Safer Sheffield Partnership (SSP)

THE EXECUTIVE SUMMARY

‘Kirsten’

October 2022

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INDEPENDENT CHAIR AND AUTHOR

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The review process

1. The Safer Sheffield Partnership[1] commissioned the DHR and those who were involved in the review as well as the professionals who met Kirsten[2], offer our sincerest condolences to Kirsten's family, friends and loved ones for their loss following Kirsten's tragic passing.

2. Kirsten was 33 years old and Jake was her 40-year-old partner and the subject of a Restraining Order at the time of Kirsten's death. Kirsten and Jake had three children who were no longer living with them following Family Court proceedings several years before Kirsten and Jake came to Sheffield in February 2019. In addition to her children, Kirsten is survived by her mum, stepdad and three siblings who live in the East Midlands. All of the family are white British and English is their language of communication. Jake's whereabouts are unknown. Jake was born in Birmingham and is from the gipsy / Roma / Irish traveller community[3] and moved around the country but retained links with the West Midlands. He is an English speaker.

3. HM Coroner's inquest concluded in July 2022 that Kirsten died by suicide from an overdose. The statutory guidance makes clear that if the circumstances of a death by suicide give rise to concern for example about evidence of domestic abuse, a DHR should be completed[4]. There had been eight reports of domestic abuse to the police between February 2019 when Kirsten and Jake arrived in Sheffield and Kirsten's tragic passing.

4. The first meeting of the DHR panel was in May 2022 followed by two further meetings. The panel met for the final time in October 2022.

1.1 Contributors to the review

5. Sixteen of the more than 40 agencies contacted as part of the initial scoping for the review confirmed that they had varying levels of contact with Kirsten or Jake and provided information. All were asked to provide chronological information. Eleven of the organisations completed an individual management review with an analysis of their contact whilst other organisations that had less significant involvement provided a shorter summary of information.

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[1] The community safety partnership set up under the Crime and Disorder Act 1998.
[2] Pseudonyms have been used
[3] https://www.ethnicity-facts-figures.service.gov.uk/summaries/gypsy-roma-irish-traveller
[4] 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).

a) South Yorkshire and Bassetlaw Integrated Care System;
b) Crown Prosecution Service (CPS);
c) IDAS (independent domestic abuse service);
d) Probation service (Sheffield);
e) Rotherham NHS Foundation Trust 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;
g) Sheffield Health and Social Care NHS Foundation Trust;
h) Sheffield Housing and Neighbourhood Services;
i) Sheffield Teaching Hospitals NHS Foundation Trust;
j) South Yorkshire Police (SYP);
k) Yorkshire Ambulance Service (YAS);

6. 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 visited between May 2019 and February 2020, the community support worker service (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 a hospital in Rotherham having taken an overdose. 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.

1.2 The review panel members

7. All of the panel members were independent of any involvement or decision-making about the events and people concerned with the circumstances examined by the review.

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 Professional for Safeguarding Vulnerable Groups	Yorkshire Ambulance Service (YAS)

Alison Higgins	Strategic Commissioning Manager	Sheffield City Council – Domestic Abuse Commissioning Team (DACT)

1.3 Author of the overview report

8. Peter Maddocks wrote the overview report and this executive summary. He never worked for any of the organisations that 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 DHR in Sheffield before.

1.4 Terms of reference

9. The timeline of the DHR is from February 2019 when Kirsten and Jake arrived in Sheffield until Kirsten's death in October 2021. 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 call 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?

1.5 Summary chronology

10. Kirsten and Jake met when she was 17 and he was in his mid-twenties. Kirsten became pregnant soon after their relationship began and her family became concerned about domestic abuse. They sought help from local services but Jake and Kirsten moved to London. Jake had grown up in a travelling community and knew people around the country.

11. The move to London was the first of several made around England. Kirsten's family say this happened to escape the attention of services when they became aware of domestic abuse. Kirsten had three children with Jake who were removed by the Family Court several years ago. Kirsten's family said they wanted to provide a home for the children but this was opposed by Jake who isolated Kirsten from family and friends.

12. Kirsten tried to leave the relationship several times and sometimes returned home to her family. She was subjected to constant harassment by Jake and she would feel compelled to return to the relationship. It was complicated further by Jake's significant physical and mental health problems which were exacerbated by substance misuse.

13. Kirsten and Jake moved to Sheffield in February 2019, presenting as homeless telling local services that they had to flee from threats of community violence. There is no record of such complaints being made to the services in the northeast. There had been several reports of domestic abuse and it remains a possibility that this prompted a further move to another city.

14. Kirsten and Jake were given temporary accommodation and were supported by Shelter to secure a permanent tenancy in the city and to also secure a personal independence payment for Jake because of his poor health.

15. Kirsten also suffered from poor mental health and often visited her GP. She was prescribed anti-depressant medication and also used street-supplied medication telling the GP it was to help with her anxiety. There was no exploration of domestic abuse.

16. The first contact with the police was in July 2019 when a CCTV operator saw the couple arguing and Jake was banging his head against a bench. A DASH was completed at standard. The police sent a VA (vulnerable adult) referral to social care along with information that he was not able to use GP and hospital services under the NHS special allocation scheme referenced in the overview report.

17. In September 2019 the police responded to a third-party report of a disturbance at the couple's property. A DASH was completed at standard.

18. In mid-November 2019 the police responded to another report of a disturbance and noted that Kirsten had marks on her neck although there was nothing further recorded in the subsequent record of the investigation and no mention of a mark. A DASH was completed at medium and a DVPO was issued. The evidence of a strangulation injury is a significant risk and is discussed in the overview report and summarised later in this summary.

19. There were complaints of anti-social behaviour made by the housing and neighbourhood service in February 2020 although the police were not involved. This is an area of learning discussed in the overview report and summarised later in this document.

20. The police were called to a disturbance in March 2020 and a DASH was completed at a standard level and was reviewed by the specialist DARA police team.

21. Five weeks later a further incident required a police response with Kirsten and Jake accusing each 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 with a dumbbell. Kirsten agreed to have support from the IDAS service and was moved into a safe location at a hotel. A referral was made to the MARAC meeting held a month later.

22. In late June 2020, a member of the public contacted the housing and neighbourhood service to report disturbances had been occurring at the property. Some of these had been reported to the police but the service did not process them as information about domestic abuse. Further complaints about noise nuisance in September 2020 were processed similarly.

23. In mid-November 2020 the police responded to a third-party report of a disturbance at Kirsten and Jake's home. Kirsten was observed again with reddening marks on her neck. 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. Both denied any assault had occurred and a DASH was recorded at medium and a referral was made to the IDAS team.

24. The incident was discussed at the MARAC in January 2021. There were further reports of disturbance and argument and a housing officer visited Kirsten in March 2021.

25. In February 2021 Jake took an overdose and was admitted to the hospital overnight and referred to mental health services.

26. During a mental health assessment in early April 2021, Jake talked about lashing out at people but there was no clarification or detail recorded about this. Jake's mental health deteriorated over the following weeks with frequent calls to the SPA (single point of access team).

27. There was further contact with the housing and neighbourhood service about disturbances at the property.

28. In June 2021 a silent call was made from Kirsten's phone which was disconnected. At the same time, the police received a call from another household on the road about a disturbance. Jake had assaulted Kirsten which included attempted strangulation again. Jake was arrested and remanded to prison appearing in court in September when he was convicted and sentenced to a Community Order with conditions and made subject to a Restraining Order. While Jake was on remand he continued to contact and harass Kirsten to get her to change her statement. The incident was discussed at a MARAC.

29. Kirsten took an overdose in late August 2021. She was taken to the hospital and discharged, telling the mental health team that it was an impulsive act.

30. Jake breached the Restraining Order only a few days after being sentenced. The court imposed a suspended prison sentence.

31. Kirsten took an overdose in October which regrettably was fatal.

Key issues arising from the review

32. There was not 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 are significant points of learning along with the absence of coordination and consistency in response. There was evidence of economic abuse which since June 2022 and the implementation of the Domestic Abuse Act is now a defined form of abuse.

33. The significance of non-fatal strangulation which was not an offence until June 2022 is discussed in the overview report given its link as a precursor to more serious offending and the adverse health consequences of whether the strangulation is fatal or not.

34. A victim like Kirsten who is entrapped by an abusive 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.

35. 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 a controlling relationship with an abusive partner. There were examples of positive practices in the SPA trying to offer a service.

36. 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.

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

38. The advice worker and support worker employed by Shelter are experienced people 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. MARAC information was not seen by staff working directly with Kirsten and Jake.

39. None of the services had a complete record of domestic abuse that occurred in Sheffield. The police responded on 11 occasions but there

were reports to other services about incidents that were not disclosed to the police. For example, 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.

40. 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.

41. Jake's longstanding mental health difficulties go back to an adverse childhood that was further complicated by his later substance misuse including Spice. Other than probation collating this information for the pre-sentencing report and the SPA mental health assessment in 2020, none of the other services mention 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.

42. Jake's history of aggressive interaction with healthcare 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.

43. 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 and to consult with the CPS as to whether a prosecution should be sought. A perpetrator program was not available in Sheffield between late 2020 and September 2021 due to a recommissioning and change of provider of the service.

44. Worryingly, when Jake was able to continue contacting Kirsten from custody to “encourage” her to “tell the truth” this 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 with corresponding alerts being placed on his prison record and restrictions under national prison instructions being implemented. 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.

45. 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 consistency of response, the absence of work with Jake as a perpetrator and the shortfall in addressing Jake’s mental health and substance misuse in particular are significant lessons from this review.

46. 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.

Conclusions

47. Perpetrators of domestic abuse employ a range of control, emotional and destructive tactics all of which can have devastating effects on the emotional and mental well-being of their victims 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.

48. Kirsten was entrapped by an abusive partner in a long-term relationship which included economic abuse which has now been given legal definition as a form of controlling abusive behaviour. 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. 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. 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.

49. The MARAC could have been an opportunity to identify potential warning markers and set in motion agreed strategies for a coordinated and consistent response across services. 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 action 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 were discussed. 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.

50. 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.

51. Research has established controlling patterns of behaviour as permeating and dominating high-risk domestic abuse[5]. 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

[5] Myhill, A. & Hohl, K. (2016). The "Golden Thread": Coercive Control and Risk Assessment for Domestic Violence. Journal of Interpersonal Violence, 34(21-22), pp. 4477-4497. doi: 10.1177/0886260516675464

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.

52. The damage that Jake had experienced 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.

53. 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.

54. The agency reports to the DHR provided no information to indicate a recognition that Kirsten was entrapped by an abusive partner in a relationship dominated by coercive control. Some reports contained narrative descriptions of Kirsten not cooperating, of Kirsten reporting contact from Jake from within the prison, to tell the truth without understanding this was Jake still seeking to control Kirsten, of relying on Kirsten being a willing prosecution witness. Unless professionals develop an awareness and understanding of coercive control, they will be incapable of understanding the true dynamics of a relationship with an abusive controlling and coercive partner 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.

55. 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[6]. Many of these characteristics are

[6] Aitken R and Munro V (2018) Domestic Abuse and Suicide: Exploring the Links with Refuge's Client Base and Work Force. London: REFUGE. Available at https://www.refuge.org.uk/wp-content/uploads/2020/08/NEW-Suicide-Report-HIGH.pdf Accessed 14th July 2022.

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.

56. It was noted by the 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 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. The 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.

57. Victims of IPA may make decisions about 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 probably crucial. Aitken and Munro's (2018) finding 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 worth consideration.

58. 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; it was certainly not understood within the context of coercive control because no other service had either.

59. 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 specialist officers in DARA for example work moving the focus from secondary risk assessments to focusing on developing 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.

60. 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.

61. The CPS's domestic abuse guidelines for prosecutors 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

62. The joint inspection of evidence-led domestic abuse 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.

63. The College of Policing provides several examples of successful evidence-led prosecutions.

64. SYP is developing proposals to extend the scope of the MATAC 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.

65. 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. 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.

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

67. 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.

Learning

68. 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; Jake's abusive behaviour 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 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 need 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 that 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..
l) Patient record systems that do not link effectively enough between different providers and areas 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.

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 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.

Home Office

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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