BEXLEY COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Overview Report into the death of Tracey

March 2020

Independent Chair and Author of Report: Mark Yexley

Associate, Standing Together Against Domestic Abuse

Date of Completion (sent to BCSP): January 2023

Dedication from Tracey's mother

"Tracey was a happy child; she had such a beautiful voice people would cry. I worked in a hospital at the time and sometimes would take her into the wards and she would sing to the patients. Dancing was another of her loves, she would dance anywhere and everywhere.

As Tracey got older, she would practice with makeup and her hair was her pride and joy, always immaculate. As her hairdresser saw her so regularly, they became friends and she was devastated by her death.

Tracey was petite, confident, beautiful, loyal and very popular. I didn't realise how popular until she died, all her work colleagues and friends let off balloons in a local park in her memory, the amount of people there was astonishing,

Tracey was very family orientated and was devasted when her dad died when she was in her early thirties.

She loved coming over to us, she would phone me up or send me a funny video saying things like "Mum get up, I am coming over, I want cake!" I still have those precious videos and messages and they still make me laugh. She loved occasions together, going out for afternoon teas especially! Christmas was very special to her too but all this ended when she met him, then we rarely saw her.

Tracey loved children, all she ever wanted was to be a mum but this has been denied to her, if she had met the right person, she would have made a wonderful mum.

From the time my daughter started seeing him, I saw her change, her confidence went and she became very conscious of her appearance in spite of her being so beautiful, he stripped her of everything so she felt worthless.

Her loss has taken away my right to be happy, Tracey filled so much of my life and now there is an empty hole that will never be replaced. She was not only my daughter but my best friend."

This report uses the following terms,

and abbreviations have the meanings assigned to them below:

124D	Domestic Violence Investigation Form - Metropolitan Police Service
ADAPT	Oxleas pathway for focused therapeutic interventions for patients who require care and treatment for **A**nxiety, **D**epression, **A**ffective disorders, **P**ersonality disorders & **T**rauma
Adastra	Clinical Patient Management Software
A & E	Accident and Emergency department (NHS)
ASC	Adult Social Care
BASW	British Association of Social Workers
BCSP	Bexley Community Safety Partnership
C.A.D.	Computer Aided Dispatch
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CCO	Care Coordinator
CCR	Coordinated Community Response
CMHT	Community Mental Health Team
COMHAD	Co Occurring Mental Health Alcohol and Drugs
CRIS	Crime Reporting Information System - Metropolitan Police Service
CPS	Crown Prosecution Service
CRU	Central Referral Unit - Kent Police
CSP	Community Safety Partnership
CSU	Community Safety Unit
DHR	Domestic Homicide Review
DA	Domestic Abuse
DASH	Domestic Abuse, Stalking and Honour Based Violence Risk Identification, Assessment and Management Model
DASV	Domestic Abuse and Sexual Violence
DHR	Domestic Homicide Review

DPS	Department of Professional Standards
DS	Detective Sergeant
DV	Domestic Violence
DVACS	Dartford Vulnerability and Contextual Safeguarding Panel
DVH	Darent Valley Hospital
ED	Emergency Department (NHS)
eTriage	Automated booking in triage system at Hurley Group UTC
FTA	Fast Track Assessment (Oxleas)
GCS	Glasgow Coma Scale
GP	General Practitioner
HER Centre	Domestic Abuse Agency Greenwich and Lewisham
HIDVA	Hospital Independent Domestic Violence Adviser
HTT	Home Treatment Team (Oxleas)
IAPT	Improving Access To Psychological Therapies
IAPTus	Digital care record for psychological therapies
IBA	Identification and Brief Advice (IBA), an online learning resource for healthcare and social care professionals working to reduce alcohol related harm.
IDVA	Independent Domestic Violence Advisor
ICM	Integrated Care Management meetings
IMR	Individual Management Review
I.O.	Investigating Officer
IOPC	Independent Office for Police Conduct
ISVA	Independent Sexual Violence Advisor
KCH	Kings College Hospital NHS Foundation Trust
LAS	London Ambulance Service
LFB	London Fire Brigade
LGT	Lewisham and Greenwich NHS Trust
MAPPA	Multi-Agency Public Protection Agreements
MARAC	Multi-Agency Risk Assessment Conferences

MASH	Multi-Agency Safeguarding Hub
MERLIN/ACN	MPS Notification of adult come to notice
MERLIN/MIS	Missing Person report
MHA	Mental Health Act 1983
MHLT	Mental Health Liaison Team
MISPER	Missing Persons
MPS	Metropolitan Police Service
NFA	No Further Action
NHS	National Health Service
NHS 111	National Health Service Helpline for Urgent Medical problems
OIC	Officer In Case (Police)
OOH	Out Of Hours
PCP	Primary Care Plus Oxleas MH Liaison Service for Primary Care
PLN	Psychiatric Liaison Nurse
PND	Police National Database
PRP	Pier Road Project - South London and Maudsley NHS Foundation Trust substance misuse service
PRUH	Princess Royal University Hospital - Kings College NHS Foundation Trust
PTSD	Post-Traumatic Stress Disorder
QEH	Queen Elizabeth Hospital - Lewisham and Greenwich
QMUH	Queen Marys University Hospital
RARA	Remove Avoid Reduce Accept - linked to Risk Assessment
RCA	Root Cause Analysis
SARC	Sexual Assault Referral Centre
SEA	Surviving Economic Abuse
SE-BCU	South East Basic Command Unit
SI	Secondary Incident - Kent Police record of non-crime domestic incident
SLaM	South London and Maudsley NHS Foundation Trust

SMART	Specific, Measurable, Achievable, Relevant, and Time-Bound
SW	Social Worker
UAL	Urgent Advice Line (UAL) Oxleas
UCC	Urgent Care Centre (can be GP led and may be linked to Hospital A & E)
UTC	Urgent Treatment Centres
VAF	Vulnerability Assessment Framework
VRC	Vocational Rehabilitation Consultant
VS	Victim Support

1. Preface

1.1 The Incident

1.1.1 In March 2020 Tracey was moving into new temporary accommodation in the London Borough of Bexley on her own. She had previously been living with a friend, Sarah, for a few months. Sarah became concerned that she could not contact Tracey and reported her as a missing person to the Metropolitan Police Service (MPS). Sarah expressed concerns about the decline of Tracey's mental health and that two weeks prior Tracey had planned to jump under a train. The police recorded the missing person's report (MISPER). After two days the enquiry was graded "HIGH RISK" as Tracey had not made contact with her friend. Three days after she was reported missing, the landlord of the temporary accommodation found Tracey dead at the property. She was hanging in the wardrobe and had apparently taken her own life.

1.1.2 Following the discovery of Tracey, police enquiries revealed that Tracey had previously been reported as a victim of domestic abuse from her then partner, Mehmed. Tracey had been admitted to hospital after assaults, resulting in serious injuries. Tracey's circumstances had been discussed at Multi-Agency Risk Assessment Conferences (MARAC) in Bexley and Kent. Tracey had also been known to NHS mental health services in South East London. Tracey's experience of trauma associated to domestic abuse was known to those services.

1.1.3 The inquest hearing was held in February 2022 where the Coroner established that Tracey had taken her own life. The Review Panel expresses its sympathy to the family, and friends of Tracey for their loss and thanks them for their contributions to and support for this process.

1.2 Introduction

1.2.1 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004.

1.2.2 This domestic homicide review (hereafter 'the review') examines agency responses and support given to Tracey,[1] a resident of the London Borough of Bexley and the County of Kent prior to the point of her death in March 2020.

1.2.3 The review will consider agencies' contact/involvement with Tracey and her ex- partner, Mehmed from October 2012 to March 2020.

1.2.4 In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse before the death, whether support was accessed within the community and whether there were any barriers to accessing support. By

[1] Not their real name.

taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

1.2.5 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004. The law states that a review of the circumstances of a death should take place if it appears to have resulted from violence, abuse or neglect by someone that they had been in an intimate relationship. The *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews* (2016) 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). The Community Safety Partnership (CSP) decided that the circumstances of Tracey's life and death warranted the commissioning of a DHR.

1.2.6 The key purpose for undertaking DHRs is to enable lessons to be learned from cases where a person dies in circumstances where it is known that they have previously been a victim of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.2.7 This review process does not take the place of the criminal or coroners' courts nor does it take the form of a disciplinary process.

1.3 Timescales

1.3.1 This review has been commissioned in accordance with the December 2016 Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (hereafter 'the statutory guidance'), following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. The MPS informed the Bexley CSP of the circumstances of Tracey's death on 14 July 2020. The Bexley Community Safety Partnership (BCSP) Board met on 28 July 2020, where it was agreed that the criteria for a DHR had been met and this review would be conducted using the DHR methodology. That agreement has been ratified by the Chair of the Bexley CSP and the Home Office were informed on 10 August 2020.

1.3.2 Standing Together Against Domestic Abuse (hereafter 'Standing Together') was commissioned to provide an Independent Chair (hereafter 'the Chair') for this review in August 2020. The completed report was handed to the Bexley Community Safety Partnership on 20 February 2023. It was tabled at a meeting of the Bexley Community Safety Partnership and signed off, before being submitted to the Home Office Quality Assurance Panel in March 2023. In November 2023 the Bexley CSP received a letter from the Home Office Quality Assurance Panel that the report could be published. The letter will be published alongside the completed report recommendations.

1.3.3 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. The Chair for the review was not commissioned until September 2020. The review was complex and involved gathering information

from Kent and NHS Trusts across South East London. The review started in the first year of the COVID-19 Pandemic. This brought additional pressures to NHS Trusts and timescales of the review were set to take into account operational priorities. There were also two separate complaints against police investigations arising from the Missing Person investigation in London and contact with police in Kent. The review also revealed Tracey's contact with a company providing occupational health support to her employers. This required the request for further information for panel review. The pandemic also restricted the ways in which the Chair could engage with and interview family and friends of Tracey. As the review progressed there were concerns raised about the police adherence to policy and handling of the discovery of Tracey's body. After discussions with the Chair, the MPS decided to extend the police review to consider this. This brought another delay late in the DHR process. There were some delays in the finalisation of the report, this was due to a period of staff shortages within the Standing Together DHR Team. Tracey's family have been updated on the progress of the review and assured that agencies will be progressing their action plans without waiting for the publication of this review.

1.4 Confidentiality

1.4.1 The findings of this review are confidential until the Overview Report has been approved for publication by the Home Office Quality Assurance Panel. In the interim, information has been available only to participating officers/professionals and their line managers. This review reveals occasions where Tracey was the victim of serious assault as well as long-term economic abuse. The ex-partner was never convicted of any offence against Tracey. The review reveals the criminal history of Tracey's ex-partner and suggested links to drug trafficking. The review also evidences the full cooperation of Tracey's family and a close friend. The panel considers this information vital to the review but also appreciates that publication of the report may increase the risk to others. The panel recommends that the final report is shared confidentially for professionals' and family's eyes only. Consideration will be given to publishing the recommendations only. It should be noted that Tracey's mother supports this approach.

1.4.2 This review has been anonymised in accordance with the 2016 statutory guidance. The name of her ex-partner, parents, relatives and friends have also been anonymised. The specific date of death has been removed. Only the independent Chair and Review Panel members are named.

1.4.3 The following pseudonyms have been used in this review to protect the identities of the deceased, other parties, those of their family members, and the ex-partner:

Name	Relationship to deceased
Tracey	Deceased
Mehmed	Ex-Partner

Anne	Mother of Deceased
Sarah	Friend of Deceased

1.4.4 These pseudonyms were agreed by the family.

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 Tracey was a heterosexual white woman who was 37 at the time of her death. Mehmed heterosexual man, of Turkish heritage and was 39 years old at the time of Tracey's death. They were not married. The protected characteristics of gender reassignment, religion/belief and sexual orientation do not pertain to this case in that neither party was at any stage of transitioning from one gender to the other. They did not hold particular religious or other beliefs as far as we can tell from the records.

1.5.3 The Review Panel identified that the following protected characteristics required specific consideration:

- *Sex*: Sex should always require special consideration. Analysis of domestic homicide reviews reveals victimisation of women across both intimate partner and familial homicides with females representing the majority of victims and males representing the majority of perpetrators.[2] This characteristic is therefore relevant for this case; the deceased was female and the perpetrator of previous abuse was male. In considering the links between domestic abuse and suicide in women, it is estimated that more women take their own life as a result of domestic abuse than those that are killed by their intimate partner. Studies have shown that almost 30 women attempt suicide every day as a result of experiencing domestic abuse. It is also estimated that every week three women take their own lives. [3]
- *Disability:* Tracey's mental ill-health during the period under review was considered as a protected characteristic of disability. The Review Panel provided special consideration to these protected characteristics throughout this review to determine if agencies' responses were motivated or aggravated by these characteristics. Tracey's mental ill-health made her more vulnerable. She was referred to specialist

[2] "In 2014/15 there were 50 male and 107 female domestic homicide victims (which includes intimate partner homicides and familial homicides) aged 16 and over". Home Office, "*Key Findings From Analysis of Domestic Homicide Reviews*" (December 2016), p.3.

"Analysis of the whole STADV DHR sample (n=32) reveals gendered victimisation across both types of homicide with women representing 85 per cent (n=27) of victims and men ninety-seven per cent of perpetrators (n=31)". Sharp-Jeffs, N and Kelly, L. "*Domestic Homicide Review (DHR) Case Analysis Report for Standing Together* "(June 2016), p.69.

[3] SafeLives, How widespread is domestic abuse and what is the impact? https://safelives.org.uk/policy-evidence/about-domestic-abuse/how-widespread-domestic-abuse-and-what-impact (accessed 16 February 2021)

services to support her in these areas and those agencies supporting Tracey clearly recognised that these were significant factors in her life. She may have been seen through the lens of a diagnosis, whether that be professional or a family suspicion. Tracey needed to be considered as a whole person and not defined by her mental ill-health.

- *Pregnancy:* Pregnancy can be a trigger for domestic abuse and abuse may increase during pregnancy. Tracey was not known to maternity services in the area, but Tracey stated that she may have been pregnant in the months before her death; she also said that she had had miscarriages. NHS records were reviewed and there were no records to confirm this. Tracey was known to have been pregnant early in her relationship with Mehmed in 2010. In 2017 Tracey and Mehmed were referred for fertility treatment but she was never reported to have conceived. The panel were mindful of the risks of domestic abuse that can arise during pregnancy.

1.5.4 Additionally, this review has taken an intersectional framework to consider the complex ways in which multiple forms of structural discrimination (based on divisions such as class, gender, migrant status, etc.) combine or intersect to create heightened and persistent forms of inequality, marginalisation, disadvantage and powerlessness. An intersectional approach to reviews is vital in identifying and analysing the multiple and overlapping barriers that create vulnerability and risks. It is key in determining questions of how a victim came to be at risk, the barriers the victim faced in reporting sex-based abuse, how she was treated, what support she had, and what options for protection was available to her.

1.5.5 The following have been identified as pertinent to the lived experiences of Tracey: -

- Substance Misuse
- Inter-Racial Relationship
- Physical Disability

1.5.6 By taking an intersectional framework, the Review Panel sought to understand the lived experiences of both Tracey and Mehmed. This means to think of each characteristic of an individual as inextricably linked with all the other characteristics in order to fully understand an individual's journey and experience with local services and within their community.

1.5.7 Tracey's protected characteristics should not be considered in isolation. She was a woman who was in a long-term relationship with a man. During that relationship, she was subject to extreme violence and this trauma had a significant impact on her mental well-being. As a result of the economic abuse suffered, Tracey moved from being a person with significant personal assets to being left homeless, and in substantial debt. As the physical and economic trauma of abuse took their toll, Tracey's mental well-being suffered leading to her death.

1.5.8 The review panel invited Bexley MIND to provide advice to the panel from a non-statutory and community perspective on mental health.

1.6 Terms of Reference

1.6.1 The Terms of Reference are included in **Appendix 1**. This review aims to identify the learning from this case, and for action to be taken in response to that learning with a view to preventing deaths and ensuring that individuals and families are better supported.

1.6.2 The Review Panel was comprised of agencies from Bexley, as Tracey and Ex-Partner were living in that area at the time of the death. Agencies were contacted as soon as possible after the review was established to inform them of the review, their participation and the need to secure their records.

1.6.3 Additionally, it was established that Tracey had contact with agencies in Kent and therefore agencies in that area were contacted for information and involved in the review as panel members from the outset.

1.6.4 At the first meeting, the Review Panel shared information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from 1 October 2012 to March 2020. This timeframe was chosen because there was a long history of reported abuse from Mehmed. The first case reported to the police was in October 2012. Agencies were asked to summarise any relevant contact they had with Tracey or Mehmed outside of these dates.

1.6.5 Normally in a DHR, the review timescales would stop at the point that a person was found to have died. During this review, it became apparent that the police management of Tracey's unexplained death did not meet the service policy standard. The panel contacted the Home Office to seek advice on the matter and it was advised that the panel could comment on actions after Tracey's death and make recommendations. This information would then be considered by the Home Office and may feature in future guidance. Whilst there will not be a detailed analysis in this area, the facts set out by the MPS have resulted in a panel recommendation.

1.6.6 *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 Tracey and Mehmed [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.
- The policies, procedures and training available to the agencies involved on domestic abuse issues.

- Whether substance misuse impacted on Tracey's access to services.
- Whether Tracey's mental health impacted her on access to services.
- Whether Tracey could have been subject to economic abuse.
- Whether Tracey or Mehmed could have been subject to or experienced any unconscious bias in their contact with agencies.

1.6.7 The panel was comprised of members from statutory agencies, and a wide range of support services, including non-government agencies, specialist domestic abuse services, and private healthcare providers.

1.6.8 The panel also decided to invite the founder of Surviving Economic Abuse (SEA) to take part in the review in the latter stages. SEA in the only UK charity dedicated to raising awareness of economic abuse and transforming responses to it. Although they were not able to attend meetings, they did support the Chair at the report drafting stages of the review and provided expert advice on the analysis. The panel wish to extend thanks to SEA.

1.7 Methodology

1.7.1 The term 'domestic abuse' is used interchangeably with 'domestic violence', and during the period under review, the cross-government definition of domestic abuse as issued in March 2013 was considered in all agency work prior to 29 April 2021. That definition is included here to help the reader understand that domestic abuse is not only physical violence but a wide range of abusive and controlling behaviours. The cross government definition states that domestic abuse was:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial[4]; and emotional.

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

Controlling or coercive behaviour in an intimate or family relationship became a crime on 29 December 2015.[5]"

1.7.2 During this review the Domestic Abuse Act 2021 was enacted on 29 April 2021. Under that act Domestic Abuse is defined as:-

"Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if—

(a) A and B are each aged 16 or over and are personally connected to each other, and

(b) the behaviour is abusive.

(3) Behaviour is "abusive" if it consists of any of the following—

(a) physical or sexual abuse;

(b) violent or threatening behaviour;

(c) controlling or coercive behaviour;

(d) economic abuse;

(e) psychological, emotional or other abuse;

and it does not matter whether the behaviour consists of a single incident or a course of conduct."

This definition will be used when considering the analysis undertaken by the panel in the latter part of this review process. This review has followed the 2016 statutory guidance for Domestic Homicide Reviews issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004.

1.7.3 On notification of the review, agencies were asked to check for their involvement with any of the parties concerned and secure their records. A total of 36 agencies were contacted to check for involvement with the parties concerned with this DHR. Of these, one had only limited contact and submitted a Summary of Engagement and one submitted a Chronology only. However, 16 had more extensive contact and were asked to submit Individual Management Reviews (IMRs). A narrative chronology was also prepared.

1.7.4 *Independence and Quality of IMRs:* All IMRs were written by authors independent of case management or delivery of the service concerned. The IMR for Bexley MARAC was completed by the Domestic Abuse and Sexual Violence (DASV) Strategy Manager & Commissioner. Whilst that person has management responsibility now, the service that responded to Tracey was previously managed under the Housing Department. Most IMRs received were comprehensive and enabled the Review Panel to analyse the contact with Tracey and/or Mehmed, and to produce the learning for this review. Where necessary, further questions were sent to agencies and responses were received.

[5] Section 76 of the Serious Crime Act 2015.

1.7.5 In some cases, IMRs reported changes in practice and policies over time and 10 IMRs made single agency recommendations of their own (these are described in section 5).

1.7.6 *Documents Reviewed:* In addition to the above information, documents reviewed during the review process have included, previous DHR reports in the area, STADA and HO DHR Case Analysis, London Borough of Bexley Domestic Abuse Health Sub Group Terms of Reference, August 2020, Kent Police Briefing on Vulnerability Panels, KCH presentation on Complex Case Pathway/Framework, Kent Police Investigator's Report, Formal Investigation Complaint from Tracey's mother, Oxleas NHS Foundation Trust Root Cause Analysis Report dated 27/05/2020, Interim Death Certificate for Tracey dated 16 April 2020, MPS Policy for managing 'apparent suicides', *London Multi-Agency Adult Safeguarding Policy & Procedures* (April 2019), *Local Government Adult safeguarding and domestic abuse - A guide to support practitioners and managers* (Second Edition 2015), British Association of Social Workers (BASW) *Substance Use and Domestic Abuse - Essential Information for Social Workers.*

1.7.7 *Interviews Undertaken:* The Chair interviewed Tracey's mother and a friend who knew her from childhood and reported her missing before her death. The Chair is very grateful for the time and assistance given by the family, friend, specialists and academics who have contributed to this review.

1.7.8 It should be noted that the MPS carried out a further interview with Tracey's friend, Sarah, in May 2022. A summary of points from that interview was provided to the Chair in order to provide additional information on Tracey's background, relationship with Mehmed and friendship with Sarah.

1.8 Contributors to the review

1.8.1 The following agencies were contacted, but recorded no involvement with the deceased or ex-partner:

- Bexley Women's Aid
- Bromley Healthcare
- Choices Domestic Abuse Service
- Dartford Borough Council Housing Services
- Family Matters - Therapy and ISVA for Kent and Bexley
- Gravesham Borough Council - Housing Options Team
- Kent Community Health NHS Foundation Trust
- Kent County Council - Adult Social Care
- Kent Homelessness Services
- Kent, Surrey and Sussex Community Rehabilitation Company - Domestic Abuse Safety Advisor

- London Community Rehabilitation Company
- London Fire Brigade
- National Domestic Abuse Helpline
- National Probation Service
- Peabody Housing
- Rethink Mental Health Services Gravesend
- Solace Women's Aid - Refuge Services Bexley
- South London and Maudsley NHS Foundation Trust - Addictions Services

1.8.2 The following agencies and their contributions to this review are:

Agency	Contribution
Able Futures - APM Ingeus UK	IMR and Chronology
Clarion Housing - Kent IDVA	IMR and Chronology
Dartford Borough Council / Sevenoaks District Council Revenue and Benefits Shared Services	Summary of Engagement
Dartford and Gravesham NHS Trust	IMR and Chronology
The Hurley Group - Urgent Care Centre	IMR and Chronology
Kent MARAC	IMR and Chronology
Kent Police	IMR and Chronology
Lewisham and Greenwich NHS Trust - Queen Elizabeth's Hospital	IMR and Chronology
Kings College Hospital NHS Foundation Trust	IMR and Chronology
Local GP Practice, Bexley	IMR and Chronology
London Ambulance Service NHS Trust (LAS)	IMR and Chronology
London Borough of Bexley - Adult Social Care	IMR and Chronology
London Borough of Bexley Housing	IMR and Chronology
London Borough of Bexley MARAC and Crisis Intervention Team	IMR and Chronology
Metropolitan Police Service (MPS)	IMR and Chronology
MIND Bexley	IMR and Chronology
Oxleas NHS Foundation Trust	IMR and Chronology
Victim Support Kent	Chronology Only

1.9 The Review Panel Members

1.9.1 The Review Panel members were:

Name	Job Title	Agency
Malcolm Bainsfair	Head of Safeguarding Adults	London Borough of Bexley
Meredith Barley	Head of Safeguarding Children	Bromley Healthcare
Eric Beckford	Interim Head of Service	National Probation Service
Shaheda Begum	Adult Safeguarding Advisor	Queen Elizabeth Hospital (QEH), Lewisham & Greenwich NHS Trust
Ida Bradford	Head of Safeguarding	Oxleas NHS Foundation Trust
Elizabeth Brailsford	Head of Children and Young People's Services	Solace Women's Aid
Caroline Brown	Adult Safeguarding Lead	Queen Elizabeth Hospital, Lewisham and Greenwich NHS Trust (LGT)
Kossar Butt	Head of Accommodation Services	Solace Women's Aid
Julie Carpenter	Safeguarding Specialist for Adults and Children	Quality Assurance Directorate London Ambulance Service NHS Trust
Susan Chandler	Head of Safeguarding Adults	London Borough of Bexley
Jennifer Cirone	Senior Manager	Solace Women's Aid
Sarah Connelly	Deputy Medical Director for Unscheduled Care	The Hurley Group
Martin Davis	Detective Inspector for Child Protection and Vulnerable Adults	Kent Police
Sue Eldred	Safeguarding Adults Specialist Advisor	Kings College Hospital NHS Foundation Trust
Amy Glover	Head of Community Services	Solace Women's Aid
Samantha Irving	IAPT Service Lead	MIND in Bexley
Leigh Joyce	Locality Manager	Clarion Housing - Kent IDVA Service

Brian Kelleher	Detective Chief Inspector	Public Protection Lead MPS South East Basic Command Unit (SE-BCU)
Grace Makoni	Addictions Governance/Senior Nurse Complex Pathway	South London and Maudsley NHS Foundation Trust, Pier Road Project
Jessica McDermott	Senior Prevention and Assessment Officer	Bexley Housing
Michael McInerney	Detective Sergeant	Serious Crime Review Group (SCRG) MPS
David Naylor	Area Manager	Kent Victim Support
Heather Payne	Head of Adult Safeguarding	Kings College Hospital NHS Foundation Trust
Sophie Scott	Domestic Abuse Manager	Kent Police
Nicola Sharp-Jeffs	CEO	Surviving Economic Abuse
Deborah Simpson	DASV Strategy Manager	London Borough of Bexley
Stacy Smith	CEO	HER Centre
Jo Songer	Housing Manager	London Borough of Bexley
Klara Sonska	Bexley Addictions	Pier Road Project, South London and Maudsley NHS Foundation Trust (SLaM)
Sonya Stocker	Acting Named Nurse for Safeguarding	Dartford and Gravesham NHS Trust
Karen Upton	Clinical Lead for Safeguarding	South East London CCG
Phillipa Uren	Designated Nurse for Adult Safeguarding	South East London CCG
Stacy Washington	Trust Lead Safeguarding Adults & Prevent	Oxleas NHS Foundation Trust
Leslee Williams	Community Safety Coordinator	London Borough of Bexley
Caroline Woodcock	Domestic Abuse Service Manager	Clarion Housing
Mark Yexley	Independent Chair	Standing Together

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

1.9.3 The Review Panel met a total of five times, with the first meeting of the Review Panel on the 9 December 2020. There were subsequent meetings on 31 March 2021, 13 April 2021, 11 August 2021, 12 November 2021 and 26 April 2022.

1.9.4 The full panel list is comprehensive and this reflects a thorough review process and a change in agencies' staff over the period of the review. The Chair wishes to thank everyone who contributed their time, patience and cooperation to this review.

1.10 Involvement of Family, Friends, Work Colleagues, Neighbours and Wider Community

1.10.1 It is important to take steps to involve the family, friends, work colleagues, neighbours and the wider community.

Deceased's Family

Name[6]	Relationship to deceased	Means of involvement
Anne	**Mother**	**Video conference**
Sarah	**Friend**	**Telephone interview**

1.10.2 Once the MPS had informed Bexley CSP of the potential for a DHR, the CSP notified Tracey's mother, Anne, by telephone and offered a referral to Advocacy After Fatal Domestic Abuse (AAFDA)[7] A letter was sent to Tracey's mother, along with the Home Office leaflet on 19 September 2020. In October 2020, the Chair also wrote to Tracey's mother, including additional information on the DHR process. These letters were also sent via AAFDA. A representative of AAFDA was present throughout the Chair's contact with Tracey's mother. All those contributing were able to do so using the medium they preferred and that being as flexible as possible. All letters made clear that the family's participation in the review was voluntary, and that they could contribute in different ways: for example, by making a statement, through a telephone conversation, and video conferencing. A face-to-face meeting was not offered for the main part of the process as COVID-19 social distancing measures were in place. The letter emphasised that their contributions could take place at a time and place of their choosing and that their involvement in the review would not be rushed.

1.10.3 An initial video conference was held with Tracey's mother on 14 December 2020. During this meeting, the Chair explained the DHR process and recorded the family's initial concerns to ensure that they were covered in the Terms of Reference. The Terms of Reference were provided and agreed upon, with the understanding that any further areas of concern could be communicated to the Chair. On 27 May 2021, a full interview with Tracey's mother took place, by video conference with AAFDA present. This

[6] Not their real name

[7] 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.

interview was used in the compilation of the background information in this report and a summary of the interview is included in the report. Tracey's mother provided the dedication at the opening of this report.

1.10.4 The Chair maintained regular contact through the family's AAFDA representative. AAFDA also supported the DHR engagement with friends.

1.10.5 The family were provided with an opportunity to review the final draft of the report in private with plenty of time to do so and given the opportunity to comment and make amendments if required. The draft overview report was shared with Tracey's family in June 2022, in a printed and electronic format. The family then reviewed the report with their representative from AAFDA. The Chair arranged to meet Tracey's mother in person to discuss the report on 2 September 2022. The Chair was contacted by AAFDA before the meeting stating that a face-to-face meeting was not necessary, and they agreed with Tracey's mother that the report was "Well written and thorough". It was agreed that AAFDA would discuss a few matters by phone.

1.10.6 The family and AAFDA noted that the report was lengthy. The AAFDA representative commented that they had never seen a case so complex or with such a comprehensive representation of agencies. The AAFDA representative said that the most important thing was that they felt that the panel 'left no stone unturned'. It was noted that the DHR Statutory Guidance had been followed throughout. The Chair discussed the length of the report and said he would learn for future cases, but the panel had considered all of the detail included and it was deemed essential to understand the narrative. AAFDA stated that they could understand the panel view and the family did not ask for further editing. Formatting of the report was considered, and the family asked that the Glossary of Terms be moved to the start of the report, from the original placement at the end, to assist the reader.

1.10.7 There was praise for the listing of the key dates at the start of the analysis, although it may have been more useful to have that earlier in the report. The Chair said that it was part of his analysis structure and moving to earlier may distract readers. It was agreed that this would remain unchanged. Some personal details were edited.

1.10.8 The family stated that the report demonstrated learning and change of practice across a number of agencies. The recommendations of the report were comprehensive and wide-ranging.

1.10.9 Consideration to providing Tracey's family with the opportunity of meeting the DHR panel was kept under review from the start of the process. It was initially thought that a panel meeting could take place with Tracey's mother, AAFDA and key agencies present. At the conclusion of the review, Tracey's mother felt that the prospect of meeting key panel members was too overwhelming and declined the offer.

1.10.10 The panel would like to thank AAFDA for the support provided to this review. Their involvement from first notification and through the challenges of the COVID-19 pandemic has been invaluable to the DHR process.

Deceased's Friends, Work Colleagues, Neighbours and Wider Community

Name[8]	Relationship to deceased	Means of involvement
Sarah	**Friend**	**Telephone interview**

1.10.11 Consideration was given to approaching Tracey's friends, work colleagues, neighbours and the wider community.

1.10.12 Tracey's mother provided the Chair with the name of a long-term friend of her daughter, who was willing to support the review. The Chair wrote to her on 31 August 2021and offered to speak to her with AAFDA support. At the time of writing this friend has not responded to the Chair or AAFDA.

1.10.13 The Chair also contacted Sarah, Tracey's friend who reported her missing shortly before her death. A letter introducing the Chair with a copy of the Home Office Leaflet was posted to Sarah's known address on 17 June 2021. There was no reply to the letter. The Chair followed up the letter with a phone call. He spoke to Sarah on 27 September 2021, and it transpired that she had moved home and not received the letter. Sarah was happy to be interviewed by phone later on the same day, this was followed up with a copy of the Home Office letter and AAFDA leaflet being emailed to Sarah.

1.10.14 In the time leading up to her death, Tracey worked at a Leisure Centre in North Kent. The Chair wrote to the manager of the Leisure Centre in June 2021. They were supplied with the Home Office leaflet for Employers in DHRs. They confirmed that Tracey had worked at the leisure centre. The current manager stated that the person directly managing Tracey at the centre was no longer employed. They stated that they "did not want to supply the panel with incomplete information, or anything that may not give an accurate reflection of what took place." They declined to take part in the review. The Chair wrote back and asked if they could confirm from company records whether Tracey had ever been placed on 'non-public facing work' due to her injuries and whether company Human Resources (HR) were informed. The company were also asked whether HR records contained information on Tracey's mental health or domestic abuse. They were also asked to disclose policies that are in place to deal with staff disclosures of domestic abuse. They were informed that the aim of the review was to make positive changes, that the panel could support employers and wanted to reflect positively in Tracey's memory. The company HR department then replied and declined to provide any information or take part in the review. This area concerned falls outside of Bexley. The panel felt that the involvement of employers in supporting

[8] Not their real name

Domestic Abuse initiatives was an area that required development in the Kent CSP area.

1.11 Involvement of Ex-Partner

Ex-Partner

1.11.1 In this case the panel did not interview Mehmed, the ex-partner of Tracey. Consideration was given to whether alerting Mehmed of the existence of the review would create any risk to family and friends supporting the DHR.

1.11.2 The MPS have made approaches to interview Mehmed in 2022 to support enquiries around the inquest. They have been unable to interview him.

1.11.3 Standing Together Against Domestic Abuse have written to the Home Office seeking guidance on the involvement of ex-partners in DHRs where it is suspected that subject took their own life. At the time of writing there had been no guidance issued.

1.12 Parallel Reviews

1.12.1 There were additional reviews that took place arising from the circumstances of Tracey's death. Two reviews were completed before the DHR process started and although not strictly parallel they are referenced for information.

Mental Health Review Oxleas NHS Foundation Trust

1.12.2 The incident involving Tracey was subject to an internal Serious Incident investigation by the Trust's Patient Safety Team. The approach used was the Root Cause Analysis (RCA) model.

1.12.3 The purpose of the investigation is to identify the root causes and key learning from the incident and use this information to significantly reduce the likelihood of future harm to patients by sharing learning Trust wide and with directorate patient safety groups. The report was completed on 27 May 2020, although this was before the DHR process had begun, a copy has been shared with the DHR Chair.

Kent Complaint Against Police

1.12.4 During the review Tracey's mother informed the Chair that she had made a complaint to Kent Police concerning police inaction and the suicide of her daughter. The Chair liaised with the Professional Standards Department of Kent Police and informed them of this DHR Process. The investigating officer decided that the service provided by Kent Police was acceptable. This decision was supported by the Officer of Appropriate Authority.

MPS Internal Investigation

1.12.5 After Tracey's body was found, a Detective Inspector from the SE-BCU referred the circumstances around Tracey's death to the MPS Directorate of Professional Standards (DPS), which is standard procedure when a death has occurred following

police contact. The DPS reviewed the incident and in turn, sent their findings to the Independent Office for Police Conduct (IOPC). The IOPC concluded the matter on 9 October 2020, stating they had not identified any organisational learning and the misconduct investigation was closed. This investigation was completed before the first DHR meeting.

Coroner's Inquest

1.12.6 The death of Tracey was referred to the HM Coroner, and an inquest was opened on 19 June 2020 at South London Coroner's Court and adjourned. The full inquest hearing was held in February 2022. A verdict of Suicide was given. Throughout the review process, the Chair has emailed the Coroner's Officer. There was a limited response to the requests from the DHR for information on Tracey's death.

1.13 Chair of the Review and Author of Overview Report

1.13.1 The Chair and author of the review is Mark Yexley, an Associate DHR Chair with Standing Together. Mark has received Domestic Homicide Review Chair's training from Standing Together and has chaired and authored 17 DHRs. Mark is a former Detective Chief Inspector with 39 years' experience of dealing with domestic abuse and was the head of service-wide Strategic and Tactical Intelligence Units, combating domestic violence offenders, head of Cold Case Rape Investigation unit and Partnership Lead for sexual violence in London. Mark was also a member of the Metropolitan Police Authority Domestic and Sexual Violence Board and Mayor for London Violence Against Women Group. Since retiring from the police service he has been employed as a lay chair for NHS Health Education England Services in London and the South East. This work involves independent reviews of NHS services, training and selection for foundation doctors, specialty grades.

1.13.2 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). 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 and deaths in circumstances of domestic abuse. Standing Together has been involved in the Domestic Homicide Review process from its inception, chairing over 80 reviews across England and Wales.

1.13.3 *Independence:* Mark Yexley has no connection with the Bexley area or CSP or any of the local agencies involved in this case, aside from having Chaired one previous DHR in the area. Mark retired from the MPS in 2011 and has had no operational involvement with the service since that time. Mark's only other connection was with Kent Police as Chair of the South East Regional Sexual Offences Referral Centre and that role ended in 2011. Mark's Health Education England work is not linked to any NHS Trust mentioned in this report.

1.14 Dissemination

1.14.1 Once finalised by the Review Panel, the Executive Summary and Overview Report will be presented to Bexley for approval and thereafter will be sent to the Home Office for quality assurance.

1.14.2 Once agreed by the Home Office, the Executive Summary and Overview Report will be shared with the bodies represented on the panel. The panel has given careful consideration to confidentiality and the privacy of Tracey's family and friends. The report reveals personal information and could have an impact on the safety of some parties, were Tracey's ex-partner made aware of the information shared. The panel represent public authorities and there is a duty of care to persons who supported this review. It is considered that publication should be limited to the final recommendations. This view is fully supported by Tracey's mother.

1.14.3 The Executive Summary and Overview Report will also be shared with the Commissioner of the MPS and the Mayor's Office for Policing and Crime (MOPAC)/the Police and Crime Commissioner.

1.14.4 The recommendations will be owned by the CSP, with the DASV lead being responsible for monitoring the recommendations and reporting on progress.

1.15 Previous case review learning locally

1.15.1 This is the fifth DHR commissioned locally.[9]

1.15.2 The Review Panel considered the learning and recommendations from other reviews in the analysis and the development of recommendations for this DHR. In particular the unpublished case of 'Blue' identifies lessons on Trauma, Routine Enquiry, and Suicide and Domestic Abuse. These are also identified in this review. It is asked that the Bexley CSP consider the impact of both in developing action plans across the Borough.

[9] To access published DHRs, go to: https://www.bexley.gov.uk/services/community-safety-and-environment/bexley-community-safety-partnership/domestic-homicide-reviews

2. Background Information (The Facts)

The Principle People Referred to in this report						
Referred to in report as	**Relationship to Victim**	**Age at time of Tracey's death**	**Ethnic Origin**	**Faith**	**Nationality and Immigration Status**	**Disability**
Tracey	Deceased	37	White European	None	British	None
Mehmed	Ex-Partner	39	British born Turkish origins	N/K	British	None known
Anne	Mother of Deceased	N/A	White European	N/K	British	
Sarah	Friend of Deceased	N/A	N/A		British	

2.1 The Death

2.1.1 *Death:* In March 2020 Tracey was reported missing to the MPS by a friend, Sarah. Sarah expressed concerns in the decline of Tracey's mental health and shared that two weeks prior Tracey had planned to jump under a train. The police recorded the missing person's report (MISPER). After two days the enquiry was graded "HIGH RISK" as Tracey had not made contact with Sarah. It was established that Tracey had collected keys to a new temporary home, in Bexley, on the date that she had originally been reported missing. Three days after she was reported missing, police officers visited the new address. There was no reply when they called, and neighbours had not seen anyone move into the address.

2.1.2 During the enquires to find her Tracey's ex-partner, Mehmed, told police that Tracey had told him that she intended to hang herself. Based on this information the landlord of the new accommodation attended the address, whilst speaking to the police on the phone. The landlord found Tracey hanging from a rail in the wardrobe at the property, she was dead.

2.1.3 It is the policy of the MPS that a Supervisor must attend the scene where it appears that a person has taken their own life. A Sergeant did attend the scene. Police examined Tracey's body and there were no unexplained marks other than those caused by the ligature. There were just a few items of Tracey's personal property where she was found. Tracey's phone was found. There was damage to a curtain rail in the bedroom. There were no signs of forced entry or suggestion that there had been a third party at the house. MPS state that there were numerous suggestions that Tracey had suicidal ideation. This information came from Sarah and Mehmed. Tracey had told

them the name of her road, but not the door number. No statements were taken from Sarah or Mehmed at the time.

2.1.4 It is believed that the Coroner's Office requested that statements were taken from Tracey's friend and Mehmed. The MPS were unable to obtain a statement from Mehmed. A statement was taken from Sarah in 2022. Information from the statement has been provided to the DHR Chair by the MPS SCRG, to support this review.

2.1.5 The MPS did not follow policy on the investigation of an unexplained death, where it is suspected that a person took their own life. It is MPS policy that an adequate forensic examination takes place. It is mandatory that scenes are photographed, and the CID must attend. Ligatures should also be seized. None of these actions took place. The matter was left with the uniform Duty Officer (Inspector) to retain responsibility.

2.1.6 Tracey's mobile phone was retained by the police. It was not submitted for digital forensic examination until late 2021. At the time of writing, there is no information on the contents of Tracey's phone and there are known delays in digital forensic examination. The MPS are still trying to access the phone memory.

2.1.7 The Chair of the review raised the matter of the investigation of Tracey's unexplained death with Senior Management within the MPS. The panel has also made a recommendation in relation to the police management of this case.

2.1.8 ***Post Mortem*****:** There was no post-mortem examination held. The cause of death is a matter for the medical profession and ultimately for the Coroner to determine.

2.1.9 The Chair made enquiries with the Coroner's Office to establish the rationale as to why a Post Mortem was not conducted following Tracey's death. The Coroner stated that the referral from the MPS confirmed that this was a 'non-suspicious death'. The Coroner stated that there was no request for the signing Coroner to agree to a Forensic Post Mortem Examination. The Coroner informed the Chair that there are times, especially during times of limited pathologist availability during a pandemic or for other reasons, where it is not uncommon for the Coroner to order toxicology and an external examination in cases of hanging.

2.1.10 At the start of the review the MPS informed the panel that samples had been taken for toxicology examination. Toxicology analysis can be used to establish the presence of alcohol or drugs in the body. It was later established, through the Coroner's Office, that there were insufficient samples available to conduct meaningful toxicology analysis.

2.1.11 The MPS were informed by the Coroner's Officer that if there had been any injuries to a body that were identified as suspicious a post-mortem would have taken place. However, the police were not provided with any details of a medical visual examination of Tracey's body.

2.1.12 The Chair wrote to the Coroner's Office, to request details of the visual examination of Tracey's body, in August 2021, October 2021 and March 2022. At the time of writing the Coroner's Office has not provided the review with the details requested. It cannot be confirmed that a visual examination of Tracey's body was conducted by a medical professional after the initial discovery by the police.

2.1.13 Tracey's family were informed, through AAFDA, of the lack of information forthcoming from the Coroner's Office. The family were able to provide the interim Death Certificate issued by the Senior Coroner for South London Area on 16 April 2020. The record states "The precise cause of death was as follows: 1a Under investigation". The panel have not been provided with any further information on the precise cause of Tracey's death.

2.2 Background Information on Tracey and Mehmed (prior to the timescales under review)

2.2.1 *Background information relating to the deceased:* Tracey was aged 37 at the time of her death. She had no particular religious beliefs. Tracey was born in Kent. She had a brother, who was three years younger than her. Her parents later divorced. Tracey left school at the age of 17 and had different jobs. She worked in supermarkets and leisure centres, and her favourite work was as a waitress. She was later employed at a leisure centre in Kent, where she worked at the time of her death.

2.2.2 At the age of 18 Tracey moved to the Penge area of South London with a boyfriend. There were no known problems in the relationship. Tracey later ended the relationship to start a relationship with Mehmed. Tracey and Mehmed lived in the London Borough of Bexley. Following a reported assault, Tracey moved temporarily to an address in Dartford Kent between July and December 2018. She then moved back to Bexley and lived with Mehmed. At the time of her death, Mehmed had just taken on a sole tenancy to a new temporary home. Tracey had no recorded disabilities. Tracey's family were aware that she sometimes smoked cannabis and that she could drink heavily. Tracey was briefly known to mental health services in Bexley and South East London in 2013 and 2015. Tracey was seriously assaulted in 2016 and 2018. The trauma of these incidents, as well as long-term domestic abuse, featured in the assessments of mental health services in the time leading up to her death.

2.2.3 *Background information relating to ex-partner:* At the time of Tracey's death Mehmed was 37. He was British born and of Turkish heritage. His faith is not known. Mehmed had previous convictions for dishonesty offences, possession of a blade, possession of drugs and driving under the influence of drugs. Mehmed was previously in a relationship with a woman, and they had a child together in 2000. It is known that they were separated by May 2001. In that month Mehmed went to his then ex-partner's address and became involved in an argument. This resulted in Mehmed grabbing the woman by the throat and punching her head. The ex-partner did not wish to support a prosecution and no further action (NFA) was taken. Mehmed's son was aged around eight months at the time of the reported assault. Mehmed had his own home in Bexley. He was known to have been involved in the motor trade. He was known to be working in a car recovery business in 2010 and a car showroom in 2011. No further details of employment are known.

2.2.4 *Synopsis of relationship with the ex-partner:* Tracey is believed to have met Mehmed around 1999 to 2000. She was 19 to 20 years of age and Mehmed was two years older. Tracey moved in with Mehmed when she was in her early 20s. They lived together in

a house owned by Mehmed in Bexley. Housing reports suggest that Tracey was living with Mehmed in 2005. During the relationship there were a number of reports to police of domestic abuse on Tracey perpetrated by Mehmed, starting in 2008. In 2015 Tracey disclosed to Improving Access To Psychological Therapies (IAPT) that she was being controlled and abused by Mehmed. In 2016 Tracey sustained a serious injury when at home with Mehmed, and part of her finger was bitten off by their dog. Tracey later told Sarah that this happened during an assault by Mehmed. In June 2018 it was reported that Mehmed had seriously assaulted Tracey. After she left the hospital Tracey stayed with her mother, Anne. She then moved to privately rented accommodation in Dartford, Kent between July and August 2018. It has been suggested that Mehmed moved with Tracey to Kent. Mehmed and Tracey had dealings with Kent Police concerning disputes with a landlord as tenants of a private property. By August 2019 Mehmed was known to have a girlfriend, not Tracey, living with him at his Bexley home. Tracey was evicted from the property in Dartford and moved temporarily to stay with her friend Sarah in Bexley. In February 2020 Tracey was arrested outside Mehmed's Bexley home for allegedly breaking a window. Tracey continued to stay with Sarah and was granted emergency accommodation in Bexley days before she was found dead in the new property.

2.2.5 *Members of the family and the household:* Tracey had no children and there were no other persons living with her at the time of her death.

3. Chronology

3.1 Significant events prior to time period under review

3.1.1 Information from Tracey's friend, Sarah, indicates that Tracey met Mehmed around 1999 to 2000. At some point, Tracey moved into to Mehmed's privately owned home in the London Borough of Bexley.

3.1.2 **Domestic Incident** - On 13 April 2008 Tracey's parents reported a domestic incident involving Tracey and her boyfriend to the MPS. They believed that they had been in a relationship for about a year. Tracey was living with Mehmed in his house in Bexley. Tracey had sustained bruising but would not engage with the police and would not provide a statement. A risk assessment recorded 'MEDIUM' risk to Tracey. During the investigation, Amphetamine (Class A drug), Cannabis (Class B drug) and five shotgun cartridges were found at Mehmed's home. The domestic abuse report was closed as No Further Action (NFA) and Mehmed was cautioned for drugs offences.

3.1.3 **Domestic Incident -** On 22 December 2008 neighbours called the police to Mehmed's house, as they heard screams from within. Tracey refused entry to the police, and entry was forced by the officers. They found Tracey bruised with facial injuries, Mehmed was not at home. Tracey declined an ambulance. As officers left the house, Mehmed arrived home. He was arrested and denied assaulting Tracey. Tracey did not make any allegations against Mehmed. Mehmed was released with NFA. The case was classified as a Domestic Incident and risk assessed as 'STANDARD'.

3.1.4 In November 2009 Tracey registered with her local GP Practice, in Bexley.

3.1.5 On 23 February 2010 Mehmed was convicted of Possession of a Class A Drug, Cocaine.

3.1.6 **Domestic Abuse - Assault** - On 20 July 2012 London Ambulance Service (LAS) attended Mehmed and Tracey's home address in Bexley to a call that she was intoxicated. Tracey reported that her partner had beaten her and she did not feel safe. She was taken to Queen Elizabeth Hospital (QEH) Lewisham & Greenwich NHS Trust. No safeguarding referral was made by LAS.

3.2 Combined Chronology (2012 to 2020)

2012

3.2.1 **Domestic Abuse - Assault** - On 7 October 2012 Tracey called the MPS to report that she had a been assaulted by her boyfriend, Mehmed. Police attended their home and when they arrived, Tracey denied being assaulted and said she had called them when she was drunk. She had no visible injuries. A Domestic Abuse Stalking and Harassment (DASH) Risk Assessment was completed, Tracey answered 'no' to all of the risk indicators listed. The risk was determined to be 'STANDARD'. Tracey was provided with a victim card, providing information on support services. The incident was recorded as a Non-Crime Domestic Incident and closed as NFA.

2013

3.2.2 **Domestic Abuse - Assault** - In January 2013 Tracey was brought into Darent Valley Hospital (DVH), Dartford and Gravesham NHS Trust, by ambulance, having been found collapsed at Dartford Train station. She was intoxicated. Her father was with her and said that she binge drank, used cannabis and had relationship problems. It was documented that Tracey said her partner 'beats her up' and would do so when she got home.

3.2.3 **Assault - Later described by friend of Tracey as Domestic Abuse** - In July 2013 Tracey called the police to report that two males had attacked her and Mehmed at Mehmed's house in Bexley. LAS attended Mehmed's house. It was recorded that Tracey had been bitten by a dog whilst in a fight. The top of a finger was missing. Tracey was taken to QEH by ambulance, accompanied by police. The investigation failed to identify the suspects involved in the attack.

3.2.4 Later in July 2013 Tracey was found, unconscious, by the MPS, in a hotel in Sidcup. She later told police she had taken an overdose. She was taken by ambulance to QEH. Police later revisited Tracey, but she refused to provide details of her partner. Police informed Anne of her daughter's hospital admission. Police created a MERLIN (Notification of adult come to notice) report. Tracey was referred to Oxleas Mental Health Liaison Team in the Emergency Department She was later discharged as medically fit and not having mental illness. She was staying with her father at the time. Tracey was referred to her GP and provided with Oxleas Crisis Team contact numbers.

2014

3.2.5 **Domestic Incident -** On 3 April 2014 the MPS were called by a member of the public to a verbal argument between Mehmed and Tracey. Both were seen and confirmed that a verbal argument took place. A Form 124D (Domestic Violence Investigation Form) and DASH risk assessment was completed, Tracey answered 'no' to all risk indicators. The risk was determined to be 'STANDARD'. The call was recorded as a Non-Crime Domestic Incident and closed with NFA.

2015

3.2.6 **Disclosure of Domestic Abuse** - In June 2015 Tracey was referred to MIND Improving Access To Psychological Therapies (IAPT) in Bexley by her GP nurse practitioner as she was feeling 'very down'. Tracey attended counselling sessions with MIND. During her assessment at MIND Tracey reported being in a historically violent relationship. Tracey was signposted to the Freedom Programme domestic abuse service. In December 2015, during a counselling session, Tracey reported that her partner was verbally abusive, threatening and controlling. There was no supervision follow up and no Risk Assessment. Tracey 'disengaged' from the service due to work commitments. She reported having a new job.

3.2.7 In February 2016 Tracey was discharged from the MIND IAPT service.

3.2.8 **Domestic Abuse - Grievous Bodily Harm (GBH) -** On 8 June 2016 the MPS were called by a member of the public who had found Tracey slumped in a doorway. Police attended and found Tracey. She said that she had been assaulted by Mehmed, who had punched her in the face. She had severe bruising to her left eye. She refused to provide a statement or answer questions for a Risk Assessment. She declined to allow her clothing to be seized. A referral was made to Crisis Intervention Team in relation to an Independent Domestic Violence Advisor (IDVA). Bexley MARAC records show a call to Tracey from the IDVA that day, with no response from Tracey.

3.2.9 Tracey was taken to QEH where she was X-Rayed and had a CT scan on her facial bones. She was found to have a broken nose, fractured eye socket and an injury to her left eye. There was no record of an Emergency Department (ED) admission. There were no records of questioning on domestic abuse or raising safeguarding concerns.

3.2.10 Later that day two friends of Tracey reported to police that they were concerned for her welfare. Officers attended Tracey's home and found her. She was not found to need medical attention, but her bruises had developed.

3.2.11 The investigation was undertaken by the Community Safety Unit (CSU) at Bexleyheath Police station, a specialist unit. It was investigated as a report of GBH. Enquiries revealed that Mehmed's father had driven Tracey to hospital on the night of 7 June 2016. Mehmed had called them to drive Tracey to hospital because she had bleeding nose. Mehmed's parents declined to make a statement.

3.2.12 Mehmed was arrested and declined to make any comment. The CSU Detective Sergeant (DS) reviewed the risk as 'STANDARD' as Mehmed was in police custody. A 124D was completed and Tracey answered 'no' to all DASH questions. She was provided with a domestic abuse form, including useful numbers for support. Intelligence checks were completed.

3.2.13 The matter was referred to the Crown Prosecution Service (CPS) for an evidential review, who concluded that there was insufficient evidence to secure a realistic prospect of conviction at court. An action plan was set and Mehmed was bailed with conditions to return to Bexleyheath Police Station on 22 July 2016.

3.2.14 On 9 June 2016 MPS Detectives and an IDVA attended Mehmed's home to offer IDVA services and ensure that there were no breaches of bail by Mehmed.

3.2.15 On 10 June 2016 Tracey was referred to Bexley MARAC by the MPS.

3.2.16 On 12 June 2016 Tracey phoned the MPS, stating that she had been asleep when they had called.

3.2.17 On 14 June 2016 the IDVA made enquiries with Adult Social Care (ASC) and Pier Road Project (PRP), South London and Maudsley NHS Foundation Trust substance misuse service, to see if Tracey was known to them. The IDVA also called Tracey, on 14 June and 17 June with no response from Tracey.

3.2.18 On 21 June 2016 Tracey was reviewed at the Oral and Maxillofacial Outpatient Department, King's College Hospital (KCH). Tracey explained that she was injured following a trip and a fall against a table.

3.2.19 On 23 June 2016 the IDVA spoke with Tracey to offer support and Tracey declined.

3.2.20 **MARAC Bexley** - On 28 June 2016 Tracey's case was heard and the Bexley MARAC. Details of the incident and attempted engagement were discussed. No partner information shared was recorded. The IDVA recorded as saying she will send a letter to Tracey. Actions recorded were for agencies to flag, police to monitor and police to contact the OIC (officer in case) regarding bail. The case was closed following the MARAC with no record of contact with Tracey and no update provided to her. The case file shows no record of contacting other agencies.

3.2.21 On 4 July 2016 Tracey was seen at KCH to reset her fractured nose under anaesthetic. She was followed up at KCH in October 2016.

3.2.22 On 15 July 2016 the IDVA emailed the MPS to inform them that they were closing Tracey's case, as she had declined support.

3.2.23 On 22 July 2016 the CPS authorised NFA on the grounds of insufficient evidence. Mehmed was charged with possession of cannabis.

3.2.24 On 25 July 2016 the MPS I.O. recorded that they had not been able to get in contact with Tracey to update her on the CPS decision. It was noted that she had stopped engaging with the IDVA and MPS.

3.2.25 On 8 October 2016 Mehmed was involved in an altercation with a woman motorist. Mehmed alleged that the woman had racially abused him. The woman alleged that Mehmed had assaulted her. The woman was charged with criminal damage to Mehmed's car. There was NFA on the assault allegation.

2017

3.2.26 In March 2017 Mehmed registered at the same GP practice as Tracey.

3.2.27 On 1 August 2017 the GP referred Tracey and Mehmed for fertility treatment, stating they had been trying for a baby for three years.

3.2.28 On 31 August 2017 the Reproductive Medicine Clinic wrote to the GP stating that Tracey and Mehmed had been referred to the Assisted Conception Unit.

3.2.29 On 10 October 2017 Tracey was sent a letter by Guy's Hospital Assisted Conception Unit informing her that Bexley CCG had authorised funding for fertility treatment.

2018

3.2.30 **Domestic Incident** - On 8 May 2018 Tracey called the MPS to report that she had a verbal argument with Mehmed. Whilst making the call, the operator heard her say 'I don't want you here'. Police saw Tracey and she provided a statement confirming that they had an argument but did not want to make any allegations. Tracey also stated that she had a recent miscarriage. Police did conduct research and intelligence records on

previously recorded incidents. A Domestic Incident CRIS report and a Form 124D were completed. Tracey replied 'No' to all questions in the DASH Risk Assessment. Tracey was provided with a Domestic Abuse form, including contact numbers for support services. The report was passed to the CSU at Bexleyheath, it was noted that the MARAC threshold was not met.

3.2.31 **Hospital Attendance - facial injuries** On 17 May 2018 Tracey attended the Hurley Group, Urgent Treatment Centre (UTC) at Queen Mary's Hospital, Sidcup. She said that she had fallen down stairs four days prior and had hit her head on a banister. She had been startled by dogs, causing her to fall. She was experiencing a headache and nausea. She was advised to attend the ED. Tracey went to the ED at Lewisham Hospital, Lewisham and Greenwich NHS Trust (LGT), she had two fractures to her cheekbone and told them she had fallen down the stairs five days prior. She had a headache and was vomiting. There was no enquiry about domestic abuse.

3.2.32 On 1 June 2018 Tracey attended KCH day surgery unit, having been referred by LGT. She had a laceration to her lip and reduced mouth opening. Tracey discharged herself and refused to take home prescribed medicine. She did not attend a planned follow up on 24 July 2018.

3.2.33 On 3 June 2018 MPS received a call to Crimestoppers, stating that a female residing at Mehmed's home was being assaulted at that time. Police attended and found Tracey alone with six dogs. The dogs started fighting in the garden and Tracey asked police to assist.

3.2.34 On 4 June 2018 MPS received information from Crimestoppers that a male living at Mehmed's address was dealing cocaine. The information was very limited, and police had visited the address the previous day. No further action was taken in 2018.

3.2.35 **Domestic Abuse – Grievous Bodily Harm** – On 16 June 2018 LAS were called to Mehmed's address to a report that Tracey had fallen and was locked in behind closed doors. MPS were called at the same time and arrived first. There was a pool of blood visible under the front door. Tracey could be seen on the sofa, unresponsive and covered in blood. Police started to force entry to the premises, Tracey got up to come to the door and then collapsed. Police described her as having multiple bruises all over her body including her legs, arms and back, swollen lip and a large cut on the bottom of her chin. She was believed to be suffering from the effects of excess alcohol. Tracey told police that she had caused the injuries herself. The LAS crew reported that Tracey was bleeding from the face, covered in bruises with a deep laceration to her chin. Dogs were in the house barking. LAS took Tracey to QEH ED on blue lights, due to her head injury. LAS records show that police informed them that the venue had been highlighted for domestic abuse risk. There was no DASH Risk Assessment completed at the scene due to Tracey's condition and transfer to hospital.

3.2.36 During the search of the house for possible suspects Tracey's dogs were found upstairs attacking each other. Three dogs were removed from the premises. The house was preserved as a crime scene. The initial investigating officer assessed the risk to Tracey as being 'HIGH'.

3.2.37 QEH records show that Tracey had a CT scan of her neck, spine and thorax following an unknown assault. Tracey rolled over during the scan and was unable to lie still. Tracey went back to ED and the scan was not resumed. There is no record of police liaison or a safeguarding referral. No information from the ED.

3.2.38 The MPS commenced an investigation, for GBH, South East Basic Command Unit (SE BCU) CSU. Police records show that Tracey had bruises over 60 percent of her body. Tracey was unwilling to speak to the police in detail or provide a statement. When asked how the injuries were caused Tracey said 'boyfriend'. She later said, without being prompted "Mehmed, why did you do it to me?" Tracey agreed to stay the night with her mother.

3.2.39 On 17 June 2018 the OIC spoke to Tracey. Tracey said that she had caused her injuries because she was drunk and fell over. She declined to provide a statement. Police installed a panic alarm. Photographs were taken of Tracey's injuries and numerous arrest enquiries were attempted for Mehmed. Neighbour and CCTV enquiries proved negative.

3.2.40 On 18 June 2018 MPS made referrals to Bexley IDVA and MARAC.

3.2.41 On 19 June 2018 the IDVA made an unsuccessful attempt to contact Tracey by phone.

3.2.42 On 20 June 2018 the IDVA checked on victim concerning her injuries. Records show that the IDVA offered Tracey the services of Victim Support Bobby Van, and London Fire Brigade and both were declined by Tracey.[10]

3.2.43 On 22 June 2018 the IDVA emailed police to check on the whereabouts of the perpetrator.

3.2.44 On the same day Tracey saw her GP for a face-to-face consultation. It was reported that Tracey had been assaulted by her partner. Tracey advised that she would be moving away and would therefore register with a new GP. It was noted that the police were involved. A sick certificate was issued because Tracey worked as a receptionist and would be 'public facing'. No further referrals were made.

3.2.45 On 25 June 2018 the IDVA telephoned Tracey to update on whether Mehmed had been located.

3.2.46 On 26 June 2018 the IDVA contacted Tracey to provide safety planning advice and complete a DASH Risk Assessment.

3.2.47 **MARAC Bexley** - Also on 26 June 2018, the Bexley MARAC meeting discussed Tracey. The IDVA briefed the meeting. They stated that Tracey was actively minimising the level of abuse and refused to recognise it as domestic abuse. Tracey had been signed off work for six weeks. Tracey reported that she had been in a relationship with

[10] The Bobby Van is a free service to provide additional security measures for the home i.e. window alarms, door locks. London Fire Brigade offer a service which includes sealing letterbox and fire precaution advice.

Mehmed for 13 years. The relationship had ended, and she now wanted to move on. It was reported that £42,000 had been taken from Tracey. Tracey had been offered temporary accommodation but had moved in with her mother. Special Schemes police alerts had been placed on the address, fireproof letter box, window locks and alarms had been offered. Tracey was reported as being scared of having nowhere to live. The actions from the meeting were for a letter to be provided to support with housing and all agencies to flag.

3.2.48 On 29 June 2018 the IDVA called Tracey and discussed the MARAC with further contact on 4 July 2018.

3.2.49 On 9 July 2018 the IDVA emailed the housing department confirming that Tracey needed temporary accommodation. This was followed by a call to Tracey for safety planning and to discuss housing.

3.2.50 On 12 July 2018 Bexley Housing provided temporary accommodation for Tracey. This was at an address in Dartford, Kent. The IDVA updated the MPS on the move.

3.2.51 On 16 July 2018 Victim Support contacted the IDVA to inform them that Tracey had declined service.

3.2.52 On 17 July 2018 Mehmed was arrested having surrendered to police. He denied any assault and said that he was out of the country at the time of the incident. He said that he had left the address on 15 June 2028, the night before Tracey was taken to hospital. He said that at the time Tracey was depressed and drinking, because their fertility treatment had not worked. He said that he flew to Amsterdam on 16 June 2018. He provided bank statements to show he was in Amsterdam between 16 and 18 June 2018. He suggested that an ex-employee was the perpetrator of the attack on Tracey, as he had recently sacked this person. Mehmed was bailed to return to the police station, with conditions not to contact Tracey. Special Schemes were put in place to highlight the home on police command and control systems. The case was eventually closed as NFA due to insufficiency of evidence.

3.2.53 On 18 July 2018 the IDVA contacted London Fire Brigade (LFB) referring Tracey for additional security. The following day the LFB informed IDVA that Tracey had declined.

3.2.54 The IDVA phoned Tracey on 23 and 24 June 2018 with no response. The IDVA also emailed the MPS advising of Tracey's new address. The IDVA attempted further telephone contact with Tracey on 25 and 16 June 2018 without success.

3.2.55 **Emergency Department - Shortness of breath** - On 26 July 2018 Tracey attended Princess Royal University Hospital (PRUH), Kings College NHS Foundation Trust, ED with shortness of breath. She was seen and discharged with no follow up required. On the same day the IDVA attempted to contact Tracey by phone without success. MPS also sent an update email to the IDVA.

3.2.56 **Emergency Department -** On 27 July 2018 Tracey was taken to the Emergency Department of QEH by LAS. She had been found sleeping outside a neighbour's house. Tracey said she had been drinking wine the night before and could not get into her house. Tracey was referred to the substance misuse team. Tracey told ED staff

that she was beaten up on 16 July when a stranger broke into her house. She said she did have a partner but denied he was responsible. Tracey denied taking drugs or trying to overdose. There was no safeguarding referral made.

3.2.57 On 1 August 2018 the IDVA called Tracey to discuss safety planning. At this point Tracey was staying in a hotel.

3.2.58 **MARAC to MARAC transfer** - On 2 August 2018 the Bexley MARAC sent a MARAC referral form to the Kent MARAC. The referral was made because Tracey had moved to Kent following domestic abuse. The case was reviewed by the Central Referral Unit (CRU). It was noted that Tracey would not cooperate with the police and information was to be recorded against her new address. The Kent Police MARAC informed the Clarion IDVA service. They also added Tracey to the MARAC case list, created a crime report on the Kent Police Intelligence system. Warning markers were added to Tracey's address. Warning markers were also added on Kent systems for Mehmed and Tracey.

3.2.59 Also on 2 August 2018 Tracey saw her GP for an extension of her sick certificate. She said she wanted to return to work to take her mind off the assault. The GP advised Tracey to contact Victim Support for information and access to counselling.

3.2.60 **Ambulance called to mental health concerns** - On 3 August 2018 at 13:57 hours LAS received a call to a hotel in Bexley as it was reported that Tracey was there and hallucinating. Tracey spoke to the LAS call handler and said that she was not taking medication and was not a threat to herself. The call for the ambulance was cancelled before arrival, as Tracey had left the premises. Later at 21:02 the LAS were called again and informed that Tracey was still at the hotel, hallucinating and was possibly a danger to herself. The LAS crew arrived and found Tracey hallucinating, talking to people who were not there. She was described as manic, and she believed she was at her parents' house. The MPS were also called to the address. The crew recorded that Tracey had been living in hotels since 16 June 2018 due to a domestic abuse case. Tracey told the officers that she had been previously assaulted by an unknown person in her home. Tracey was taken, voluntarily, by ambulance to PRUH. The MPS officers completed a MERLIN report and shared this with Bexley ASC.

3.2.61 Tracey was taken to the Emergency Department at PRUH. She was found not able to hold a logical conversation. It was noted that she had been living in a hotel since 16 June 2018, after domestic violence. Tracey left without being seen by the medics. There is no record of any safeguarding concerns being recorded or police being called after Tracey left.

3.2.62 On 6 August 2018 Bexley ASC received the MERLIN form from the MPS. It was referred onwards to Primary Care Plus (PCP), Oxleas Mental Health Services.

3.2.63 On 7 August 2018 a Senior Social Work Practitioner at Oxleas PCP Community Mental Health Team (CMHT) screened the MERLIN report and recorded NFA. The outcome was to forward the report to Tracey's GP.

3.2.64 On 8 August 2018 the Clarion IDVA in Kent spoke to Tracey by telephone. Tracey declined the support of the IDVA but did take the IDVA's phone number. This was to cover Tracey changing her mind or just seeking advice. The IDVA was unable to safety

plan with Tracey, as Tracey cut short the call. The IDVA then informed Bexley IDVA that support had been declined. The IDVA also notified the North Kent MARAC coordinator that Tracey had declined support.

3.2.65 On 10 August 2018 Tracey contacted Council Tax Department to inform them that she had moved into an address in Dartford, Kent

3.2.66 On 14 August 2018 the Clarion IDVA reviewed Tracey with their line manager and decided to close the case.

3.2.67 **MARAC Kent** - On 15 August 2018 the Kent Police MARAC took place. The Kent IDVA reported that they had made contact with Tracey, who declined support. Tracey had kept the IDVA's phone number but no further support was discussed. Kent Police reported only one notification, a Secondary Incident (SI) to them, reporting that Tracey had been placed in emergency accommodation fleeing domestic abuse. Reported incidents were being investigated by the MPS. Details of Mehmed and bail conditions were recorded. Tracey's case was not heard again at Kent MARAC as they were not notified of any further incidents in the 12 months following the meeting.

3.2.68 On 7 September 2018 Tracey informed the MPS OIC that Mehmed did not assault her and that she wished to provide a withdrawal statement. She said that she did not remember what happened on the day in question and felt pressured by her parents to provide a statement when she was in a vulnerable state.

3.2.69 On 5 November 2018 Tracey was interviewed by Bexley Housing in person. A homeless application was made.

3.2.70 On 7 December 2018 Tracey vacated the address in Dartford.

2019

3.2.71 On 11 January 2019 the MPS OIC recorded that significant evidence had been obtained that showed that Mehmed was out of the country, travelling on a ferry, hours before Tracey was found injured. Tracey had not signed a medical disclaimer. There was insufficient evidence to treat Mehmed's ex-employee as a suspect.

3.2.72 **Domestic Incident** - On 17 February 2019 Kent Police received a call from a third party that there was a domestic incident between Mehmed and Tracey. When police arrived Tracey told the officers that she and Mehmed had a verbal disagreement over their dog and the lack of space in the flat. A report was made and referred to the CRU. A Risk Assessment was recorded as "HIGH' and reassessed to "MEDIUM" following a review by an Acting Detective Inspector. No MARAC referral made.

3.2.73 On 27 February 2019 the MPS CSU closed the investigation into the assault of June 2018, noting NFA due to insufficient evidence.

3.2.74 On 8 May 2019 Mehmed called the MPS to complain about his treatment by the police the previous year when he had been accused of beating up his partner. The report was passed to a supervisor. The following day Mehmed called the police stating he was still waiting for a call back. Mehmed refused to speak to anyone below the rank of Chief

Superintendent and stated that he would contact the Independent Office For Police Conduct (IPOC) directly.

3.2.75 **Civil Dispute - with landlord** - On 6 June 2019 Tracey called Kent Police to report that she and Mehmed were in dispute with the landlord over rent and the landlord had come to their flat. This was recorded as a civil dispute.

3.2.76 **GP Consultation - anxiety and panic attacks** - On 2 July 2019 Tracey saw her GP in Bexley for a face-to-face consultation. Tracey reported anxiety and panic attacks. It was noted that it was a year ago that Tracey was attacked. It was noted that Tracey had good support from work. She was advised to self-refer to MIND.

3.2.77 **Work Mental Health Support self-referral** - On 7 August 2019 Tracey telephoned Able Futures (Mental Health Support). Tracey said that she had been advised about the service by her employer. Tracey asked about the services provided and the Contact Centre details to complete the Access to Work Mental Health Support Direct Referral Form. The form was forwarded to check Tracey's eligibility for the service.

3.2.78 On 8 August 2019 Able Futures spoke with Tracey. An appointment was made to meet a Vocational Rehabilitation Consultant (VRC) at Tracey's workplace on 27 September 2019. The referral form included reference to previous physical abuse from Tracey's ex-partner, including attempted murder.

3.2.79 On 19 August 2019 the MPS executed a search warrant under the Misuse of Drugs Act at Mehmed's home address in Bexley. Present at the address was a woman, who Mehmed stated was his partner. This woman was not Tracey. Mehmed was arrested for Possession of Cannabis and given a fixed penalty notice.

3.2.80 On 23 August 2019 Mehmed was arrested for trying to break into a car with another male. He was charged with Theft. He was later sentenced to financial penalties, on 6 September 2019.

3.2.81 **GP Consultation - panic attacks** On 26 September 2019 Tracey called her GP as she was suffering with severe panic attacks. Tracey wanted to be seen that day. She was told that there were no urgent appointments available and that she should attend the Urgent Care Centre or an Emergency Department if she considered self-harm. Tracey did not make an appointment, as she said she was seeing her therapist.

3.2.82 On the same day Tracey called the Able Futures Contact Centre as she had not heard from the VRC. A message was passed to the VRC.

3.2.83 On 27 September 2019 Tracey had a face-to-face meeting with the VRC at Tracey's place of work. An initial support plan was completed. The assessment noted that "She has some past DV issues, and it seems that she still live (sic) with him, so her safety will be paramount". Safety measures and accommodation were discussed. Objectives were set in a support plan, to be reviewed at the next appointment. The VRC did not raise a safeguarding concern and no immediate threat was identified.

3.2.84 Around October 2019 Tracey contacted her friend Sarah and informed her that she had moved into a flat rented for her by Mehmed. She said she was having issues with Mehmed, as he had started a relationship with another woman.

3.2.85 **GP Consultation** - On 1 October 2019 Tracey had a face-to-face consultation with her GP. Diagnosis of Post-Traumatic Stress Disorder (PTSD). Tracey said that she was getting support and that her employers were organising a referral for her. Blood tests were recommended as she reported being tired. She had no thoughts of self-harm or suicide.

3.2.86 **GP Referral to Oxleas** - On 14 October 2019 Tracey saw her GP in a face-to-face consultation. Tracey explained that she had had a lot of traumatic experiences in life and had been left feeling panicky. It was noted that she was taking Citalopram but Tracey said she did not want to take this as she wanted to be free of medication. It was noted that Tracey was having counselling through her work, and this was with a specialist in trauma counselling. Tracey requested a confirmed diagnosis of PTSD. It was explained that this diagnosis is made by a psychiatrist and the GP would urgently refer requesting this. Tracey discussed that she had taken an overdose. Tracey was advised she should immediately attend ED if she had thoughts of suicide, Tracey stated that she will not attend ED as she would not take an overdose again. The GP referred Tracey to the Oxleas CMHT. This was followed, the next day, by a clinical meeting of the GP practice to agree the course of action. It was noted that the specialist counsellor would be writing to the GP. There was no letter received by the practice.

3.2.87 On 15 October 2019 Oxleas PCP CMHT screened the urgent referral from the GP. The referral sought diagnosis of PTSD and highlighted concerns around Tracey's stress. It noted that Tracey was receiving counselling for trauma. The plan was to offer Tracey a telephone assessment.

3.2.88 On 17 October 2019 Oxleas PCP staff tried to contact Tracey twice by mobile phone. There was no answer or facility to leave a message. They then checked with the GP, who had no landline number. This was followed up with an unannounced visit to Tracey's home. There was no answer, and a letter was left, giving crisis contact details and asking for Tracey to make contact with PCP.

3.2.89 On 18 October 2019 Mehmed was convicted for driving a motor vehicle under the influence of drugs.

3.2.90 On 23 October 2019 Oxleas PCP manager reviewed Tracey's referral. The plan set was for a further attempt to contact Tracey to arrange an assessment. Risks were considered as being "LOW." A date for closure was set as 6 November 2019. A letter was sent to Tracey on 25 October 2019 requesting that she contact to arrange an assessment. The GP received a letter from PCP on this date.

3.2.91 On 25 October 2019 Tracey had a telephone appointment scheduled with her VRC. Able Futures are unable to confirm whether the appointment took place.

3.2.92 On 29 October 2019 Tracey telephoned Oxleas PCP in response to the letter. A request for assessment was sent to the PCP assessment coordinator.

3.2.93 **Civil Dispute** - On 1 November 2019 Tracey called Kent Police concerning property being held by their landlord. The parties included Mehmed and Tracey. It was considered as a civil dispute. The MPS recorded that Kent Police had received a call from Tracey in distress. She was concerned that her landlord had taken her dog,

medication and passport. Tracey was seen by the MPS, and enquiries were referred back to Kent Police.

3.2.94 Around the same time Sarah received a call from Tracey stating she had been locked out of her flat and was waiting for Mehmed to resolve the issue. Mehmed then called Sarah reporting Tracey to be hysterical and drunk. Sarah went to Tracey's flat, and it was not in a good state. Sarah asked Tracey to leave the flat with her, Tracey declined. Mehmed then said he would speak to Tracey alone. Sarah heard Mehmed shouting at Tracey and sounds that she believed to be choking. Sarah did not witness this but heard the noises, and noise of Mehmed dragging Tracey down the stairs. At this point Sarah took Tracey to her home, where she was living until March 2020. This incident was not reported to the police at the time. The account above was provided to the MPS in 2022. Sarah had previously told the DHR Chair she had on one occasion seen Mehmed with his hands around Sarah's throat. It is not clear if these accounts referred to the same event.

3.2.95 In November 2019 Tracey was staying with Sarah, when Sarah heard 'howling' noises coming from her room. Sarah found Tracey in an intoxicated state. Sarah called Mehmed and he suggested looking for a vodka bottle in Tracey's room. Sarah found an empty vodka bottle. Sarah called LAS and Tracey was seen by an ambulance crew, Tracey declined to leave the house and attend hospital. Sarah later told the MPS that this was the beginning of many episodes of Tracey becoming intoxicated. A check has been made of LAS records and the only visit to the address known for Sarah was in December 2019.

3.2.96 On 4 November 2019 Oxleas PCP contacted Tracey to arrange an appointment. An appointment for a telephone consultation was set for 8 November 2019.

3.2.97 On 5 November 2019 Victim Support Kent received a data transfer referral from Kent Police listing Tracey as a victim of blackmail by her partner. Victim Support emailed a Detective Sergeant dealing with the case requesting explicit consent from Tracey for the referral or to ask Tracey to contact Victim Support. There was no response to the email from Kent Police.

3.2.98 On 8 November 2019 Oxleas PCP called Tracey for her assessment. There was no answer on the numbers provided.

3.2.99 **Disclosure of economic abuse** - On 12 November 2019 Tracey called Oxleas admin to apologise for not attending the phone appointment. She reported that her partner had locked her out of the house and was demanding £5000 from her in order to get her belongings. The information was passed to the PCP to review. It is not current practice for administrative staff to assess risk. The practitioner referred to would be required to assess risk.

3.2.100 **Disclosure of domestic abuse** - On 14 November 2019 a telephone assessment was made by Oxleas. The PCP assessment documented a history of domestic abuse. PCP offered and booked Tracey a face-to-face assessment on 27 November 2019. There was no DASH assessment completed. A letter detailing the appointment was sent the following day. The GP received an update letter from Oxleas on 15 November 2019.

3.2.101 On 21 November 2019 Tracey called Oxleas PCP to advise that she was not living at the address on file. She provided an email address, to which Oxleas sent the appointment details.

3.2.102 **Call to GP - panic attacks** - That same day Tracey called her GP. She requested an appointment as she was feeling very low, depressed and anxious. She asked to speak to a specific member of staff, who was aware of her history. Tracey was spoken to by a clinician. This was not the doctor requested by Tracey. Tracey said that she had found out that her partner had been having an affair. She was experiencing panic attacks. Tracey was staying with a friend. She was unable to attend the practice in person. She was issued with a sick certificate for Anxiety and Panic Attacks. She was advised that if she felt suicidal, she should attend Accident and Emergency (A&E).

3.2.103 On 27 November 2019 Tracey contacted her art therapy assessor at Oxleas PCP due to transport problems. It was agreed to have another face-to-face assessment with a psychology therapist. A letter offering the appointment on 18 December 2019 was sent to Tracey.

3.2.104 **Oxleas Assessment – disclosure of domestic abuse** – On 18 December 2019 Oxleas ADAPT (**A**nxiety, **D**epression, **A**ffective disorders, **P**ersonality disorders & **T**rauma) Team completed a face-to-face assessment with Tracey. The plan was for Tracey to go on the waiting list for trauma focused psychological therapy. Due to long NHS waiting lists, it was recommended that her employer could offer private therapy. Tracey disclosed that she had experienced violence from her partner of 15 years, over this time he had fractured her face and cheekbones. This included a time when she was unable to work for a period because of the seriousness of his assault on her. Tracey was asked to self-refer to Women's Aid for support. Tracey said that she would not want to access that support and she had capacity to decline a referral. A crisis plan was to be included in a letter to Tracey. The GP was updated by letter that day. The panel has not been provided with any details of a DASH assessment from this contact.

3.2.105 **Call to NHS 111 from friend** – On 20 December 2019 at 07:06 a call was received from NHS 111 from Sarah, a friend of Tracey. Sarah reported that Tracey was having night terrors and was missing medical appointments. It was impossible for the operator to triage Tracey as the caller was not with her at the time. There was no immediate threat to life mentioned. The address provided was in the London Borough of Bromley.

3.2.106 Sarah called the GP. She explained that Tracey had been found by her in a comatose state and she was very worried. The Duty Doctor advised she needed to be booked an appointment or to be taken to A&E. When the Doctor rang back there was no answer on Tracey or Sarah's number.

3.2.107 **Ambulance Call – distressed state** – Later (on 20 December 2019) at 15:28 Sarah called NHS 111 to report that she was having difficulty in waking Tracey, and she was screaming in pain every 30 minutes. An ambulance was called.

3.2.108 **Economic Abuse Disclosure** – LAS arrived at 15:29 and saw Tracey. She was described as being distressed and her speech was slow and slurred. It was noted that Tracey had been victim of a home invasion two years before, assaulted and left for

dead. She then lived with her 'husband' in an apartment, and he had stopped paying rent. Tracey had been staying with a friend since becoming homeless. The LAS took Tracey to PRUH.

3.2.109 **Emergency Department – reported overdose** – On arrival at PRUH it was recorded that Tracey had overdosed on paracetamol. It was noted that she was of No Fixed Abode. The Critical Care Unit at PRUH contacted Oxleas Mental Health Liaison Team (MHLT) and referred Tracey. It was recorded that Tracey had reportedly taken 40 paracetamol. There was no evidence of paracetamol in her blood samples. PRUH records show Tracey described the incident as impulsive and that she regretted her actions. She said she knew how to access support in a crisis.

3.2.110 **Economic Abuse Disclosure** – Tracey was seen by a nurse from the Oxleas MHLT at 02:30 on 21 December 2019. Tracey said she felt ashamed. It was recorded that there had been a 'relationship breakdown'. Her ex-partner owed her £67,000 inheritance money from her late father, she was in substantial debt, living with a friend and not speaking to her mother or younger brother. She was no longer expressing suicidal ideations or had any plans of suicidal intent. The outcome was to offer a period with the Home Treatment Team (HTT). Tracey declined the referral, maintaining that she would be fine. She was aware of how to contact crisis services and encouraged to use the crisis line. An email was sent to the Care Coordinator (CCO) advising of the contact. Tracey was given Oxleas Urgent Advice Line (UAL) card and a Samaritans Card. There is no evidence of a Risk Assessment for financial abuse.

3.2.111 On 24 December 2019 the MHLT emailed the CCO at the ADAPT CMHT. It was established that Tracey did not have an allocated CCO. ADAPT admin liaised with MHLT to ask if they considered that Tracey needed a CCO. It was advised that if a CCO was considered appropriate then MHLT should send a referral for ADAPT. The team manager could then review the recent presentation of Tracey to the MHLT. There was no referral sent.

2020

3.2.112 At the start of 2020 Tracey was still living with her friend Sarah. Sarah later told the MPS that between January and February 2020, Tracey would leave the house and Sarah would try to find her. Sarah commented that Tracey was a regular attendee at hospital.

3.2.113 **Call to NHS 111 and Oxleas – from friend** On 6 January 2020 NHS 111 received a call from Sarah reporting that Tracey was drinking to excess and had not been sober for four days. Tracey was also reported to be having PTSD symptoms. NHS 111 referred Tracey to Mental Health Crisis Service. Sarah called Oxleas Triage Nurse and gave the same information, stating Tracey was saying she wanted to die. Contact was made with ADAPT. The Triage Nurse said that she supported the friend in not allowing Tracey to remain living with her and that it could cause safeguarding concerns for the friend's children. She advised that Tracey should present to Bexley Council as homeless. Sarah was advised on risk of withdrawal from alcohol. The Triage Nurse would contact the ADAPT team to request an urgent follow up. It was suggested that

Tracey be contacted in the morning before she consumed alcohol. Emergency contact details were provided.

3.2.114 On 7 January 2020 Sarah called the London Borough of Bexley Contact Centre. She said that she was struggling to support Tracey because of her mental health and her drinking was spiralling out of control. Sarah was given contact numbers for the mental health team. Sarah stated that she would see if Tracey was open to contact, if not she would call back. Sarah then called Oxleas Crisis Line Team. The team offered to provide an assessment for Tracey.

3.2.115 The Oxleas Crisis Line Team telephoned Tracey. She reported feeling slightly better. She was not compliant with medication and said she was waiting for a diagnosis from ADAPT. Crisis Line agreed to notify ADAPT and advised Tracey to contact ADAPT to check on waiting time for treatment.

3.2.116 The ADAPT team attempted contact twice on 7 January 2020, without success. After a further call on the morning of 8 January 2020, Tracey then phoned the ADAPT team back. She reported that she had been struggling lately but was OK at that time. She had no thoughts of self-harm of plans of intent. She said she would start taking the prescribed medication and pursue therapy offered through work. She requested a copy of the ADAPT assessment to show her work. She was continuing to work. It was agreed that copies of the assessment would be sent to Tracey and her GP. She would remain on the waiting list, but if she started therapy at work, she would no longer require therapy from the CMHT.

3.2.117 **Call to Work Support** – On 8 January 2020 Tracey called the Able Futures Contact Centre. It was noted that Tracey had been trying to get in touch with her VRC. Tracey said she has had her psychiatrist assessment done and will be picking up the results on Friday 10 January 2020 and the VRC needed to organize her counselling. An email was sent to the VRC and Contact Centre Manager.

3.2.118 **Consultation with GP and referral to Oxleas**. At 10.22 on 10 January 2020 Tracey had a face-to-face consultation with her GP. Tracey discussed that she had taken an overdose of paracetamol with alcohol, noted as being on 20 December 2019. Tracey was under the Erith mental health team; she had declined medication and had the crisis number. Tracey had no feelings of self-harm. Tracey was awaiting Cognitive Behavioural Therapy (CBT) to be arranged by work. The GP phoned and asked the CMHT to see Tracey. She was prescribed one week of medication and issued a sick certificate.

3.2.119 On the same day at 10:39 a person introducing themselves as a “Support Worker” called ADAPT. They refused to give a name. They said that Tracey was unhappy with the outcome letter and wanted to be reassessed. It appeared that Tracey was with the “Support Worker” during the call. The ADAPT team manager tried to explore why Tracey was unhappy. The “Support Worker” said they would speak to the duty doctor and hung up.

3.2.120 **Found intoxicated in street** – **ED attendance-** -At 12:56 the same day MPS were called to Tracey when she was found lying drunk in the street, in Bexley. Police arrived

at 13:10. Tracy had a letter to state that she had PTSD and depression. She said she was of No Fixed Abode. She appeared to be drunk. LAS were called but were unable to attend. The MPS took Tracey to QEH. The MPS officers completed a MERLIN form and discussed Tracey with ASC. The police decision to share the report with Social Services without Tracey's consent was taken due to her need for care and support. QEH recorded that Tracey was brought to the ED by police. She left prior to being seen. There is no record that this was reported to the police.

3.2.121 **Found collapsed in street – ED attendance** – At 19:04 Tracey was seen in the ED of DVH. She had been found collapsed on a bus outside the ED with a half-empty one litre bottle of vodka and an empty packet of Citalopram (antidepressant tablets). Tracey was admitted to hospital for blood tests and to see Psychiatric Liaison. The ED contacted the Oxleas Crisis Line Team to obtain details regarding Tracey. Tracey denied taking an overdose and was discharged with a referral to CMHT for follow up.

3.2.122 On 11 January 2020 Sarah called Bexley ASC on behalf of Tracey. She said that Tracey was currently in hospital and would like to discuss an emergency care package as Tracey had no one to look after her. The ASC Out Of Hours (OOH) manager contacted Sarah and was informed that Tracey had been discharged from hospital that afternoon and was temporarily staying with her. Sarah had contacted the Mental Health Team earlier in the week and wished to be considered as Next of Kin for Tracey. Sarah said she would contact Mental Health Team again. There was no further action from OOH. An email was sent to Screeners and the Rapid Response Team.

3.2.123 On 13 January 2020 Bexley ASC emailed Screeners at the Bexley Single Point of Contact. The email was forwarded to the Mental Health Team

3.2.124 **Oxleas CCO allocated** On 15 January 2020 Oxleas ADAPT Team held an allocation meeting. Tracey was discussed and allocated a Social Worker (SW) was allocated as her CCO.

3.2.125 On 17 January 2020 the allocated worker from ADAPT telephoned Tracey to introduce herself. Tracey declined support and reported that she already had a support worker through work and paid for by work "AWOL Futures" (sic.). It was decided that Tracey would remain on the NHS waiting list and the allocated worker was removed at the request of Tracey.

3.2.126 On 21 January 2020 Oxleas ADAPT received a letter from DVH, following Tracey's presentation on 10 January 2020. The letter requested that psychological interventions were expedited. The letter was passed to the consultant psychiatrist to review.

3.2.127 On 23 January 2020 Tracey called the Able Futures Contact Centre. It was noted that Tracey had received a diagnosis but was waiting for a call back from her VRC. An email was sent to the VRC.

3.2.128 In January 2020 Able Futures received an email from Tracey's employer, raising concerns on the lack of contact from Tracey's VRC.

3.2.129 On 24 January 2020 the lead VRC at Able Futures called Tracey. The lead VRC apologised to Tracey for the lack of contact and informed her that another VRC had

been allocated to her. It was noted that Tracey was happy to continue with her new VRC.

3.2.130 **Found intoxicated ED attendance** - At 07:11 on 26 January 2020 Tracey was brought into the Emergency Department at PRUH, by ambulance. LAS have no record of this, but emergency ambulance calls are generally linked to home addresses. She admitted to using drugs and alcohol but denied an overdose. She was diagnosed with a low Glasgow Coma Scale (GCS) on arrival, and this was diagnosed as a result of drugs and alcohol and a suspected head injury. Her CT scan showed no abnormalities. She was treated and once she had recovered capacity was allowed to discharge. There are no records of any attempted contact with Oxleas. Tracey's GP was notified.

3.2.131 **Call to NHS 111 and LAS** - At 18:50 on 3 February 2020 Sarah called NHS 111 to report that her friend, Tracey, was an alcoholic with anxiety and PTSD, and she was depressed and unresponsive. After telephone assessment an LAS ambulance was requested to attend the address in Bromley. The ambulance was cancelled en route to the address as Sarah called and said that Tracey was now responsive and fine. Within an hour Sarah called back and said that Tracey was unresponsive and had taken medication and alcohol. The LAS crew arrived and assessed Tracey, they were informed that she had a history of alcohol abuse, PTSD and overdoses. Following an assessment it was decided that conveyance to hospital was not needed. Sarah was advised to call back if Tracey deteriorated and Tracey was asked to keep her appointment with her psychiatrist.

1.1.1 On 6 February 2019 Oxleas ADAPT worker contacted Tracey to discuss her thoughts on Care Coordination. It was confirmed that allocation of a CCO was not a requirement for Tracey to access psychology services. Tracey reported feeling much better and receiving support from work. Tracey said the reason for her attending DVH was due to receiving news that her cousin had died. She had started telephone counselling, which was helpful. Tracey stated that she did not need an allocated worker but wanted to stay on the waiting list for therapy.

3.2.132 ADAPT followed up the meeting with a call to Sarah, who had previously called. Sarah reported that Tracey was drinking large amounts of alcohol and experiencing night terrors. There had been numerous calls to LAS. Sarah was concerned that her child may witness Tracey drunk, and although this had not yet happened, information was provided regarding Pier Road Project (PRP) substance misuse services. The case was closed for care coordination at Tracey's request. There were no safeguarding issues to be reported in relation to Sarah's child.

3.2.133 **Domestic Incident - Criminal Damage - Tracey's arrest** - On 11 February 2020 the MPS were called to Mehmed's home in Bexley. It was reported that Tracey was trying to smash a window. Police arrived and spoke to a woman, identified as the then current girlfriend of Mehmed. Tracey had left by the time that police arrived. Mehmed refused to provide MPS with Tracey's details. He did say that this was the third time that it had happened. The damage at the premises was considered to be old and it had been taped up. Mehmed was given advice regarding non-molestation orders, but he said he was moving soon. Tracey was not recorded as a suspect and was not contacted by the

MPS. Police created a Non-Crime Domestic CRIS Report. There was no MERLIN report submitted.

3.2.134 On 26 February 2020 the VRC from Able Futures telephoned Tracey. Tracey said that she had accessed support from the GP, psychiatrist, Adult Mental Health Team, and occupational health. Her employers had supported reasonable adjustment in the workplace. Tracey had crisis numbers and support services details. Tracey explained that she was currently on the waiting list for CBT trauma therapy and had last contacted them the previous day to chase that up. Tracey said she was attending work for 40 hours per week. She found work helpful and wanted to continue to attend. The VRM explored coping strategies with Tracey. They agreed to meet again on 17 March 2020. Tracey was set the goal to develop strategies to help her staying in work when she was feeling anxious. There were no safeguarding concerns raised.

3.2.135 On 6 March 2020 Sarah was away from home when she received a phone call from her partner. Her partner reported that Tracey had suffered another 'episode'. Sarah advised "to keep an eye on her and to call an ambulance if her breathing goes shallow or if they believe they need to call an ambulance". Sarah later advised Tracey that she needed to leave her home as she was causing too much stress for her family.

3.2.136 On 7 March 2020 Sarah arrived home and found that Tracey had left the premises.

3.2.137 **Suspected overdose - ED attendance -** disclosure **of domestic abuse** - At 00:09 on 8 March 2020 Tracey was admitted to the ED at PRUH after being found unconscious in an alleyway. Tracey later said she had taken an overdose of ibuprofen and alcohol. She reported a history of low mood, worsening over the past few weeks. A Social Work entry on the PRUH records stated that Tracey was living with friend as she had a 'fight with her partner'. Tracey had then fallen out with the friend but would be going back to the house she shared with her partner, she was not homeless. She knew how to contact the council if she feared becoming homeless. The Psychiatric Liaison Nurse (PLN) reviewed Tracey. Tracey was offered a referral to a Co-Occurring Mental Health Alcohol and Drugs (COMHAD) practitioner and she declined this. An email was sent to Oxleas MHLT.

3.2.138 Oxleas MHLT recorded a referral from PRUH that Tracey was brought in by LAS. Her head CT scan and blood tests had returned as 'normal'. It was decided that Tracey would be assessed by the MHLT.

3.2.139 At 17:22 on 8 March 2020 Tracey was seen in a face-to-face appointment by the Oxleas MHLT. She could not recall what led up to her collapse the night before. She discussed past trauma and current stressors. She denied that she had a drinking problem and did not feel that she needed help. She denied any thoughts of self-harm or plans of intent. It was decided to inform ADAPT of the events and continue to wait for therapy. Details were given for agencies supporting with alcohol issues, but Tracey declined. Crisis numbers were provided.

3.2.140 On 10 March 2020 the Oxleas ADAPT worker telephoned Tracey. Tracey declined an offer of care coordination and said that she did not feel she needed further support.

She declined support linking with alcohol services. It was agreed Tracey would continue to wait for psychology support and her case was closed to care coordination.

3.2.141 **ED Attendance - suspected overdose** - On 11 March 2020 Tracey was taken to the Emergency Department at PRUH by LAS. Tracey was found by hotel staff after she did not check out on time, suspected to have taken an overdose. On this occasion her diagnosis was intoxication and an ibuprofen overdose. Tracey had bottles of alcohol with her and continued to drink in the ED. Tracey refused to be assessed by MHLT. Her GP was notified of her ED attendance and the letter states that Tracey required a mental health follow up and she was to be admitted.

3.2.142 At 08:50 on 12 March 2020 the Oxleas MHLT reviewed Tracey's case and agreed to close the referral as she had declined assessment.

3.2.143 At 11:20 Tracey was re-referred back to Oxleas MHLT as Tracey had been reported to have taken an overdose in the ED at 07:00. Tracey was seen by the COMHAD practitioner, but they were due to see another patient. When the COMHAD practitioner returned, Tracey was vomiting. COMHAD practitioner noted Tracey had been offered a COMHAD referral four days prior. As there was no current consent it was noted that the Psychiatric Liaison Nurse should assess Tracey the next day and ask for COHMAD consent.

3.2.144 On the same day a friend of Tracey, Sarah, called Tracey's GP. She said that Tracey was currently living with her. She was worried about her recent actions and decline in health. The friend said she would see if she could get Tracey to attend the GP with her.

3.2.145 On 13 March 2020 the Oxleas MHLT reviewed Tracey's presentation at PRUH. It was decided that the COMHAD practitioner would offer Tracey an assessment and MHLT would assess Tracey when she was medically cleared.

3.2.146 Tracey was assessed by the MHLT. She reported feeling much better and felt stupid for taking an overdose. She took overdose to deal with alcohol intoxication. She said that she had no suicidal thoughts and wanted to go home and have a bath. She had been signed off work for a month. Tracey denied she had a problem with alcohol. She did not give MHLT permission to contact her friends or family. It was decided to discharge Tracey when she was medically cleared and to inform the CMHT of the presentation at hospital.

3.2.147 Oxleas ADAPT team contacted Tracey. Tracey said that she felt stupid and had learned a lesson from the incident. She denied misuse of alcohol. A face-to-face assessment was booked for three days before she was found dead.

3.2.148 In March 2020, ten days before Tracey was found dead, at 08:06 police were called to a disturbance at Mehmed's home address in Bexley. Police officers spoke to a woman (not Tracey) who said she had had a verbal argument with her boyfriend, Mehmed. The incident was recorded as a Non-Crime Domestic Incident.

3.2.149 At 09:45 MPS were called by staff at PRUH asking if Mehmed was in custody, as he was due to collect Tracey from the hospital. The police established that Tracey had

been texting Mehmed, who had agreed to collect her. Mehmed told Tracey that he was currently in Bristol. Tracey told the police that she could not go home, as she did not have house keys. Tracey was advised that the police had no knowledge of Mehmed's whereabouts.

3.2.150 **Domestic Incident - Criminal Damage - Tracey's arrest** - Later that night at 22:58 a passer-by called MPS to a woman banging on the door of Mehmed's home. Police arrived to find Tracey on the driveway, with bags and a suitcase. She was intoxicated and had blood on her clothes. This was from an injury to her arm caused when she had broken a window at the address. Tracey informed the police that that was her home address, but she had not lived there for two years. An ambulance was called but Tracey refused treatment when they arrived. The LAS crew deemed that Tracey had the capacity to refuse to go to hospital. Tracey was arrested for criminal damage.

3.2.151 Tracey told police that she had been in hospital due to an overdose. She stated that she might be pregnant. She said she had cut her arm banging on a window that was already broken. She was trying to get Mehmed's attention, because she thought he was at home with another woman. The police contacted Mehmed in Bristol and he said that he did not wish to press charges. The case was NFA'd, and Tracey was released from custody. There were no onward referrals made by police. A 124D was completed and risk was assessed as 'STANDARD' as Tracey had been arrested. A 'Non-Crime Domestic' CRIS report was created. A MARAC referral was not made as the criteria had not been met and Tracey had not been subject to a MARAC in the last 12 months.

3.2.152 **Housing Notification of Homelessness -** Seven days before Tracey was found dead, Bexley Housing recorded that Tracey had attended the Civic Offices for homeless assistance. An appointment was booked for Tracey to make a homeless application in three days' time.

3.2.153 Six days before Tracey was found dead, the Able Futures VRC telephoned Tracey. Tracey said that she had been in hospital and seen a psychiatrist and the hospital had contacted her GP. A referral had been made to the Erith Mental Health Team. Tracey had crisis numbers and an allocated support worker. She said that she was living in a hotel and had a support coordinator. She woke up that day feeling "in control and much better place". She was not having to worry about the restrictions of living with a friend. She was staying in a hotel. She had seen the housing department the previous day and had an appointment with 'homeless' booked. She expected to go into temporary accommodation. She was on the wating list for talking therapies and meeting her support coordinator on the same day as the 'homeless' appointment. She would be meeting her coordinator every week until she was seen by a therapist. A support plan was agreed between VRC and Tracey, this included the use of crisis numbers and maintaining contact with GP and her support coordinator.

3.2.154 On the same day, Oxleas MHLT contacted ADAPT to ensure that the information regarding Tracey's presentation on 12 to 13 March 2020 had been received and actioned.

3.2.155 Five days before Tracey was found dead, she phoned Sarah to apologise for what had happened. Tracey said that she was staying in a hotel room paid for by Mehmed.

3.2.156 Four days before Tracey was found dead, she attended the Hurley Group Urgent Care Centre at Queen Mary's Hospital, Sidcup following the injury sustained to her arm four days prior. A dressing was applied and wound care advice was given.

3.2.157 On the same day, Bexley Housing completed a homeless application with Tracey by phone. Tracey contacted Oxleas ADAPT to give permission for information to be shared with Bexley Housing. Bexley Housing emailed Oxleas for information to support the housing application.

3.2.158 Three days before Tracey was found dead Tracey told Sarah that she was going to collect keys for a new place to live. She did not disclose the address but said she would attend Sarah's home to collect some belongings.

3.2.159 On the same day, Tracey did not attend her appointment with ADAPT. She was contacted by phone at 11:20. She said there was confusion over the appointment and whether Tracey had the correct information. Tracey felt overwhelmed by things. Her partner did not collect her from hospital, and she was picked up by the police. She stayed overnight at the Police Station. She had been given temporary accommodation and she was unhappy about that. It was arranged that further telephone contact would take place on the date she was later found dead.

3.2.160 Police also established that on this day Mehmed had transferred £5 to Tracey's bank account and this had been spent in a supermarket in Bexley.

3.2.161 **Oxleas designate HIGH RISK** At 11:44 ADAPT held a team meeting and Tracey was placed in the "RED Zone" this is a designation of HIGH RISK.

3.2.162 Two days before Tracey was found dead, Sarah received a telephone call from Mehmed asking if she had heard from Tracey. Mehmed sounded calm during the call. Sarah said that she had spoken to Tracey the previous morning. Mehmed told Sarah that he had spoken to Tracey the previous afternoon, when she said there was not electricity or gas at the new property. During the same call, Mehmed told Sarah to report Tracey as a missing person.

3.2.163 Sarah called hospitals and could not locate Tracey, she also called Tracey's mother.

3.2.164 **Reported Missing** - Sarah called the MPS to report Tracey missing. She said that Tracey had been staying with her, but she had asked her to leave due to her deteriorating behaviour. Tracey had been staying in a hotel in Sidcup, but had not paid for her room and had left her belongings there. Tracey had not been to work and her mobile phone was switched off. Sarah told the police that she was concerned about a recent incident where Tracey was found, about to jump in front of a train. A missing person's investigation - MISPER, commenced and was classified as "MEDIUM to HIGH RISK". Enquires show that Tracey had spoken to her care coordinator and collected keys to a new address in Bexley on the day before or after the MERLIN report was completed.

3.2.165 One day before Tracey was found dead, MPS made enquiries with Bexley ASC on whereabouts of Tracey. Information was provided to police that Oxleas may have placed Tracey in an address. MPS then contacted Oxleas and the new temporary

housing address in Bexley was provided. Information was shared with CAT Team (Mental Health Practitioner and Police Response). ADAPT were informed of the MISPER enquiry.

3.2.166 At 11:23 on the day Tracey was found dead the MPS called at Tracey's new temporary address. They receive no reply after repeated knocking. Mehmed had called the MPS on numerous occasions requesting the new address, stating he wanted to force entry. This was refused as there were concerns about the history of domestic abuse. Mehmed told the police that Tracey had contacted him three days prior, where she commented about trying to hang herself from the curtains. When he was asked if the comments were verbal or in a text, Mehmed became abusive and ended the call. The landlord was contacted and attended with keys. Police were no longer present.

3.2.167 **Found deceased** – When the landlord entered the premises at 14:49 Tracey was found, hanging inside her temporary home. LAS were called by MPS at 14:50. The ambulance crew arrived and assessed and recorded Recognition of Life Extinct at 15:08. A Police Inspector attended the scene. He recorded that the bedroom curtain rail was broken. Tracey was found inside a bedroom wardrobe, using a shower curtain as a ligature. It was the Inspector's opinion that the death was not recent. The police considered that there was no evidence of third-party involvement. There were no concerns of inconsistent injuries. There were no notes left at the premises or indications of her intent.

4. Overview

4.1 Summary of Information from Family, Friends and Other Informal Networks

Tracey's mother - Anne

4.1.1 Anne has helped to provide details of her daughter's life and some of this has been included in "Background Information" in this report. Tracey spent her early years living in Kent. Anne described her daughter as 'bubbly and chatty'. She was seen as being artistic and had a good singing voice. Tracey left school when she was seventeen. She had a boyfriend after leaving school and there were no known problems in the relationship and they stayed together for around five years.

4.1.2 After leaving school she was mainly in employment. She took time off work to help her father when he was terminally ill. Tracey was described as happy and bubbly when she was at work, but her mother had not seen that in the past few years.

4.1.3 Tracey then started a relationship with Mehmed. Anne believed that Mehmed had good parents and two brothers. Tracey's parents never met Mehmed's parents. She believed they met through a mutual friend. Mehmed was Turkish and had two brothers, and a son who was now around 20 years old. Mehmed's Turkish background was not of concern for Anne.

4.1.4 It initially appeared that Mehmed was trying to impress Tracey, but the relationship later developed to a point where Mehmed was treating Tracey "like nothing". The couple first lived in Mehmed's flat in Bromley and then moved to Bexleyheath. After this move contact reduced between Tracey and Anne and things started "going downhill". Tracey stopped seeing Anne and would not contact her for months. At one point Mehmed made threats to Anne. Mehmed threatened to smash the door of her house and described Tracey to Anne as being 'a drunk'. Mehmed said that Tracey's drinking was her own fault.

4.1.5 When asked about substance misuse, it was believed that Mehmed dealt drugs. She knew that Tracey used cannabis but was not sure about other drugs. When asked about alcohol she said that if something went wrong, Tracey would drink to cope but it made things ten times worse. "I saw her drunk, it got more frequent, two or three times I'd get a phone call per year. From what I heard it was a lot more. Whenever there was a problem and he'd go away and take everything, and she was left there, and her escape was to drink. I found bottles everywhere. Wine bottles."

4.1.6 A key event for Anne was an occasion when Tracey's finger was bitten off by a dog. Mehmed had six 'staffie' dogs at the house. Some men were after Mehmed and came to their house. Tracey tried to stop the men getting to Mehmed and at that point one of the dogs bit her finger off. Anne said, "It looked like something out of a horror movie."

4.1.7 Tracey's father died in approximately 2015. Tracey is described to have to found this very traumatic. When Tracey's father died he left her £135,000 in his will. Anne believed that Mehmed took most of that money when Tracey was drunk. Tracey's mother noticed

that Mehmed had started being nice to her daughter when her dad was dying. Tracey told Anne that she was lending money to Mehmed. Mehmed had a mortgage but he was in arrears. Tracey built up credit card debts and a lot of this was for petrol although she did not drive. At the time of Tracey's death she was £11,000 in debt. Her mother felt that Mehmed did not want her after she had run out of money.

4.1.8 A key event for Anne was when her daughter was assaulted in 2018. The police contacted Anne to inform her and advised her to come and see her daughter immediately. The officer said, "I've not seen someone alive with the amount of bruising on her body". Tracey was unrecognisable to her mother and there was not a part of her body that was not bruised. Her house was being treated as a crime scene. At that point Tracey was going through 'withdrawal'. She described the officers that she initially spoke to as 'wonderful'; they worked beyond their hours to help her.

4.1.9 Anne was not impressed with the police follow up enquiries. She was not allowed to be with her daughter to support her whilst a detective spoke to her. When the photos were taken of Tracey, Anne was left standing outside her own house for two hours.

4.1.10 Around this time it was discovered that Mehmed had taken £19,000 from Tracey's bank account. Six weeks later she returned to Mehmed and withdrew her statement about the assault and said someone else was responsible. This was the last time that Anne saw her daughter. She did not speak to any other agencies to get support for Tracey. Tracey was adamant that there was nothing wrong, and she did not need help.

4.1.11 Tracey worked in a leisure centre and she had been there for quite a few years. Tracey was very popular in her work and liked working in an environment where she could meet lots of people. Anne knew there were concerns that Tracey was absent from work, but believed work were trying to help her.

4.1.12 When asked if there was anything she felt could have been done to help Tracey, Anne said (referring to the assault in 2018) "I just think with the police, although Tracey retracted the statement, to me there was enough evidence to prove what he did and about the money. She was let down, all they saw was that she was a drunk, not why she was drinking, why she was in this state. Whether I could have done more I don't know, because she wouldn't let any of us into that side of her life… I just think there was so much evidence that time, and even looking back on the things there could have been more done to take him further down the line."

4.1.13 Anne also expressed concerns about her treatment for mental ill-health. She said, "I feel she was let down, I don't quite know what happened but Mental Health was involved at Princess Royal, but she wasn't sectioned and within two days back out and a week and a half later she killed herself. I feel there could have been more, she could have had more support or be kept in for longer to stop her from having these suicidal thoughts."

4.1.14 She went on to say "I couldn't do a lot with what went on because Tracey hadn't allowed me and I hadn't seen her for over a year and then she was dead, there wasn't anything I could do. She was an adult, she was 36. I didn't know anything until they said she

was missing, but I knew then on the Friday that my daughter was dead because she would have contacted us otherwise."

Sarah Tracey's friend - who reported her missing

4.1.15 Sarah first met Tracey at Primary School they had been close friends ever since. They went to the same secondary school too. They knew each other's family and would stay visit. Sarah described Tracey as *"Always bubbly and kind. Would send lovely cards and we were friends for life."*

4.1.16 Tracey had really nice boyfriends in the past, before Mehmed, and there were never any problems. Tracey was bulimic and Sarah would sometimes speak to her old boyfriend when he was concerned about Tracey's eating disorder. Tracey would sometimes 'go off the radar' for a bit but always got back in touch.

4.1.17 Tracey met Mehmed through mutual friends when she was 19 to 20 years old. Tracey and Sarah would go to clubs and drinking and that was where she met Mehmed. Mehmed came from a good family. He owned property in South East London. Tracey moved into Mehmed's home in her 20s. They were happy and they had loads of dogs, Staffies, Tracey loved dogs.

4.1.18 Sarah did not have any concerns about the relationship at the outset. She later found out that Mehmed was beating Tracey up. Sarah saw Tracey with bruises and she eventually opened up and told her about the abuse. Mehmed was hitting Tracey quite frequently. Mehmed used the dogs to control her, in that he bought the dogs and that would keep her at home. This led up the incident where Tracey's finger was bitten off. Tracey told Sarah that Mehmed has assaulted her and was beating Tracey; when she fought back, the dogs then bit off her finger. Tracey did not want to tell the whole truth to the authorities because she did not want the dogs put down, as she loved her dogs.

4.1.19 Sarah saw Tracey once every few months. Sarah knew that Mehmed was into heavy stuff, dealing drugs. He was selling large quantities. On one occasion Tracey told Sarah that Mehmed had been kidnapped and beaten up by drugs dealers. Mehmed owed money to drugs dealers. Tracey was quite relieved that Mehmed was away from her during the kidnap. They had double doors on the house for security and Tracey would be locked in the house to keep safe.

4.1.20 Sarah was asked about the occasion when Tracey was seriously hurt with fractures to the face. Sarah said it was drug dealers that were involved. Mehmed was away in Amsterdam and had an alibi. Sarah believed that Mehmed's girlfriend set up Tracey knowing she was alone in the house. Two men came in and 'beat Tracey to a pulp'. Tracey knew who they were, but did not say.

4.1.21 Mehmed was assaulting Tracey regularly. She would show Sarah pictures of her injured face. On one occasion Sarah went to see Tracey, she witnessed an assault. As Sarah entered the house she saw Mehmed with hands around Tracey's throat. He saw Sarah and stopped. Sarah immediately took Tracey away from the premises.

4.1.22 It came to a point where Mehmed wanted Tracey out of his house. He moved Tracey to the flat in Kent and moved his new girlfriend into his home in Bexley. Mehmed was

paying the rent on Tracey's flat at first but later stopped paying it. Tracey was evicted and had to move in with Sarah.

4.1.23 Tracey was afraid of sleeping alone at night. She stayed with Sarah for about three months. During this time Tracey was drinking a lot and off work. Sarah was aware that Mehmed would come to the area near Sarah's home and give Tracey money. Sarah would not allow him at her house. Mehmed would wait at the bottom of the road to meet Tracey and give her £15-£20. Tracey would spend the money on alcohol.

4.1.24 Mehmed was keeping Tracey hanging on with the promise of money. He had taken a large amount of money from her and had promised to pay it back. Mehmed had accessed Tracey's bank account through her phone. The phone had eye scanner security on it. Mehmed would scan Tracey's eye when she was drunk and transfer her money to his account. Tracey would also spend her money on herself and Mehmed. Tracey discussed with Sarah how she could get her money back from Mehmed. She thought she could get a charge against his house, so that she could be given a proportion of the money when Mehmed sold it. Mehmed had repeatedly told Tracey that she could have her money when he sold his house.

4.1.25 Sarah was asked what she felt could have been done to help Tracey. She said that she had been trying to get help for Tracey, speaking to her doctor and counsellor. Tracey kept trying to kill herself. At one point Sarah had to ask Tracey to leave her home as she was worried about her being around her own daughter. Sarah told doctors that Tracey needed to stay in hospital. Sarah was asked if Tracey ever talked about hanging, she said that she never did. Her attempts at suicide involved pills and alcohol. When Tracey sobered up, she would apologise.

4.1.26 Three days before her death Tracey moved into a new place. Sarah did not know where it was. Mehmed spoke to Sarah and named the road where Tracey was moving to. On the day before her death Tracey had been seen drunk in a supermarket. Sarah found out she was dead the next day.

4.1.27 Although Sarah had reported Tracey missing, the police never told her that Tracey was dead. She does not remember the police speaking to her or taking a statement from her after Tracey's death. Sarah said she was pretty 'messed up' after Tracey's death.

4.1.28 Sarah was asked if she felt anything could have been done to help Tracey. She said that Tracey was mostly let down by adult mental health. Sarah tried to help her and called helplines 'But it was falling on deaf ears'. Sarah did not know how to help Tracey, Tracey would go into hospital but would then be released.

4.1.29 When the MPS spoke to Sarah in 2022 she made reference to suicide by stating "I just feel confused as to why the previous times where she tried to commit suicide through overdosing and the way she was found was a completely different scenario, on her own, isolated".

4.2 Summary of Information known to the Agencies and Professionals Involved

4.2.1 Able Futures

4.2.2 Able Futures are a private service offering support for individuals with mental health issues. The company employs Mental Health Professionals. Tracey self-referred to the service through an employer assistance programme. Able Futures aims to provide confidential advice to clients to enable them to cope with work, whilst managing a mental health condition.

4.2.3 Tracey was referred to the service on 7 August 2019 and assigned a Vocational Rehabilitation Consultant (VRC) to develop an initial support plan and then had limited contact. She was assigned a new VRC and had two telephone contacts shortly before her death. The company did not identify any safeguarding concerns and there were no risk assessments.

4.2.4 There were 11 contacts recorded in the submitted chronology.

4.2.5 **Clarion Housing**

4.2.6 Clarion Supported Housing Services are part of Clarion Housing Association. Clarion are commissioned by Kent County Council (KCC) to provide domestic abuse services across north and south Kent; services include refuge provision, community outreach for medium risk victims and Independent Domestic Violence Advisor (IDVA) services to high-risk victims. Clarion also deliver IDVA services in two Kent hospitals; Darent Valley and the William Harvey hospital.

4.2.7 Tracey was referred to the IDVA service when she was known to have moved into the Dartford, Kent area from Bexley in June 2018. This was a result of a MARAC to MARAC referral. As a result of the transfer into the area the Clarion IDVA made contact with Tracey. Tracey declined IDVA support. Clarion updated the Kent MARAC and closed the case.

4.2.8 There were six contacts recorded in the submitted chronology

4.2.9 **Dartford Borough Council / Sevenoaks District Council Revenue and Benefits Shared Services**

4.2.10 There was limited contact with the council in Kent. Records show that Tracey telephoned the Council Tax Department on 10 August 2018 informing them that she had moved into a flat in Dartford on 12 July 2018. The second call was on 20 December 2018 confirming she had left the address - there was no mention of Mehmed.

4.2.11 A total of two contacts were made.

4.2.12 **Dartford and Gravesham NHS Trust**

4.2.13 Dartford and Gravesham NHS Trust run Darent Valley Hospital (DVH). DVH is an acute NHS Hospital. Tracey attended the Emergency Department (ED) on two occasions during the period reviewed. Her first visit was on 24 January 2013. She was taken to hospital by her father, after he found her collapsed and intoxicated. She was discharged the following day. During her stay Tracey stated that her boyfriend ‘beats her up’. Her second was on 10 January 2020 when she was found collapsed on a bus, with a half-empty bottle of vodka. When Tracey regained consciousness, she denied taking an overdose. She was referred to the Psychiatric Liaison Service.

4.2.14 A total of two contacts were made.

4.2.15 **GP Practice, Bexley**

4.2.16 The medical centre provides Primary Care GP services on a number of sites in Bexley. Both Tracey and Mehmed were registered at the practice. Tracey was registered at the practice from November 2009 to the date of her death. Mehmed was registered with the practice since 29 March 2017 and throughout the period under review. The practice has provided chronology information on the contact with Tracey from June 2018. This was raised with the CCG and they have confirmed that the IMR questions considered Tracey's whole registration at the practice.

4.2.17 The information from the GP starts on 22 June 2018 with the recording of the assault by Tracey's partner. She informed the practice that she would be registering with a new practice. Tracey was seen again in August 2018 and there is no comment on whether she registered with a new practice. Tracey was then seen by the practice in July 2019 and was seen on a number of occasions through to January 2020. During the visits Tracey discussed her past trauma and she requested a diagnosis of PTSD. She was referred to the Oxleas CMHT. There was liaison between the GP and the CMHT. Tracey saw her GP on a number of occasions to report a low mood and panic attacks. The practice was aware of links with CMHT and advised on going to ED if in crisis. In December 2019 and March 2020 a friend of Tracey's contacted the practice with her concerns about Tracey. The friend was advised on how to get Tracey to access healthcare.

4.2.18 There were 15 contacts recorded in the submitted chronology.

4.2.19 **The Hurley Group - Urgent Care Centre**

4.2.20 The Hurley Group provides two Urgent Treatment Centres (UTC) at Queen Mary's Hospital, Sidcup and Erith District Hospital. These provide GP-led walk-in unscheduled care services for patients in Bexley and surrounding boroughs. A GP Out of Hours Service is also run by the Hurley Group from the UTC at Queen Mary's Hospital, Sidcup.

4.2.21 Tracey attended Hurley Group UTCs on two occasions. On 17 May 2018 when she reported that she had fallen down stairs four days prior. Four days before she was found dead, in March 2020, Tracey attended the UTC to report that she was concerned about an injury to her arm sustained four days prior. There were no reported concerns or disclosures of domestic abuse.

4.2.22 Mehmed presented to the UTC with minor medical complaints in January 2019.

4.2.23 There were four contacts recorded in the submitted chronology.

4.2.24 **Kent MARAC**

4.2.25 Kent MARAC is not an agency. The MARAC is a meeting where information is shared on domestic abuse cases between representatives of police, health, child protection, housing practitioners, probation and other domestic abuse specialists from the statutory and voluntary sectors. The Kent MARAC IMR was completed by Kent Police.

The IMR author provided information on the MARAC to MARAC referral from Bexley MARAC, dated 1 August 2018.

4.2.26 The Kent MARAC, listing Tracey's case, was held on 15 August 2018. The MARAC was not informed of any further incidents relating to Tracey or Mehmed after that date.

4.2.27 It is Kent MARAC policy that a case should be heard again at MARAC, if there is another incident within 12 months of the mention at MARAC. That incident should amount to a criminal offence.

4.2.28 There were three contacts recorded in the submitted chronology.

4.2.29 **Kent Police**

4.2.30 Kent Police were the police service for the Dartford area, where Tracey lived from August 2018 until November 2019. Kent Police were first made aware of Tracey moving into the area when the Central Referral Unit were notified of the transfer from Bexley MARAC.

4.2.31 The CRU is at Kent County Council premises where police are co-located with Kent Child and Adult Social Services, Probation, Education and Health. The CRU also have an information coordinator placed in the MASH with Medway Child and Adult Services**.** The CRU team provide a multi-agency initial response to those at risk of harm from domestic abuse. The CRU also supports Local Policing Teams who are responding to domestic abuse incidents where vulnerable children or adults have been identified at the scene, to conduct multi-agency checks to inform the risk assessment. CRU are responsible for screening all domestic abuse reports on vulnerable adults who may be at risk of harm due to involvement or exposure to abuse, and ensuring these reports are lawfully shared with partner agencies.

4.2.32 Kent Police chaired the MARAC where Tracey was mentioned in August 2018 and were panel members. It is the responsibility of the Kent Police, Vulnerability Investigation Team to research the current circumstances of a case before a MARAC meeting.

4.2.33 Kent Police also responded to a reported domestic incident on 17 February 2019 where Tracey and Mehmed were seen over a 'verbal disagreement'. The original 'HIGH RISK' report was later downgraded to 'MEDIUM RISK'. Although this incident took place six months after the Kent MARAC was held, it was not reported by the police to the MARAC.

4.2.34 On 6 June 2019 police were called when the landlord of Tracey's address was trying to get into the premises. This was recorded as a dispute over rent. On 1 November 2019 Tracey called Kent Police concerning property being held by her landlord.

4.2.35 There were four contacts recorded in the submitted chronology.

4.2.36 **Kings College Hospital NHS Foundation Trust**

4.2.37 KCH provides a full range of local hospital services for people in the London boroughs of Lambeth, Southwark, Lewisham and Bromley as well as specialist services for

patients across the South East and beyond. This includes the Princess Royal University Hospital in Bromley, a neighbouring borough to Bexley.

4.2.38 Tracey was under the care of the Trust from 21 June 2016 to 11 March 2020. In June 2016 she was referred to the Oral and Maxillofacial outpatient department after she sustained a nasal bone fracture. She explained that this was as a result of a trip and falling against a table. She was treated for the injury and discharged. This appears to be as a result of the assault reported to the police. In May 2018 Tracey was referred back to the Oral and Maxillofacial department by Lewisham and Greenwich NHS Trust. Tracey was treated for a broken cheekbone. This appears to be linked to the reported fall down stairs after Tracey was startled by dogs. On 26 July 2018 Tracey attended PRUH ED with shortness of breath. On 4 August 2018 Tracey was brought into the PRUH by the LAS due to hallucinations, it was reported that she had been living in a hotel since 16 June 2016 due to domestic abuse. Tracey left without being seen. Tracey had four further attendances at the PRUH where she was seen either in the ED or the Clinical Decision Unit (CDU) on the 20 December 2019, 25 January 2020, 08 March 2020 and the 11 March 2020. Reasons for attendances relate to overdoses/ suicidal ideation, alcohol and drug intoxication and head injuries. The last three presentations are similar with Tracey being found unconscious or incoherent at a bus stop, in an alleyway and in her hotel room. Critically two of the final four attendances occurred in March 2020 shortly before her death.

4.2.39 There was only one mention of domestic abuse within Tracey's records, this related to the event on 4 August 2018, when Tracey left without being seen.

4.2.40 There were 19 contacts recorded in the submitted chronology.

4.2.41 **Lewisham and Greenwich NHS Trust - Queen Elizabeth's Hospital**

4.2.42 Lewisham and Greenwich NHS Trust provides acute services to the people living in Greenwich and Bexley, and acute and community services to people mainly living in Lewisham. The Trust has two hospital locations; Queen Elizabeth Hospital (QEH) in Woolwich and University Hospital Lewisham (UHL) in Lewisham. The Trust have had two IDVAs based at the QEH site since 2015/2016.

4.2.43 Tracey attended the ED of QEH on a number of occasions and also had scans following a reported assault. Her first visit during the period under review was 27 July 2013 owing to a suspected overdose, Tracey also attempted an overdose whilst in the ED. On 8 June 2016 Tracey had facial x-ray and CT scans that revealed fractures. The hospital holds no information on who referred Tracey or any questions being recorded about abuse. On 7 May 2018 Tracey attended the ED as she reported a fall down stairs, having been startled by dogs. The possibility of domestic abuse was not explored. On 16 June 2018 Tracey had a CT scan of her thorax, neck and spine following an assault. There was no information on whether this incident had been reported to the police. On 27 June 2018 Tracey was brought into the ED by the LAS. She had been found drinking outside her home and was referred to the substance misuse service. Finally on 10 January 2020 Tracey was brought into the ED by the police. She left the ED before she could be seen by staff.

4.2.44 There were no DASH assessments completed by the Trust and no referrals to domestic abuse services.

4.2.45 There were 10 contacts recorded in the submitted chronology.

4.2.46 **London Ambulance Service NHS Trust**

4.2.47 LAS are responsible for Emergency Ambulance and NHS111 services for London. If an Ambulance crew have safeguarding concerns a form is submitted to the internal referral department. The referral is then reviewed and forwarded to Local Authority Single Point of Access. The LAS do not routinely refer to MARAC.

4.2.48 In July 2012 the LAS responded to a call to Mehmed's home in Bexley. It was reported that Tracey had been assaulted by Mehmed and she did not feel safe. Tracey was taken to QEH. No Safeguarding Referral was made.

4.2.49 The first incident within the review timescales was on 20 July 2013 when police called LAS to Tracey after her finger had been bitten off by a dog, whilst in a fight. It was not recorded who else was involved in the fight. She was taken to QEH ED. No Safeguarding Referral was made.

4.2.50 On 16 June 2018 LAS responded to a 999 call to Tracey being injured and locked in her house. Police reported recent domestic abuse to the LAS crew. Tracey was treated for severe facial injuries and taken to the ED at QEH. No Safeguarding Referral was made.

4.2.51 On 3 August 2018 LAS were called to a hotel in Sidcup where Tracey was found hallucinating. The ambulance was cancelled when it was established that Tracey had left the hotel. LAS were called back to the same hotel in the evening with concerns that she had returned and was a danger to herself. The crew attended and found Tracey presenting as manic and not being rational. It was reported that she had been residing in hotels due to a domestic violence case. She was taken to PRUH and handed over to ED staff. The LAS safeguarding team commented that if the police were present it would have been their responsibility to complete a MERLIN or MARAC referral if appropriate.

4.2.52 On 19 December 2019 a friend called NHS111 to report Tracey, staying with her in Bexley, having night terrors and missing medical appointments. LAS did not attend. A further call was made to NHS111 stating that Tracey was unconscious, and an ambulance attended. The ambulance crew took Tracey to PRUH.

4.2.53 On 6 January 2020 the LAS received a 999 call from the same friend reporting Tracey in pain and difficult to wake. Tracey was again taken to PRUH. On 3 February 2020 LAS were called again by the friend with concerns that Tracey was unresponsive having taken medication or alcohol. LAS attended and considered that conveyance to hospital was not needed. There was a call to 999 on 7 February 2020 to Tracey having a breakdown at her friend's home. Tracey was seen and not taken to hospital. Ten days before Tracey was found dead, LAS were called by the police to Tracey having a cut to her arm outside Mehmed's address. Tracey declined to be treated. The LAS were also called to Tracey's address after her landlord had found her deceased.

4.2.54 There were 16 contacts recorded in the submitted chronology.

4.2.55 **London Borough of Bexley - Adult Social Care**

4.2.56 The London Borough of Bexley provides the Local Authority ASC service for residents of the borough operating to the Care Act 2014.

4.2.57 Tracey first came to notice of ASC on 6 August 2018 when a police MERLIN form was received and forwarded to Oxleas mental health services. The next contact was on 7 January 2020 when a person representing themselves as a friend of Tracey reported concerns in supporting her due to deteriorating mental health and alcohol misuse. The friend was referred to mental health services. The friend made further contact on 11 January 2020 with Out of Hours service following Tracey's admission to hospital due to alcohol intake. They wanted to discuss an emergency care package for Tracey and to be recorded as her next of kin. The friend was advised to go back to the mental health service to follow up. On 22 March 2020 ASC received a call from the MPS conducting a missing persons enquiry. The police were informed that Tracey had been placed at an Oxleas premises in Dartford. There were no concerns on domestic abuse reported to ASC.

4.2.58 There were six contacts recorded in the submitted chronology.

4.2.59 **London Borough of Bexley Housing**

4.2.60 Bexley Homeless Prevention and Assessment Teams are based within the Bexley Housing team. They take and assess homeless applications from people who are threatened with homelessness or who are homeless to determine whether the Authority has a duty to accommodate them both temporarily and permanently. They also assist homeless applicants in sourcing and securing alternative privately rented accommodation where appropriate. For those that are homeless and fit the criteria they may be provided with temporary accommodation during the assessment of their homelessness application.

4.2.61 Tracey contact with the Housing office came just before she died in March 2020. Seven days before she was found dead Tracey met the Duty Officer at the Civic Centre and reported that she was staying with a friend. She had previously lived with a violent partner and had been evicted from his home. An appointment was made for her to come back three days later and complete a homeless application. She then returned on that day. Staff spoke with Sarah and Oxleas to request medical records to support the application. It was agreed that Tracey would be provided with temporary accommodation.

4.2.62 There were five contacts recorded in the submitted chronology.

4.2.63 **London Borough of Bexley MARAC and Crisis Intervention Team**

4.2.64 Before 2018 the MARAC was managed by the London Borough of Bexley Housing Department. The IDVAs were employed by the same department. The IDVAs were in-house and one IDVA was based at Bexleyheath Police Station.

4.2.65 The responsibility for domestic abuse services which includes MARAC and commissioning of services, transferred from LBB Housing in September 2018 to the Domestic Abuse & Sexual Violence Strategy Manager in communities. The IDVAs were part of the commissioned service review and transferred to the new provider from 1st April 2019.

4.2.66 Tracey was first referred to the MARAC by the MPS on 10 June 2016. This was following a reported serious assault, where Tracey sustained fractures to her nose and skull. Mehmed had been arrested as a suspect for the assault. Tracey did not provide information for a DASH Risk Assessment. Tracey declined the IDVA service. It was noted that a colleague reported that Tracey regularly turned up to work with bruises. The case was closed following the MARAC. There were no recorded contacts with other agencies.

4.2.67 A second MARAC referral was made by the MPS on 18 June 2018. Tracey had been found with severe facial injuries. Tracey stated that the injuries resulted from a fall. Anne stated that Tracey had disclosed that she had been assaulted by her partner. At the next MARAC meeting on 26 June 2018 the IDVA provided information on the case. Safety planning had taken place and protective measures taken at properties. It was disclosed that Tracey had had £42,000 taken from her out of an inheritance of £120,000. It was noted that Tracey was considering the Freedom Programme.

4.2.68 On 24 July 2018 it was established that Tracey had moved to North Kent. A MARAC to MARAC referral was made to the Kent MARAC.

4.2.69 There were 35 contacts recorded in the submitted chronology.

4.2.70 **Metropolitan Police Service**

4.2.71 The MPS were the police service responsible for the London Borough of Bexley where Tracey and Mehmed lived for the majority of the period under review. Initially that was through the Bexley Borough Operational Command Unit. Reported domestic abuse was investigated by the Bexleyheath Community Safety Unit (CSU). In 2018 that changed to the South East Basic Command Unit (SE-BCU) comprising of the London Boroughs of Bexley, Greenwich and Lewisham. Reported domestic abuse was then investigated by the SE-BCU CSU.

4.2.72 Tracey first came to notice within the MPS on 20 March 2001. Between then and the date of her death in March 2020 the MPS had contact with Tracey on 20 occasions. Nine contacts were recorded as Domestic Abuse (DA) incidents involving Mehmed. Four contacts related to misuse of alcohol or controlled drugs. The remaining incidents were not of a safeguarding nature. Of the nine domestic incidents, six were recorded as non-crime domestic / arguments. Two reports from 2016 and 2018, were classified as Grievous Bodily Harm (GBH). Mehmed was arrested for these allegations and no further action (NFA) was taken in relation to these matters. The final report from 2020, was classified as criminal damage. Tracey was arrested for this allegation and no further action was taken.

4.2.73 The MPS has had sixteen contacts with Mehmed prior to the terms of reference. Mehmed came to notice for one DA incident involving another partner, not a subject of

this review. This took place prior to the relationship between Tracey and Mehmed. The remaining reports do not involve safeguarding issues.

4.2.74 The first reported domestic abuse of Tracey by Mehmed came in April 2008. Her family reported Tracey being involved in a domestic incident with Mehmed, resulting in bruises. Tracey declined to cooperate with the police. Police found a large quantity of Amphetamine and some shotgun cartridges at Mehmed's house. The risk was determined to be MEDIUM. Mehmed was cautioned for drugs offences.

4.2.75 In December 2008 police were called by neighbours and found Tracey with bruises. She declined to engage with the police. Mehmed was arrested but released with NFA. The case was risk assessed as 'STANDARD'. In October 2012 Tracey called police to report that her boyfriend, Mehmed, had assaulted her. When police met Tracey, she declined to report the assault and said an argument had taken place. Risk was assessed as 'STANDARD' and the case closed as NFA.

4.2.76 In April 2014 neighbours called police to Mehmed's home, after hearing arguing. There were no allegations of assault made. A domestic incident was recorded and risk was determined to be 'STANDARD'.

4.2.77 In June 2016 Tracey was found in public with visible injuries. Tracey told police that Mehmed had punched her in the face. She declined to support an investigation. Mehmed was arrested. Risk was assessed as 'STANDARD' as Mehmed was in custody. Police referred the report to an IDVA and MARAC and imposed bail conditions on Mehmed. The case was later NFA'd by the CPS.

4.2.78 In May 2018 Tracey called police and an argument could be heard on the line. Officers attended Mehmed's house and saw Mehmed and Tracey. It was reported that there had been an argument, no assault. The case reported as a Domestic Incident and risk assessed as 'STANDARD'. The case was not referred to MARAC.

4.2.79 In June 2018 police were called to Tracey collapsed at home, by the LAS. She was found with multiple injuries, with bruises over 60 percent of her body. Tracey declined to make a statement but when asked how the injuries were caused, she said 'boyfriend' and 'Mehmed why would you do it to me'. Tracey declined permission for medical evidence of her injuries. Risk was assessed as HIGH. Referrals were made to IDVA and MARAC. Mehmed was arrested and provided an alibi that that he was out of the country. He implicated a disgruntled ex-employee as the perpetrator. Protective measures and bail conditions were put in place. In September 2018 Tracey informed police that Mehmed was not responsible, stating she did not remember how her injuries were caused. The case was closed in February 2019 as NFA due to insufficient evidence.

4.2.80 In August 2018 Tracey was found in a hotel in Sidcup. She was in a distressed state and hallucinating. Tracey was taken to hospital by ambulance and a MERLIN report was shared with ASC.

4.2.81 In January 2019 police were called to Tracey in the street, where she was found drunk. Tracey had a letter indicating mental ill-health. LAS were called but were unable to attend. Police took Tracey to hospital. MERLIN reports were shared with ASC. In

February 2019 police were called to Mehmed's home by his girlfriend (not Tracey). It was reported that a woman was trying to smash windows. Mehmed said the person was his ex-girlfriend but would not provide her details. In March 2019 police were called back to the same address. Tracey was found outside with suitcases and bags. She had blood on her clothing and a window was broken. She was arrested for criminal damage. Mehmed declined to make a statement and the investigation was NFA'd. There was no DASH assessment. No MARAC referral was made and a MERLIN report was not completed.

4.2.82 Later in March 2019 Tracey's friend Sarah reported her as a Missing Person to the MPS. Officers conducted enquiries. Tracey was at first considered a 'MEDIUM' risk and then the case was escalated to 'HIGH' risk. Checks were made with health services, housing, supported by financial checks. It was established that Tracey had new temporary accommodation in Bexley. Police contacted the landlord of the premises. He entered the house and found Tracey dead, three days after she had been reported missing.

4.2.83 There were 33 contacts recorded in the submitted chronology.

4.2.84 **MIND Bexley**

4.2.85 MIND Improving Access To Psychological Therapies, is the primary mental health service for adults registered with a GP in the London Borough of Bexley.

4.2.86 Tracey was referred to MIND in June 2015 by her GP. Tracey was assessed for suitability for IAPT and attended 4 sessions of counselling. During her assessment Tracey reported that she was in a historically violent relationship. There were no details of the abuse recorded. In a session on 15 December 2015, Tracey reported that her partner was verbally abusive, threatening and controlling. Tracey was signposted to the Freedom Programme domestic abuse service. Tracey was discharged from the IAPT on 16 February 2016. There were no Risk Assessments recorded and no MARAC Safeguarding referrals made.

4.2.87 There were 15 contacts recorded in the submitted chronology.

4.2.88 **Oxleas NHS Foundation Trust**

4.2.89 Oxleas NHS Foundation Trust provides a wide range of health and social care services to people living in south-east London and parts of Kent. This includes community health care such as district nursing and health visiting, care for people with learning disabilities and mental health care such as psychiatry, nursing and therapies. The multi-disciplinary teams look after people of all ages and work in partnership with other parts of the NHS, local councils and the voluntary sector. During her contact with Mental Health Services Tracey received support from Mental Health Services including assessments and crisis intervention. Mehmed was subject to one referral by his GP and was not discussed by Oxleas.

4.2.90 Tracey's first contact with Oxleas was in 2013 following an overdose, when she was assessed by the MHLT based in hospital ED. This followed the incident when Tracey

had part of her finger bitten off by her dog. This was reported by Tracey to have been linked to intruders in her home. She was discharged to stay with her father.

4.2.91 In August 2018 Oxleas PCP received a MERLIN report from the MPS with concerns following Tracey being found in a Sidcup Hotel, presenting as confused, agitated, and possibly experiencing some psychotic phenomena. The MERLIN was reviewed and passed to Tracey's GP.

4.2.92 Tracey's GP referred her to Oxleas PCP on 15 October 2019 for an urgent assessment in order to provide a diagnosis of PTSD. Tracey was assessed and a Fast Track Assessment (FTA) planned. Tracey was unable to attend initial appointments and was assessed on 18 December 2019. She said she had experienced violence from her partner of 15 years resulting in facial injuries. She reported the incident in which her finger was bitten by dogs and the serious assault in 2018. She said she could not remember the incident and said that her partner had an alibi. She also reported that her landlord had been blackmailing her for money in exchange for her belongings. Tracey was placed on the trauma focused psychological therapy waiting list within the Bexley ADAPT service. The waiting list time was 18 weeks.

4.2.93 On 21 December 2019 Tracey was seen by the MHLT after she was admitted to PRUH with a suspected overdose. She reported that Mehmed owed her £67,000, substantial debt, homelessness, and not speaking to her mother and brother. There was a referral offered for the HTT, but Tracey declined. The ADAPT team were informed but no further action was taken.

4.2.94 In January 2020 Tracey's friend, Sarah, contacted Oxleas Crisis Line. As a result, Tracey was contacted, and this was followed up by ADAPT. On 10 January 2020 Oxleas were informed that Tracey was at DVH ED having been found collapsed.

4.2.95 On 15 January 2020 Tracey was allocated a Social Worker as her CCO. Tracey declined the offer of CCO as she was being supported by Able Futures. The ADAPT team were informed of Tracey's presentation to DVH on 19 January 2020 and this was passed to the consultant psychiatrist. Tracey was then contacted by the SW on 6 February 2020 and declined the offer of a CCO. On the same day Sarah reported concerns to Oxleas.

4.2.96 The MHLT received a referral from PRUH ED on 8 March 2020, after Tracey had been found collapsed and intoxicated. She was assessed and referred to ADAPT. ADAPT contacted Tracey and she declined the offer of CCO. On 12 March 2020 MHLT received another referral from PRUH ED as Tracey had been found intoxicated saying she had taken an overdose. The COMHAD Practitioner agreed to offer an assessment for Tracey in ED, she declined. Tracey was assessed by the MHLT the following day.

4.2.97 Tracey did not attend planned face-to-face appointments with her SW. his was followed up with telephone calls and an appointment for later in March. Tracey was assessed as being in the RED Zone and she agreed to the SW working as her CCO.

4.2.98 Later in March 2020 Oxleas were contacted by the MPS to support their Missing Person investigation. Information was provided to the MPS. Tracey was found dead the following day.

4.2.99 There were 59 contacts recorded in the submitted chronology.

4.2.100 **Victim Support Kent**

4.2.101 Victim Support is an independent charity dedicated to supporting victims of crime and traumatic incidents in England and Wales.

4.2.102 On 5 November 2019 Victim Support were informed by Kent Police that Tracey was a victim of blackmail by her partner. The agency policy is that they require explicit consent to contact the victim and emailed the Kent OIC, requesting that consent. There was no record of a reply to that email and the case was closed. The agency was not required to complete an IMR.

4.2.103 There was one contact recorded in the submitted chronology.

There were a total of 246 contacts recorded in the combined chronology for the review.

4.3 Any other Relevant Facts or Information

4.3.1 **Metropolitan Police Service**

4.3.2 Tracey had no police cautions or criminal convictions.

4.3.3 Mehmed had seven criminal convictions and four police cautions. His first conviction was in 1997 for possession of a bladed article. He had five convictions / cautions for offences of dishonesty. These included Forgery and Theft. He had cautions for Possession of Class B and C Drugs and a Conviction for possession of Class A drug - cocaine. He also had a conviction in 2019 for driving under the influence of drugs.

4.3.4 **National Domestic Abuse Helpline**

4.3.5 The helpline team were contacted and provided with details of parties named in this report. There were no records relating to the names or phone numbers known to have been used. A check was also made cross-referencing the first name of a caller and locations known to the review, without success.

4.3.6 **Sexual Assault Referral Centres (SARC)**

Neither party were known at SARCs in London or Kent.

4.3.7 **Victim Support**

4.3.8 There were four contacts referring Mehmed to Victim Support as a victim of crime for other matters in London. There was no interaction between Victim Support and Tracey or Mehmed.

5. Analysis

5.1 Tracey and Domestic Abuse

5.1.1 Taking into account the cross government definition of domestic abuse, in existence during the review period, and the new definition under the Domestic Abuse Act 2021, it is clear that Tracey was a victim of domestic abuse over a period of many years. After reviewing information presented by agencies and from family and friends it is clear that that Tracey had experienced domestic abuse from Mehmed. The trauma of domestic abuse had a significant impact on her physical and mental health.

5.1.2 Tragically, it will never be possible to know the full extent of Tracey's experiences. However, as a minimum it appears Tracey experienced the following:

- *Physical abuse:*
- *Coercion, threats and intimidation:*
- *Emotional abuse and isolation:*
- *Economic abuse[11]:*

5.1.3 The panel gathered a catalogue of reported physical assaults and disclosures of emotional and economic abuse across a number of agencies :-

December 2008	Neighbours heard screams from Mehmed's house and MPS found Tracey bruised with facial injuries. Tracey declined to make an allegation. Mehmed arrested and released NFA.
July 2012	Tracey told the LAS that her partner had beaten her. No domestic abuse referral made.
October 2012	Tracey called MPS and reported that she had been assaulted by her boyfriend, she then denied being assaulted. Recorded as Non-Crime Domestic Incident and NFA.
January 2013	Tracey taken to Darent Valley Hospital intoxicated - stated that her boyfriend beats her up. No domestic abuse referral made.
July 2013	Tracey reported to MPS that she was attacked at home by strangers and had her finger bitten off by her dog. No suspects identified. Tracey later disclosed to friend that it happened during an assault by Mehmed.
April 2014	MPS called to a verbal argument between Tracey and Mehmed. Recorded as Non-Crime Domestic Incident and NFA.

[11] "Economic Abuse" means any behaviour that has a substantial adverse effect on a person's ability to (a) acquire, use or maintain money or other property or (b) obtain goods or services - Section 1(4) Domestic Abuse Act 2021.

2015	Tracey inherited £135,000. Family and friends state that a large sum of money was lent to Mehmed and never returned. It is known that Tracey built up credit card debts and paid for Mehmed's fuel.
June 2015	Tracey informed MIND IAPT she was in a historically violent relationship. Signposted to Freedom Programme. No domestic abuse referral made.
June 2016	Tracey found in a doorway with facial bruising, stated she had been punched in the face by Mehmed. Tracey declined to make a statement. MPS referred to IDVA and Bexley MARAC. Mehmed arrested and CPS declined charge.
June 2016	Tracey discussed at Bexley MARAC.
May 2018	Tracey called MPS to report a verbal argument with Mehmed. No criminal allegations were made. Recorded as Non-Crime Domestic Incident and NFA.
May 2018	Tracey sustained fractured cheekbone, attended UTC, Lewisham Hospital and KCH for surgery. She stated she had fallen down stairs. No questions on domestic abuse.
June 2018	Tracey found collapsed at home with facial injuries and multiple bruises. Initially stated Mehmed was responsible. Later told friend she was set up by Mehmed. Case referred to Bexley MARAC and IDVA. MARAC were aware of financial exploitation of Tracey. Case NFA by police due to insufficient evidence.
August 2018	Tracey was listed for mention at Kent MARAC, after transfer from Bexley.
February 2019	Call to Kent Police from a third party to a domestic incident between Mehmed and Tracey. Tracey stated this was a verbal argument. No MARAC referral made.
June 2019	Tracey reported to Kent Police that she was in dispute with her landlord over rent arrears. Economic abuse not explored.
August 2019	Tracey's self-referral to employer's Rehabilitation Consultant referred to physical abuse from her ex-partner. No domestic abuse referral made.
September 2019	Tracey disclosed to Rehabilitation Consultant previous domestic abuse and that she still lived with perpetrator. No domestic abuse referral made.
October 2019	Tracey disclosed traumatic life experiences to GP. No referral to specialist domestic abuse service.
November 2019	Tracey was reported that her property was being held by her landlord.

November 2019	Tracey informed Oxleas CMHT administrator that she had been locked out of her house and her partner was demanding £5000 for the return of her belongings. No domestic abuse referral made.
December 2019	Tracey assessed by Oxleas ADAPT, she disclosed 15 years of domestic abuse. She reported her level of debt and financial exploitation. Tracey was asked to self-refer to Women's Aid.
December 2019	Tracey informed Oxleas MHLT psychiatrist that her ex-partner owed her £67,000 and she was in substantial debt. No domestic abuse referral made.
March 2020	Tracey found unconscious in alleyway and taken to PRUH, stated she had taken an overdose. She was living with a friend as she had a fight with her partner. No domestic abuse referral made.
March 2020	Tracey discussed her past trauma with Oxleas MHLT. No referrals made to specialist domestic abuse services.
March 2020	After Tracey's death her family discovered that she was £11,000 in debt.

5.1.4 These disclosures show a pattern of reported abuse over a period of years, culminating in Tracey being left in 2019 in a traumatised state, stripped of significant sums of money, in debt and homeless. The history of abuse should be considered against an escalating number of hospital ED attendances where Tracey was either heavily intoxicated and/or reporting taking an overdose. These attendances increased in the time immediately before Tracey's death in March 2020.

5.1.5 The panel has heard from Tracey's family and a friend how Mehmed coercively controlled Tracey. Tracey also disclosed the years of abuse to mental health professionals and counsellors. She inherited a large sum of money when her father passed away and that money disappeared with Mehmed promising to pay her back. When the money had gone, Mehmed moved on to a new girlfriend and Tracey was moved to rented accommodation in Kent. Tracey reported to agencies that she had been in an abusive relationship but after years of control, Tracey found it hard to live apart from Mehmed. In the days before her death she was expecting him to collect her from hospital.

5.1.6 Tracey's loss of a significant amount of inheritance money and homelessness may have left her ashamed of her circumstances, socially isolated and unable to go to her family for support. This could be seen as a barrier to Tracey disclosing any abuse. Her family had reported serious assaults involving Mehmed and Tracey had declined to support the police investigations.

5.1.7 The impact of the trauma of domestic abuse on Tracey was clearly evident to some agencies when she was found with physical injury or when she revealed her history and experiences to counsellors and mental health professionals. Tracey was referred directly to medical specialists to mend her broken bones, but she was 'sign posted' or asked to 'self-refer' to specialists who could help keep her safe from further abuse.

5.1.8 A critical factor in the case are Tracey's repeated contacts with the Ambulance Service and attendances at Hospital Emergency Departments. She often presented in an intoxicated state, distressed, or reporting overdose. It is appreciated that some of those attendances may have been brief, but the experiences that led to Tracey needing medical help were rarely explored.

5.1.9 In considering the contact with Healthcare Agencies, reference should be made to the Department of Health - Responding to Domestic Abuse Guidelines: "All health practitioners, whether working in emergency, acute, primary care or community health, have a professional responsibility, if you identify signs of domestic abuse or if things are not adding up, to ask patients alone and in private, whether old or young about their experience of domestic or other abuse, sensitively. Routine enquiry into domestic violence and abuse is Department of Health policy in maternity and adult mental health services". When dealing with practice around substance misuse the professional guidance is clear "Assessments of clients using substance misuse services are also expected to take domestic abuse into account as a routine part of good clinical practice, even where there are no indicators of such violence and abuse".

5.2 Through the eyes of the deceased - intersectional analysis

5.2.1 Tracey presented to agencies in number of ways and generally at times of crisis. She presented as a victim of crime, a person with mental ill-health, a person with physical injuries and scars, an intoxicated person, a person in debt, a person at risk of abuse. All of these issues were problems for very different agencies to try to solve. Tracey was also a woman who maintained life-long friendships, was supportive of her dying father, and employed in a community environment. Tracey was not a single issue; Tracey was a whole person. She was a woman with her life affected by long-term domestic abuse and trauma.

5.2.2 It appears that when Tracey was seen at times of crisis she could be seen as responding negatively to offers of help. After the initial call to police reporting abuse, Tracey would decline to indicate that any risks were present. She could be seen as a reluctant victim who kept returning to her abuser. In the background Tracey was being exploited and controlled by Mehmed, who was using her money with the promise of paying her back. This should be considered as control through economic restriction. Tracey was being exploited and her finances were being sabotaged. On some occasions Tracey did reveal the abuse that was taking place. When she was seen in less stressful and pressured times, she disclosed to IAPT, employers support counsellors, and mental health professionals. She revealed the history of abuse and trauma. Those occasions presented the opportunity to engage and reveal the true Tracey without the barriers of being seen as uncooperative, evasive or drunk.

5.2.3 Tracey was a woman, in a relationship with an abusive partner. During that relationship she was economically controlled, seriously assaulted, and made homeless. As those stressors in her life combined, Tracey's mental health suffered and she started use alcohol problematically. The combination of all these issues placed Tracey in a particularly vulnerable position when she died.

5.3 Analysis of Agency Involvement / Responding to the Terms of Reference

5.3.1 Each agency has conducted their own analysis considering Tracey and domestic abuse. Tracey had a number of contacts with many agencies. All those agencies had established policies and protocols for reporting and managing domestic abuse. The agencies have been grouped into the following categories:-

Employment;

Health;

Housing;

Police;

Social Care; and

Specialist Domestic Abuse Services - IDVA and MARAC.

Employment

5.3.2 **Able Futures** When Tracey first contacted the service, she disclosed that she had previously been subject to domestic abuse by her ex-partner, and this was contributing to her mental health issues. She did not disclose any current threats and there were no safeguarding concerns recorded. At her first face-to-face assessment, Tracey disclosed that she had been victim of an attempted murder in June 2018 and this caused her to have PTSD. She said that the PTSD was affecting her work. Tracey also talked about physical abuse from her ex-partner. The records suggested that Tracey still lived with her ex-partner. Safety measures were also discussed. Although risk seems to have been considered, there was no formal risk assessment or onward referral for specialist Domestic Abuse (DA) services. Able Futures records show that the VRC did not update records on planned appointments. Appointments should have been scheduled on a monthly basis.

5.3.3 After a gap of over three months Tracey called Able Futures to say that she had been trying to contact her VRC. Tracey was eventually spoken to by a new VRC four months after her first face-to-face meeting. At this point Tracey described her involvement with NHS GP and Mental Health services and said that she had crisis numbers. Able Futures last spoke to Tracey five days before she was found dead. At this point she discussed a move into temporary housing. There were no disclosures or threats of current domestic abuse. A plan to deal with thoughts of self-harm was discussed but no safeguarding concerns were raised.

5.3.4 The IMR author stated that no safeguarding concerns were raised and staff were not concerned for Tracey's immediate safety or well-being. "The individual staff who came into contact with Tracey had all completed mandatory safeguarding training and all used their professional judgement within the capabilities of their job role to determine that the participant was not in any immediate risk of harm."

5.3.5 The IMR author stated, "The two VRCs who supported Tracey during her time on programme followed our safeguarding policy and procedure by determining the perceived level of threat and the level of support the participant had from other services we would contact if we had a safeguarding concern. However, undertaking this review of Tracey's case has highlighted some areas for improvement." Able Futures have now changed policy. They now include advice to staff to contact the police and DA support groups where a client discloses that they are in an abusive relationship 'but they are not in immediate danger'. They now recognise that this should be raised as a safeguarding concern.

5.3.6 It is not clear from the IMR that any communication was sent to Tracey's GP or Oxleas MH on the level of service being provided to Tracey.

5.3.7 The company have now trained a number of VRCs as Designated Safeguarding Officers (DSO) to support all VRCs with advice and guidance. Able Futures considered that if the VRC had raised a safeguarding concern to a better trained safeguarding officer, they may have been able to identify any gaps in the support Tracey was already receiving from other statutory organisations. They also recognised a need for clearer documentation of contact with relevant organisations on a safeguarding system.

5.3.8 Able Futures did state that their VRCs are qualified to identify and raise safeguarding concerns regarding self-harm and suicide. In this case, Able Futures acknowledged that there was no contact between the VRC and Tracey for four months. The panel considers that the contact between Tracey and VRC should have been identified through supervisory processes. Able Futures have introduced new supervisory standards and support for the VRC role.

5.3.9 There were a number of single agency recommendations.

Health

5.3.10 **Dartford and Gravesham NHS Trust**

5.3.11 Tracey was seen at DVH twice for treatment of alcohol intoxication, with a suspected overdose on the latter attendance. Investigations and treatment in the emergency department concentrated primarily on her medical recovery. Tracey presented to hospital with a complicated and vulnerable situation. The IMR author commented, "there appeared to be a lack of professional curiosity or enquiry into her life and the circumstances that had caused her to misuse alcohol to the point of being found collapsed".

5.3.12 Tracey came into the ED in an intoxicated state and her initial presentation made it challenging for staff to complete a full assessment. When she recovered it was reported that she was distressed and crying, providing a further challenge for staff to understand Tracey's needs. There was no evidence of Tracey being signposted to support services for alcohol misuse.

5.3.13 When Tracey came to the ED in 2013 there was no knowledge or disclosure of mental health problems. The use of alcohol is not considered a disorder of the mind and was not a reason, on its own, to refer to mental health services. However, this came at the

same time that Tracey disclosed domestic abuse. There appears to have been no link made between Tracey's trauma and misuse of alcohol. It is appreciated that professional guidance on trauma has developed since 2013. In 2013 the Care Act of 2014 was not in place and staff had a more limited understanding of an adult at risk.

5.3.14 There was a clear disclosure of domestic abuse by Tracey, supported by her father, at the attendance in 2013. Her father described her 'problematic relationship'. The IMR author stated, "it would…have been reasonable to have expected domestic abuse support services to be offered but it seems that this was not done. There does not appear to have been a DASH risk assessment completed or any referrals made to adult safeguarding or domestic abuse agencies. A completed DASH assessment may have identified the potential risks for Tracey, increased professional curiosity and informed more appropriate decision making, which may in turn, have led to Tracey accepting specialist support services." It could be considered that there was not a great need for curiosity. Tracey told staff that she had been subject to domestic abuse and nothing was done about it.

5.3.15 On Tracey's second attendance to DVH, in January 2020, there were concerns that she had taken an overdose. Staff at DVH did contact Oxleas MH crisis line for information. She was referred to the onsite Psychiatry Liaison for a mental health assessment, in line with procedures. Information sharing on the attendance with GP and mental health services was good practice. There were no disclosures of domestic abuse. It was not apparent that Tracey was asked about abuse or that previous concerns on abuse were shared by Oxleas. Consideration was not given as to whether Tracey's condition could be linked to previous trauma. It is also appreciated that staff were working in an ED setting with the associated pressures.

5.3.16 There have been a number of developments in policy and practice since 2013. A lead for Safeguarding started in post that year and works to promote the Care Act of 2014, supporting staff to identify risks. There is also a system developed for the ED where patients can be highlighted for the safeguarding teams. Since 2018 the Trust has had a Hospital Independent Domestic Violence Adviser service (HIDVA) that staff can refer patients to for support and advice. The HIDVA or members of the safeguarding teams can complete the Safe Lives DASH assessment tool and refer patients for support or to the Multi-agency Risk Assessment Conference (MARAC). A new, family focused, safeguarding training day has been developed in the last year which gives all clinical staff a virtual reality experience where domestic abuse is a feature. This is followed by a session on domestic abuse presented by the HIDVA, which encompasses specific training around identification of concern, assessment of risk, support agencies and referrals.

5.3.17 The IMR author states that the developments and training have led to more recognition by staff that people experiencing domestic abuse may use substances as a coping mechanism. It does not appear that the link was made in this case between Tracey's history of trauma and her misuse of alcohol.

5.3.18 The IMR author made a number of single agency recommendations.

5.3.19 **General Practice for Tracey and Mehmed**

5.3.20 The IMR offers limited analysis of Tracey's contact with the practice. There was no reference to registration at the practice and whether any form of Routine Enquiry was in place. It is unclear when Tracey registered as a new patient at the practice, and the IMR only extends back to 2018.

5.3.21 The IMR author stated that Tracey was always 'safety netted' when she attended the surgery in person or spoke on the telephone.

5.3.22 The reported assault by Tracey in June 2018 was recorded in her medical records. At the same time she indicated that she would be registering with a new surgery. At this time a sick certificate was issued as Tracey had a public facing job and she had facial injuries. The IMR author considered that the practice could have offered more support in contacting domestic abuse services and consideration could have been given to these services being provided in the new area that she was moving to. At this point Tracey had been referred to MARAC and IDVA in Bexley and then transferred to services in Kent. There was no recorded notification to the GP that Tracey had been listed at a MARAC.

5.3.23 In October 2019 Tracey was back with the Sidcup practice. It is unclear whether she was involved in re-registration. At this point she stated that her employer was arranging a referral for her. It was not accurately recorded what this referral was, and it should be noted that there was no letter from the service, Able Futures, to the GP.

5.3.24 The IMR author highlighted a contact in November 2019 when Tracey reported being very low, depressed and anxious. She did ask to speak with a particular doctor who was already aware of her history. Ideally the practice would allocate all vulnerable patients to a particular doctor, but given the situation it was felt to be more appropriate for the first available doctor to see Tracey. There was no suggestion that Tracey was unhappy with the solution.

5.3.25 The final contact with the practice was a call from a person representing themselves as a friend of Tracey, with whom she was living. This came shortly before Tracey's death. The practice did not disclose patient information to the person calling and this is entirely correct. The practice did give appropriate advice, advising the caller to bring Tracey to the practice. It needs to be considered that in some cases, partners will try to access medical records of a patient. It should be considered good practice that this contact was recorded in patient notes.

5.3.26 The practice has a safeguarding policy. All staff complete annual mandatory safeguarding training.

5.3.27 The practice has made single agency recommendations. Given the brief nature of the IMR and limited analysis, it is thought that the GP practice could benefit from some training on the completion of IMRs.

5.3.28 **The Hurley Group - Urgent Treatment Centre**

5.3.29 Tracey's first attendance at the UTC was when she presented as a walk-in patient. She was triaged by a nurse and reported falling down stairs. Her presentation of having hit her head in the fall and subsequent headaches was deemed a 'red flag' symptom and

she was directed to the Emergency Department. Tracey did attend the ED as directed. Tracey did not disclose abuse or indicate that any other person was involved in the fall.

5.3.30 When Tracey attended the UTC, four days before her death, she was concerned about a wound that was not healing. This would appear to be the injury sustained at Mehmed's home, where Tracey told police she had cut it banging on a window. MPS had provided first aid to Tracey until she was seen by LAS. Tracey said that she had previously had the wound dressed at Lewisham Hospital. There was no suggestion that the injury resulted from abuse. UTC staff did not record any concerns with substance misuse.

5.3.31 The IMR author considered that there were three points in the UTC attendances when domestic abuse and risk could have been identified. The booking in process uses an automated triaging system, eTriage, which books patients in. The system asks clinical questions to ascertain clinical risk. "In the case of injuries and Tracey's attendances, there is a specific question relating to abuse/assault and infliction of injuries. This was not disclosed by Tracey on booking in." Once Tracey had been assessed, the clinical system used within the service, Adastra, had a specific question relating to adult safeguarding and domestic abuse concerns before closing down the clinical notes. This was not flagged as a concern by any of the professionals who saw Tracey on either attendance. There was also the opportunity for all clinicians to ask questions directly about the nature of injuries and how these were sustained. There was no statement in any of the clinical notes to confirm whether this question was asked to Tracey directly. The IMR author states "an inference, from the non-flagging of the mandatory question within the clinical system, that this risk was not identified by any clinicians following their assessments."

5.3.32 Whilst there were processes in place that could lead to identification of domestic abuse, the Hurley Group have highlighted areas that can be improved. It is recognised that there needs to be a more consistent approach to questioning and documentation of injuries. This should be done in conjunction with a review of clinical notes to look at previous attendance and patterns of attendance. The IMR noted that there was the opportunity to question Tracey on the history and causes of her injuries. There was no documented statement to indicate that the issue of domestic abuse was discussed. The current processes do have prompts for identifying abuse and the IMR author has recommended ways for the systems to be improved. This includes a requirement for a written statement to show that domestic abuse has been considered for all patients attending with an injury.

5.3.33 Hurley Group staff have mandatory domestic abuse training and attendance is monitored. The Safeguarding Leads have established links with domestic abuse services with referral pathways.

5.3.34 The IMR made a number of single agency recommendations.

5.3.35 **Kings College Hospital NHS Foundation Trust**

5.3.36 Between 2016 and 2018 Tracey was seen in the Dental and Maxillofacial Department for treatment for a broken nose and a broken cheekbone. While the injuries were

treated, both requiring day surgery procedures, it appears that the reasons for the injuries were accepted at face value. Tracey suffered from a broken nose in 2016. It is documented in her clinic review that she sustained this injury after tripping and hitting her face on a table. In 2018 she was referred back to the Dental and Maxillofacial Department having sustained a fractured cheekbone. Her records note that this injury occurred when she fell down the stairs after being startled by multiple dogs. Again there appears to have been a lack of professional curiosity around the cause of this injury. This was the second facial fracture in two years. It should be noted that these two incidents had been reported to the MPS as domestic assaults.

5.3.37 On the 26 June 2018 Tracey attended the PRUH ED for shortness of breath but left without being seen. On 4 August 2018 she was bought in to the PRUH ED by ambulance due to hallucinations. Records note that she had been living in a hotel since 16 June 2018 due to domestic abuse. This was the only entry in all of Tracey's records that mentions domestic abuse. Tracey left the hospital without being seen. The IMR author has found that there was a missed opportunity by the PRUH ED to follow up on Tracey's welfare. Her GP was notified of her ED attendance. The panel note that this attendance was at the point that Tracey had been transferred to the Kent MARAC and she had told the IDVA that she did not require support. Given the reported history of domestic abuse it appears that a follow up and a Safeguarding referral would have been appropriate.

5.3.38 The IMR highlighted the attendances at PRUH in the four months before her death. These included an overdose and referral to Oxleas MH, on 20 December 2019. At this point Tracey disclosed financial abuse from Mehmed, reporting that he owed her £67,000. On 25 January 2020 she was found unresponsive at a bus stop, having been using drugs and alcohol. Her GP was notified. On 8 March 2020 Tracey was found unconscious in an alleyway having been drinking. She requested the Psychiatric liaison team contact Oxleas. On 11 March 2020 Tracey was found at a hotel and she was diagnosed with intoxication and ibuprofen overdose. The IMR author wrote that these attendances "In the four months before her death, and when reviewed together highlight a person in crisis. Consideration of domestic abuse or the effects of domestic abuse were not documented in these attendances."

5.3.39 The IMR also highlights Tracey being homeless at a result of abuse. Her attendances in 2018 and 2020 were as a result of Tracey being found at hotels. In March 2020 Tracey was seen by a social worker about her homelessness at the hospital. Tracey said that she was not homeless and then shortly after she was brought in again from a hotel.

5.3.40 On Tracey's final visit to PRUH she told the Psychiatric Liaison Nurse that she was suffering from PTSD after a burglary in which she was badly beaten. She also said that she had been through IVF the previous year. She told her PLN that she was accessing support for herself through her work, although it is not documented what work she did. It is clear that the trauma of 2018 was a factor in her presentation to the ED.

5.3.41 The IMR author notes that in March 2020 the Trust was entering the first wave of the COVID-19 pandemic, "however it is clear that the professionals looking after Tracey

during the final four attendances did not have the full picture of the different issues impacting on Tracey. This subsequently impacted on possible onward support referrals for Tracey and a further missed opportunity."

5.3.42 The Trust have a Safeguarding Adults Policy, currently under review. Domestic Abuse Training is mandatory within Safeguarding Adults Training. Bespoke domestic abuse training is delivered by IDVAs where a training need is identified. Although there was Safeguarding Policy in place during the period under review, it does not appear that the policy had been followed despite clear safeguarding concerns being mentioned. Consideration needs to be given to assurance processes and audit, to ensure that the policy is implemented.

5.3.43 The IMR author made a number of single agency recommendations.

5.3.44 **Lewisham and Greenwich NHS Trust - Queen Elizabeth's Hospital**

5.3.45 Tracey attended the Trust on a number of occasions between 2013 and January 2020. The reasons for her attendance were owing to overdose and alcohol misuse. She also presented after physical assaults for which she required X-ray and CT scans.

5.3.46 Tracey's first presentation in 2013 resulted in her being reviewed by the mental health liaison team. As this was the first incident of overdose recorded, Tracey was deemed low risk and a plan for her to stay with her father upon discharge was made. Tracey was released into her father's care as a form of 'safety netting'. There were no formal referrals made. It is noted that this was before the emphasis on domestic abuse and safeguarding outlined in the Care Act 2014.

5.3.47 There does not seem to be any further record of the substance misuse involvement until July 2018 when Tracey was brought to ED after neighbours were concerned she was locked outside her house drinking alcohol. On this occasion she was seen by the substance misuse team, however it was felt she did not require further input and no further action was taken.

5.3.48 The IMR author wrote "In 2013, she was reviewed by the inpatient mental health liaison team. She was provided with the urgent advice line should she require any further support. In July 2018, Tracey was reviewed by the inpatient substance misuse team however there does not seem to have been any further follow-ups with regards to alcohol misuse." There does not appear to have been any exploration of the underlying causes for Tracey's substance misuse, although it could be seen that this was an area that could have been explored by other agencies.

5.3.49 In considering physical injuries, staff showed professional curiosity when Tracey said she had been assaulted on 16 July 2018. The interest in the abuse did not result in a formal safeguarding referral. The IMR author wrote, "The notes available do not clearly indicate any safeguarding concerns were raised with regards to the facial trauma Tracey had experienced in 2016 or in 2018. The Trust's policy for domestic violence and abuse was drafted in 2013 and subsequent updates have been made, however the policy does not seem to have been followed." It is clear that policies were in place but there has been no evidence presented to show that there were checks on

compliance and supervision of those policies. It should be noted that the Trust had hospital IDVAs in place from 2015/2016.

5.3.50 Tracey's final contact at the Trust was in January 2020. She had been brought to the hospital by the police and left before seeing a clinician. There appears to have been no evidence that a welfare check was carried out and no referrals to the community. This should have been followed up.

5.3.51 There is now a mandatory question as part of the triage in ED, to ask if the patient has been experiencing domestic abuse. There has been on-going training with staff about the different categories of abuse and how to report concerns. The training modules have now changed and staff are required to continually update their knowledge, with a minimum of 8 hours training over a 3-year period.

5.3.52 The IMR author made single agency recommendations.

5.3.53 **London Ambulance Service NHS Trust (LAS)**

5.3.54 On two attendances of LAS crews in 2013 and 2018 the crew managed serious injuries to Tracey. In 2013 she was involved in a 'fight' at home, and her finger was bitten off by her dog. There is no record of who the fight was with but given the domestic setting it seems appropriate that a Safeguarding Referral was made. On 16 June 2018 LAS treated Tracey for serious facial injuries. The case presented as domestic abuse and police were in attendance. The LAS crews on these two separate occasions did not make Safeguarding Referrals.

5.3.55 The other key attendance was on 3 August 2018 when Tracey was found in distress at a hotel and taken voluntarily to hospital. The police were also in attendance. She presented in distress and hallucinating and made reference to her recent report of assault. The LAS considered that Tracey was not known to have care and support needs. Police made a MERLIN safeguarding report. At this point Tracey had just been transferred to the Kent MARAC.

5.3.56 The LAS IMR author states that they have highlighted some missed safeguarding opportunities before September 2019. In considering LAS contact the IMR author stated that "We are satisfied that measures have been put in place to support ambulance staff on scene in relation to assessing and the following up of safeguarding concerns". The panel has considered the events of 20 December 2019, when Tracey was found in distressed state and informed the LAS crew that she was homeless because her 'husband' had stopped paying her rent. This is a clear indicator of economic abuse and this was a missed opportunity for a domestic abuse referral.

5.3.57 Since September 2019 the LAS has implemented mandatory level 3 training, which encompasses in depth training in relation to Domestic Abuse, encompassing how to recognise signs of DA and how to discuss concerns with victims safely, and access support.

5.3.58 LAS have implemented new domestic abuse awareness stickers to be worn on uniform or placed on electronic tablets and visible to patients. The sticker has the National

helpline number for people to see. We hope that this will enable those who don't feel safe enough to disclose abuse to know what support is available.

5.3.59 The Trust have also introduced a process to deal with feedback from incidents to highlight missed opportunities and promote good practice.

5.3.60 Since July 2020 the LAS introduced the role of Governance and Training support. This role, as well as supporting the training agenda, has a key role in creating and developing further governance and assurance systems for the team. They have introduced a learning database where LAS log and track all learning identified and ensure the Trust have implemented changes/learning from the recommendations. They have also completed an Audit based on referrals during the COVID-19 pandemic to see if LAS referral rates increased during this time.

5.3.61 The LAS did not make any single agency recommendations.

5.3.62 **MIND Bexley**

5.3.63 Tracey's only contact was in 2015 following a referral from her GP. At this point Tracey reported being in a 'historically violent relationship', but no details were recorded. In a counselling session Tracey disclosed that her partner was verbally abusive, threatening and controlling. There was no record of a supervisory follow up or a risk assessment in the case. Tracey was informed of or 'signposted' the Freedom Programme, a domestic abuse initiative, but this prompt was not followed up.

5.3.64 It should be considered that there have been a number of changes in processes and supervision since 2015. More rigorous safety/risk training has been introduced to ensure that safeguarding issues are identified and acted on appropriately. All staff are now trained in Safeguarding up to Level 3. A key change is that MIND have developed joint agency working with Solace Women's Aid and referrals are made directly and not signposted.

5.3.65 A single agency recommendation is made linking DASH Risk Assessment to patient record systems.

5.3.66 **Oxleas NHS Foundation Trust**

5.3.67 Tracey was first referred to Oxleas in July 2013 following an overdose. This case came shortly after the incident where her finger was bitten by her dogs. There was no evidence of probing into the incident as to whether there were any concerns for her ongoing safety. At this point it would have been prudent to explore whether Tracey felt safe and whether other agencies could help support her. The panel considered that this could be seen as historic, but agencies should still have been addressing domestic abuse as an issue in 2013. Risks at this point were considered low.

5.3.68 The next notification of concerns came, via an MPS MERLIN, in August 2018 when Tracey had been found with concerns for her mental health by police and ambulance. The referral also contained reference to previous serious assaults. The police referral was assessed by a PCP (CMHT) Senior Social Worker. The SW did not consider any further action was required by the CMHT. The IMR author commented, "Given the history and current presentation of Tracey, this appears to be an oversight of the

seriousness of concerns reported by the Police. It may have been appropriate in this case to have made contact with Tracey to assess current mental state and risk and also to establish her vulnerability in relation to domestic abuse. If contact was not made with Tracey, good practice would have been to discuss concerns with the GP and request if they have any concern regarding Tracey's mental health to make a referral for assessment". It appears that the SW did not demonstrate professional curiosity. At this point in time Tracey had just been referred to the Kent MARAC.

5.3.69 The next referral came in October 2019 when Tracey's GP referred her to PCP. PCP are the gateway into the service. After initial difficulties in contacting Tracey they were able offer her a Fast Tracked Assessment. At this point a number of significant life events were identified as triggers for high anxiety and stress levels, and there were high risk factors for domestic abuse. She disclosed that she had been subject to physical abuse from her ex-partner over 15 years. The details were added to Tracey's file but there was no updated risk assessment, and the concerns were not highlighted for other professionals. The IMR author added "This is a concerning oversight as crisis services such as the MHLT review recent contact and risk documentation when undertaking any assessment in a crisis presentation. Therefore some vital information was not easily accessible to teams assessing Tracey when she was presenting in crisis." After the disclosure of domestic abuse Tracey was advised to self-refer to Women's Aid. The panel noted that partner agencies are encouraged to make a direct referral as victims will often not self-refer.

5.3.70 Oxleas were also aware that Tracey had been unable to work for a period of time due to her injuries. There was no exploration of the fact that sabotage or interference with employment can be evidence of economic abuse. In December 2019 Tracey made a clear disclosure to a psychiatrist that she was in substantial debt and not speaking to her family. There appears to have been no appreciation of the stigma attached to her situation. Tracey also disclosed that she was being 'blackmailed' by her landlord for money in exchange for her belongings. There was no offer of support around financial matters. There is no evidence that any of this information was considered in relation to Tracey's risk status or vulnerability. This was a clear report of economic abuse and there was no domestic abuse report or referral made.

5.3.71 It is considered that the Social Worker's continued offering of support as a Care Coordinator demonstrated exemplary care. The SW made an offer of on-going support at each contact. The consistent approach allowed for Tracey to develop a rapport with someone who understood her backstory rather than a duty contact with a different worker each time contact was made. The SW updated the risk assessment and explored the consequences of harmful use of alcohol and contact was made with Sarah to support Tracey in accepting help. Towards the end of Tracey's contact she did accept the offer of the CCO. Tracey was seen as HIGH RISK with the wider ADAPT team and placed in the RED Zone. Being in the RED Zone would trigger more frequent contacts from the team.

5.3.72 The panel considered the lack of communication from Able Futures. Whilst Tracey had told her SW that she was being supported by Able Futures, there was a long gap in her

contact with the company. Whilst Able Futures offers support, they do not offer access the crisis line and Psychiatric Specialty medicine provided by the NHS. Oxleas would not consider the service offered by Able Futures as an alternative to the NHS therapy that Tracey was on the waiting list for.

5.3.73 In the lead up to her death Tracey had three contacts with the Mental Health Liaison Team. These were on 21 December 2019, 8 and 13 March 2020. This was when Tracey came into hospital EDs in an intoxicated state. When Tracey was sober, she was seen to minimise the events and her risk on discharge was seen as being low. The assessments focused on Tracey's self-harm rather than what was behind her problems. The IMR author noted that domestic abuse issues "Were not explored fully in either the risk assessment or assessment documentation in all crisis presentations. This is an oversight by the team given that on two occasions Tracey was found collapsed in alleyways, she clearly was vulnerable at times and unable to make safe decisions."

5.3.74 Tracey was offered a referral to HTT, where housing, alcohol use and crisis could have supported her in a more structured way. Tracey declined this referral.

5.3.75 There was some contact between Sarah, Tracey's friend, and the Crisis Line. Sarah was becoming concerned about the welfare of her child when Tracey was in crisis. The IMR considered that appropriate advice was given to support Sarah.

5.3.76 The IMR author considered that "It may have been useful for the ADAPT team and MHLT to review Tracey's frequent presentation jointly and to pull together a shared management plan. There was no direct consultation with Tracey's GP. It should be noted that Oxleas did make a referral to housing to obtain temporary accommodation for her. There were frequent references to Tracey staying in hotels following incidents; she was staying with a friend in the weeks leading up to her death. This was causing strain as her friend was seeking advice and support regarding how to manage Tracey's chaotic behaviour particularly when she was drunk. Tracey appeared socially isolated and was estranged from her family."

5.3.77 The Oxleas CMHT did write to Tracey's GP with updates on contact and referrals directly with Tracey's GP. Referrals by the GP to Oxleas were dealt with in a timely manner.

5.3.78 The IMR author considered that Tracey was displaying high risk behaviour while under the influence of alcohol. Working together with local alcohol services or involving the Oxleas lead for Co Occurring Mental Health, Alcohol and Drugs (COMHAD) may have provided an opportunity to consider approaches staff could use to offer psych education or engagement in the pre-contemplation stage of addressing harmful alcohol use. Tracey declined a COMHAD referral on 8 March 2020. On 12 March 2020 Tracey was seen by a COMHAD practitioner when she was in hospital.. The consultation was delayed as the practitioner had to see another patient. When they returned to see Tracey, she was vomiting and being attended. The COMHAD practitioner was not able to speak to her that day. The COMHAD practitioner requested that Tracey be assessed the following day and asked to consent to COMHAD. Information was provided on the SLAM Pier Road Project.

5.3.79 Safeguarding adult and safeguarding children training is mandatory for all staff and includes domestic abuse awareness. The Trust has a specific domestic abuse E-learn which can be accessed by all staff and is an option for staff requiring mandatory level 3 update training for SGC as per the intercollegiate guidance. Oxleas also have a domestic abuse handbook available for all staff on the Trust intranet.

5.3.80 There are a number of single agency recommendations in the areas of safeguarding, joint working, risk management and routine questioning on domestic abuse.

Local Housing

5.3.81 **London Borough of Bexley Housing**

5.3.82 Tracey's contact with the Homeless Prevention and Assessment team came seven days before she was found dead. Tracey made it clear that she was a victim of domestic abuse. It was identified that she was receiving support from mental health services but not whether she was receiving support from specialist domestic abuse services. This could have been an opportunity to refer Tracey to a specialist service or ASC.

5.3.83 The IMR author considered "Practice can be improved by putting clear policy and procedures in place for the Duty Officers at the front desk of the Civic Offices, so that when they identify someone as needing additional assistance from another agency, they are aware of what referrals need to be made, when and in what format. This could also fall under a necessity for training on how to make referrals as well as more general training relating to domestic abuse and safeguarding." It was acknowledged that clearer guidelines between partner agencies could provide a homeless applicant with a more well-rounded support network.

5.3.84 The medical information provided by Tracey was deemed, by an independent medical advisor, not to meet the criteria for housing. The Homeless team used their professional judgement to consider Tracey's vulnerability and provided her with temporary accommodation whilst a full assessment took place. This should be considered as good practice.

5.3.85 Single agency recommendations were made in the areas of training.

Police

5.3.86 **Kent Police**

5.3.87 The initial information on the notification transfer from Bexley to the Kent MARAC was correctly recorded on county systems on 2 August 2018. This allowed officers to access information when they were called to Tracey's new address. The original MARAC referral had been made after Tracey had sustained serious injury, where she first named Mehmed as the perpetrator. There was no further analysis of the MARAC involvement by the IMR author. The MARAC took place on 15 August 2018.

5.3.88 In between the MARAC transfer on 2 August 2018 and the meeting on 15 August 2018 there were a number contacts, starting on 3 August 2018, between the MPS, LAS, QEH ED and Oxleas Mental Health Services. It appears that Tracey had been staying

in a hotel in Sidcup, Metropolitan Police Area and was presenting in crisis. LAS believed she was having a mental breakdown and took her to hospital. The MPS completed MERLIN reports to be shared with mental health services. This information was not reported to the MARAC in Kent.

5.3.89 Kent MARAC consider it to have been the responsibility of Kent Police Vulnerability Investigation Team to research Tracey's current circumstances during the 13 days before the Kent MARAC date. This only relates to police databases. The Vulnerability Investigation Team would then present to the MARAC meeting. It is the responsibility of other MARAC panel members to research their own specialty areas. It should be noted that the Kent Police research did not extend to the MPS and the MERLIN report completed on 3 August 2018. Identification of that event could have directed the Kent MARAC to make further enquiries with healthcare professionals in the neighbouring area of Bexley. The panel considered that police input on MARAC to MARAC transfers could be improved if checks were made on the Police National Database (PND).

5.3.90 The Kent MARAC were not aware of Tracey's contact with healthcare agencies in the immediate lead up to the Kent MARAC meeting. The panel considered that all CCGs should be working more closely in cross-border MARAC cases, where information could be missed during the transfer process.

5.3.91 The next contact with Kent Police came on 17 February 2019 when police officers were called to a 'verbal dispute' between Tracey and Mehmed over a dog. This was originally a third-party report from a neighbour. Officers were aware of the previous MARAC referral when they attended. The officers completed a DASH assessment and graded risk as HIGH. It was noted that a RARA assessment (Remove Avoid Reduce Accept) reduced the risk as Mehmed left the premises. The Detective Inspector at the CRU reviewed the attending officer's initial assessment to MEDIUM. The IMR provided no rationale for the decision to reduce the risk.

5.3.92 This incident took place six months after the initial Kent MARAC on 15 August 2018. Kent MARAC state that they will list a case for MARAC if a further incident, that would constitute an offence, occurs within 12 months of previous mention. It is of concern that an incident initially graded as HIGH RISK and then inexplicably downgraded to MEDIUM RISK would not be referred to Kent MARAC unless the incident amounts to a criminal offence. Police grading of a HIGH RISK domestic incident for a person already known to Kent MARAC would not result in an automatic MARAC referral.

5.3.93 The calls to police that followed this incident were listed as civil disputes 'over rent' and the IMR records that they were dealt with appropriately. On 6 June 2019 Tracey called the police as she was in dispute with her landlord over rent. On 1 November 2019 Tracey again contacted police concerning property being held by her landlord. The matters were considered not to be relevant to the review by the IMR author.

5.3.94 A line of enquiry of this review is to consider whether Tracey was subject to economic abuse. We know that Tracey had previously inherited a large amount of money and the information from Kent Police suggests that she had financial problems. The fact that Tracey was in arrears with her rent could be considered as a warning sign of domestic abuse. The first incident recorded as a 'civil dispute' took place within 12 months of the

Kent MARAC. This should be considered as a missed opportunity to explore to risk of domestic abuse by the officers attending and the IMR author.

5.3.95 Given the known MARAC referral, and a reported domestic incident in Kent, it is considered that officers should be alive to the fact that evidence of economic abuse can arise in many ways. That could be evidenced in a victim's inability to pay rent or being relied upon financially by an abusive partner. The framing of this incident as a 'civil dispute' could show a lack of professional curiosity by Kent Police and this was not identified in the subsequent IMR. This is a matter that needs to be explored further in operational and review processes.

5.3.96 Kent Police have policies in place in relation to domestic abuse. This includes positive action, including arrest and safety planning and use of DASH. All officers have readily available guidance and national online training packages have been mandatory since 2012.

5.3.97 There were no single agency recommendations made. The panel were informed that the Domestic Abuse Tactical Group in Kent is currently conducting a full review into the whole MARAC process.

5.3.98 **Metropolitan Police Service**

5.3.99 Tracey first came to the notice of MPS in 2008 when her father reported domestic abuse from Mehmed. She declined to report the abuse. Mehmed and Tracey were suspected of being involved in producing cannabis plants, Tracey revealed that Mehmed was responsible and that she did not challenge him due to abuse. She was seen to have injuries but declined to make a statement about the abuse. This case fell outside the review timescale but shows that she had been seen with physical trauma 12 years before her death and with Tracey stating she was being coercively controlled.

5.3.100 In July 2012 Tracey made a report herself that Mehmed had assaulted her. When she was seen by police, she was intoxicated and then stated that she had not been assaulted. Officers correctly completed DASH Risk Assessments and referred for investigation. Tracey denied any risk factors were present and she repeated this practice whenever police completed DASH assessments thereafter. There is no evidence to suggest that any referrals were made to specialist domestic abuse services. Tracey was provided with information on support. A further report was made in 2014 when a neighbour heard Mehmed and Tracey arguing but there were no allegations made by either party and Tracey denied any DASH risk factors in her life.

5.3.101 In June 2016 police responded to Tracey being found in the street with facial injuries. She initially stated that her boyfriend had punched her in the face. Tracey's clothing appeared to be blood stained, but she declined to give it to the police. She again denied that there were any DASH factors. The MPS were proactive in their response to the assault, protecting Mehmed address as a crime scene and activity seeking to arrest him. He declined to answer questions when interviewed. The case was put to the CPS but there was insufficient evidence to proceed. Officers engaged with IDVA to seek temporary accommodation. Tracey apparently recognised that she should have ended

the relationship but stated that she needed Mehmed in her life. Tracey was correctly referred to MARAC.

5.3.102 The next call to the MPS came on 8 May 2018. Tracey called the police to a verbal argument with Mehmed at home. Although Tracey again declined to answer DASH questions it was recorded that she had recently had a miscarriage. At the time the officers considered a MARAC referral, but it did not reach the threshold in place at the time.

5.3.103 Ten days later Tracey was seriously assaulted at home, and she was found collapsed with extensive bruising and facial injuries. When asked who caused the injuries she said 'boyfriend' and also 'Mehmed why would you do this to me'. The crime was effectively managed and referred to specialist investigators. Thereafter Tracey said she caused the injuries as she was drunk and fell over. She refused to make a statement or give consent for access to medical records of her injuries. Mehmed was arrested, he denied the assault and gave an alibi that he was out of the UK at the time. He suggested that the suspect for the assault was a disgruntled ex-employee. The investigating officer recorded that they found significant evidence that Mehmed was out of the country, travelling on a ferry. The case was closed as NFA due to insufficient evidence.

5.3.104 This incident now needs to be considered against the account given by Tracey's friend Sarah. Sarah states that Tracey said she was set up by Mehmed, and other men came to the house and assaulted her. This account could also fit with the initial comments made to police. The possibility of Tracey being set up could be considered plausible, given Mehmed's decision to answer police questions and with such a clear alibi. Whether Mehmed assaulted Tracey or knew that others would, it still shows culpability.

5.3.105 The police did make appropriate referrals to MARAC and IDVA. The police MERLIN report was reviewed at the MASH. A decision was made not to refer Tracey to ASC, it was noted that she was vulnerable to domestic abuse but was not a 'vulnerable adult'. There was no appreciation that the trauma and coercive controlling behaviour experienced by Tracey put her in a position where she was vulnerable and not able to take care of herself.

5.3.106 On 4 August 2018 MPS were called to a hotel in Sidcup where there were concerns for Tracey's mental health. Whilst there was no reported domestic abuse or risk from Mehmed, Tracey had just been passed from Bexley MARAC to Kent MARAC. The officers correctly completed a MERLIN report. The report was shared with ASC but there was no link made to the current MARAC process. It is not known what information would have been available to MPS or ASC of the MARAC. The fact that Tracey was residing in a London Borough, albeit in a hotel should have been made known to the IDVA supporting Tracey.

5.3.107 When Tracey was found in intoxicated state in hotels or in public places the MPS always considered her immediate welfare and sought medical help. These reports were accompanied by MERLIN reports to inform health and social care of concerns. This is evidenced in the incident when Tracey was found drunk, injured and in possession of a letter indicating she had PTSD on 10 January 2020. A MERLIN report shared with

MASH made the link to Tracey's mental health crisis on the previous MASH in August 2019. Tracey was referred to ASC, without her consent, due to her need for care and support. It is of concern that there is no mention of this MERLIN report by ASC in their IMR or Chronology.

5.3.108 On 14 March 2020 police were called to Tracey where it was suspected that she had broken a widow at the house in Bexley that she previously shared with Mehmed. Tracey was arrested and gave an account of her past abusive relationship with Mehmed. Tracey was released without charge. A DASH assessment was completed in relation to Mehmed being a victim but this was not recorded on the CRIS record of investigation. Tracey was clearly presenting in a vulnerable condition, giving details of past abuse, but there were no referrals made to consider support through MERLIN or MARAC.

5.3.109 When Tracey was later reported missing the MPS undertook the investigation. Sarah reported Tracey missing and the case was initially deemed to have been considered 'MEDIUM RISK' as it was believed that Tracey was moving home, and the new address was not known. The following day the investigation was escalated to 'HIGH RISK'. Officers did carry out comprehensive financial and telecoms enquiries and made contact with professionals dealing with Tracey.

5.3.110 MPS spoke with Mehmed by phone, and he told them that Tracey had commented about trying to hang herself from the curtains. Mehmed asked to be informed of Tracey's new address, information was not passed on due to the known domestic abuse. Mehmed became verbally abusive to police.

5.3.111 When Tracey was discovered in the new address a Police Inspector attended the scene. There were no notes or evidence of suicidal ideation. There were no obvious inconsistent injuries found on Tracey at the scene.

5.3.112 The MPS did not follow service policy and procedure for managing cases where a person is suspected to have taken their own life. A detective officer was not called to the scene when Tracey's body was found. There was no forensic management or photographs taken to record the evidence. Neither Sarah nor Mehmed were interviewed to provide a statement on the ideations of Tracey at the time of the initial investigation of the incident It is appreciated that the events took place during the early stages of the COVID-19 pandemic, with particular demands on emergency services, but the MPS did not record the lack of action being linked to resource issues at the time.

5.3.113 The panel have raised concerns on the management of post mortem procedures. There was no post mortem examination of Tracey's body. The Coroner informed the panel that in times of high demand, like the pandemic, that it would have been accepted practice that a visual examination of Tracey's body and toxicology tests would have been relied upon. The Coroner ordered toxicology tests from Tracey's body. The tests failed and no other samples are known to have been taken. The panel has not been provided with any evidence of a visual examination of Tracey's body being undertaken by a medical professional, as the Coroner suggested should have happened. Whilst the initial police examination of Tracey's body at the scene, did not suggest foul play,

the Coroner's Office had not provided any evidence of medical examination. There was consideration that the COVID-19 pandemic may have affected some processes. It is appreciated that there would have been additional pressures on the NHS at this point.

5.3.114 The police have not secured any direct evidence of suicidal ideation since Tracey's death. There were no notes discovered. Tracey was reported to have made comments about two weeks before her death, to Sarah, about jumping in front of a train. During the missing person's investigation, Mehmed told police, by phone, that Tracey had mentioned hanging herself from the curtain rail. There was no statement taken from Mehmed or other evidence to support this. Since Tracey's death, police have been unable to obtain a statement from Mehmed, despite further attempts. There is no evidence that Mehmed's communication data was considered by the police. Tracey's mobile phone was seized at the time of the incident, but it was not submitted for digital forensic examination until sometime after Tracey's death. Tracey's mother was contacted by the MPS, in late 2021, to request the passcode for the phone. Sarah has been interviewed by the Chair of the review. During the interview, although Sarah did disclose previous attempts of overdose by Tracey, Tracey had never mentioned hanging to Sarah. The MPS interviewed Sarah in 2022. She did not mention any suicidal ideation concerning hanging. Sarah said that she was confused that on previous occasions Tracey had attempted suicide through overdosing and she was found in different circumstances, on her own and isolated.

5.3.115 The MPS have made recommendations on assessment of Vulnerable Adults and MARAC referral protocols. The panel have made recommendations on the MPS management of unexplained deaths.

Social Care

5.3.116 **London Borough of Bexley - Adult Social Care**

5.3.117 Bexley ASC did not hold Tracey as a client within their service. They had no direct contact with Tracey. The first contact came through a MERLIN referral in 2018, that was forwarded to Oxleas mental health services.

5.3.118 On 11 January 2020 Tracey's friend, Sarah contacted ASC about with concerns on Tracey's mental health. The friend was again referred to Oxleas. The IMR author stated, "Referral onward to mental health services was appropriate, conducted in a timely manner".

5.3.119 It is of concern that the IMR and Chronology submitted by ASC does not mention a MERLIN report submitted by the MPS on the 10 January 2020. MASH records show a discussion with ASC and a decision to share the report on Tracey's need for care and support without her consent. It appears the timing of this coincides with the contact from Sarah. The discussion between MASH and ASC indicates that this is a clear referral that was not actioned. The view of ASC is that as Tracey was known to Oxleas, that the matter report was passed to them.

5.3.120 Bexley ASC work to Pan-London Policy and Procedures for Safeguarding. ASC staff attend Adult Safeguarding training which incorporates domestic abuse, but additionally

the e-learning module and training provided via the London Borough of Bexley Domestic Abuse and Sexual Violence Strategy Manager.

5.3.121 There were no single agency recommendations.

Specialist Domestic Abuse Services - IDVA and MARAC

5.3.122 **Clarion Housing Association - Domestic Abuse Service Kent**

5.3.123 Tracey was referred to the Clarion IDVA when it was known she had moved into the Dartford, Kent area from the London Borough of Bexley on 2 August 2018. The transfer from the Bexley IDVA to Clarion included minutes of the Bexley MARAC in June 2018. The IMR author cited this as good practice, as it gave the Clarion IDVA better insight into Tracey's case.

5.3.124 The IDVA tried to make contact with Tracey within a day of notification and well within the Clarion policy of attempting to contact new clients within 48 hours. The panel identified that that the day after this MARAC to MARAC referral, 3 August 2018, Tracey had been found hallucinating in a hotel in Bexley and taken by Ambulance Hospital. The MPS recorded concerns in a MERLIN report. Tracey was seen by the MPS, LAS and PRUH, with a MERLIN form recording concerns being assessed by Oxleas and there was no communication with her allocated IDVA.

5.3.125 When the IDVA spoke with Tracey on 8 August 2018, they were unsuccessful in encouraging her to accept support. The call ended before safety planning could be discussed. This was followed up with communication to the original Bexley referrer and complies with Clarion policy. The Kent MARAC Coordinator was also updated and informed them that no further safety planning had taken place.

5.3.126 The Kent MARAC was held on 15 August 2018 with representation from the IDVA and Kent Police. The IMR author wrote "This case was designated 'for mention only' at the north Kent MARAC which was an accepted practice in 2018. 'For mention' meant a case would be added to the MARAC list with case research completed and circulated. However, the case itself would not be scheduled for discussion. The referring agency in Tracey's case may not have known this." The panel note that Tracey had come to the attention of four agencies 12 days before the MARAC and this information was not noted in the research or brought to the MARAC's attention. There needs to be clarification on the research process and timing in relation to the MARAC.

5.3.127 The IMR author notes that Kent MARAC no longer accepts cases 'for mention only'.

5.3.128 Tracey's case was also reviewed during a scheduled case management meeting on 15 August 2018. At that point it was agreed that the case should be closed, as Tracey had declined support, she was more settled and had resumed working. There were no further actions at Clarion.

5.3.129 The IMR author noted that the IDVA did not make any case notes regarding a discussion on cultural issues, disabilities or barriers to accessing support. They noted that the original MARAC referral made reference to Tracey staying with her mother, suggesting some family support. Consideration could have been given to reasons why Tracey did not engage, and communication with other agencies would have revealed

that Tracey had presented in crisis to the police and NHS after the case had been transferred to Clarion.

5.3.130 The original MARAC referral form did not highlight Mehmed's offending history and the IMR author believed that this may have affected the IDVA's decision as to whether to close the case or request that the case be heard at a full MARAC. It needs to be considered that the case was closed two months after Tracey had suffered significant injuries, that she initially attributed to Mehmed and then withdrew. At that point there had been no further enquiries into Tracey's welfare, personal safety or any form of risk assessment.

5.3.131 The IMR author noted "Clarion have participated in previous reviews; we have developed and improved our ways of working and implemented recommendations from these reviews e.g. stipulating the time scales for contacting new referrals. As a result of the reviews, Clarion have, in conjunction with the Clarion IDVA team and Kent CSU, developed mandatory Practice Standards for all Clarion IDVAs. Please note, Clarion's engagement with Tracey was prior to these practice developments, but I have considered them when completing this IMR".

5.3.132 Clarion were unable to identify any specific recommendations that have not already been implemented as a result of more recent reviews.

5.3.133 **Kent MARAC**

5.3.134 The Kent MARAC is not an agency, and the IMR format has been used by the Kent Police MARAC lead to introduce information on the initial referral, minutes and information provided by Bexley MARAC. There is also comment on change in policy since Tracey's case was heard.

5.3.135 Tracey's case had originally been heard by the London Borough of Bexley MARAC. Tracey then moved to Kent, via MARAC to MARAC transfer. Bexley sent Kent a copy of the original MARAC referral, completed by the MPS on 18 June 2018, and extracts of minutes of the Bexley MARAC on 26 June 2018. The notification arrived on 2 August 2018 and the Clarion IDVA was informed that day.

5.3.136 Tracey's case was added to the list for the Kent MARAC on 15 August 2018. A case list for the MARAC circulated to all agencies attending the meeting on 7 August 2018.

5.3.137 The case was listed 'for mention'. This means it was listed on the case list for information only. The MARAC would only discuss cases 'for mention' if an agency specifically requested the MARAC to do so. This would be done for MARAC transfers where a person had only just come into area, where it was unlikely agencies would know the people being discussed but needed to know the victim was in the area. The MARAC would also list cases 'for mention' if they had heard the case in their own area within the previous three MARAC meetings.

5.3.138 It should be noted that the MARAC no longer lists cases 'for mention'.

5.3.139 The MARAC meeting was held on 15 August 2018. It is known that the Clarion IDVA, Kent Police and DVH attended the meeting. It is not clear what mental health services were aligned to the MARAC. It is also not clear what a cut-off time was for agencies to

research the MARAC list, for contact with the victim, before the agency attended the meeting. The circulation for the meeting went out on the 7 August 2018 and Tracey had been seen in crisis between 3 and 4 August 2018.

5.3.140 It does not appear that Tracey was listed at the MARAC for a meeting following the meeting of the 15 August 2018. At that point the information was that the MPS investigation was still ongoing with Mehmed under bail conditions not to contact Tracey. At that point it was known that Tracey did not want to engage with the IDVA but there were no enquiries to see what other agencies were involved, such as mental health trusts and GP. The minutes do not record any information from other agencies.

5.3.141 The MARAC IMR states, “After a case is heard, we do not hear it again unless a further incident occurs in the 12 months following a MARAC. No further incidents were reported, and this case was not heard again.” It is known that Tracey reported a domestic incident on 17 February 2019 to Kent Police, initially graded as HIGH RISK and then reduced to MEDIUM risk. Kent MARAC have informed the panel that an incident will only be referred back if it amounts to an offence.

5.3.142 The Kent MARAC were not made aware of Tracey’s move back to Bexley, although it appears that this took place after the ‘12 months from the initial meeting’ expired. Any case suitable for a MARAC referral after that 12 month period should have resulted in a new MARAC referral to the area where the victim was residing.

5.3.143 The IMR author concluded, “We have changed our MARAC working practice already to ensure we discuss cases in full, all the time. This change happened before this death occurred, not as a result of any formal recommendations. We do not know what impact this would have had on this particular case, but we do know in general this promotes better information sharing and action planning and is a safer approach to MARAC.”

5.3.144 There were no single agency recommendations.

5.3.145 **London Borough of Bexley MARAC and Crisis Intervention Team**

5.3.146 The MARAC policy for 2016 is no longer available, but the MARAC referral from the MPS in 2016 was appropriate based on ‘Professional Judgement’. There had been a serious assault and Tracey had declined to complete a DASH assessment. The original IDVA accompanied police to check on Mehmed’s compliance with bail and victim welfare. There was no recorded risk assessment for the IDVA or the impact on the victim. The IMR author states that the practice of visiting to check bail conditions was not appropriate and it is no longer practice in Bexley.

5.3.147 The MARAC meeting showed good multi-agency representation, but there was no record of any information being shared by agencies other than the MPS and IDVA. There was no record of a safety plan from 2016 being available for review. There were no records of further planning to consider Tracey’s safety at work. There was no discussion on liaison with the GP. The case was closed without any update on communication with Tracey.

5.3.148 The next MARAC meeting was in 2018 following the serious assault on Tracey. There was no disclosure from Tracey, she was staying with her mother and Mehmed was

noted to be out of the country. There was no record of which agencies attended the meeting. It was noted that Oxleas reported that neither party were known to them. It should be noted that Tracey had been a patient of Oxleas in 2013. Other agencies have not noted invites or submissions to the MARAC.

5.3.149 The MARAC focussed on safety planning and protection of Tracey, but her mother's address was not noted. It is therefore not clear how agencies could have planned safety measures around the mother's address. The records do not include details of the plan going forward. There appears to have been no consideration of any potential risk to Tracey's mother. In this meeting it was noted that Tracey had been signed off work for six weeks. It should be considered that interfering with employment can be seen as economic abuse.

5.3.150 As Tracey moved into Kent there was a MARAC to MARAC referral. It is seen that copies of the original police referral and MARAC minutes were provided to Kent MARAC and this should be seen as good practice. The referral was not recorded in Bexley, demonstrating poor record keeping within the borough at that time.

5.3.151 The MARAC process in Bexley in 2018 did not appear to fully address Tracey's housing needs. The MARAC was aware that Tracey had some issues with alcohol use, but they were not explored and there were no referrals for support. There appears to have been no link made between Tracey's housing needs and economic abuse.

5.3.152 The conclusion of the IMR author is that that Bexley MARAC in 2016 to 2018 was not fit for purpose and did not adhere to the recommended practice for an effective MARAC. There was a poor level of record keeping. There was no supervision of the IDVA role. At the time the MARAC and IDVA were based within the housing department.

5.3.153 It should be noted that there was a review and extensive restructuring that took place after the last MARAC considered in this report. The CSP recruited a Domestic Abuse & Sexual Violence Strategy Manager and Commissioner to oversee and review all domestic abuse services within Bexley. The MARAC remains under the remit of the DASV Strategy Manager & Commissioner. Bexley have recently completed a Peer Review and are currently preparing a Safe Lives review to ensure that the MARAC meets all objectives. The MARAC minutes are structured and highlight the risk factors and a shared action plan is formulated with SMART actions.

5.3.154 There are single agency recommendations to review referral protocols, audit and improvement.

Good practice identified

5.3.155 Whilst there are learning points for how practice can be improved, the review has also identified areas of good practice.

5.3.156 The transfer from the Bexley IDVA to Clarion included minutes of the Bexley MARAC and the original MPS MARAC referral. The IMR author cited this as good practice, as it gave the Clarion IDVA better insight into Tracey's case.

5.3.157 In considering Tracey's request for housing before her death. The Homeless team used their professional judgement to consider Tracey's vulnerability and provided her with temporary accommodation whilst a full assessment took place. This should be considered as good practice.

5.3.158 Shortly before Tracey's death a person representing themselves as her friend made enquiries with her GP on Tracey's welfare. The practice did not disclose patient information to the person calling and this is entirely correct. The practice did give appropriate advice, advising the caller to bring Tracey to the practice. It needs to be considered that in some cases, partners will try to access medical records of a patient. It should be considered good practice that this contact was recorded in patient notes.

5.3.159 The panel considered Oxleas Social Worker's continued offering of support as a Care Coordinator demonstrated exemplary care. The SW made an offer of on-going support at each contact. The consistent approach allowed for Tracey to develop a rapport with someone who understood her backstory rather than a duty contact with a different worker each time contact was made.

5.3.160 Bexley CSP and local Healthcare agencies have introduced the ICM (Integrated Care Management meetings) that provide a forum for partner agencies to come together and plan shared care with complex cases. The GP is a key figure in this model. Presentations to MHLTs at Hospital can be shared at this type of forum. The meetings provide an opportunity to share concerns and provide a better understanding of how to develop a relevant holistic plan of care.

5.3.161 The London Borough of Bexley have established a Domestic Abuse Health Sub Group. The group is a multi-agency health partnership which is a subset of the Domestic Abuse Operational Group and reports into the Bexley Domestic Abuse Partnership Strategic Group. The Sub Group's function is to oversee and manage the health response to domestic abuse, ensuring all health services are responding effectively to domestic abuse. This Health Sub Group has been formed in response to the Pathfinder which has been developed with Standing Together and its partners and is built on the existing good practice of health partners from acute health, mental health and primary care with local domestic abuse specialist services. This promotes the use of governance and policies, coordination, data collection, specialist interventions and training to build the capacity of local health systems to respond to survivors of domestic abuse. The terms of reference for the Sub Group were set in August 2020.

5.3.162 The South East London CCG and KCH provided information to the panel on the Complex Care Pathway that is being used in the South East London area including a neighbouring borough. The Complex Case Pathway was created by partners from both the Lambeth and Bromley Safeguarding Adult Boards. The pathway and associated guidance document were developed in response to separate Safeguarding Adult Reviews in each board; both SARs having similar themes. These themes related to concerns about how agencies worked together effectively to support adults at risk of self-neglect, where the risks (both known and unknown) are increasing, and where providing support for the person is either challenging or those support pathways are unclear. These risks and challenges can often be compounded as the adult may not

meet the criteria for a formal adult safeguarding response, or the person may not be in receipt of a service with clear responsibility for overall care co-ordination that takes into account the entire well-being of the person, or the person may fall outside eligibility criteria for a service or for several services.

5.3.163 The pathway seeks to: encourage a pro-active responsibility to act, from the agency, that identifies the concern, encourages the facilitation of multi-agency conversations about risk, and develops on-going consideration of risk and actions through the identification of a lead agency.

5.3.164 Kent CSPs have now established Vulnerability Panels across the county. The panels are a forum where various agencies come together to discuss cases they are holding and offers support offers made to vulnerable adults within the local community. The expected outcome from the panels is to prevent or to end these individuals' feelings of isolation, obtain appropriate support for those experiencing mental health issues, and to prevent or avoid repeat victimisation due to crime or anti-social behaviour.

6. Conclusions & Lessons to be Learnt

6.1 Conclusions (key issues during this review)

6.1.1 It is not the purpose of this review to establish the cause of Tracey's death or to attach blame to any person. The inquest has concluded that Tracey took her own life. This review was established to consider how agencies worked with Tracey and how the domestic abuse in her life was responded to.

6.1.2 The Review Panel extends its sympathy to the family and friends of Tracey. Their involvement in the review process has provided a valuable insight into Tracey as a person, and some of her experience of agencies. This review aims to use their contribution and the work of the panel to bring improvements for other people and to help prevent future tragedy. Tracey's family have fully supported this review in the hope that it will somehow reflect Tracey as a person. It is of note that the review took place during the time that the inquest into Tracey's death was ongoing. This was a particularly challenging time for Tracey's family and the significance of their input to this review under these circumstances is recognised. It is recognised that the family received support throughout this process from AAFDA. The Chair would also like to extend thanks to AAFDA for their support and professional communication.

6.1.3 This review is a learning process, and the aim is to share that learning across all agencies involved to improve services in the future.

6.1.4 The information provided to the panel clearly indicated that that the trauma of domestic abuse was a major factor in Tracey's life from 2008. Her history of trauma and the number of incidents she experienced do not appear to have been fully considered by agencies. She was still suffering from the trauma and economic abuse at the time of her death. There were several reports of assaults on Tracey, she was found with injuries in 2008, in 2012 she told NHS staff that her partner had beaten her. In the same year she told police she had been assaulted by her boyfriend, and then withdrew the

report. In 2013 Tracey's finger was bitten off by her dog. Tracey reported to police that this resulted after an attack by strangers, she told her friend that her partner was responsible. In 2015 she informed MIND that she was in a historically violent relationship. The following year she told police that Mehmed had punched her in the face. In 2018 Tracey was victim of a serious assault. Police suspected her partner; Tracey told her friend that he had set her up.

6.1.5 When Tracey presented to healthcare services in an intoxicated state it is not clear that there was any link made to the trauma experienced by Tracey from domestic abuse. Tracey was considered for assessment for substance misuse when she was seen in hospital. The opportunity was missed when the assessment was delayed and then Tracey was unwell. Assessments of clients using substance misuse services are expected to take domestic abuse into account. This should be a routine part of clinical good practice. Domestic abuse should be considered "*even when there are no such indicators of such violence and abuse*".[12] It was clear that healthcare staff were aware of Tracey's history of domestic abuse. It is not clear that the link between fears for her safety due to intoxication were linked to Tracey's trauma from domestic abuse.

6.1.6 In 2015 Tracey inherited a significant sum of money following her father's death. Family and friends told the review that the money disappeared over the years. Her partner was accessing her money, often with a promise to return. He had direct access to her bank account. The economic abuse was a trauma in her life that she recounted to her friends and agencies. It is hard not to think that the stigma of losing her inheritance may have stopped Tracey seeking support from her family. Throughout her contact with healthcare agencies Tracey recounted being victim of economic abuse. Police were called to 'civil disputes' over rent arrears but the links to economic abuse were not explored, despite her being a MARAC subject.

6.1.7 It is not apparent that agencies clearly identified economic abuse of Tracey as domestic abuse in itself. Tracey disclosed her financial situation on a number of occasions. Tracey's family were clearly concerned about economic exploitation in the summer of 2018. She was off work for six weeks following a serious assault. Economic abuse can often be evident in the sabotage or interference with employment. The Bexley MARAC were aware of the financial loss of £42,000 to Tracey in 2018. As Tracey moved from Bexley to Kent, indicators of economic abuse continued. Police were called to 'Civil Disputes' because Tracey was in rent arrears, these were not considered as economic abuse. In December 2020 Tracey told LAS crew that she was homeless because her husband had stopped paying rent, the LAS did not recognise this as domestic abuse.

6.1.8 A significant number of victims of domestic abuse commit suicide.[13] The issue of suicide should be key for those responding to and managing domestic abuse. Studies have shown that almost 30 women attempt suicide every day as a result of

[12] Department of Health, *Responding to domestic abuse: a resource for health professionals* p.32

[13] "*Of women who have experienced domestic abuse in the last six months, 500 commit suicide every year. Almost 200 of those had attended hospital for domestic abuse on the day they died, (p.32) Department of Health Responding to Domestic Abuse - A Resource for Healthcare professionals*
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/597435/DometicAbuseGuidance.pdf

experiencing domestic abuse. It is also estimated that that every week three women take their own lives. The DASH risk assessment considers suicide and self-harm, for victims. The link between mental ill-health and domestic abuse is also clearly recognised in guidance for healthcare professionals. Routine enquiry into domestic abuse is required in adult mental health services. [14] On many occasions Tracey told healthcare professionals about the abuse. She was advised to self-refer to specialist agencies.

6.1.9 The review has established that there were at least nine occasions when Tracey had disclosed to healthcare professionals that she had been victim of domestic abuse. This excludes occasions when she was admitted to hospital following serious assaults. The disclosures were made to ambulance, GP, mental health, and emergency department staff. There were no DASH assessments completed by any healthcare professionals. Tracey was asked to self-refer to specialist domestic abuse services on some occasions. The panel recognises steps taken by some trusts to bring IDVAs into healthcare settings, but identification of abuse is a responsibility for all. This review has highlighted the need for improvement in the working practice to utilise DASH assessments as a routine tool to assess risk and improve patient safety.

6.1.10 This review has revealed gaps in MARAC processes and missed opportunities to link Tracey with specialist services. The MPS did make appropriate MARAC referrals following serious assaults in Bexley. The first referral was made based on the professional judgement of the police, as Tracey had declined to complete the DASH assessment following a serious assault. The 2016 MARAC meeting did not record any information being shared by agencies other than MPS and IDVA. There was no discussion of Tracey's safety at work and no liaison with the GP. The case was closed without communicating further with Tracey.

6.1.11 In 2018 Tracey was referred, by the MPS, to the MARAC again. The meeting noted that Tracey was not previously known to Oxleas mental health services. This was not correct, as Tracey had been seen in 2013. There were no adequate safety plans made at the meeting. The local IDVA did attempt to engage with Tracey, without success. Shortly after the Bexley MARAC was held, Tracey moved to another area, Kent. The appropriate MARAC to MARAC referrals were made and information was passed across. It should be noted that there has been a complete change in the management and processes of the Bexley MARAC since 2018.

6.1.12 The transfer to Kent MARAC coincided with a time of mental ill-health crisis for Tracey. The case was listed for 'mention only' at the Kent MARAC and research processes failed to identify Tracey coming to notice of police, ambulance GP and NHS Trust in Bexley. Kent MARAC no longer list cases for 'mention only'. It should be noted that in other parts of Kent there is a process where the CCG will research all cases before they appear at a MARAC. The panel have been given reassurance that a full county

[14] Department of Health, *Responding to domestic abuse: a resource for health professionals* (March 2017) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/597435/DometicAbuseGuidance.pdf (accessed 7 Sept 2020) p. 32

wide review of MARAC processes is taking place. The review will consider learning from this DHR.

6.1.13 Tracey came to the notice of police whilst she was a subject of the Kent MARAC. On one of those occasions officers attended an incident that required a DASH assessment and they graded it as HIGH RISK. That grading was changed to MEDIUM without a rationale being recorded. Police were also called to a 'civil dispute' over rent whilst Tracey was on the MARAC register. There was no consideration of how economic abuse of a MARAC subject could trigger a referral back to MARAC. The Kent MARAC representative on the panel stated that at the time of the incident, a case could only be brought back to the process if an offence was committed.

6.1.14 In cases of unexplained death and where a person is suspected of taking their own life, the police have a responsibility to fully investigate and provide information for the Coroner. This investigation should involve trained detective officers and forensic examination of the crime scene. This did not take place. There were no statements taken, at the time that Tracey was found, that could be used to confirm the suicidal ideation. Tracey's telephone was seized for digital forensic examination. It was not submitted for analysis until the end of 2021. The panel takes into account that Tracey died at the start of the COVID-19 pandemic and that would have had an impact on police resources. The pressure of the pandemic was not recorded in any rationale not to fully investigate Tracey's death at the time. The panel were informed that the police would have expected a post mortem examination to be conducted, but the COVID-19 pandemic may have impacted on this. It appears that the lack of a full investigation into the apparent suicide, of a woman known to have a lengthy history of domestic abuse, was an oversight by the police and demonstrates a need for learning and increased supervision.

6.1.15 The Coroner has informed the Chair that the need for a Forensic or "Special" Post Mortem was not requested by the police. The Coroner's processes at the time were affected by the pressures of the pandemic. They relied on a toxicology examination and a visual examination of Tracey's body. The toxicology examination failed and no further toxicology tests were taken. The Chair has asked the Coroner on a number of occasions for details of the physical examination. To date no information has been provided. The Coroner's Inquest has given a verdict of suicide. To date, medical evidence to indicate the exact cause of Tracey's death has not been provided to this review.

6.1.16 This DHR has also shown the importance of employers understanding domestic abuse. It is known that when Tracey was seriously assaulted, she requested a role at work that was not public facing. Despite repeated efforts of the Chair, Tracey's employers refused to support this review in any way. The panel were able to identify the company that provided occupational health support and counselling to Tracey. That company, Able Futures, provided valuable information to the review. It has to be concluded that the failure of Tracey's employer to contribute to the review limited the opportunity to understand more of Tracey's life. There is no assurance that the company has any protocols to manage domestic abuse disclosures from employees or customers. Given that the company is a public leisure centre, this is a matter of great concern.

6.2 Key Themes & Learnings Identified

6.2.1 The lessons identified by the panel are:

6.2.2 **Trauma Based Work** Tracey experienced serious physical and emotional trauma during her abusive relationship. The physical injuries were clear for agencies to see, and Tracey disclosed to professionals how trauma impacted on her life. Many women who have experienced such abuse and trauma will be more likely to experience mental ill-health and substance misuse problems. Services need to be actively aware of this association with domestic abuse and provide services tailored to their needs and welfare.

6.2.3 **This lesson translates into recommendations 11, C, G, I, O, W, and AE.**

6.2.4 **Economic Abuse** It is clear from Tracey's' family and disclosures to numerous professionals that she suffered a significant financial loss. Economic abuse should be treated in the same way as any other form of domestic abuse, as opposed to treating it as a property crime. In dealing with physical abuse, professionals can jump to a safety plan, but use of DASH can evidence economic abuse.

6.2.5 **This lesson translates into recommendations 1, 2, 4, and 5.**

6.2.6 **Suicide and Separation** Agencies should have an increased awareness of the potential for suicide in people subject to domestic abuse and separating from abusers. The issue of separation is recognised in Risk Assessments, but this tends to focus on the increased risk of attack from a perpetrator following separation. The coercive controlling actions of perpetrators can socially isolate their victims. When that perpetrator moves on, their victim can be left homeless, with limited financial resources, and cut off from their family. This can severely affect the victim's mental health and well-being. This lesson can be clearly seen in this case. It is essential that the risk of suicide is always considered in risk assessment and steps are taken to address the care and support needs of a victim. This requires a multi-agency approach to provide a network of support. Learning from this case should also be considered together with the findings of a previous DHR at Bexley (Death of "Blue" 2019).

6.2.7 **This lesson translates into recommendations 11, P, R, W, Y, and AE.**

6.2.8 **DASH Risk Assessment** The DASH Risk Assessment tool provides proven methodology in the assessment of risk from domestic abuse. The DASH tool was used by the police to trigger a MARAC referral. In one police area the DASH assessment was used but the risk was downgraded, without a recorded rationale. There is no evidence of the DASH assessment being used by the key agencies managing Tracey's healthcare. The DASH assessment should be considered as a standard tool to support a patient's wellbeing and safety. Professional use can lead to a holistic multi-agency response to protect and support victims of domestic abuse.

6.2.9 **This lesson translates into recommendations 4, 8, G, I, L, O, V, W, Z, and AE.**

6.2.10 **MARAC** The four aims of MARAC are to safeguard victims of domestic abuse, manage perpetrators' behaviour, safeguard professionals and make links with all other

safeguarding processes. [15] In order for MARAC to work effectively to meet these aims there needs to be a robust referral process and this has been considered in reference to DASH. Once a person becomes subject to a MARAC the process needs to add value and promote safety. The MARAC can only work effectively if all relevant information is presented to the meeting. There need to be a process in place to ensure that all healthcare agencies provide timely information. There also need to be processes in place to ensure that incidents of abuse taking place whilst a person is a MARAC subject are reported to the meeting.

6.2.11 **This lesson translates into recommendations 6, 7, T, and Y.**

6.2.12 **Police Management of Suspected Suicide** The police management of unexplained death is a critical area of work. The work requires high levels of professionalism, to ensure that all reasonable lines of enquiry are considered. It also requires sensitivity in dealing with the family the deceased. Whilst on some occasions the cause of death may appear obvious to police officers who discover the death, the circumstances need to be thoroughly investigated to ensure that the correct cause of death is established. In cases of suspected suicide the scene should forensically examined, and investigations should involve detective officers. The effective and sensitive management of investigations can help families to understand the events and enable multi-agency reviews to learn and improve services.

6.2.13 **This lesson translates into recommendation 3.**

6.2.14 **Employers** In considering the impact on domestic abuse on employers, it is known that domestic abuse impacts on staff welfare, retention, productivity and safety. It is important that the roles of non-police agencies and third-party police reporting are promoted to employers. The training of businesses on the impact of domestic abuse could have positive benefits for many and improve public safety.

6.2.15 **This lesson translates into recommendations 9, A, B, C, D, and E.**

[15] https://safelives.org.uk/sites/default/files/resources/The%20principles%20of%20an%20effective%20MARAC%20FINAL.pdf

7. Recommendations

7.1 Multi Agency Recommendations (developed by the Review Panel)

7.1.1 The Review Panel has developed the following recommendations during this DHR. These are described in section 5 as part of the analysis.

7.1.2 These recommendations are also presented in the multi-agency recommendation action plan template in **Appendix 2**. The Bexley Community Safety Partnership is responsible for overseeing then development and monitoring of an action plan.

7.1.3 **Recommendation 1** That the Home Office engage with financial institutions to consider the learning from this report on economic abuse and how security measures for banking can be bypassed by perpetrators of domestic abuse.

7.1.4 **Recommendation 2** That the Home Office and College of Policing review guidance on economic abuse to ensure that homelessness and rent arrears are considered as indicators of economic abuse in any changes to national Risk Assessment Guidance.

7.1.5 **Recommendation 3** That the MPS, in conjunction with the Coroner's Officer, conduct a thematic review of reported Sudden Deaths in the South East Basic Command Unit to ensure that all cases where a person is suspected to have taken their own life have been investigated to the standards set out by the service.

7.1.6 **Recommendation 4** That Bexley Community Safety Partnership and partners all review training in the light of Domestic Abuse Act 2021 and learning from this case, to ensure that economic abuse is highlighted.

7.1.7 **Recommendation 5** That Bexley Community Safety Partnership ensure that future DHRs consider the involvement of Citizens Advice Bureau, financial institutions and money/debt advice agencies at the outset of all future reviews.

7.1.8 **Recommendation 6** That Kent county-wide review of MARAC process considers the learning from this review, to develop and implement systems to ensure up to date research has been completed on each case prior to a MARAC meeting. Particular attention should be paid to processes for MARAC to MARAC transfers from other areas.

7.1.9 **Recommendation 7** That the Bexley MARAC and MASH review processes and protocols to ensure that agencies in the Borough are aware of MARAC transfers and how to ensure that appropriate information is passed to the new MARAC.

7.1.10 **Recommendation 8** That Bexley Adult Social Care review policy and process for notifications from police for Adults In Need of Care and Support. This should be followed up with audit to ensure compliance.

7.1.11 **Recommendation 9** That the Bexley Community Safety Partnership contact Gravesham and Dartford Community Safety Partnership and Tracey's employer to

discuss the learning from this case and promote engagement with employers on domestic abuse initiatives.

7.1.12 **Recommendation 10** That Bexley Community Safety Partnership promote the process of proactive referrals of clients/patients to specialist domestic services by agencies. Clients/patients would have the option to 'opt out' of a referral rather than them being relied on to self-refer.

7.1.13 **Recommendation 11** That Bexley Community Safety Partnership use the learning from this review to support the learning from the recommendations of the DHR in the name of 'Blue' (2019) in the areas of trauma informed practice, suicide in circumstances of domestic abuse, and routine enquiry.

7.1.14 **Recommendation 12 T**hat Bexley Community Safety Partnership use the learning from this review to support the learning from the recommendations of the DHR in the name of 'Blue' (2019) to inform new work on alcohol misuse.

7.2 Single Agency Recommendations

7.2.1 The following single agency recommendations were made by the agencies in their IMRs. They are described in section 5 following the analysis of contact by each agency.

7.2.2 These recommendations are also presented by agency in the single agency recommendation action plan template in **Appendix 3**. These recommendations should be acted on through the development of an action plan, with each agency reporting on progress to the Bexley Community Safety Partnership.

7.2.3 These are as follows:

Able Futures

7.2.4 **Recommendation A** Review the Safeguarding Participants & DSO Process v4.0 in relation to Domestic Violence to ensure our responsibilities for DV as a non-statutory organisation are clearly detailed.

7.2.5 **Recommendation B** Following the review of the process, a review mandatory staff training for safeguarding in relation to domestic violence will be undertaken if required.

7.2.6 **Recommendation C** Training to increase awareness within the VRC team of safeguarding issues not specific to mental health i.e. domestic violence, prevent duty, etc.

7.2.7 **Recommendation D** To discuss the findings of Able Futures IMR at the monthly Safeguarding Forum to share best practice across our business.

7.2.8 **Recommendation E** Review management procedures for ensuring VRCs contact and support all participants in line with the contractual minimum requirements and the agreed support plan.

Dartford and Gravesham NHS Trust

7.2.9 **Recommendation F** Emergency Department Staff to provide information on alcohol reduction and signpost to local addiction services, Assurance to be sought that Psychiatry Liaison signpost to local addiction services and GP to be informed of

concern around alcohol misuse. That staff use Identification and Brief Advice (IBA), an online learning resource for healthcare and social care professionals working to reduce alcohol related harm.[16] This would be used to enable staff to signpost patients to local addiction services.

7.2.10 **Recommendation G** Promote use of referral systems and HIDVA trust-wide to ensure staff awareness. When a disclosure of domestic abuse is made it would be expected that a DASH risk assessment is completed and domestic abuse support services are offered, with appropriate referrals being made to safeguard vulnerable adults via electronic referral systems.

General Practitioner

7.2.11 **Recommendation H** To ensure that a standalone domestic violence policy is made available by end of June 2022 and then reviewed every 2 years along with all the other Practice policies.

7.2.12 **Recommendation I** We have a designated Mental Health Nurse Practitioner who is carrying out the mental health reviews. We have added to her usual template of review questions to also ask patients whether there are any domestic violence concerns to ensure that patients are supported.

7.2.13 **Recommendation J** To include a rolling agenda item in the clinical meeting to discuss domestic violence training and guidance. As usual individual cases will be discussed immediately.

7.2.14 **Recommendation K** For the staff member who has been identified to become the Domestic Abuse Champion to undertake the necessary training and to feedback to the practice staff their role and help/support they can offer.

7.2.15 **Recommendation L** To ensure that up-to-date resources are displayed and staff are advised of correct process for referral, this should be raised in the clinical meeting.

The Hurley Group

7.2.16 **Recommendation M** A system prompt if a patient has attended with a previous injury.

7.2.17 **Recommendation N** Update on DA/DV at next educational event for all staff, April 21 (including learning from DHRs).

7.2.18 **Recommendation O** An agreement re consistent questioning/approach for exploration of those patients presenting with injuries and how this is documented. We are aiming for a written statement relating to DA/DV in all patients attending following an injury. This is currently being asked and a tick box filled in if there is a concern but we would like to extend this as above.

[16] https://www.e-lfh.org.uk/programmes/alcohol/

7.2.19 **Recommendation P** Review of our Adult safeguarding policy/DA policy as part of this review.

Lewisham and Greenwich NHS Trust

7.2.20 **Recommendation Q** Following the introduction of revised mandatory L3 adult safeguarding training for frontline staff which supports staff to recognise that people who suffer from mental health or substance misuse are vulnerable, to audit the effectiveness of this training through post training evaluation from staff, and monitor and track the number of safeguarding concerns raised regarding people with mental health, substance misuse or domestic violence.

London Borough of Bexley Housing

7.2.21 **Recommendation R** Training with relevant partners both within Bexley Council and external partners on the services they offer, who qualifies for that service and how we can refer into it. Potential for all training to be completed within the next 6-12 months, with a view to then have ongoing updates where needed.

7.2.22 **Recommendation S** Training for all officers on effective note keeping. Within one month.

London Borough of Bexley MARAC and Crisis Intervention Team

7.2.23 **Recommendation T** Should continue to review its MARAC protocols annually to ensure that all partners are identifying domestic abuse and referring appropriately, pathways are in place, partners are agreeing to the protocols and ensuring that they are adhering to them.

7.2.24 **Recommendation U** To complete yearly audits to identify areas of practice and improvement.

Kings College Hospital NHS Foundation Trust

7.2.25 **Recommendation V** Dental and Maxillofacial Department and the PRUH ED department to receive bespoke domestic abuse training.

7.2.26 **Recommendation W** Routine domestic abuse enquiries to be made at patient contact in the ED department. Patients attending the EDs across the Trust should be asked routinely about domestic abuse. Question about domestic abuse to be included within triaging documentation.

7.2.27 **Recommendation X** Vulnerable people leaving the ED department without being seen require a consideration for welfare checks Review of current ED pathways to include a welfare check where a vulnerable person has left the ED department without being seen.

Metropolitan Police Service

7.2.28 **Recommendation Y** Local Level - South East Basic Command Unit Senior Leadership Team (SE BCU SLT) It is recommended that the SE BCU SLT debrief the individuals involved in CRIS 3904104/20, reminding the officers and supervisors of their responsibilities under the Vulnerable Adult assessment Framework (VAF) and the criteria for Multi-Agency Risk Assessment Conference (MARAC).

MIND Bexley

7.2.29 **Recommendation Z** To add the DASH risk assessment template to our patient records system (IAPTus) by the end of this month. This will ensure that therapists have immediate access whilst working remotely, to be used in the event of abuse reporting.

Oxleas NHS Foundation Trust

7.2.30 **Recommendation AA** To review the current Merlin process within the PCP team to be reassured that all safe guarding concerns are being reviewed and processed effectively.

7.2.31 **Recommendation AB** To further develop the safe guarding hub model within Bexley Mental Health Services. This would allow complex cases to be reviewed across teams and services where joint care / management plans can be developed.

7.2.32 **Recommendation AC** ICM meetings were stepped down during the COVID pandemic; they are scheduled to be restarted in April 2021. The integrated care meetings provide an opportunity for complex cases such as Tracey's to be managed across agencies with a shared care approach where the person is centre.

7.2.33 **Recommendation AD** If a patient repeatedly presents to services but follow up is declined, consideration should be made to whether all avenues of engagement have been considered when patients are exhibiting escalating risk behaviour. There should be a clear system in place to ensure all MDT discussions about care planning and risk management are recorded in the RiO progress notes, so that should an assessment under the Mental Health Act be required, a full risk picture is in the clinical record.

7.2.34 **Recommendation AE** That all teams are aware of the Trust's domestic abuse handbook and that routine questioning around domestic abuse is included in all assessments and clearly documented and included in risk formulations and subsequent referrals.

Appendix 1: Domestic Homicide Review Terms of Reference

Domestic Homicide Review Terms of Reference: Case of Tracey

This Domestic Homicide Review is being completed to consider agency involvement with Tracey and Mehmed following the death of Tracey on 23/03/2020. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose of DHR

1. To review the involvement of each individual agency, statutory and non-statutory, with Tracey and Mehmed during the relevant period of time 1 October 2012 to 23 March 2020 (inclusive). To summarise agency involvement prior to 1 October 2012.

2. To establish what lessons are to be learned from the domestic abuse related death regarding the way in which local professionals and organisations work individually and together to safeguard victims.

3. To identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

4. To apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

5. To prevent domestic abuse and domestic abuse related deaths and improve service responses for all domestic violence and abuse victims by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

6. To contribute to a better understanding of the nature of domestic violence and abuse.

7. To highlight good practice.

Role of the DHR Panel, Independent Chair and the CSP

8. The Independent Chair of the DHR will:

a) Chair the Domestic Homicide Review Panel.
b) Co-ordinate the review process.
c) Quality assure the approach and challenge agencies where necessary.
d) Produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.

9. *The Review Panel will:*

a) Agree robust terms of reference.
b) Ensure appropriate representation of your agency at the panel: panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.
c) Prepare Individual Management Reviews (IMRs) and chronologies through delegation to an appropriate person in the agency.
d) Discuss key findings from the IMRs and invite the author of the IMR (if different) to the IMR meeting.
e) Agree and promptly act on recommendations in the IMR Action Plan.
f) Ensure that the information contributed by your organisation is fully and fairly represented in the Overview Report.
g) Ensure that the Overview Report is of a sufficiently high standard for it to be submitted to the Home Office, for example:
    - The purpose of the review has been met as set out in the ToR;
    - The report provides an accurate description of the circumstances surrounding the case; and
    - The analysis builds on the work of the IMRs and the findings can be substantiated.
h) To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.
i) On completion present the full report to the Bexley Community Safety Partnership.
j) Implement your agency's actions from the Overview Report Action Plan.

Bexley Community Safety Partnership will:

a) Translate recommendations from Overview Report into a SMART Action Plan.
b) Submit the Executive Summary, Overview Report and Action Plan to the Home Office Quality Assurance Panel.
c) Forward Home Office feedback to the family, Review Panel and Standing Together.
d) Agree publication date and method of the Executive Summary and Overview Report.
e) Notify the family, Review Panel and Standing Together of publication.

Definitions: Domestic Violence and Coercive Control

10. The Overview Report will make reference to the terms domestic violence and coercive control. The Review Panel understands and agrees to the use of the cross government definition (amended March 2013) as a framework for understanding the domestic violence experienced by the victim in this DHR. The cross government definition states that domestic violence and abuse is:

    "Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.
    Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
    Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

    This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group."

Equality and Diversity

11. The Review Panel will consider all protected characteristics (as defined by the Equality Act 2010) of both Tracey and Mehmed (age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation) and will also identify any additional vulnerabilities to consider (e.g. armed forces, carer status and looked after child).
12. The Review Panel identified the following protected characteristics of Tracey and of Mehmed as requiring specific consideration for this case; Disability, Pregnancy, and Sex.
13. The following issues have also been identified as particularly pertinent to this domestic abuse related death:- substance misuse, mental health (including PTSD), inter-racial relationship, physical disability.
14. Consideration has been given by the Review Panel as to whether either the victim or the perpetrator was an 'Adult at Risk' Definition in Section 42 the Care Act 2014: "An adult who may be vulnerable to abuse or maltreatment is deemed to be someone aged 18 or over, who is in an area and has needs for care and support (whether or not the authority is meeting any of those

needs); Is experiencing, or is at risk of, abuse or neglect; and As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it."

Abuse is defined widely and includes domestic and financial abuse. These duties apply regardless of whether the adult lacks mental capacity.

If it is the case that any party is an adult at risk, the review panel may require the assistance or advice of additional agencies, such as adult social care, and/or specialists such as a Learning Disability Psychiatrist, an independent advocate or someone with a good understanding of the Mental Capacity Act 2005.

The Care Act 2014 states; "Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances."

The conclusion by the is that neither party can be defined as an 'Adult at Risk'

15. *Expertise:* The Review Panel will therefore invite Bexley MIND to the panel as an advisory panel member to the Chair to ensure they are providing appropriate consideration to the identified characteristics and to help understand crucial aspects of the suicide.
16. If Tracey and Mehmed have not come into contact with agencies that they might have been expected to do so, then consideration will be given by the Review Panel on how lessons arising from the DHR can improve the engagement with those communities.
17. The Chair of Review will make the link with relevant interested parties outside the main statutory agencies.
18. The Review Panel agrees it is important to have an intersectional framework to review Tracey and Mehmed's life experiences. This means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand one's journey and one's experience with local services/agencies and within their community.

Parallel Reviews

19. If there are other investigations or inquests into the death, the panel will agree to either:
    a. Run the review in parallel to the other investigations.
    b. The panel will do the following to ensure the DHR process dovetails with the police internal investigations:
        - The Chair has provided contact details to Kent Police and Metropolitan Police Service and will lawfully provide relevant material on request and after consultation with the originating agency.

c. It will be the responsibility of the review panel Chair to ensure contact is made with the chair of any parallel process.
d. The Chair of the DHR will inform the Coroner of the current DHR process.

Membership

20. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.

21. The following agencies are to be on the Review Panel:
    a) Ambulance Trust
    b) Clinical Commissioning Group representing GPs
    c) Hospital
    d) Local Authority Adult Social Care Services
    e) Local Authority Community Safety
    f) Local Authority Housing services
    g) Local domestic abuse specialist service provider e.g. Women's Aid / IDVA
    h) Mental Health Trust
    i) NHS England
    j) Police (Borough Commander or representative, Investigating Officer (for first meeting only) and IMR author)
    k) Probation Service
    l) Substance misuse services
    m) Victim Support

22. Tracey lived in Kent for a period of time under the review. The Review Panel considered this and the following agencies will be invited to contribute to the review:
    a) Local domestic abuse specialist service provider e.g. Women's Aid / IDVA
    b) NHS Ambulance Trust
    c) MARAC service
    d) Police
    e) Victim Support

23. As set out in paragraph 15 the following will contribute to the review as experts:
    a) Bexley MIND

Role of Standing Together Against Domestic Violence (Standing Together) and the Panel

24. Standing Together have been commissioned by the Bexley CSP to independently chair this DHR. Standing Together have in turn appointed their DHR Associate, Mark Yexley to chair the DHR. The DHR team consists of two Support Officers and a DHR Manager. The DHR Support Officer Helene Berhane will be the main point of contact and will coordinate the DHR and the DHR Team Manager Hannah Candee will have oversight of the DHR. The manager will quality assure the DHR process and Overview Report. This may involve their attendance at some panel meetings. The contact details for the Standing Together DHR team will be provided to the panel and you can contact them for advice and support during this review.

Collating evidence

25. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted, and secure all relevant records.

26. Chronologies and Individual Management Review (IMRs) will be completed by the following organisations known to have had contact with Tracey and Mehmed during the relevant time period:
    a. Clarion IDVA Service Kent
    b. Dartford and Gravesham NHS Trust
    c. GP in Kent
    d. The Hurley Group
    e. Kent MARAC
    f. Kent Police
    g. Kings College Hospital NHS Foundation Trust
    h. Lewisham and Greenwich Queen Elizabeth Hospital
    i. London Ambulance Service NHS Trust
    j. London Borough of Bexley Adult Social Care
    k. London Borough of Bexley Crisis Intervention Team
    l. London Borough of Bexley Housing
    m. London Borough of Bexley MARAC
    n. Metropolitan Police Service
    o. Oxleas NHS Foundation Trust
    p. Sidcup Medical Centre GP
    q. Victim Support (Kent/London)

27. Further agencies may be asked to completed chronologies and IMRs if their involvement with Tracey and Mehmed becomes apparent through the information received as part of the review.

28. Each IMR will:
    - Set out the facts of their involvement with Tracey and/or Mehmed;
    - Critically analyse the service they provided in line with the specific terms of reference;
    - Identify any recommendations for practice or policy in relation to their agency;
    - Consider issues of agency activity in other areas and review the impact in this specific case.

29. Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought Tracey and Mehmed in contact with their agency. These agencies are:
    a) Pier Road Project - South London and Maudsley NHS Foundation Trust

Key Lines of Inquiry

30. In order to critically analyse the incident and the agencies' responses to Tracey and/or Mehmed, this review should specifically consider the following points:
    a) Analyse the communication, procedures and discussions, which took place within and between agencies.
    b) Analyse the co-operation between different agencies involved with Tracey and Mehmed [and wider family].
    c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.
    d) Analyse agency responses to any identification of domestic abuse issues.
    e) Analyse organisations' access to specialist domestic abuse agencies.
    f) Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.
    g) Analyse whether substance misuse impacted on Tracey's access to services.
    h) Analyse whether Tracey's mental health impacted her on access to services.
    i) Analyse whether Tracey could have been subject to economic abuse.
    j) Analyse whether Tracey or Mehmed could have been subject to or experienced any unconscious bias in their contact with agencies.

As a result of this analysis, agencies should identify good practice and lessons to be learned. The Review Panel expects that agencies will take action on any learning identified immediately following the internal quality assurance of their IMR.

Development of an action plan

31. Individual agencies to take responsibility for establishing clear action plans for the implementation of any recommendations in their IMRs. The Overview Report will make clear

that agencies should report to Bexley Community Safety Partnership on their action plans within six months of the Review being completed.

32. Bexley Community Safety Partnership to establish a multi-agency action plan for the implementation of recommendations arising out of the Overview Report, for submission to the Home Office along with the Overview Report and Executive Summary.

Liaison with the victim's family and [alleged] perpetrator and other informal networks

33. The review will sensitively attempt to involve the family of Tracey in the review, once it is appropriate to do so in the context of on-going criminal proceedings. The Chair will lead on family engagement with the support of Advocacy After Fatal Domestic Abuse (AAFDA).

34. Mehmed will be invited to participate in the review.

35. Family liaison will be coordinated in such a way as to aim to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.

36. The Review Panel discussed involvement of other informal networks of the Tracey and agreed it was proportionate to the DHR to invite the following persons:- friends and colleagues (to be identified by panel or family) to be involved in the DHR.

Media handling

37. Any enquiries from the media and family should be forwarded to Bexley Community Safety Partnership who will liaise with the chair. Panel members are asked not to comment if requested. Bexley Community Safety Partnership will make no comment apart from stating that a review is underway and will report in due course.

38. Bexley Community Safety Partnership is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

39. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

40. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

41. It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Documents will be password protected.

42. If an agency representative does not have a secure email address, then their non-secure address can be used but all confidential information must be sent in a password protected attachment. The password used must be sent in a separate email. Please use the password provided to you by the Standing Together team. They should be reminded that they should remove the password and only share appropriate information to appropriate front line staff in line with the DHR Confidentiality Statement and the specific Terms of Reference.

43. If you are sending password protected document to a non-secure email address it must be a recognisable work email address for the professional receiving information. Information from DHR should not be sent to a gmail / hotmail or other personal email account unless in rare cases when it has been verified as the work address for an individual or charity.

44. No confidential content should be in the body of an email to a non-secure email account. That includes names, DOBs and address of any subjects discussed at DHR.

Disclosure

45. Disclosure of facts or sensitive information will be managed and appropriately so that problems do not arise. The review process will seek to complete its work in a timely fashion in order to safeguard others.

46. The sharing of information by agencies in relation to their contact with the victim and/or the alleged perpetrator is guided by the following:
    a) The Data Protection Act 1998 governs the protection of personal data of living persons and places obligations on public authorities to follow ‘data protection principles’: The 2016 Home Office Multi-Agency Guidance for the Conduct of DHRs (Guidance) outlines data protection issues in relation to DHRs(Par 98). It recognises they tend to emerge in relation to access to records, for example medical records. It states ‘data protection obligations would not normally apply to deceased individuals and so obtaining access to data on deceased victims

of domestic abuse for the purposes of a DHR should not normally pose difficulty - this applies to all records relating to the deceased, including those held by solicitors and counsellors'.

b) Data Protection Act and Living Persons: The Guidance notes that in the case of a living person, for example the perpetrator, the obligations do apply. However, it further advises in Par 99 that the Department of Health encourages clinicians and health professionals to cooperate with Domestic Homicide Reviews and disclose all relevant information about the victim and where appropriate, the individual who caused their death unless exceptional circumstances apply. Where record holders consider there are reasons why full disclosure of information about a person of interest to a review is not appropriate (e.g. due to confidentiality obligations or other human rights considerations), the following steps should be taken:
    - The review team should be informed about the existence of information relevant to an inquiry in all cases; and
    - The reason for concern about disclosure should be discussed with the review team and attempts made to reach agreement on the confidential handling of records or
    - partial redaction of record content.

c) Human Rights Act: information shared for the purpose of preventing crime (domestic abuse and domestic abuse related suicides), improving public safety and protecting the rights or freedoms of others (domestic abuse victims).

d) Common Law Duty of Confidentiality outlines that where information is held in confidence, the consent of the individual should normally be sought prior to any information being disclosed, except for the following relevant situations - where they can be demonstrated:
    i) It is needed to prevent serious crime
    ii) there is a public interest (e.g., prevention of crime, protection of vulnerable persons)

47. If there is a criminal investigation, the investigating agencies are bound by law to ensure that there is fair disclosure of material that may be relevant to an investigation and which does not form part of the prosecution case. Any material gathered in this DHR process could be subject to disclosure to the defence, if it is considered to undermine the prosecution case or assisting the case for the accused.

48. The DHR Chair will discuss the issues of disclosure in this case with any nominated Disclosure Officer.

49. The Chair, investigating agencies and CPS will be minded to consider the confidentiality of material at all times and to balance that with the interests of justice.

Appendix 2: Multi Agency Action Plan Template

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome

Appendix 3: Single Agency Action Plan Template

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome