Domestic Homicide Review (DHR)

Jean Carter

2018

Executive Summary

Author: Dr Liza Thompson

Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

Review completed: June 2022

1. The Review Process

1.1. This summary outlines the process undertaken by the Domestic Homicide Review (DHR) panel in reviewing the death of Jean Carter, who lived in Kent.

1.2. To protect the identities of the deceased and her family members, the deceased is referred to in this DHR as Jean Carter, a pseudonym which was chosen by her mother.

1.3. Jean was not a victim of a homicide (the killing of one person by another), but paragraph 18 of the Multi-Agency Statutory Guidelines for the Conduct of Domestic Homicide Reviews states:

> *Where a victim took their own life (suicide) and the circumstances give rise to concern, for example that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if the suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.*

1.4. In early 2018 a body was found which was identified as Jean Carter. Her partner at the time fled the scene and handed himself in to police 24 hours later. The circumstances surrounding her death remain largely unknown and on 16th May 2019 the Kent Coroner returned a verdict of misadventure.

1.5. The DHR process commenced in April 2018, on the understanding that whether the findings were suicide, homicide, or misadventure, the events leading up to Jean's death presented opportunities for significant learning related to domestic abuse.

1.6. A ruling of misadventure refers to an accident that occurred due to a risk that was taken voluntarily. In their summing up, the Kent Coroner found that at the time of her death, Jean's judgement was affected, and she may not have intended death to be the outcome of her actions.

1.7. Jean Carter was a White British woman, who was in her early thirties when she died.

1.8. David Baker is a white British man, of similar age to Jean, who has connections to the gypsy/traveller community. David was Jean's partner at the time of her death. Although he was not found criminally culpable for Jean's death, his involvement with Jean and her children is pertinent to the circumstances of her death – and subsequently pertinent to this DHR.

1.9. The DHR Core Panel met on 24th April 2018 and agreed that the criteria for a DHR were met. The Chair of the Kent Community Safety Partnership then made the formal decision that a DHR would be conducted. Agencies that potentially had been in contact with Jean and/or David prior to Jean's death were requested to provide a summary of that contact. Those agencies who confirmed contact with Jean and/or David were asked to secure their files.

2.1 The Home Office provided feedback to be addressed in early 2020. Following further feedback from the Home Office later in 2020, an additional independent chair and author was appointed to undertake the further work required to address the Home Office's feedback sufficiently and be granted approval for publication.

2. Contributors to the Review

2.1. IMR authors were independent of any operational or supervisory involvement in this case.

2.2. Each IMR was signed off by a senior manager from the various organisations involved.

2.3. The following organisations completed an IMR or summary report:

Agency/Contributor	Nature of Contribution
Kent Police	Independent Management Report
Sussex Police	Summary Report
Kent County Council Integrated Children Services (ICS) includes Early Help services	Independent Management Report

Agency/Contributor	Nature of Contribution
Southeast Coast Ambulance Service (SECAmb)	Summary Report
Kent and Medway Clinical Commissioning Group	Independent Management Report
Town A DA Service	Independent Management Report
Town B DA service	Summary Report
Kent and Medway NHS & Social Care Partnership Trust (KMPT)	Independent Management Report
KCC Education Safeguarding Team	Summary Report
Town A and Town B Borough Councils	Summary Report
Kent Surrey & Sussex Community Rehabilitation Company (KSS CRC)	Summary Report
East Kent University Foundation Hospital Trust (EKUFHT)	Independent Management Report
Kent Community Health NHS Foundation Trust (KCHFT)	Independent Management Report

3. Review Panel Members

3.1. The initial Review Panel (2018/19) consisted of an Independent Chair and senior representatives of the organisations that had relevant contact with Jean Carter, David Baker, Child A and Child B. It also included a specialist domestic abuse worker from the local voluntary sector and a senior member of the Kent Community Safety Team. Panel members were independent of any operational or supervisory involvement in this case.

3.2. The members of the panel were:

Agency	Name
Independent Chair	David Stevens
Kent and Medway Clinical Commissioning Group	Sallyanne Baxter Caroline Peters Clare Bright
Kent County Council Early Help and Preventative Services	Nigel Baker Paul Startup
Kent County Council Community Safety	Shirley Brinson
Town B Borough Council	Toni Carter
Kent County Council Adult Safeguarding	Catherine Collins
Domestic Abuse Support Services (DAVSS)	Henu Cummins
Kent Surrey & Sussex Community Rehabilitation Company (KSS CRC)	Victoria Green
Kent County Council Adult Safeguarding	Annie Ho
Centra	Leigh Joyce
Rising Sun Domestic Abuse Service	Anne Lyttle
Town A Borough Council	Ray O'Shea
Kent County Council Education Safeguarding	Claire Ray
Kent Police	T/D/Sup Lee Whitehead
Kent and Medway NHS & Social Care Partnership Trust (KMPT)	Cecilia Wigley Sarah Fowler

3.3. The members of the review panel (2020/21) for the amended report were independent of any operational or supervisory involvement in this case.

3.4. The members of the panel were:

Agency	Name
Independent Chair	Dr Liza Thompson
Kent Community Safety Team	Kathleen Dardry
Kent and Medway Clinical Commissioning Group (CCG)	Lisa Lane
Kent and Medway Partnership Trust (KMPT)	Nam Maredza
Kent County Council Integrated Children's Service	Kevin Kasaven
Kent Police	DI Christopher Rabey
Domestic Abuse Volunteer Support Service (DAVSS)	Henu Cummins

4. Author of the Overview Report

4.1 The Independent Chair, and the Author of the final Overview Report, is Dr Liza Thompson.

4.2 The Independent Chair is a Safe Lives Accredited Service Manager who has worked within the field of domestic abuse, initially as an accredited Independent Domestic Violence Advisor, and later as the Chief Executive of a specialist domestic abuse charity. She delivers domestic abuse and coercive control training to a variety of statutory, voluntary sector and private sector agencies. Her doctoral thesis examines the experiences of abused mothers within the child protection system. She has independently completed specialist review Chair training with Advocacy After Fatal Domestic Abuse, is a member of the AAFDA DHR Network, and has completed Kent County Council training required to undertake the role of Independent Chair.

4.3 The Independent Chair has no connection with the Community Safety Partnership and agencies involved in this review, other than previously being involved in review panels as an independent domestic abuse specialist; and

currently being commissioned to undertake Domestic Homicide Reviews and Multi-Agency Reviews.

5. Terms of reference for the review

5.1. The terms of reference were agreed by the DHR panel following their meeting on 18th May 2018.

5.2. The initial Review Panel met on three occasions, firstly in May 2018 to agree terms of reference and then on 20th August 2018 to consider the IMRs. Finally, they met on 1st October 2018 to consider the draft Overview Report.

5.3. The amended review was written by a second independent chair and author and a panel was reconvened to review the redrafted version on three further occasions.

5.4. The Purpose of this DHR:

The purpose of the DHR is to:

a) establish what lessons are to be learned from the death of Jean Carter, regarding the way in which local professionals and organisations work individually and together to safeguard victims;
b) identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
c) apply these lessons to service responses, including changes to inform national and local policies and procedures as appropriate;
d) prevent domestic violence and related deaths and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
e) contribute to a better understanding of the nature of domestic violence and abuse; and
f) highlight good practice.

5.5. The Focus of this DHR:

5.5.1. This review established whether any agency or agencies identified possible and/or actual domestic abuse that may have been relevant to the death of Jean Carter.

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

5.5.3. This review also focused on whether each agency's response to the identification of domestic abuse was in accordance with its own and multi-agency policies, protocols, and procedures in existence at the time. The review examined which methods were used to identify risk and any action plans which were put in place to reduce that risk.

5.6. DHR Methodology

5.6.1. Independent Management Reviews (IMRs) were submitted using the templates current at the time of completion.

5.6.2. This review is based upon the IMRs provided by the agencies that were notified of, or had contact with, Jean and/or David in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse. IMR was prepared by an appropriately skilled person who did not have any direct involvement with Jean or David, and who is not an immediate line manager of any staff whose actions were subject to review within the IMR.

5.6.3. Each IMR included a chronology and analysis of the service provided by the agency submitting it. The IMRs highlighted both good and poor practice, and made recommendations for the individual agency and, where relevant, for multi-agency working. The IMRs included issues such as the resourcing/workload/supervision/support and training/experience of the professionals involved.

5.6.4. Each IMR included all information held about Jean and/or David from 1st January 2017 to the date of Jean's death in 2018. Any information relating to Jean as the victim(s), or David being a perpetrator of domestic abuse before 1st January 2017 was also included in the IMR.

5.6.5. Any issues relevant to equality, i.e. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation were identified.

5.6.6. IMRs received were considered by the DHR panel on 20th August 2018, the initial review report was then drafted by the initial Independent Chair, sent to the panel for consideration at a meeting on 1st October 2018.

5.6.7. The updated version of the report was shared with the panel at a meeting in March 2021, and further discussed at a panel meeting in May 2021, and final sign off was agreed via email in September 2021.

5.7. Specific Issues Addressed

The following specific issues were considered within each agency IMR, and subsequently by the panel:

5.7.1. Were practitioners sensitive to the needs of Jean and David?

5.7.2. Were practitioners knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect practitioners, given their level of training and knowledge, to fulfil these expectations? Did agencies have policies and procedures in place for dealing with concerns about domestic abuse?

5.7.3. How accessible were the services for Jean?

5.7.4. Did agencies comply with domestic violence and abuse protocols agreed with other agencies including any information sharing protocols?

5.7.5. Did actions or risk management plans fit with the assessment and decisions made?

5.7.6. Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

5.7.7. When, and in what way, were Jean's wishes and feelings ascertained and considered?

5.7.8. Was Jean informed of options/choices to make informed decisions?

5.7.9. Was Jean signposted or referred to services specific to her needs?

5.7.10. Were agency procedures sensitive to Jean's needs linked to her protected characteristics, for example was consideration given to her vulnerabilities as a victim of domestic abuse who was also struggling with substance misuse and mental health?

5.7.11. What were the key points or opportunities for assessment and decision making in this case?

5.7.12. Do assessments and decisions appear to have been reached in an informed and professional way?

5.7.13. Are there lessons to be learned from this case relating to the way in which an agency or agencies worked to safeguard Jean and promote her welfare, or the way it identified, assessed and managed the risks posed by David?

5.7.14. Where could practice have been improved, and what are implications for improving the ways of working, training, management and supervision, working in partnership with other agencies and resources, to better support victims of abuse?

6. Summary Chronology

6.1. When Jean was 12 years old, it is reported that she spent time in foster care.

6.2. When Jean was 15 years old, she made an allegation of rape against a family friend – which had occurred when she was 12 years old. The alleged perpetrator was arrested and charged, however the case with discontinued by the Crown Prosecution service (CPS).

6.3. In 2005, when Jean was 19 years old, she met Roy Davis who was more than 10 years her senior. In November 2005, Jean experienced an episode of depression which is recorded in her GP notes; it is recorded that Jean is thought to have experienced mental health concerns since the age of 12.

6.4. Between 2007 and 2008, Kent Police received five reports of domestic abuse which involved Jean being the victim of violence perpetrated by Roy. One such incident was five days before Child A was born, which resulted in a safeguarding referral being made by Jean's Health Visitor. Jean indicated to the Health Visitor that she believed that she'd deserved the abuse.

6.5. In 2010 Jean and Roy's relationship ended, and Jean began a relationship with Paul Williams.

6.6. Towards the end of 2010 Roy Davis alleged in a children social care referral that Child A faced a risk of harm due to Paul Williams' behaviour.

6.7. In 2013 Paul Williams assaulted Jean and damaged property. Jean was reluctant to engage with police and Paul Williams was refused charge.

6.8. During January 2014 Paul Williams was threatening towards Jean after using alcohol with medication. Jean informed children social care that all was well. Whilst attending a meeting with Paul's mental health worker, Jean admitted that she had misled social workers, as all was not well. And later in the month Jean reported Paul to Kent Police due to violence on at least three occasions. Jean attempted to end the relationship at this point, and again in March 2014 following a further violent incident. Jean told police that she'd been warned by social workers about her relationship with Paul, and she was reluctant to report the abuse as she thought she would lose the care of her child.

6.9. Jean and Paul separated in 2015 – by which time they had a child together – Child B.

6.10. From August 2016 to May 2017, Jean approached her GP on a number of occasions for help with drug and alcohol use, migraines and depressive symptoms, for which she was prescribed medication.

6.11. In July 2017 Jean and David Baker began an intimate relationship, having met through friends.

6.12. Between August and October 2017 Jean attended her GP practice regarding her mental wellbeing, and in early November Jean attended the local minor injuries unit with a contusion to her wrist which she said she sustained during a fight whilst under the influence of alcohol.

6.13. Later in November 2017 police were called to Jean's home, and she was admitted to hospital following a sustained assault which had resulted in bruising to her face and various areas of her body. Police completed a DASH risk assessment, which assessed that she was at high risk of harm, and a Multi-Agency Risk Assessment Conference (MARAC) referral was made.

6.14. Jean had initially identified her current partner, David Baker, as the assailant, but later retracted this and indicated that she had been attacked by another male with whom she was having an affair.

6.15. Jean's main concern was that due to the assault, her children would be removed from her care. A children's social care referral was made by police, as was a referral into the local domestic abuse service.

6.16. A few days later David Baker was arrested for Grievous Bodily Harm and released on conditional bail but following a lack of evidence he was refused charge around three weeks later.

6.17. Jean had some engagement with the domestic abuse service but struggled to engage in any meaningful way with the allocated social worker. An Initial Child Protection Conference was held mid-December and the children were made subjects of a Child Protection Plan.

6.18. In November 2017 Jean had approached her GP for support with her mental health and this had resulted in an initial assessment with the Community Mental Health Team in mid-December, where an appointment was made with the Consultant Psychiatrist to explore a diagnosis and treatment plan.

6.19. During this time, Jean was also liaising with Town A and Town B housing departments, in order to organise a mutual exchange to Town B. This was to take

her closer to David's family, and further away from her children's fathers, and the support of her mother. This move was intended to go ahead before Christmas 2017.

6.20. Throughout this period, the children's fathers were raising concerns to the social worker regarding the behaviour of Jean and David. The social worker was attempting to engage with Jean, who was adamant that David was not near the children, despite professionals believing this to be untrue.

6.21. Early January 2018, Jean had attempted to take her own life, David had discovered her but had not sought medical attention. It transpired that David had discovered previous attempts during October and November 2017 and medical attention had never been sought. When asked about these attempts, she indicated that she was stressed by the involvement of social workers.

6.22. The following day, Jean attended the Community Mental Health Team, and a diagnosis of Emotionally Unstable Personality Disorder was made – along with probable Bi-Polar Disorder, and a Mental and Behavioural Disorder due to alcohol use. She was commenced on medication and referred to a specialist programme.

6.23. In early January 2018 a legal planning meeting was held, where it was agreed that the threshold for pre-proceedings had been met. An initial pre-proceedings meeting was planned for late January 2018, which would include Jean at a separate meeting to the children's fathers.

6.24. Jean was advised of this decision by a "letter before proceedings" which detailed concerns that she had been in previous violent relationships, that she was now in an abusive relationship with David Baker, that she was denying the abuse and that her recent diagnosis would be having an impact on her capacity to parent her children.

6.25. During this period Jean was living outside of Kent, in County B, having left the property in Town A but not yet moved to the property in Town B.

6.26. Also, during January 2018, the social worker received calls and emails of concern from the children's fathers.

6.27. The planned pre-proceedings meeting was rescheduled twice due to Jean and/or her solicitor being unable to attend. The meeting was booked for mid-February 2018.

6.28. The week before this meeting was due to take place, Jean was involved in an incident which ended her life. In May 2019, the Kent Coroner returned a verdict of misadventure.

7. Conclusions

7.1. Trauma Informed Practice

7.1.1. There appeared to be a lack of trauma informed practice deployed by most of the professionals responding to Jean's needs.

7.1.2. Adverse childhood experiences (ACEs) are traumatic events occurring in early years; these events include neglect, violence between or perpetrated by parents or caregivers, alcohol or substance misuse within the home, and peer, community or collective violence, and which are associated with the development of health harming behaviours, physical and mental ill health in adulthood.

7.1.3. In order to respond to adults presenting with vulnerabilities and complexities linked to early years trauma, professionals must "show understanding" and "help explore through (their) work the question 'what happened to you and what may help you?'.[1]

7.1.4. The British Association of Social Workers (BASW)[2] have recently called for social workers to approach working with survivors in the context of their abuse, including holding perpetrators to account, whilst also ensuring that interventions remain child focused – and in the child's best interest. They argue that this approach will reduce practices which shame, penalise, and hold abused mothers solely responsible for their children's welfare.[3]

> "The impact of living with domestic abuse is traumatic. Often, there are long-lasting outcomes for mental and physical wellbeing. Trauma-informed practice for social work is not about therapy and treatment, but about doing no further harm. It is

[1] SPACE matters - Kent County Council
[2] www.basw.co.uk | The professional association for social work and social workers
[3] BASW *England Domestic Abuse Practice Guidance: for Children and Family Social Workers* (March 2021) p.7 Available: Layout 1 (basw.co.uk)

> about creating a safe environment, building trust, promoting collaboration and sharing power to be empowering and help a survivor regain confidence in their own ability to move forward and create a safe, nurturing home for their child or children."[4]

7.1.5. All services responding to victims of abuse, and early years trauma should adopt a trauma informed approach, this requires "an organisational transformation model that improves awareness of trauma and it's impacts, supports services to consider and put in place appropriate support, and prevents re-traumatising those accessing or working in services."[5]

7.1.6. Trauma informed practice includes the ability to identify signs and symptoms of trauma, utilising a strengths-based model which empowers service users to collaborate in the design and delivery of their support – and asks, "what happened to you" instead of "what's wrong with you".[6]

7.1.7. For people living with a mental health diagnosis, trauma informed approaches mean that:

> "it can be extremely empowering and healing to explore and recognise that many or even all of their symptoms are linked to chronic traumatic experiences in childhood rather than innate 'defects' or 'disorders'."[7]

7.1.8. From the information available about Jean's life experiences, it is clear she experienced trauma in childhood, through her teens and into adulthood – predominantly in the form of sexual abuse and male violence.

7.1.9. NAPAC[8] argue that responses to survivors of sexual abuse, which do not utilise a trauma informed approach can lead to:

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[4] *Ibid* p.30
[5] RELATE-framework.pdf (kent.gov.uk)
[6] See Trauma-informed practice: what it is and why NAPAC supports it | NAPAC Accessed 29th April 2021
[7] See Trauma-informed practice: what it is and why NAPAC supports it | NAPAC Accessed 29th April 2021
[8] NAPAC | Supporting Recovery From Childhood Abuse

> "disbelief, coercion, manipulation, restriction of movement, shaming, belittling and many other behaviours and dynamics that are reminiscent of the original abuse"[9]

7.1.10. Women and girls' charity AVA provide three key messages for those supporting victims of abuse. First that Professionals should work in a way that understands trauma, its impact on the body and focus on interactions that maximise both physical and emotional safety. Second is that when women use substances is it often as a coping strategy to manage their experiences. They ask that professionals work in a way that acknowledges what women have done to survive and not to blame the women but rather listen to them and believe them. And finally, that professionals must understand behaviour as a form of communication and consider what is going on under the surface for women, take the time to be professionally curious, and focus on building trusting relationships with women that acknowledge their strengths and capabilities.[10]

7.1.11. A vital element of practising in a trauma informed way is to understand the experiences and challenges the victim is facing. Although most of the professionals involved with Jean and her children were able to identify domestic abuse as an issue, they appeared to lack an understanding of the effects of domestic abuse and coercive control, which undermine the autonomy of a victim rending it difficult to simply leave their abuser.[11] This led to an absence of empathy for Jean which reduced their ability to identify the risk that Jean posed to herself.

7.1.12. Alongside Jean's experience of trauma as a child - and possibly due to this trauma – and her experiences of male violence as an adult, was her diagnosis of EUPD. Although this diagnosis was made less than two months before her death, professionals did not appear to adjust their plans or approaches to Jean once they were informed that she was living with a personality disorder. This may have been due to a lack of understanding of the condition, alongside a lack of clarification from mental health professionals to support social workers and IDVAs

[9] Trauma-informed practice: what it is and why NAPAC supports it | NAPAC Accessed 29th April 2021

[10] AVA Project *Breaking Down the Barriers: Findings of The National Commission on Domestic and Sexual Violence and Multiple Disadvantage* (2019) Available: Breaking-down-the-Barriers-full-report-.pdf(avaproject.org.uk) Accessed 30th April 2021

[11] BASW *England Domestic Abuse Practice Guidance: for Children and Family Social Workers* (March 2021) p.10-11

understanding of EUPD; along with a lack of triangulation of the pieces of information they each held.

7.1.13. NICE guidelines on treating patients with personality disorders include the:

> "Need to explore treatment options in an atmosphere of hope and optimism, explaining that recovery is possible and attainable, and build a trusting relationship, work in an open, engaging and non-judgemental manner and be consistent and reliable."[12]

7.1.14. Rose Buckland argues that this rhetoric should function across all services when responding to the needs of mothers faced with mental ill health, and specifically personality disorders.[13] She warns how the multi-organisational context of mental health and child protection arenas, can couple with the complexities of information sharing and collaboration which exists across health and social care settings and lead to "professional dangerousness" – where "professionals can behave in a way which either colludes with or increases the dangerous dynamics of the abusing family members."[14]

7.1.15. No one will ever know what happened at the scene of Jean's death. The Kent Coroner found that Jean died following an act she took voluntarily. As introduced above, in summing up, the coroner stated that he could not be satisfied that Jean had intended to take her life but found that her judgement was affected by the level of alcohol and drugs in her system. He also cited the domestic abuse, current and historic. He found that she may not have intended the outcome of her action to be death.

7.1.16. As with suicide, Jean died because of her own actions, and in the absence of available research into the links between domestic abuse, and/or EUPD and death by misadventure the author has therefore highlighted the relevant aspects

[12] NICE, "Borderline personality disorder: the NICE guideline on treatment and management" *National Clinical Practice Guideline Number 78* The British Psychological Society and the Royal College of Psychiatrists (2009) P.380

[13] Buckland, R "Working with Josie: Swimming Against the Tide" *Critical and Radical Social Work* 7 (1) (2019) p.122

[14] Morrison, T *The Emotional Effect of Child Protection on the Worker* Practice 4 (4) (1990) p262

of the available research linking the experiences of domestic abuse and suicidality.

7.1.17. There is a raft of research available linking the experiences of domestic abuse and suicidality. This research includes failure to identify risk of suicide when risk assessing harm from domestic abuse.[15] Kent County Council's Suicide Prevention Team have recently undertaken research, aiming to identify the link between suicidality and domestic abuse. They found that 63% of domestic abuse victims had feeling of suicidality. Although the Coroner returned a verdict of death by misadventure, Jean had told mental health practitioners and her GP that she had thoughts of suicide, including jumping off a motorway bridge. However, she did not disclose these thoughts to social workers, and in this way, none of the agencies had the full picture of Jean's current circumstances or state of mind. Jean's mother told the review author she also did not know Jean's state of mind at the time of her death.

7.1.18. At the time of her death, Jean was under the influence of alcohol and cocaine, an alternative narrative to the circumstances of her death is that the action which led to her death was due to an impulsiveness and lack of consideration of consequences which is often seen in people with EUPD,[16] mixed with the disinhibiting effects of drug and alcohol use.

7.1.19. Despite the uncertainty of the circumstances surrounding Jean's death, there is no doubt that her life at the time of her death – and arguably a good proportion of her life overall – was shaped by domestic abuse. Jean may not have directly been killed by a third party, but her death was unexplained. In 2017 Professor Jane Monckton-Smith began blogging about unexplained deaths which she termed as hidden homicides.[17] Professor Monckton-Smith argues the statistic of two women killed, by a partner or former partner, every week is an underestimation. Jean may not have been directly murdered by her partner, however the abuse she had been experiencing since her teens certainly factored in the circumstances of her death.

[15] Munro, V and Aitken, R "From Hoping to Help: Identifying and Responding to Suicidality Amongst Victims of Domestic Abuse" *International Journal of Victimology* (26) 1 (2020)
[16] NHS Highland *Personality Disorder; Integrated Care Pathway* (July 2015) p.10
[17] HIDDEN HOMICIDE – FORENSIC CRIMINOLOGY (janems.blog)

7.1.20. MP Jess Phillips has called for a national count of women who die suddenly, or in unexplained circumstances, and who are known to have been victims of domestic abuse.[18]

7.1.21. Victims face multiple barriers to reporting domestic abuse; these have been discussed throughout this review, for example fear of reprisals from the abuser, fear of children being removed from the victim's care, the victim's inability to identify the risk they face due to normalising the abusive behaviour, risk of homelessness, debt, and other practical factors – all of these are further exacerbated when the victim is suffering from poor mental health.[19] Domestic abuse perpetrators use mental health as a tool to control, questioning the memory of experiences of abuse, placing the blame for their behaviour on the victim's mental health and over time this worsens the victim's mental health. Yet systems surrounding Jean were better established to identify - and professionals were certainly more focused on - the potential risk of harm from David than from the risk of Jean dying due to her own actions. Despite Jean telling professionals that was her intention.

7.2. Multi-Agency Mechanisms

7.2.1. Following the incident on 15th November the Kent Police immediately made a referral to Integrated Children's Service, which was processed through the Central Referral Unit. A Strategy Meeting was held and there then followed two Multi-Agency Risk Assessment meetings and an Initial Child Protection Conference – all attended by several relevant agencies. This use of these multi-agency mechanisms is identified as good practice.

7.2.2. However, following these initial meetings there appeared to be missed opportunities to utilise multi-agency working to its full potential. There seemed to always be at least one agency missing from meetings. Those with the greatest knowledge of Jean's mental and physical health issues were not present, or involved, at either a MARAC or at the ICPC. This was unfortunate as Jean's situation was profoundly influenced by her mental health, together with her consumption of alcohol and drugs.

[18] Jess Phillips MP: We count what we care about - Tortoise (tortoisemedia.com)

[19] Rose, D et al "Barriers and Facilitators of Disclosures of Domestic Violence by Mental Health Service Users" *The British Journal of Psychiatry: The Journal of Mental Science* (198) 3 (2011) pp.189-94

7.2.3. The purpose of multi-agency forums is to share all the small pieces of information each agency holds, to allow a clearer picture of the victim, family, perpetrator, as well as contextual information; all of which allows a more accurate assessment of risk of harm and provides the basis for more robust safety planning.

7.2.4. Introduced across England and Wales in 2006 as part of a Coordinated Community Response[20] to domestic abuse, the MARAC was designed to take the responsibility for high-risk cases away from just one or two agencies.[21] A multi-agency response to domestic abuse is vital because:

> "No single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety."[22]

7.2.5. This periodic meeting is held to discuss victims of abuse who are faced with a high risk of death or serious injury.[23]

> "A MARAC meeting consists of representative of both statutory and non-statutory organisations who are actively supporting those at high risk of domestic abuse. Representatives discuss and analyse the ongoing risk to the safety and wellbeing of both adult survivors, and children, and actions are agreed with a view to safeguarding them."[24]

7.2.6. Research in 2007 illustrated that victims were better able to live in safety, without violence, following their inclusion in the MARAC.[25]

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[20] What is a CCR? — Standing Together

[21] Coordinated Action Against Domestic Abuse *MARAC Chair – toolkit for MARAC* Somerset (2009) p.1

[22] Sharp-Jeffs, N and Kelly, L *Domestic Homicide Review (DHR) Case Analysis: Report for Standing Together* (2016) p.6

[23] Robinson, A *Domestic Violence MARACs (Multi Agency Risk Assessment Conferences) for Very High-Risk Victims in Cardiff, Wales: A Process and Outcome Evaluation* (2004)

[24] BASW *England Domestic Abuse Practice Guidance: for Children and Family Social Workers* (March 2021) p.30-31

[25] Robinson, A and Tregidga, J "The Perceptions of High-Risk Victims of Domestic Violence to a Coordinated Community Response in Cardiff, Wales" *Violence Against Women* 13 (11) (2007) pp.1130 - 1148

7.2.7. Pivotal to the MARAC process working successfully is the role of the Independent Domestic Violence Advocate, who in the victim's absence represents their wishes and feelings, and advocates for them as a victim of abuse.[26]

7.2.8. The MARAC process includes the allocating of actions for agencies, in this way the work of the MARAC is intended to extend beyond the meeting. In Jean's case there could have been a much more proactive use of the MARAC mechanism to make robust actions, to encourage engagement with Jean and promote joint working with agencies not yet working together.

7.2.9. For example, the social worker told the IMR writer that she had a good relationship with the IDVA, and they spoke and texted frequently to plan how best to manage contact with Jean. This relationship could have been expanded upon to include meetings taking place between the IDVA, the social worker and Jean. An action from the MARAC could have included a joint visit to Jean.

7.2.10. There could have been an action for a referral into Adult Social Care to support Jean with the complexities of mental health, alcohol use and domestic abuse that she faced.

7.2.11. On 18th December Jean told the IDVA that she was moving to Town B that day. As per the MARAC actions, the IDVA made a MARAC-to-MARAC referral – this is a process where a victim with a live MARAC case open moves to a different area. Jean's case was then added to the next MARAC listing at Town B MARAC as a "mention only" case.

7.2.12. The "Mention only" process was introduced in Kent following a sharp increase in repeat MARAC cases. The process was intended to streamline the meetings, where a case which was returning to MARAC within a 6-month period was not discussed at length – the understanding being that the details of the case were already known to the MARAC attendees. This process has recently ceased as it was felt by MARAC Coordinators that it was not the in the best interest of victims, and invariably the cases required further discussion despite being listed as mention only.

[26] Robinson, A *Independent Domestic Violence Advisors: A Multisite Process Evaluation* (2009)

7.2.13. The MARAC-to-MARAC process was incorrectly used in Jean's case, as she had not physically moved to Town B when the transfer was made. The MARAC guidelines state that there should not be two MARACs running in two places for the same victim. The MARAC which "owns" the case should be the one suited where the victim resides. In this case, Jean was residing outside of the County, so technically the transfer should have been to the MARAC in County B.

7.2.14. The IDVA made the MARAC-to-MARAC referral in good faith, when Jean stated that the move to Town B was going ahead. There is a reliance on each area's MARAC to run the process in line with the national best practice guidelines. This is because the MARAC process is not written into legislation and is not a statutory process. Coordinators are able to utilise a National Database which is managed by Safe Lives – this records the movement of MARAC cases across England and Wales.

7.2.15. It could be argued that MARAC as a process was not fully utilised in Jean's case. The actions appeared to be standard, and lacklustre. As a high-risk case involving a lack of engagement with the victim, and a perpetrator with a long criminal history, the MARAC process could have been utilised to create actions which would not have been possible from any other source.

7.2.16. A positive action from the MARAC was the delay of the mutual exchange which would not have been possible if it had not been a MARAC action. This is an example of a proactive action which utilises the power of the MARAC process.

7.3. Challenge and Triangulation of Information

7.3.1. As mentioned above, the IDVA role is pivotal to the MARAC process as she represents the wishes and feelings of the victim and advocates for her in her absence. One of the important elements of advocacy is challenge. Domestic abuse, coercive control, and the trauma that it causes are complex concepts and often involve nuanced behaviours, from victims and perpetrators, which those outside of the field of domestic abuse sometimes struggle to identify or understand. As also mentioned above, professionals are able to identify the presence of domestic abuse, and social workers especially are well trained around the effects of domestic abuse on children. However, many professionals remain

unsure of the difficulties in leaving an abuser[27], the multi-layered experiences which reduce a victim's confidence, financial stability, and social standing, and in cases like Jean's intersect with enduring mental health issues. It is up to the IDVA within the MARAC, and other multi-agency forums, to respectfully challenge thinking that can be construed (by others, and specifically by the victim) as victim-blaming and encourage a trauma informed approach to responding to victims.

7.3.2. The presence of the IDVA at the MARAC is "intrinsic"[28] to the overall process of multi-agency working. The presence of the victim is not permitted at the MARAC meeting[29] and so the IDVAs "speak up for victims"[30] with the intention of ensuring their wishes and feelings are taken into consideration amongst the decisions that are made by the representatives of the police, social services, health and education departments.[31] The IDVA should be an "effective advocate"[32] at the centre of the MARAC proceedings, representing the views of the victim in her absence.

7.3.3. There is no evidence of robust challenge from the IDVA at the meeting – although minutes from MARACs are not comprehensive so this may have been missed. The IDVA presented Jean's wishes and feelings, to continue a relationship with David, and included her own concerns about the safety of the children. It is recorded in the IDVAs own notes that she explained "why victims minimise".

7.3.4. The social worker's danger statement of 6th December 2017 uses language which appears to situate the blame for the risk to the children upon Jean, implying the violence was mutual, consensual and that Jean was culpable for the potential risk of harm to the children. This language used may have further alienated Jean from asking for help. She would have already been self-identifying as responsible for the violence and abuse. This language will exacerbate this viewpoint and could lead to Jean feeling that she is safer to stick with David who is likely to have been vocally self-identifying as being victimised by the social worker and the wider systems. This danger statement was accepted at the ICPC held on 13th December,

[27] Stahly, G. B *Battered women: Why don't they just leave?* In J. C. Chrisler, C. Golden, & P. D. Rozee (Eds.), *Lectures on the psychology of women (2008)*
[28] Home Office, above n 67
[29] Kent Police *Kent and Medway Multi Agency Risk Assessment Conference (MARAC) Operating Protocol and Guidelines* (2013) p.6
[30] Harne, L and Radford, J *Tackling Domestic Violence: Theories, Policies and Practice* (2008)
[31] Kent Police above n 89 pp.5-6
[32] *Ibid* p.10

where the IDVA was in attendance. This would have been an opportunity for the IDVA to challenge the lack of trauma informed practice, and the use of language which situated the blame for the risk to the children with Jean. However, there is no evidence that any challenge occurred. The ICPC could have been a good opportunity for the IDVA to advocate for Jean, which may have encouraged Jean's engagement with the specialist domestic abuse service – however there is no evidence that this happened.

7.3.5. Another area the IDVA could have challenged was the language used within the letter before proceedings which was given to Jean on 17th January 2018. It stated that Jean had a "history of engaging in ongoing domestic abuse relationships." It is important for any professional responding to – or supporting victims of – abuse, that relationships are not abusive, people are abusive. Although this may appear to be simply a case of semantics, this language negates David, Roy, Paul and their behaviours from the dialogue. Again, this situates the problem as Jean being in relationships with violent men, not the violence itself.

7.3.6. Triangulation refers to the use of multiple datasets and viewpoints to cast light upon a topic. The agencies did not work together in the multi-agency forums available, to triangulate the evidence which each of them held about Jean, the children and David.

7.3.7. As introduced above, multi-agency meetings provide a vehicle for sharing the small pieces of information which each agency holds, in order to build a full picture about a victim and their family.

7.3.8. KMPT could have utilised the multi-agency forums available, and specifically the core group, to raise questions about the domestic abuse mentioned on the GP referral. Triangulation of the information held by KMPT regarding Jean's suicidal ideation and attempts; with the information that ICS and Kent Police held about David's violent history and current suspicion of his control of Jean, would have facilitated a greater understanding of Jean's situation and would have allowed an element of challenge at subsequent meetings between Jean and KMPT.

7.3.9. The GP did not provide specific information about the domestic abuse on the referral, despite having this information directly from ICS. The GP did not attend,

or send a report to the MARAC, despite being asked to do so by the MARAC Coordinator.

7.3.10. Apart from ICS, each agency had the information which Jean presented to them – which was based upon a narrative prepared for a reason – to shine a positive light upon David, and to retain the care of her children.

7.3.11. If the information held by all agencies had been triangulated – using a multi-agency mechanism already in place – the bigger picture could have been viewed by all, and agencies could have worked together on a plan suited to the family's needs.

8. Lessons to be Learnt

8.1. There is no dispute that agencies involved with Jean and her family followed their policies and the formal and informal protocols in place at the time. What appears to be lacking in the agency responses to Jean is a trauma informed approach, with such approach improving empathy, understanding of her life-long experiences, alongside the sensitive challenging of Jean's perception of events and the challenge of other professionals' approaches to Jean's situation. There appeared to be a lack of understanding of other agencies' remits, priorities, and roles within a multi-agency response to a high-risk victim of domestic abuse who was presenting with complex needs and a reluctance to access specialist domestic abuse support.

8.2. It is evident throughout this review – and indeed in other reviews – that professionals are becoming more experienced in recognising domestic abuse. Social workers especially demonstrate an understanding of the effects of domestic abuse on children. However, there is a need for learning and development around the effects of domestic abuse and coercive control on adult victims, and in Jean's case, how EUPD particularly influenced this dynamic. Without this knowledge, professionals will identify that there is a problem, but will not be able to respond to the victim in a way which encourages engagement with services.

8.3. This review identified that the professionals "around" Jean and her children were all focused on a different aspect of the family's life, all approaching the situation from a different standpoint. Their focus was either on safeguarding the children, or bringing an assailant to justice, or reducing the risk of harm to Jean, or supporting her physical, or mental health. In this way agencies largely worked in silo, despite

there being multi-agency mechanisms available, agencies appeared to concentrate on their specific focus without deviating from their path. A victim's life does not exist in silo, the sections of their life intersect, and domestic abuse is all pervasive, interweaving throughout all parts of their life. Agencies' responses to domestic abuse victims should work in the same way, utilising the multi-agency mechanisms and information sharing protocols in place throughout the County.

8.4. One of the missed opportunities to engage with Jean occurred whilst she was receiving treatment for injuries in hospital. The presence of a Hospital Independent Domestic Violence Advisor may have caught her ready to engage, directly after the attack and before David could coerce her into changing her version of events.

8.5. Good practice can be identified, where ICS, IDVA and police were in constant contact to share information. However, the IDVA missed opportunities to take this further, and stringently collaborate with other agencies to engage with Jean on a level which illustrated to her that professionals understood her plight; and that they could be relied upon to properly protect her from her prolific and violent partner. Professor Jane Monckton Smith argues that victims of domestic abuse are experts at consequence management, and their disengagement is often due to their lack of faith in professionals to manage the consequences of police, social care, or support services' involvement. To put it plainly, victims of domestic abuse need to have more confidence in the ability of police to protect them from the abuser than they are afraid of repercussions from the abuser.[33]

8.6. The MARAC process is intended to go some way to facilitate such planning, however, in this instance it can be argued that the MARAC process was not used to its full potential and actions arising from the MARAC fell short of the multi-agency collaboration needed to both understand and protect victims like Jean – who was struggling with her long term mental health, who was telling professionals that she was suicidal and was using alcohol to cope with the effects of a life time of abuse; whilst being faced with a high risk of harm from a coercively controlling partner with a history of violence. At the time of the MARAC-to-MARAC mention only of Jean at Town B MARAC, she had received her diagnosis of EUPD, however the "mention only" did not provide the opportunity for sharing of information about this diagnosis with professionals who would soon be responding to her needs, had she completed the move to Town B. The MARAC process could be enhanced by the attendance

[33] Monckton-Smith, J *In Control; Dangerous Relationships and How they End in Murder* (2021)

of professionals with most information about a family. For example, the allocated social worker or mental health worker attending could bring direct information about the family.

8.7. Victims of domestic abuse are often coerced during appointments, by the very presence of an abuser or another family member. Jean was never seen alone, and this could have been addressed with her. Linked to the recommendation to encourage challenge, where agencies do not have policies to insist on meeting with patients or clients alone, this should be considered, and professionals should be urged to follow these policies. It is accepted that EUPD may have meant that for Jean attending appointments alone caused her distress, however, introducing the practice of always starting an appointment by seeing the patient alone for a short period, during which time the direct question of coercion can be posed to them, could provide the opportunity for a victim to disclose they are being coerced.

8.8. Jean was not allocated a mental health worker, which led to a lack of mental health knowledge at the core group. As Jean's experiences of abuse were compounded by her poor mental health, which was in turn exacerbated by her experiences of abuse – the lack of mental health expertise at the various meetings where she was discussed resulted in a missed opportunity to fully understand Jean and her life experiences. It is understood KMPT have adapted their model to a Choice and Partnership Approach, which means patients no longer experience a period without a named worker whilst awaiting care coordination and, therefore, any immediate actions required, such as sharing or gathering information, is undertaken promptly.

8.9. Whilst Jean was in local authority care there was a case regarding sexual abuse taken to court which did not result in a prosecution. It is possible that this experience of the criminal justice system (CJS) influenced her disengagement with subsequent CJS processes. The review panel suggested exploring a national recommendation surrounding the support for families who are looking to prosecute or have experienced abuse.

8.10. The panel are keen to share learning from this review in terms of the unexplained nature of Jean's death and would like to support the development of a central repository such learning.

9. Recommendations

The Review Panel makes the following recommendations from this DHR:

	Recommendation	**Organisation**
1.	The panel support recommendations emerging from other Kent Reviews which pertain to the evaluation of MARAC purpose and processes.	-
2.	Development of a secure professionals' virtual networking "Domestic Abuse Hub" within the Kent and Medway Domestic Abuse Website – to aid sharing of knowledge and referral pathways.	Kent CSP
3.	HIDVA service to be expanded to all Acute Trusts across Kent and Medway.	KCC Commissioning
4.	Domestic abuse training to include the effects of coercive control on victims.	KMSAB and KCC Learning and Development.
5.	A multi-agency learning event focusing on trauma informed practice, which raises awareness about responding to victims in a trauma informed way.	KCC Public Health
6.	Suicide prevention team to link in with (AAFDA) to join the conversation regarding unexplained deaths.	KCC Suicide prevention team
7.	Social landlords to include a section in their mutual exchange forms addressing the reason for a mutual exchange – if this reason is due to domestic abuse landlords should follow their safeguarding procedures.	Kent Housing Group
8.	Investigate the possibility of a central repository for unexplained deaths linked to domestic abuse.	Domestic Abuse Commissioner's Office

	Recommendation	Organisation
9.	All agencies and commissioned services to adopt trauma informed approaches and/or discussions within their staff supervision.	Kent Police, Education, K&M ICB, KMPT, Council A, Council B, KCC ICS, CENTRA, Rising Sun
10.	All agencies and commissioned services to have provision for a trauma informed training offer, which is accessible to all staff, and includes practices for their specific client group.	Kent Police, Education, K&M ICB, KMPT, Council A, Council B, KCC ICS, CENTRA, Rising Sun
11.	For agencies to have a lead person with knowledge of trauma informed practices.	Kent Police, Education, K&M ICB, KMPT, Council A, Council B, KCC ICS, CENTRA, Rising Sun