SAFER VALE PARTNERSHIP

DOMESTIC ABUSE-RELATED DEATH REVIEW

EXECUTIVE SUMMARY

Report into the death of Kim

January 2022

Independent Chair and Author of Report: James Rowlands

Associate, Standing Together Against Domestic Abuse

February 2024

1. Preface

1.1 The Review Process

1.1.1 This report examines agency responses and support given to Kim,[1] a resident of the Vale of Glamorgan before the point of her death by suicide in January 2022. Kim was found deceased at her home by her mother, Kris[2], having died from self-inflicted injuries.

1.1.2 Kim had been in a relationship with Ethan[3] since around February 2021, although they had separated towards the end of the year.

1.1.3 The Review Panel has considered what Ethan's status should be in the review given he has never been found guilty of any offences related to domestic abuse and Kim died by suicide. The Review Panel concluded that, based on the evidence available, it was reasonable to assume on the balance of probability that Ethan was responsible for domestic abuse towards Kim. Ethan will therefore be referred to as the '(alleged) perpetrator' of domestic abuse. This has had implications for publication, the information gathered from agencies, as well as whether Ethan was approached.

1.1.4 The Review Panel expresses its sympathy to the family and friends of Kim for their loss and thanks them for their contributions to, and support for, this process.

1.1.5 The following pseudonyms have been used in this review to protect the identities of the victim, other parties, those of their family members, and the perpetrator:

Name	Relationship to victim
Kim	Victim
Ethan	Partner / (Alleged) Perpetrator
Kevin	Previous Partner / Perpetrator
Kris	Mother
Ava	Neighbour
Mia	Neighbour

1.1.6 Kim's family chose the pseudonym for Kim and Kris, with other pseudonym chosen by the Chair and agreed with the family.

[1] Not her real name.

[2] Not her real name.

[3] Not his real name.

1.1.7 The Review Panel has recommended that, in the absence of a criminal conviction and to protect the privacy of Kim's family, only the Executive Summary is published.

1.1.8 There has been no criminal trial in this case, although AG's death was referred to the HM Coroner who recorded a verdict of death by suicide in March 2023.

1.1.9 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004 and should be conducted in accordance with the December 2016 Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (hereafter 'the statutory guidance').

1.1.10 The statutory guidance states that: "Where the victim took their own life (suicide) and the circumstances give rise for concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken…Reviews are not about who is culpable" (Para 18). Given the circumstances of Kim's death by suicide, a DHR has been commissioned but it is described as a 'Domestic Abuse-Related Death Review' (hereafter 'the review').

1.1.11 This review applies the statutory definition[4] of domestic abusive behaviour as consisting of a single incident or course of conduct between two people who are personally connected. In Wales, the relevant legislation is section 5 of the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 (the Act).

1.1.12 In undertaking this review, the Review Panel has struggled with the limited guidance available about how to conduct a review into a death by suicide, particularly regarding what this means for information sharing about, or engaging with, the (alleged) perpetrator of domestic abuse. The Review Panel considered making a recommendation on this issue, but has not done so, given the Home Office is currently working to reform the DHR system, including providing further guidance on suicide DHRs.[5] The Review Panel also noted the ongoing work in Wales with respect of the Single Unified Safeguarding Review (SUSR) process.[6]

1.1.13 This review was commissioned by the local Community Safety Partnership (CSP), the Safer Vale Partnership. Having received notification from South Wales Police in January 2022, a decision was made to conduct a review in consultation with the statutory partners who make up the Safer Vale Partnership (i.e., Vale of Glamorgan Council, South Wales Police, South Wales Fire and Rescue, Probation and Health). In future, the Safer Vale Partnership is encouraged to be mindful of the statutory guidance paragraph 22, which includes a requirement to consult with local partners with an understanding of the dynamics of domestic violence and abuse. That might include, for example, the local domestic abuse specialist service.

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[4] The Domestic Abuse Act 2021 received Royal Assent on 29 April 2021: https://www.legislation.gov.uk/ukpga/2021/17/part/1/enacted

[5] For more information, go to: https://www.gov.uk/government/publications/tackling-domestic-abuse-plan.

[6] For more information, go to: https://www.gov.wales/single-unified-safeguarding-review-guidance#116851.

1.1.14 Subsequently, the Home Office was notified of the decision to conduct the review in writing in February 2022.

1.1.15 Standing Together Against Domestic Abuse (hereafter 'Standing Together') was commissioned to provide an Independent Chair (hereafter 'the Chair') for this review in May 2022. In January 2024, the Chair presented the findings of the review to the Safer Vale Partnership and, after review panel finalisation in February 2024, the report was circulated and signed off electronically by the partnership. The completed report was then submitted by the Safer Vale Partnership to the Home Office Quality Assurance Panel in November 2024. In June 2025, the completed report was considered by the Home Office Quality Assurance Panel. In the same month, the Safer Vale Partnership received a letter from the Home Office Quality Assurance Panel approving the report for publication. The letter will be published alongside the completed report.

1.1.16 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. This timeframe was not met due to:

- The timeframe for the first panel meeting, which was set to allow all agencies to participate, and then the progress of subsequent meetings (see 1.9 below); and
- The need to enable engagement with Kim's family (see 1.10 below).

1.2 Contributors to the Review

1.2.1 Reflecting the potential geographical scope of the review, a total of 36 agencies were contacted to check for involvement with the parties concerned with this DHR. Of these, 8 had only limited contact and submitted a Summary of Engagement. However, 9 had more extensive contact and were asked to submit a Short Report or Individual Management Reviews (IMRs). A narrative chronology was also prepared.

1.2.2 Summary of Engagements were provided by the following agencies in these cases, this information was sufficient to build a case summary as the contact was relatively limited.

Vale of Glamorgan

- Shared Regulatory Services – provides Environmental Health, Trading Standards and Licensing functions on behalf of the Bridgend, Cardiff and Vale of Glamorgan Councils (joint submission including noise complaints and animal welfare).

Rhondda Cynon Taf

- Children's Social Care Services
- University Health Board – Mental Health Services

Northamptonshire

- East Midlands Ambulance Service NHS Trust

National/Other

- Avon and Somerset Police
- British Pregnancy Advisory Service (BPAS)[7]
- Gwent Police
- National Probation Service

1.2.3 The following agencies had more substantial or significant contact and their contributions to this review are:

Vale of Glamorgan

Agency	Contribution
Vale of Glamorgan Local Authority Domestic Abuse Assessment and Referral Co-ordinator (DAARC) service[8]	Short Report
Cardiff and Vale University Health Board (UHB)	IMR and Chronology (also facilitated information sharing from the General Practitioner (GP) 1 and Cwm Taf Morgannwg UHB)
South Wales Police (including information on the local Multi Agency Risk Assessment Conference, MARAC[9])	IMR and Chronology
Victim Focus[10]	Short Report and Chronology
Welsh Ambulance Service Trust (WAST)	Short Report and Chronology

Northamptonshire

Agency	Contribution
Northampton General Hospital NHS Trust (NGH)	Short Report and Chronology
Northamptonshire Healthcare NHS Foundation Trust (NHFT)	Short Report and Chronology

[7] An independent healthcare charity which, for more than 55 years, has been advocating and caring for women and couples who decide to end a pregnancy. For more information, go to: https://www.bpas.org/about-bpas/.

[8] Employed by the Vale of Glamorgan Council, the DAARC service receives standard and medium referrals from the police where consent had been given. The DAARC service will assess the report, drawing on any other information held by the police and children's services, before attempting to contact the victim to offer support and signposting, including referral to other local services.

[9] Overseen by the Cardiff and Vale VAWDASV Executive Board and Safer Vale Partnership.

[10] Provides help and support to victims of crime in South Wales. For more information, go to: https://www.southwalesvictimfocus.org.uk.

Northamptonshire Police	IMR and Chronology
Voice For Victims and Witnesses,[11] including the Sunflower Centre[12] (and information on the local MARAC)	Short Report and Chronology

1.2.4 The Review Panel also approached the following agencies, who also provided an IMR and Short report respectively, as well as Chronologies. None of these agencies joined the Review Panel, but they were provided with the opportunity to see and comment on the relevant sections of the report:

- The Adult Entertainment Company,[13] operating within the sex industry, with whom Kim was involved as a freelance performer, usually carrying out shifts from home. The Adult Entertainment Company describes its business as providing a platform for individuals to appear both on television and online to interact with members of the general public.
- As part of this request for information, checks were also undertaken with an industry-based support service used by the Adult Entertainment Company (Pineapple Support[14]), which confirmed it had not had contact with Kim.
- The Letting Agency through which the property where Kim lived was rented.

1.2.5 Finally, given the importance of Kim's dogs to her, attempts were made to identify organisations that may have had contact with Kim in this respect, including the Dogs Trust and the RSPCA. During scoping, neither reporting any contact with Kim.

1.2.6 The IMRs were written by authors independent of case management or delivery of the service concerned.

1.3 The Review Panel Members and Involvement of Family, Friends, Work Colleagues, Neighbours and Wider Community

1.3.1 The Review Panel members were:

Name	Job Title	Agency
Anita Lindsay	Clinical Governance and Quality Improvement Manager for Substance Use	Cardiff and Vale UHB
Alice Fairman	Safeguarding Nurse Advisor	Cardiff and Vale UHB

[11] Voice is a **free**, confidential support service for anyone affected by crime, life-changing fire incidents and serious road traffic collisions in Northamptonshire. For more information, go to: https://www.voicenorthants.org.

[12] The Sunflower Centre is partnership funded and provides support to victims of domestic abuse. For more information, go to: https://www.voicenorthants.org/about-voice-northants/sunflower-centre/.

[13] Anonymised to protect Kim's identity.

[14] For more information, go to: https://pineapplesupport.org.

Benedicte Lepine	Community Safety Policy Manager	Vale of Glamorgan Local Authority Community Safety
Beth Aynsley	Independent Protecting Vulnerable Person Manager	South Wales Police
Ceri Fowler	Regional Lead for Suicide and Self-harm Prevention (South Wales)	Hosted by Cardiff and Vale UHB and funded by Welsh Government
Deborah Gibbs	Principle Community Safety Officer	Vale of Glamorgan Local Authority Community Safety
Fiona Campbell	Chief Executive Officer	Voice For Victims and Witnesses/ Sunflower Centre
Gwenan Jones- Parry	Senior Safeguarding Specialist	WAST
Jessica Rees	Area Manager for Victim support	Victim Focus
Julie Grady	Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Manager	Vale of Glamorgan Local Authority Community Safety
Kevin Fagan	Community Safety Manager	West Northants CSP
Leoni Oxenham	National development Officer (Wales) and Deputy Safeguarding Lead	Church Army (The Amber Project)[15]
Linda Woodley	Operations Manager - Safeguarding	Vale of Glamorgan Mental Health Services
Mike Ingram	Head of Housing and Building Services and Community Services	Vale of Glamorgan Local Authority Housing Services
Natasha James	Operations Manager	Vale of Glamorgan Local Authority Children's Social Care Services
Nick Peters	Detective Inspector	Northampton Police
Nicole Devonish	Adult Safeguarding Team Manager	Vale of Glamorgan Local Authority Adult Social Care
Steven Pope	Lead Nurse for Safeguarding adults	NHFT
Vicky Friis	Chief Executive Officer	Vale Domestic Abuse Service

[15] A Church Army project which supports young people aged 14-25 in Cardiff and surrounding areas who experience self-harm. For more information, go to: https://www.amberproject.org.uk. Included on the Review Panel to bring expertise.

Victoria Shaw	Named Nurse for Safeguarding Adults	NGH

1.3.2 Additionally, Dr Katie Thorlby, the Research and Impact Manager at Beyond the Streets,[16] acted as a critical friend to the Review Panel.

1.3.3 Review Panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case.

1.3.4 The Review Panel met a total of four times, with the first meeting of the Review Panel on the 22nd September 2022. There were subsequent meetings on the 10th March 2023 and the 16th June 2023, when the first draft report was shared. A revised draft of the report was circulated for electronic feedback and comments in September 2023, with a final meeting held on the 25th October 2023. Thereafter, after finalisation and a period of time to allow for family engagement, the report was circulated and signed off electronically in February 2024.

1.3.5 Kim's family were involved in the review,

- When the Chair was appointed in May, the Safer Vale Partnership had not notified the family of the decision to conduct a review. In future, the Safer Vale Partnership should be mindful of the statutory guidance paragraph 25, which includes a requirement to notifying a family of the decision to commission a review.
- As a result, it was agreed that a joint notification letter would be sent, with this being shared with Kim's mother (Kris) in June 2022 via South Wales Police,[17] along with the Home Office leaflet, as well as information on Advocacy After Fatal Domestic Abuse (AAFDA)[18].
- Contact was established by the Chair with Kris in February 2023, although there had been attempts to do so and liaison between the Chair and the officer in charge of an investigation (OIC) prior to this date. Having had an initial discussion, including explaining the review process and the different ways that Kris could be involved, the Chair secured Kris's consent for a referral to AAFDA, who thereafter provided support.
- Kris shared information with the Chair about Kim and, in July 2023, met and discussed Kim, her life, and her experiences. Kris was provided with, and agreed as accurate, a record of this discussion. The Terms of Reference were also reviewed.

[16] Works with women involved in the sex industry. For more information, go to: https://beyondthestreets.org.uk.

[17] As Kim died by suicide, there was no Family Liaison Officer, but this was facilitated via the Officer in the Case.

[18] AAFDA provide emotional, practical and specialist peer support to those left behind after domestic homicide. For or more information, go to: https://aafda.org.uk.

- The Chair shared information with Kris about the opportunities for other family members to be involved in the review, but Kris explained that they did not feel able to participate and she would represent the family. The Chair and Kris also discussed contact with Kim's friends, but Kris said that while Kim was with Ethan, she had not spent much time with other people and did not feel able to provide any introductions.
- With their agreement, the draft Overview Report was shared with the family in December 2023. Kris responded that she was happy with report and did not provide any additional feedback. Kris initially agreed to provide a pen portrait, however, despite being contacted at appropriate stages throughout the process to encourage engagement, she ultimately chose not to participate further.
- Kris was offered the opportunity to meet the Review Panel but chose not to do so.
- Kris will also be provided with a final copy of the Overview Report.

1.3.6 With respect to Ethan:

- As noted in 1.1.4, the Review Panel considered Ethan's status in the review. This included considering whether – as the (alleged) perpetrator – Ethan should be invited to participate in the review. In making this decision, the Review Panel sought to balance Ethan's interests (including whether he had a right to be informed of the review, as well as having the opportunity to contribute) alongside welfare concerns (including for Ethan himself, as well as the potential impact on Kim's family).
- This issue was considered over several meetings before the Review Panel decided not to contact Ethan, in a large part because of the absence of guidance as to how to involve alleged perpetrators into the review of domestic abuse-related deaths.
- As a result of this decision, the Review Panel also agreed that contact should not be made to others who knew Ethan.

1.3.7 The Chair wishes to thank everyone who contributed their time, patience and cooperation to this review.

1.4 Chair of the DHR and Author of the Overview Report

1.4.1 The Chair and author of this review is James Rowlands, an Associate of Standing Together. James is a qualified Social Worker and Independent Domestic Violence Advisor (IDVA) and has worked in a variety of frontline and strategic roles in the domestic abuse sector since 2004. James has received Domestic Homicide Review Chair's training from Standing Together and has chaired and authored 18 previous DHRs.

1.4.2 Standing Together is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community

Response (CCR).[19] The CCR is based on the principle that 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. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides. Standing Together has been involved in the Domestic Homicide Review process from its inception, chairing over 90 reviews across England and Wales from 2013 until the present day.

1.4.3 *Independence*: James has no connection with the Vale of Glamorgan, the Safer Vale Partnership or any of the agencies involved in this case.

1.5 Equality and Diversity

1.5.1 The Chair and the Review Panel have considered the protected characteristics under the Equality Act 2010 of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation during the review process.

1.5.2 Throughout the review, the Review Panel identified that the following protected characteristics required specific consideration:

- *Age*: At the time of her death Kim was 24 and, as a result, the Review Panel agreed to consider age, particularly as rates of self-harm among women are highest between the ages of 16 and 24.[20]
- *Disability:* At the start of the review, it was identified that Kim had experienced periods of mental ill health which the Review Panel agreed to consider. A mental health condition is considered a disability if it has a long-term effect on someone's normal day-to-day activity. This is defined under the Equality Act 2010. Ethan had no known disability.
- *Gender Reassignment:* It is believed that both Kim and Ethan identified with the sex that was assigned to them at birth.
- *Marriage and Civil Partnership:* Neither Kim or Ethan were married or in a civil partnership.
- *Pregnancy and Maternity:* Around 30% of domestic abuse begins during pregnancy, while 40–60% of women experiencing domestic abuse are abused during pregnancy.[21] This was not identified as relevant for Kim and Ethan.
- *Race*: Both Kim and Ethan were White Welsh.

[19] For more information, go to: https://www.standingtogether.org.uk/ccr-network.

[20] Samaritans (no date) *Research briefing gender and suicide*. Available at: https://www.samaritans.org/about-samaritans/research-policy/gender-and-suicide/ (Accessed 30 August 2023).

[21] Friend. J (1998), 'Responding to violence against women: a specialist's role', Editorial, Hospital Medicine, September, Vol 59, No. 9, pp 98-99. https://safelives.org.uk/policy-evidence/cry-health/idvas-maternity-units (Accessed 30 August 2023)

- *Religion or Belief*: No information has been shared with the Review Panel that would suggest religion or belief was significant in the context of this review.
- *Sex*: Sex should always require special consideration, given the gendered nature of domestic abuse. Deaths by suicide revealed are consistent with this pattern of gendered victimisation, with women who die by suicide often having experienced domestic abuse.[22] It is estimated that more women take their own life because of domestic abuse than those that are killed by their intimate partners. Studies have shown that almost 30 women attempt suicide every day because of experiencing domestic abuse. It is also estimated that every week three women take their own lives.[23]
- *Sexual Orientation:* It is believed that both Kim and Ethan identified as heterosexual.

1.5.3 The Review Panel also considered the Welsh language and noted that Kim was an English speaker.

1.6 Terms of Reference for the Review

1.6.1 At the first meeting, the Review Panel shared information about agency contact with the individuals involved, and as a result, established that the period to be reviewed would be from January 2021 to the date of Kim's death. This timeframe was chosen because this period covered the relationship between Kim and Ethan. Additionally, it was agreed to consider historical agency contact before this period where relevant, with a particular focus on the contact in Northamptonshire.

1.6.2 *Key Lines of Inquiry:* The Review Panel considered both the generic issues as set out in the 2016 statutory guidance and identified and considered the following case specific issues:

- The communication, procedures and discussions, which took place within and between agencies
- The co-operation between different agencies involved with Kim and Ethan [and wider family].
- The opportunity for agencies to identify and assess domestic abuse risk.
- Agency responses to any identification of domestic abuse issues.
- Organisations' access to specialist domestic abuse agencies.

[22] Monckton-Smith, J., Siddiqui, H., Haile, S., & Sandham, A. (2022) *Building a temporal sequence for developing prevention strategies, risk assessment, and perpetrator interventions in domestic abuse related suicide, honour killing, and intimate partner homicide*. Available at: https://eprints.glos.ac.uk/10579/ (Accessed 30 August 2023).

[23] SafeLives. (2021) *How widespread is domestic abuse and what is the impact*? Available at: https://safelives.org.uk/policy-evidence/about-domestic-abuse/how-widespread-domestic-abuse-and-what-impact.

- The policies, procedures and training available to the agencies involved in domestic abuse issues; and
- Any evidence of help seeking, as well as considering what might have helped or hindered access to help and support.

2. Findings

2.1 Background Information

The Principal People Referred to in this Report						
Referred to in report as	**Relationship to the victim**	**Age at time of Kim's death**	**Ethnic Origin**	**Faith**	**Nationality & Immigration Status**	**Disability**
Kim	Victim	24	White Welsh	None identified	British Citizen	None identified
Ethan	Partner / (Alleged) Perpetrator	27	White Welsh	None identified	British Citizen	None identified
Kevin	Previous Partner / Perpetrator	-	-	-	-	-
Kris	Mother	-	-	-	-	-
Ava	Neighbour	-	-	-	-	-
Mia	Neighbour	-	-	-	-	-

The Death

2.1.1 On a day in January 2022, Kim was found deceased at her home by her mother, Kris. Kris initially contacted WAST, who in turn contacted South Wales Police.

2.1.2 *Post Mortem*: Kim died from self-inflicted injuries, specifically asphyxiation due to hanging from the neck. (In line with guidance on the reporting of suicides, no further information on the method of Kim's suicide is described here[24]).

Background Information on Victim and (Alleged) Perpetrator

2.1.3 *Relating to Victim:* Kim was white, Welsh British and had no known disability, although she had a history of mental health issues. Kim was 24 when she died. Kim was involved in the sex industry as a freelance performer, working for an Adult Entertainment Company. Kim's experiences in the sex industry began in 2017 (when she was 19).[25]

2.1.4 *Relating to (Alleged) Perpetrator:* Ethan was white, Welsh British and no known disability. He was 27 when Kim died.

[24] Samaritans (2020) *Media guidelines for reporting suicides*. Available at: https://media.samaritans.org/documents/Media_Guidelines_FINAL.pdf (Accessed 30 August 2023).

[25] Language around the sex industry is discussed specifically in Section 5.1.

2.1.5 *Synopsis of Relationship with (Alleged) Perpetrator:* Kim and Ethan had been in a relationship since the start of 2021, with this beginning between February and no later than March or April. The status of Kim and Ethan's relationship is unclear, with some reports that they had separated between September and December, although it is apparent that they were still in contact at the date of Kim's death.

2.1.6 *Members of the Family and the Household:* Kim and Ethan did not live together, although Ethan would stay with Kim in her privately rented accommodation. Kim would also stay with Ethan.

2.1.7 Kim did not have any children but during her life she was passionate about dogs, and at the time of her death had two pet dogs which her mother (Kris) described as "*being like her children*". When Kim died, Kris took on the care of the dogs.

2.1.8 Kim was one of five children. She did not have contact with her father. Kim's surviving siblings, as well as her mother, have been greatly affected by her death.

2.2 Summary Chronology

2.2.1 The Review Panel agreed, reflecting the Terms of Reference, to focus on the period from 2021 (when Kim and Ethan met), summarising contact before that date and, in doing so, to concentrate on Kim's previous relationship and reported experiences of domestic abuse in Northamptonshire (with Kevin). The Review Panel was also mindful of Kim's relatively young age, as she was 24 when she died.

2.2.2 In addition, in approaching the chronology, the Review Panel has been limited in the picture it can generate of Ethan due to the decision not to approach him (see 1.1.4 for a summary). Information on Ethan is only included where it is directly relevant to Kim.

2.2.3 In 2019, Kim was known to agencies in both Wales and Northamptonshire, as she was primarily living in Northamptonshire but regularly visiting and staying with family in Wales. Significant contact this year included with health services in South Wales, relating to an intentional overdose and later treatment for minor injuries when Kim had been intoxicated and had taken cocaine. At these contacts, there is no evidence to indicate that domestic abuse or self-harm was considered.

2.2.4 In 2020, Kim was still living in Northamptonshire and her contact with services was linked to her experiences of abuse from Kevin. In February, Kim contacted Northamptonshire Police, and this led to an investigation into allegations of domestic abuse, including controlling and coercive behaviour. However, ultimately, no further action was taken as Kim declined to make a statement, and there was no other evidence to support a criminal investigation.

2.2.5 Relating to these allegations:

- Kim also had contact with Kettering General Hospital and, subsequently, the Acute Liaison Mental Health Service (ALMHS) provided by NHFT.[26] There is no evidence

[26] ALMHS helps people with mental health needs who are attending A&E or are inpatients and those who have physical health needs which affect their mental health. For more information, see: https://www.nhft.nhs.uk/acuteliaison/.

to indicate that domestic abuse was considered further, despite the original referral being made due to an incident that had been reported to the police.

- Kim was referred to Voice for Victims and Witnesses, triggering attempts to contact her. This contact was unsuccessful but triggered a referral to the local MARAC.

2.2.6 In March 2020, a MARAC meeting discussed Kim's case. While the MARAC did identify some risks and agreed on actions, these were limited. Additionally, while Voice for Victims and Witnesses had not been able at that point to contact Kim, at the MARAC, this was agreed as an action, but this was not subsequently completed.

2.2.7 In April 2020, Kevin attended Kim's address and, after refusing to leave, threatened and assaulted her. Only after a few days was Kim able to escape and contact the police. Subsequently, Kevin was charged with assault by beating and criminal damage and was remanded into custody. The court then bailed him with bail conditions not to contact Kim and not to enter Northampton.

2.2.8 As a result of this contact, Kim was referred again to Voice for Victims and Witnesses. This led to successful contact with Kim, although she then declined support. Nonetheless, a further MARAC referral was made.

2.2.9 Before the second MARAC meeting was held, a police officer from Northamptonshire Police saw Kevin heading towards the home of Kim. He was subsequently arrested and remanded in custody because of breaching bail.

2.2.10 At the second MARAC, further risks were identified, and actions were agreed upon, although these were not comprehensive.

2.2.11 Thereafter, Voice for Victims and Witnesses was in liaison with Witness Care about the trial and sentencing of Kevin. While Kim declined ongoing support, this liaison meant that, for example, Kim's wishes concerning a restraining order were shared. Subsequently, Kevin was sentenced to a Community Order, with a 12-month Restraining Order with conditions not to contact Kim.

2.2.12 In June 2020, Kim moved back to Wales and ultimately rented a property privately in the Vale of Glamorgan. Significant contact in this period included contact between Kim and the:

- GP, who was aware of the domestic abuse but did not explore this further. This related to Kim restarting anti-depressant medication.

- South Wales Police, who had received a request relating to a Domestic Violence Disclosure Scheme (DVDS) application relating to Kevin[27] from Northamptonshire Police (this had been agreed upon at the second MARAC meeting). Subsequently,

[27] The DVDS enables the police to disclose information to a victim or potential victim of domestic abuse about their partner's or ex-partner's previous abusive or violent offending. Applications can be made by the police or other agencies ('Right to Know') or by the victim or a relevant third party ('Right to Ask'). For more information, go to: https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/domestic-violence-disclosure-scheme-factsheet.

erroneously, the DVDS application was not progressed, as Kim stated she had separated from him.

- Cwm Taf Morgannwg University Health Board and BPAS, relating to a pregnancy and later termination. In her contact with BPAS, Kim neither disclosed any concerns nor were any identified by staff, but she did talk about her mental health and explained that this was being managed through her GP.

2.2.13 In 2021, Kim was still living in Wales. Kim had several contacts with her GP relating to her anti-depressant medication. No disclosures or concerns about domestic abuse were made, and Kim said she had good support from her family.

2.2.14 Kim's relationship with Ethan began sometime between February and no later than March or April 2021.

2.2.15 In July 2021, a report of an assault by Ethan in July was made to South Wales Police. However, subsequently, Kim amended her previous statement, saying she could not be sure of what happened and had "*assumed*" Ethan had caused her injury. Kim also said she would not support further action. Subsequently, no further action was taken.

2.2.16 Linked to this:

- Kim accepted a referral to Victim Focus (a generic victim support service, with referrals made where someone has been identified as a victim of crime). There was a short delay in contacting Kim due to an administrative error at Victim Focus. However, contact was established with Kim, who did not disclose previous domestic abuse and said that she wished to remain in the relationship with her partner, did not want to press charges, and did not feel unsafe. As a result, Victim Focus closed the case.

- Kim was also referred to the DAARC service, which attempted to contact Kim but could not do so. A message was left for Kim, but the DAARC did not attempt to contact her again.

- Kim also attended the Accident and Emergency Department in Cardiff (provided by the Cardiff and Vale UHB) in relation to the assault she had reported to South Wales Police. In addition to providing medical treatment, health staff asked directly about domestic abuse using an 'Ask and Act' form.[28] After Kim made disclosures of domestic abuse, consent was obtained to make a referral to the Health Independent Domestic Violence Advisor (HIDVA) service – an in-house service provided by Cardiff and Vale UHB – as well as to share medical records with South Wales Police. The HIDVA contacted Kim and worked with her to develop a safety plan. However, no record indicates a DASH RIC was completed or any evidence that further action was considered, e.g., a MARAC referral. Nor was there any liaison with victim

[28] 'Ask and Act' refers to targeted enquiry in all public services for violence against women, abuse and sexual violence in Wales. For more information, see: https://www.gov.wales/sites/default/files/publications/2019-05/ask-and-act-10-principles.pdf (Accessed 30 August 2023).

support services like Victim Focus or the community-based specialist domestic abuse (the Vale Domestic Abuse Services). Subsequently, several attempts to contact Kim were unsuccessful, and the case was closed.

2.2.17 In August 2021, a neighbour of Kim – Ava – contacted Shared Regulatory Services with concerns there were "*nightly domestic fights and* [Kim and her partner were] *screaming at one and other*", with an additional concern that this meant that there was further disturbance because a dog was locked out of the property during the fights and was barking. Advice was given to the Ava, including on how to monitor the noise (using the Noise App), and they were advised to contact the police about the domestic abuse concerns. A standard letter was sent to Kim – addressed to 'the occupier' – regarding the dog barking. Kim did not respond, and as no further complaints were received from Ava, no further action was taken.

2.2.18 Ava also contacted Kim's letting agency to share her concerns and was advised to call the police. The Letting Agency then texted Kim and left a voicemail, but she did not respond. No further action was taken.

2.2.19 In the same month, another neighbour also reported concerns to South Wales Police. While police officers attended, when they arrived, there was no sign of any disturbance and Kim and Ethan were both spoken to separately. Both admitted to arguing but denied any violence. As a result, no further action was taken.

2.2.20 However, a referral was made to the DAARC service, which, after some delay, made an initial contact attempt in September, although this was unsuccessful. After that, a message was left for Kim, but the DAARC did not attempt to contact Kim again.

2.2.21 In September 2021, another neighbour contacted South Wales Police, as did (for the second time) Ava. This led to police attending the property twice, and Ethan was arrested and interviewed. Concerning the allegations against Ethan, at the end of October, after advice from the Crown Prosecution Service, no further action was taken because of insufficient evidence.

2.2.22 However, notably, during the period Ethan was on bail, Kim was in contact with him. She wrote: "*How many times did I say to you, I know you're gonna end up killing me you'll end up in prison for my murder!!!*" Kim also wrote: "*I shouldn't be made to feel the bad person for me boyfriend beating me!!!*" The text exchange ends with them arranging to meet, although it is unknown if they did so. (This information was identified during the investigation after Kim's death and was not known to South Wales Police at the time).

2.2.23 Treating these two callouts on the same day as connected, this was the third time a report had been made to South Wales Police relating to Kim and Ethan, each of which was assessed as medium risk.

2.2.24 In late December 2021, Kim contacted her GP and requested an online consultation. On the online form, Kim wrote:

"*My anxiety has become increasingly worse lately. I'm unable to sleep, unable to leave the house for days on end. Constantly overthinking and unable to focus on anything. I've been experiencing really bad panic attacks*".

2.2.25 In the form, Kim disclosed some of the difficulties she had been having with low mood and sleeping, although she did not disclose self-harm or suicide ideation.

2.2.26 As a result of these scores, a GP attempted to call Kim, but there was no answer. Later that day, Kim booked an appointment with the GP for the end of December. Kim did not attend this appointment, and it is unclear from the records if any telephone attempts were made to follow up with Kim.

2.2.27 By the end of the year, the status of Kim and Ethan's relationship is unclear. Although Kim told South Wales Police in September that she and Ethan had separated, they were still in contact in the days before Kim's death.

2.2.28 At the end of the year, as established by South Wales Police during their enquiries after Kim's death, Kim posted twice on social media. The first post included photographs of Kim's hair extensions having been pulled from her head and a caption: "*to be told this is normal if you get angry*". On the same day, Kim also posted two additional photos and the text "*imagine having someone brainwash you so badly for almost a year saying how fat you are on a daily basis! That even being a size 6/8 makes you feel insecure!!"*.

2.2.29 In 2022, in January, Kim was found deceased at her home by her mother.

2.2.30 Following Kim's death, South Wales Police identified previous reports of domestic abuse and established that Ethan was possibly the last person to see Kim alive. When interviewed, Ethan said that the relationship between him and Kim ended in December but that they had spent some time together.

2.2.31 As a result of this information, South Wales Police investigated allegations of controlling or coercive behaviour and assault by Ethan towards Kim. Ethan was initially arrested, denied the allegations and then bailed. Subsequently, he was released with no further action.

Any Other Relevant Facts or Information:

2.2.32 Information was also provided by the Adult Entertainment Company with whom Kim had been involved since 2017 as a freelance performer. During this time, Kim had contacts with three members of staff, with most communication relating to her work pattern. Notably, in 2021 Kim cancelled her shifts, stating this was because she was ill, without providing an explanation, to recover from cosmetic surgery, or because she was concerned about the care of her dogs. On two occasions, Kim was signposted to an industry-based support service (Pineapple Support), although it does not appear she took this up and this was not explored further by staff at the Adult Entertainment Company.

2.3 Domestic Abuse

2.3.1 Tragically, it will never be possible to know the full extent of Kim's experiences. However, in addition to the reports of abusive behaviour in her previous relationships (including by Kevin), as a minimum it appears Kim experienced the following from Ethan:

- *Physical abuse:* There are accounts of Ethan assaulting Kim, including causing injuries that required treatment and, on other occasions, of Kim sharing photos of bruising and other injuries. Kim also told her mother (Kris) and later the South Wales Police and health staff that Ethan had tried to crash a car. Neighbours, like Ava, also reported their concerns. Kim also posted on social media about her experiences, including describing how her boyfriend was "*beating me*".
- *Coercion, threats and intimidation:* Kris said she felt that Ethan was coercive. One example she provided was an occasion when Kim said that Ethan "*wouldn't let her*" sleep.
- *Emotional abuse and isolation:* Kris said that Kim had told her siblings that Ethan would call her names, making negative comments about her appearance or weight. Kim also posted on social media about her experiences, including describing being "*brainwash*[ed]" *about* her weight.
- *Sexual abuse:* No evidence was identified by the Review Panel.
- *Children and pregnancy:* No evidence was identified by the Review Panel.
- *Economic abuse:* While no specific evidence was identified by the Review Panel, there were reports by family members that Ethan was jealous of Kim's income, did not like her involvement in the sex industry, and would "*interfere*" with her work. Additionally, while it is not possible to correlate any incidents of physical abuse directly, clearly any injuries that Kim sustained because of Ethan's actions could have affected her ability to work.

2.3.2 The Review Panel also felt several areas were particularly relevant to Kim's experiences:

- *Her age*: Kim was 24 when she died. Younger people aged between 20 and 24 are the age group most likely to report domestic abuse.[29] Although it has not been possible to explore the impact of Kim's age specifically, Kim's mother (Kris) felt that her age may have been a barrier to identifying experiences as abusive and/or help-seeking, an issue also identified in research.[30]
- *Mental Health, including evidence of self-harm*: From both the accounts of her family, and information from health services, Kim was living with depression. Kim accessed help and support from GP 1, meaning she had been prescribed anti-depressants, had medication reviews, and had been signposted to other services. Additionally, this was an ongoing issue for her which affected her day-to-day life.

[29] Office for National Statistics (2022) *Domestic abuse victim characteristics, England and Wales: year ending March 2022*. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2022#age (Accessed 30 August 2023).

[30] Barnes, M. *et al.* (2023) 'Young People and Intimate Partner Violence: Experiences of Institutional Support and Services in England', *Journal of Family Violence* [Advance Online].

For example, Kim had cancelled several shifts with the Adult Entertainment Company and explained this was because of mental health.

- *Substance use*: Although substance use – for both Kim and Ethan – was noted across several agency reports, there is relatively limited information about this, and Kim was not known to substance misuse services.
- *Use of Animals:* From the accounts shared with the Review Panel, Kim cared deeply about her pet dogs. Evidence has been shared with the Review Panel about how previous partners may have used animals to abuse, either to hurt or threaten Kim by proxy or by hurting the dogs themselves, and in turn how this could have affected Kim's confidence in the agencies (specifically Northamptonshire Police). However, no evidence was identified by the Review Panel about specific threats or abuse by Ethan towards Kim's pet dogs. Nonetheless, Kim was concerned about their wellbeing (there were, for example, reports of Ethan locking the dogs outside and her asking her mother – Kris – to care look after them when she was distressed after incidents with Ethan). In this context, concerns about the care for her dogs could also have limited Kim's ability to access help and support.

2.3.3 Finally, Kim was involved in the sex industry as a freelance performer. It is important to note the limited overall information the Review Panel has had to assess the nature of Kim's experiences within the sex industry (both generally, including from her young age at the start of her involvement, through to with respect of Ethan and his reaction to this). Additionally, the Review Panel noted that there are different opinions around the Adult Entertainment Industry, including terminology such as 'sex work' and the spectrum of experiences of those involved in the sex industry (including those who experience selling sex positively, and those who are subject to exploitation and harm).[31] With this in mind, the Review Panel agreed to focus its analysis on (1) the context of, potential harm to Kim, and understanding of the sex industry (2) the Adult Entertainment Company specifically in respect of its identification and response to domestic abuse.

2.3.4 With respect to potential harm and understanding of the sex industry:

- Kim's involvement in the sex industry was relevant to what is believed to have been Ethan's abusive behaviour given reports that he did "*not like what* [she] *did for work*" and "*would interfere with her ability to carry out her work"*. That Kim's involvement in the sex industry could have meant she was at increased risk of domestic abuse is supported by a recent study of 23 reviews into domestic abuse-related deaths. In

[31] Hester, M., Mulvihill, N., Matolcsi, A., Lanau Sanchez, A., & Walker, S.-J. (2019). *The nature and prevalence of prostitution and sex work in England and Wales today*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/842920/Prostitution_and_Sex_Work_Report.pdf (Accessed 30 August 2023).

these cases, it was identified that in 17% of cases the victim's partner's jealousy had been related to their involvement in the sex industry.[32]

- It also seems that Kim wanted to leave the sex industry, but did not know what to do, and appears to have felt isolated (based on what her mother, Kris, said about Kim "*not always speak about her* work *and* [that she] *kept this quite separate to her home life*" and the absence of colleagues who could be engaged by the Review Panel).
- It is therefore of note that no agency was aware that Kim was involved in the sex industry (for example, South Wales Police confirmed no employment information was recoded on its PPNs. While Kim had described herself as a model to BPAS, they did not have further information about this). It is not possible to know why Kim did not share this information with agencies, although she was under no obligation to do so. More broadly, there may have been good reasons she did not, not least given her reported reluctance to discuss her involvement in the sex industry. While it is not possible to know if this was the case for Kim, she may also have been fearful to do so: research has highlighted how those involved in the sex industry can either be fearful of and/or experience stigma from professionals and agencies.[33]
- Taken together, the Review Panel felt it likely that Kim was isolated and noted that isolation is a common experience faced by those involved in the sex industry and has implications for mental health and for accessing support services. In a recent report, the top three most frequently recurring support themes identified were (1) Mental Health, (2) Family, Friends & Relationships, and (3) Support Service Access. Moreover, a reoccurring theme in the report was that there was limited awareness of support services and/or a belief that these were only available for those involved in selling sex on the streets.[34]

2.3.5 With respect to the Adult Entertainment Company:

- While it is positive that Kim was signposted to support in relation to her mental health, the company recognised that support could have been offered earlier and, in contact with Kim, staff could have followed up with Kim about their previous discussions, including exploring whether she had accessed the industry-based support service and/or if other support options would be appropriate.
- More broadly, no information was shared by Kim specifically regarding domestic abuse concerns nor were concerns identified by staff. However, the company

[32] Hasham, J. and Thorlby, K. (2023) *Lessons Learnt? Domestic Homicide Reviews through a Sex Industry Lens*. Available at: https://beyondthestreets.org.uk/dhr-report-research/ (Accessed 30 August 2023).

[33] Jobe, A., Stockdale, K. and O'Neill, M. (2022) 'Stigma and Service Provision for Women Selling Sex. Findings from Community-based Participatory Research', *Ethics and Social Welfare*, 16(2), pp. 112–128.

[34] Collis, G. and Thorlby, K. (2022) *Support Needs of Women Involved in the UK Sex Industry: Learning from Frontline Services*. Available at: https://beyondthestreets.org.uk/wp-content/uploads/2022/01/Support-needs-of-those-involved-in-the-UK-sex-industry-FINAL-for-publication.pdf (Accessed 30 August 2023).

acknowledged that it did not have a Domestic Abuse Policy and, in so far as it considered risk, this was primarily related to concerns about potential abuse from customers.

2.3.6 The information shared by agencies, as well as Kim's family, gives some sense of Kim's experiences:

2.3.7 Kim's experience of domestic abuse appears to have been long term, over several relationships and, in terms of Ethan, multi-faceted. At the same time, despite some contact with agencies (both in Northamptonshire and Wales) Kim appears to have been reluctant to disclose to or engage on an ongoing basis with agencies. It is not possible to know the reasons for Kim's reluctance, but Kim's mother (Kris) felt that her experience of abuse in several relationships may have meant violence and abuse had been normalised for her. Along with this normalisation, there may have been additional barriers to Kim identifying her experiences as abusive and/or help-seeking. These barriers, as noted above, could have included Kim's age, and other concerns (including a reluctance to talk about her involvement in the sex industry, which given the potential for high levels of exploitation and harm – as summarised above and as reported in research – could also have contributed to a normalisation of violence and abuse).

2.3.8 More broadly, Kim was involved with multiple agencies at different times but – as will be explored below – agencies did not always communicate or coordinate with each other directly or she may have felt they had not previously supported her effectively.

2.3.9 Collectively, this could have affected how Kim understood her experiences and her options. This may have meant Kim felt isolated, even though she continued to seek support from her family. This sense of isolation may have, in turn, been linked to her decision to die by suicide. Research into the experience of victims of domestic abuse who have felt suicidal has highlighted how exhausting victims may find their experiences to be, as well as a sense of hopelessness.[35]

2.3.10 Kim also experienced ongoing mental health issues which affected her day-to-day life. These experiences may have also been affected by both her ongoing struggles with perception of her body and appearance. In turn, Kim's struggles with her self-image appear to have been exploited by Ethan.

[35] The Kent and Medway Suicide Prevention (no date) *Highlighting the link between domestic abuse and suicide.* Available at: https://nspa.org.uk/resource/link-domestic-abuse-and-suicide/ (Accessed 30 August 2023).

3. Conclusions and Lessons to be Learnt

3.1 Conclusions

3.1.1 Kim's death was a tragedy, and the Review Panel extends its sympathy to her family and those who knew her.

3.1.2 The Review Panel has sought to try and understand Kim's lived experiences and consider the issues she faced to try and understand the circumstances of her death by suicide and identify relevant learning. It is not possible to say how Kim's relationship and experience of abuse affected her death, but nonetheless it is likely that these provided an important background to her decision to die by suicide.

3.1.3 Complicating this review is the fact that Ethan, Kim's partner and the (alleged) perpetrator, has never been found guilty of any offences relating to domestic abuse and Kim died by suicide. With respect to this, the Review Panel has operated on the assumption that it was more likely than not that Ethan was responsible for domestic abuse towards Kim. Ethan has therefore been referred to as the (alleged) perpetrator of domestic abuse, although as he was not approached for this review, this has limited specific learning.

3.1.4 Nonetheless, there has been significant learning identified during this review in relation to how agencies identified and managed Kim's potential risk and needs, and how they worked together. While it is not possible to say if an improved response could have averted Kim's death, it is vital that the appropriate agencies and partnerships consider this learning to develop and enhance their responses. This is summarised below.

3.2 Key Themes and Learning Identified

3.2.1 The learning in this case has both been particular to individual agencies but also cuts across agencies and the wider local partnership. The specific learning for individual agencies has been described in detail and has included issues relating to policy and procedure, as well as the response of staff in specific circumstances, both internally and concerning multi-agency working. The broad issues identified cut across agencies and relate to several areas:

3.2.2 *First, the understanding and response to domestic abuse:* in particular, this review has identified how Kim's experience of domestic abuse appears to have been long term, over several relationships and, in terms of Ethan, multi-faceted. The Review Panel has examined issues like Kim's relatively young age, her mental health, as well as the possible impact of Kim's involvement in the sex industry. It is also clear that Kim may have felt isolated for several reasons despite, for example, the support of her family.

3.2.3 This review has also explored the links between domestic abuse and its impact on mental health, including suicidality. While the opportunities to respond to Kim specifically were limited, the learning identified here is further evidence of the

importance of improving professional and agency understanding of, and responses to, domestic abuse and its impact on mental health and suicidality.

3.2.4 A further issue is the importance of ensuring domestic abuse is understood as a housing issue, including both in terms of council services responding to issues like noise complaints, but also the private housing sector. This also links to the themes below because, having recognised domestic abuse, it is important agencies can work together and that this is supported by a robust multi-agency partnership.

3.2.5 *Second, the importance of multi-agency working:* Kim was involved with multiple agencies at different times and this contact has been analysed, with both good practice but also learning and recommendations for specific agencies being identified. However, agencies did not always communicate or coordinate with each other directly. This, combined with Kim's experience of agency responses - which she may have felt did not meet her needs - could have affected her confidence in seeking help. Learning from this case has also included considering the pathway to, and practices by, domestic abuse support services.

3.2.6 *Third, the importance of robust multi-agency partnerships*: While there is evidence of good local partnerships, the review has made specific recommendations to ensure that local strategies address the needs of young adults aged 18-25, the links between domestic abuse and suicide, and consider issues like gender-specific commissioning in substance misuse services. Learning has also been identified for processes like the MARAC, both for local process, but also to address weaknesses in national oversight.

3.2.7 *Fourth*, ranging beyond the usual confines of a review, the Review Panel has considered *media reporting* of Kim's death. It is regrettable that much media coverage sensationalised Kim's involvement in the sex industry. Further work should be undertaken to encourage the media to report sensitively on deaths by suicide.

3.2.8 In addition to this range of learning, good practice has also been identified. For example, while learning was identified around MARAC-to-MARAC transfers, is it commendable that Northamptonshire Police sought to trigger a DVDS disclosure following a MARAC discussion. In contact with health services, while there was learning around the identification of domestic abuse for NGH and NHFT, it is also evident that health staff provided a patient-centred response to Kim's needs. Different domestic abuse services had contact with contact with Kim. Again, while there was learning for these agencies too, there was also evidence of good practice, including safety planning by Voice for Victims and Witnesses / The Sunflower Centre and the Cardiff and Vale UHB HIDVA respectively.

3.2.9 Following the conclusion of this review and its learning, there is an opportunity for agencies to consider the local response to domestic abuse. This is relevant to agencies both individually and collectively. The Review Panel hopes that this work will be underpinned by a recognition that the response to domestic abuse is a shared responsibility as it is everybody's business to make the future safer for others.

4. Recommendations

4.1 Single Agency Recommendations (Identified by Individual Agencies)

4.1.1 The following single agency recommendations were made by the agencies in their IMRs.

Northamptonshire Police

4.1.2 **Single Agency Recommendation 1:** Northamptonshire Police to continue to reinforce the message with officers and staff that, in line with the now statutory guidance on DVDS, disclosures can be given in relation to ex-partners.

NGH

4.1.3 **Single Agency Recommendation 1:** Training to be provided to the Emergency Department to raise awareness of the reporting and risk assessments to be undertaken following disclosure or identification of Domestic Abuse. The training should highlight the need to refer to the Police and/or the Sunflower Centre and into the HIDVA service with the completion of a DASH and/or also to the Local Authority for a safeguarding adult referral or children's safeguarding if the patient meets the threshold.

NHFT

4.1.4 **Single Agency Recommendation 1:** Safeguarding Adults/Children team should consider the Think Family approach in the delivery of their safeguarding training, either as part of the core training or as a separate entity.

4.1.5 **Single Agency Recommendation 2:** Staff should consider the combination of looking, listening, asking direct questions, checking out the information, and reflecting on the information they have received.

4.1.6 **Single Agency Recommendation 3:** Staff should keep records of the pace of any progress and should feel confident in direct questioning where appropriate. The record keeping should be clear and concise and including considering a multi-agency approach.

Voice for Victims and Witnesses / The Sunflower Centre

4.1.7 **Single Agency Recommendation 1:** All IDVAs to ensure case notes include a record of all actions taken, and any reasoning and rationale why they were unable to complete a key action.

Cardiff and Vale UHB

4.1.8 **Single Agency Recommendation 1:** HIDVA's working within Cardiff and Vale UHB to record details of their safety plan (if) discussed with the victim. This is to enable appropriate information sharing and to ensure other involved staff can reiterate the safety plan with the victim.

4.1.9 **Single Agency Recommendation 2:** HIDVA's working within Cardiff and Vale UHB to inform the GP of any new referrals and/or closures to their service.

4.1.10 **Single Agency Recommendation 3:** Cardiff and Vale UHB to remind primary and secondary care staff that any health appointments or attendances could be considered as an opportunity to identify violence against women, domestic abuse and sexual violence, which in turn could prevent further abuse, identify risk to children and save lives.

(As part of this recommendation, Cardiff and Vale UHB to share the learning for the Cwm Taf Morgannwg University Health Board about learning in relation to their contact with Kim on 27th November 2019).

South Wales Police

4.1.11 **Single Agency Recommendation 1:** South Wales police to continue to reinforce the message with officers and staff that, in line with the now statutory guidance on DVDS, disclosures can be given in relation to ex-partners.

4.1.12 **Single Agency Recommendation 2:** Officers should make every effort to ensure they make themselves aware of any previous incidents of domestic abuse when responding to and investigating such incidents.

4.1.13 **Single Agency Recommendation 3:** A more holistic approach should be adopted and not to simply take the disclosures of the victim as factual, as was done in this case in respect of whether there had been previous incidents. Furthermore, officers should recognise the evidential benefit in ensuring they speak to reporting persons in such incidents, who may be able to provide a far more accurate picture of the regularity of domestic incidents involving neighbours.

4.1.14 **Single Agency Recommendation 4:** Consideration should be given to increasing awareness and training for officers in respect of Domestic Abuse, specifically in relation to coercive control and the detrimental impact this has on victim's mental health. A development and refresh of the 'information sessions' already provided may be an appropriate way to disseminate these matters along with training in relation to the 'Vulnerability app'.

WAST

4.1.15 **Single Agency Recommendation 1:** Continue to ensure WAST colleagues remember the importance of detailed documentation by circulating a reminder that discussions (especially regarding possible domestic abuse and/or Live Fear Free referral) should always be documented safely.

4.1.16 **Single Agency Recommendation 2:** Continue to provide induction training on VAWDASV to new WAST colleagues. During 2023/2024 provide standalone VAWDASV training for existing WAST colleagues.

4.1.17 **Single Agency Recommendation 3:** During 2023/2024 complete work to digitalise the Live Fear Free referral pathway for WAST colleagues who work within the 999 and NHS111 Wales call centres.

The Adult Entertainment Company

4.1.18 **Single Agency Recommendation 1:** A Domestic Abuse Policy to be shared with any and all people(s) engaged with the business.

4.1.19 **Single Agency Recommendation 2:** Further communication on how the business might support individuals with signposting on how to access these services. (Whether these be Pineapple support or an in-house mental health first aider).

4.1.20 **Single Agency Recommendation 3:** To ensure training is provided for key staff responsible for our work force, specifically related to Domestic Abuse. In addition, to keep this training up to date.

Shared Regulatory Services

4.1.21 **Single Agency Recommendation 1:** Shared Regulatory Services to undertake a review of its processes and procedures to ensure that it is always able to fulfil its safeguarding duties in relation to VAWDASV.

4.2 Review Panel Recommendations (Developed by the Review Panel)

4.2.1 The Review Panel has made the following recommendations during this review in response to learning identified.

4.2.2 **Review Panel Recommendation 1:** The Safer Vale Partnership to work with local partners to review the local response to young adults aged 18-25. This should include:

- Developing evidence of the local need.
- Ensuring professionals and agencies are able to recognise, identify, assess, and respond.
- Establishing robust referral pathways to specialist support.
- Completing a training needs assessment to identify the skills and training required by professionals to enable this response.
- Identifying the actions that agencies can take individually and collectively.

4.2.3 **Review Panel Recommendation 2:** The Cardiff & Vale Regional Partnership Board and Cardiff and Vale UBH to integrate domestic abuse in the review of the Suicide and Self Harm Prevention Strategy.

(As appropriate, this should also make links to, and be reflected in, the next Cardiff and Vale of Glamorgan VAWDASV Strategy).

4.2.4 **Review Panel Recommendation 3:** The Safer Vale Partnership to work with local substance misuse commissioners to review existing pathways and the need for gender-specific provision.

4.2.5 **Review Panel Recommendation 4:** The Safer Vale Partnership to work with local partners to review the local response to the sex industry. This should include:

- Developing evidence of the local need.
- Ensuring professionals and agencies are able to recognise, identify, assess, and respond.
- Establishing robust referral pathways to specialist support.
- Completing a training needs assessment to identify the skills and training required by professionals to enable this response.
- Identifying the actions that agencies can take individually and collectively.

4.2.6 **Review Panel Recommendation 5:** The West Northamptonshire CSP to work with local partners to ensure consistent understanding and practice with respect to MARAC-to-MARAC referrals.

4.2.7 **Review Panel Recommendation 6:** The Safer Vale Partnership to work with South Wales Police and other local partners to ensure consistent understanding and practice with respect to MARAC-to-MARAC referrals.

4.2.8 **Review Panel Recommendation 7:** The Home Office works with key stakeholders (including the National Police Chiefs' Council and SafeLives) to review practice and policy in respect of processes in place to ensure MARAC transfers occur when a victim of domestic abuse moves to and from area(s). Such a review should ensure that the new 'home area' of a victim is aware of any existing risks and needs and warning markers can be put in place following a MARAC transfer after a move.

4.2.9 **Review Panel** Recommendation **8:** The Safer Vale Partnership to review the practice and policy for the DAARC with respect to victim contact attempts.

4.2.10 **Review Panel Recommendation 9:** The Safer Vale Partnership to work with South Wales Police and other local partners to ensure consistent understanding and practice with respect to MARAC referral criteria, particularly escalation, because of the learning from this review.

4.2.11 **Review Panel Recommendation 10:** The Home Office to commission a review into the MARAC process nationally and associated guidance, training and tools.

4.2.12 **Review Panel Recommendation 11:** The Safer Vale Partnership to work with the private housing sector to develop a consistent domestic abuse response and to do so as part of a wider review of the value of adopting the Domestic Abuse Housing Alliance (DAHA) [36] Whole Housing Approach.

4.2.13 **Review Panel Recommendation 12:** The Safer Vale Partnership to ensure that the learning in this case is fed into the action plans in response to recommendations from

[36] For more information, go to: https://www.dahalliance.org.uk/innovations-in-practice/private-rented-sector.

the other DHRs around referral pathways (including enquiring about whether a victim is being supported by another agency) and information sharing (including non-consent referrals).

4.2.14 **Review Panel Recommendation 13:** As part of the above work around referral pathways and information sharing, the Safer Vale Partnership to work with local partners to review safety netting practices in response to case closure.

4.2.15 **Review Panel Recommendation 14:** The Safer Vale Partnership to write to both UK press regulators (IPSO[37] and IMPRESS[38]) to express their concerns about the media reporting in this case and encourage them to promote the existing Samaritans guidance on the reporting of suicide.

[37] For more information, go to: https://www.ipso.co.uk.

[38] For more information, go to: https://www.impressorg.com.

Appendix 1: Glossary

AAFDA	Advocacy After Fatal Domestic Abuse
ALMHS	Acute Liaison Mental Health Service
BPAS	British Pregnancy Advisory Service
CAVDAS	Cardiff and Vale Drug and Alcohol Service
CCR	Coordinated Community Response
CSP	Community Safety Partnership
DAARC	Domestic Abuse Assessment and Referral Co-ordinator
DAHA	Domestic Abuse Housing Alliance
DASH RIC	Domestic Abuse Stalking and Harassment Risk Indicator Checklist
DHR	Domestic Homicide Review
DVDS	Domestic Violence Disclosure Scheme
DVPO	Domestic Violence Protection Order
GP	General Practice / General Practitioner
HIDVA	Health IDVA
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review
ICB	Integrated Care Board
MARAC	Multi Agency Risk Assessment Conference
NGH	Northampton General Hospital NHS Trust
NHFT	Northampton Healthcare NHS Foundation Trust
OIC	Officer In Charge of an Investigation
PPN	Public Protection Notice
SIO	Senior Investigating Officer
UHB	University Health Board
VAWDASV	Violence Against Women, Domestic Abuse And Sexual Violence
WAST	Welsh Ambulance Services NHS Trust