DHR: Kelly

# Cumberland Community Safety Partnership

## Executive Summary for the Death of Kelly on January 2022

Parminder Sahota

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# Preface

The Independent Chair, Author, and Review Panel extend their sincere condolences to everyone affected by Kelly's tragic death and gratefully acknowledge their efforts and support during this procedure.

The main objective of a Domestic Homicide Review (DHR), when domestic abuse or violence is known to have happened in the relationship, is to allow lessons to be learned from the victim's death. Professionals must understand what happened in each case for lessons to be broadly and effectively conveyed. What must be done to decrease the likelihood of such a tragedy?

The Chair appreciates the panel's time, patience, and cooperation, as well as those who provided chronologies and material.

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## Section One: The Review Process

1.1.1 This summary outlines the process undertaken by the North Cumbria Community Partnership domestic homicide review panel in reviewing the death of Kelly, who was a resident in their area.

1.1.2 The following pseudonyms have been used in this review for the adult and partner to protect their identities:

- The adult: Kelly
- The partner: Michael

1.1.2 Kelly was a 57-year-old White British female. Kelly died in the hospital following an untreated compound fracture; the cause of death was Sepsis and Hemorrhage due to the compound fracture of the clavicle (collarbone). Kelly informed the ambulance that Michael had pushed her, causing her clavicle injury.

1.1.3 The process began with an initial meeting of the Community Safety Partnership on 9 February 2022, when the decision to hold a domestic homicide review was agreed upon. All agencies that potentially had contact with Kelly and Michael before the point of death were contacted and asked to confirm whether they had been involved with them.

1.1.3 Eight of the eleven agencies contacted confirmed contact with Kelly and/or Michael and were asked to secure their files.

1.1.4 A Coronial Inquest was held in Spring 2024:

*1.1.5 The Coroner concluded that based on the evidence presented, 'it has not been possible to determine the cause of the fall', and that her death would be classed as accidental. The Coroner said: "Only Kelly or her partner can say what happened. "We also know she's been very vulnerable, even prior to that accident, or whatever it may be. "You have to stand back as family. "You tried your best, as indeed did many of the health professionals, but someone has to want to be helped." Her daughter's statement said: "It was sad that Kelly missed the majority of all her children's lives and never met her grandchildren."*

## Section Two: Contributors to the Review

2.1.1 The following agencies and their contributions to this review:

| Agency and Profile | Contribution- Chronology/IMR/Letter/Other |
|---|---|
| **Adult Social Care**<br>The lead agency for making enquiries for Adults with Care and Support needs who are at risk of abuse and Neglect: Care Act 2014 | Chronology and Reflective Summary |
| **Cumbria Constabulary** | Chronology and IMR |

| | |
|---|---|
| **Cumbria Northumberland Tyne & Wear NHS Foundation Trust**<br>One of the largest mental health and disability trusts in England. Providing mental health, learning disability and neurological care for people across the north of England, as well as some national specialist services | Chronology and IMR |
| **North Cumbria Integrated Care**<br>**Cumberland Infirmary**<br>**Carlisle**<br>They provide hospital and community health services to half a million people and are responsible for delivering over 70 services across 15 main locations. | Chronology and IMR |
| **North West Ambulance Service** | Chronology and IMR |
| **Probation Service** | Chronology and IMR |
| **Recovery Steps Cumbria**<br>A drug and alcohol recovery service provides treatment and recovery support for individuals (aged 18 years and above) and their family members affected by substance misuse (including alcohol, illicit drugs, and over-the-counter and prescribed medication). | Chronology and IMR |
| **Riverside Housing**<br>Social Housing | Chronology |
| **Warwick Square Group Practice**<br>GP practice, including Out-Of-Hours | Chronology and Reflective Summary |

2.1.2 The chronologies and reports were authored by professionals independent of the case management or service delivery.

## Section Three: The Review Panel Members

3.1.1 The independent panel members for this review were the following:

| Name | Role | Organisation |
|---|---|---|
| **Anna Bates** | Head of Housing | Castles and Coasts Housing Association |
| **Becky White** | Area Manager | Recovery Steps Cumbria |
| **Detective Inspector Matthew Belshaw** | VAWG Inspector | Cumbria Constabulary |
| **Gemma Qi** | Safeguarding Advisor | North Cumbria Integrated Care<br>Cumberland Infirmary<br>Carlisle |
| **Sheona Duffy** | Acting Named Nurse | Cumbria Northumberland Tyne& Wear NHS Foundation Trust |
| **Sean Carroll** | Senior Probation Officer | Probation Service |
| **Sarah Edgar** | Domestic Homicide Review DC | Cumbria Constabulary Police |
| **Sarah Joyce** | Service Manager Safeguarding | Adult Social Care - Cumbria |
| **Sharon McQueen** | Safeguarding Practitioner | North West Ambulance Service |

| | | |
|---|---|---|
| **Susan Mein** | Deputy Designated Nurse for Safeguarding | North East and North Cumbria Integrated Care Board |
| **Vikki Pattinson** | Housing Services Manager | Riverside Homes |
| **Parminder Sahota** | Independent Chair/Author | PS. Safeguarding LTD |

3.1.2 The panel met a total of five times.

## Section Four: Author of the Overview Report

4.1.1 Parminder Sahota is an independent author with ten years of experience in domestic abuse and safeguarding. Advocacy After Fatal Abuse provided the DHR Chair training in 2021. She has worked as a mental health nurse in the NHS for over twenty years and is a Director of Safeguarding, Prevent, and Domestic Abuse Lead for an NHS Trust.

4.1.2 Parminder Sahota is independent of all agencies involved and has no prior contact with family members or the Cumbria Community Safety Partnership.

## Section Five: Terms of Reference for the Review

5.1.1 The statutory guidance sets out the purpose of domestic homicide reviews to:

- Establish the facts that led to the death in January 2022 and whether any lessons can be learned from the case about how local professionals and agencies worked together to safeguard Kelly.
- Establish what lessons will be learned from the death regarding how local professionals and organisations work individually and together to safeguard victims.
- Identify these lessons, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change.
- Apply these lessons to service responses, including changes to inform appropriate national and local policies and procedures.
- Prevent domestic violence and related deaths and improve service responses for all domestic violence and abuse victims by developing a coordinated multi-agency approach to identify and respond to domestic abuse at the earliest opportunity.
- Contribute to a better understanding of the nature of domestic abuse.
- Highlight good practice.
- Ensure that Kelly's voice is heard regarding her lived experiences and the impact of domestic abuse on her mental health. Allowing her journey to be told and identifying the lessons that may be learnt.

5.1.2 The review's time frame was set to cover the months of May 2021 to January 2022. The selected chronology mirrored Kelly's heightened engagement with the police, throughout which she communicated her desire to end her life.

5.1.3 The panel agreed on the following terms of reference, which are explored in the overview report:

1. Were local domestic abuse and adult safeguarding procedures followed by agencies contacting Kelly?
2. Were any other options for perpetrator disruption or victim safety planning available to your agency/agencies during this review? If so, why were they not considered, or were there barriers to using them?
3. Were service responses to Kelly affected by the COVID-19 pandemic (review relevant contact/response with current impact)?
4. Was information shared promptly and to all appropriate partners during the period covered by this review?
5. Can agencies identify areas where the existing legal and policy framework could be improved at the national or local level?
6. What was the sequence of events up to the date of the death?
7. Information: What knowledge/information did your agency have that indicated that those involved might be victims and perpetrators of domestic abuse, and how did your agency respond to this information?
8. In considering your response, think about the impact of abuse upon Kelly and, specifically, respond to the following (where possible):
    a) To what extent did Kelly consider herself a victim?
    b) Did Kelly understand that the risks she faced impacted her decision-making?
9. Does your agency have any information that helps understand the possible 'triggers' in Kelly's life that may have led to her alcohol misuse and life circumstances?
10. Were practitioners alert to potential domestic abuse indicators and aware of what to do if they had concerns about a victim or perpetrator?
11. Have your agency policies and procedures for identifying domestic abuse and dealing with those concerns? Were these assessment tools, practices, and policies considered adequate? Was it reasonable to expect staff to fulfil these expectations given their level of training and knowledge?
12. What were the key points or opportunities for assessment and decision-making in this case? Have reviews and decisions been informed and professional, keeping with organisational and multi-agency policies and procedures?
13. Were joint assessments to assess substance misuse, mental ill-health, and domestic violence abuse?
14. Should the information your agency knows have led to a different response?
15. How accessible were the services for Kelly?
16. Were the identified needs unmet or conflicts between Kelly's requirements and her response to these?
17. Was there any additional action that could have been taken, and would it have made a difference? (Missed opportunities?)
18. Capacity and resources: Were there issues about capacity in your agency that impacted the ability to provide services to Kelly, the alleged perpetrator, or any other relevant

persons? Did these issues affect the agency's ability to work effectively with other agencies?

19. Are there lessons to be learned from the case relating to how your agency safeguards victims and promotes their welfare or how it identifies, assesses, and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for working, training, management, and supervision in partnership with other agencies and resources?
20. Identify good practices where responses may have exceeded the required standards.
21. The reports should consider any equality and diversity issues pertinent to Kelly and the alleged perpetrator, e.g., age, disability, gender reassignment, marriage, civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation.

## Section Six: Summary Chronology

6.1.1 Kelly was the mother of six children, all of whom were removed from her care as infants and raised by Kelly's siblings and three of the children by the paternal grandmother. She had a lengthy history of substance abuse, from the age of 14 to 15, and was under the care of Recovery Steps Cumbria on a Methadone prescription. Over the past decade, alcoholism has been the leading concern.

6.1.2 Michael called 999 fourteen days before Kelly died; he disclosed that his 'friend' Kelly had sustained a shoulder injury after falling at home. When paramedics arrived, Michael was asleep, and they examined Kelly. An isolated injury with bruising and swelling was observed over her right collarbone. They speculated that Kelly's limited mobility indicated a potential clavicle fracture.

6.1.3 Kelly told the paramedics that Michael pushed her during an argument, causing her to lose balance and fall against the wooden bedframe, hurting her shoulder. She stated he pushed her because he believed she would punch him. Kelly declined to attend A&E. The paramedics inquired about Kelly's safety and the need for assistance contacting the police. Kelly declined.

6.1.4 On the same day the ambulance attended, Michael accompanied Kelly to the pharmacy to pick up her methadone prescription. The pharmacist remarked on her appearance, describing her as pale and perspiring. They were particularly concerned about Michael's conduct. Recovery Steps Cumbria was informed of the issues.

6.1.5 Kelly retracted her statement that Michael pushed her. When agencies (Pharmacy and Recovery Step Cumbria) spoke to Kelly alone about her safety and whether she was at risk of harm, she denied this.

6.1.6 Michael made a final call to the ambulance three days before Kelly died, indicating that Kelly was having trouble breathing and her wound was bleeding. The ambulance attended to and transported Kelly to the hospital under emergency conditions.

## Section Seven: Key Issues arising from the Review/Lessons Learned

7.1.1 **Trauma Informed Care** - Kelly disclosed trauma to the police and Recovery Steps Cumbria, stating that she had been beaten, sexually abused, and a victim of domestic violence in the past and that her children had been removed from her custody.

7.1.2 Drug and alcohol use is a set of coping skills to suppress underlying issues, usually some trauma. Adopting a trauma-informed approach has been evidenced as the preferred method for services to respond effectively to these complex issues.

7.1.3 Trauma-informed care suggests that service and practice responses must be designed to recognise and respond to the experience of complex trauma in the lives of the people with whom they interact. In addition, the underpinning assumption is that it involves relational and strengths-based ways of addressing trauma's impact.[1]

7.1.4 Agenda's research reported that one in twenty women had experienced extensive physical and sexual violence as a child and adult.[2] Therefore, it highlights a link between trauma and addiction and the requirement for practitioners to be aware of the trauma's impact and prevent re-traumatisation.

7.1.5 Kelly had disclosed trauma, reporting to have been beaten, sexually assaulted, and a previous victim of domestic abuse and had her kids had been removed from her care.

7.1.6 **Alcohol and Domestic Abuse** - Kelly was a dependent drinker with a history of abstinence from illegal substances while on a methadone programme. Her prior partners had been either dependent drinkers or utilising illicit narcotics.

7.1.7 Alcohol has been linked with crimes, such as domestic abuse. It is part of the trilogy of risk: Alcohol/substance misuse, poor mental health, and domestic abuse–risk indicators that increase the risk of harm.

7.1.8 Alcohol was cited as a common theme in a sample of 39 DHRs, with fifteen identifying the victim as experiencing alcohol problems and fifteen with both the victim and perpetrator.[3]

7.1.9 The awareness of alcohol is commonplace in such tragedies. It requires services to ensure they have processes to identify victims/perpetrators who present with alcohol issues and work with multiple agencies to respond to this.

7.1.10 Kelly described being a dependent drinker and successfully abstaining from illicit substances while on a methadone programme. Her previous partners had been either dependent drinkers or using illegal substances.

[1] https://tce.researchinpractice.org.uk/wp-content/uploads/2020/02/Developing-and-leading-trauma-informed-practice.pdf
[2] https://alcoholchange.org.uk/blog/2019/women-and-alcohol-why-we-need-a-trauma-informed-response
[3] https://avaproject.org.uk/wp-content/uploads/2016/09/Alcohol-Concern-AVA-guidance-on-DA-and-change-resistant-drinkers.pdf

7.1.11 People who misuse substances may surround themselves with others who misuse both to receive validation and satisfy their need for belonging. Consequently, the need to address these enablers' dual nature can impact clients.

**7.1.12 Professional curiosity**

7.1.13 Professional curiosity is being interested in the individual and listening to their story without judgment or assumptions.

7.1.14 Cumbria Safeguarding Children Partnership[4] highlights the importance of improving decision-making and reducing risks. Further work performed by Cumbria Safeguarding Children Partnership, Safer Cumbria, and Cumbria Safeguarding Adults Board resulted in producing material designed to increase practitioners' professional curiosity.[5]

7.1.15 Services demonstrated they wished for Kelly to receive help; the ambulance crew suggested alternative transport to convey her to the hospital. RSC was aware of her wishes and strengths.

7.1.16 The practitioner event highlighted the difficulty of patient databases. Since agencies use different databases, they are only sometimes aware of the services a person receives. Therefore, reliance is placed on the individual to reveal this information.

7.1.17 For all services engaging with people in similar complex situations, Kelly may consider using professional curiosity to agree to the care plan collaboratively.

7.1.18 **Routine Enquiry** - Not all services enquired about domestic abuse.

7.1.19 Victims of domestic abuse often come to the attention of healthcare professionals, and thus, they are ideally placed to identify domestic abuse.[6]

7.1.20 To support practitioners with facilitating enquires a research paper[7] revealed the following findings:

- Interpersonal relations – Listening skills, Trust, Empathy
- Safety – Privacy and confidentiality, home visits
- Validation

[4] https://cumbriasafeguardingchildren.co.uk/professionalcuriosity.asp
[5] https://www.cumbria.gov.uk/elibrary/Content/Internet/327/949/38407/44846101828.pdf
[6] https://safelives.org.uk/sites/default/files/resources/Domestic%20abuse%20guidance%20for%20virtual%20health%20settings-%20C19.pdf

[7] https://link.springer.com/content/pdf/10.1007/s10896-020-00236-3.pdf

7.1.21 Kelly was not asked about domestic abuse, with NCIC assuming the person bringing her to the hospital was her husband. As previously stated, most victims will not disclose that they are experiencing domestic abuse and have reported feeling relieved to be asked.

7.1.22 Safe Lives produced guidance on how to conduct a routine enquiry[8].

7.1.23 **Alcohol and Capacity** - The necessity to balance capacity and unwise decisions. Kelly, a dependent drinker, had refused to attend A&E despite the advice of healthcare professionals.

7.1.24 The case concerning Tower Hamlets V PB (2020) involved a 52-year-old male with a history of alcohol misuse and whether he could decide on his care and residence.[9]

There were several key points arising from the case.[10]:

- If an individual has the capacity to make decisions around care and residence and is content to remain in the placement while being able to access alcohol, local authorities may feel that they have no other option than to let that individual take risks with their health that the local authority is uncomfortable with.
- The real question is how alcohol consumption affects individuals' decision-making capacity in other areas. Capacity assessments should consider the individual's ability to understand, use, retain and weigh information about the consequences of their alcohol consumption and how that affects their decision-making in other vital areas, including care and support. The effect on their health and potential risk to their life will be part of that consideration.
- If an individual cannot understand, use, retain and weigh information because of their dependency on alcohol, they will lack the capacity to make those decisions. However, where the individual clearly understands the risks to their health presented by their use of alcohol, it is likely to be found by courts that they will have the capacity to make decisions about care and support. This will apply whether an individual does not have a realistic view about how to moderate or manage their drinking. As long as the individual understands the risks posed by heavy drinking, although the decision may be considered unwise, it does not mean they cannot necessarily make it.

7.1.25 The case demonstrates the need to balance capacity with unwise decisions.

7.1.26 Alcohol Change UK has produced a guide to further support practitioners in understanding the legal frameworks. It should be shared with all agencies to inform them of their legal responsibilities better and safeguard dependent drinkers.

[8] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC196400/

[9] https://www.39essex.com/vice-presidents-judgment-on-capacity-and-alcohol-dependence/

[10] https://invicta.law/news/capacity-to-make-decisions-on-care-and-alcohol-dependency/

## Section Eight: Conclusion

8.1.1 Kelly had a lengthy history of substance abuse; she had previously used heroin and benzodiazepines. Kelly was taking 30ml of methadone, which maintained her heroin abstinence. Her recent substance abuse involved alcohol abuse.

8.1.2 Kelly has been in abusive relationships and remarked, "I must have been born to be abused." In December 2021, Kelly began a new relationship with Michael and moved in with him.

8.1.3 After a verbal altercation between the couple in early January 2022, the police became aware of their relationship. This resulted in no further action. However, the Police contacted adult social care and filled out a safeguarding form. They also shared information with the GP.

8.1.4 Kelly experienced a fall fourteen days before she died. She initially told the ambulance service that Michael pushed her against the wooden bedpost. However, she did not make the same disclosure and informed agencies that she had fallen. Kelly did not obtain care for her injury despite being urged to use a sling.

8.1.5 The review determined that services supported Kelly's access to services by acting immediately and appropriately.

## Section Nine: Recommendations from the Review

### 9.1.1 Recommendation One: Trauma-Informed Care

1. The senior leadership must invest in and support organisations to adopt a trauma-informed strategy. The leadership group develops the plan for a trauma-informed organisation. This will entail consideration of patient participation, clinical and non-clinical staff training, and establishing a safe environment.

### 9.1.2 Recommendation Two: Compassionate Curiosity

2. The three boards have developed guidelines for practitioners to strengthen and cultivate their curiosity around their practice. The guidance must be evaluated, and mechanisms put in place to assess its impact, including staff and patient feedback on its use.

### 9.1.3 Recommendation Three: Routine Enquiry

3. Responding to domestic violence is everyone's responsibility. To enable organisations to fulfil their responsibilities effectively, all staff must obtain the necessary training to identify victims/survivors and ensure they receive the support required. This will necessitate the implementation of information-sharing protocols and efficient systems for recording and

directing victims/survivors to the appropriate services. Organisations must be able to efficiently extract the necessary data to guarantee compliance with this obligation.

### 9.1.4 Recommendation Four: Alcohol and Capacity

4 Safer Cumbria will collaborate with the Cumbria Safeguarding Adults Board to raise awareness among system-wide practitioners about dependents with impaired mental capacity and executive functioning.