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Southend, Essex
& Thurrock Domestic
Abuse Board

Domestic Abuse Related Death Review Executive Summary

Under s9 of the Domestic Violence, Crime and Victims Act
2004

Basildon Community Safety Partnership

A Review into the death of Delphine in July 2023

Report produced by Joanne Majauskis

Date April 2026



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Preface

This is a Domestic Abuse Related Death Review (DARDR) referring to the life and death of 'Delphine'. This is a pseudonym, as is the name 'Keith' which will be used to refer to her partner. The pseudonyms were chosen by her family and will be used throughout the report.

I would like to begin by expressing my sincere sympathies, and that of the panel, to the family and friends of Delphine. We appreciate their input during this difficult process.

The review was commissioned by Basildon Community Safety Partnership on receiving notification of the death of Delphine in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004. It follows the guidance set out by the Home Office.

This review has been undertaken in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of this incident in a meaningful way and address the issues that it has raised. I would like to thank all those who contributed.

It is always of great importance that we do not forget the individual behind the review. As such, Delphine's mother has provided some words of tribute to her beloved daughter so we may know her better.

"She was incredible. So talented and clever, wise, kind and beautiful inside and out. She gave her last pennies to a man before because he was desperate and homeless and she felt bad for him. That was how she was. She was a singer song writer, she was a daughter, a friend and an incredibly compassionate, empathetic human being. When she was at junior school she was placed on the gifted and talented register for English. She wrote incredible stories, books and poems. She truly earned her place on that register. She played the guitar and ukelele along with a little of the keyboard. Music was her passion and gave her an outlet yet she'd lost confidence in senior school and didn't share much with people other than on videos sometimes or just an audio. She was never on time and yet if you needed her, she would be there. As her mum I was always in awe of her intellect and wisdom. She shone in a way that's difficult to describe and yet all who knew and loved her could see. Her light was bright and she was precious. From the age of 13 years old she struggled with her mental health, self-harming started, and she felt like she didn't belong in this world. She was vulnerable and open. I would not describe her as weak as she was incredibly strong however her vulnerability and innate kindness left her perhaps as an easy target. Delphine sometimes wanted children, other times not... she would change her mind on this. Life was not easy for her. Yet when she had a good time, her laugh would light up a space and people loved to see her happy. She has left behind not just her family but

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also many friends who admired her and wanted her to live a safe, healthy, happy and abundant life. Delphine was not an ordinary human being. She was extraordinary in very many ways. Words would never do her justice. A multifaceted diamond, a beautiful gem and star twinkling down on me and others who love her. She was so much more than she could ever see, and she was her mother's world."

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1. Review Process

- 1.1 This summary outlines the process undertaken by the Domestic Abuse Related Death Review Panel in reviewing the death of 'Delphine', a 26-year-old female and resident of the Basildon Community Safety Partnership area.
- 1.2 The summary will use the pseudonym's 'Delphine' and 'Keith' throughout.
- 1.3 The review process began when Essex Police notified SETDAB and Basildon Community Safety Partnership of the homicide in August 2023.
- 1.4 The Domestic Homicide Review Core Group met to discuss the case on 18th September 2023, and considered the circumstances of the case, with the assistance of thorough scoping from organisations. A decision was reached that the death met the criteria for a DARDR and an Independent Chair, Joanne Majauskis, was appointed to carry out the review.
- 1.5 Where it was established that there had been contact, agencies promptly secured all relevant documents, and those who could make an appropriate contribution were invited to become panel members.
- 1.6 Agencies that were deemed to have relevant contact were asked to provide an IMR and a chronology, detailing the specific nature of that contact. The aim of the IMR is to look openly and critically at individual and organisational practice to see whether changes could or should be made to agency policies and practice. Where changes were required then each IMR also identified how those changes would be implemented.
- 1.7 A panel meeting was held on 15th April 2024, to consider the case and capture key issues for this report.
- 1.8 Information from records used in this review was examined in the public interest and under Section 115 of the Crime and Disorder Act 1998, which allows relevant authorities to share information where necessary and relevant for the purposes of the Act, namely the prevention of crime. In addition, Section 29 of the Data Protection Act 1998, enables information to be shared if it is necessary for the prevention and detection of crime, or the apprehension and prosecution of offenders. The purpose of the review is to prevent a similar crime.

2. Contributors to the Review

- 2.1 The following agencies contributed to this Review through submitting a chronology, an IMR or a Summary Report:
 - Essex Police
 - Essex Partnership University Trust (EPUT)
 - Mid and South Essex ICB
 - Mid and South Essex NHS Foundation Trust
 - Probation Service
 - Basildon Council
 - Chelmsford City Council

3. Involvement of Family, Friends and Wider Community

- 3.1 The chair was introduced to Delphine's mother by a representative from Victim Support. The Chair met with Delphine's mother and explained the process and purpose of the review.

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Delphine's mother was invited to attend the panel meeting to share her thoughts and ask questions of the panel.

- 3.2 The Chair also had a conversation with a close friend of Delphine who was suggested by her mother as someone who may have insight into Delphine and Keith's relationship.
- 3.3 The points raised during these meetings have been reflected on in the analysis section of this document.
- 3.4 The Chair would like to thank Delphine's family and friends for their engagement and the contribution that they have made to this review. It has been invaluable and has helped in our understanding of Delphine and Keith's relationship.
- 3.5 Delphine's family were provided with a copy of the report before it was concluded to allow them to consider this in private and without time pressures.

4. Review Panel

- 4.1 The panel for this review was made up of the following representatives:

Jo Majauskis	Independent Chair, Author
Michelle Williams	Senior Domestic Abuse Partnership Officer, SETDAB
Ben Pedro Anido	Essex Police
Julie Long	Basildon Council & CSP
Julie Turner	Midlands Partnership Foundation Trust
Amanda Atherton	Midlands Partnership Foundation Trust
James Butler	Essex Safeguarding Adult Board
Carolyn Butlin	Probation
Aliyah Monroe	Department of Work and Pensions
Angela Little	Mid and South Essex ICB
Dr Caroline Dollery	Beacon Health Group
Alice Faweya	Mid and South Essex NHS Trust
Gifty Arthur	Essex Partnership University Trust
Alison Clark	Adult Social Care
Gemma Andrews	Public Health
Winnie Blackwell	Mid and South Essex ICB and Primary care
Michelle Fraser	Probation
Ranjit	Changing Pathways
Alison Hawkins	Chelmsford City Council
Kaylie Charlery	Chelmsford City Council
Caroline Sexby	East of England Ambulance Service

5. Review Chair and Overview Report Author

- 5.1 SETDAB appointed Joanne Majauskis as DARDR Chair and author of the Overview Report.

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- 5.2 Joanne is an independent consultant and trainer with fifteen years' experience working in the domestic abuse sector. Joanne has experience of working both in frontline and strategic management roles. Joanne is also an Associate Lecturer for the Department of Violence Prevention, Trauma and Criminology (School of Psychology) at the University of Worcester, having completed her own Masters in Dynamics of Domestic Violence with Distinction in 2015.
- 5.3 Joanne completed the Independent Domestic Abuse Chair Training with Advocacy After Fatal Domestic Abuse (AAFDA). AAFDA are a Centre of Excellence for Reviews after Fatal Domestic Abuse and for Expert and Specialist Advocacy and Peer Support.
- 5.4 Joanne has been working independently for four years, is not employed by, nor otherwise directly associated with any of the statutory or voluntary agencies involved in the review.

6. Terms of Reference

6.1 Based on the information gathered during the setting up of the DARDR and following consultation with Delphine's family, the following issues have been identified as areas for the independent chair, involved agencies and the panel to consider:

- To gain an understanding of the life of the victim through her eyes to understand her reality in her dealings with those around her including professionals.
- To identify the history of the victim and perpetrator and provide a detailed chronology of relevant agency contact with them.
- To examine whether there were signs or behaviours exhibited by either the victim or perpetrator in their contact with services which could have indicated the level of risk.
- Agencies reporting involvement with the victim and/or the perpetrator to assess whether the services provided offered appropriate interventions, risk assessments, care plans and resources. Assessment should include analysis of any organisational and/or frontline practice level factors which impacted upon service delivery.
- What learning if any is there to be identified in the management of either party. Is there any good or poor practice relating to this case that the Review should learn from. Each agency is asked to examine best practice in their specialist area and determine whether there are any changes to systems or ways of operating that can reduce the risk of a similar fatal incident taking place in future.

The following are key issues which will be explored further with the relevant agencies in the review:

- Both Delphine and Keith's history of mental ill-health
- Delphine and Keith's history of alcohol and/or drugs dependency.
- The dynamics of Delphine and Keith's relationship.
- Keith's history of domestic abuse with previous partners.

6.2 Agencies completing Independent Management Reviews (IMRs) were required to analyse these issues in relation to their contact with Delphine and Keith, with specific reference to:

- What policies, procedures and guidelines provide the framework for the agencies' response to the above issues.
- What training is available to and accessed by staff in relation to responding to the above issues.
- What communication should have taken place between agencies in relation to the above issues; whether this took place; the quality and outcomes of that communication.

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7. Summary of the Chronology

- 7.1 Delphine was 26 years of age at the time of her death. She had been staying in a refuge since 3rd July 2023 but had returned to her Mum's for the weekend where she took an overdose of an unknown substance.
- 7.2 Delphine's mother had entered her room and found her unresponsive. She called an ambulance, and Delphine was taken by them to Basildon Hospital but had sadly died. Delphine had taken an unknown substance and died, as a result of a suspected overdose. Police attended and found that there was a shoebox filled with open medication (used blister packs) – including co-codamol, codeine phosphate, propranolol, naprosyn, and promethazine hydrochloride.
- 7.3 Delphine's stepfather has said that she had recently met up with Keith and he had told her about all the women he had slept with, and this caused her a degree of emotional distress. He believes that this may be what caused her to take an overdose.
- 7.4 Delphine and Keith had been in a relationship since August 2022, after meeting in a psychiatric assessment unit. Delphine had been admitted following suicidal ideation following a break-up with her boyfriend.
- 7.5 Delphine had a history of mental ill - health issues, including diagnoses of borderline personality disorder, anxiety and depression. She also had a diagnosis of Graves' disease.
- 7.6 Keith also had a history of mental ill health issues.
- 7.7 From the information provided by agencies, both Delphine and Keith appeared to misuse substances. Delphine had disclosed using cocaine, MDMA, cannabis and speed. Keith was noted to be under the influence of alcohol and had tested positive for cocaine on occasions when he was in contact with police.
- 7.8 Prior to meeting Delphine, Keith was in an on/off relationship with his partner and mother of his children (referred to as Female A for the remainder of the report) for approximately 9-10 years. Keith was known to police for historic domestic abuse against her, as well as other offences.

Combined chronologies

- 7.9 5th December 2018 -Delphine presented to hospital Emergency Department as she was feeling suicidal. Delphine was discharged home to her boyfriend (not known who this was). Delphine was referred to Improving Access to Psychological Therapies (IAPT) and the crisis team number was provided.
- 7.10 26th December 2018 – Police attended a high-risk domestic abuse incident. Keith had assaulted Female A, and their two young children. A Children's Social Care assessment was undertaken, and a MARAC referral made. Keith was subsequently sentenced to 30 months imprisonment.
- 7.11 19th February 2019 – Delphine presented to the hospital Emergency Department for an overdose of paracetamol, ibuprofen, carbamazepine, fluoxetine, naproxen, and alcohol.
- 7.12 20th July 2021 to 22nd March 2022- Delphine attends a weekly online Dialectical Behaviour Therapy (DBT) skills class through EPUT. This is delivered online due to Covid restrictions. It is noted that Delphine attends on time, engages effectively, contributes to group discussions, and appears receptive to the teachings.

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- 7.13 23rd February 2022 - Police are called to a disturbance where Keith is found to be agitated and intoxicated. Upon approaching him, he becomes violent and kicks a police vehicle. When searched, he is found in possession of a Stanley knife. During his arrest he is resistant and is handcuffed. When being removed from the vehicle he headbutts one of the arresting officers. He is further arrested for assaulting an emergency worker and subsequently charged with offences.
- 7.14 17th March 2022 – Delphine’s mum makes a 999 call to Essex Police reporting that she has concerns for her daughter, who had, the night before, expressed suicidal thoughts following an argument with Male A. The family have awoken the next morning, and Delphine is no longer at home. A unit is dispatched but prior to arrival Delphine arrives home. The police unit is cancelled, and Delphine is not seen.
- 7.15 22nd March 2022 - Delphine attends her weekly DBT session. During the break Delphine discloses that she is struggling after a relationship breakdown. Delphine states that she feels empty and suicidal and cannot see a future for herself. She discloses that she has been researching online how to hang herself. Delphine agrees to a referral to the Home Treatment Team (HTT) stating that she cannot keep herself safe. Delphine says that she isn’t comfortable with HTT coming to her home address where her mum is. They agree for Delphine to attend the Accident and Emergency Department.
- 7.16 23rd March 2022 – Delphine is admitted to Basildon hospital, her mum has been to visit her. Delphine reports that she is still feeling low, with suicidal thoughts, but feels safe and will not act on thoughts. She says that she would like to be discharged home with HTT support.
- 7.17 3rd August 2022 – Keith is informally admitted into Basildon Mental Health Unit (BMHU) Assessment Unit for suicidal ideation following the break-up of his relationship. This is Keith's first admission on to a psychiatric ward.
- 7.18 14th August 2022 – Delphine attends Basildon emergency department complaining of being unable to sleep, feeling suicidal and afraid of being on her own. She reports that she took Cocaine last night with alcohol. She is referred to Mental Health services for assessment.
- 7.19 17th August 2022 – Delphine is admitted to Basildon Mental Health Unit (BMHU) Assessment Unit.
- 7.20 26th August 2022 – During a ward review, Keith reports that he feels ready for discharge. He is informed that the Crisis Team will be contacted to discuss their support in the community. Keith denies any current thoughts of self-harm or suicide. It is noted that Keith is now homeless following his breakup.
- 7.21 26th August 2022 - Delphine is reviewed by the medical team at the Assessment Unit. It is agreed that she will be discharged back home and referred to the First Response Team and HTT for a 48 hour follow up. Delphine presents as having full insight and capacity and denies thoughts of self-harm or suicide.
- 7.22 26th August 2022 - Essex Police receive a 999 call from Keith’s mother reporting that Keith had attended her home address and smashed a photo of his ex-partner on her drive. When challenged he made off in a car. She is concerned as he had that day been discharged from hospital where he had been receiving support for mental health, and she believes he may have been drinking. Whilst she does not think he would harm his ex-partner she is also concerned that he may attend her address. Whilst the incident is recorded, no further police action is taken as it is considered that no offences have occurred.

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- 7.23 30th August 2022 – Keith presents to Chelmsford City Council to make a homeless application.
- 7.24 24th October 2022 - Keith appears in court for an offence of having a bladed article in a public place. Keith is sentenced to four weeks imprisonment suspended for twelve months and is required to undertake rehabilitation activity with a mental health treatment requirement (MHTR).
- 7.25 7th December 2022 – Keith is signed up to interim accommodation in Havering by the Chelmsford City Council's Temporary Accommodation Team as his mother could not accommodate him further.
- 7.26 13th December 2022 – Delphine has a face-to-face meeting at Basildon Resource Centre with her care coordinator. Delphine presents in a calm mood, interacting well. She requests a referral to Peabody for support with accommodation and says she is spending time at her boyfriends to avoid being at home. She states she would like her own place as the relationship can be unpredictable.
- 7.27 3rd January 2023 – Delphine has a face-to-face meeting with her care coordinator. Delphine interacts well and states that she is still staying at her boyfriend's. She says that she struggles with her mental health but is able to cope. She states that she is experiencing intrusive, disabling and suicidal thoughts to slash her throat. Delphine is prescribed Sertraline but states that she would like to see the doctor to prescribe a different medication. Her care plan is reviewed and it is agreed to reduce face to face contact to twice monthly.
- 7.28 30th January 2023 – Keith gets a new probation officer, but only for a few weeks as she changes role. During the time with Keith, she completes social care checks and makes contact with the allocated worker. She completes a police check, but police refuse to give her information under data protection. It is noted that this is not followed up or flagged with management.
- 7.29 31st January 2023 - Delphine is seen face to face by the Mental Health Practitioner. Delphine presents as calm, but states that she had suicidal thoughts and tried to harm herself following an argument with her boyfriend. Delphine reports that her boyfriend takes money from her, and she may not get money back. She says her boyfriend gambles and, as a result of this, so does she. Delphine recognises this is a negative, toxic relationship and is encouraged to engage with positive relationships. She is due to start behavioural activation therapy today.
- 7.30 7th February 2023 - Delphine attends a session with her Mental Health Practitioner. She reports having a bad week. Delphine said that whilst at her boyfriend's, he began provoking her about cheating on him. She said that her boyfriend was mopping, and she snatched the mop out of his hand. He then pinned her down and twisted her hand behind her back on the floor. Delphine said she started to panic. Delphine states that she used a knife and made a cut on her right thigh. This is the first time she has self-harmed in two years. Delphine denies any current plan or intent to end her life. Her medication is changed from Sertraline to Mirtazapine with a plan to review in 8 weeks.
- 7.31 10th February 2023 –Keith has a mental health review which states he attended with his partner.

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- 7.32 14th March 2023 - Delphine is seen face to face by the Mental Health Practitioner for a Recognising and Managing Emotion session. Delphine expresses that she is having persistent suicidal thoughts, stating she has a plan. They discuss contingency planning, grounding techniques and create a safety plan.
- 7.33 17th April 2023 – Delphine calls 111 and reports that she is struggling and needs someone to talk to. She says that she is having thoughts of suicide by jumping in front of a train later on tonight. Delphine states that her boyfriend went missing and came back with a “hickie”. Delphine says she will go out tonight to a gig with friends. She is encouraged to call her mum for support and agrees to do this. Delphine is advised that if she feels she can’t, to call 111 again. Delphine denies any plan or intent to end her life, although she says she is still having fleeting thoughts.
- 7.34 27th April 2023 - Delphine is seen face to face by the Mental Health Practitioner for a Recognising and Managing Emotion session. She states that she has broken up with her boyfriend, saying that her relationship had been a trigger for her deterioration in mental health.
- 7.35 8th June 2023 – Keith attends his first MHTR session with probation. It is agreed there will be weekly sessions for this. However, Keith’s attendance over the following weeks is sporadic with him only attending approximately every other session.
- 7.36 13th June 2023 - Delphine is seen face to face by the Mental Health Practitioner. Delphine reports that she has taken Cocaine within the last two weeks, and her prescribed medication. She thought this would send her into cardiac arrest. Delphine says that she is fed up and it’s not worth it, and nothing changes. Delphine still feels like the government is listening to her, and she is being monitored. She says she can hear a “hum” in her head. Delphine speaks about spirituality; feeling the light and dark inside and out.
- 7.37 16th June 2023 - Delphine is seen face-to-face by her care coordinator. Delphine reports that her mood continues to fluctuate but she is “ok”. A routine drug screen is completed and tests positive for cocaine, amphetamine, benzos and ketamine. Delphine says she had only taken cocaine and is disappointed as the drug dealer had sold fake cocaine. Delphine is advised that she would benefit from addressing the use of illicit substances with Open Road, but she declines.
- 7.38 20th June 2023 - Delphine is seen face to face by the Mental Health Practitioner for a Recognising and Managing Emotion session. Delphine reports that her new anti-depressants are making her hungry, sleepy and tired all the time. Delphine discloses that she self-harmed due to a disagreement with her boyfriend. She has superficial cuts on her thigh and inside her left arm that were made with a blunt. They discuss early trigger warnings and support, and Delphine is provided with details of local organisations who provide support. Delphine is encouraged to self-refer.
- 7.39 30th June 2023 - Basildon Council South Essex Domestic Abuse Hub (SEDAH) phone Delphine for triage. The notes state that Delphine has been in a relationship with Keith since August 2022. She went to live with him in his temporary accommodation, but he was very controlling and wouldn’t let her out. He had constant affairs and when Delphine told him she would tell the mother of his children, he retaliated by pinning her arm around her back saying, ‘you know I have been to prison for beating women and have no worries about doing it again’. He told her he was bugging the house so not to try to call anyone. Delphine told

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staff that in January 2023, Keith went to court for Domestic Violence with another victim and had a £1000 fine, he made the victim pay this as 'it was her duty to'.

Delphine has tried to leave several times, and when she does, Keith threatens to burn down her mother's house. They complete a DASH risk assessment with Delphine – her score is 16 (high risk). A referral is made to Changing Pathways (Domestic Abuse Support Service) and Delphine is contacted to complete an assessment.

- 7.40 30th June 2023 – Changing Pathways offer Delphine a refuge space and it is arranged for her mum to drop her off the same day.
- 7.41 18th July 2023 – Delphine calls 111 stating that she is in a women's refuge centre and has been in an abusive relationship. She says she has thoughts about harming herself, but no plans. Delphine reports low mood as 1/10. An ambulance is called due to imminent risk.
- 7.42 19th July 2023 - Delphine has a support session with Changing Pathways support staff. Delphine says that she felt very low last night. Delphine also admits to unblocking Keith [on her phone] but then regretting it as he messaged her stating he misses her.
- 7.43 19th July 2023 - Delphine's mental health worker from the First Response Team visits Delphine at the refuge. Delphine reports relationship issues with her boyfriend, saying he became violent physically and verbally towards her. He has threatened to burn down her mother's house and has body shamed her, telling her she is ugly. Delphine reports she was fine at the refuge, until she sent text messages to her ex-boyfriend. He was not responding so Delphine decided to call him, but he did not pick up. Delphine says that when he did pick up, he sounded like he was with another woman. Delphine reports that she became suicidal at this point and called 111 due to the urges to self-harm, but she didn't want to go through with it.
- 7.44 20th July 2023 – A joint assessment by HTT and care coordinator from First Response Team is carried out at the refuge. Delphine reports the trigger for this crisis being due to contact with her ex-boyfriend. Delphine is able to engage with a problem-solving conversation and with full insight into her mental health difficulties. Delphine says she feels that she may benefit from an increase in prescribed medication, mirtrazepine. She denies any illicit substance misuse. Delphine expresses that she feels safe at the refuge despite having anxiety and suicidal thoughts.
- 7.45 21st July 2023 – Delphine has a face-to-face meeting with the Inclusion Visions service alcohol practitioner. They complete a structured assessment of her substance and alcohol use. Delphine reports use was MDMA, cannabis speed, and cocaine. Delphine is offered naxolone but declines. Delphine states she suffers with chronic suicidal ideation and that she was in a crisis two days prior to the assessment after unblocking her ex-partner and contacting him. Delphine reports using alcohol and drugs to cope with this. A referral is made to IAPT with Delphine's consent.
- 7.46 24th July 2023 – Delphine messages her Changing Pathways support worker, stating she is with a friend in Basildon. Delphine said she has been out and met up with Keith over the weekend. She says she knows this was a mistake and that it totally backfired on her, that he does not care about her, and just wants control of her. Delphine states that she feels very silly and even more so because she has spent all the £130.00, she had on cocaine. Delphine says she is skint and regrets the whole weekend. The support worker asks Delphine to call her later. She replies that she will, once she feels a little better, and is not under the influence of drugs. Following this message, the support worker texts Delphine later in the

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day to check on her wellbeing. Delphine messages them back and advises she is at her mum's and is safe.

- 7.47 July 2023 – Delphine's mum calls an ambulance after finding Delphine unresponsive in her room. Delphine's mother tells the crew that Delphine had admitted taking prescribed and non-prescribed medication, alongside alcohol and cocaine within 24 hours. On arrival, Delphine is breathing but has a seizure when they try to move her. It is confirmed she is in cardiac arrest, and the crew requested another crew for immediate backup, and an Air Ambulance, Delphine is transported to hospital. The ambulance crew make note of an unsanitary environment with clutter of food waste, alcohol, prescribed and non-prescribed medication. Delphine sadly passes away in the emergency department.

8. Key Issues arising from the Review

- 8.1 The questions raised in the terms of reference have been grouped into three main themes for the purposes of analysis:
- Whether there were signs or behaviours exhibited by either the victim or perpetrator in their contact with services which could have indicated there was coercive control and the level of risk.
 - The information that agencies held about Keith's violent and offending behaviour including domestic abuse, and how they responded to any risks this may have posed.
 - How agencies responded to Delphine and Keith's mental health and substance misuse problems and whether the services provided offered appropriate interventions, risk assessments, care plans and resources. These themes are discussed below.

The dynamics of Delphine and Keith's relationship. Whether there were signs or behaviours exhibited by either the victim or perpetrator in their contact with services which could have indicated there was coercive control and the level of risk.

- 8.2 From the information provided by agencies and by Delphine's family, it is evident that Keith was perpetrating Domestic Abuse against Delphine. She disclosed this to services including mental health services, housing and Changing Pathways. It was also witnessed by family and friends. However, most of these disclosures were made some time into the relationship and shortly before her death.
- 8.3 In discussions with Delphine's mother, concerns were raised about Delphine and Keith meeting in the psychiatric unit. Delphine was clearly vulnerable at the time of her admission, and it was known that Keith had been violent prior to admission. There is a clear correlation in research about the links between mental health and domestic abuse with studies suggesting that women with mental health problems are more likely to be victims of violence or domestic abused than the general population (Rossa-Roccor, et al 2020; Howards et al, 2009). Studies also suggest that personality disorders are associated with an increased risk of Intimate Partner Violence (IPV) perpetration by men towards women. Given these additional risk factors, it could be argued that there is rationale for considering gendered wards for patients undergoing psychiatric assessment.
- 8.4 Prior to Delphine's death, Essex Police only have one recorded contact relating to her. This incident occurred twelve months prior to her death when they were contacted by her mother, reporting her missing following an argument with her boyfriend during the course of that night and discussing suicide. The police unit was cancelled when they received a further call saying she had arrived home safely. Whilst the cancellation of the unit was in line with the Concern for Welfare policy, who the boyfriend was and what the argument had

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been about does not appear to have been explored by the Call Handler. The cancellation of the police unit meant that Delphine was not seen in person and, as a result, whether the argument, in effect, amounted to a potential domestic incident, was not determined.

- 8.5 There appears to be a further missed opportunity to explore the risks and posed to Delphine in regard to her relationship to Keith in February 2023. During a session with her Mental Health Practitioner, Delphine reported whilst at her boyfriend's house he began provoking her about cheating on him. She then goes on to disclose physical abuse, saying he then pinned her down and twisted her hand behind her back on the floor and that she started to panic. Whilst the notes for this session state that there was a discussion about creating a safety plan, it does not elaborate on what this consisted of or any other action that was taken. There also appears to be no further enquiries into the nature of Delphine's relationship, nor any safeguarding completed, including appropriate risk assessments or referrals.
- 8.6 Research suggests that women experiencing abuse are three times more likely to develop a mental health problem (Rossa-Roccor, et al 2020) and more than half of all women accessing Mental Health services have experienced abuse (Scott and McManus, 2016). It is, therefore, imperative that routine enquiry about domestic abuse and appropriate responses to disclosures are embedded into practice within the mental health sector. The lack of professional curiosity meant an opportunity was missed to understand more about the risks posed to Delphine by her relationship with Keith.
- 8.7 There were discrepancies in the risk assessments that were carried out for Delphine by Basildon Council, when she was applying for housing, which should have been explored. There seemed to be a presumption that Delphine going into the refuge reduced her risk to the extent that she did not require a MARAC referral. However, it is well documented that risk increases on separation (Safelives, 2019; Home Office 2023). It is of note, therefore, that it was three days after Delphine made her application to Basildon Council housing that she was contacted, and a risk assessment carried out. The IMR from Basildon Council also mentions that DASH risk assessment "lacked some detail". Furthermore, Delphine was leaving the refuge at weekends and booking out to go to her mum's house. Keith knew where this was and had previously threatened to burn the house down if she left him, and the potential risk around this was not explored.

Information agencies held about Keith's violent and offending behaviour, including domestic abuse, and how they responded to any risks this may have posed.

- 8.8 In 2018, police respond to the serious incident that Keith is later imprisoned for, regarding the assault of his partner and two children. The subsequent DASH Risk Assessments completed with Keith's partner assessing the risk as High Risk.
- 8.9 Keith was remanded, and referrals were made to Children's Social Care in relation to the children involved in the incident as well as a referral to MARAC. Referrals were made to partner agencies such as the NCDV and IDVA. In this case, the police response, subsequent investigation and safeguarding was appropriate and met the organisation's expectations set out in Policy and Procedure.
- 8.10 Following this incident, there was an assessment by Children's Social Care. This was closed after approximately two months in February 2019. Keith was in prison and his partner had said she would not resume the relationship with him when he was released. The summary

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stated that should their relationship resume, a re-referral to Children's Social Care would be expected, and this was shared with the health visitor.

- 8.11 However, Children's Social Care became involved again, in April 2022, following an anonymous tip regarding Keith and his partner's cocaine use, it became clear the relationship had resumed. It was estimated that this had been the case for some time as they had since had another child together. An assessment was undertaken, and at that time, there was no evidence that the parents had used cocaine, and it was noted that Keith had undertaken some work and had made changes, so no further action was taken.
- 8.12 The IMR notes that the Child and Family assessment is thorough and specifies the changes made, work they have both undertaken, insight into each other's needs and how they de-escalate disagreements. However, given the risks posed to both Keith's partner and his children it is a consideration that a longer assessment period and monitoring of their relationship may have been warranted.
- 8.13 On Keith's release from prison, a Multi-agency Public Protection Arrangement (MAPPA) screening document was submitted by the probation service, and it was determined that he was suitable to be managed at level one by a single agency, that being probation. There is no mention of whether any agency was tasked to contact Keith's ex-partner on his release from prison. Best practice would have been to inform his partner of his release and attempt to re-engage her with services, in order to safeguard both her and the children and to monitor the status of the relationship.
- 8.14 During his time on probation, Keith was regularly seen for appointments. These were delivered through a blended supervision approach of telephone and face-to-face office appointments. In general, he attended most of these, with absences tending to be due to him forgetting, or employment. However, there was a lack of enforcement from probation practitioners, and no evidence was sought to confirm missed appointments, suggesting that practitioners did not enforce absences in accordance with agency policy and procedure.
- 8.15 Keith also changed probation officers throughout his sentence, being allocated to five different supervisors over the course of a year. There was no management oversight of the case. Probation practitioners stated in interview that they had ongoing supervision discussions with management regarding the case, but this is not recorded on the system, which is against policy and procedure. The report from the probation service notes that the last allocated probation officer Keith had completed a police check, but police refused to give her information under data protection. This was not followed up or flagged with management.
- 8.16 There was an absence of management oversight on this case, this was completed only once during Keith's time under probation. At no point was management oversight added on transferring the case between practitioners; there were no oversights following supervision discussions and no evidence of considerations made about the management of Keith's case, which is of significant concern considering some of the events that took place during his time under the supervision of probation.
- 8.17 Whilst under probation Keith was subject to a Mental Health Treatment Requirement, although there were significant waiting lists for this service, meaning he didn't start this until eight months into his order. It was also included as a Licence condition for him to complete a perpetrator rehabilitation programme, Building Better Relationships, following the 30 months in custody. This condition was removed by his probation worker due to his

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employment commitments and it does not appear that he has ever completed any Domestic Abuse programme.

- 8.18 In 2022, on the day of Keith's discharge from hospital, police were called to the incident where Keith attended his mother's house and smashed a photo of his former partner on the drive before driving off. The incident was subject of a THRIVE risk assessment with the risk assessed as minor, with no apparent offences being reported or alleged. The FCR Call Handler determined that there would be no police response, and the incident was closed.
- 8.19 The closing of the incident without any further police action appears to have been premature and further action was warranted especially given Keith's history of domestic violence and self-harm. His mum said he had driven off in his car, but the vehicle was not circulated and, as such, any potential opportunity to stop and engage with Keith was lost.
- 8.20 No PNC or Athena checks were undertaken in relation to Keith in order to inform the risk assessment. Had this been done, it would have revealed that Keith had multiple warning markers including self-harm, mental health, drugs, and violence. These checks would also have shown convictions for violence and weapons and, in particular, violence towards his ex-partner. Whilst no further incident involving Keith occurred on that day or over the following months, there were undoubtedly missed opportunities to safeguard those involved.

Delphine and Keith's history of mental ill-health. How agencies responded to Delphine and Keith's mental health and substance misuse problems.

- 8.21 It is worth noting that whilst not included in the chronology, there were multiple case notes that showed that both Delphine and Keith were regularly phoned or texted prior to appointments to remind them to attend which was identified as good practice. The case notes also show that enquires appear to have been made at every contact about thoughts of suicide or self-harm, and information about where to get help or support and contact numbers were given regularly.

Delphine

- 8.22 Delphine was under mental health services for a significant period of time and appeared to receive good care. She was seen regularly and attended a DBT programme with which she engaged well. Delphine had requested trauma-based support but there is no evidence that this was explored. This could present as a missed opportunity to have a greater understanding of her emotional wellbeing.
- 8.23 There was one contact when Delphine was seen in March 2023, by the Mental Health Practitioner and expressed that she was having persistent suicidal thoughts, stating she had a plan which she shared with the Practitioner. The Practitioner passed this information on to Delphine's care co-ordinator and arranged for a duty call.
- 8.24 Duty calls were made on the following two subsequent days by the First Response Team, but they received no answer and there was no further attempt to contact her until she attended her appointment the following week. Given the risk and the disclosure of a suicide plan, it is considered that further attempts to make contact could have taken place and if unsuccessful this could have prompted further safeguarding to ensure Delphine's welfare.
- 8.25 When Delphine went into refuge in July 2023, her support workers made enquiry about her Mental health, which is documented in her case notes, and referrals were made to appropriate services. During one of her support sessions, it was noted that Delphine was struggling with her mental health and that she was considering increasing her medication.

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She also disclosed taking cocaine and sleeping with her drug dealer. The refuge's complex needs advocate was on leave at the time, so the refuge support worker advised that she consult with her GP. It is possible that the refuge support worker could have delved further into how Delphine was feeling and her thoughts of suicide.

- 8.26 During her time in the refuge, there was a three-way meeting, with mental health (EPUT), the refuge and Delphine which is considered good practice; coping mechanisms were discussed for Delphine. However, there was no clear documentation in regard to a joint support plan/risk management plan.
- 8.27 However, there were some concerns raised by Delphine's mother over the three-way meeting. Delphine's mum felt that Delphine had been subjected to 'victim blaming' during this session when she was asked "why would you let a man lay his hands on you". Her mum also said that Delphine had been tested for drugs and was then accused of lying about what she had taken. This was anecdotal information that had been passed on to her by Delphine and there is no mention of this in EPUT's case notes or the case notes from the refuge.
- 8.28 The last refuge contact with Delphine, was when Delphine informed her support worker that she had met with Keith. This was a known trigger for Delphine and she reported feeling low and suicidal. The support at this point was client led. Delphine stated that once she had slept off the substances, she would make contact, however, due to her known vulnerabilities the refuge practitioner could have applied professional curiosity in regard to the current level of risk of harm to herself. This may have triggered communication with the mental health team and or the Inclusion Visions service.
- 8.29 Delphine attended her appointment with Inclusion Visions on 21st July 2023. They completed a comprehensive initial assessment in respect of the service and support they provide. A treatment plan was agreed in partnership with Delphine and was formulated to meet her needs as identified in the assessment. However, no enquiry was made in relation to her recent flee from a domestic abuse relationship, services being accessed for support, the safety plan that was in place, or the name of the perpetrator. Inclusions operating procedure for domestic abuse suggests there should have been an enquiry around this.
- 8.30 When Delphine moved into the refuge, she began the process of transferring to a new GP surgery. However, the transfer of medical records can take up to 28 days meaning the complexity of her mental illness was not known. The safeguarding lead for the surgery confirmed that Delphine's registered address is known to be a refuge for domestic abuse victims. This should have been identified as a vulnerability during registration, and information added to her records, with consent, in accordance with the practice's registration policy.
- 8.31 During the time period until review, Delphine had four attendances to the hospital Emergency Department (ED) due to mental health breakdown. On each occasion, she was assessed in ED and referred to a Mental Health Liaison Team there was evidence of joint working with the Mental Health Team.
- 8.32 Delphine twice reported being afraid to be alone and having arguments with her stepfather, but this was not explored by practitioners in ED or by the Mental Health Liaison Team. There was no documentation or evidence to confirm if there was any enquiry about domestic abuse or why Delphine was afraid of being alone, or an attempt to proactively investigated what was happening in Delphine's home or family life. Professional curiosity is required for

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practitioners to question and challenge the information they receive, identify concerns, and make connections to enable a greater understanding of a person's situation.

Keith

- 8.33 Keith also had regular contact with the First Response Team and was provided with therapy with a psychologist and occupational therapist.
- 8.34 Risk assessments and care plans were in place along with a contingency plan, all of which were regularly reviewed. Medical reviews were provided for Keith at eight-week intervals with a psychiatrist, during the six-month period of care interventions.
- 8.35 MIND provided consistent support in the form of Admission Prevention Early Discharge Sanctuary services. Where referrals were declined by Keith, these were reoffered.
- 8.36 Whilst under probation, Keith was sentenced to a Mental Health Treatment Requirement (MHTR) and Rehabilitation Activity Requirement (RAR) days to support his rehabilitation and reduce his risk of further offending. An accredited programme of Thinking Skills was considered suitable, but he had completed this on two previous occasions. Keith was offered 12 sessions of emotional regulation treatment.
- 8.37 It is of concern that Keith did not begin his MHTR until eight months into his order. Referrals/consideration could also have been made to other services, such as Adult Social Care and practitioners gaining details of mental health providers.
- 8.38 An Alcohol Abstinence Monitoring Requirement was also recommended by Probation, but the sentencing court did not choose to include this. The reasons for this are unknown. It is considered that it would have been beneficial to the management of the case. It is noted that substance misuse was rarely discussed with Keith in supervision sessions, despite his record showing that this is linked to risk of serious harm and violence.
- 8.39 Keith disclosed to probation practitioners about his mental health struggles and did want support. However, his attendance was sporadic, and he missed 9 out of his 19 offered mental health appointments. This was not enforced by his probation officers and, as such, there were gaps in the treatment provided to him.
- 8.40 As mentioned previously, there was an issue of re-allocation of probation workers in Keith's case. This was considered by the author of the report to be excessive given Keith's fragile mental health and noted instability.
- 8.41 Good practice was highlighted when Keith disclosed problems with his mental health, and contact was increased from monthly to fortnightly. It is also noted that practitioners regularly checked in with social care throughout the duration of Keith's management with them.

9. Conclusion

- 9.1 It is clear that Delphine was a victim of domestic abuse at the hands of Keith, and that her meeting with him was a trigger that impacted on her existing mental health issues. However, it is impossible to say with any clarity whether any different interventions by services involved with either Keith or Delphine would have altered the outcome of the tragic event that is the focus of this review. However, the following section details the lessons that can be learnt from the analysis of this case and will put forward recommendations for future practice in the hopes of preventing further tragedies.

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Essex Police

- 9.2 Essex Police were not aware that Delphine and Keith were in a relationship prior to her death and there are no records of domestic abuse investigations between the two. As a result, opportunities did not present themselves for police intervention in terms of enforcement or by way of safeguarding or information sharing with partners.
- 9.3 Over a number of years, there were several recorded incidents involving Keith all of which featured substance misuse and or mental health. Analysis has shown that in most, and where required, positive enforcement action took place. However, there were individual incidents, such as the harassment reported in July 2022, where positive investigative action did not take place, resulting in missed opportunities to address wider safeguarding and risk.
- 9.4 When coming into custody Keith, when needed, was seen by Health Care Professionals with no significant medical issues being identified. However, on one occasion when it was clear he was in mental health crisis, he was taken to hospital following which he was admitted into hospital under Section 136 of the Mental Health Act. This is seen as an example of good practice, ensuring that an individual receives the right care by the right professionals.
- 9.5 Whilst the incidents by and large were dealt with in line with organisational expectations, this IMR has highlighted learning for individual staff members and areas of organisational practice that may require improvement, particularly in the area of mental health, some of which had been recognised prior to the commissioning of this IMR and have been addressed through organisational change.
- 9.6 This IMR identified a number of occasions on which it may have been appropriate to share information between Essex Police and partners within Mental Health. This issue has been highlighted in previous Domestic Homicide Reviews (DHRs), DARDRs, SAR's and internal operational debriefs. Towards the end of 2022 and during 2023, Essex Police has sought to address this issue at an operational and organisational level and instil in staff a culture of being aware of when they can share information with partners and have named this principle as, 'Time to Share'.
- 9.7 In October 2022 the Mental Health Risk Management Board (MHRMB) was established to act as a strategic level multi-agency coordination group that sets out to discuss and agree mitigating actions around strategic level risks regarding homicide and serious violence with mental ill health indicators. Most importantly, this process offers opportunities to prevent future homicides and serious violence with improved information sharing around cohorts of individuals of 'concern' who have indicators of serious violence and homicide who fall outside of the MAPPAs arena. This allows for a targeted multi-agency approach through an agreed tactical plan.
- 9.8 During the latter part of 2023, the Mental Health Team was established to improve information sharing between agencies. A key function of the Team is to assist in highlighting and identifying high harm and high-risk individuals in order to ensure that all partner agencies and relevant stakeholders have a working plan in place to identify, monitor and prevent/reduce risk.
- 9.9 The importance of sharing of intelligence is a thread that runs through a variety of training courses including Detective Training. More in-depth training is provided to those officers and staff who then specialise and perform intelligence -based roles within the organisation.

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However, as this case has demonstrated, there are occasions where officers and staff do not recognise or miss the opportunity to submit intelligence.

- 9.10 In all of the cases subject to analysis, it was noted that intelligence considerations did not form part of the Case Action Plan's (CAP) set by Supervisors at the commencement of an investigation or considered at the completion of an investigation at the Supervisors Closing Review prior to filing.
- 9.11 As such, a recommendation will be made that Supervisors include intelligence considerations within CAP's and form part of the Closing Review to ensure that all relevant intelligence is captured.

Probation

- 9.12 It is recommended that the allocation of cases must have management oversight and consideration should be given to the necessity of changing officers.
- 9.13 MHTR waiting times is still an ongoing issue. However, better practices are now in place, including the service providing contact to People on Probation with updates on wait times and checking in with them.
- 9.14 The Practitioners involved in this case had a good response to the safeguarding of Keith's children. Good interaction with Children's Social Care was documented in reference to the associated risks. Referrals were made when concerns increased, and liaison was evidence throughout the order.
- 9.15 It is noted that police intelligence checks are often declined to practitioners due to data protection which does cause a problem when probation is trying to ascertain risk information. Practitioners are aware they need to be clear in their ask of police and have been informed to raise concerns to managers where this occurs.
- 9.16 The review highlights a need for further discussion and training around the disclosure of relationships where DA is of concern. Whilst the Probation worker at the time completed checks, this was not followed up and further information was not gained from Keith at a better time.
- 9.17 In this case it is also apparent that Management Oversight models were not followed. This needs to be addressed on an individual level as the guidance and training is available to understand when this is necessary.
- 9.18 This case also raised issues around poor sentence planning, recording and handovers which all link to an individual training need, which probation intend to discuss with practitioners. It was the view of the probation IMR author that the sentence plan and initial risk assessment should have included more information, and a more structured plan of support should have been in place. This links directly to management oversight.
- 9.19 Enforcement of licence conditions was also a significant area of concern, this case highlighted that policy and procedure was not followed by practitioners. There is now in place a practitioner dashboard which is reviewed regularly by managers and practitioners, which highlights potential breaches and outstanding enforcement, and they are regularly discussed in meetings and supervision.
- 9.20 The transfer policy was also not followed in this instance when Keith moved to a new area, he remained under the same area rather than being transferred. Whilst practitioners attribute this to providing stability, Keith should have been transferred in accordance with

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guidance and management oversight should have been provided to ensure this happened. This could have led to easier information gathering, quicker implementation of the MHTR and resources being used within the correct area.

Children's Social Care

- 9.21 There was significant contact between agencies and notifying Children's Social Care between 2018-2023, when concerns were expressed for Keith being in the lives of his ex-partner and their children. Health, Probation and MAPPA appear to have communicated regularly as needed.
- 9.22 However, it was noted that there could have been further monitoring of the relationship between Keith and his partner in 2022 when it became apparent, they had rekindled their relationship. A previous recommendation on case closure was that there would be a re-referral should they relationship recommence.

Beacon Health Group – Keiths G.P. Surgery

- 9.23 It was noted that there was a lack of information sharing to primary care around Keith's previous convictions and allegations. The surgery felt that any safeguarding/ MARAC notes completed in other areas of Greater Essex should be available on primary care records as well as wider systems.
- 9.24 There was good information sharing by mental health to the GP Information on Keith's attempted suicide was provided promptly leading to the surgery talking to Keith and offering support, although, he did turn this down as he was already under the mental health team. However, the surgery flagged him as vulnerable on the basis of his suicidality, and he was added to their complex care MDT.

Essex Partnership University NHS (EPUT)

- 9.25 Good practice was identified in the following areas for both Keith and Delphine:
- There was regular contact with Delphine and Keith from all services involved.
 - Therapy interventions were provided regularly and where appropriate in line with Covid restrictions, were offered face to face contacts.
 - There was regular review of risk assessments, monitoring scales and contingency planning.
 - There is evidence of encouragement to engage with tertiary services for substance misuse.
- 9.26 The First Response Team Multi-Disciplinary meetings that occurred were not documented or attached within the Mobius notes, the impact being that information discussed, and decisions made are not available for review by practitioners responsible for Delphine's care.
- 9.27 Safeguarding should have been considered or discussed when Delphine disclosed concerns that could possibly be abuse from a partner. She disclosed concerns about her boyfriend taking money from her and on another occasion her boyfriend had pushed her. These were not explored further with her; neither was she offered referral to a specialist domestic abuse agency. There should have been greater professional curiosity in regard to the relationships within Delphine's life. A consideration could also have been given, by practitioners, to a Domestic Violence Disclosure Scheme (DVDS) enquiry– commonly known as Claire's Law. This would have both highlighted Delphine to services and would have allowed police to make a disclosure to her around Keith's history of domestic violence.
- 9.28 Further safeguarding actions could have been prompted when the duty team failed to make contact with Delphine following her disclosure of a suicide plan in March 2023.

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- 9.29 With regard to the meeting referenced by Delphine's mum felt that she had been subjected to 'victim blaming' and accused of lying. It is obviously always concerning where these things are raised and, therefore, this is being looked into independently by EPUT.

Changing pathways

- 9.30 There is evidence of lots of good practice and support that was offered to Delphine. The need for referrals to substance misuse and mental health services were recognised. There was a joint meeting with the mental health team and staff had made contact with the Community Mental Health Team so that Delphine could access mental health support locally. Delphine also had access to in-house group therapy. When Delphine disclosed that she had been using cocaine, she was offered a referral to Inclusion Visions. Refuge staff also carried out regular welfare calls when Delphine stayed away from the refuge.
- 9.31 The question arises whether the refuge was suitable to manage Delphine's complex needs. There are policies and procedures in place but in practice there was a lack of attention to explore and enquire about information from mental health services at the referral stage, to enable a "risk informed" decision.

Inclusions

- 9.32 The identified learning relates to routine enquiry, opportunistic or targeted inquiry in relation to domestic abuse. Although, the assessing practitioner was aware that Delphine had recently left an abusive relationship no enquiry was made regarding the support, safety plan or the name of the perpetrator, to enable the team to identify if there was any ongoing risk should Keith present at an appointment with her.

Mid and South Essex NHS Foundation Trust

- 9.33 Mid and South Essex NHS Foundation Trust's learning from this review was around the lack of a Domestic abuse risk assessment or referral and the lack of professional curiosity.

Basildon Council

- 9.34 This IMR identified that upon individuals making an online housing application, there isn't an option to highlight that there is immediate danger or abuse. This, therefore, resulted in Delphine's contact not being prioritised and a delay in contacting her to explore the support required. This has been highlighted as an immediate concern with the Head of Housing taking swift and appropriate action to ensure all contact requests are manually "screened" while a suitable update is made to the website. It also noted that the DASH was completed but lacked some detail.

Chelmsford Council

- 9.35 The case has highlighted a potential gap in information sharing between agencies and that important information regarding Keith's offending history not being known to the Council resulted in direct contact with one of his previous victims.

10. Recommendations

Recommendation One:

- 10.1 Essex Police should ensure that through relevant training and CPD (Supervisors Courses, FLEX Training Days) and via internal communications (Force Intranet, Learning the Lessons Board) Supervisors, as a matter of routine practice, include within initial Case Action Plan's

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and Closing Reviews the need for officers/staff to consider and submit relevant intelligence through the use of PIR's.

Recommendation Two:

- 10.2 Where specific concerns are identified during panel meetings, for instance, in this review, not knowing the whereabouts or status of Keith following Delphine's suicide, this information is to be shared with police problem solving teams for intelligence gathering, and the ongoing management of risk.

Recommendation Three:

- 10.3 Probation to liaise with Essex Police colleagues regarding effective information sharing. Head/Deputy head of Probation area to meet with Police to discuss information sharing, expectations, and availability of information. Management to discuss with probation practitioners, the importance of being clear in their requests for information and the reasons why.

Recommendation Four:

- 10.4 Probation to ensure the effective management oversight of cases, in line with Touch Point Model. Cases should be reviewed before being re allocated and should be discussed in supervision. The management team will need to revisit policy and ensure this is occurring across the board, and the Head of the Probation Delivery Unit (PDU) to discuss this in supervision with managers.

Recommendation Five:

- 10.5 Practitioners within the probation service to have refresher training on the use of CRISSA model in contact logs. (Check in, Review/Risk, Implementation, Summary, Set tasks, Next appointment)

Recommendation Six:

- 10.6 Probation to provide training and supporting policies and documents to practitioners who join the service from the prison to provide cover for staffing shortages.

Recommendation Seven:

- 10.7 Probation to review their Transfer Policy and introduce a case tracking system to ensure that transfer processes are followed in all cases and management oversight is provided.

Recommendation Eight:

- 10.8 Probation to introduce monitoring procedures to ensure that enforcement policies are followed and that managers review and discuss cases accordingly.

Recommendation Nine:

- 10.9 Probation to review regionally the Mental Health provisions for Mental Health Treatment Requirements and to introduce contingency plans to support individuals with mental health needs.

Recommendation Ten:

- 10.10 Basildon Council to fully review SEDA procedures to ensure they are fit for purpose and used to manage cases of domestic abuse appropriately. It is also recommended that the procedures upon review include a monthly case audit, including the review of all DASH risk assessments to ensure they are completed in full, with an appropriate amount of narrative.

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Recommendation Eleven:

- 10.11 Chelmsford City Council to enhance the process of information sharing and dissemination within the Housing Service across teams including ensuring case notes are comprehensive and reflective of all actions/decisions taken, as well as ensuring DARD learning is disseminated effectively where there has been housing involvement in a case.

Recommendation Twelve:

- 10.12 Chelmsford City Council to make proactive and sensitive enquiry about historic domestic abuse when contacting family members or ex-partners during homelessness enquiries.

Recommendation Thirteen:

- 10.13 Essex Partnership University NHS (EPUT) to provide training to staff regarding professional curiosity and the exploration of possible indicators of abuse in regard to patient's partners and significant others.

Recommendation Fourteen:

- 10.14 EPUT to establish routine enquiry about domestic abuse and ensure the identification of significant relationships is recorded in the patient's notes so that their impact can be considered and incorporated into risk assessment and plan of care, included safeguarding and other actions that are taken. This should include consideration of a Domestic Violence Disclosure Scheme (DVDS) enquiry on disclosure of domestic abuse from a patient.

Recommendation Fifteen:

- 10.15 EPUT to review guidance around escalation of risk where there has been a disclosure of suicidal ideation and then they are unable to contact the patient.

Recommendation Sixteen:

- 10.16 EPUT to undertake risk assessments into co-gendered wards and to consider the possibility of gendered wards in psychiatric assessment centre.

Recommendation Seventeen:

- 10.17 EPUT to ensure that staff receive appropriate training and guidance around appropriate language to use when working with individuals who may be experiencing Domestic Abuse.

Recommendation Eighteen:

- 10.18 Mid & South Essex ICB (Tilbury Chadwell Medical Centre) to review the effectiveness of their current policy and process of registration and identification of vulnerabilities in patients, including the practice manager working in collaboration with safeguarding administrators to ensure that all administrators processing information are aware of the vulnerable adults flags and when to use them.

Recommendation Nineteen:

- 10.19 Changing Pathways to formulate service level agreements and information sharing protocols with EPUT and substance misuse services to inform shared multi-agency risk assessments and risk management support plans with EPUT, Drug & Alcohol and DA services.

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Recommendation Twenty:

10.20 Mid and South Essex NHS Foundation Trust to provide safeguarding / domestic violence training to improve staff knowledge and understanding of professional curiosity across all of its services.

Recommendation Twenty-one:

10.21 Mid and South Essex NHS Foundation Trust to review their Domestic Violence Policy and ensure it provides clear guidance to staff on assessment, routine domestic abuse enquiry, the use of professional curiosity and when to challenge.

Recommendation Twenty-two:

10.22 Inclusion Visions to provide domestic abuse training for practitioners to ensure they are identifying and responding to domestic abuse for victims and perpetrators.

Recommendation Twenty-three:

10.23 For Children's Social Care Services to review their processes for reopening and monitoring domestic abuse cases that are closed due to separation when it comes to light that the relationship has then recommenced.

Recommendation Twenty-Four

10.24 Routine enquiry regarding domestic abuse, together with appropriate and trauma-informed responses to disclosures should be formally embedded into standard practice across the mental health sector. This should be implemented consistently at a national level to ensure early identification, effective safeguarding, and appropriate multi-agency intervention.

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