Safer Sheffield Partnership

A DOMESTIC HOMICIDE REVIEW (DHR)

‘Kirsten’

DHR V

October 2021

REPORT PRODUCED BY PETER MADDOCKS

INDEPENDENT AUTHOR AND PANEL CHAIR

February 2024

Contents

Introduction

1. The Safer Sheffield Partnership[1] that commissioned this DHR and the people who were involved in this review as well as those who knew 33-year-old Kirsten, offer their sincerest condolences to Kirsten's family, friends and loved ones for their loss following her tragic passing. We know from the notes that Kirsten left that she did not want to upset her family who remained important to her and who loved her. She missed her children who were no longer living with her at the time of her death. Kirsten is remembered as having "the biggest heart ever" and caring about other people despite the adversities in her life.

2. Kirsten died as a result of suicide having reached a point when she felt she could no longer go on. The focus of this review is on the cumulative impact on Kirsten of the controlling and coercive domestic abuse she was subjected to over many years from when she was a teenager. We have never forgotten that she was loved by those who were close to her. We hope those who knew Kirsten who read this report or the shorter executive summary feel we have told Kirsten's story with sensitivity. We have worked to make sure that we have understood what happened and want to make sure that where lessons can be learnt that this happens.

3. This report examines agency responses and support given to Kirsten, who lived in Sheffield after moving from the northeast in February 2019 with her 40-year-old partner Jake. Kirsten died from a fatal overdose in October 2021. Government guidance requires that if an adult takes their own life and the circumstances give rise to concern for example regarding evidence of domestic abuse, a DHR should be completed[2]. Kirsten's partner, Jake, had been convicted of assault and breaching court orders that are described later in the report.

4. The key purpose of undertaking DHRs is to enable lessons to be learned. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future

Timescales

[1] The community safety partnership set up under the Crime and Disorder Act 1998.
[2] The circumstances under which a domestic homicide review must be carried out are described in the Domestic Violence Crime and Victims Act 2004 and associated national guidance described in multi-agency statutory guidance for the conduct of domestic homicide reviews (December 2016).

5. The review began in March 2022. The review was completed in December 2022 although one of the services identified factual errors in the information that had been provided which required further work.

Confidentiality

6. The findings of a domestic homicide review are confidential as far as identifying Kirsten or Jake, their families or professionals. Information is available only to officers/professionals and their line managers who were involved.

7. Pseudonyms that were discussed with the family are used in the report to protect the identity of the people involved. This includes Natasha who lived on the same road as Kirsten and was the friend who summoned help when Kirsten took her overdose. Professionals are referred to by their roles such as GP, police officer or probation officer for example. The services that were involved are described in paragraph 25.

Methodology and terms of reference

8. The circumstances of Kirsten's death were reported to the Domestic Abuse Coordination Team in Sheffield City Council which manages the domestic homicide review process on behalf of the Safer Sheffield Partnership (SSP). It was agreed by the Sheffield DHR Consideration Panel that the criteria for a domestic homicide were met under paragraphs 5 and 18 of the statutory guidance.

9. The methodology of the review complies with national guidance. This includes identifying a suitably experienced and qualified independent person to chair the panel and to provide the overview report for publication described in paragraph 29. Agencies who had significant contact with Kirsten or Jake provided management reports against the terms of reference described in paragraph 12.

10. The initial scoping agreed on the list of services who would be asked to provide an individual management report if their involvement was significant; for services who had very brief contact a shorter statement of information was requested. Details are included in paragraph 26.

11. The timeline for the detailed analysis of information is from February 2019 when Kirsten and Jake arrived in Sheffield until Kirsten's death in October 2021.

12. Agencies contributing reports or information to the domestic homicide review used the following terms of reference to provide information and analysis for the domestic homicide review.

a) What contact, knowledge and information did services have that indicated, or could have indicated, that Kirsten was vulnerable to, or could be at risk from domestic abuse and what response was there? This should include whether relevant history was inquired about and considered alongside any enquiries or assessment of risk.
b) What contact, knowledge and information did services have with Kirsten that could have indicated a risk of self-harm and what response was there? What knowledge and consideration were explored about other potential risk factors including the use of substances and what response was there?
c) Did services manage to engage effectively enough with Kirsten? Was there enough understanding and sensitivity about potential barriers or difficulties in helping Kirsten? Are there any lessons to be identified about agency practice or policy?
d) Were there opportunities to complete a risk assessment about domestic abuse or self-harm? Was it completed? How effective was the assessment?
e) Was the MARAC effective in addressing how to keep Kirsten safe from domestic abuse? Was MARAC timely? Were the MARAC plans good enough with clear actions? What difference did MARAC make? What lessons can be identified?
f) What legal measures were used to stop Jake from abusing and harming Kirsten? Were these timely? Were they effective? What lessons can be identified?
g) What services were offered to Jake as a perpetrator of domestic abuse? What lessons can be identified?
h) What other services were offered to Jake to address his mental health and substance abuse? What lessons can be identified?
i) Was there ever any cause to escalate any issues to senior managers in the agency or with any other specialist professionals or organisations? If so, were there any barriers or evidence of delay in terms of escalating issues? What outcome was there? What lessons can be learned?
j) Were there issues about the capacity or resources of services that had an impact on the ability to help Kirsten or to prevent domestic abuse, or had an impact on the ability to work with other services? This should include a comment about the impact of Covid as well as the quality of supervisory or management oversight, and the extent to which professionals in the agency have enough training and understanding about domestic abuse, safeguarding and workload. This will include the response to the 999 calls on the day that Kirsten died. What lessons can be learned?
k) Were there any issues about the impact of any organisational changes covered by the period under review that influenced how the agency or partnership arrangements were operating?
l) What can be identified as good practice in this case?
m) Are there action(s) by the agency that in retrospect and with reflection might have led to better outcomes in this case? Why were these not considered/not taken at the time from the agency's perspective?
n) Identify any lessons to be learnt from the review for the agency to promote greater knowledge and understanding of domestic abuse processes and services. This should be explicit if any shortfalls in meeting standards have been identified as well as any gaps in policy, protocols or professional practice and understanding. This section should also link to any action being

taken by the agency or recommendations being made. Are there any repeated issues that were identified in earlier DHRs?

Scope of the review

13. The review considers the contact and involvement of 15 organisations with Kirsten and Jake, from February 2019 when Kirsten and Jake arrived in Sheffield up until Kirsten's death in October 2021. Additional information was sought from services outside Sheffield to provide history and context. This was primarily the police and probation service in northeast England where Kirsten and Jake were living until February 2019 and from the prison where Jake was remanded in June 2021 after he assaulted Kirsten.

14. The review takes account of the national guidance regarding any specific issues relevant to the circumstances of the review. Kirsten was the subject of a MARAC on three occasions between May 2020 and August 2021. Jake was prosecuted for assaulting Kirsten. He was subject to a Restraining Order which he breached and was convicted of harassment. The IDVA service was working with Kirsten at the time of her death.

15. Kirsten and Jake both had poor mental health and were on medication. They had both been referred to substance misuse services and both had a history of self-harm through overdose. This is explored in the report.

16. Panel membership has included professionals with specific expertise and knowledge to inform the learning from the review.

17. The review gave careful attention to how family members, friends or other support networks could contribute to the review described in the following section.

Involvement of family and friends

18. The independent reviewer and author of this report first spoke to Kirsten's sister in April 2022 to advise her and the family about the review. A letter with information about the review including the scope and terms of reference and details of advocacy and support available from organisations including AAFDA[3] was sent the day after the conversation with the contact details for the reviewer. Kirsten's family subsequently provided information for the review and had a copy of the draft report for a consultation about factual accuracy, analysis and conclusions.

19. Kirsten grew up in Northamptonshire and is where her mum, two sisters, brother and stepdad live. Kirsten met Jake when she was 17 years old and living with her birth father who was separated from her mum. There had

[3] Advocacy after fatal domestic abuse

been domestic abuse and Kirsten's birth dad misused alcohol. Kirsten's mum was worried about Kirsten's relationship with Jake who was in his mid-twenties when they met. The relationship developed quickly and Kirsten's pregnancy occurred early in the relationship with domestic abuse beginning during that pregnancy; these are significant risk markers discussed later in the report. The family sought help from local services some of which is reflected in historical information contained in agency records discussed later in the report although lacking detail. Information given to the review by Kirsten's family describes how Kirsten had believed very early in the relationship that she and Jake loved each other and Kirsten was increasingly isolated from her family by Jake. This was also a significant marker which is discussed later in the report. Kirsten and Jake moved to London which was the first of several moves to different locations in the country. These moves the family say occurred after Kirsten had been seriously assaulted and the couple had come to the attention of domestic abuse services in the area prompting a move to a new location. It is known that child protection services became involved in some of those areas leading eventually to Family Court proceedings.

20. Kirsten maintained some contact with her family which in later years had been mainly with her younger sister who had been 11 years old when Kirsten's relationship with Jake had begun. Kirsten would occasionally return to Northampton usually when she had become very frightened and was trying to leave the relationship. On each occasion Jake continued to contact Kirsten, often threatening to die by suicide (another warning marker discussed later in the report) and Kirsten would feel she had no option other than to return. Kirsten told her sister that she continued to love Jake throughout their relationship and she described it as Kirsten feeling "you are everything to the person who is trying to destroy you".

21. Kirsten and Jake had three children. The eldest was born in early 2007 and the youngest was born in 2011. Kirsten's family only ever saw the first child before Kirsten and Jake left Northampton for London after the first incidents of domestic abuse had been recorded by police in Northamptonshire. During a consultation with a SPA SMS[4] worker in February 2021, Kirsten said that her older children had been removed in 2009. Kirsten's family told the reviewer about their efforts to provide a home for the children when they became aware of Family Court proceedings. The family said they were told that they needed Jake's permission for this to happen and that he withheld that consent. The Family Court proceedings fall outside the scope of the review and therefore no further information has been sought about the circumstances of the proceedings and the family putting themselves forward as potential carers. Based on what the family say they do not appear to have been fully advised about the Family Court proceedings which would

[4] Single point of access substance misuse service (SPA SMS)

routinely explore all options for children unable to remain with their birth parents. It would be more usual practice for the court to be made aware of all potential options for caring for children and to direct assessments to be completed that balance a range of different issues that include the best interests of the child and the views of parents. A recommendation is included at the end of this report concerning the importance of domestic abuse advocates having access to advice and information to support the families affected by domestic abuse. The children are adopted.

22. Kirsten's last contact with her family was in September 2021 just before she died. Kirsten wanted to see her mum who suggested she join her and her stepdad on a week's break which she did. As will become clear from the information later in the report this followed Kirsten's first overdose in August 2021 which in turn had followed Jake being arrested earlier in the year for assaulting Kirsten and being remanded and subsequently convicted and made the subject of a Restraining Order.

23. Kirsten's family spoke positively of the support that was given to Kirsten by various domestic abuse services in Sheffield and the family commented that on previous occasions court action would probably have led to Jake and Kirsten leaving the city to move elsewhere. In hindsight, and after reading some of Kirsten's comments and notes to friends and families she came to a point in the late summer of 2021 of feeling she was never going to escape from Jake's abusive behaviour.

24. The reviewer contacted Natasha, Kirsten's friend who was with her on the day she took her fatal overdose. The reviewer sent a letter and information to Natasha including support that is available and how to contact the reviewer. The reviewer has phoned and sent messages to Natasha and although a date was agreed upon to talk with each other this appointment was not kept.

25. According to information recorded by the Probation Service, Jake is from the traveller community and is thought to have family links to the West Midlands. An induction pack completed by a probation officer in 2021 recorded that Jake was from an Irish traveller/ Roma / Gypsy background. Jake was brought up by an uncle whose identity and whereabouts are unknown. Attempts to find Jake and inform him about the DHR were unsuccessful. Jake's whereabouts were unknown at the time of the review. Contact details for any other family or friends are also unknown.

Contributors to the review

26. Over forty organisations were contacted as part of the original scoping for the review, to inquire about any contact and knowledge they had about Kirsten. Of those organisations, the following services confirmed having information relevant to the review and provided an individual management

review (IMR) that was written by authors who were independent of any contact or decision-making and had appropriate experience and expertise.

a) NHS South Yorkshire Integrated Care System; GP primary health care services; **Kirsten** was registered with **GP1** in December 2019; **Jake** was registered at **GP2** from July 2020 and had been assigned to the NHS special allocation scheme[5] since 2013 following a violent incident and removal from a GP patient list;
b) Crown Prosecution Service (CPS); Jake has been known since 1998 mainly in the West Midlands for acquisitive offending linked to his substance misuse. Jake was prosecuted for assault on Kirsten in June 2021 and was also convicted of harassment; he received a four-month prison sentence, suspended for 12 months.
c) IDAS (independent domestic abuse service); is a specialist domestic abuse charity working across Yorkshire providing domestic abuse community support across Sheffield since April 2019; Kirsten was known from April 2020 to October 2021;
d) Probation service (Sheffield); the national Delius system has records of contact dating from 1998 in Northampton, Sheffield and West Midlands; Between 1998 and 2006 there were eight offences which brought Jake into contact with probation for burglary and theft;
e) The Rotherham NHS Foundation Trust (TRFT); Kirsten had one hospital emergency attendance in August 2021 due to an overdose of medication. Jake had two attendances at the Emergency Department (ED) that led to admission to the hospital;
f) Shelter Sheffield Hub comprises a range of services including a Homeless Prevention and Resettlement Service and a Drug and Alcohol Prevention and Recovery Service; also, an Advice and Legal Team providing housing advice and legal representation; Kirsten and Jake initially came to Shelter in June 2019 for advice regarding their housing situation;
g) Sheffield Health and Social Care NHS Foundation Trust; Kirsten had contact for anxiety and substance misuse with IAPT, SPA[6] and SMS START[7]. Jake had contact with SPA, SMS START and the Crisis/out-of-hours service for anxiety, depression, autism and ADHD;
h) Sheffield Housing and Neighbourhood Services; Kirsten and Jake attended Sheffield housing as being homeless in early February 2019 after fleeing from Newcastle;
i) Sheffield Teaching Hospitals NHS Foundation Trust; Kirsten attended the emergency department (ED) and fracture clinic appointments in April 2020 with a head injury and disclosed domestic abuse and attended

[5] https://www.england.nhs.uk/contact-us/privacy-notice/how-we-use-your-information/safety-and-quality/if-you-are-a-patient-assigned-to-the-special-allocation-scheme/
[6] Single point of access
[7] Substance misuse services (SMS) which was provided through Sheffield Treatment and Recovery Team (START)

again in October 2021. Kirsten also attended two neurology out-patient appointments;

j) South Yorkshire Police (SYP); recorded 11 reported incidents of domestic abuse between 23rd July 2019 and 5th October 2021.

k) Yorkshire Ambulance Service (YAS); had four contacts with Kirsten and eight contacts with Jake.

27. Other services provided information but not IMRs. Adult social care had information recorded about the MARAC but had no involvement with either Kirsten or Jake. CAB had two contacts in April and August 2019 to help with benefits advice and food bank vouchers. The Department of Work and Pensions (DWP) had contact with Kirsten and Jake as claimants since March 2019. Information was sought from the Cathedral Archer Project that Kirsten and Jake visited between May 2019 and February 2020; information was also sought from the community support worker service (a referral was open for 21 days about housing advice from May 2019 to June 2019) and the prison where Jake was remanded between June 2021 when he was arrested for assaulting Kirsten and September 2021 when he was sentenced to a Community Order. The Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) had one contact with Kirsten via the hospital liaison team in August 2021 the day after she was admitted to the hospital in Rotherham having taken an overdose. Information about the circumstances of the overdose was not included in the information passed to the service and is explored in later sections of the report. Northumbria Police along with probation and domestic abuse services in the northeast provided written summaries. Information was provided by the Humber and South Yorkshire Magistrates Courts service about Jake's sentencing by the magistrate's court in Sheffield in September 2021. The first occasion on the 13th of September 2021 was for sentencing to a Community Order with requirements and a Restraining Order; the second occasion was on the 25th of September 2021 for breach of the Restraining Order.

The review panel membership

28. The first meeting of the panel was in May 2022. There were two further meetings of the panel in October 2022. All the panel members were independent of contact and decision-making and had relevant experience and expertise. The strategic lead for domestic abuse in South Yorkshire Police and the Humber and South Yorkshire Magistrates Courts Service was invited to participate in the panel meeting in October 2022 to assist in shaping recommendations and action from the DHR. Additionally, the independent reviewer attended a meeting of the Sheffield Domestic Abuse Strategic Board (local partnership board) in September 2022 to brief them about the issues, particularly about the workload and role of MARAC in helping identify markers of entrapment and high-risk, evidence-led investigation and coordination of responses to domestic abuse.

Name	Role	Organisation
Peter Maddocks	Chair and report author	Independent reviewer
Sam Goulding Chris Davies	Regional Manager Head of Client Services	Independent Domestic Abuse Service (IDAS)
Sally Adegbembo	Head of Probation Yorkshire and Humber	Probation Service
Sarah Guttman Ryan Gill	District Crown Prosecutor Senior District Crown Prosecutor	CPS
Joanna Stevens	Advanced Customer Support Senior Leader	DWP
Louise Bertman	Safeguarding nurse consultant	Rotherham Doncaster and South Humber NHS Foundation Trust
Lindsay Hood	MCA Lead and Named Nurse Adult Safeguarding	Rotherham NHS Foundation Trust
Sarah Fearon	Service Manager Tenancy Enforcement, Sustainment and Fraud Team	Sheffield Housing and Neighbourhood Services
Patrick Chisholm	Service Manager Legal Services	Sheffield City Council Legal
Dr Amy Lampard	Designated Doctor for Adult Safeguarding	NHS South Yorkshire Integrated Care System
Kitty Reilly	Designated Professional Safeguarding Adults	NHS South Yorkshire Integrated Care System
Stephanie Barker	Adult Safeguarding Advisor/Domestic Abuse Lead	Sheffield Health and Social Care (SHSC)
Christina Blaydon	Head of Safeguarding	Sheffield Teaching Hospital Foundation Trust (STHFT)
Katie Ryan	Service Manager	Shelter
Gary Thompson	Case Review and Policy Officer	South Yorkshire Police (SYP)

Catherine Holliday	Named Nurse for Safeguarding	Yorkshire Ambulance Service (YAS)
Alison Higgins	Strategic Commissioning Manager	Sheffield City Council – Domestic Abuse Commissioning Team (DACT)

The author of the overview report and chair of the review panel and the statement of independence

29. Peter Maddocks wrote this report. He has worked in local authority, voluntary and national services in senior and practitioner roles. These have included working with families and children harmed by domestic abuse including work on policy and service development as well as direct work. He is a qualified and registered social worker who continues to participate in regular professional training and development that includes domestic abuse. He has completed domestic homicide reviews with other community safety partnerships in England. He has not worked for any of the organisations that have contributed to this review and has not held any elected position in Sheffield or South Yorkshire. He is not related to any individual who either works or holds an elected office in Sheffield or South Yorkshire. He had completed one previous DHR in Sheffield.

Parallel reviews

30. The coroner was informed of the DHR. A documentary inquest was completed in July 2022[8]. The independent reviewer attended the inquest which concluded that Kirsten had died by suicide following a fatal overdose.

Equality and diversity

31. The review panel considered whether discrimination, harassment or victimisation relating to the protected characteristics set out in the Equality Act applied to Kirsten or Jake and whether for example there were lessons for how reasonable adjustments should be used or the public sector equality duty was understood and applied. Jake for example had long-term mental conditions although it was the impact of substance use which adversely effected his day-to-day activity. The panel considered how disadvantage and inequality applied to Kirsten and Jake and highlighted examples in the report of where help could have been better

[8] Documentary inquests, also known as 'short form of or rule 23 inquests', are inquests which do not require witnesses to attend to give evidence and are conducted using documentary evidence only. A documentary inquest may be held where a coroner is satisfied that the statements of witnesses are not contentious and that there is good and sufficient reason why the makers of the statements should not attend.

32. Kirsten was white British, English-speaking and grew up in Northampton where her family still live. Kirsten told her GP in May 2019 that she enjoyed reading.

33. Jake was born in Birmingham and is from the gipsy / Roma / Irish traveller community[9] and moved around the country but retained links with the West Midlands. He is also an English speaker. There is no information about Jake's literacy.

34. Kirsten and Jake had three children who were removed through Family Court proceedings and placed for adoption before they arrived in Sheffield.

35. There is no record of a formal or informal religious affiliation or faith for either Kirsten or Jake. They were not registered as disabled although the GP had information that Jake had been diagnosed with a hearing impairment and there is a reference to Jake saying he had been diagnosed with autism and ADHD in childhood.

36. People with an autism spectrum disorder (ASD) may behave, communicate, interact, and learn in ways that are different from most other people. The abilities of people with ASD can vary significantly. For example, some people with ASD may have advanced conversation skills whereas others may be nonverbal. Some people with ASD need a lot of help in their daily lives; others can work and live with little to no support. As children with ASD become adolescents and young adults, they may have difficulties developing and maintaining friendships, communicating with peers and adults, or understanding what behaviours are expected in school on the job or in relationships. They may come to the attention of healthcare providers because they also have conditions such as anxiety, depression, or attention-deficit/hyperactivity disorder, which occur more often in people with ASD than in people without ASD.

37. People with ADHD are more likely to experience difficulties with their mental health. Some adults who have the condition were not diagnosed as children. ADHD can present with a variety of symptoms including poor listening skills, impatience, mood swings, irritability and risk-taking.

38. Kirsten and Jake suffered from poor mental health but neither was diagnosed with a mental illness or disorder (Jake was awaiting allocation to a psychiatrist).

39. A mental health assessment by the SPA (single-point access to mental health services) in 2021 recorded that Jake's mum had multiple health needs and as she got older, she had become almost blind in addition to

[9] https://www.ethnicity-facts-figures.service.gov.uk/summaries/gypsy-roma-irish-traveller

being deaf and having no speech. Jake had infrequent contact with her and admitted he found it difficult seeing her. He left the family as soon as he was 18 years old. Jake told the SPA assessor that he had used different names over the years and also used two different dates of birth. No other services had been told this. During the same assessment, Jake talked of having no hobbies or interests other than playing on his X-box for several hours a day. Jake had lived with an uncle. He was looked after by the local authority for about three months. Jake cited an experience of childhood physical abuse for ruining his ability to pursue his ambition to join the army; he was in the army cadets as a juvenile. The same assessment identified that Jake exhibited possible emotionally unstable personality disorder or anti-social personality traits and reported having a diagnosis of ADHD as a child.

40. The Housing and Neighbourhood Service had recorded a code relating to mental health issues for Jake when the couple contacted homeless services on 5th December 2019. The records show autism, epilepsy, asthma, anxiety, and depression. The GP records include a reference to Jake having a hearing loss recorded in 1994.

41. Jake told Northumbria Police that he was bipolar and repeated it to South Yorkshire Police in November 2020 but there is no other record of this from any other service although he was waiting for a psychiatric assessment for several months before Kirsten's death.

42. The probation pre-sentence report written in August 2021 includes information about Jake being part of the travelling community moving throughout the country. Jake described his adverse childhood that according to the probation officer's assessment has had a lasting impact on Jake and his emotional wellbeing. His mum was unable to care for Jake partially because of his behaviour and her health difficulties, including being deaf and unable to speak. Jake grew up with his grandmother and uncle and became a looked-after child for a while. There is no information about Jake's father recorded by any service.

43. At Shelter Jake described having autism, depression and anxiety. He struggled with communication and was reliant on Kirsten's help. Jake needed routines and if things did not work out or happen as he expected he could become physically aggressive. Staff at Shelter never saw this behaviour although it was displayed with health care staff and Jake was registered with the primary care violent patient scheme. Apart from a letter from a neurology nurse specialist to the GP suggesting Jake may have additional needs including autism and ADHD, there is no other reference to the history in medical records or of the additional needs being addressed.

44. Shelter advised and supported Jake's application and the successful award of a back-dated personal independence payment (PIP). Kirsten described

herself as a carer for Jake and this was a role that was acknowledged by health professionals in contact with Jake in particular. Jake did not have any assessment under the Care Act 2014 to establish if he had care and support needs and a carers assessment was not considered and therefore offered to Kirsten at any stage. The Sheffield Carers Centre offers such assessments in the city. A previous DHR in Sheffield had made recommendations for improvement in local practice.

45. Yorkshire and Humber along with the North East and South West have higher rates of death by suicide compared to other English regions[10] although Sheffield is below the national average.

46. There is a strong correlation between deprivation, domestic abuse, poor health and suicide. Kirsten and Jake lived in an area of Sheffield that is in the highest 27 per cent of deprivation in England[11]. About a third of Sheffield residents live in the 20 per cent most deprived areas of England.

47. It's been well known for some time that suicide is an *inequality* issue as disadvantage and vulnerability, including losing a job or being unemployed, being in debt and having insecure housing, make it more likely to die by suicide. Rates of hospitalised self-harm are also twice as high in the most deprived neighbourhoods compared to the most affluent, which is significant because more than 50 per cent of people who die by suicide have previously self-harmed[12].

48. Intersectionality describes the interconnection of various factors including race, class, and gender among an individual or group. It is often related to an experience of discrimination or a disadvantage. Not all victims experience domestic abuse in similar circumstances. Personal histories of adverse childhood experiences (ACEs), poverty and housing insecurity can all contribute to a feeling of expendability and are reflected in the circumstances of Kirsten and Jake.

49. Being female is a significant risk factor for being a victim of domestic abuse; women are more likely than men to be subject to abuse. Poverty or lack of access to financial or social resources contributes to dependency on a violent partner as a risk factor. This was a factor for Kirsten. It impacts women's health and independence, reduces their ability to work and creates a cycle of economic dependence. Women's inequality limits their ability to escape from relationships with perpetrators who are abusing them; it can make it more difficult for them to assert their rights and are more likely to

[10] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2020registrations
[11] ONS Postcode Database
[12] https://nspa.org.uk/wpcontent/uploads/2021/04/NSPA_InfoSheet_SocioeconomicDeprivationSuicidalBehaviour_v1.pdf

experience sexual harassment and violence. Women like Kirsten who report that they are in poor emotional, mental or physical health have suffered more than twice the rate of domestic abuse and stalking than women who report that they are in good health.

50. Women are around twice as likely to experience domestic abuse and men are far more likely to be perpetrators. Most domestic homicide victims are women, killed by men[13]. On average, two women are killed each week by their current or former partner in England and Wales, a figure that has changed relatively little in recent years[14]. It impacts women's health and independence, reduces their ability to work and creates a cycle of economic dependence. Women's inequality limits their ability to escape from relationships with perpetrators of domestic abuse; it can make it more difficult for them to enforce their rights and more likely to experience sexual harassment and violence.

51. Domestic violence often starts early in the life of those relationships where it is present and is reflected in this relationship although unbeknown to people working with Kirsten in Sheffield. The presence of children in the household is associated with nearly double the risk of domestic abuse for women and again is reflected in the circumstances of Kirsten and Jake.

52. Women who report having poor health have suffered more than twice the rate of domestic abuse and stalking than women who report that they are in good health[15].

53. Kirsten had presented to her GP with symptoms of low mood and had been referred to a talking therapy service. She was prescribed anti-depressant medication at different times. She was never diagnosed with a mental illness or disorder and she was not diagnosed with self-harming behaviour or suicidal ideation.

54. Domestic abuse is a very significant although often unrecognised issue for mental health care services. Some research studies put the number of women mental health patients being subjected to domestic abuse as high as 69 per cent[16]. Other research provides evidence that a significant risk

[13] Office for National Statistics. 'Domestic Abuse in England and Wales'. 2018. Crown Prosecution Service 'Violence against women and girls report.' 2018.
[14] Office for National Statistics 'Crime Statistics, Focus on Violent Crime and Sexual Offences, Year ending March 2016, Chapter 2: Homicide'. 2016
[15] Walby, S. and Allen, J. (2004). Domestic violence, sexual assault and stalking: findings from the British Crime Survey. London: Home Office.
[16] Khalifeh. H, Moran. P, Borschmann R, Dean. K. (2014) Domestic and sexual violence against patients with severe mental illness, Psychological Medicine, Volume 45, Issue 4 March 2015, pp. 875-886

factor for attempting suicide is a prior history of experiencing intimate partner violence (IPV)[17].

55. Depression and suicide are significant health problems, particularly for women. Notably, in studies, the experience of domestic abuse is strongly and consistently associated with both depressive disorders and suicide in a report that attracted considerable policy attention at the time, Sylvia Walby extrapolated from research conducted elsewhere to suggest that more than one-third of female suicides in England and Wales are partly caused by women like Kirsten having been subjected to domestic abuse[18]. There are, of course, several factors that contribute to a person's decision to take, or attempt to take their own life. Nonetheless, research has established a significant negative physical and psychological health effect associated with experiencing domestic abuse[19]. Across several studies, women who experience intimate partner abuse are more likely than their non-abused counterparts to attempt suicide[20]. More recent research by others including the Refuge study (2018, Atkins and Munro) and work by Monckton Smith develops this further and is cited later in this report.

56. Mental illness associated with being a perpetrator of domestic abuse can be a significant risk factor not restricted to a specific condition such as psychopathy. Threats or attempts to die by suicide, far-reaching dependency on their victim and fear of abandonment are identified in men who had killed partners.[21] Jake was highly dependent on Kirsten; a fact recognised by several professionals.

Dissemination

57. In addition to Kirsten's family, all organisations that participated in the review will receive a copy of the published overview report including services that provided information but were not participants in the panel. This includes HMP Doncaster, the Prison and Probation Service, and the Yorkshire Prisons Group Regional Office. The report will also be sent to the Domestic Abuse Commissioner, the Sheffield Domestic Abuse Strategic Board, the

[17] Stark, E., & Flitcraft, A. (1996). Women at risk: Domestic violence and women's health. Thousand Oaks, CA: Sage.
[18] Walby, S (2004) The Cost of Domestic Violence. London: Women and Equality Unit. Cited by Munro VE, Aitken R. From hoping to help: Identifying and responding to suicidality amongst victims of domestic abuse. International Review of Victimology. 2020; 26(1):29-49. doi:10.1177/0269758018824160.
[19] Oram, S, Khalifeh, H, Howard, L (2017) Violence against women and mental health. Lancet Psychiatry 4(2): 159–170
[20] Blasco-Ros, C, Sanchez-Lorente, S, Martinez, M (2010) Recovery from depressive symptoms, state anxiety and post-traumatic stress disorder in women exposed to physical and psychological, but not to psychological intimate partner violence alone: A longitudinal study. BMC Psychiatry 10: 98. Available at https://bmcpsychiatry.biomedcentral.com/articles/10.1186/1471-244X-10-98 (accessed 9th November 2021).
[21] Monkton-Smith, J, Williams, A and Mullane, F, 2014 Domestic Abuse, Homicide and Gender Strategies for Policy and Practice Palgrave Macmillan p55.

chief officers of the Safer Sheffield Partnership who are Sheffield City Council, South Yorkshire Police, NHS South Yorkshire Integrated Care System, and South Yorkshire Fire and Rescue Service and the Probation Service. Additionally, the report will be sent to the South Yorkshire Police Crime Commissioner, the Sheffield Suicide Prevention Steering Group, the Sheffield Health and Wellbeing Board, the Sheffield Child Safeguarding Partnership, the Sheffield Drug Strategy Implementation Group and the Sheffield Adult Safeguarding Partnership. A copy of the report will also be provided to HM Courts and Tribunal Service and the Chair of the Magistrates Association.

The chronology

58. Kirsten and Jake moved to Sheffield in February 2019. When they first contacted local housing services as being homeless, they described having to flee their previous address in the northeast due to community harassment and threats. They were provided with temporary housing and were put in contact with Shelter to provide advice, support and advocacy over the following months.

59. Kirsten's initial contact with primary health care was at a walk-in centre on the 20th of February 2019 when she complained of lower back pain and a limp. There is no record of inquiry about the circumstances for having pain and a limp or whether she was seen alone; analgesics were prescribed. Kirsten was registered with a GP by the end of February 2019. Early consultations focussed on her anxiety and Kirsten's wish to have prescriptions for mirtazapine and pregabalin. The GP discussed IAPT with Kirsten who said that she had tried therapy in Newcastle but had not "gelled" with the therapist. Although there was a discussion about Kirsten's relationship with an unnamed partner over 13 years and that her children had been adopted there is no record of further inquiry about this or domestic abuse.

60. A GP consultation in April 2019 noted Kirsten's good eye contact and self-care but disclosed that her living conditions were not good with neighbours using drugs and fighting and her (unnamed) partner was struggling with autism. Neither had contact with their respective families. Kirsten disclosed previous self-harm and overdoses when she felt isolated. During a GP consultation in July 2019, Kirsten disclosed that her partner (still unnamed) was using spice (a psychoactive drug)[22] and Kirsten was finding it difficult to cope with him; she disclosed previous domestic abuse saying she "had not been hit for a long time" and would "not put up with it". It was confirmed that she had the contact number for a local domestic abuse service. Kirsten wanted to get involved in activities away from people misusing substances;

[22] Spice, synthetic cannabinoids are lab-made drugs that are prevalent in some of the most ignored and vulnerable communities particularly street homeless and prisons.

Kirsten enjoyed reading and colouring and agreed with a plan to contact IAPT (which was subsequently done in late December 2019). A consultation less than two weeks later the 23rd of May 2019 included a request to replace her mirtazapine which she reported leaving at her family's home in Northamptonshire. She reported having recent thoughts about self–harm and had intended to cut herself until Jake had intervened when he returned home. Although there was discussion about strategies to deal with her thoughts of self-harm and making sure Kirsten had information about local services including the Samaritans there was no record of discussion, attempted or otherwise, about domestic abuse.

61. In early June 2019, Kirsten and Jake were advised that they could not remain in the temporary accommodation and were advised by the housing service that they should return to Newcastle. Shelter provided legal support for a "202 review"[23] and negotiated an extension to their temporary accommodation.

62. Three days later Kirsten consulted the GP about her mental health and an unrelated infection. Kirsten told the GP that she sometimes visited the Cathedral Archer Project; she discussed the recent threat of eviction and the support being given by Shelter. Kirsten said that she had "sorted things out with her partner" who was going to stop using Spice. Kirsten was to continue with her prescription which would be reviewed four weeks later. At the next GP consultation in early July 2019, Kirsten reported that her partner (still unnamed) was continuing to use Spice. She reported being stressed by the threat of being forced to return to Newcastle given they continued to have verbal and physical threats directed at them. The GP agreed to provide a letter of support for the "202 reviews" describing the adverse impact on Kirsten's mental health and concerns about self-harm.

63. In late July 2019, whilst walking through the city centre, Kirsten and Jake were observed having a verbal argument which was captured by CCTV. Jake was also seen by the CCTV operative to self-harm by hitting his head against a bench and the police were summoned. The couple stated that they had recently moved down from Newcastle to Sheffield. There were no previous incidents recorded by South Yorkshire Police. Jake was checked over by paramedics but he declined to attend the hospital; he was happy for paramedic observations to be completed, his head injury to be examined and a plaster to be applied to a cut. Kirsten was also spoken to by officers on her own and she said was "happy" to be in the company of Jake. A DASH was completed at standard and a VA (vulnerable adult) referral was sent to social care along with information that he was not able to use GP and

[23] Under section 202 of the Housing Act 1996 applicants have a right to request an internal review of most local authority homelessness decisions. The review is carried out by the authority that made the decision, which should follow a specific procedure.

hospital services under the NHS special allocation scheme referenced earlier in the report.

64. Kirsten missed her scheduled monthly appointment with the GP but visited the drop-in four days later reporting that she had lost all of her medication. Kirsten reported that her (still unnamed) partner was on the special allocation scheme (previously a violent patient scheme) and found it difficult to get support and was using Spice. During this consultation, Kirsten said that she was originally from Northampton but had no contact with her family since she was 17. This contradicted information earlier in the year that she had left medication at her family's home when visiting.

65. Jake's medical notes were processed by the primary care service in late August 2019. It confirmed he was registered with the special allocation scheme. The notes refer to Jake having asthma and hearing loss (diagnosed in 1994), a history of self-harm and poor mental health.

66. In early September 2019, a third-party report was made to the police of a female screaming and shouting for the police. Kirsten and Jake had left the property separately. Police attended and while there, Kirsten and Jake both returned together. Officers spoke to them separately and they stated that there had been no argument or assaults and that they had been "messing around" and "play fighting". Kirsten said she had not shouted for the police but had said "please, not police". Neither Kirsty nor Jake had visible injuries. A DASH was completed at a standard level with Kirsten declining to answer any questions.

67. In mid-September 2019 Jake attended a GP appointment to discuss his anxiety and depression. He described suffering several seizures during the year involving going blank and falling to the floor with shaking arms and legs. He sometimes experienced incontinence and bit his tongue. He denied illicit substance misuse or drinking alcohol. He asked for sleeping tablets and a sick note. A provisional diagnosis of epilepsy was discussed with a referral made to the epilepsy clinic.

68. In early October 2019, having had the original housing decision changed by the 202 reviews Kirsten and Jake accepted the tenancy of the property where Kirsten lived until her death.

69. In mid-November 2019 the police responded to reports of an altercation at Kirsten and Jake's home. According to the initial offence information the response officers noted red marks on Kirsten's neck although there was nothing further recorded in the subsequent record of investigation and no mention of a mark. A DASH was completed at a medium level. Jake was arrested and taken into custody. A 14-day DVPO was granted by Sheffield Magistrates Court on 12th November 2019. A referral was not sent to IDAS who were notified about the DVPO by a notification from the court. This did

not include contact details for Kirsten and no contact was made with Kirsten. The police closed the case due to “evidential difficulties preventing further action”. The significance of possible non-fatal strangulation is discussed in other parts of the report given its link as a precursor to more serious offending and the adverse health consequences of whether the strangulation is fatal or not. NFS did not become an offence until June 2022 with the implementation of the Domestic Abuse Act 2021.

70. Shelter's support worker’s updated risk assessment in early January 2020 recorded that both Kirsten and Jake felt in need of mental health support. It noted that Jake had not used Spice for about a week and that he said he was engaging with health services. The assessment recorded Kirsten as Jake’s carer. The risk assessment described action to be taken in response to Jake’s seizures.

71. The housing officer’s annual tenancy visit in early 2020 found Jake in a very agitated state, jumping around, and ranting that the officer had “knocked on the door as police do”. He had shut the door and then opened it again to rant again, at which point Kirsten came to the door and told Jake to go into the bedroom, which he did and she shut the bedroom door and spoke to the officer on the doorstep. Kirsten advised that Shelter were working with them and gave the name of the support worker.

72. In late January 2020, Kirsten was referred to the IAPT by the GP. She did not attend the first appointment ten days later and she was discharged from the service without any follow-up. The panel discussed this as an example of where for example reasonable adjustments under the Equality Act should expect to see a more proactive approach to the management of appointments whether or not it is linked to a protected characteristic and therefore a legal requirement such as helping people with a disability make it to an appointment. The proactive practice would establish if factors were putting a patient at a disadvantage that would include any of the protected characteristics set out in the Equality Act[24] In this case, there was no inquiry from anybody as to why Kirsten did not keep her appointment.

73. In mid-February 2020 a complaint recorded as ASB (anti-social behaviour) was made to the housing service. This complaint related to the smell of drugs, multiple visitors to the property who only stayed a brief time and allegations of drug dealing. Housing officers spoke to Kirsten on 18th February 2020 and she admitted to smoking cannabis and said it was for medicinal purposes to help with her anxiety. On 25th February 2020, the complainant contacted the service again to say that they had been threatened by Jake. It was the same complainant who would contact the service again in June 2020 (24th) to say that Jake had been arrested for

[24] it is unlawful to discriminate against someone on the grounds of any of these characteristics: age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion/belief, sex (gender) and sexual orientation.

assaulting Kirsten; they had heard Kirsten shouting and screaming at him to stop (para 71).

74. In late March 2020, the police responded to a third-party report from neighbours who could hear a couple shouting and arguing for over two hours. When police officers attended, they could hear an argument from within the property. They spoke to Kirsten and Jake who stated it was a "verbal argument only" and did not disclose any threats or violence. A DASH was completed at the standard level. A negative PNB[25] was obtained and "words of advice" were given to both Jake and Kirsten. A copy of the victim domestic abuse booklet was sent out later to the address.

75. In mid-April 2020, just over two weeks after the previous incident, the police responded to a further third-party report of a domestic abuse incident taking place. In the police attendance, both Kirsten and Jake accused the other of assault. Jake had initially said that he had fallen causing the cut to his forehead although following his arrest he accused Kirsten of hitting him over the head with a weighted dumbbell. Kirsten stated Jake had caused the injury to himself whilst he had repeatedly punched and hit her around the face and head. Kirsten had a bruise on her left cheek. Kirsten was transferred to emergency housing by officers at a location unknown to Jake. Jake was initially detained but subsequently released with bail conditions to have no direct/indirect contact with Kirsten. Kirsten agreed to engage with support services. Referrals were submitted to Sheffield IDVA (IDAS) services & MARAC. The Clare's Law single point of contact (spoc) was tasked due to Jake's offending history and Kirsten claiming to be unaware although was subsequently rescinded given evidence of the previous history of contact about domestic abuse with Kirsten and Jake. The DARA team reviewed the incident and queried whether a DVDS disclosure should be provided to Kirsten. This was declined by the DI "due to the length of the relationship" and a non-crime was filed with no disclosure. A high-risk DA marker was added to Smart Contact (the police online portal) for six months (on the offender's address due to Kirsten currently being in safe housing (a hotel). IDAS attempted to call Kirsten without success to arrange food and offer support on the day of the referral. Three days later Kirsten told IDAS that she was withdrawing support for criminal proceedings. Kirsten was offered an assessment and ongoing telephone contact both of which were declined. The police were informed that Kirsten no longer wished to make a statement and wanted to "re-kindle" the relationship.

76. The incident was discussed at MARAC a month later on the 19th of May 2020. A summary of the incident is recorded in the MARAC minutes along with the incidents recorded in July and November 2019. There is no record of information from the PNC being shared at the meeting and although there is a reference to "historic DV" no detail is recorded about any of the

[25] This is a reference to a negative pocket notebook entry by the officer noting that an aggrieved party does not wish pursue a complaint and no statement has been taken.

respective histories of abuse from before Kirsten and Jake arrived in Sheffield in February 2019. There is a reference to Jake having a criminal record with several police forces but no other detail is recorded and therefore communicated to the participating services. The action plan was to "update Kirsten on the MARAC, flag to the local neighbourhood officer to try to discover Kirsten's current location and flag and tag local services".

77. On the 24th of June 2020, a member of the public contacted the housing and neighbourhood service to report that a man (Jake) had been arrested for beating up a woman (Kirsten) who lived at the address and had heard the woman shouting and screaming at him to stop. The call was logged as anti-social behaviour. There was no contact with the police from Kirsten or anybody else on that date and may therefore have been a reference to the incident in April 2020. The information although recorded by the housing service was not reported to the police; there was no discussion with Shelter who had been providing advice and tenancy support; it did not lead to any inquiry with IDAS about whether Kirsten was currently known to the service.

78. In mid-September, 2020 people living on the road complained to the housing service about noise nuisance and multiple visitors to the property in breach of Covid regulations in place at the time. There was no attempt to speak to Kirsten or Jake and the complaint was closed.

79. Shelter was continuing to give support in resolving the couple's financial difficulties which included securing enhanced payments for daily living. In early October 2020, Jake was awarded the personal independence payment (PIP) at the enhanced rate and backdated with a payment of just over £4000[26].

80. On the 17th of November 2020, the police responded to a third-party report of an ongoing disturbance at Kirsten and Jake's home. The response officers heard Kirsten shout "just get away from me". Kirsten and Jake were spoken to separately. Kirsten was initially observed to have reddening marks on her neck (an indication of non-fatal strangulation) and her nose was marked. The attending police officer stated that when Kirsten was seen in different lighting there were no marks on her neck and that Kirsten stated that the mark on her nose was from wearing spectacles which the officer believed to be consistent with the marks. Kirsten denied being assaulted. Kirsten and Jake both stated that the argument had been verbal despite the physical marks and denied any assault had taken place. A DASH was completed at medium and a referral was made to the IDAS service on the 24th of April 2020 and a case note warning marker was recorded by the MARAC coordinator on the 30th of December 2020.

[26] Personal Independence Payment (PIP) are to help with extra living costs for people who have both: a long-term physical or mental health condition or disability and difficulty doing certain everyday tasks or getting around because of the condition

81. The SPA processed a vulnerable person (VA) referral from the police on the 21st of November 2020. The VA recorded concerns from the police about Jake's mental health whilst in custody. Jake had disclosed having a split personality disorder, ADHD, bipolar and depression PTSD from being locked in rooms as a child. He had also disclosed his history of being prescribed medication and whilst in custody was agitated and expressed intentions to self-harm. He was seen by a health care professional (HCP) whilst in custody.

82. On the 31st of December 2020, the domestic abuse service made a referral to the adult mental health crisis out-of-hours service. No details are recorded for the referral or action taken.

83. There was a MARAC discussion on the 5th of January 2021 to discuss the incident in November 2020; the MARAC was outside timescales. A summary of the incident is included in the minutes along with a note that the response officer's initial observation of reddening injuries on Kirsten's neck was on the balance of probability evidence of a notifiable offence of ABH (or from June 2022 under subsequent legislation a possible offence of non-fatal strangulation). As at the first MARAC, there is no record from the PNC about the significant history of domestic abuse before Kirsten and Jake arrived in Sheffield. The action plan was for Kirsten to be "updated about the MARAC and to flag it to the local housing office". There was no consultation by the police with CPS about a charging decision.

84. On the 11th of January 2021, a different neighbour contacted the housing service to report hearing regular arguments at Kirsten and Jake's home. On 2nd March 2021, a housing officer spoke at length to Kirsten about the complaint. Kirsten advised that Jake had taken an overdose of his medication due to his poor mental health, he had been admitted into intensive care and this had developed into pneumonia. He was out of the hospital and Kirsten said that a good thing to come out of it was the mental health team was going to work with him; Jake was waiting for them to call. Kirsten explained she had a friend around supporting her. Kirsten admitted that both she and Jake smoked cannabis but that Jake had stopped due to his pneumonia, Kirsten continued to smoke it and said she would smoke it outside/away from other properties on the road.

85. On the 8th of February 2021, Jake was taken to a hospital in Rotherham following an overdose (Propranolol[27]) and admitted for in-patient treatment. He discharged himself against medical advice on the 11th of February 2021.

[27] Propranolol belongs to a group of medicines called beta blockers. It's used to treat heart problems, help with anxiety and prevent migraines.

86. Kirsten spoke by phone to the GP on the 19th of February 2021 on behalf of Jake; Kirsten talked about having to keep an eye on Jake and preventing him from self-harming. She did not think his medication was helping as Jake still had suicidal thoughts.

87. The SPA processed a referral about Jake from the GP on the 19th of February 2021 who reported recent suicidal ideation and a recent overdose. A letter was sent to Jake inviting him to contact the service. He responded on the 22nd of February 2021 with a phone call to the SPA Jake was struggling, having nightmares, and was agitated. Kirsten reported that Jake was safe at present but was unpredictable.

88. Kirsten contacted the Crisis out-of-hours service on the 22nd of February 2021 enquiring about follow-up from the service; Jake was having a panic attack and was very anxious. Kirsten also reported the recent overdose by Jake. Kirsten contacted 111 services twice on the evening of the 22nd of February 2021 on behalf of Jake. His mental health was deteriorating and Jake was upset about not getting support. Jake was referred to the crisis team telephone support service.

89. On the 23rd of February 2021, a mental health nurse (MHN) spoke to Jake by telephone about his overdose and substance misuse. Jake said he had been experiencing post-traumatic stress disorder (PTSD) since an attempt on his life (no further information is recorded anywhere about this); Jake did not elaborate and it may have been a reference to what had happened in Newcastle. Jake denied any current plans about suicide but was experiencing thoughts of suicide. PTSD-type symptoms, hypervigilance, nightmares and flashbacks were recorded by the MHN.

90. On the 24th of February 2021, the SPA substance misuse worker completed the assessment following the referral from the GP service. Substance misuse issues were identified for both Jake and Kirsten. Jake was concerned about possible withdrawal symptoms and did not have money to buy street-supplied drugs. Advice had been given on managing withdrawal symptoms. The assessment noted some social isolation due to covid and some symptoms of anxiety. No current crisis but a history of a drug overdose of prescribed medication was noted. It was confirmed that there were no children in their care (but no inquiry about the circumstances). Kirsten said that she cared for Jake who she believed had complex mental health problems. Jake was discharged from the SPA and referred to the substance misuse service (SMS) which was processed the same day and a letter inviting Jake to make contact was sent out to him with an offer of an appointment on the 3rd March 2021

91. A GP spoke to Jake and his still-unnamed partner by phone on the 2nd of March 2021. Kirsten described his difficulties in getting phone support from the mental health team. A phone call the same day by Kirsten with the

neighbourhood officer about a complaint of anti-social behaviour discussed Jake's poor mental health but she hoped that because Jake had recently been in hospital, he would be getting support from the mental health team.

92. At an appointment on the 3rd of March 2021, Kirsten was under the impression she was being referred to START (Sheffield Treatment and Recovery Team) for a prescription of pregabalin (rather than harm reduction advice). She requested pregabalin for anxiety. She said that she was not taking them for the "buzz" but just to help manage her anxiety. She was buying pregabalin from a drug dealer buying whatever strength tablets they had. Kirsten said that she had asked the GP to prescribe these but had been declined and they were looking at switching antidepressants as an alternative. Kirsten was taking 200-300mg daily and reported smoking one cannabis joint at night to help her to sleep. It was noted that Jake had recently been discharged from the ICU following an intentional overdose of Kirsten's propranolol tablets. Partner (name not confirmed) was also smoking crack cocaine and was reported to have autism. Kirsten reported being a carer for her partner (name not confirmed).

93. On the 10th March 2021, Jake had three telephone contacts with the SPA during which he talked about his difficulties in sleeping due to nightmares, having thoughts about self-harm and using cannabis to try to calm down.

94. On the 15th of March 2021, Jake made several telephone calls to the GP service complaining that the SPA was doing nothing; the duty GP phoned the SPA asking for a Mental Health Act assessment for Jake due to his substance misuse and suicidal ideation.

95. A mental health nurse from the SPA telephoned Jake on the 16th of March 2021; Jake was initially angry but soon calmed. There was no change in Jake's presentation; he had poor sleep, fleeting thoughts of suicide, and no plans. Jake reported a previous diagnosis of ADHD and ASD. He reported hearing voices at times of stress but was not hearing at the time of this contact. The nurse explained further contact would be made when the substance misuse worker returned from illness. Jake was still awaiting a routine assessment.

96. Kirsten spoke to the GP in late March 2021 about her use of street-bought pregabalin to help her anxiety. She wanted the GP to prescribe it who would not; Kirsten was already on sertraline and propranolol. The GP wanted to direct Kirsten to the substance misuse service but she was not happy with the advice and her unnamed partner was making comments in the background that the GP "does not know anything".

97. On the 9th of April 2021, a mental health nurse completed an assessment with Jake. He described his mood as up and down. He described feeling out

of control when 'up' and didn't feel able to manage it. He couldn't describe triggers. During these times Jake described being more irritable and had 'lashed out' at people but no record of who or context. Jake felt people who had wronged him were at risk during these times; Jake described being more impulsive and not considering consequences. The assessment noted some overvalued ideas including being sent from God to protect people and having read about 'light workers'. It was not felt to be a delusional belief. Jake described hearing voices telling him to harm himself. He described poor sleep, poor self-care, little energy/motivation, and a difficult and abusive childhood. Jake described ongoing thoughts about suicide, with no plan or intent. Jake described a supportive partner (no name provided) of 15 years and a couple of friends who help. Jake described smoking cannabis daily, and said it 'calms him down'. An unnamed partner was identified as a support factor but "also vulnerable". There is no record of inquiry about domestic abuse at any stage or the "vulnerability". The assessment was sent to the GP. The plan was for a doctor to review the diagnosis and consider medication; there was a waiting list. The letter was sent to Jake advising that he would be seen by a medic in the team around diagnosis and treatment. Jake was advised there was a waiting list and advised to contact the duty team if he was in crisis, or needed support in the interim.

98. On the 13th of April 2021, the SPA community risk assessment was updated which highlighted Jake's assault on Kirsten in November 2020. It did not identify any current threat of harm to other people but identified an increased risk of substance misuse and self-harm.

99. On the 13th of April 2021, the mental health nurse updated the community risk assessment (DRAM). It highlighted the previous assault of Kirsten by Jake (no name was recorded) in November 2020 under the 'risk to others' domain. It did not identify any current threats to harm others. It identified an increased risk of substance misuse and ongoing risk to self. The risk management plan included an ongoing assessment and clarity around diagnosis, Jake had been provided with contact details for duty and out-of-hours teams should the risk increase, and he was also provided with the details for substance misuse services.

100. The mental health liaison team sent Jake's mental health review assessment for secondary care to the GP on the 13th of April 2021. This followed the GP's referral to the service in February 2021 following Jake's overdose and the earlier assault on Kirsten in November 2020. The mental health review recorded some information about Jake's childhood in the traveller community, living with an uncle and being looked after by a local authority and Jake disclosing, he had been abused as a child. The assessment identified a potential emotionally unstable personality disorder and anti-social behaviour traits with a childhood diagnosis of ADHD. The assessment concluded that Jake should be assessed for treatment for his ADHD and be offered support to manage his emotions and anger. The assessment concluded that there was not an immediate risk of harm to

himself although he posed more of a risk of aggression to other people and that his impulsivity put him at greater risk of suicide attempts.

101. On the 16th of April 2021, Jake made a crisis call to the SPA. He was aggressive and shouting when asked to explain the nature of his call. Staff explained they could speak now if he could explain the situation more fully, or he could receive a call back after having a chance to read the notes. Jake chose a call back after further hostility.

102. A mental health practitioner phoned Jake. There was verbal abuse from Jake to the practitioner who explained that Jake was on the waiting list to be seen and “reassured there is a very clear plan of care”. An apology was offered for the waiting time. The practitioner made it clear that he was welcome to call again at any time. Jake advised he was going to stop his medication as it wasn't helping. He informed the practitioner that if something happened it would be their fault. The practitioner did not feel it would be helpful to call him back or text him.

103. On the 28th of April 2021, Jake was taken to the urgent and emergency care centre (UECC) in Rotherham following an overdose. He discharged himself the same day.

104. In early May 2021, the GP noted that Jake was becoming increasingly challenging; he was often shouting, rude and made “difficult demands”. A GP talked to Jake about needing to “reflect on his behaviour”.

105. On the 19th of May 2021, Jake self-harmed cutting his left wrist and causing significant bleeding; he later ran from police and went back to his home address where he was located by police. Jake raised concerns over his mental health and how he was not getting help so all he could do was self-harm. He stated he had no further thoughts of self-harm and was in a better mood. An ambulance attended to care for the cut to his arm. The police sent a notification of concern about a vulnerable adult (VA) to the SPA detailing their contact with Jake. This was their second VA referral the first occurring in November 2020. In addition to the history recorded in November 2020, Jake had expressed his frustration at the lack of support he was getting and help with his poor mental health. He was on prescribed medication but felt his mental health was deteriorating.

106. The notification of concern was reviewed by the SPA mental health nurse who decided not to call Jake as it might provoke an angry response. It was agreed to write to Jake instead to reiterate the existing plan. The letter advised Jake of the recent concerns raised by the police and a reminder of the current plan of care; the letter advised Jake that there was still no appointment date and high waiting list numbers. Jake was invited to contact

crisis services or SPA duty if necessary and was given details for the Rethink helpline[28] and SHOUT[29].

107. On 24th May 2021, the housing and neighbourhood service had contact with a householder on the same road who said that Jake had been arrested the previous week believed to be due to domestic abuse as they had heard female screams coming from the property. The following day the neighbour contacted the service to say that there was still blood outside the property. This was the incident when Jake had cut his wrist.

108. On the 21st of June 2021, a silent call was made from Kirsten's phone to the police; the caller believed to be Kirsten stayed on the line for only a few seconds during which time she did not speak. Coincidentally another householder on the road made a call to the police to report a disturbance. Kirsten had contacted the police after an argument as Jake was "rattling" for drugs; he had pinned Kirsten to the floor, strangled her and also knelt on her head during the assault. Kirsten engaged with officers and gave a statement however would not give her consent to share her information with partner agencies. Jake was arrested and remained in custody until 13th September 2021 when he was found guilty at Sheffield Magistrates Court and sentenced to a 24-month Community Order with a 30-day rehabilitation activity and a 30-day accredited programme requirement. The police made a referral to IDAS who tried unsuccessfully to contact Kirsten.

109. On 28th June 2021, the housing and neighbourhood service was contacted by a householder living on the road who advised that there had been further incidents of domestic abuse and they had reported this to the police who arrested a male. This householder complained about noise from loud arguments, loud TV, multiple visitors to the flat and the persistent smell of cannabis. The contact was processed as an antisocial behaviour (ASB) complaint ASB officers visited Kirsten on 2nd September 2021 and she advised that Jake was in custody, there is no explanation or inquiry about why Jake was in custody. The ASB officers spoke to the complainant who said that they were aware Kirsten had made a suicide attempt the previous week as they saw an ambulance at the address.

110. On the 25th of July 2021, Kirsten reported to the police that Jake had been contacting her from prison by telephone and letter, asking her "to tell the truth" and to change or withdraw her statement. Kirsten acknowledged that she had been actively engaging with Jake whilst he was in prison and there was some form of relationship that still existed. She did not want to report harassment, she wanted to make the police aware of the conversations between herself and Jake. Later Kirsten did not attend a police diary appointment and this was followed up to conclude the investigation. From the record by the police officer, it is apparent that there was a lack of understanding about how victims can be coerced and controlled even when

[28] https://www.rethink.org/aboutus/who-we-are/contact-us/
[29] https://giveusashout.org/

perpetrators are placed in custody. The letters were seen as not harassing; Jake had asked Kirsten to tell the truth only after she had agreed to engage in a two-way conversation. There is no exploration as to what Kirsten might have feared would happen if she had declined contact with Jake. Kirsten was viewed as being at no risk as Jake had been remanded in prison until his court date. Kirsten confirmed that she had not been harassed, she had just been wanting to make SYP aware of the conversations. Again, this is not explored in the discussion with Kirsten or the analysis of risk. Kirsten had her number blocked by the prison so no more calls could go through to her. From then Kirsten did not engage with the police who recorded that there had not been sufficient evidence or complaint from Kirsten to enable the police to consider a prosecution for harassment.

111. There was a MARAC discussion on the 10th of August 2021. This was about the assault in June 2021 and as before the MARAC was outside timescales. The minutes of the MARAC include brief details including Jake's remand to custody until the end of August 2021. As before there is no record of the history of domestic abuse before Jake and Kirsten arrived in Sheffield. The action plan was for Kirsten to be updated about the MARAC, be "reminded about IDAS", and a note that the joint tenant and perpetrator could return to the property and flag and tag to local services.

112. On the 28th of August 2021, Kirsten was taken by ambulance to the Rotherham Hospital UECC. Kirsten had taken an overdose of propranolol and mirtazapine. Kirsten's friend Natasha had made the 999-emergency call to YAS advising that the overdose was intentional and had sent her a message saying "*I'm done, I've had enough, I'm so sorry, love you*". Kirsten had contacted her friend to tell her. Kirsten's friend said that she had done this following an argument with her current partner (no name provided). This information was included in the ambulance handover sheet given to the hospital staff. The handover information also reported Kirsten's friend saying that Kirsten had been speaking with a man living in London to whom Kirsten had lent money but it had not been repaid leaving her with thoughts of suicide. Whilst at the hospital Kirsten spoke to a mental health practitioner. Kirsten sought help straight away and advised that she 'surprised herself' with overdosing and showed regret in doing so. A follow-up telephone call was made on the 30th of August 2021, Kirsten had plans in place to keep herself safe and had no further thoughts of self-harm or suicide. Kirsten was discharged. There was no recorded evidence of a detailed assessment of Kirsten's circumstances or exploration of the history of domestic abuse and the fact that her partner was in prison awaiting prosecution for assaulting her. Information about the Rotherham Rise domestic abuse service was provided.

113. On the 13th of September 2021, Jake was sentenced to a 24-month Community Order with 30 RAR days and BBR programme requirements. A Restraining Order was also imposed.

114. On the 14th of September 2021, Jake contacted the probation duty officer to inform them he was staying at a friend's home that was on the same road where Kirsten was living. A risk assessment by probation on the 15th of September 2021 concluded that Jake posed a serious risk of harm to others and was allocated as a high-risk case for supervision. This was not discussed with any other service and there appeared to be no recognition of the potential risk to Kirsten.

115. On the 22nd of September 2021, Jake breached the Restraining Order and was arrested at Kirsten's home. The DASH was completed at a medium level without Kirsten providing information. A referral was made to the IDAS and Jake was charged and remanded to appear in court.

116. Jake was convicted on the 25th of September 2021 of breaching the Restraining Order and was sentenced to four months imprisonment suspended for 12 months. Jake declined an appointment with a substance recovery practitioner whilst in police custody although the practitioner left an appointment card inviting Jake to attend the service on the 29th of September 2021.

117. On the 4th of October 2021, Kirsten told the police that Jake was constantly texting, phoning and attempting to have direct contact. Kirsten made further contact with the police the following day to report the continuing contact with Jake. Jake was using social media to message and call her a 'snitch' and a 'grass', was posting pictures of Kirsten and was saying that nobody should trust her. Kirsten was reluctant to unfriend Jake on social media. The information was recorded as an offence under the Malicious Communication Act. The DASH assessment was completed at a medium level a referral was made to the IDVA and was listed for a MARAC on the 2nd November 2021. The continued harassment and stalking of Kirsten were significant in terms of assessing and understanding risk and developing a more appropriate response. This is analysed later in the report.

118. On 8th October 2021, there was a record saying that Jake was not allowed back to the address due to other reasons (these are not explained) but that complaints of noise and the smell of cannabis continued.

119. An IDVA (based with IDAS) made contact with Kirsten on the 14th of October 2021 by telephone and completed an assessment during which Kirsten talked about her thoughts of suicide and that she had not had support since she had taken an overdose in August 2021. The IDVA secured Kirsten's agreement to make a referral to the mental health service and agreed that they would meet face-to-face rather than by telephone. The IDVA also provided details about the Samaritans and encouraged Kirsten to talk with her GP. The IDVA contacted the SPA the same day. The IDVA tried to arrange a home visit on the 15th of October 2021 but Kirsten said that she

was busy and the face-to-face meeting was scheduled for the 18th of October 2021.

120. During the IDVA's home visit on the 18th of October 2021, a fuller assessment was completed with Kirsten. During this, they discussed Kirsten's emotional and practical support needs, her thoughts about suicide, her safety and her debts. Following the visit, the IDVA made a range of referrals with Kirsten's agreement to help with furniture, specialist debt and benefit advice. Target hardening equipment was also provided to Kirsten on the 22nd of October 2021. A referral was made from the IDVA hub to the longer-term IDVA team and on the 21st of October 2021, an IDVA from the long-term team contacted Kirsten to introduce herself. They agreed to a follow-up call for the 25th of October 2021 when Kirsten had more time to talk in more detail. During that follow-up call, they discussed the support that Kirsten needed and agreed that a referral would be made to a women's counselling service and the IDAS Power to Change group. This was the last contact that the IDVA had with Kirsten.

121. Shelter processed a referral from the IDAS on the 22nd of October 2021 for debt advice. Kirsten had significant debt which included £300 rent arrears, unpaid council tax for two years and unpaid utility bills. The referral was redirected to CAB who tried to contact Kirsten without success before she died.

122. On the 25th of October 2021, Natasha summoned an ambulance after finding Kirsten at home having taken a suspected overdose. Kirsten was taken for emergency treatment but regrettably passed away.

Overview

123. Kirsten and Jake's arrival in Sheffield followed reported threats to their safety in the northeast although specific details are unrecorded either in Sheffield or the northeast. Kirsten's family say that previous moves usually occurred when a significant incident such as the physical assault of Kirsten prompted a flight from the authorities. The DHR sought information from the northeast which confirmed there had been contact with the police on eight occasions between January 2016 and August 2018 and most were related to domestic abuse. There had been no contact or complaint to the police about threats of violence prompting the move from the northeast. There were never referrals to or contact with the domestic abuse service in the northeast.

124. Kirsten and Jake were helped to find a home in Sheffield and to make a successful claim for a personal independence payment based on Jake's complex health needs. Advice and health services interaction with Kirsten as Jake's carer reinforced a sense of dependency and made it even more difficult and risky for Kirsten to separate from Jake. Kirsten never had her needs as a carer living with a man presenting with complex needs

considered and her difficulties with mental health, substance misuse and self-harm were not understood or explored within the context of being an entrapped woman in a relationship with a perpetrator of domestic abuse. There were examples of positive practice in the SPA trying to offer a service.

125. Kirsten's struggle with poor mental health was recognised in her discussions with the GP practice where she also disclosed her use of street-supplied medication. During those GP consultations, there was no inquiry or exploration about Kirsten's relationship or domestic abuse. The GP was made aware of the overdose in August 2021 and although a follow-up appointment was offered it was a month after the overdose and Kirsten did not respond. The GP was not aware of any MARAC referral or discussion; they were not asked to provide information and did not have a copy of MARAC's actions. The name of Kirsten's partner was not recorded and there was no exploration of the circumstances under which her children no longer lived with her. This loss of her children in itself was a very significant source of distress to Kirsten and a discussion could have opened up important disclosures to inform the GP's care of Kirsten and to have signposted to domestic abuse services.

126. Kirsten also talked about her low mood and thoughts about suicide in some of the DASH assessments completed by police officers.

127. The advice worker and support worker employed by Shelter are experienced people who are familiar with how to respond to domestic abuse. They work regularly with adults and children who have been impacted by domestic abuse. The support worker's risk assessments highlighted complex vulnerabilities for the couple but did not reveal domestic abuse. Shelter was one organisation that highlighted how MARAC information was not seen by staff working directly with Kirsten and Jake and is recognised as a learning point for the organisation.

128. None of the services had a complete record of domestic abuse that occurred in Sheffield. and some of these were not recognised as potential domestic abuse such as the complaints that were processed as anti-social behaviour by housing and neighbourhood officials. The police responded on 11 occasions. The housing and neighbourhood service had complaints from a third party in June 2020 that Jake had assaulted Kirsten. On another occasion, in September 2020 third-party complaints about noise nuisance and there were further reports in May and June 2021. These were processed as anti-social behaviour without enough thought as to whether the behaviour causing concern was indicative of domestic abuse.

129. The extensive history of domestic abuse in several areas before Kirsten and Jake arrived in Sheffield in February 2019 is not described in any recording by Sheffield services until June 2021 when the police arrested Jake for assaulting Kirsten. and a check was made on the police national database

(PNC). This revealed a history of domestic abuse in three other areas dating back to when Kirsten was 17 years old and soon after the relationship began with Jake who was then in his mid-twenties. The database had information about Kirsten's attempts to leave the relationship on more than one occasion and each time being tracked down by Jake. This crucial information was not available to the MARAC in May 2020 or January 2021. Apart from the MARAC, there was never any other multi-agency discussion or planning. The PNC search also revealed Jake's history of violence toward other people. Probation had a record of a MARAC In Northamptonshire in November 2015 which is not mentioned by any other service involving Jake but does not identify Kirsten. The probation service does not describe the same level of detail about the history of domestic abuse that was extracted by the police search in June 2021.

130. Jake's longstanding mental health difficulties are believed to go back to his adverse and abusive childhood that was further complicated by his substance misuse including Spice. Other than probation which collated this information for the pre-sentencing report and the SPA mental health assessment in 2020, none of the other services mentions this complicated history. His health problems were a significant factor in his successful application for a personal independence payment (PIP). Staffing shortfalls in mental health services meant that Jake was on a waiting list for psychiatric help and support after the initial assessment by the SPA.

131. Jake's history of aggressive interaction with health care professionals contributed to his registration on the special allocation scheme for violent patients. He initially had difficulty getting access to a GP service but on the advice of Shelter and with the support of the local MP's office, he was registered at a city centre practice. However, when Jake wanted to consult a GP, he was directed to a city-wide duty system of GPs who were available to respond to patients on the scheme. This further exacerbated the lack of continuity in contact which was magnified by the Covid lockdown from March 2020.

132. Kirsten supported the police taking further action against Jake on more than one occasion although this did not achieve an effective cessation of the abuse primarily due to Jake ignoring restrictions and boundaries even in prison on remand. On more than one occasion the police closed investigations due to "evidential difficulties" when Kirsten said she was unwilling to make statements and on others declined to prosecute. It is a well-established principle that it is the police who have a responsibility to determine if there are crimes to be investigated. A perpetrator programme was not available in Sheffield between February 2021 and September 2021 due to a recommissioning and change of provider of the service.

133. Worryingly, when Jake was able to continue contacting Kirsten from custody to encourage Kirsten to "tell the truth" was not recognised by the police for what it was; potential intimidation, evidence of coercive control and

harassment. It was also despite Jake being recognised as a perpetrator of domestic abuse alerts being placed on his prison record and restrictions under national prison instructions being implemented[30]. Similarly, when he was released after being sentenced to a Community Order in September 2021 and made subject to a three-year Restraining Order he was allowed to stay at a property on the same road where Kirsten lived without challenge. He had breached the order within a day and when breached was given a suspended sentence. The legal sanction was ineffectual and coincided with Jake's mental health deteriorating without effective support. It is an example of where the action was not consistent or coordinated.

Analysis

134. There were opportunities to address domestic abuse and there was an attempt on more than one occasion to do that. Three referrals to the MARAC; a DVPO and a Restraining Order were granted and Jake was remanded to prison following his assault on Kirsten in the summer of 2021. The domestic abuse continued. The lack of knowledge and understanding about the longer-term history and narrative of domestic abuse, inconsistency of response, the absence of work with Jake as a perpetrator or providing a more trauma-informed approach and the shortfall in addressing the mental health and substance misuse of Jake, in particular, are significant lessons from this review.

135. At the time of Kirsten's overdose in August 2021, she told Natasha her friend she had had enough and it was not long after that Kirsten took another overdose that regrettably proved fatal.

136. The challenge for the DHR is to think about how and why the response to domestic abuse can be made more effective. Nobody had enough understanding of the narrative of Kirsten and Jake's relationship The lack of knowledge as well as curiosity about the long history and nature of domestic abuse and the focus on incidents rather than understanding it as the pattern of coercive control is a significant learning along with the absence of coordination and consistency in response.

137. A victim like Kirsten who is entrapped in a relationship with an abusive and controlling partner needs to have a sense of security about their safety and have confidence that the risk of repeat violence is reduced. This has to be rooted in a local evidence-based approach to risk-led interventions that understand coercive control and give greater attention to markers or patterns of abusive behaviour. Strategies need to address and curtail the behaviour of the perpetrator. This involves the effective use of law as well as having appropriate perpetrator interventions to offer more effective support for issues such as poor mental health and substance misuse.

[30] The interception of communications in prisons and security measures. (PSI/ 04/2016)

138. Perpetrators of domestic abuse employ a wide range of tactics to control and abuse their partners or ex-partners. Survivors report a range of control, emotional and destructive tactics all of which can have devastating effects on their emotional and mental well-being and without support or safety many women feel there is no escape other than by ending their life by suicide. Kirsten's mental health and use of substances were linked to her experience as an entrapped victim of domestic abuse. Attempting to treat symptoms without understanding and addressing the stressors was never going to be effective enough and needed much more cross-agency coordination which should be doing that coordination is a challenge to the city's partnership from this review.

139. Professor Jane Monckton-Smith and other academic researchers highlight that many suicides are the "hidden victims" of domestic abuse. A 2018 study of 3500 women accessing services that support women and children experiencing domestic abuse estimated that about one-third of female suicides were women who had experienced domestic violence. The study reported that 24 per cent had felt suicidal and 18 per cent had made plans to end their life[31].

140. Monckton-Smith describes the importance of identifying and understanding markers and clusters in risk assessments and the value of developing narrative tools to inform prevention strategies, risk assessment and perpetrator interventions. She identifies eight stages in the most dangerous cases of domestic abuse involving homicide[32]. Although the final three stages are related to instances where men have gone on to kill their partner or estranged partner and are therefore not relevant to this particular review, the first five stages have relevance in responding to and assessing the risk of domestic abuse. Further study is developing the model and understanding of prevention strategies, risk assessment, and perpetrator interventions in domestic abuse-related suicide, honour killing and intimate partner homicide[33].

141. The first five stages of Monckton-Smith's model for intimate partner homicide are:

[31] Aitken, R and Munro, V (2018) Domestic abuse and suicide: exploring the links with Refuge's client base and work force. London: Refuge.

[32] Monkton-Smith. J, Intimate Partner Femicide: Using Foucauldian Analysis to Track an Eight Stage Progression to Homicide First Published August 5, 2019 Research Article https://doi.org/10.1177%2F1077801219863876 accessed 23rd January 2020

[33] Monckton-Smith, J, Siddiqui, H, Haile, S and Sandham, A (2022) Building a temporal sequence for developing prevention strategies, risk assessment, and perpetrator interventions in domestic abuse related suicide, honour killing, and intimate partner homicide. Project Report. University of Gloucestershire, Cheltenham, Gloucestershire.

a) A pre-relationship **history** of stalking or abuse by the perpetrator; none of the services has any history of Jake's intimate relationships or whether Kirsten was his first relationship; there was a significant age difference of Jake being in his mid-twenties and Kirsten just 17 when they began their relationship;

b) The romance **develops quickly** into a serious relationship; Kirsten's family have confirmed that this was what happened when she met Jake conceiving her first child very early in the relationship; this early history of the relationship was unknown to all the services in Sheffield and has implications for future practice, especially in domestic abuse assessments and MARAC plans; the fact that this was a long relationship was known but that in itself does not give any insight into how the relationship had developed; the age difference and early pregnancy accompanied by early onset of domestic abuse are significant factors that were unknown and therefore not taken account of in for example understanding how Kirsten would interact with response police officers; there is little record of curiosity about the children no longer being with Kirsten and Jake or about the impact;

c) The relationship becomes dominated by **coercive control;** Kirsten's family confirmed that this was behaviour they witnessed and tried to get help with very early in the relationship; the history of domestic abuse that the police describe from a PNC search in June 2021 refers to Kirsten attempting to leave the relationship; she moves to different areas and returns to her family at times; the circumstances are not explored as a pattern of behaviour;

d) A **trigger** to threaten the perpetrator's control - for example, the relationship ends or the perpetrator gets into financial difficulty; there is little curiosity and therefore little detail recorded by any service about triggers for incidents relationships which gives little insight about whether in reality, this was a relationship that Kirsten was never allowed to leave for example; the remand to prison and the granting of court orders marked heightened and escalating risk that was not recognised in how arrangements such as where Jake lived were agreed;

e) **Escalation** - an increase in the intensity, frequency or variety of the partner's control tactics, such as stalking or threatening suicide which was observed in the summer of 2021; Jake was able to contact Kirsten; from prison and was permitted to live on the same road upon his release from prison.

142. According to Monkton-Smith's research, where the early stages 1-2 are positively identified, there is a much higher likelihood that attempts at separation should the relationship continue, will be met with significant resistance (as occurred in this case). Where there is a progression through stage three there is a much higher likelihood that separation will be very difficult or even dangerous. Progression through stages four and five provides the clearest indication of an increased potential for fatal domestic abuse.

143. The model has been further developed concerning domestic abuse-related deaths by suicide to develop narrative tools for prevention strategies, risk assessment and perpetrator interventions in domestic abuse-related suicide as well as intimate partner violence homicide.

144. The model for domestic abuse-related deaths by suicide follows a similar trajectory through the first three stages. Monckton Smith et al[34] describe disclosure at stage four where disclosing domestic abuse is more common than has generally been thought although initially, victims disclose to family and friends and within the dynamics of control and coercion, this can be considered as an escalation in risk. In Kirsten's case, the disclosures of abuse and the use of court orders and remand were an escalation of risk.

145. Assessments of risk that do not take account or recognise longer-term patterns of behaviour and risk-based meetings such as MARACs that do not have sufficient and accurate information about history are inherently flawed, resulting in false or inadequate conclusions. At the time Kirsten arrived in Sheffield in February 2019 her history was indicating high risk and would be further aggravated by the onset of a worldwide pandemic and a severe deterioration in Jake's mental health. Monckton Smith **differentiates disclosure from seeking help** as disclosure may be incremental before seeking help; in Kirsten's case, it was part of a coping strategy in terms of discussions she had with her friend before and after occasions when the police had become involved.

146. Monckton Smith et al discuss stage five as **active help seeking** where the victims consider the situation has become so serious often after an escalation in abuse or fears for the safety of children for example. Studies also show that help is not sought if victims feel the services will not be useful or effective or if they feel professionals will not consider it serious enough. Erosion of self-worth and identity are significant inhibitors. Monckton Smith discusses the prevalence of help being sought from mental health services driven by victims seeking help to alleviate the distress caused by the abuse and is witnessed in Kirsten's circumstances where she was consulting her GP and often contacting services on behalf of Jake to get help. Children can be seen as a protective factor in suicidality and a significant reason for victims not acting on suicidal thoughts. The fact that Kirsten's children had been removed from her care was never understood as potentially elevating the risk of self-harm after her first overdose in August 2021.

[34] Monckton-Smith, J, Siddiqui, H, Haile, S and Sandham, A (2022) Building a temporal sequence for developing prevention strategies, risk assessment, and perpetrator interventions in domestic abuse related suicide, honour killing, and intimate partner homicide. Project Report. University of Gloucestershire, Cheltenham, Gloucestershire. https://doi.org/10.46289/RT5194YT

147. Suicidal ideation and threats of self-harm by the victim or perpetrator are warning markers for serious harm including homicide. Suicidal ideation can develop in parallel with homicidal ideation in perpetrators of high-risk abuse. All suicidality needs to be taken seriously.

148. Monckton Smith's final stage is the **complete entrapment** of the victim which applied in Kirsten's circumstances and her family described this to the reviewer. Kirsten felt there was no escape from Jake and his abuse. Her conversations with her friend reflected feelings of having no hope. It was the persistence of Jake over many years combined with a lack of consistency in agency responses between different areas as well as within Sheffield. An example is a Restraining Order being made but Jake being allowed to live in a neighbouring property to Kirsten. The consistency of response when responding to intimate partner controlling behaviour is crucial[35].

149. Processes such as the DASH completed by a first response police officer will never have the capacity to capture the detail required to make informed judgments that take account of the interplay of these different factors. This is much more likely to happen through proactive specialist domestic abuse workers developing a relationship of trust with the victim and building a narrative-informed understanding. In this case, the DASH which was completed 'in the moment' by first response police officers was the only record of risk assessment regarding the domestic abuse. On the final contact with YAS in October 2021, Kirsten's comments to her friend were not set out in detail in the information transfer between YAS and hospital-based practitioners. The ambulance handover sheet recorded that Kirsten's friend had received a text saying that she had taken an overdose with the intent to end her life after an argument with her current partner. Her words reflected deep despair and nobody was able to explore that with Kirsten. The handover sheet contained information that Kirsten had lent money to a man who lived in London that had not been returned to her and it was this that led to her suicidal ideation.

150. Alongside understanding the motivation and behaviour of the perpetrator is understanding the strategies and impact on the victim. When a victim is trying to calm a partner's aggressive behaviour or minimising concerns or questioning the veracity of reports about behaviour or arguments, for example, this may be a reflection of the victim protecting herself from possible reprisals. It is an example of where sceptical curiosity is needed alongside a good enough understanding of coercive and controlling behaviour and the impact on how the victim will behave.

151. The following sections summarise the learning from agencies.

[35] Alison, E. and Alison, L. (2012) A stalking management programme: preparing advisory material for nonpsychologists in Alison (ed) (2012) The Forensic Psychologists Casebook London: Routledge

Contact, knowledge and information services had about Kirsten's vulnerability to domestic abuse.

152. The GP practice was regularly consulted by Kirsten for poor mental health. Although there is some historical information from 2007 about a MARAC outside Sheffield the GP practice had no other or more up-to-date information such as the three MARACs in Sheffield. Jake's GP practice had no information about domestic abuse until June 2021 when the practice received the routine notification from the police custody suite referring to Jake's assault on Kirsten involving him putting his hands around Kirsten's neck and kneeling on her. A month before that incident Jake had attended the practice demanding medication. He was very agitated and aggressive and the reception staff had to contact the police for support. Although Jake was invited to book an appointment with a GP to discuss the aggression he did not and it was not followed up. Being a patient registered on the special allocation scheme reduced the opportunity for oversight by the primary care service. Given his history described earlier in the report a more trauma-informed approach and thought about reasonable adjustments would have been appropriate and was reflected in the discussion at the panel.

153. There were opportunities to inquire about domestic abuse. Routinely, it could have been done when Kirsten registered as a new patient in 2019. It could have occurred when Kirsten mentioned "previous domestic abuse" or disclosed having arguments with her partner. And it could have been done when Kirsten presented with poor mental health and her wish to be prescribed medication.

154. IDAS was first given information via a routine court notification about the DVPO made in November 2019. This did not contain contact details for Kirsten. The police had not made a referral; the medium DASH did not come within the circumstances of an automatic referral. IDAS could have contacted the police or court to get contact details for Kirsten. This has to be seen within the context of IDAS responding to 100 referrals a week sometimes being as high as 175. The first referral to IDAS from the police happened in April 2020 and was followed up by five others up to the 7th of October 2021. Kirsten declined support from IDAS until the referral in October 2021 when a risk assessment and safety plan were completed by phone. This did not explore any of the history that is now known from the DHR. The safety plan recorded 37 actions for Kirsten to remain safe. This included fitting chains to doors, installing apps on her phone and having a safe route out of her home. IDAS had their last contact with Kirsten on the day that Kirsten died. This contact was also by phone. Kirsten said that she felt low although had no plans to harm herself. Kirsten agreed for referrals to be made to a counselling service and the IDAS emotional recovery group as an opportunity to consider the impact of Jake's abuse on Kirsten.

155. The mental health assessment in April 2021 in response to the GP referral in February 2021 following Jake's overdose and earlier assault on Kirsten in November 2020 included information about Jake's unpredictable mood, poor impulse control exacerbated by his substance misuse and his admission of lashing out, especially to people he felt had wronged him. The assessment did not record any inquiry about Jake's relationship with Kirsten over and above that she was part of his support. The report included details about Jake's childhood which included his disclosure of childhood abuse and growing up in the "gipsy community". The assessment identified a potential emotionally unstable personality disorder and anti-social behaviour traits with a childhood diagnosis of ADHD. The assessment concluded that Jake should be assessed for treatment for his ADHD and be offered support to manage his emotions and anger. The assessment concluded that there was not an immediate risk of harm to himself although he posed more of a risk of aggression to other people and that his impulsivity put him at greater risk of suicide attempts. None of this was considered within the context of the established history of domestic abuse or ongoing risk to Kirsten. The assessment was sent to the GP.

156. The Royal College of Psychiatrists report in 2020[36] highlighted that the long-term treatment of self-harm is affected by the lack of an accurate assessment tool and expresses caution in relying on tools and questionnaires that use terms such as low risk or reducing risk. The report argues that when somebody like Jake is in a deep psychological crisis over several months or years what is required is an in-depth conversation and a detailed appreciation of circumstances and background.

157. The police contact with Kirsten after she reported that she was being contacted by Jake from prison in July 2021 was recorded as harassment and subsequently stalking. There is no record of why Jake was allowed to make contact from prison given he had been remanded for assaulting her. The prison confirmed that he had been identified as a perpetrator of domestic abuse and the required alerts were placed on his record at the prison.

158. There is a lack of understanding about how victims continue to be controlled and coerced as well as the emotional barriers that victims have to process. Kirsten had been put in the position of being Jake's carer for many months if not years. Her lack of employment and money combined with her poor health all contributed to Kirsten having few options to escape from Jake's abusive behaviour. The risk assessment was flawed and the reason for Kirsten no longer engaging with the police was misunderstood. The fact that a remand prisoner was able to contact their victim from within a prison

[36] RCPSYCH Self-harm and suicide in adults. Final Report of the Patient Safety Group 2020 https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr229-self-harm-and-suicide.pdf?sfvrsn=b6fdf395_10

deserved further attention from the police and the prison. It is not the victims to find evidence to pursue investigations.

159. In August 2021 when Kirsten took an overdose and was taken to the hospital coincided with Jake was in prison awaiting a court appearance for assaulting Kirsten. It is known now that Jake was continuing to contact Kirsten from prison. The assessment by mental health services did not have any recorded inquiry into Kirsten's history and circumstances. It relied on Kirsten saying that she had sought help straight away and advised that she 'surprised herself' with overdosing and showed regret in doing so. The Royal College of Psychiatrists cautions against assessments that rely on judgments about low-risk or high-risk and instead argues for good-quality psychosocial assessments that reveal the circumstances of a person. This should include significant relationships and, in this case, the history of domestic abuse deserves more focused sensitive inquiry.

160. When Jake told the probation duty officer that he was staying at a friend's home located on the same road where Kirsten was living this was not challenged. A risk assessment by probation the following day concluded that Jake posed a serious risk of harm to others and he was allocated as a high-risk case for supervision. The level of risk to Kirsten specifically was not recorded despite the circumstances of the offence and remand to prison. Less than a week later Jake breached the Restraining Order and was arrested at Kirsten's home. The DASH completed at a medium level recorded Kirsten's reluctance to give information to the police. This was not explored further in any assessments with Kirsten; it was significant information indicating Jake's persistence and the impact on Kirsten. A referral was made to the IDAS where there was a history of Kirsten not wanting to engage with IDAS. Little information is recorded about the contact with IDAS over and above Kirsten's "declining support and going through safety planning". Jake was convicted on the 25th of September 2021 of breaching the Restraining Order and was then sentenced to four months imprisonment which was suspended for 12 months and leaving Jake free to continue his behaviour.

161. Almost immediately Jake was phoning and texting Kirsten and using social media to blame her for what was happening. When Kirsten told the police on the 4th of October 2021 that Jake was constantly texting, phoning and attempting to have direct contact it was processed as malicious communication. The reasons why Kirsten might be reluctant to unfriend Jake on social media were not explored. The information was recorded as an offence under the Malicious Communication Act but was subsequently reclassified as stalking; a DASH assessment was completed at a medium level and a referral was made to the IDAS and was listed for a MARAC on the 2nd November 2021. Kirsten died before that discussion had taken place.

162. The housing and neighbourhood service observed evidence of potential domestic abuse in July 2019 when a housing officer heard banging and shouting from the property and Kirsten left the building upset. There is no evidence of follow-up. The service received five reports of anti-social behaviour which it is acknowledged could have been domestic abuse rather than just the noise nuisance as processed. The complaint made in June 2020 included information that Jake had been beating up Kirsten and had heard shouting and screaming. This information was not known to the police and it was not followed up on by the housing officer. There is no evidence that the MARAC alerts were considered when officers were dealing with subsequent contacts.

163. Jake's first contact with the hospital emergency department was in April 2020 after the police had arrested Kirsten and Jake because of an incident at their home. The hospital has a domestic abuse communication form (a shortened version of DASH) although this was not completed. This might reflect an assumption that the police would probably have completed a DASH during their first response. The Sheffield Teaching Hospital Trust has had clinical navigators since November 2020 whose role is to support and signpost patients following domestic abuse or other violent incidents.

164. The first YAS contact with Kirsten in January 2021 was via the 111 service when a male voice could be heard in the background talking over her and speaking disparagingly about Kirsten and the NHS. Kirsten remained "pleasant and polite" during the call not acknowledging what was happening. The YAS IMR acknowledges that the call handler should have asked if Kirsten was OK; they did not. The fact that Kirsten was phoning on behalf of her partner was a potential indicator of control or concern. The call handler did not establish if Kirsten was using a speakerphone or not. They did not use closed direct questions with yes/no to establish whether Kirsten was safe. The YAS did not have any MARAC flag on their system.

165. The final call between YAS and Jake in June 2021 involved Kirsten being heard trying to intervene and calm Jake who had been told that an ambulance response was not appropriate and to contact his GP. The YAS did not have any information to indicate that Jake was on the special allocation scheme for GP care. Jake became very stressed and Kirsten attempted to terminate the call in "an obvious attempt to calm Jake". Although the clinician spoke calmly and kindly with Jake and tried to conclude the triage positively there was again no consideration of potential risk to Kirsten.

166. The YAS report discusses the national clinical guideline that YAS follow that advises using a triggered enquiry approach only when signs are seen.

Arguably, there were indicators in some calls to YAS although national clinical guidelines probably need further development.

Contact, knowledge and information services had to indicate a risk of self-harm to Kirsten

167. Kirsten and Jake had histories of self-harming thoughts and behaviour. The importance of good psycho-social assessments that can develop an understanding of the circumstances of people's lives and the stressors they are living with is set out in clinical guidance and research discussed in other parts of the report. None of the various health professionals gave enough attention to domestic abuse being a factor and there are few recorded details about the circumstances of Jake and Kirsten. Often, details about a partner such as a name are not recorded.

168. The risk of death by suicide was assessed by the SPA SMS worker in February 2021. Kirsten described ongoing symptoms of low mood, anxiety and hopelessness. She denied suicidal ideation or thoughts of deliberate self-harm. Kirsten reported that Jake was a protective factor. This may have been Kirsten describing her caregiving role to Jake. The IMR comments that details about Kirsten's family and domestic circumstances are minimal as they are for Jake. There is no exploration of the circumstances of Kirsten's children not living with her either in terms of opening up a discussion about the domestic abuse or considering how the absence of children had removed a potential source of resilience for Kirsten.

169. The Royal College of Psychiatrists report in 2020[37] describes the importance of practitioners identifying risks but not specifically predicting suicide. The importance of understanding the individual experience of a person to intervene using a bio-psycho-social model to mitigate or decrease risk in the immediate and longer future is discussed. It is why paying attention to the circumstances of the person and especially domestic abuse as part of a person's experience is required particularly when it is a pattern of ongoing behaviour or symptoms.

170. Kirsten talked about how she felt isolated due to Covid; she had limited social support generally and her family lived in another part of the UK. This was not inquired about. There is no record of the SPA SMS triage being sent to the GP.

171. Kirsten disclosed to START an intentional overdose in 2013 following the removal of her children. Kirsten denied current thoughts of self–harm but described anxiety, hopelessness and low mood. Kirsten was very focused on getting a prescription for pregabalin but this was interpreted as an issue of addiction rather than exploring for example why Kirsten was looking for

[37] RCPSYCH Self-harm and suicide in adults. Final Report of the Patient Safety Group 2020 p 47 https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr229-self-harm-and-suicide.pdf?sfvrsn=b6fdf395_10

prescription medication or why for example Kirsten's children were no longer living with her.

172. The YAS was contacted by Natasha, Kirsten's friend, in late August 2021 after Kirsten had sent a text message *"I'm done, I've had enough, I'm sorry, love you".* Natasha had found Kirsten at her home having taken an overdose. The response crew were also told that Kirsten had sent money to a male in London (identity unknown) and was now without money herself. Kirsten already had significant debts that the crew would not have known about. There is no further record of any inquiry about any of this information and no recorded evidence that a safeguarding referral was considered. The crew recorded the information and this was included in the handover to the hospital urgent and emergency care service in Rotherham and was on Meditech; the RDASH mental health liaison team would have been able to see this as they record on the same electronic record system when reviewing patients at TRFT. The RDaSH mental health liaison practitioner saw Kirsten the following day. During that discussion, Kirsten said that she had surprised herself by the overdose and had sought help immediately and expressed regret. It is not clear from the record that the practitioner had read the information in the ambulance handover sheet. The circumstances of the overdose and having come soon after Kirsten's previous attempt in August 2021 do not appear to have been disclosed either through discussion or a review of the previous contact. There is no record of exploring Kirsten's circumstances including domestic abuse. RDaSH did not have any MARAC flags on their system but would have access to Meditech's electronic patient record system in the hospital which would show a MARAC flag when recorded.

173. The GP received the discharge summary from the hospital describing Kirsten's admission overnight following an overdose of propranolol and mirtazapine on the day of Kirsten's discharge. A second letter summarised the mental health referral to RDaSH at the hospital and that Kirsten had been seen alone. No safeguarding issues were known. A longer summary arrived with the GP the following day describing that Kirsten had been in a violent relationship that lasted five years until she reported him and he went to prison. Although factually incorrect the letter goes on the say his release was imminent and that Kirsten felt anxious and unsettled. The summary also described Kirsten being isolated during the relationship although now rebuilding her life. Discussed overdose and assessed the risk of further attempts to be low. Kirsten had agreed to counselling and details had been given. The GP sent a letter two weeks later asking Kirsten to make an appointment to discuss her overdose. No appointment was made and the GP did not see Kirsten.

Services engagement with Kirsten and understanding and sensitivity about potential barriers or difficulties in getting help and support

174. The IDVA service allocated a long-term IDVA to work with Kirsten from October 2021 and referrals were being made to help Kirsten with emotional and practical needs such as benefits and debt. The IDAS service was developing an understanding of Kirsten's needs and vulnerability including self-harm. Although there were referrals and discussions about safety plans regrettably Kirsten died less than a week after the long-term IDVA had first made contact. The IDAS service is reviewing its arrangements for allocating long-term IDVA support.

175. Kirsten was referred to IAPT on two occasions in less than a month although neither resulted in Kirsten being seen. The reasons were not explained at the time. The appointment letter for one appointment on file does not include the date and time for the appointment. A text message should have been sent to the GP. The letters sent to Kirsten did not include details about how to change an appointment. All of this coincided with the Covid lockdown when services were forced to close face-to-face contact and were having to implement new working arrangements. The GP was not notified about the IAPT discharges.

176. If Kirsten had attended the IAPT appointment and had been offered an assessment as part of the IAPT care pathway it would be an expectation that a person-centred assessment would include an exploration of the multiple adverse circumstances in her life and should have included domestic abuse and about the use of prescribed and non-prescribed medication (drug and alcohol use). National guidance states that drugs and alcohol should not be an automatic exclusion from accessing IAPT if following assessment it is determined that a person would benefit from IAPT Interventions. However, IAPT at local and national levels[38] does not provide complex interventions to treat drug and alcohol misuse. NICE guidelines recommend treatment for substance misuse first and are the position of the local service in Sheffield. Kirsten might not have been able to engage with IAPT if she had attended an initial appointment. The absence of service should have been an important issue for the GP to be made aware of.

177. Although Shelter had extensive contact with Kirsten their 'registered client' for the legal aid assistance was Jake. With the reflection from their agency review, they consider how this probably framed people's thinking; that Jake was the focus and Kirsten more of "an enabler".

178. STHT had few contacts with Jake or Kirsten. The neurology nurse specialist who saw Jake in April 2021 had contact with Kirsten and appeared to have some understanding of the complexity of Jake's needs and their impact on Kirsten. The nurse specialist did not have access to Kirsten's health records who in any case was not her patient but she offered advice to Kirsten about safety planning and advice about Jake's substance misuse and the impact on his neurological condition. The nurse specialist shared information with the GP following the

[38] https://www.england.nhs.uk/wp-content/uploads/2018/06/the-iapt-manual-v5.pdf

consultation. The IMR highlighted that there could have been more discussion and signposting to support Kirsten such as the Sheffield Carers Centre.

Opportunities to complete a risk assessment about domestic abuse or self-harm

179. The discussion at the start of this section of the report raises questions about the efficacy of risk assessments that are not rooted in understanding the narrative of the victims' (and the perpetrators') lives.

180. The history of Kirsten trying unsuccessfully to leave the relationship was unknown and was therefore not factored into any risk assessment and discussion or the non-fatal strangulation. Kirsten had learnt from the previous contact with police and other services that Jake was highly likely to be able to continue his abuse and control. She also probably felt a responsibility for looking after Jake and had few options as a woman with significant debts and who was socially isolated.

181. Shelter advisors routinely completed and updated a risk assessment with Kirsten and Jake in October 2019, January 2020 and June 2020 which were completed by an experienced and knowledgeable worker. Although the assessments and other information recorded by Shelter had included information about Jake's difficulties with aggression, his registration with the special allocation scheme as a violent patient together with information about Kirsten's poor mental health, history of self-harm and the couple's use of substances, there was no disclosure or report to the service about domestic abuse. As part of the 202 housing decision review, the GP had written a letter of support that detailed Kirsten's mental health history and self-harm and concerns about suicide if she were to be sent back to Newcastle. This legal letter restricted access to the records system and was not accessible to the support worker. The advice worker had referred to Kirsten as having depression and anxiety which missed important detail for the support worker completing the assessment. There is no recorded evidence of a worker enquiring with Kirsten in particular about the relationship with Jake. This may in part have been because Kirsten presented as being concerned for Jake and motivated to give him support and appeared content to be his carer. Inverting this, Kirsten's role as Jake's carer along with the multiple difficulties and the known history of violence Jake's autism and use of substances such as spice and Kirsten's debts were all factors that could inhibit and prevent a volunteered disclosure. The support worker was not aware of the MARAC discussions because this information although recorded on Shelter's system was not forwarded to the worker involved with Kirsten and Jake.

182. The SHSC uploaded an adult safeguarding referral on the 21st of November 2020. This referral from the police followed the domestic abuse incident where police officers had observed reddening marks on Kirsten's neck and nose but neither she nor Jake wanted to make a complaint about each other. The referral

described an argument associated with Jake having “a mental health episode” and that he had been shouting. It described Jake’s poor mental health, a history of self-harm and suicidal ideation. The referral was opened by the SPA six days later to triage the safeguarding concerns although this did not get done until the 1st of December 2020. At that stage, the triage concluded that the incident was “domestic in nature” that neither Kirsten nor Jake had given their consent to have information shared and that the police had provided advice and support at the time. It was closed as a “managed concern”. Within the context of the problems the service was experiencing in terms of capacity an apparent lack of curiosity about the circumstances and the respective pressures on Kirsten and Jake and the evidence of enduring poor mental health and domestic abuse.

183. An adult safeguarding referral from the police to SPA on the 19th of May 2021 about Jake who had cut his wrists. He had been very aggressive with paramedics and had declined further treatment. The referral was discussed with the RMN who had recently assessed Jake. They concluded that initiating contact was probably unhelpful if it provoked further angry responses. They agreed to write to Jake confirming the current plan which was awaiting a psychiatric assessment and to contact the CRISI out-of-hours service when needed.

184. The SPA SMS worker was the only SHSC practitioner to have significant contact with Kirsten. Domestic abuse was not disclosed and was not inquired about. The risk assessment focussed on risk from self-harm. Given the limited information recorded about Kirsten’s circumstances and the lack of curiosity about her relationship with Jake, there is potential to learn about developing an increased focus on psycho-social factors.

185. The College of Policing guidance describes an expectation that after a DVPO is made a fresh risk assessment is completed and if necessary multi-agency referrals or plans are developed. This was not done in this case.

186. The breach proceedings represented a potential escalation in risk for Kirsten and should have made the completion of an urgent risk assessment even more compelling. There was no contact with the IDAS. In 2020 the police DVPN/DVPO process was streamlined. The DARA team did not identify and recognise the significance of historical information recorded on the PNC; at least there was no change in strategy and understanding of risk.

Effectiveness of MARAC

187. MARACs were undermined by being late in discussing the referral and were not given a good enough history. They resulted in weak actions and information was not effectively circulated to services. The GPs were completely unaware of the MARACs. Other services had problems with how the information was recorded and accessed by their staff.

188. The MARAC was held outside timescales on two occasions which require a MARAC to be within 28 days of being referred. On none of the three occasions that a MARAC discussed Kirsten and Jake was there any recorded information about the domestic abuse before the couple arrived in Sheffield in February 2019. There was no information about the age difference when they first met (she was barely 17 and he was in his mid-twenties) and the first incident was soon after they met and she was pregnant; information that was still relevant to a risk assessment several years later. There is no information about Kirsten trying to leave the relationship more than once and relocate to different parts of the UK for Jake to track her down. One of the MARACs refers to Kirsten and Jake's poor mental health and use of drugs but there is no discussion about the involvement of health services or the significance in terms of domestic abuse. The GP service was unaware of the MARAC referrals and outcomes due to a lack of representation across the city's 76 GP practices.

189. The quality of information recorded by the MARAC is poor. The quality of risk identification is not adequate and does not identify and understand the nature of the domestic abuse and the implications for strategies to control Jake and provide better protection for Kirsten. A recording of the MARAC was checked and this confirmed that although the PNC history was checked and the MARAC was told that Jake had an extensive history of violence in different areas albeit without much detail shared there was no specific reference to important information such as Kirsten's efforts to leave the relationship and being found by Jake or the pattern of escalation. None of the three MARACs resulted in any substantial action being recorded over and above telling Kirsten about the MARAC and flagging alerts to services and support offered to Kirsten. Participants at the MARAC are certain there would have been more actions but acknowledge it is not recorded. There is no information about what support plans would be developed to address safety as well as mental health substance misuse. Some of this probably reflects a MARAC process that is overwhelmed by the volume and complexity of issues being brought. In 2021 MARAC referrals rose by 14 per cent which required four MARAC meetings (rather than three in each month) from February until October 2021 and five in November 2021. South Yorkshire, led by SYP, introduced a 'gatekeeping' process for MARAC in autumn 2021 which has reduced the number of cases referred for discussion; this has not reduced the number of cases heard per MARAC but has meant the number of cases overall has reduced.

190. Although it is the responsibility of all services to develop and improve awareness and capacity to respond to domestic abuse it will remain the case that specialist services and advisors have an important role in developing analysis understanding and challenging the quality of information being brought to the MARAC and responding to the respective needs and requirements of victim and perpetrator.

191. Shelter recorded the receipt of information about the MARAC in May 2020, but did not forward it to the support worker involved with Kirsten and Jake. Shelter routinely receives agendas and as with other services should check if they need to attend. Although having substantial contact with the couple until October 2020, they were not involved in the MARAC discussion in May 2020.

192. Kirsten's GP was never aware of the MARAC discussions. It received no request for information from the MARAC or notification of the discussion and actions. This was a significant gap given the information the GP had about Kirsten's mental health, substance misuse and self-harm. The GP may have been prompted to make routine inquiries at the GP consultations. There were opportunities for the GP to have done this on more than one occasion. In April 2019 Kirsten talked about a partner who was generally supportive but when they argued she felt alone; there was no exploration of how often they argued, the circumstances or physical and emotional consequences. The month after in May 2019 Kirsten disclosed "previous domestic abuse" but had not been hit for a long time; there was no recorded exploration of the domestic abuse. Jake's record of violence is not on the GP records or the fact that Kirsten was living with a partner on the special allocation scheme or any information about his health and substance misuse issues.

193. The Sheffield Hospital's Lorenzo system did not have MARAC alerts recorded. There was also no alert recorded on the system about Jake being on the special allocation system for GP contact and care due to his violence; the hospital Trusts are not routinely informed.

194. The Sheffield mental health service recorded MARAC information on their Insight system which provided a notification that there had been a MARAC discussion but provided no further detail unless staff cross-referenced with a MARAC tab and contacted the safeguarding team for further information. The IMR concedes that it was unlikely staff would know how to access the tab or to contact the safeguarding team. The MARAC marker should at least have signified high-risk domestic abuse and should have been noted when various practitioners had contact with Kirsten and Jake and have factored it into their various assessments. When the Crisis/out-of-hours service was contacted in late December 2020 with a referral from domestic abuse services no details were recorded about the referral and no record of action.

195. Kirsten's assessment with SPA in February 2021 was after the MARAC notification in May 2020. Neither the MARAC flag nor the low mood and substance misuse prompted an abuse inquiry.

Legal measures used to stop Jake from abusing and harming Kirsten

196. The police secured a Domestic Violence Protection Order (DVPO) in November 2019 following Jake's assault on Kirsten. This does not involve any other multi-

agency discussion or action if the risk assessment of a specific incident is not high. The College of Policing states that risk assessment and safety planning must be reviewed and updated on the issue, refusal and expiry of the DVPO as part of an overall multi-agency approach to managing a victim's needs[39]. The first MARAC did not happen until six months later in May 2020. Taking account of the discussion about research evidence at the start of this section of the report, the involvement of the police and courts has to be seen and understood as an escalation in risk for victims. The College of Policing recommends that a refreshed risk assessment is undertaken at the point of DVPO being made and expects that following a breach of DVPO a risk assessment is completed and if necessary, a multi-agency plan developed; it should be part of the local arrangements involving relevant services and people. When police responded to third-party reports in April 2020 the police arrested Jake and Kirsten who both made allegations against each other. Kirsten was moved into emergency accommodation and a referral was made to the IDAS and Jake was bailed with conditions not to contact Kirsten. IDAS subsequently reported that Kirsten was returning to the relationship although no further information was recorded. The MARAC met three weeks later.

197. CPS was consulted about a charging decision in June 2021 and supported a charge of actual bodily harm (ABH). There was enough evidence in the file of the serious and sustained nature of Jake's assault on Kirsten. The charge was authorised within three hours and the court advocate was instructed to apply for a remand into custody. The CPS was not asked to consider any other potential offences on this or any other occasion and was only sent material to support this single incident. Although the charge of ABH is serious within the context of a controlling and dangerous relationship the police investigation focused on a single incident rather than seeing it as part of a far longer pattern contributes to a misunderstanding about the nature of risk to a victim, in this case, Kirsten. Jake was remanded until his conviction in August 2021 and the subsequent sentencing in September 2021. CPS applied and was granted permission for Kirsten to present her evidence to the court via a cloud-based platform.

198. The court sentenced Jake to a two-year Community Order with requirements on the recommendation of the probation service's pre-sentence report. No consideration is recorded about where Jake would live and, unsurprisingly, he breached the Restraining Order almost immediately upon leaving prison although it was a fortnight before a third-party report to the police made them aware that he was living at Kirsten's home in breach of the order. The police arrested Jake and the CPS out-of-hours service authorised a charge of breaching the Restraining Order. Jake appeared before the magistrates at Saturday court pleading guilty and was sentenced to a four-month term of

[39] https://www.college.police.uk/app/major-investigation-and-public-protection/domestic-abuse/using-domestic-violence-protection-notices-and-domestic-violence-protection-orders-make-victims-safer

imprisonment although suspended for 12 months. The Restraining Order was still in place as was the Community Order with requirements.

199. The pre-sentencing assessment identified the risk to Kirsten and recommended the Restraining Order. The pre-sentence assessment did not include consideration about where Jake would and should live. It also did not trigger any referrals to various health services for substance misuse or the need for greater mental health support.

200. The probation service prepared its report and recommendations in compliance with national guidelines. National guidance on sentencing[40] includes a description of three levels of Orders and requirements based on the seriousness of the offence (low, medium and high). The high level is when the offences fall just below the custody threshold or the threshold is crossed but a Community Order is appropriate in the circumstances. The offence of ABH falls within that category. The national guidance includes a list of requirements that can be used. This includes a residence requirement to live at a specified place or as directed by the responsible officer as well as drug rehabilitation and mental health treatment. These conditions were not included. In determining requirements for a Community Order a range of factors must be considered including the risk of re-offending, the ability of the offender to comply as well as the availability of requirements in a local area. Although the probation agency review confirms that the history of the relationship and domestic abuse was extensively inquired about and recorded by the pre-sentence report author it does not clarify with or without hindsight the process by which judgments were made against the sentencing guidelines or the level of detail the officer writing the report knew.

201. There was clear evidence that Jake would not comply with court orders and it should have been clear that there was a high risk of Kirsten continuing to be abused. The matter was further exacerbated when Jake was permitted to live with a household on the same road that Kirsten lived. The housing and neighbourhood service told the panel that if the service is asked to provide accommodation in a situation such as Jake's they would be able to respond. The pre-sentence report author nor the supervising officer made any referrals or discussed with mental health or substance abuse services.

202. When Jake was presented to the court for breaching the Restraining Order, he was sentenced to a term of four months imprisonment suspended for a year. A suspended sentence cannot be imposed as a more severe form of Community Order. A suspended sentence is, as made clear in the national sentencing guidance, a custodial sentence. Factors that a court takes into account when considering a custodial sentence are whether the offender presents a risk/danger to the public, there is a poor history of compliance with court orders

[40] https://www.sentencingcouncil.org.uk/overarching-guides/magistrates-court/item/imposition-of-community-and-custodial-sentences/

and/or appropriate punishment can only be achieved by immediate custody. Any court is reliant on being given the relevant history and information.

203. Based on the information provided about the circumstances of the offences, the weekend court had no reason to postpone Jake's sentencing. The PSR that had been presented at the original court hearing had described Jake's cooperation with the probation officer.

Services offered to Jake as a perpetrator of domestic abuse

204. There is no record of Jake being offered services until he was convicted of assaulting Kirsten and made subject to a Community Order with requirements that included participation in 30 sessions of an accredited programme specifically building better relationships (BBR). He did not participate in any sessions. The gap in a perpetrator programme has been described elsewhere in the report.

205. While Jake was on remand and the presentence report was being prepared that would recommend a Community Order there was no referral to any accommodation service or substance or mental health services. It was not discussed at any of the MARAC meetings.

Services offered to Jake to address his mental health and substance abuse

206. Jake told Shelter's advice staff about his adverse childhood and the difficulties associated with autism and ADHD. The only reference in the health record appears in a letter from a neurology nurse specialist to Jake's GP suggesting that Jake might have additional needs associated with autism and ADHD. It is not apparent there was an assessment of these additional needs. Jake was never referred to substance misuse services whilst in Sheffield but was referred to mental health services.

207. The probation service acknowledged that during the preparation of the presentence report in September 2021 it was clear that Jake had significant substance misuse difficulties and was having problems getting the support he needed for his mental health difficulties. Referrals were not made by the probation officer who was working under short deadlines and with a large caseload.

208. The housing and neighbourhood service acknowledge that Jake's mental health needs were recorded as an assistance code on their information system and Kirsten talked about Jake's admission to the hospital following an overdose when housing officers followed up on a report of ASB. There is no record of discussion with Kirsten or Jake about the help that they were getting and no evidence that advice or help was offered in making referrals to mental health or substance abuse services. The IMR concludes that it

was likely an assumption was made that help and support were already in place.

209. Kirsten and Jake both had contact with the SPA service about substance misuse. Kirsten had a telephone in late February 2021 (shortly after Jake's admission to the hospital for an overdose) as a result of the self-referral opened by the SPA SMS nurse specialist. The same service had contact with Jake following his overdose. They were both discussed at a SPA multi-disciplinary team (MDT) and agreed that they would be signposted and needed to engage with SMS before mental health services could help them. There was no exploration of domestic abuse as part of the SPA assessment or the MDT discussion. The contact with the SPA service has been described in the chronology earlier in this report.

210. Jake's risk to others was identified although not explored in enough depth by mental health services. Contact with the SPA SMS service was disrupted by staff absence. Jake was reliant on using the Crisis out-of-hours service. On each occasion, he spoke to different people. Jake struggled with controlling his emotions. Jake was not seen by a psychiatrist due to a lack of people in the post. Jake's registration with the special allocation scheme meant that he did not have a consistent GP Practice to contact and oversee his primary care.

Escalation of any issues to senior managers in the agency or with any other specialist professionals or organisations

211. The SPA has raised the absence of medical cover within the service which has been a constant and consistent issue and creates significant and unacceptable delays to people such as Jake using their service. The issues have been escalated to the Trust's medical director who is responsible for the recruitment of staff including psychiatrists. Attempts to cover the gaps have included recruiting locum staff. At the time of the DHR, there was one locum psychiatrist, a speciality doctor and a consultant for one day a week. The service should have two consultant psychiatrists and two speciality-grade doctors.

212. The service is unable to provide same-day triage on referrals and has a significant backlog. Triage is taking several weeks. The SPA knows it is under-resourced and that the waiting times are unacceptable.

The capacity or resources of services to help Kirsten or to prevent domestic abuse

213. Covid had a major impact on services and how they worked and were able to give support to Jake and Kirsten. Local data shows that referrals about

domestic abuse declined but as the lockdown eased the level of referrals by professionals increased; in June 2020 they were up by 24 per cent[41].

214. Shelter describes that whilst they maintained contact with all clients during this time, the focus of work often needed to be on meeting the immediate needs of people and providing essential support, such as food parcels and medication. That is certainly what happened with Kirsten and Jake's support during that time. The impact of Covid on staffing disrupted the delivery of supervision and oversight and the workload of staff was exacerbated by numerous clients in crisis during a period of unprecedented challenge.

215. The housing service was required like other services, to severely restrict the circumstances under which visits or direct contact was attempted with tenants. Processes such as annual visits and other direct contacts were halted. At the time of the lockdown, this included MARAC-related actions which were converted into follow-up by phone. The service, with hindsight in their review, has acknowledged that in future these are contacts that should be exempt from restrictions.

216. The long wait that Jake had for a mental health diagnosis after the initial SPA assessment reflected longstanding shortfalls in the capacity of the local service which was exacerbated by Covid. Their advice to Jake in May 2019 to contact third-sector helplines that were also experiencing high levels of demand did not address Jake's needs.

217. The SPA nurse consultant who saw Kirsten in February 2021 created a self-referral to substance misuse services in recognition of her disclosures. The aim is for any referrals relating to dual diagnosis to be assessed by the Band 4 SPA SMS worker, under the supervision of a Band 6 qualified professional within SPA. In theory, the SMS worker due to the links across teams could facilitate quicker access to each service.

218. The SPA Substance Misuse Services (SMS) worker role was a pilot scheme between SPA and SMS. At the start of COVID, there were staff that had transferred over to the Trust under TUPE[42] who weren't able to work in custody and courts and prison and SPA was struggling with a lot of people coming through with alcohol issues. Two recovery workers were placed in SPA to support and complete triage support the staff with advice and make a referral easier. It proved a good opportunity to demonstrate how well having recovery workers in SPA with SM experience could work so it was a good way to pilot this. The feedback from SPA was positive and the service decided to recruit recovery workers as the pilot staff went back to deliver their permanent commissioned activity once the lockdown was lifted.

[41]Sheffield Covid-19 Rapid Health Impact Assessment

[42] The Transfer of Undertakings (Protection of Employment) regulations (TUPE)

219. There is no substance misuse worker employed in the SPA and this is a recommendation included within the SHSC agency report and referenced in the appendix to this report.

220. The probation service reported that workloads were “extremely high” in 2021 for qualified and experienced probation officers and this remains the case. Allied with this was the reorganisation of probation services needed to reunite and create local services following national changes imposed on services across the country.

221. On the day that Kirsten had taken her fatal overdose, YAS was working under increased levels of demand. Natasha was initially advised to try to self-transport Kirsten to the hospital. This was not possible. YAS has confirmed that their response was within the recommended timeframes.

Impact of any organisational changes

222. The national probation service was re-established in June 2021. These significant organisational changes involved moving staff into different roles. The probation service was not made aware of the adjourned sentencing and request for a pre-sentence report in September 2021 which led to a foreshortened timescale to complete work. It coincided with recruitment difficulties exacerbated by the Covid pandemic. The probation officer who completed the presentence reports in 2021 had recently returned to work and was allocated a large caseload has subsequently become absent from work due to health difficulties and was therefore unavailable to have any discussion with the IMR author for the service.

Good practice

223. The legal advice and advocacy provided by Shelter led to Kirsten and Jake being able to continue living in Sheffield. Kirsten’s family say that Kirsten had more help in Sheffield than had been the case in other places she had lived. The advice work by Shelter also resulted in a material improvement in income through the PIP. The service also recognised and provided tenancy support to the couple. The agency review has provided good learning for the organisation that is described in other parts of the report.

224. In February 2021 the SPA SMS nurse specialist opened a self-referral with Kirsten. Although it does not have a detailed recording it appears to be the result of the nurse specialist talking with Kirsten who was concerned about Jake’s substance misuse and recognised that she needed an assessment of her own needs. The creation of the pilot SPA SMS service using staff who found themselves unable to deliver their commissioned service during lockdown led to the permanent creation of a service.

Action(s) by agencies that in retrospect and with reflection might have led to better outcomes in this particular case

225. The panel agreed that the lack of understanding and framing the domestic abuse as coercive and controlling meant that risk was not understood well enough. Probably the single action that could have created better outcomes is if the information recorded on the PNC had been properly searched, analysed and discussed at multi-agency risk conferences. The police are the only service to acknowledge and provide information about the history that goes back to the beginning of the relationship when Kirsten was still an adolescent and Jake was an adult in his twenties. It was in June 2021 after Jake had been arrested for his assault on Kirsten and remanded to custody that a more detailed history of domestic abuse was recorded by the police.

226. None of the three MARACs had a record of knowing about this history other than a general acknowledgement that there is history. The specialist DARA (domestic abuse risk assessor) officers did not appear to identify the significant history or its relevance for risk assessment and planning; they did not challenge or change risk assessment or strategies. It contributed to the misunderstanding about Kirsten "returning to the relationship" rather than seeing her as a victim who was entrapped by the behaviour of Jake and barriers such as debt, poor health and isolation. When Jake was allowed to continue contacting Kirsten from prison during his remand the letters and texts that he sent were not understood as harassment and intimidation; it was Jake asking Kirsten "to tell the truth". The phone contact was blocked by the prison. When Kirsten on this occasion and others said that she did not want to support prosecution the police cited evidential difficulties preventing further action due to the victim withdrawing her support.

227. Understanding and framing Kirsten's behaviour within the context of the coercive and controlling abuse she had been subjected to over many years should have prompted a more proactive evidence-led approach and investigation by the police on more than one occasion. For example, the incident in November 2020 when the police responded to a third-party report found Kirsten with reddening marks on her neck and nose. Kirsten was asked to confirm a police notebook entry that no assault had taken place rather than the police considering whether there was evidence of an assault. The Domestic Abuse Act 2021 and the introduction of non-fatal strangulation (and non-fatal suffocation) offences since June 2022 and understanding the association with its use to instil fear, power and coercive control and the high risk of serious injury and terror for a victim requires improved attention to observing and recording of any evidence. The Act also includes economic abuse as a legally recognised form of domestic abuse that involves the control of money to maintain economic instability and entrap a victim like Kirsten. It was during this incident that the DASH

recorded Kirsten as saying she “felt down” when asked about depression or thoughts about self-harm.

228. The probation service had access to the history but is not recorded in detail as part of the pre-sentencing report. Sentencing recommendations were not informed by a detailed enough understanding of the history and the significance of Jake’s threat and there was insufficient attention to addressing accommodation and mental health concerns.

229. IDAS has recruited complex need IDVAs with reduced caseloads and a remit to work more intensively with other services.

230. The housing service has updated the training being given to housing officers about ASB and investigation of complaints for example of noise nuisance that might be indicative of domestic abuse. The service is also working with the information officers on how the protocols around privacy notices between different sections such as homeless and housing teams can allow more appropriate sharing of information

231. The lesson from research and this DHR is that the response from services has to be consistent and based on a good narrative understanding of risk.

Lessons learnt from the review identified by agencies

232. The housing service has recruited practice development coordinators to help train and support staff in safeguarding practice with a focus on domestic abuse. This is a recognition that neighbourhood officers need to develop their confidence and have support. The service acknowledges that in responding to Kirsten and Jake there could have been more curiosity and a proactive approach to considering whether the police were aware of incidents being reported to the service, checking whether IDAS were in contact and supporting Kirsten as well as the mental health and substance abuse issues.

233. IDAS is reviewing whether those vulnerable victims who face multiple adversities should be provided with one key worker from the first point of assessment rather than moving from a ‘Hub IDVA’ to a long-term IDVA. This may assist in engagement for this group of women, many of whom feel that they’ve already been passed from pillar to post in terms of the number of professionals they have contact with.

Other issues identified by agencies

234. User permission settings on the Shelter case management system restricted access to legal documentation that was collated for the 202-review procedure. The GP’s letter that was submitted to support the case for reversing the decision to refuse housing to Kirsten and Jake in Sheffield

included Kirsten's history of mental health problems, self-harm and taking an overdose. Her mental health was described as deteriorating because she was concerned about being made to return to Newcastle and she felt that she would be at high risk of suicide rather than having to go back. The Shelter IMR identified that advice staff could have put a welfare alert about the potential risk to Kirsten on the case management system.

235. The SHSC described limitations in the recording of MARAC and client warnings more generally. The IT system is designed to have a single warning for the victim and perpetrator respectively no matter how many of each occur. The IT warning system is designed to alert practitioners to domestic abuse but the system requires more extended navigation of the record system to access more details. If it had occurred in this case there was limited information recorded as a result of the MARAC,

236. This information was placed on the housing information system but was not accessible to housing and neighbourhood staff who provided support to the tenancy and responded to complaints. This is because of the privacy policy that restricts access to information. This is being addressed by the service. If the housing and neighbourhood officers who were dealing with what they framed as ASB, knew about mental health and self-harm concerns would have made risk assessments more informed and prompted curiosity about anti-social concerns being an indicator of domestic abuse. As a result of the discussion at the panel, the service has reviewed its policy and is implementing training and updated guidance.

237. IDAS has recruited complex needs IDVAs with reduced caseloads and with the capacity to work with victims alongside other services as part of a more coordinated response.

238. The MATAC (multi-agency tracking and coordination) introduced in March 2021 is a partnership to target the behaviour of serial domestic abuse perpetrators. The scheme did not apply to Jake because one of the criteria is that a perpetrator has two or more victims within two years. The MATAC manager is working on extending the remit of MATAC to cover repeat offenders with one victim and perpetrators who move into South Yorkshire from other areas.

239. Kirsten's role as Jake's carer and Jake describing Kirsten as supportive during SPA assessments for example contributed to domestic abuse not being considered well enough. The lack of professional curiosity was identified by several services.

240. The quality of the recording was highlighted by mental health services. Some of this was attributable to human and administrative errors. However, a contributing factor was the use of drop-down boxes to record information for example about referrals.

241. Other than the CCG (now the ICS) no other health provider was aware that Jake was on the special allocation scheme due to violence. This has

implications for safety assessments for other health professionals as well as alerting them to the fact that Jake was not able to consult a consistent GP practice but was reliant on a city-wide duty GP system. This meant that any GP who had contact with Jake was even more reliant on accessing whatever information had been recorded on the system. They were completely unaware of the MARAC flags or concerns about domestic abuse.

Conclusions

242. Kirsten was entrapped in an abusive long-term relationship. Her family understood this from early in the relationship and tried to get help before Kirsten left Northampton. Her family also know that in the end Kirsten still loved Jake. She did not want to be abused and wanted the abuse to stop over many years. Although help was offered by services in Sheffield, none of them had an understanding about this being a controlling relationship and did not understand Kirsten's entrapment until this DHR. This led to serious misunderstandings; for example, the contact with Jake whilst in prison, how Kirsten interacted with first response officers and the DASH processes. Some narrative descriptions for example about Kirsten reporting contact from Jake whilst in prison "to tell the truth" did not understand that this was Jake still seeking to control Kirsten, and trying to get Kirsten to withdraw her statement as a prosecution witness.

243. Unless professionals can develop an awareness and understanding of coercive control, they will be incapable of understanding the true dynamics of a relationship with a perpetrator of abuse and will make very risky and uninformed judgements such as permitting Jake to live on the same road as Kirsten after his release from prison and sentencing.

244. The response by services was not consistent enough. Securing legal orders is not enough without robust plans involving different services that understand the dangers and dynamics. Victims of IPA may make decisions around whether they seek or accept help based on how useful they think the help will be: the timing, speed and nature of the help offered are crucial. Aitken and Munro's (2018) findings that there are damaging gaps and delays when referring victims for community services and that short-term risk management services are inadequate in the context of suicidality are pertinent.

245. Research finds notable consistencies in the characteristics of victims who take their own lives in the context of intimate partner violence. These include control, coercion, intimidation, stalking, isolation, threats to themselves and others, threats and assaults with weapons, entrapment and failure of services. Many of these characteristics are found in the history of this relationship. Almost all (96 per cent) of the victims of intimate partner abuse (IPA) who were identified as suicidal suffered from feelings of hopelessness and despair (Aitken and Munro 2018), and these feelings are

a key determinant for suicidality. Hopelessness or lack of hope brought about through entrapment has been found to influence victim decision-making in this context. Hopelessness can focus individuals on the short term with little sense of a longer-term future that is different.

246. It was reported by her family that Kirsten had wanted to spend time with her mum in particular shortly before she died and soon after her first overdose in August 2021. On both occasions, Kirsten also spoke to Natasha in Sheffield about her feelings of hopelessness which were reported to the paramedics. Kirsten felt trapped over several years according to her family unable to escape the relationship. Kirsten's family speak positively about steps taken in Sheffield to help Kirsten and this suggests that this was different to what had happened in other places where Kirsten and Jake had lived. Given court orders had been taken on more than one occasion, Kirsten had been housed in protected accommodation from Jake and he had been required to live at a different address Kirsten may well have felt there were no further steps that could be taken to escape. The lesson from this DHR has to be how entrapment is recognised and addressed more effectively in the future through more consistent and coordinated action across services.

247. The overdose in August 2021 was not understood or assessed as a planned attempt on her life within the context of Kirsten's experience of domestic abuse.

248. The MARAC should have been an opportunity to identify potential warning markers and set in motion agreed strategies for a coordinated and consistent response across services. The DARA should also have been an opportunity for more intensive intervention that included an evidence-led investigation rather than relying on Kirsten to engage with the prosecution or discuss the use of Clare's law.

249. Starke argues that coercive control is the most common type of partner abuse for which victims seek and/or require assistance[43]. It is considered to be the most dangerous abuse, having strong associations and links to serious harm and homicide[44] and has been an offence in England since 2015.

250. More recent links have been made between domestic abuse perpetrators and other forms of violence and homicide, supporting the idea that it may

[43] Stark, E. (2009) Coercive Control: how men entrap women in personal life Oxford: Oxford University Press

[44] Monckton Smith, J. (2020) Intimate Partner Femicide: Using Foucauldian Analysis to Track and Eight Stage Progression to Homicide Violence Against Women 8 476-494

link more closely to notions of domestic abuse as a form of violent crime and has implications for how services such as the police and courts view it[45].

251. Research has established controlling patterns of behaviour as permeating and dominating high-risk domestic abuse. It has implications for the way the police and domestic abuse services collate information and assess risk, the type of information and analysis that needs to be achieved in forums such as MARAC, the management of remands and information given to courts including pre-sentence reports as well as the management of mental health consultations and support in primary and specialist health services.

252. Perpetrators use a broad range of abusive and controlling tactics to subjugate or dominate a partner, rather than just hurt them. It is characterised by a pattern of behaviour that in many cases reflects the motivation of perpetrators to achieve control. The damage that Jake had reported experiencing during his life and childhood, in particular, his complicated mental health and chronic substance misuse exacerbated the level of risk in this relationship. Although the response from SPA was timely this did not progress to more substantial and longer-term support. The limited offer of crisis support and being told that there is "a clear plan of care" (April 2021) was an inadequate level of response caused by staffing shortfalls in the service.

253. Defining Kirsten as a carer effectively bound her even more into a relationship that damaged her. Kirsten's role as a carer for Jake can and probably should be viewed as one mechanism by which Jake maintained emotional and psychological control that was reinforced by the interaction with various professionals who accepted this delineation of roles but provided no opportunity for discrete and focussed enquiry with Kirsten about her circumstances and needs. Her poor mental health and reliance on medicating with a variety of substances were never explored within the context of domestic abuse. When Kirsten self-harmed she downplayed the circumstances. There were opportunities in mental health services and with the GP to have followed up. Kirsten was still having to deal with the reality of Jake's continuing abuse and control.

254. The SYP Force Management Statement states a commitment to put vulnerable victims at the centre of their daily business of policing. It goes on to say "the ability to retain victim engagement and empower victims to support a prosecution after the initial response remains a challenge, with up to 49 per cent of domestic abuse victims not supporting (or withdrawing initial support for) police action. Despite this, work continues to try to identify improvements through victim feedback. Engagement with the CPS and HM Courts and Tribunals Service is continuing as part of the joint Domestic

[45] Walby, S., Towers, J. and Francis, B. (2016) Is Violent Crime Increasing or Decreasing. British Journal of Criminology n56 (6): 1203-1234

Abuse Best Practice Framework which aims to improve outcomes for victims of domestic abuse and reduce delays in the system"[46].

255. This does not entirely align with the CPS's domestic abuse guidelines for prosecutors that make it clear that all cases of domestic abuse should have an evidence-led approach and that the starting point should be to build cases in which the prosecution does not need to rely on the victim[47]. The safety of victims has to involve multi-agency discussion; discussion at the panel included the importance of developing trauma-informed and confidence-building strategies with victims across all services.

256. SYP was asked to provide information on any policy guidance about the evidence-led investigation and decline to prosecute statements from victims of domestic abuse. Further information was provided about the response to incidents and an acknowledgement about opportunities to have for example sought third-party statements. There are many reasons why victims do not engage with the police, particularly where coercive control, harassment and stalking are being used by the perpetrator. Any guidance or working practices that are based on a supposition that a victim will support police action and offer little or no advice and training to specialists and response police officers will not promote the requisite mindset and practical interventions to address the safety of a victim and perpetrator's behaviour. Unless police officers are given explicit guidance on how they should proceed where a complainant does not wish to make a statement or support prosecution then the policing response will not change. It also requires senior officers to provide leadership and direction in achieving a focus on evidence-led investigation and has implications for how supervisory police officers in sergeant and inspector roles with the support of officers involved in evidence review develop strategies for evidence-led investigation where there is a decline to prosecute statement. In this case, the secondary assessment did not identify the extent of history, and its relevance to investigating domestic abuse in Sheffield and inform enhanced interventions which are supported by the work of specialist domestic abuse workers.

257. There can be many reasons for officers to think an evidence-led approach is unnecessary. A misplaced belief that the police should be victim-led and act following a victim's wishes rather than being clear that the police must determine if they consider there is a crime to be investigated or prevented and a victim safeguarded. They can fail to understand that an offence is part of a longer-term pattern of behaviour; in this case, it goes back seventeen years.

[46] South Yorkshire Police Force Management Statement 2021 p 110
[47] https://www.cps.gov.uk/legal-guidance/domestic-abuse

258. The joint inspection of evidence-led domestic abuse[48] makes clear that details of evidence-led cases and requirements should be included as a matter of course within domestic abuse training. This point is that evidence-led cases should receive the same attention; effectiveness and efficiency of response; supervisory oversight; and quality assurance as all domestic abuse cases cut across the findings and underpins the joint inspection recommendations.

259. The creation of a specific criminal offence of non-fatal strangulation and suffocation from June 2022 covers a range of behaviours. Strangulation has been identified as one of the most lethal forms of domestic abuse. Unconsciousness can occur within seconds and death within minutes. When domestic violence perpetrators choke (strangle) their victims, not only is this a criminal assault, but it may be an attempted homicide. A strangulation is an ultimate form of power and control, where the perpetrator can demonstrate control over the victim's next breath; having devastating psychological effects or a potentially fatal outcome. Victims who survive non-fatal strangulation may suffer a range of physical and psychological symptoms some of which can be enduring. It is an example of where an evidence-led approach is so important. CPS has been training prosecutors since the legislation was amended and is having more cases referred for prosecution decisions involving non-fatal strangulation.

260. The College of Policing provides several examples of successful evidence-led prosecutions[49].

261. SYP is developing proposals to extend the scope of the MATAC that was established in 2021. This includes repeat offending in one relationship and perpetrators who move into South Yorkshire from other areas with a history of domestic abuse.

262. The government has announced its intention to publish a perpetrator strategy within one year of Royal Assent of the Domestic Abuse Act 2021. The Home Office and Ministry of Justice have jointly funded a new Multi-Agency Public Protection System (MAPPS) which will replace ViSOR and create greater functionality in enabling criminal justice services to more efficiently share information, and improve risk assessment including management of domestic abuse perpetrators and MAPPA nominals. The act also introduces new Domestic Abuse Protection Orders for managing the risk posed by a perpetrator such as Jake. This will be an opportunity for a multi-agency response to be set within a court order.

[48] Evidence led domestic abuse prosecutions 2020 HMCPSI and HMICFRS available from https://www.justiceinspectorates.gov.uk/hmicfrs/publications/evidence-led-domestic-abuse-prosecutions/

[49] https://www.college.police.uk/app/major-investigation-and-public-protection/domestic-abuse/investigative-development accessed on 11th July 2022.

263. The College of Policing has also issued guidance to police forces on the identification, assessment and management of serial or potentially dangerous domestic abuse and stalking perpetrators[50]. The key principles set out that forces should have processes in place to identify serial or potentially dangerous domestic abuse or stalking perpetrators and ensure that information about the perpetrator is recorded on the Police National Computer, the Police National Database or ViSOR as appropriate.

264. There is a palpable sense that no single agency or professional was in a position to properly understand and see events and information from Kirsten's perspective. The incidents were treated as separate incidents rather than a series of occurrences over several months and were the continuation of behaviour from before arriving in Sheffield. The MARAC displayed a similar inability to see the separate dots that needed linking.

265. The MARAC did not identify the underlying pattern of the incidents of domestic abuse despite three referrals in 15 months. There is no recorded evidence that the MARAC was given a detailed account of the history and pattern of domestic abuse recorded on the police PNC at any of the meetings. None of the MARAC recorded actions was to investigate history. The absence of knowledge and understanding about the nature and extent of domestic abuse probably contributed to no action being agreed upon for attempting to signpost Jake to a local programme or organising more intensive intervention with the couple. The MARAC discussions were late after the incidents that led to the referrals. Some of the agencies that received information that a MARAC had discussed with Kirsten and Jake filed it without alerting staff working with the couple. Other services such as the GP never received a notification.

266. Safe Lives was commissioned to undertake a systemic review in Sheffield through the lens of the whole family, identifying opportunities for improving the response to high-risk abuse, as well as early intervention and prevention. The public health approach includes a systems-wide assessment of the current local arrangements and consulting with service users and providers to understand opportunities, strengths, and gaps. The DHR and the Safe Lives review identify the heavy workload of MARAC, low capacity in mental health services and dual diagnosis services and not enough appropriate housing. These are issues that represent a complex challenge at a time of constrained funding and workforce shortages and are reflected in this DHR.

267. The response of services to domestic abuse needs to address the perpetrator's violence effectively and increase the safety of victims and

[50] https://library.college.police.uk/docs/appref/Serial-dangerous-domestic-abuse-stalking-perpetrators-principles.pdf

needs to be consistent particularly in addressing the control of the perpetrator's behaviour. Although there was a response to Jake's violence, it did not address enough the motivating factors of the violence, misunderstood the nature of risk at critical points and legal sanctions were not effective enough. This included the court's disposal when Jake breached the Restraining Order. It is concerning that there was very little understanding about the potential for elevated risk associated for example with a remand to and release from prison, court disposals and particularly when the outcomes at court did not result in stopping the abuse.

268. Jake's behaviour and level of risk were exacerbated by his mental ill health and substance misuse. Although Covid presented extraordinary and unprecedented challenges and changes to how services were provided particularly in face-to-face contact it is clear that there are long-term structural problems regarding the staffing of some mental health services and dealing effectively with people who have a dual diagnosis of mental health and substance misuse.

269. A suicide support website[51] has been established in Sheffield since September 2020 that pulls together information and signposts to services. Training for local professionals is also being promoted through the zero-suicide alliance[52]. This training can be accessed by GPs who will also have the opportunity to access a two-hour taught suicide prevention programme that has been developed as part of the local action plan to prevent suicides.

Lessons learnt

270. The learning is summarised;

a) Curiosity and understanding of history and narratives; Kirsten was a long-term victim of Jake's controlling and abusive behaviour that was not understood and caused reflection for all services in this review; Jake's abuse was exacerbated by his complex mental and physical health needs and was overwhelming for Kirsten; the implementation of The Domestic Abuse Act 2021 requires clear responses to evidence of economic abuse and non-fatal strangulation;

b) Interventions have to be coordinated and consistent across different services in addressing the behaviour and threat from the perpetrator and giving support and confidence to the victim; interventions to address the most dangerous forms of abuse involving coercion and entrapment need consistency and robust strategies that are understood by the respective agencies and are

[51] https://sheffieldsuicidesupport.co.uk/
[52] https://www.zerosuicidealliance.com/training

evidence-led through coordinated intensive intervention involving criminal justice and specialist domestic abuse services; this has implications for how DARA, IDAS and MATAC develop; availability of perpetrator programmes in the community and prison;

c) Domestic abuse that is framed as violence between two adults with equal choice and opportunity and is assumed capable of stopping the abuse creates the most dangerous context for considering risk. It leads to a failure to understand the true nature of the danger, leaves the victim responsible for leaving the relationship/ sustaining separation isolates them from help and gives greater power to the perpetrator.

d) Victims of domestic abuse are often left with very low self-esteem and confidence; they need to have a safe and supportive relationship with a person they believe they can trust and have confidence in and who can help them; the IDAS proposals to allocate long-term IDVA support at an earlier stage is welcome; IDVAs who are appropriately trained, resourced and supported are a critical part of gathering information about perpetrator patterns, building confidence with victims and developing interventions;

e) Looking for and understanding the markers and clusters that help identify the particular dangers posed by coercive control and entrapment to inform prevention strategies, risk assessment and perpetrator interventions; the city is hosting a conference in February 2023 with national and international speakers to help develop guidance, resources and learning tools.

f) MARAC capacity, purpose and effectiveness; the capacity issues for MARACs in managing the workload; reducing the time between incident and referral to MARAC; the police with other agencies providing marker-informed history from local and national databases that helps to flag markers of coercive control and escalation; MARAC resulting in actions that address both victim and perpetrator and are forwarded to people in direct contact with the victim or perpetrator; ensuring that GP services are a part of the process;

g) Help and action to address and disrupt the perpetrator's abusive behaviour needs to include addressing issues such as chronic mental health and substance misuse; access to trauma-informed dual diagnosis services and community mental health services beyond SPAs; a copy of the report will be sent to the chair of the MHLDDA Board for further discussion at the Operational & Delivery Group; the strategic manager for sexual health and substance misuse is to facilitate a workshop;

h) Police policy frameworks and working practices should promote appropriate evidence-led prosecution of domestic abuse in

response to coercive control/entrapment/strangulation; SYP has developed policy, provided training and introduced legal clinics to support staff; this needs to be embedded and officers to have a good understanding about the significance of behaviours such as non-fatal strangulation.

i) Ensuring courts are sufficiently informed about patterns of behaviour and markers of risk involving coercion and control; offender risk assessments and pre-sentencing reports involving domestic abuse offences being informed by a clear and complete history of domestic abuse and take full account of sentencing guidelines; ensuring information about domestic abuse history is provided to prison staff and that victims are protected from ongoing contact; prisoners on remand for domestic abuse offences not being able to contact their victims directly or by proxy; ensuring that the accommodation at pre-charge bail, upon conviction and release from prison, are checked as suitable;

j) The link between poor mental health, self-harm and use of substances with the distress and fear created by domestic abuse has implications for primary health, mental health and substance misuse services; services need people who have informed curiosity and can make the link that the abuse is what needs to be addressed and to act accordingly;

k) Anti-social behaviour involving arguments between people in the same household needs to be seen and processed as potential domestic abuse by housing and neighbourhood services. Anti-social behaviour training for housing staff has been updated to advise when receiving 'noise nuisance' reports, officers explore the possibility that the noise nuisance could be a result of DA/DV.

l) Patient record systems do not link effectively enough between different providers and areas and are a national issue; the use of other national systems in criminal justice is not yet effective enough in identifying victims and perpetrators who have lived in multiple locations.

271. A learning brief from the DHR will be published and disseminated to local services.

Recommendations

The Sheffield Domestic Abuse Coordination Team (DACT)

1. The Sheffield Domestic Abuse Coordination Team (DACT) and IDAS should use evidence from this DHR to review the content of local training and domestic abuse assessment practice and align this with the proposed introduction of the DARA risk assessment by SYP.
2. The Sheffield Domestic Abuse Coordination Team (DACT) should ensure that a review of MARAC and its linkage with existing complex case management and other safeguarding processes are completed

with recommendations made to the Domestic and Sexual Abuse Strategic and Local Partnership Board.

3. The Sheffield Domestic Abuse Coordination Team convene a multi-agency task and finish group to coordinate and develop the city's perpetrator strategy.

NHS South Yorkshire Integrated Care System (SYISC)

4. The SYISC should develop proposals for responding to the learning from this DHR and in particular how information about MARAC and other domestic abuse risk discussions are linked with GP practices.

IDAS

5. IDAS should IDAS should monitor and evaluate how the revised engagement strategies and risk assessments and the allocation of long-term IDVAs from the first point of contact for victims with multiple adversities and risks are working.

Sheffield Health and Social Care NHS Foundation Trust

6. SHSC should respond to the learning from the DHR, about how individuals with dual diagnosis access appropriate services to address co-existing needs. There is ongoing work involving people who have substance misuse issues and mental health problems to ensure they can access appropriate services at the right time to ensure consistency across the organisation.

Sheffield Housing and Neighbourhood Services

7. SCC's Information Officer is reviewing the privacy notice for applicants approaching SCC as homeless, to review if relevant information can be shared with Housing Staff if that applicant subsequently signs for an SCC tenancy
8. Practice Development coordinators will provide training to housing staff to educate them on what MARAC is / and the importance of undertaking actions identified/notebook outcomes.

The Probation Service

9. The probation service should respond to the learning from the DHR about assessment and response to coercive and controlling perpetrator offending and use of the law. This should also include how the accommodation needs of the perpetrator are checked as part of any pre-conviction measures including court-imposed bail conditions and following a conviction; using conditions in community orders to access and direct to perpetrator programmes and accessing appropriate health care.

The South Yorkshire Police

10. The South Yorkshire Police to review the mechanisms for the management of potentially dangerous domestic abuse and stalking perpetrators who do not have a recent repeat offence history that comes within the scope of MATAC and the local intensive intervention strategy.

National issues

1. Inspection of prisons routinely checking on how prisoners on remand are managed and prevented from contacting their victims
2. Guidance to domestic abuse advocates where Family Court proceedings relate to concerns about domestic abuse involving coercion and control
3. Access to perpetrator programmes in prison.
4. The use of police national databases for recording information about victims and perpetrators of domestic abuse varies between different areas and is not supported by any national guidance to promote consistency in recording information about perpetrators and victims moving around different areas.
5. Coordinating and collating information between individual GP practices and MARAC has resource implications.
6. The absence of a consistent patient record system across different health providers is an issue when patients have accessed different services.

Agency recommendations

NHS South Yorkshire Integrated Care System (SYICS)

1. The SYICS will encourage GP practice staff to enquire about all elements of the Trilogy of Risk each time one element is mentioned
2. The SYICS will remind GP practice staff that when domestic abuse has been identified the risk of harm to that person should be assessed using the DASH risk assessment tool.
3. The SYICS will encourage GP practice staff to document when they speak to a “partner” and record other identifying details
4. Vulnerable families’ meetings provide a forum to link patients who disclose elements of the Trilogy of Risk and thus more accurately assess the risk of harm to those in that household. The SBICS will promote this good practice.
5. The SYICS will encourage clinicians to consider the appropriateness of informal carers to fulfil this role if they are aware of any element of the Trilogy of Risk.

CPS (action taken in response to the DHR)

1. The prosecutor was under the mistaken impression that prospective changes to legislation which would provide automatic entitlement to special measures were in force at the time of their review. Notwithstanding the foregoing, the lawyer dealt with the case well and this positive feedback has been provided.
2. A reminder has been sent to all prosecutors to ensure a check is made as to whether the victim has been referred to support services, regardless of whether they are supportive of the prosecution or not. If a referral has been made,

prosecutors have been advised this is to be marked on the case review. If a referral has not been made, prosecutors have been reminded of the requirement to request this be actioned by the police.

3. The findings of this report have been referred to the CPS Yorkshire and Humberside Area Domestic Abuse lead, who chairs the Area Domestic Abuse Forum. The lessons learned will be considered at the Forum, as part of the ongoing work carried out across the Area to improve the handling of domestic abuse cases and embed best practices.

Housing and Neighbourhood Services

1. When receiving 'noise nuisance reports ensure officers explore the possibility that the noise nuisance could be a result of DA/DV
2. Provide training to staff to educate them on what MARAC is / and the importance of undertaking actions/notebook outcomes

IDAS

1. Develop communication and information to raise awareness of Complex Needs IDVA's specialism

Shelter

1. Shelter to review Safeguarding Policy/guidance to insert specific references to safeguarding around domestic abuse concerns
2. Shelter to review staff understanding, and practice around professional curiosity, including consideration of where vulnerable people are considered 'carers'.
3. Shelter to implement refresher training on high-quality and safeguarding-focused case notes for the staff team

Sheffield Health and Social Care NHS Foundation Trust

1. The process used to add a MARAC warning to be reviewed to ensure information is explicit to all staff accessing the Insight
2. Level 3 safeguarding training to cover MARAC warnings
3. SHSC Safeguarding Team to work with the RiO consultation group to create a module whereby confidential documents can be stored.
4. Since the discontinuation of the SPA SMS role, SPA and START to review current working arrangements to ensure any gaps in service are mitigated and services are working collaboratively

Sheffield Teaching Hospitals NHS Foundation Trust

1. Front-line staff will be made aware of the Sheffield Carers Centre and Care Act assessments.
2. Safeguarding training will include recognition of carer needs and how to request an assessment of care and support needs from adult social care
3. ED staff will continue to be reminded about the need to apply professional curiosity and the circumstances and purpose of completing a Domestic Abuse

Communication Form when a victim of domestic abuse attends ED irrespective of whether they are with the police.

The Probation Service

1. Review of the current system monitoring completion of Initial Sentence Plans within the required timescale to ensure practitioners and line managers are aware of drift
2. Organisational expectations are to be re-issued to practitioners and line managers where drift in completion of the Initial Sentence Plan is identified.

The South Yorkshire Police

1. The South Yorkshire Police should ensure that domestic abuse training and operational briefing reinforce the importance of prompt submission of DASH assessments and have considered a referral to domestic abuse services.
2. The South Yorkshire Police should ensure that a copy of police-completed DASH is included with any other call-out response information sent to another agency and that those agencies are reminded to complete their specific risk screening and assessment.
3. The South Yorkshire Police should ensure that the College of Policing guidance on risk assessment is followed when a DVPO is applied for, and breach proceedings are pursued and this should be extended to cover circumstances when a decision to not prosecute has been made.

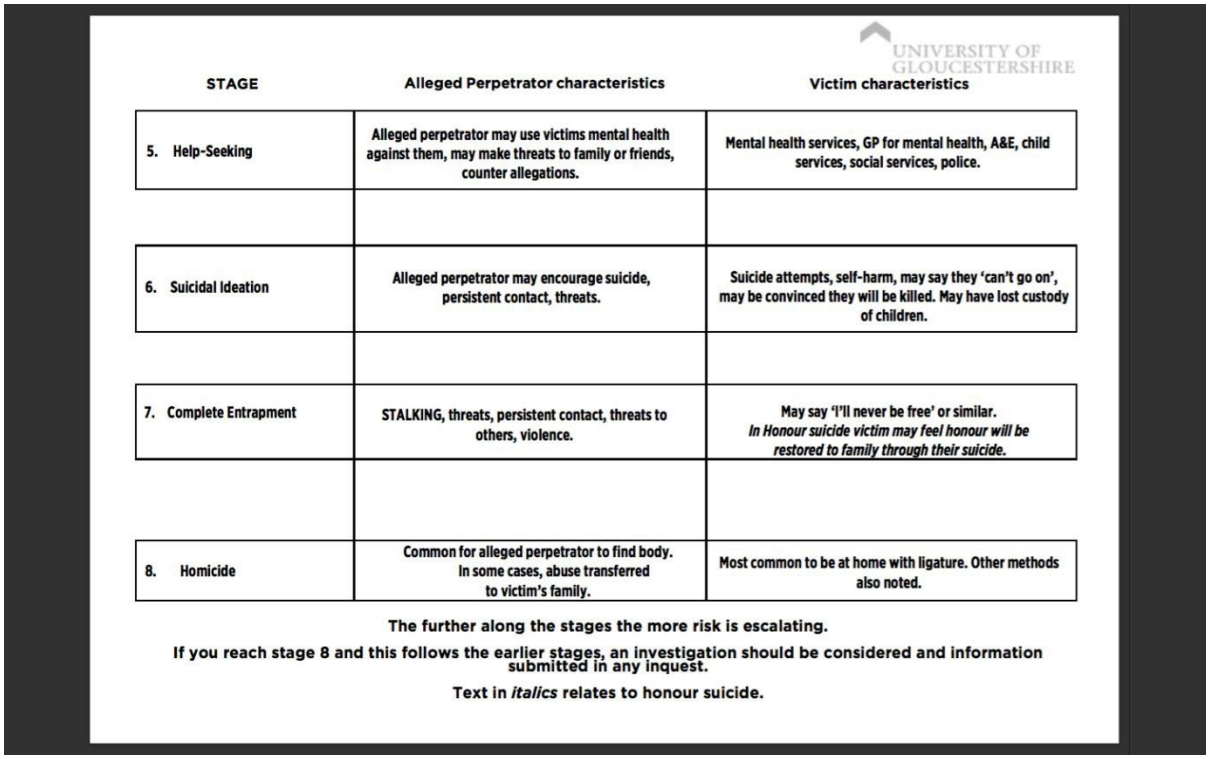
The Yorkshire Ambulance Service

1. To continue to raise awareness in YAS staff of attempted suicide as a potential indicator of domestic abuse
2. To actively encourage professional curiosity and to purposefully question when concerns are evident during a call to 999/111.

Glossary

CPS	Crown Prosecution Service
CSP	Community safety partnership
College of Policing	The College of Policing is a professional body for everyone working across policing.
DACT	Domestic Abuse Coordination Team
DARA	Domestic abuse risk assessment (domestic abuse risk assessment team at SYP)
DASH / DASH RIC	Domestic Abuse, Stalking, Harassment and Honour-Based Abuse Risk Indicator Checklist
DBTH	Doncaster Bassetlaw Teaching Hospital
DHR	Domestic Homicide Review
DWP	Department of Work and Pensions
FLO	Family Liaison Officer
ICB	Integrated Care Board
IDAS	Independent Domestic Abuse Service
IDVA	Independent Domestic Violence Advocate/Advisor
IDVA Hub	Domestic Abuse Hub
IPA	Intimate partner abuse
IMR	Individual Management Review
MARAC	Multi-Agency Risk Assessment Conference
MATAC	Multi-Agency Tracking and Coordination
MDT	Multidisciplinary Team
NFA	No Further Action
OIC	Officer in the Case
Police Bail	Bail granted by Police pre-charge, to allow for further enquiries to be made or CPS advice to be sought.
RDaSH	Rotherham Doncaster and South Humber NHS Trust
SHSC	Sheffield Health and Social Care NHS Foundation Trust
SIO	Senior Investigating Officer (Insp or above)
SSP	Safer Sheffield Partnership
SPA	Single Point of Access
STHT	Sheffield Teaching Hospitals NHS Foundation Trust
SYP	South Yorkshire Police
YAS	Yorkshire Ambulance Service

IPS/HS draft tool[53]



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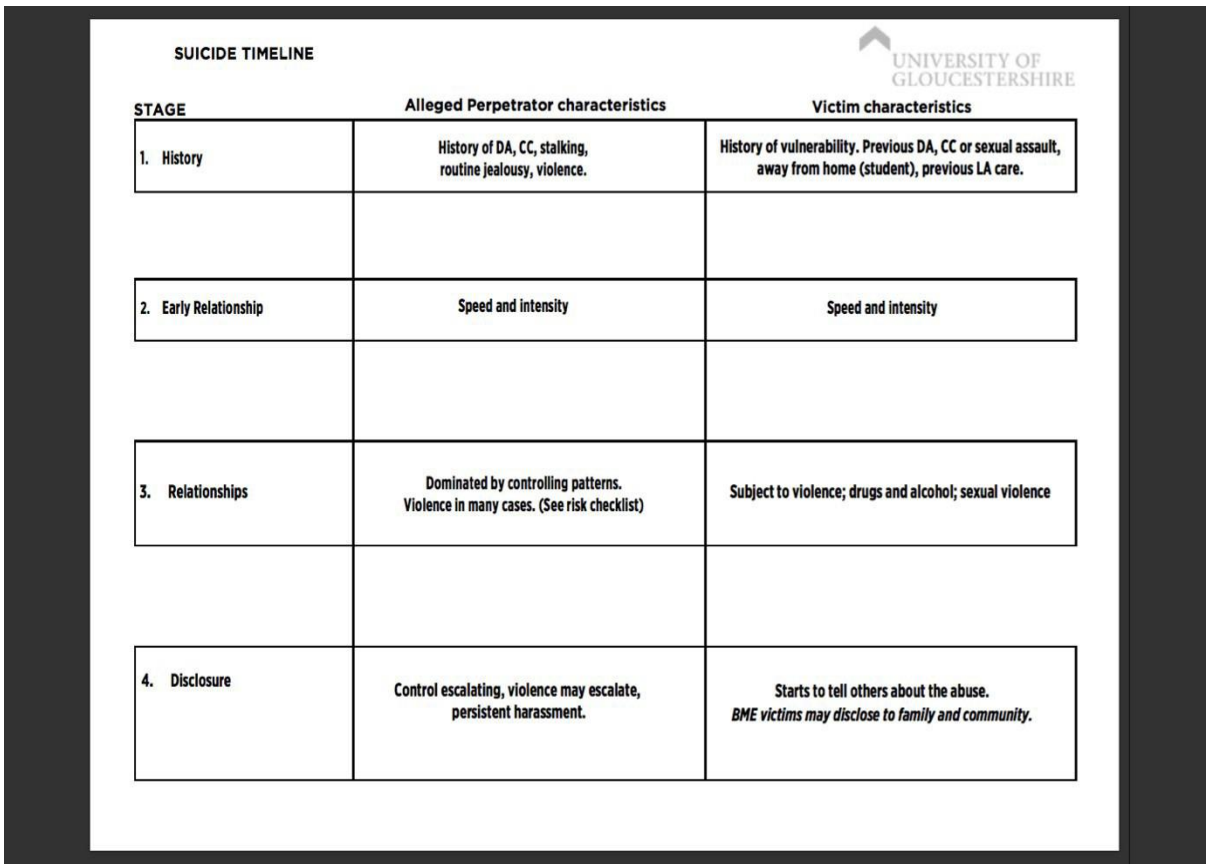
STAGE	Alleged Perpetrator characteristics	Victim characteristics
5. Help-Seeking	Alleged perpetrator may use victims mental health against them, may make threats to family or friends, counter allegations.	Mental health services, GP for mental health, A&E, child services, social services, police.
6. Suicidal Ideation	Alleged perpetrator may encourage suicide, persistent contact, threats.	Suicide attempts, self-harm, may say they 'can't go on', may be convinced they will be killed. May have lost custody of children.
7. Complete Entrapment	STALKING, threats, persistent contact, threats to others, violence.	May say 'I'll never be free' or similar. *In Honour suicide victim may feel honour will be restored to family through their suicide.*
8. Homicide	Common for alleged perpetrator to find body. In some cases, abuse transferred to victim's family.	Most common to be at home with ligature. Other methods also noted.

The further along the stages the more risk is escalating.

If you reach stage 8 and this follows the earlier stages, an investigation should be considered and information submitted in any inquest.

Text in *italics* relates to honour suicide.



SUICIDE TIMELINE

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STAGE	Alleged Perpetrator characteristics	Victim characteristics
1. History	History of DA, CC, stalking, routine jealousy, violence.	History of vulnerability. Previous DA, CC or sexual assault, away from home (student), previous LA care.
2. Early Relationship	Speed and intensity	Speed and intensity
3. Relationships	Dominated by controlling patterns. Violence in many cases. (See risk checklist)	Subject to violence; drugs and alcohol; sexual violence
4. Disclosure	Control escalating, violence may escalate, persistent harassment.	Starts to tell others about the abuse. *BME victims may disclose to family and community.*

[53] Monckton Smith et al

Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848
www.homeoffice.gov.uk

Alison Higgins
Strategic Commissioning Manager
Domestic and Sexual Abuse
Domestic Abuse Co-ordination Team
Sheffield City Council
Floor 9, West Wing, Moorfoot Building
Sheffield
S1 4LP

13th February 2024

Dear Alison,

Thank you for submitting the Domestic Homicide Review (DHR) report (Kirsten) for Sheffield Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 10th January 2024. I apologise for the delay in responding to you.

The QA Panel felt this was a good report that managed to place the victim front and centre. Family input is clear throughout and although there is not a specific tribute to Kirsten, there is a good sense of her as a person and the adversities that she faced during her life and during her relationship with Jake.

The report also benefits from having specialist domestic abuse representation on the panel and the Equality and Diversity section considers the relevant protected characteristics, as well as other social factors, drawing on research and evidence.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

- Whilst paragraph 29 asserts the independence of the chair, there is no information on the chair's career history, previous employment, professional background or relevant experience. It would be helpful if this could be included.

- Paragraph 26 (a-k) lists the agencies providing individual management review (IMRs) and goes into some detail about the contact they had with the victim. This veers into the purpose of the chronology and/or overview of agency

involvement, meaning there is unnecessary repetition later. Also, it seems the information may have been cut and pasted from agency reports as it is inconsistent in stating what the agency does or not, doesn't always use full sentences and the grammar is poor in places. This section would be improved by just providing a list of agencies and what they provided for the review.

- The report notes that the perpetrator's whereabouts were unknown. Could a comment be added on whether attempts were made to locate him and make contact regarding the review.

- Whilst the Equality and Diversity section does well to consider the range of relevant protected characteristics and other social factors, this would be strengthened by further consideration of the perpetrator's background and how this may have posed a barrier to seeking help. Additionally, the perpetrator claimed to have been diagnosed with autism and ADHD as a child, but there is no reference to the potential impact of this.

- Paragraph 51 of the executive summary asserts that 'research has established controlling patterns of behaviour as permeating and dominating high-risk domestic abuse'. It would be helpful if the source of this reference could be included. Other areas of the report make reference to specific research which is a useful, and welcome addition to the report.

- It would have been helpful to have had a public health / suicide prevention representative on the panel, to provide the lens of domestic abuse and increased links to suicidality.

- There is some repetition within the overview report which adds to the length of the document. There is another name also mentioned at page 13 which is not the perpetrator's pseudonym. This could be his given name which could compromise anonymity.

- The report would benefit from the addition of a glossary/list of abbreviations given the many abbreviations used.

- The executive summary has many highlighted in red paragraphs and some in bold (red), this needs to be reviewed as part of proof reading.

- A number of spelling and grammatical errors appear in the report which will need to be corrected before it can be published.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel