-health to the GP. The review was also conscious of the limited contact that Martha and Malcolm had with services during the period immediately prior to Martha's death.

1.4 Terms of Reference

The terms of reference, (ToR), for the DARDR are set out in Appendix 2 to this report. The ToR were discussed with Mark during his conversation with the Independent Chair as part of the review process.

1.5 The Subjects of the Review

1.51 The subjects of this review are the victim of abuse, Martha and her husband and perpetrator of abuse, Malcolm. These names used are pseudonyms in order to protect the identity of the family. Where there is reference to the adult children, pseudonyms are used for them for the same purpose.

1.52 Any relevant addresses have been referred to in general terms to protect the identity of those involved.

1.6 Terms of Reference

1.61 Specific issues that will be considered, and if relevant, addressed by each agency in their IMR are:

- Were practitioners sensitive to the needs of Martha and Malcolm, and were they knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to deliver against those expectations?

- Did practitioners have the knowledge and confidence to use the DASH, (Domestic Abuse, Stalking and Harassment), risk assessment for domestic abuse victims and perpetrators? If so, were those assessments correctly used in the case of Martha and Malcolm?
- Were Martha and/or Malcolm subject to MARAC, (Multi-Agency Risk Assessment Conference), or any other multi-agency forum?
- Did the agency comply with domestic violence and abuse protocols agreed with other agencies including any information sharing protocols?
- Were there missed opportunities for intervention? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in light of the assessments, given what was known or what should have been known at that time?
- When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they sign posted to other agencies?
- Was anything known about the perpetrator of abuse? For example, were they subject to MAPPA, (Multi-Agency Public Protection Arrangements), MATAC, (Multi-Agency Tasking and Coordination) or any other perpetrator intervention programme? Were there any injunctions or protection orders that were, or had previously been in place?
- Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration of vulnerability or disability necessary? Were any of the other protected characteristics relevant in this case?
- Had Martha made relevant disclosures to any practitioners or professionals and if so, was the response appropriate?
- Was this information recorded and shared, where appropriate?
- Were senior managers or other agencies/professionals involved at the appropriate points?
- Did staff involved have the necessary skills and training?

- Are there lessons to be learned from this case relating to the way in which an agency, or agencies, worked to safeguard the family and promote their welfare? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies or resourcing?
- Was Martha or Malcolm a mental health service user and if so, were their treatment/support needs being met appropriately?
- How accessible were services to Martha and Malcolm?
- Did any restructuring take place during the period under review and if so, is it likely to have had an impact on the quality of service delivered?
- Did the COVID-19 pandemic impact on the services provided to Martha and Malcolm?

1.62 The full terms of reference can be found at appendix 2 to this report.

2. Methodology

2.1 This overview report is an anthology of information drawn from independent management reports, (IMRs), prepared by representatives from the organisations that had contact and involvement with Martha and Malcolm between 1 August 2017 and Martha's death in October 2022.

2.2 **Protected Characteristics**

The report also considered the nine protected characteristics, (age, disability, including learning disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion and belief, ethnicity, sex and sexual orientation) as prescribed within the public sector Equalities Act duties to assess if they were relevant to any aspect of this review. The review considered whether access to services or delivery of services were impacted upon by such issues.

a, Age-At the time of her death, Martha was 51 years of age, Malcolm was also 51, there are no known age considerations in this case.

b, Disability-Neither Martha or Malcolm identified as having any disabilities. It is recognised that Martha had suffered from low mood issues for a number of years. The review noted the research linking mental ill-health and domestic abuse. The same research identifies that excessive use of alcohol can be a coping mechanism used by domestic

abuse victims in such cases. It was also noted that this is often not recognised by professionals. This is explored in more detail in section 7.3 of this report.

c, Gender assignment-This was not a consideration in this case.

d, Marriage and Civil Partnership-Martha and Malcolm were married throughout the period subject of this review and although they lived together until Martha's death, records would suggest that they had separated but remained living under one roof for financial reasons. The review will also conclude that their separation may have been a trigger that escalated the abuse the Martha suffered in their relationship.

e, Pregnancy-This was not a consideration in this case.

f, Race-This was not a consideration in this case.

g, Religion and Beliefs- This was not a consideration in this case.

h, Sex -Sex is always a significant consideration in DHRs. Analysis from the British crime survey[2] suggests that 74.1% of domestic abuse victims identified by police forces in the year ending March 2022 were female. Whilst this case did not involve a homicide, the victim Martha was female, the perpetrator of abuse, Malcolm, was male.

i, Sexual Orientation-This was not a consideration in this case.

2.3 Although a number of these characteristics are relevant to the review and were considered by the panel, there is no evidence to suggest that they had an impact on the ability of the subjects of the review to access services. Service delivery by any of the agencies involved, was not impacted by these characteristics.

2.4 A letter was sent to senior managers within each agency or body identified within the scope of the review, requesting the commissioning of IMRs. The aim of the IMR is to:

- Allow agencies to look openly and critically at individual and organisational practice and the context in which practitioners were working, (culture, leadership, supervision, training etc), to see

[2] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2022#sex

whether the suicide indicates that practice needs to change or be improved to support the highest standard of service delivery.

- Identify how and when those changes or improvements need to be delivered.
- Identify good practice within agencies.
- Provide an independent assessment of practice and service delivery by ensuring that the individual responsible for the IMR has not had involvement with anyone who is subject of the review. The IMR is signed off by a senior manager from that organisation before being submitted to the DARDR panel.
- Each of the following organisations completed an IMR or a short information report, (if an IMR was not required), for this DARDR:
  a, Northumbria Police.
  b, North East and North Cumbria Integrated Care Board. (ICB).
  c, NCC Adult Social Care, (ASC).
  d, Department for Work and Pensions, (DWP).
  e, North East Ambulance Service, (NEAS).
  f, Northumbria Healthcare NHS Foundation Trust, (NHCFT).

2.5 In each of the IMRs, interaction with Martha and Malcolm was recorded. In the main for Martha, this related to the police, and healthcare. Whilst Malcolm had contact with healthcare, universal credit and the police.

3.The Review Process

3.1 Contributors to the Review

3.11 The review panel consisted of an Independent Chair and senior representatives of the organisations that had relevant contact with Martha and her family. The IMR authors and the DARDR panel members have not been the immediate line manager of any staff involved with them.

3.12 The Panel members were:

Chris Hogben	Independent Chair/report author.
Chris Grice	NCC Community Safety.
Shlomi Isaacson	NCC Legal Services.
Steve Gilbert	HM Probation Services.

Jackie Butson	Department for Work and Pensions, (DWP).
Lesley Pyle	NCC Domestic Abuse & Sexual Violence, (DASV).
Luke Robertshaw	NCC Public Health.
Heather McKenzie	NCC Adult Social Care, (ASC).
Helen Visocci	Northumberland Fire and Rescue Service.
Ian Callaghan	Northumbria Police.
Jane Stubbings	North East Ambulance Service, (NEAS).
Caroline Bainbridge	Cumbria, Northumberland, Tyne and Wear NHS Trust, (CNTW).
Paula Shandran	Northumbria Healthcare NHS Foundation Trust, (NHCFT).
Leesa Stephenson	North East and North Cumbria Integrated Care Board. (ICB).
Sharon Brown	Northumberland Domestic Abuse Services, (NDAS).

3.13 The Independent Chair of the review panel is a retired senior police officer. As the strategic lead for crime investigation, criminal justice and safeguarding both adults and children within Kent Police, he has significant experience and knowledge of domestic abuse issues and legislation as well as wider safeguarding issues. Having worked closely with partner agencies in the multi-agency safeguarding field, he has a clear understanding of the roles and responsibilities of those organisations. He has a background in serious crime investigation, including leading murder investigations, reviews and the chairing of multi-agency meetings. Having undertaken review training within the police service, he has also completed the new mandatory Home Office training for DHR Independent Chairs. As well as working as the Independent Chair for DHRs, he also chairs Safeguarding Adult Reviews and works on Mental Health Homicide Reviews commissioned by NHS England.

3.14 The Independent Chair has no association with any authority in Northumbria and is completely independent of all of the agencies involved with this review.

3.2 Review Meetings

3.21 The review panel met on:

- 6 September 2023, to discuss the terms of reference and early scoping documents.
- 10 January 2024, to consider the IMRs.
- 24 April 2024, to discuss additional IMRs and the early themes emerging from the review.
- 5 June 2024, to consider the conclusions, the learning from the review and to agree the recommendations.

3.22 Following the June 2024 panel meeting, the action plan was finalised and agreed through separate meetings with the Independent Chair or through email contact. Having been signed off by the individual agencies, the report was then presented to the SNP board on 15 November 2024 for formal approval.

4. Family Engagement

4.1 The review panel considered which family members and friends of Martha and Malcolm should be consulted and involved with the review process.

4.2 The panel were keen to involve the views of close family and friends of Martha and Malcolm. The Independent Chair wrote to Martha's husband Malcolm, and to her adult daughter, Melissa, to introduce himself, to explain the DARDR process and to encourage their participation. He also provided them with the Home Office and AAFDA[3] information leaflets.

4.3 Unfortunately, Martha's husband Malcolm decided not to engage with the review or provide any information as to others who may be able to provide information about Martha's life. Martha's adult daughter also declined to engage with the process.

4.4 The panel managed to identify and locate Martha and Malcolm's adult son Mark towards the later part of the review process. The Independent

[3] AAFDA---Advocacy After Fatal Domestic Abuse. A charitable organisation who provides specialist support to families affected by domestic homicide. They also provide support, training and resources to professional working in this field.

Chair contacted the son and although he declined to meet face to face, he agreed to talk remotely.

4.5 As well as explaining the process to Mark, and offering to share the report findings once completed, the Independent Chair also talked through the terms of reference with him. Mark understood why the review was being undertaken but had no comments to make about the process or the terms of reference.

4.6 Mark talked about his relationship with his parents. He said that his mother could be quite confrontational and would not accept the views of others. He said that he had some good memories with his parents but also some bad ones.

4.7 He informed the review that both of his parents had experienced difficult childhoods. His father had been brought up by a single parent. He believed that his mother had experienced an abusive relationship as a child, with a father who drank a lot.

4.8 Mark had left home when he was aged about 23 years but generally saw his parents once a month or so. He described both of his parents as having long term alcohol problems. He said that his mother was a long-term drinker, in his words, drinking heavily on almost a daily basis. From his memory, Martha had begun drinking more heavily when she lost her job. He could not remember exactly when this was but believed that he was in his early twenties so between ten and twelve years ago. She had also suffered from low moods and depression for a long period.

4.9 Mark spoke about his father in more general terms. His father had also been a heavy drinker at times but this was not to the point of impacting on his ability to work. He said that he was aware that his parents relationship was an abusive one and had been that way for a number of years. He described a relationship where both parents had, in his words, been abusive towards each other. When asked about controlling behaviour, Mark replied that although he had witnessed abusive behaviour between his parents, he was not aware of his father being controlling towards his mother. He did not say that this would not have happened, rather that he had not seen evidence of it.

4.91 Mark said that his mother, Martha, could be nice at times and that he tried hard to keep a good relationship with her. In his view, it was her excessive use of alcohol that affected her behaviour. He described both

of his parents as having problems with alcohol but that neither of them would seek any help to address this.

4.92 At the conclusion of the review process, the Independent Chair contacted Mark and Melissa and offered to share the review findings with them, either through a face-to-face meeting or by other means of their choosing. Both Mark and Melissa asked to see a copy of the report which was provided to them. Only Mark agreed to discuss the review's findings. Mark informed the Independent Chair that he accepted the findings of the review and was not surprised by any of the information about his parents. He had no observations to make but said that he was pleased if the findings and recommendations from the review would help other people in the future.

5. Background

Primary care records document that Martha gave birth to a baby boy in early 1990 and a baby girl in late 1992. Martha had routine contact with primary care prior to the period under review but the following entries within the primary care records were of relevance to the review:

The first entry was on 30 July 1999, when Martha attended a routine, face to face medical appointment. She disclosed to the GP that her marriage had difficulties due to her health issues.

On 25 October 2002, Martha attended a face-to-face GP appointment and informed the GP during the consultation that she had fallen out with her husband and that they would probably divorce.

On 24 April 2013, The police were contacted by Martha's adult daughter's boyfriend reporting threats made by Martha to him. He did not want any formal police action but wanted Martha spoken to. Police officers spoke to Martha who admitted threatening him on the basis that she did not approve of his relationship with her daughter. Both parties were advised to avoid contact with each other.

On 14 May 2013, Martha attended a face-to-face appointment with a practice nurse. She informed the nurse that she felt 'her world was crumbling'. She was using alcohol, especially in the morning, and she stated that she had no suicide or self-harm plans.

Between March 2013 and February 2016, ASC records documented involvement with Martha and Malcolm's adult daughter but these matters do not involve Martha or Malcolm and are not relevant to this review.

On 13 May 2014, Martha reported the theft of a plant pot from her front garden. There was no evidence to identify an offender and the crime report was subsequently filed in accordance with policy.

6. Narrative Chronology

6.1 1 August to 31 December 2017

On 14 August, Martha had a face-to-face appointment with her GP in the presence of her husband Malcolm for a routine health issue.

On 8 November, Martha had a face-to-face appointment with her GP, again her husband was present. Martha reported a routine medical matter.

6.2 1 January to 31 December 2018

On 6 February, Martha attended a face-to-face appointment with her GP. She reported suffering from low mood following the death of her dog and had ongoing stomach problems. There was no record of any domestic abuse enquiry being completed.

On 13 March, Martha attended an appointment for routine health matters. The NHCFT records document that Martha disclosed that she drank only small amounts of alcohol. She was referred for further tests.

On 26 March, Martha attended a face-to-face appointment with the practice nurse for a routine medical matter. She disclosed being in a low mood following the death of her dog. She also disclosed smoking and drinking heavily. There is no record of any domestic abuse enquiry being completed.

On 28 March, Martha attended a pre-assessment appointment.

On 16 April, Martha attended an appointment for routine health tests to be carried out. She was referred back to her GP for treatment.

On 4 June, the GP records documented that Martha had punched her daughter's boyfriend in the face and damaged her hand on his tooth causing a laceration. The record suggests that Martha was using alcohol and smoking heavily to cope with stress in her life. There was no record of any enquiry about domestic abuse or to ascertain what was causing her stress.

Martha attended a clinical review appointment on 1 August. She was discharged with advice for ongoing treatment.

On 13 November, Malcolm attended an orthopaedic appointment following an accident involving a mechanical digger in previous years.

On 19 December, Martha attended a face-to-face appointment with her GP, her husband was recorded as being present. Martha reported having hurt herself leaning over a fence. She requested, and was prescribed, painkillers.

6.3 1 January to 31 December 2019

On 5 February, Malcolm attended a physiotherapist appointment accompanied by Martha.

On 13 March, NHCFT sent a letter to Malcolm, referring him to the pain management team

On 23 March, following a 999 call by Malcolm to the NEAS, Martha was admitted to A&E with abdominal pain, nausea and vomiting. Malcolm was with her. Martha left after 3 hours having signed a self-discharge form.

On 30 May, Martha attended a face-to-face appointment with the practice nurse with respect to a routine health matter. There was no record of any domestic abuse enquiry being completed.

On 30 July, Malcolm attended A&E, with broken fingers on his right hand with an explanation that it was caused through a fall. He was referred to the fracture clinic for a follow up appointment.

On 6 August, Malcolm attended a pain management team appointment. Pain management advice was given, a pain management plan agreed and Malcolm was referred back to his GP for an acupuncture referral.

On 12 August, Malcolm attended a fracture clinic appointment for an injury review.

On 10 September, Malcolm attended a pain management team appointment for routine care.

On 23 September, Malcolm attended a fracture clinic appointment for an injury review.

On 29 October, NHCFT records document that Martha contacted the pain management team expressing concerns about Malcolm's neck pain symptoms. Malcolm was referred back to his GP for an increase in pain control prescription.

On 26 November, Malcolm attended a routine pain management appointment, informing them that he had been in less pain for the last two months---contradicting what Martha was recorded as telling the pain management team in late October.

6.4 1 January to 31 December 2020

On 2 February, following a call to 111 by her husband Malcolm with respect to a health matter for Martha, the threshold was met for a category two ambulance to be dispatched. Martha declined the ambulance service and was advised to attend a local urgent treatment centre.

On 6 February, Martha attended a face-to-face appointment with the practice nurse with respect to a routine health matter. There was no record of any domestic abuse enquiry being completed.

On 24 February, Martha attended a face-to-face appointment with the practice nurse with respect to a routine health matter. There was no record of any domestic abuse enquiry being completed.

On 28 March, Martha called 111 re dental pain and was triaged to the dental hub. An appointment was made for Martha to attend the Northumberland Treatment Centre.

On 17 April, Martha and Malcolm made a joint on-line application for universal credit. Martha stated that she was unfit to work due to a health condition. Malcolm was unable to work due to the COVID-19 pandemic.

On 27 April, Martha attended a face-to-face appointment with her GP, for a routine health matter. There was no record of any domestic abuse enquiry being completed.

On the same day, following a telephone conversation, a journal message was sent informing Martha that she needed to provide additional information before their claim could be assessed.

On 28 April, Universal credit contacted Martha to verify her bank details. Whilst speaking to Martha, Malcolm joined the conversation, stating that he did not have the IT skills and no previous experience of claiming universal credit. He requested that their claim be back dated to 17 April, this was subsequently declined.

On 30 April, Malcolm called 111 reporting dental pain, this was triaged to a dental practice.

On 11 May, Malcolm was asked by Universal credit to provide more information about his previous earnings.

On 13 May, in a journal message, Malcolm asked if there were any other benefits he could claim, he was advised that he could request a New Claim Benefit Advance. He made a claim on 14 May and it was approved the same day, a total of £500 that would be repaid over a twelve-month period.

On 19 May, Malcolm attended a telephone medical review. He was discharged back to his GP.

On 27 May, Martha and Malcolm received their first universal credit payment of £552.37. Malcolm responded via his journal, that he was unhappy with the amount but this was conformed as correct.

On 8 June, Martha attended an appointment with a work coach. On the same day, Malcolm informed Universal Credit that he had returned to his previous self-employment.

On 29 June, Malcolm's earnings were confirmed and it was deemed that they exceeded the entitlement and therefore universal credit was not paid for that period.

Throughout July, August and September, Malcolm did not declare his earnings so universal credit was not paid. Although attempts were made

to contact Martha and Malcolm, there was no record of any further contact being made with the Universal Credit team.

On 14 July, the police received a telephone call from a neighbour's son reporting that Martha had been abusive and threatening to their neighbour. The victim in this case did not want formal police action. Police spoke to Martha and provided her with advice to prevent further issues.

6.5 1 January to 31 December 2021

On 17 January, NEAS received a 999 call from Martha reporting that Malcolm had lost consciousness following an attempt to remove his own tooth, he had regained consciousness but was suffering chest pain. Malcolm was admitted to the A&E department having collapsed with chest tightness. He was discharged home with head injury advice and advised to see a dentist.

On 18 January, Malcolm contacted 111 reporting dental pain, he was referred to a local dental hub.

On 20 March, following a 999 call to the NEAS by Malcolm, Martha was admitted to the A&E department in the early hours of the morning with a sudden pain in the side and other health issues. No history of an injury. She reported that she had crawled to the door of her room to call her husband for help. She informed staff that she drank a small amount of vodka each week, the records document quarter of a 70cl bottle. Martha discharged herself later that day against medical advice. Martha was deemed to have capacity with respect to decision making. A referral was made to the GP for further tests due to the liver function test results. There was no record of whether Malcolm was with her or of any domestic abuse enquiry being completed.

On 6 May, police officers attended Martha's address following a 999-emergency call. Martha reported that she had been involved in an argument with Malcolm who was intoxicated. He had dragged her by her neck, pinned her against a wall and threatened to kill her. The record did not state if Martha had been drinking. Malcolm was arrested and received a police caution for assault. A DASH[4] risk assessment

[4] The purpose of the DASH Risk Assessment Checklist is to give a consistent risk assessment tool for practitioners who work with adult victims of domestic abuse. It's used to help practitioners identify

assessed the level of risk at 'standard'. Martha had informed the police that she did not want any safety measures and that she was happy for Malcolm to return to the home address. The police record also documented that Martha did not give consent to share information and that the circumstances did not meet the threshold to override consent.

On the same day, ASC received an adult concern notification from the police in relation to Martha. Martha was not previously known to ASC and had not consented to information sharing by the police. The information shared related to a domestic abuse incident that the police had assessed as standard risk. The notification did not highlight any previous police information or that Martha had any care or support needs that might have reached the safeguarding threshold as neither agency held any relevant information to share.

On 23 July, Martha contacted the police, she had been involved in an argument with Malcolm over a text message. It had become very heated, with Malcolm throwing items around the garden shed. Police officers attended and Malcolm agreed to go and stay at a family member's address. There was no evidence of a criminal offence and both parties were advised to 'not deal with marital issues whilst drunk'. The police record documented Martha being offered support but declining it. A DASH risk assessment was completed, determining the risk to be at standard.

On 13 August, Martha attended a face-to-face appointment with her GP and disclosed hot flushes, mood swings and poor sleep. There was no record of any domestic abuse enquiry being completed.

On 7 September, the primary care records documented a face-to-face GP appointment with Martha who disclosed that Malcolm was physically and financially abusive towards her. She disclosed allegations of his putting his hands around her throat and threatening to slit her throat. She stated that Malcolm would not give her any money, she therefore could not afford to pay for prescriptions. She informed the GP that she did not have a safe place to go to, she would stay in the bedroom and drink excessively. The record stated that a safety plan was discussed and that Martha was sign posted to domestic abuse services. The GP

those who are at high risk of harm and whose cases should be referred to a MARAC, (Multi-Agency Risk Assessment Conference), meeting in order to manage their risk.

also requested that the social prescriber[5] submitted a referral to ASC as Martha was a vulnerable person. There was no risk assessment completed, domestic abuse referral made or any referral offered to address her alcohol use.

On 9 September, police officers attended Martha's address following reports of an argument between Martha and Malcolm. The situation had calmed down on police arrival. The police records documented that it had been a verbal argument only, that Malcolm and Martha were sleeping in separate bedrooms and that both of them were seeking legal advice about getting divorced. There was no record about alcohol being involved. The DASH risk assessment graded this incident as standard, the record also documented that safeguarding measures were discussed with Martha.

On 17 September, the social prescriber contacted the GP by telephone. Martha was locked in her bedroom but the reason was unknown. The GP records are unclear as to whether a referral to NDAS or ASC were made, from the records made available to the review, it would appear that referrals were not made. NDAS have confirmed that they did not receive a referral and have not worked with Martha at any time. The records do state that the GP and social provider discussed referrals but felt that Martha had the capacity to make her own decisions. There was no risk assessment or referral made nor was there any recorded thought about contacting the police to deal with any immediate risk to Martha.

On 24 September, ASC records documented that they were contacted by a community link worker[6] requesting a safeguarding referral form. There was no information shared about what that concern might be. Although the community link worker was spoken to by ASC to confirm receipt of the safeguarding referral form, there is no evidence that the referral was ever received by ASC. Although the context of the concern remains unknown, records documented that there were concerns around housing and finance as the ASC enquiry and coordinators had

[5] Social prescribers, often called 'link workers', provide support for individuals through identifying what needs are not being met, identifying what is having a negative impact on their lives and working with that individual to develop plans to provide them with direct practical support.
[6] A social prescriber is often referred to as a 'link worker' and the panel took the view that this was a reference to the 'social prescriber' referred to in the GP practice records.

previously provided advice in Martha's case to other local authority departments.

On 28 September, there was telephone contact between the GP and Martha. The records document that Martha informed the GP that she did not feel she could leave her husband and start again. The record also documented that she was aware of available support. There was no evidence within the medical record of any response from the ASC referral or any referral with respect to domestic abuse risk to Martha.

On 10 October, police records documented that their officers had attended an incident where Martha had punched her adult daughter's partner. After investigation, it was determined that this may have been self defence during an argument. There was no formal police action taken. There is no record of alcohol being involved.

On 12 October, Martha attended a face -to-face appointment with the GP to follow up the telephone appointment on 28 September. The issue discussed was a routine health matter, but there was no domestic abuse enquiry despite the disclosures in early September.

On 26 October, Martha attended the breast care department for a routine health matter. The medical records document what appeared to be some bruising to her chest. Martha informed practitioners that she bruised easily. Martha was discharged. There is no record of any domestic abuse enquiry.

On 1 December, Martha attended a face-to-face appointment with the GP practice nurse. The issue was a routine medical matter but it was noted that Martha declined the treatment on the basis that her husband would not give her money to pay for a prescription. This disclosure of controlling and financial abuse was not identified as such and did not result in a domestic abuse referral or any form of enquiry.

The following day, Martha attended a face-to-face appointment with the practice nurse for a routine health matter.

On 14 December, Martha attended a face-to-face appointment with the practice nurse for a routine health matter.

6.6 1 January to 17 October 2022

On 19 January, Martha attended a face-to-face appointment with the practice nurse reporting injuries following a fall down the stairs. Pain killers were declined although no rationale for this was recorded. There was also no record of any domestic abuse enquiry despite the history of disclosed abuse and other indicators of abuse.

On 18 February, Martha attended an appointment with her GP for a routine health matter.

On 29 April, Martha attended a telephone appointment with the practice nurse reporting abdomen pain, she was advised to attend A&E immediately.

On 10 May, Martha attended a telephone appointment with her GP for routine health matters.

On 24 May, the primary care records documented a face-to-face appointment where Martha discussed various issues with her GP. There was no record of any discussion around low mood or domestic abuse.

On 6 June, Martha messaged a police officer stating that she could no longer take the physical and mental abuse from her husband and was asking for advice. When the officer contacted Martha, she informed them that this was an old message sent months ago and that she and her husband were working things out. She was told that she could contact the police if she needed more support. There was no record of any risk assessment or professional curiosity to better understand the risk of ongoing domestic abuse that Martha may have been experiencing.

On 8 June, Martha attended a face-to-face appointment with her GP, Malcolm was present. A routine health matter was discussed.

On 6 July, Martha had a telephone appointment with her GP. She stated that she wanted to be out of pain and to have her issues 'fixed'. Malcolm came onto the phone; he expressed his displeasure that Martha's issues had not been 'sorted'.

On 11 July, Martha had a telephone appointment relating to a routine health matter.

On 24 August, Martha had a face-to-face appointment with the practice nurse to discuss routine health matters. Whilst doing so, she informed

the nurse that she was not sexually active but this did not prompt any enquiry around domestic abuse.

On 15 September, Martha had a telephone appointment with the practice nurse asking for pain killers due to back pain flaring up following the previously reported fall down stairs. (January 2022).

On a date in mid-October, the GP practice received a call from Malcolm, informing them that Martha had taken an overdose of paracetamol and had been vomiting all day. He was advised to take her to A&E.

Later the same day, NEAS received a 999 call from Malcolm reporting that Martha had taken an overdose of paracetamol. Due to likely ambulance delays, NEAS agreed that it would be appropriate for Malcolm to convey Martha to A&E. NHCFT records documented Martha being brought to A&E by Malcolm, reporting an overdose of paracetamol the previous day. She disclosed that her husband was verbally and physically abusive and that she did not want to 'be here anymore'. Martha informed staff that Malcolm had previously threatened to kill her, that she was financially dependent on him and that he suffered from mental health issues. She also admitted drinking a bottle of spirits on a daily basis. She was transferred to critical care.

On the following day, critical care staff submitted an adult safeguarding referral, a DASH risk assessment and a MARAC[7] referral which were completed with Martha's consent. Obtaining the relevant information and completing both documents was challenging as Martha was so unwell and found answering questions challenging. The records documented that the Trust IDVA[8] was consulted. A pre-discharge plan was documented including the IDVA engaging with Martha.

On the same day, ASC received a referral from NSECH critical care advising that Martha had been admitted following a paracetamol overdose. The referral provided information about a history of domestic abuse and that Martha and her husband were separated but living in the

[7] A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors.

[8] Independent Domestic Violence Advisor, the main purpose of IDVAs is to address the safety of victims at high risk of harm from intimate partners, ex-partners or family members to secure their safety and the safety of their children.

same home. Safeguarding enquiries were commenced with ASC noting that Martha was 'safe' in hospital care.

Two days after her admission to hospital, Martha sadly passed away.

7. Findings and Analysis

7.1 Substance Misuse

Agencies that had contact with Martha and Malcolm documented that both had issues with alcohol use on occasions, there is no documented evidence of either Martha or Malcolm misusing other substances. The long term and excessive use of alcohol, particularly by Martha, was also highlighted in the information provided to the review by her adult son, Mark.

There was a history of alcohol use by Martha, often described as excessive use, both during the period subject to the review and in the years beforehand. This started in May 2013 when Martha informed the practice nurse that 'her world was crumbling' and that she was using alcohol to cope which included drinking in the mornings. There was no evidence of any professional curiosity to understand why Martha felt that her world was crumbling or any referral with respect to concerns about her alcohol use.

On 26 March 2018, Martha had an appointment with the practice nurse and disclosed that she was drinking heavily and suffering low mood. There was no recorded professional curiosity to understand why and no referrals offered to try and address either issue. In June that year, Martha had a face-to-face appointment with the GP and again disclosed heavy alcohol use to cope with what she stated were the stresses in her life. The primary care records do not document any questions to try and understand what those stresses were and there was no referral for support with respect to the alcohol misuse.

In May 2021, there was a domestic abuse incident where the police documented that Malcolm was intoxicated but do not record if Martha had been drinking. In July the same year, there was another domestic abuse incident and the police records document that both Martha and Malcolm were intoxicated. There was no recognition of alcohol misuse as an issue and no referral or other steps taken, to address it.

In September 2021, Martha disclosed the fact that she was drinking heavily to the GP and was suffering domestic abuse, including Malcolm putting his hands around Martha's throat. The GP sign posted Martha to domestic abuse support but made no referral. Whilst the GP did ask the social prescriber to refer Martha to ASC as she may have care and support needs, there was no record of any referral or other steps being taken to address her alcohol misuse. This was despite the number of previous disclosures, history of low mood and domestic abuse.

In January 2022, Martha consulted with the practice nurse having injured herself in what she described as a fall down the stairs. This was accepted at face value, (we will consider this in terms of the history of domestic abuse again at section 7.3 of this report). There was no documented evidence of any professional curiosity around alcohol misuse, despite the history of excessive alcohol use.

In October 2022, Martha was admitted to hospital following what we now know, to have been a fatal overdose of paracetamol. It is clear from medical records that she had a significantly damaged liver which would be consistent with long term alcohol misuse and had disclosed to hospital staff that she had been drinking a bottle of spirits a day. It is a reasonable conclusion from the information recorded within agency records, that Martha had been misusing alcohol for a significant period of time. Despite a number of disclosures where Martha admitted excessive alcohol misuse, alcohol recorded as an issue with incidents that Martha was involved in and the domestic abuse risks identified, there was no evidence of any agency taking any action to try and address her alcohol misuse.

Although the police records documented incidents involving Malcolm being intoxicated, the review has not seen any evidence of Malcolm disclosing information about his alcohol use to professionals. The panel was not able to comment on Malcolm's use of alcohol outside the information provided by his adult son, Mark.

7.2 Professional Curiosity and Mental Capacity

It is clear from Martha's medical records that practitioners deemed her to have mental capacity with respect to her decision making, indeed the records documented this being discussed between the GP and the social prescriber in September 2021. The records do not make it clear as

to what the decision was that Martha had capacity for. It may have been Martha not wishing to have information shared with other agencies but the record do not make this clear.

If we accept that Martha was significantly misusing alcohol over a number of years, which would be in line with the disclosures that she makes, (and the information from her adult son), she may reasonably have been considered a dependent drinker. If this was the case, it is worth reflecting on the impact that compulsive behaviours, which includes alcohol dependency, can have on the two elements of mental capacity, decisional and executive capacity.

Ward and Preston-Shoot, (W and PS), provide guidance in their safeguarding dependent drinkers report, (2020). They describe dependent drinkers who are not only hard to engage but are also vulnerable and have a significant impact on public services. W and PS make a number of key points; firstly, that the Care Act 2014 does apply to people with alcohol problems, they also remind professionals that it is a misconception that dependent drinkers are making life style choices, alcohol dependency, as with drug addiction, is a compulsive behaviour and should be considered when assessing an individual's mental capacity, particularly their executive capacity. (Their ability to not only understand the decision in the abstract but to know when to put the decision into effect and the ability to execute it). The research identifies that dependent drinkers are often difficult to engage with or refuse to accept services offered. They suggest commissioning alcohol services that meet the needs of clients through persistent, assertive services built on relationship building, harm reduction and motivational interventions.

In Martha's case, there were a number of occasions throughout the 5-year period subject to the review, and before this period starts in 2017, where Martha disclosed to practitioners that she was drinking excessively, primarily to manage stress she faced in life. There were also incidents that she was involved in where alcohol use was either recorded in agencies records or was likely to have been involved. Based on the evidence available, Martha could reasonably have been described as a dependent drinker. Martha engaged with services; indeed, she disclosed issues relating to alcohol misuse and domestic abuse to practitioners on several occasions, but she was unable to accept the support that was offered.

The fact that Martha was not referred to alcohol services is covered in section 7.1, it is also important to consider the impact of compulsive behaviour on both her decision making and her ability to engage with services offered.

Throughout the period of the review, Martha was considered, or assumed, as having the capacity to make decisions. This was rarely documented in agency records, one exception being the GP discussion with the social provider in 2021. What is recorded, was the fact that Martha did not consent to the sharing of her information with other agencies on a number of occasions, primarily on the basis that she did not consider that she needed support. Her lack of consent was respected on the majority of occasions. At no point was the impact of her apparent dependency on alcohol recognised as a compulsive behaviour or how that might affect her capacity to make decisions and make it more challenging for her to engage with some services. For the sake of clarity, it is important to note that there was no information made available to the review, that suggested that Martha did not have capacity to make any specific decision.

Whilst there were occasions where practitioners demonstrated professional curiosity when engaging with Martha, for example in early 2018, she had appointments with both the GP and the practice nurse where low mood is identified. Both the GP and the nurse asked questions to identify the cause of the low mood. However, there are a number of occasions where professional curiosity could and should have been employed and potentially, a greater understanding of the risks Martha faced may have been established.

In May 2013, Martha informed the practice nurse that her ‘world was crumbling’ and that she was using alcohol to cope, including drinking in the morning. There was no recorded exploration of why Martha felt that her ‘world was crumbling’ or establishing why Martha was drinking excessively and what could be done to support her. In June 2018, Martha disclosed to the GP that she was drinking excessively to cope with stresses in her life. Again, there was no documented record of any professional curiosity being used to understand what these stresses were or to explore the excessive use of alcohol.

Low mood is a consistent theme throughout Martha’s engagement with health services and particularly her GP practice during the review period.

In early 2018, practitioners made some enquiries to establish why, but there is limited evidence of any recorded professional curiosity between June 2018 and Martha's death in October 2022. Martha presented to the NHCFT breast care clinic in October 2021 with bruising to her chest and her explanation of bruising easily is accepted at face value despite her history of domestic abuse. Similarly in January 2022, Martha presented to the surgery in pain following what she reported as a fall down the stairs. Despite a history of both domestic abuse and alcohol misuse, there was no documented evidence of any professional curiosity to explore this explanation.

7.3 Identifying and Referring Domestic Abuse

The review considered the issue of domestic abuse training as a key element of enabling frontline practitioners to identify the risk of domestic abuse in service users, and where appropriate, to take the necessary action to mitigate that risk. It was clear that each of the agencies involved in this review have policies and provide training for staff, relating to domestic abuse. However, it was noted that the level of domestic abuse training that staff had received was not consistent system wide. It was recognised that whilst front line practitioners had an understanding of domestic abuse, the knowledge of specific aspects of domestic abuse, including coercive/controlling behaviour and financial control, were less well developed.

The panel noted that NDAS had been working with health partners as part of a project to work with older adults affected by domestic abuse with a focus on building links to health services. As part of the project, NDAS have developed and delivered domestic abuse training to frontline healthcare professionals including GPs, nurses and social prescribers.

The NICE guidelines, 2014[9], recommend that frontline staff in all health services, are trained to recognise the indicators of domestic abuse and that they should ask relevant questions to support service users to share their past or current experiences of such abuse. The recommendation states that the enquiry should be made in private, on a one-to-one basis and in an environment where the person feels safe. The guidance goes on to emphasise the need to specifically ensure that trained staff ask

[9] https://www.nice.org.uk/guidance/ph50/chapter/recommendations

about domestic abuse experience when dealing with service users in relation to antenatal and post-natal care, and mental health issues. NICE state that this should be a routine part of good clinical practice, even where there are no indicators of domestic abuse.

In Martha's case, there was no documented record of routine enquiry or targeted enquiry for domestic abuse being used by health practitioners in line with the NICE guidance. Although there were occasions where Martha disclosed domestic abuse to either the GP or to nursing staff, there was no recorded evidence of targeted enquiry about domestic abuse on occasions where Martha had presented alone and there had been indicators of domestic abuse which would include mental health, alcohol misuse and physical injuries.

Domestic abuse is a key cause of women's mental health according to research by Women's aid et al (2021). They describe women who were the victims of domestic abuse, suffering mental ill health because of the trauma of being subjected to abuse and violence. The research also suggests that the impact of this, together with the coping strategies they employ such as alcohol or drug use, is not well understood, including by some healthcare professionals. Other research[10] suggested that victims of domestic abuse who suffer from mental ill health often express a fear of being labelled as 'mentally unwell' and that this would impact on the likelihood of them being believed. This in turn, may make them less likely to disclose abuse or to seek support from services.

In Martha's case, her mental ill health, low mood and depression, were identified by practitioners and steps taken to treat this. There was however, no record of her mental ill health being potentially linked to domestic abuse by professionals.

Financial abuse, as part of the controlling behaviour that is a common feature of abusive relationships that is often identified in research, was evidenced in Martha's case but not identified as a concern, or if it was, there was no documented evidence of any consideration around making a domestic abuse referral. The panel noted reference to that fact that Martha was unable to access prescribed medicines on occasions as her husband would not give her money to do so. This was not recognised as domestic abuse or subject to the appropriate referral.

[10] McGarry and Hinsliff-Smith, (2021).

In May 2021, police officers spoke to Martha following an emergency 999 call and she made allegations of being dragged by the neck by Malcolm, who then pinned her against a wall and threatened to kill her. Malcolm was arrested and received a caution for assault. The panel has not reviewed the decision making about the criminal justice disposal but does note that the DASH risk assessment completed assessed the risk at 'standard'.

The assessment of risk to Martha as being standard was questioned by the review. The incident in question related to domestic violence where a threat to kill had been made by a perpetrator who had immediate access to the victim and was physically capable of carrying out the threat. Making a threat to kill is a serious offence in its own right and whether or not there is evidence to support a prosecution for such an allegation, this should not impact on the risk assessment.

The panel noted that there was no recorded history of domestic abuse between Martha and Malcolm. The review also took into account that neither the police, nor ASC, held any information that would have increased the assessment of risk to Martha at this time. Based on the information available to decision makers, the panel believed that the risk to Martha should have been graded at medium. It was also noted that a significant investment in training and enhancing police decision maker's knowledge of domestic abuse, including controlling behaviour, has been undertaken since 2021. It is worthy of note that even if the DASH risk assessment had been graded at medium, it would not have led to any further information sharing or a different outcome in Martha's case.

In July 2021, police attended an argument between Malcolm and Martha and whilst there was no evidence of an assault, Malcolm was recorded as having been throwing things around the garden shed. The police records document that both Malcolm and Martha were 'drunk' and their marital difficulties identified. Martha declined any support; the DASH risk assessment assessed the risk as being 'standard'.

There was a further incident in September that year, with Malcolm and Martha arguing over a text message. When officers attended, the argument was over, the police record documented that safeguarding was addressed but doesn't state how. It was noted that Martha and Malcolm were living in the same house but consulting solicitors with a view to divorcing. The risk assessment was graded at standard. Whilst

not documented, it is likely that the police officers involved saw the planned separation as a protective factor.

Since 2002, there were documented disclosures from Martha suggesting that her marriage was in difficulties and that divorce was being considered. In 2021 it was evident that Martha and Malcolm were sleeping in separate rooms and considering divorce, Martha also informed a practice nurse that she was no longer sexually active. It was likely that practitioners would have seen separation as a protective factor.

Separation is recognised as a trigger for escalating risk in domestic abuse in the research by Professor Jane Monkton Smith et al in 2022[11]. This research describes eight stages that show a potential and incremental escalation in risk towards suicide in victims of domestic abuse:

Stage one- A history of domestic abuse, either in the perpetrator or victim's history.

Stage two- A controlling relationship that develops quickly, often involving early co-habitation and/or pregnancy.

Stage three- In all of the cases that this research looked at, the relationship was dominated by control and abuse, often from a very early point within that relationship.

Stage four- In 83% of the cases, the victim disclosed abuse, not always to services, but to family members. Other research, (Vasiliauskaite and Gaffner 2020)[12], found that shame and secrecy were influential in preventing disclosure by victims but also fears of retaliation and fears of not being believed were key issues. Monckton-Smith et al go on to describe disclosure as an escalation in risk, not the beginning of risk progression. They observed that control and abuse may already be at a high level of risk at the point of first disclosure.

[11] Building a temporal sequence for developing prevention strategies, risk assessment, and perpetrator interventions in domestic abuse related suicide, honour killing and intimate partner homicide. Monckton-Smith et al, 2022.
[12] Eight Forms of Abuse: The Validation and Reliability of Two Multidimensional Instruments of Intimate Partner Violence--- Vasiliauskaite and Gaffner 2020.

Stage five- Help seeking was present in more than 80% of the cases this research looked at, it came after the first disclosure. They quote previous studies that found that victims do not report abuse or seek help where they believe that the service would not be useful or they might not be believed. Monckton-Smith et al describe active help seeking as potentially being seen by the perpetrator as challenging their control and can provoke consequences for the victim.

This research also noted that although calls to the police were made in 78% of the cases they looked at, the police intervention did not, in any of the cases, halt the abuse or the stalking, this included cases where the perpetrator was arrested, charged and released on conditional bail and where the perpetrator was in prison. They also noted that the lack of consistency, especially in risk considerations across agencies, was described by families of the deceased, to actually encourage the perpetrator.

Stage 6- In a high percentage of cases, suicidal ideation was identified, this tended to coincide with the victim feeling trapped and in a hopeless situation. It was also noted that there were cases where the perpetrator actively encouraged the victim to end their life. Monckton-Smith et al also noted previous research that found that children were a protective factor in suicidality and the primary reason why victims did not act on such thoughts. Monckton-Smith et al also observed that the thought of having lost the children would create a feeling of entrapment and hopelessness.

Stage 7-In just under half of the cases looked at, the relationship between victim and perpetrator had ended but the contact, control and stalking persisted. Perpetrators seemed oblivious to the deteriorating mental health of the victim, some actively encouraged suicide. In most of the cases considered, the victim had said that they were trapped in a situation from which they felt there was no escape.

Stage 8- The suicide.

Applying this model to Martha's case, the lack of information about Martha and Malcolm's early relationship makes it difficult to comment on stages one and two although it is noted that the marriage was having difficulties as far back as 2002. In terms of stage three, there was little direct evidence of controlling behaviour from the information provided to

the review prior to 2021 although there was evidence of other accepted indicators of domestic abuse including mental health and alcohol misuse.

In stage four, Monckton Smith et al describe disclosure of abuse as an escalation in risk, not the beginning of risk progression. In 2021, Martha disclosed abuse to services, including the police and her GP practice, this included Malcolm making a threat to kill her. It would be reasonable to describe this as an escalation in risk of domestic abuse rather than the start of it.

Although it is clear that Martha and Malcolm had difficulties within their marriage over many years, Martha had first disclosed issues in 2002, the information from Agency records would suggest that the level of abuse escalated during 2021. This included Malcolm making a threat to kill Martha and his physically assaulting her in May that year. There were then a number of calls to the police as well as disclosures to other agencies, particularly the GP. In disclosing information to the GP service and reporting incidents to the police, it may be reasonable to conclude that Martha was seeking help in line with stages four and five of the model described by Monckton Smith et al. It was during this period that agencies documented information clearly suggesting that Martha and Malcolm were separated but living within the same premises, sleeping in separate rooms. The separation in 2021, rather than a protective factor that some services saw this as, could be seen as a trigger for further escalation of the abuse, and, as described by Monckton-Smith et al, police intervention did not mitigate or reduce the risk of further abuse.

In stage six, the research suggests that suicidal ideation was often identified and that this tended to coincide with the victim feeling trapped in a hopeless position. In Martha's case, it was likely that Martha was subject to a controlling and abusive relationship, this included not being able to obtain prescriptions as Malcolm would not give her money, suggesting financial control. Martha presented to health care with unexplained bruising and on another occasion, reported a fall down stairs. It is also apparent that Martha was drinking heavily.

In the research, Monckton Smith et al describe stage seven as the relationship having ended in about half of the cases looked at, this was the case for Martha and Malcolm. In the research, victims often described feeling as if they were trapped in a situation with no escape. In

September 2021, Martha informs the GP that she did not feel that she could leave her husband and start again. In June 2022, she texted a police officer to say that she could no longer take the physical and mental abuse from her husband and asked for advice. Whilst she claimed this was an old text and that they were now working things out, these two disclosures may be seen as reflecting Martha's state of mind along the lines of feeling trapped in a hopeless situation as laid out in stage seven of the model.

Stage eight would be the deliberate act of the victim ending their life. In Martha's case, whilst the circumstances are yet to be assessed by the Coroner, it would appear to be suicide with Martha having disclosed that she could no longer live with the abusive relationship that she felt she was in.

Understanding the eight stages of domestic abuse related suicide and particularly the impact of controlling behaviour and financial abuse, would help practitioners recognise the risk to victims. The successful use of checklist risk assessments such as DASH, require practitioners to have a sound understanding of coercive control and domestic abuse, (Turner et al, 2019)[13].

7.4 Information Sharing

The sharing of information between agencies to enable a more holistic understanding of risks that Martha faced and her support needs, was identified as an issue during the review. The sharing of information between the safeguarding partners was a key element of enabling decision makers to understand the holistic picture around Martha and to have a better appreciation of the risks she faced. The panel noted that there were some examples of good information sharing between the safeguarding partners. This included the A&E department notifying the GP practice of contact with Martha and Malcolm and the GP working with the social prescriber to refer Martha to ASC. The best example of information sharing was sadly the day before Martha died in October 2022. Following disclosures relating to domestic abuse, the critical care

[13] https://www.researchgate.net/publication/345039139_Dashing_Hopes_the_Predictive_Accuracy_of_Domestic_Abuse_Risk_Assessment_by_Police

team liaised with the Hospital IDVA, completed a DASH risk assessment and submitted referrals to ASC and MARAC.

There were however, occasions where information was not appropriately shared with relevant agencies:

On 7 September 2021, Martha disclosed domestic abuse to the GP, including strangulation and threats to slit her throat. Martha also reported financial abuse and that she was drinking excessively. Although the GP contacted the social prescriber to request a referral to ASC with the records describing Martha as a vulnerable person, there is no other information shared with partner agencies, no referral to MARAC or to the police with respect to the significant level of risk that Martha faced. There was also no referral with respect to her excessive use of alcohol. Although the records document Martha being sign posted to domestic abuse services, Martha was clearly at risk of serious harm through domestic abuse and information should have been shared with the police and a referral made to MARAC. This was a missed opportunity to bring agencies together to properly assess the risk to Martha.

On 17 September 2021, 10 days after the original disclosure to the GP, the social prescriber contacted the GP by telephone and they discuss Martha's case. The GP records document the social prescriber informing them that Martha had reported being locked in her bedroom, although the records don't document if that was a live incident or perhaps referring back to the original disclosure on 7 September. The records do document that both the GP and social prescriber believed that Martha had capacity to make her own decisions. The panel noted that there was no risk assessment completed, no referral to the police or to MARAC and, if it was relevant, no consideration of contacting the police if there was an immediate threat to Martha's safety through being locked in her room. Although not specifically stated, the reference to Martha having capacity to make decisions would suggest that Martha had not consented to information being shared with other safeguarding agencies.

The issue of consent to share also featured in the police response to the incident in early May 2021 in which Martha reported that Malcolm had assaulted her and threatened to kill her. The police record documented that Martha did not consent to information being shared with other agencies and that the threshold for overriding the lack of consent had

not been met. The review noted that all of the adult concern notifications, which included the one submitted by officers who had spoken with Martha, are considered within the safeguarding triage process where the police and ASC practitioners would have access to their respective information systems when assessing risk and, when considering if a section 42 referral under the Care Act 2014[14] was required. Whilst the police records document that there was no consent from Martha to share information, the police and ASC have a process in place that enables them to consider all of the relevant information they hold prior to deciding whether to override that lack of consent in a particular case. In Martha's case, neither the police or ASC held any information that could have met the threshold for initiating a section 42 enquiry.

The issue of consent to share safeguarding information with partner agencies is a challenging one for safeguarding professionals. Making safeguarding personal, MSP, is a person centred approach which means that adults are encouraged to make their own decisions and are provided with the appropriate support and information to empower them to do so. This approach recognises that adults have a general right to independence, choice and self-determination, including control over information about themselves. Adults may choose not to consent to professionals sharing information about them with other agencies for a variety of reasons, if this is the case, their wishes should, in general, be respected. However, there are some circumstances where practitioners can reasonably override such a decision, including:

- The adult lacks capacity to make such a decision, practitioners should consider both decisional and executive capacity when assessing this issue.
- Emergency or life-threatening situations may warrant the sharing of relevant information with the emergency services.
- Other people are or may be at risk, including children.
- Sharing information could prevent a serious crime.
- A serious crime has been committed.
- The risk is unreasonably high and a duty of care needs to be considered.

[14] Section 42 of the Care Act 2014 states the duty of the Local Authority to cause enquiries to be conducted where an adult has care and/or support needs, is at risk of abuse or neglect and is unable to protect themselves from that abuse or neglect.

- There is a court order or other legal authority for taking action without consent.

In such circumstances, practitioners should carefully record their decision-making process and where practicable, seek advice from managers and/or their legal services as appropriate. (SCIE guidance, Consent in relation to safeguarding, published in 2021)[15].

In Martha's case, and in both the May and September incidents, the information disclosed to practitioners clearly related to domestic abuse and included a threat to kill her by her husband. In May 2021, the police assessed the risk within the DASH risk assessment as standard, which is reviewed at section 7.3 of this report. There was no DASH risk assessment for the September 2021 disclosure to the GP. Making a threat to kill someone is a serious crime and the panel would note that domestic abuse should be considered a serious crime, whether or not serious physical injury is involved as the psychological or emotional damage caused by violent, controlling or coercive behaviour should also be considered serious harm.

Dealing with the May incident first; there was a documented threat to kill Martha, this amounts to a serious crime and would suggest that there was a significant risk of a serious crime being committed in the future. This would indicate that the lack of consent to share information could and should be overridden. Whilst it is right to consider the wishes of the individual in terms of information sharing, it is clear that the threshold for overriding the lack of consent to share information with safeguarding partners in this case would have been met. The review however, found that although the DASH risk assessment and ACN were endorsed with the fact that Martha did not consent to information being shared, the triage process ensured that practitioners assessed the risk based on information held by both the police and ASC, i.e. the police and ASC shared the limited information they held to assess risk and to consider Martha's potential care and support needs appropriately.

The September 2021 disclosure to the GP also involved Martha describing a threat to have her throat slit, non-fatal strangulation,

[15] Social Care Institute for Excellence, SCIE, produce a range of products to support safeguarding adults under the care Act 2014. The document is at https://www.scie.org.uk/safeguarding/adults/practice/sharing-information

financial as well as physical abuse and alcohol misuse. Whilst accepting that Martha would need to consent to an alcohol services referral, it is difficult not to conclude that the risk of serious harm to Martha is high based on the disclosure made. Whilst it was right to identify that Martha's wishes should be identified and where appropriate, respected, this is also a corner stone of making safeguarding personal, it is important that practitioners understand when the lack of consent to share should be overridden.

In both of these cases, the sharing of information without Martha's consent would have been justified if the SCIE guidance was applied to the decision making. With respect to the May 2021 incident, information was shared between the police and ASC through the triage process and the review accepted that there was insufficient information available to either agency to support wider information sharing. The documented disclosures in September 2021 suggested a risk of serious harm from domestic abuse as well as the risk from alcohol abuse. The information relating to the risk of serious harm from domestic abuse should have led to a domestic abuse referral despite Martha's lack of consent. The review recognised that the GP identified the need for a referral to ASC with respect to her care and support needs albeit that referral was never actually made.

7.5 Adult Safeguarding

Whilst the main focus of the review has been on the risk of domestic abuse to Martha, it is also important to consider whether Martha could, or should, have been considered to have care and support needs under the Care Act 2014.

The ASC records documented three occasions where they received some form of contact with respect to Martha and potential adult safeguarding concerns. The first occasion was in May 2021 when they received a police notification following concerns around a domestic abuse incident. Although Martha had not consented to information sharing, the police and ASC considered the information available to both agencies through the joint agency triage process. As there was no information held by either agency that would have supported a section 42 Care Act enquiry, the ASC records document that no further safeguarding action was taken as there was insufficient concern to override the lack of consent.

In September 2021, ASC records document contact from the community link worker, who requests that a safeguarding referral form is sent to them from the Enquiry and Referral team. Whilst the form was sent, there was no record as to what the safeguarding concern was and there is no evidence that any safeguarding referral was actually received by ASC. There was also no documented evidence of any professional curiosity to understand what the safeguarding concern related to.

The third occasion related to a referral submitted to ASC from NSECH staff in October 2022. The ASC documented that the initial assessment was that Martha was safe as she was in hospital, they received notification of her death the following day so the referral was not progressed.

The review also identified the fact that the relationships section within the ASC records were not updated, as a result, Martha and her adult daughter were not linked within the record system. As her adult daughter was already known to ASC with concerns for domestic abuse, this may have prompted further checks to have been completed by practitioners to establish if the daughter was an adult at risk or if she had children who may have been at risk of harm.

The decision with respect to whether a case met the threshold for further adult safeguarding enquiries to be conducted under section 42 of the Care Act 2014 is based on the following:

This section applies where the local authority has reasonable cause to suspect that an adult in its area, (whether or not ordinarily a resident there), ---

a, has needs for care and support, (whether or not the authority are meeting any of those needs),

b, is experiencing, or is at risk of, abuse or neglect, and

c, as a result of those needs, is unable to protect themselves against the abuse or neglect or the risk of it.

When considering the holistic circumstances around Martha's life, particularly during the last two years prior to her death, it would be reasonable to conclude that Martha would have met the threshold for a section 42 enquiry under the Care Act 2014.

Agency records documented that Martha was experiencing abuse and was at risk of serious harm through domestic abuse. She was undoubtedly misusing alcohol as a means of coping with stress and her low mood and had a number of health issues. It would be reasonable to describe Martha as a dependent drinker and this should be considered to meet the requirement to have needs for care and support under the Care Act[16]. In his paper on 'effective work with adults who self-neglect' (2020), Preston-Shoot describes the care that needs to be given when assessing mental capacity involving people with compulsive behaviours, which would include dependent drinkers. This would include a particular emphasis on the executive capacity of the individual. This is reinforced in case law, the judge in NHS Trust v L Ors, (2012), EWHC, found in his judgement, that compulsive behaviours may impair someone's executive capacity. Compulsive behaviours could include both substance addiction and self-neglect.

The use of a section 42 assessment would have the advantage of placing a statutory duty to cooperate on agencies and effective information sharing would have taken place, enabling a more effective risk assessment and the implementation of a cross agency safeguarding plan. In Martha's case, the lack of information sharing led to no single agency having that holistic understanding of the risk that Martha faced and her care and support needs were neither identified or addressed.

The panel noted that since Martha's death, there have been a number of changes in working practice, including the level of domestic abuse training for all MASH[17] staff and the fact that there is now an IDVA working within the MASH to provide the relevant expertise to support both victims and front-line decision makers.

7.6 Impact of COVID-19

The pandemic lockdown saw everyone being confined to their homes, together with family members, for almost 24 hours a day. It is clear from research conducted by the Women's aid organisation[18], that this had a significant negative impact on many women and children who were experiencing, or had experienced, domestic abuse. The survey carried

[16] Ward and Preston-Shoot, 'Safeguarding dependent drinkers' report (2020).
[17] MASH---Multi-agency Safeguarding Hub.
[18] Women's aid. (2020), A perfect Storm: The impact of the COVID-19 pandemic on domestic abuse survivors and the services supporting them.

out by Women's aid found that more than 60% of domestic abuse victims who had been living with their abuser during the lockdown, reported an increase in the level of abuse. Many also reported that it was more difficult for them to consider leaving their abuser because of the pandemic. The research also noted that the availability of refuge places was reduced during the pandemic.

All of the services were impacted by the COVID-19 pandemic to a degree albeit there is clear evidence that a significant effort was made to maintain core services. Resourcing and workloads were a key issue for practitioners with staff being either sick or at times, required to isolate during those periods of time that the restrictions were in place. This led to increased workloads for those staff in the work place. The review noted that all of the key services maintained a good level of service provision throughout this challenging period. There was no evidence to suggest that Martha or Malcolm were unable to access services due to the COVID-19 pandemic.

In March 2020, in response to the COVID-19 pandemic, the NHS made some changes to how health care was accessed and delivered, which included GP care. This led to an increased use of telephone and online contacts with a triage service, ensuring that face to face contact only took place where there was a clinical need. This was for the protection of both staff and patients. The use of a telephone triage and where appropriate, telephone consultations continue with a hybrid approach to delivering GP care. In both Martha and Malcolm's case, they were able to access primary care, with both telephone and face to face appointments when required.

8. Conclusion and Recommendations

8.1 Substance Misuse

Agencies that had contact with Martha and Malcolm documented that both had issues with alcohol on occasions, there was no evidence of either individual misusing other substances. The fact that both Martha and Malcolm were drinking heavily was supported by the information provided to the review by their adult son, Mark.

Martha made disclosures to practice nurses in both 2013 and 2018, that she was using alcohol to cope with stresses in her life, this included

describing drinking heavily and drinking in the mornings and linking it to low mood. In May 2021, police records documented a domestic abuse incident where Malcolm was intoxicated but the record did not comment on whether Martha had been drinking. In July the same year, there was a further domestic abuse incident and the police records documented that on this occasion, both Malcolm and Martha were intoxicated.

In September that year, Martha disclosed to her GP that she was drinking heavily and was suffering domestic abuse. The GP sign posted her to domestic abuse support and asked the social prescriber to refer Martha to ASC as she may have had care and support needs. In January 2022, Martha consulted with the practice nurse having injured herself in what she reported as a fall down stairs. There was no documented evidence of any professional curiosity relating to alcohol misuse, despite Martha's history of excessive alcohol use.

Martha was admitted to hospital in October 2022 following what we now know to have been a fatal overdose of paracetamol. It is clear from the medical records that Martha had significant liver damage consistent with long term alcohol abuse. Martha also disclosed to hospital staff that she had been drinking a bottle of spirits each day. It is a reasonable conclusion that Martha had been misusing alcohol for a significant period of time. Despite several disclosures where Martha admitted excessive alcohol misuse, alcohol being recorded as an issue with incidents that Martha was involved in and the domestic abuse risks identified, there is no evidence of any agency taking any action to try and address her alcohol misuse. This was a significant missed opportunity.

Recommendation 1

The Domestic Abuse Board should seek reassure from relevant agencies that frontline practitioners have the skills, knowledge and confidence to identify service users who use alcohol as a coping mechanism.

Recommendation 2

The Domestic Abuse Board should satisfy itself that relevant practitioners across each agency understand how to make referrals to specialist services to support individuals who use alcohol as a coping mechanism.

8.2 Professional Curiosity and Mental Capacity

The review noted that there were reasonable grounds to believe that Martha was a dependent drinker, this included her disclosing to practitioners that she drank alcohol excessively and that she drank alcohol to cope with the stresses in her life. The research referred to in section 7.2 of this report, seeks to remind practitioners that alcohol dependency is a compulsive behaviour and the potential impact of this should be considered when assessing an individual's mental capacity, particularly their executive capacity. The same research also found that that dependent drinkers are often difficult for services to engage with or may refuse to accept services offered.

Throughout the period of the review, Martha was assumed by professionals to have the mental capacity to make decisions, with one exception, when the GP discussed the issue with the social provider in September 2021. There was no documented record of practitioners considering the potential impact of compulsive behaviours on Martha's decisional or executive capacity, or perhaps, the impact of being in an abusive relationship where she may have been subject to controlling and coercive behaviour. What was recorded was the fact that on a number of occasions, she did not consent to the sharing of information with other agencies. Primarily this was on the basis that in her view, she did not need any support. Her lack of consent was respected on the majority of occasions. There was no recognition of the potential impact that compulsive behaviour, specifically alcohol dependency, may have had on her capacity to make specific decisions or perhaps, how that might make it more challenging for her to engage with services.

Recommendation 3

The Domestic Abuse Board should seek reassurance from agencies that relevant practitioners understand the impact that compulsive behaviours may have on an individual's decision-making capacity.

8.3 Identifying and Referring Domestic Abuse

Domestic abuse training was recognised as a key element in providing practitioners with the skills and knowledge to identify the risk of domestic abuse that service users may face and where appropriate, take the necessary action to mitigate that risk. All of the agencies involved with this review provide training to their staff with respect to domestic abuse.

Whilst it is accepted that front line practitioners have an understanding of domestic abuse, the panel was less confident that practitioners had a good understanding of certain aspects, specifically, the impact of controlling/coercive behaviour and financial abuse.

The review considered the research relating to domestic abuse victims and suicide by Professor Jane Monckton-Smith et al, (2022). The research highlighted the impact that controlling/coercive behaviour can have on a victim, it also recognised that separation is not the protective factor that some professionals see it as, but actually a trigger for escalated risk to the victim.

It was clear from agency records that Martha and Malcolm experienced difficulties within their marriage as far back as 2002. The information from agency records would suggest that the level of abuse escalated in 2021. There were a number of contacts with the police and disclosures to other agencies, which may be seen as Martha seeking help in line with stages four and five of their research model. It was noted that agency records would suggest that Martha and Malcolm had separated but were living in the same premises which may support the view that this could have been a trigger for escalating abuse.

Understanding the impact of controlling behaviour, including financial abuse, and how this features in the eight stages of domestic abuse related suicide, would help practitioners recognise the risk to victims. In Martha's case, she reported not being able to pay for a prescription because her husband would not give her money to pay for it. This was a clear disclosure of controlling behaviour that wasn't identified by the practitioner. There is also separate research that observes that the effective use of check list risk assessments such as the DASH risk assessment, depend on the practitioner having a sound understanding of coercive control to be effective.

The NICE guidelines, 2014, recommend that frontline staff in all health services, are trained to recognise indicators of domestic abuse and that they should ask relevant questions to support individuals to share their experience of such abuse. In Martha's case, there was no documented record of routine enquiry or targeted enquiry for domestic abuse being used by health practitioners in line with the NICE guidance. Although there were occasions where Martha disclosed domestic abuse to either the GP or to nursing staff, there was no recorded evidence of targeted

enquiry about domestic abuse on occasions where Martha had presented alone. This was despite the presence of a number of indicators of domestic abuse which included mental health, alcohol misuse and physical injuries.

Recommendation 4

The Domestic Abuse Board should seek reassurance from each agency that relevant practitioners understand the impact of controlling behaviour, including financial abuse, on victims of domestic abuse and their ability to disclose abuse or seek help.

Recommendation 5

Health agencies should ensure that frontline practitioners carry out the appropriate routine or targeted enquiries in line with local policy and procedures, to better understand the risk of domestic abuse faced by service users.

8.4 Information Sharing

The sharing of information between agencies to support a better understanding of the risk that a victim of domestic abuse faces and her support needs is invariably a key issue in domestic abuse and wider safeguarding reviews nationally as well as in Northumberland. The sharing of information supports the risk assessment process. It was noted that there were examples of good information sharing between safeguarding agencies in Martha's case but there were other occasions where information could and should have been shared but was not.

In May 2021, the police records documented that the threshold had not been met to enable Martha's lack of consent for information to be shared with other agencies to be overridden following the assault on Martha by Malcolm and him making a threat to kill her. It was noted that the police and ASC did share information to enable the safeguarding risks to be assessed. In September the same year, Martha made disclosures of domestic abuse, including strangulation and that Malcolm had threatened to 'slit her throat', to her GP. Although there was a discussion around a referral to ASC, Martha's lack of consent to share information appeared to prevent any domestic abuse related information sharing.

The panel was clear that professionals would understand that generally consent was required to share personal information with safeguarding

partners but that there were circumstances where the lack of consent could be overridden. Panel members were less confident that frontline practitioners would have a clear understanding of those reasons why consent should be overridden.

In both of these cases, the sharing of information without Martha's consent would have been justified if the SCIE guidance was applied to the decision making. With respect to the May 2021 incident, information was shared between the police and ASC through the triage process and the review accepts that there was insufficient information available to either agency to support wider information sharing. The documented disclosures in September 2021 suggested a risk of serious harm from domestic abuse as well as the risk from alcohol abuse. The information relating to the risk of serious harm from domestic abuse should have led to a domestic abuse referral despite Martha's lack of consent. The review recognised that the GP identified the need for a referral to ASC with respect to Martha's care and support needs albeit that referral was never actually made.

Recommendation 6

Agencies should satisfy themselves that frontline practitioners understand when the lack of consent to share information relating to adults at risk with partners should be overridden.

8.5 Adult Safeguarding

Whilst the main focus of the review has been on the risk of domestic abuse to Martha, it is also important to consider whether Martha could, or should, have been considered to have care and support needs under the Care Act 2014.

Martha could reasonably be described as a dependent drinker which should be considered as meeting the requirement for care and support under the Care Act 2014. Martha was clearly at risk of abuse and as a result of her care and support needs, may have been unable to protect herself from the risk of abuse.

ASC had three contacts with Martha, one of which related to the hospital admission immediately prior to her death. The remaining two included a police notification where the joint agency triage process determined that there was insufficient information to suggest that Martha had care and

support needs. There was no information available to either agency that Martha was a dependent drinker.

The second saw a community link worker request a safeguarding referral form in September 2021, which although provided, was never completed and returned to ASC. This would have raised the GP's concerns about Martha's care and support needs. The panel noted that there was no professional curiosity or follow up to the request for a safeguarding referral form which appeared to be a gap in the process.

Had a section 42 assessment been undertaken, this would have provided a statutory framework for information sharing to take place and may well have enabled a more holistic understanding of Martha's care and support needs, as well as the risk of domestic abuse that she faced. In Martha's case, the lack of information sharing led to no single agency understanding the risks that she faced and her care and support needs were neither identified or addressed.

It was also noted that in Martha's case, practitioners had not updated the relationships section within the ASC records which prevented Martha's record from being linked with her adult daughter's record. Her adult daughter was already known to ASC in relation to concerns about domestic abuse. Had the records been linked, it may have prompted the practitioner to carry out further checks with respect to whether the adult daughter, or any children she may have had, were at risk of harm.

The panel noted that there have been a number of changes in working practice since Martha's death in 2022. This includes additional domestic abuse training for all MASH staff and the appointment of an IDVA to work within the MASH to provide the relevant expertise to support both victims and frontline line decision makers.

Recommendation 7

ASC should reassure itself that the measures are in place to ensure that safeguarding referral requests are followed up and completed appropriately and in a timely fashion.

Recommendation 8

ASC should ensure that relevant practitioners accurately record relationships within the Swift system to reflect family members known or not known to ASC.

Working together for a safer county
SAFERNORTHUMBERLAND

Appendix 1, Table of Recommendations

No.	Recommendation.	Theme.	Agency.
1	The Domestic Abuse Board should seek reassure from relevant agencies that frontline practitioners have the skills, knowledge and confidence to identify service users who use alcohol as a coping mechanism.	Substance misuse	Northumberland Domestic Abuse Local Partnership Board.
2	The Domestic Abuse Board should satisfy itself that relevant practitioners across each agency understand how to make referrals to specialist services to support individuals who use alcohol as a coping mechanism.	Substance misuse	Northumberland Domestic Abuse Local Partnership Board.
3	The Domestic Abuse Board should seek reassurance from agencies that relevant practitioners understand the impact that compulsive behaviours may have on an individual's decision-making capacity.	Professional curiosity and mental capacity	Northumberland Domestic Abuse Local Partnership Board.
4	The Domestic Abuse Board should seek reassurance from each agency that relevant practitioners understand the impact of controlling behaviour, including financial abuse, on victims of domestic abuse and their ability to disclose abuse or seek help.	Identifying and referring domestic abuse	Northumberland Domestic Abuse Local Partnership Board.
5	Health agencies should ensure that relevant practitioners carry out the appropriate routine or targeted enquiries in line with local policy and procedures, to better understand the risk of domestic abuse faced by service users.	Identifying and referring domestic abuse	NHCFT. ICB.
6	Agencies should satisfy themselves that frontline practitioners understand when the lack of consent to share information relating to adults at risk with partners should be overridden.	Information sharing	Police. ASC. ICB.

7	ASC should reassure itself that the measures are in place to ensure that safeguarding referral requests are followed up and completed appropriately and in a timely fashion.	Adult safeguarding	ASC.
8	ASC should ensure that relevant practitioners accurately record relationships within the Swift system to reflect family members known or not known to ASC.	Adult safeguarding	ASC.

Appendix 2, Terms of Reference

1. Background

1.1 The chair of the Safer Northumberland Partnership, (SNP), has commissioned this DARDR in response to the death of Martha. Martha's death would appear to be suicide through an overdose of paracetamol but the inquest into her death has yet to be concluded. The death falls within the statutory parameters for a DARDR as there are believed to be causal links between Martha's death and domestic abuse she suffered in her relationship with her husband.

1.2 Martha was 51 years old at the time of her death, she was married to her husband Malcolm, who was also 51 years old. Martha and Malcolm had two adult children, a daughter, Melissa, who was 29 years old when Martha died, and a son, Mark, who was 32 years old. Both adult children were living at separate addresses to their parents.

1.3 Martha and her husband Malcolm were known to services, including in relation to allegations of domestic abuse. Malcolm had a previous caution for an offence of domestic assault on Martha.

1.4 On a date in mid-October 2022, Martha was taken to the Northumbria Specialist Emergency Care Hospital, NSECH, where she sadly died on two days later. At the time of her admission to the NSECH, Martha made disclosures about her husband Malcolm being verbally and physically abusive towards her and that she had taken an overdose as she did not want to live anymore. This provided a clear causal link between domestic abuse and her death.

1.5 The SNP was informed of Martha's death on 21 October 2022. A senior SNP management meeting, held on 9 December 2022, determined that this case met the criteria for a DARDR, in accordance with section 9 of the Domestic Violence, Crime and Victims Act 2004. This decision, was subsequently ratified by the SNP Chair.

1.6 The Home office was informed of the intention to commission the DARDR on 9 December 2022.

2. The Purpose of the DARDR

2.1 The purpose of the review is to;

i. to establish the facts that led to Martha's death in October 2022, and produce a comprehensive and balanced analysis of the information to inform organisational learning and influence change.

i. establish what lessons can be learned from Martha's suicide with regard to the way in which local professionals and organisations work individually and together to safeguard the family;

ii. 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;

iii. apply these lessons to service responses, including changes to inform national and local policies and procedures as appropriate;

iv. prevent domestic violence, homicide and improve service responses for all domestic 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;

v. identify potential gaps in service provision and/or potential barriers to accessing services;

vi. contribute to a better understanding of the nature of domestic violence and abuse;

vii. highlight good practice.

viii. The key reason for undertaking a DARDR where a person has died through suicide because of domestic abuse, is to enable lessons to be learned through professionals being able to understand what happened and most importantly, what needs to change to reduce the risk of similar tragedies happening in the future. The DARDR is not an enquiry into how a victim of abuse died or who may be responsible.

3. The Focus of the DARDR

3.1 This review will establish whether any agency or agencies identified potential and/or actual domestic abuse that may have been relevant to the death of Martha.

3.2 If such abuse took place and was not identified, the review will consider why not and how such abuse can be identified in future cases.

3.3 If domestic abuse was identified, this review will focus on whether each agency's response to it was in accordance with its own and multi-agency policies, protocols and procedures in existence at the time. In particular, if domestic abuse was

identified, the review will examine the method used to assess risk and the action plan put in place to reduce that risk. This review will also take into account current legislation and best practice. The review will examine how any pattern of domestic abuse was recorded and what information was shared with other agencies.

4. DARDR Methodology

4.1 This review will be based on IMRs provided by the agencies that were notified of or had contact with Martha, or her husband Malcolm, the perpetrator of abuse, in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse, e.g., mental health, alcohol or substance misuse. Each IMR will be prepared by an appropriately skilled person who has not had any direct involvement with Martha or Malcolm, and who is not an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR.

4.2 Independent Management Reports, (IMRs), must be submitted using the approved templates current at the time of completion.

4.3 Each IMR will include a chronology, a genogram, (if relevant), and analysis of the service provided by the agency submitting it. The IMR will highlight both good and unsatisfactory practice, and will make recommendations for the individual agency and, where relevant, for multi-agency working. The IMR will also provide context through including information relating to resourcing, workload, supervision, support and training/experience of the professionals involved.

4.4 Each agency required to complete an IMR must include all information held about Martha and Malcolm from 1 August 2017 to Martha's death in October 2022. If any information relating to Martha as the victim or Malcolm as the perpetrator, or vice versa, of domestic abuse before August 2017, comes to light, that should also be included in the IMR.

4.5 Information held by an agency that has been required to complete an IMR, which is relevant to the death of Martha, must be included in full. This might include for example: previous incidents of abuse (as a victim or perpetrator), alcohol or substance misuse, or mental health issues relating to Martha or Malcolm. If the information is not relevant to the circumstances or nature of Martha's death, a brief precis of it will suffice.

4.6 Any issues relating to equality, for example disability, cultural and faith matters, should also be considered by the author of an IMR. If none are relevant, a statement to the effect that these have been considered must be included.

4.7 When each agency that has been required to submit an IMR does so in accordance with the agreed timescale, the IMRs will be considered at a meeting of the DARDR panel and an overview report will then be drafted by the chair of the panel. The draft overview report will then be considered at a further DARDR review panel meeting before a final, agreed version is submitted to the chair of the SNP.

4.8 The report author will conduct relevant research and include lessons learned from previous DHRs where similar issues are identified.

Family Involvement

5.1 Engagement with the family and friends of Martha is an important part of this review. They will be given the opportunity to make a meaningful and effective contribution to the process and where appropriate, specialist support to enable them to fully engage with the review.

5.2 The independent chair will ensure that there is an effective communication strategy in place to keep the family informed, if they so wish, throughout the process, being sensitive to their wishes, support needs and any existing arrangements in place to do this.

Timescales, Report Author and Final Report

6.1 Home Office guidance requires the review to be completed within six months of the first review panel meeting; it is our intention to meet this requirement.

6.2 The report will be a transparent, honest and thorough analysis of the circumstances to inform learning and influence change as appropriate.

6.3 Any learning points will be considered and agreed by the review panel before being included in the final report and subsequent action plans. Should any urgent learning points or issues to be addressed be identified, they will be brought to the attention of the SNP Chair to enable sharing prior to Home Office approval of the final report.

6.4 The SNP Chair will send a copy of the final report, together with any action plan, to relevant agencies for comment before sign off and submission to the Home Office. Following Home Office approval, the SNP Chair will provide a copy of the overview report, executive summary and any action plan to the relevant senior manager of each participating agency.

6.5 The SNP Chair will send an anonymised copy of the final report to all relevant forums/stakeholders to share learning and where appropriate, influence priorities and work programmes.

6.6 The SNP Chair will publish an anonymised overview report and executive summary on the SNP website.

6.7 The SNP will be responsible for monitoring the delivery of any action plan in line with the guidance.

6.8 Subject to the recommendations of the review panel, the SNP Chair will hold a learning event if appropriate.

Parallel Reviews

7.1 There are no parallel reviews relating to the death of Martha. It is noted that the coroner's inquest has yet to be concluded.

Specific Issues to be Addressed

8.1 Specific issues that will be considered, and if relevant, addressed by each agency in their IMR are:

- Were practitioners sensitive to the needs of Martha and Malcolm, and were they knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to deliver against those expectations?
- Did practitioners have the knowledge and confidence to use the DASH, (Domestic Abuse, Stalking and Harassment), risk assessment for domestic abuse victims and perpetrators? If so, were those assessments correctly used in the case of Martha and Malcolm?
- Were Martha and/or Malcolm subject to MARAC, (Multi-Agency Risk Assessment Conference), or any other multi-agency forum?
- Did the agency comply with domestic violence and abuse protocols agreed with other agencies including any information sharing protocols?
- Were there missed opportunities for intervention? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in light of the assessments, given what was known or what should have been known at that time?
- When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they sign posted to other agencies?
- Was anything known about the perpetrator of abuse? For example, were they subject to MAPPA, (Multi-Agency Public Protection Arrangements), MATAC, (Multi-Agency Tasking and Coordination) or any other perpetrator intervention programme? Were there any injunctions or protection orders that were, or had previously been in place?
- Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration of vulnerability or disability necessary? Were any of the other protected characteristics relevant in this case?
- Had Martha made relevant disclosures to any practitioners or professionals and if so, was the response appropriate?
- Was this information recorded and shared, where appropriate?
- Were senior managers or other agencies/professionals involved at the appropriate points?

- Did staff involved have the necessary skills and training?
- Are there lessons to be learned from this case relating to the way in which an agency, or agencies, worked to safeguard the family and promote their welfare? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies or resourcing?
- Was Martha or Malcolm a mental health service user and if so, were their treatment/support needs being met appropriately?
- How accessible were services to Martha and Malcolm?
- Did any restructuring take place during the period under review and if so, is it likely to have had an impact on the quality of service delivered?
- Did the COVID-19 pandemic impact on the services provided to Martha and Malcolm?

Confidentiality

9.1 All information discussed or shared through the Domestic Homicide Review is **strictly confidential** and must not be disclosed to third parties without the prior agreement of the SNP Chair/DHR Panel Chair—in line with the confidentiality agreement that panel members and other participating individuals will be required to sign.

9.2 All documentation should be marked **Confidential draft-not to be disclosed without the consent of the Safer Northumberland Partnership.**

9.3 Each Agency is asked to adhere to their own data protection procedures, including the security of electronic data.

9.4 The draft overview report will remain a confidential document until it is approved for publication by the Home Office Quality Assurance Panel.