

Completed
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safe & sound

Dudley's Community Safety Partnership

Katherine: Domestic Abuse Related Death Review
D.o.d. August 2023

'Safe And Sound' Dudley's Community Safety Partnership
Simon Hill - Independent Chair

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Pen portrait of Katherine

1. The Domestic Abuse Related Death Review (DARDR) made initial contact with Katherine's daughter who understood why a DARDR was taking place but felt unable to engage with the review at that time. This continued to be her position when the Chair informed her the review was completed. She was given the option to read the DARDR or simply contribute a pen picture but chose not to take up these options.
2. Katherine's line managers and colleagues described her as a caring, empathetic and patient-centred individual who was deeply committed to helping others. They reflected that she loved her job and thrived on contact with patients, consistently striving to provide support and make a positive difference in people's lives. She was known for her willingness to help anyone in need, her approachable nature, and her ability to put people at ease. They further described her as kind and considerate, noting that she never spoke unkindly of others. These qualities were reflected in the support and goodwill shown towards her by colleagues throughout her employment.
3. Despite experiencing significant personal, financial and health challenges, Katherine remained committed to her work and to supporting others. The information available to the Review suggests that she took great pride in her role, valued her relationships with colleagues and family, and demonstrated considerable resilience in the face of adversity. Although only limited personal information was available to the Review, the accounts received consistently describe Katherine as a compassionate, dedicated and caring person whose positive impact on those around her was evident both personally and professionally.

1 Introduction to the Domestic abuse related Death Review (DARDR)

4. The Chair and the members of the DARDR panel as well as agencies involved in this review and the Dudley Community Safety Partnership wish to express their sincere condolences to the family of Katherine for their loss.

2 Confidentiality and anonymity statement

5. The DARDR nominated the anonymisation used in the absence of involvement by family or friends.

- **Katherine:** the victim of the domestic abuse was of white British origin and 51 years old at the time of her death.
- **Lester:** the perpetrator of domestic abuse was of white British origin and 50 years old.

3 Terms of Reference¹

- To establish through enquiry with the families of the victim and perpetrator, as well as friends, neighbours and employers, the nature, duration and impact of the domestic abuse of Katherine by Lester. (*Chair and panel, WMP*)
- To describe the extent of reported history of domestic abuse and consider whether police DASH and DARA risk assessments correctly identified the level of risk Katherine faced. (*WMP*)
- To review police investigations of domestic abuse reported within the timeframe of the DARDR, and clarify decisions around prosecution of Lester, with particular emphasis upon evidence led prosecution in the light of the two most recent PEEL reviews of WMP. (*WMP*)
- Although outside the timeframe, to review MARAC involvement with Katherine in 2018, and identify decisions taken, to establish what impact they had on Katherine's safety in the immediate and longer term. (*WMP, MARAC, BCWA*)
- To establish whether after May 2021 (the last domestic abuse incident known to professionals) Katherine was still at risk from Lester, and whether blocks existed which prevented Katherine making further reports. (*All*)
- To identify the support offered to Katherine by her employers, Dudley Group NHS Foundation Trust when they became aware of her experience of domestic abuse and to identify the extent to which it met Katherine's needs and was consistent with the Trust's Domestic abuse policy. (*DGFT*)
- To establish whether their respective GP practices had identified Katherine as a victim and Lester as a perpetrator of domestic abuse. (*BC ICB H&W ICB*)
- To clarify the level of engagement the GP practices used by the victim and perpetrator had with local commissioned domestic abuse services during the timeframe under review. (*BC ICB, BCWA, H&W ICB*)

¹ The DARDR Chair shared the Terms of Reference with Katherine's daughter, but she declined to comment upon them .

- To establish whether Identification and Referral to Improve Safety (IRIS) was available to Dudley (Black Country ICB) and Kidderminster GP Practices and Primary Care Networks (Herefordshire & Worcestershire ICB) GP Practices (PCNs) in the period under review. *(BC ICB, H & W ICB)*
- To identify any causal links between eating disorders, asthma, alcohol misuse and a patient's experience of domestic abuse and identify whether health professionals recognised these comorbidities as potential indicators of their patient's experience of domestic abuse and responded appropriately and effectively. *(BC ICB, DGFT, BCWA, CGL)*
- To identify how health professionals can best support change resistant drinkers. *(BC ICB, H&W ICB Dudley ASC, CGL)*
- To examine the circumstances surrounding Katherine's death and identify whether the causes of that death could be attributable directly to abusive acts or indirectly to her experiences of domestic abuse. *(All)*
- To establish whether it is reasonable to assume that in the months before her death, Katherine should have been identified as at risk of serious harm or death? *(All)*
- To identify whether Dudley Adult Social Care or the BC ICB in Dudley have processes in place to identify adults at risk of serious harm or death. This could be in circumstances where the risk could be from any combination of comorbid medical conditions, alcohol or drugs misuse, possible self-neglect or domestic abuse, but where the adult does not meet the threshold for MARAC or section 42 Care Act Safeguarding plans. Would existing processes identify a lead professional? *(BC ICB, Dudley ASC, MARAC)*
- Are referral pathways to these processes clear and known by professionals in Dudley? Are the pathways available to concerned members of the public and are they judged to sufficiently well publicised? *(BC ICB, Dudley ASC)*

3.1 Equality & diversity

6. The DARDR considered the nine protected characteristics under the Equality Act 2010 in setting the Terms of Reference and in panel meetings.
7. There was no evidence that any of the protected characteristics impacted on service delivery. The gendered nature of domestic abuse was an issue that all panel members fully understood and recognised particularly in relation to coercion and control. Evan Stark noted '*coercive control is*

personalised, extends through social space as well as time, and is gendered in that it relies for its' impact on women's vulnerability as women due to sexual inequality².

8. Women's Ai³ describe the gender nature of domestic abuse in the following terms; *'Whilst both men and women may experience incidents of inter-personal violence and abuse, there are important differences between male violence against women and female violence against men, namely the amount, severity and impact. Women experience higher rates of repeated victimisation and are much more likely to be seriously hurt (Walby and Allen, 2004; Walby and Towers, 2018) or killed than male victims of domestic abuse (ONS, 2025a).*
9. *Further to that, women are more likely to experience higher levels of fear and are more likely to be subjected to coercive and controlling behaviours (Dobash and Dobash, 2004; Hester, 2013; Myhill, 2015). It is particularly important to understand that men do not experience domestic abuse as part*

² Coercive control: how men entrap women in Personal Life Evan Stark

³ Barlow, C., Walklate, S., Johnson, K., Humphreys, L. and Kirby, S. (2018) Police responses to coercive control. Published [online](#): N8 Policing Research Partnership Dobash, R.P. and Dobash, R.E. (2004) 'Women's violence to men in intimate relationships. Working on a Puzzle', British Journal of Criminology, 44(3).

Hester, M. (2013) 'Who Does What to Whom? Gender and Domestic Violence Perpetrators in English Police Records', European Journal of Criminology, 10.

Hester, M., Jones, C., Williamson, E., Fahmy, E., & Feder, G. (2017) 'Is it coercive controlling violence? A cross-sectional domestic violence and abuse survey of men attending general practice in England.' Psychology of Violence, 7(3), 417-427.

Monckton Smith, J., Szymanska, K., and Haile, S. (2017) Exploring the Relationship between Stalking and Homicide. Published [online](#): University of Gloucestershire, in association with Suzy Lamplugh Trust.

Myhill, A. (2015) 'Measuring coercive control: what can we learn from national population surveys?' Violence Against Women. 21(3), pp. 355-375.

Office for National Statistics (ONS). (2025a) Domestic abuse victim characteristics, England and Wales: year ending March 2025. Available [online](#).

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Walby, S. & Allen, J. (2004) Domestic Violence, Sexual Assault and Stalking: Findings from the British Crime Survey. Home Office Research Study 276. London: Home Office. Available [online](#)

Walby, S. and Towers, J. (2018) "Untangling the concept of coercive control: Theorizing domestic violent crime", Criminology & Criminal Justice, Vol 18, Issue 1. Available [online](#).

Women's Aid, Hester, M., Walker, S-J., and Williamson, E. (2021) Gendered experiences of justice and domestic abuse. Evidence for policy and practice. Bristol: Women's Aid

Women's Aid. (2025). On Track Data Briefing: 2023-2024. Available [online](#).

UN Committee on the Elimination of Discrimination Against Women (CEDAW). (1992) CEDAW General Recommendation No. 19: Violence against women. Available [online](#).

1. The Women's Aid case management and outcomes monitoring system.

of embedded, structural inequalities against their sex. For women, however, domestic abuse is deeply rooted in inequalities between women and men. Other forms of inequality (such as racism, ageism, discrimination against disabled women and women who self-define as LGBT+) also intersect with sexual inequality to affect a woman's experiences of domestic abuse.

10. *Domestic abuse perpetrated by men against women is rooted in women's unequal status in society and is part of the wider social problem of male violence against women and girls. We found in our research with the University of Bristol that sexism and misogyny set the scene for male abusive partners' coercive and controlling behaviours. Sexism and misogyny serve to excuse abusive behaviour by men in intimate relationships with women and put up barriers to female survivors being believed and supported to leave abusive men (Women's Aid et al, 2021)'.*

4 DHR Process

4.1 Timescales

11. The Review commenced in November 2023 where a meeting of the Dudley DHR Core Panel agreed that a DARDR should be commissioned. The DARDR met three times between June 2024 and April 2025. The Overview was presented to Safe and Sound the Dudley Community Safety Partnership in December 2025.

4.2 Involvement of family and friends

12. Katherine's daughter was contacted but it became evident that she felt unable to engage with the review process at this time. She gave some information to the Chair in an initial phone call, but thereafter the Review was unable to share its' conclusions with Katherine's daughter, because she declined to reply to our attempts at further contact. This meant that Katherine's daughter was not referred into Advocacy After Fatal Domestic Abuse (AAFDA), although their leaflets were shared with her.
13. The Dudley Group Foundation NHS Trust from the outset of the review were concerned that the DARDR may impact negatively upon staff members who had managed or worked with Katherine. Therefore, the Chair agreed that there should not be contact with individual staff members, and that relevant information would be gathered by the Individual Management Reviews (IMRs) author.

4.3 Contributors to the DARDR

14. The following agencies provided Independent Management Reviews to the DHR:

- West Midlands Police
- Black Country Integrated Care Board
- Dudley Group Foundation NHS Trust
- Black Country Women's Aid
- Change, Grow, Live

The Worcestershire Acute Hospitals NHS Trust provided a summary report of their engagement with Katherine.

The Chair met with a senior HR manager from DGFT in April 2025.

4.4 The DARDR panel members ⁴

Role	Agency
Senior social worker and safeguarding lead	Change,Grow,Live
Associate Director for Safeguarding and Complex Vulnerabilities	Dudley Group Foundation NHS Trust
Lead Nurse Safeguarding Children	Dudley Group Foundation NHS Trust
Chief Executive Officer	Black Country Women's Aid
Former Director of Community Services	Black Country Women's Aid
Designated nurse adult safeguarding	Black Country Integrated Care Board
Review Team	West Midlands Police
Community Safety Officer	Dudley MBC
Domestic Abuse Coordinator	Dudley MBC

⁴ All panel members were independent of the events described. The DGFT safeguarding leads were aware of the case as it developed and had advised managers on the appropriate corrective safeguarding steps which were adopted, albeit belatedly, in this case.

Chief Executive Officer	Churches Housing Association of Dudley and District (CHADD)
Head of Safeguarding	Adult social care (Dudley MBC)
Independent review assistant	2 hills consultancy
Independent chair	2hills consultancy
Safeguarding lead -Education	Dudley MBC

4.5 The Review Author

15. The Independent Chair of this DARDR has had thirteen years' experience chairing DHRs and DARDRs and Safeguarding Adult Reviews (SARs). He is a retired officer from West Midlands Police (WMP) (retirement date November 2013) who undertook DHR Chair training with the providers at that time, Against Violence and Abuse (AVA). During his service he spent a large period on the Public Protection Unit investigating both child and adult safeguarding concerns in a multi-agency context. He was also responsible for the WMP Review Team contributing and overseeing WMPs IMRs into both Child and Adult Statutory Reviews. He retired before any of the events described in the timelines for this Review.

4.6 Parallel Reviews

16. HM Coroner held an inquest and determined the cause of death as described at paragraph 24.

4.7 Scoping Review

17. Scoping was carried out with the agencies listed as contributors, but also with Children's Services Dudley MBC, Dudley and Sandwell Probation service, Churches Housing Association of Dudley and District (CHADD)

4.8 Dissemination

18. The Overview report will be shared with the agencies contributing to this review, 'Dudley Safe and Sound' the Dudley Community Safety Partnership, also the Office of the Police and Crime Commissioner for the West Midlands Police. The Overview will also be shared with the Domestic Abuse Commissioner.

19. At the point of publication of the Review, the DARD author will attempt further contact with Katherine's daughter, to make her aware of the Community Safety Partnership's intention to publish. The co-ordinator will ensure publication does not occur in or around the anniversary of Katherine's death or birthday and will offer her daughter any support required.

5 Background information (the facts)

20. The absence of a police investigation of Katherine's death in this case and the understandable decision of Katherine's immediate family that they did not feel able to engage with the DARD at this time, means that details about Katherine are imprecise. There were two and a half years between the last reported domestic abuse incident and Katherine's death.
21. The Chair had the opportunity for a brief introductory conversation with Katherine's daughter, and she explained that Lester was still living in her mother's house after her death and in her words, she *'kicked him out'*. This was a preliminary chat prior to a more detailed conversation, so she was not asked about her mother's and her, experiences of domestic abuse. Although Katherine's daughter was very anxious about the impact upon her, of re-visiting the trauma she had experienced, she was initially willing to engage. She later felt unable to proceed with any engagement with the DARD. The DARD has no way of establishing whether domestic abuse continued in the last two and a half years of Katherine's life. However, given the deterioration in her health, and the continued presence of Lester, it is very likely it did, but that agencies were unaware.
22. Katherine died at Worcester Royal Infirmary (WRI) in late August 2023. Her cause of death was pneumonia, spontaneous oesophageal perforation, haematemesis 2 chronic alcoholic liver disease⁵. Katherine had an eating disorder, suffered from asthma and had a history of alcohol misuse.
23. Concerns were raised to the MASH following her death, by family members, because of Katherine's experience over many years of domestic abuse and coercive and controlling behaviour at the hands of Lester. There was a review conducted of the surrounding circumstances to identify whether there was any evidence that domestic abuse could have been a contributory factor. The Worcestershire Medical Examiner's Office consulted with the Worcestershire Coroner's Office and reported on the at the end of September 2023 that they would not be taking further action.

⁵ Oesophageal perforation is a rare and potentially life-threatening condition. Spontaneous oesophageal perforation, also known as Boerhaave's syndrome, is a rare but life-threatening condition that occurs when the oesophagus ruptures. It's caused by a sudden increase in pressure in the oesophagus, which can happen during vomiting, straining, lifting, or laughing. Hematemesis, or vomiting blood, can be a symptom of chronic alcoholic liver disease (ALD). ALD can cause the development of oesophageal varices, which are dilated veins in the oesophagus. Bleeding from these varices can lead to hematemesis. The most common underlying cause for oesophageal varices is alcoholic-related liver disease (however can occur with any patient with chronic liver disease.)

24. Katherine had been considered at high risk and heard at Dudley MASH in 2018.
25. This case was considered for a Safeguarding Adult Review (SAR) but then referred to the Dudley Community Safety Partnership in November 2023 for a Domestic Homicide Review. Following consultation with the Home Office it was agreed that because of Katherine's experience of domestic abuse a Domestic Abuse Related Death Review (DARDR) should take place.
26. Katherine was an employee at a Black Country General Hospital in a role that was patient facing. She had a home in Stourbridge where she brought up her daughter, following her separation from her husband. It is not clear when her relationship with Lester commenced, but he appears to have lived with Katherine in her home for most of the period under review, although he had an address in the Kidderminster area; around 9 miles away.

6 Combined Chronology

27. Katherine experienced domestic abuse at the hands of Lester for many years. The first reported DA was in 2009, but our understanding of domestic abuse would suggest that it may have been a feature of the relationship for some time before.
28. Lester was known to both West Midlands Police and West Mercia Police and was a serial domestic abuser. West Mercia Police had attended six incidents in 2006 and 2007 at the home of Lester's former partner. (Although it is not clear, it seems they may have had children together). The brief details describe the fact that the verbal arguments between the couple generally involved alcohol consumption by both parties. It is of note that neighbours reported the rows had '*gone on for hours*.' As was common during this period, officers characterised the incidents as '*equal blame on both sides*' and other than referrals to domestic abuse officers the incidents generally ended with Lester being required to leave. Lester's alcohol related problems included a drink drive conviction in 2006.
29. West Midlands Police reported that in 2009 Katherine disclosed a domestic abuse incident involving Lester, who had been drinking. She had been to his flat to '*discuss their relationship*'. She intimated that although Lester had '*pushed her around*' before this was the first violent episode. Lester had produced a knife and told Katherine, '*I could kill you*', whilst holding her down on a sofa. She broke free and left. Lester was arrested and charged with an offence, but Katherine withdrew her complaint, and the Crown Prosecution Service (CPS) did not proceed with a prosecution.
30. The Domestic Abuse Response Team (DART) had six referrals between 2009 and 2016 concerning the impact of domestic abuse on Katherine's daughter. All were recorded as 'no further action'. The

DARDR recognised that the response to child victims of DA has changed considerably since that time, and that under section 3 of the Domestic Abuse Act 2021 children are now recognised as victims. The DARDR panel felt no learning would be achieved examining practice from that period.

31. In later years, Katherine would indicate that her relationship with Lester started in 2009, but it was not clear whether it was uninterrupted through its' duration. In 2014, West Midlands Police attended the home of a woman (not Katherine) who stated she had had enough of Lester's controlling and jealous ways and wanted him to leave. He had a key to her house, and she stated they had been in a relationship for a year. When he refused, she called police, and he left to go to his mother's house. Police did not get any further calls to the address, which is not to say this woman did not suffer further abuse at Lester's hands. It is also possible that Lester was involved in two relationships characterised by his domestic abuse, at the same time. (Later Katherine described to officers that she knew Lester was coercively controlling to other women).
32. The following year, Katherine reported a further domestic abuse incident to police. In March 2015, police attended Katherine's home after Lester arrive drunk and become violent. There is an indication in the police account that alcohol had become a cause of problems but also a 'bone of contention' when Katherine revealed Lester had become upset when he had found her in bed drinking wine. Lester had pushed her causing her to injure a finger. Lester returned and was arrested but Katherine would not provide a statement of complaint. The matter was filed by police without further action.
33. A few months later Lester arrived outside Katherine's home, drunk and neighbours called police. He was removed to his mother's address to prevent a breach of the peace. Over the next year police attended four more similar calls where Lester was drunk and demanding alcohol, or money for alcohol. Officers completed Domestic Abuse Stalking and Harassment (DASH)⁶ assessments which led Katherine to be assessed at medium risk.
34. In March 2017, Katherine called police reporting that Lester refused to leave her property. He had left prior to officers attending the address and she explained that he had physically assaulted her. She did not provide a complaint, stating that she simply wanted Lester removed from the location. Whilst Katherine had bruising to her arm, she would not allow this to be photographed.

⁶ The Dash risk checklist is used by Independent domestic violence advisors IDVAs and other frontline professionals to identify and assess risks when a potential victim discloses domestic abuse, 'honour'- based violence or stalking. The questions in the Dash risk checklist are based on extensive research about domestic abuse. The Dash risk checklist aims to enable frontline professionals and Multi agency Risk Assessment Conference (Marac) practitioners to identify high risk cases and decide which cases should be referred to Marac and what other support might be required. <https://safelives.org.uk/resources-library/dash-risk-checklist/>

35. 2017 saw several further calls where arguments ensued, generally concerning Lester's drinking. Although Katherine alleged being slapped, she would not formalise her complaint and remained assessed at medium risk.
36. In early February 2018, Katherine called police after an assault by Lester. He had left but she explained '*he had hurt her loads of times before*'. She claimed the incident had been caused by her '*mistakenly*' accusing Lester of stealing from her, but she also explained that his cannabis use exacerbated his aggression. Whilst not supporting a prosecution, Katherine did support a suggestion from the officers of a community resolution through an out of court drug diversion programme for Lester.
37. Katherine described to police her experience of coercion and control at the hands of Lester. Katherine spoke of being very fearful of Lester and described how he isolated her from family and friends and '*bombarded*' her with texts and calls. She recognised because Lester was unemployed, his financial demands had increased as well as his level of control. She had tried to separate from him, but this had led to his abuse increasing. She knew that Lester had done the same thing to previous partners. The attending officers suggested a referral to the National Centre for Domestic Violence (NCDV)⁷ which was good practice. Assessed under the DASH, Katherine was identified as at high risk leading to a referral to the Multi Agency Risk Assessment Conference (MARAC⁸).
38. Police had been unable to affect the arrest of Lester when the next day at around 1am, he returned to the house, intoxicated, letting himself in through an insecure back door. He turned on the TV, made himself food and then entered Katherine's bedroom, turning on the light. An argument ensued over Lester's refusal to apologise for his recent behaviour, so Katherine told him to leave. When he refused, she called police, and this prompted him to go immediately before the police arrived. Katherine chose to go to stay at her mother's address for her own safety.
39. Over the next few days, police made attempts to trace Lester through the Department of Work and Pensions as well as emailing him suggesting he attend a police station as soon as possible. A Safeguarding officer called Katherine to tell her that arrest attempts were being made. Katherine

⁷ The National Centre for Domestic Violence was established in 2003 to help survivors of domestic violence and abuse obtain protection against an abuser, as well as offering services to the police, probation service, domestic abuse agency workers, the legal profession and judiciary. We specialise in providing free, fast and effective support to survivors of domestic abuse, usually by helping individuals obtain injunctions from their local county court. This free service is provided to everybody, regardless of their financial circumstances, sexual orientation, race, gender, age, political, religious belief or otherwise. <https://www.ncdv.org.uk/about-ncdv/>

⁸ MARAC stands for Multi-Agency Risk Assessment Conference. It's a meeting where professionals from various agencies collaborate to discuss high-risk domestic abuse cases and develop safety plans for victims. The goal is to ensure the safety and well-being of victims and their families by sharing information and coordinating efforts among different support services.

expressed concern that she was causing people '*bother*' but was reassured that this was not the case. Katherine did not, however, take up support from an IDVA. Two weeks later, Katherine was discussed at MARAC and Lester had not yet been arrested. The MARAC chair concluded that all the appropriate safety measures were in place.

40. It was not until April, two months later, that Lester was found; he was at Katherine's home when police called. He was arrested but Katherine was described as upset because she did not want this course of action taken as they were now '*fine*'. When Lester confirmed this during an interview during which he denied the assault, the matter was filed.
41. In early October 2018, at around midnight, Katherine called police saying she wanted Lester removed. She was crying and explained that Lester had broken her bedroom door off its hinges and was now downstairs. She explained to the call handler that Lester objected to her drinking and went on to claim that Lester did not like anything she did. (This was the first occasion that Katherine's own alcohol use was raised directly). Katherine was clear she did not want Lester arrested, but she also disclosed that four weeks before he had headbutted her, breaking her nose and causing black eyes. She had not reported this assault. Officers did arrest Lester who was intoxicated having drunk eight cans of beer. Fading injuries to Katherine's eye were photographed.
42. When officers returned to Katherine's home, she claimed that Lester's mother and sister had come to the house and removed some of Lester's possessions but told Katherine not to press charges. Katherine for her part reported she was not scared of them. However, officers noted a change in Katherine's responses, and they recorded that they were not sure she was truthful in her DARA assessment. (Although they do not describe in what respect, the implication was that Katherine was 'playing down' her fear or the extent of the domestic abuse).
43. Katherine alleged that Lester spent all his wages on cocaine and produced a saucer from under the sofa that had traces of white powder on it, together with other drug paraphernalia. The police IMR noted that although officers had noted this in the investigation log, no questions were asked of Lester in interview about potential drug misuse. Whilst proving possession would be challenging without an admission, and without that, testing the substance would be costly and pointless, the possible drug use by Lester was a missed opportunity to address a key element of Lester's domestic abuse behaviours. (The proposed drug intervention, described at paragraph 38, had never occurred).
44. Given the belief that Lester was suspected to be a drug user and there was evidence of drug use in the house officers could have sought authority for drug testing. The police IMR noted a positive test would have allowed a requirement to be made to attend a compulsory drug intervention programme.

45. In interview Lester denied assault and made the claim that Katherine had banged her head when she was removing things from the loft. He did not account for the damage to the bedroom door. In the absence of a statement of complaint supervisors assessed that there was insufficient evidence to meet the CPS threshold. In subsequent months, safeguarding officers made several welfare calls, during which Katherine said she was *'fine'* but expressed doubts as to whether she would resume a relationship with Lester. The matter was filed in January 2019. There are no further West Midlands police reports until March 2021.
46. In 2018 Katherine's neighbours had started action with the Local Authority in relation to anti-social behaviour from next-door, *'Ongoing issues for a while with noise, doors banging, shouting and screaming and swearing going on into the middle of the night'*. They made it clear alcohol was a contributory factor.
47. In January 2020, Katherine joined a hospital managed by Dudley Group Foundation Trust (DGFT) working in a role that was patient facing and could be described as safety critical.
48. Her line managers and senior managers were aware of Katherine's vulnerability to domestic abuse early in her employment. It is of note that managers and staff did not establish the identity of the alleged perpetrator, either during the presentations described below to Hospital Emergency Department (HED), or during one-to-one supervision by line managers. This will be considered as learning in the analysis.
49. Although Katherine had four different line managers during her employment, the DGFT IMR noted that a senior manager (SM2) was aware of the concerns throughout the period under review. The ability to maintain a consistent approach to supporting Katherine with her experience of DA will be considered in the analysis.
50. **It is of note that in 2020 and 2021, the country was experiencing the COVID pandemic, lockdowns and restrictions. The DARD has been unable to identify whether Lester and Katherine lived together permanently during the 'lockdowns' although Lester's presence answering Katherine's phone in the incident below suggests they were. Katherine's role was not one that was suitable for working from home and therefore she would have been expected to be at the Hospital to work.**
51. Close to the start of the first national lockdown, in April 2020, Katherine contacted her line manager (LM1) on Facebook. This was because they were friends outside work. She said she was hiding under her bed because her partner had entered the property, and she had previously been assaulted but she was locked into her bedroom and that she was waiting for police to attend. This information was

passed to a senior manager, SM1. Shortly after, a male, identified as Katherine's partner, called and when SM1 asked to speak to Katherine he said she was sick and would not be coming to work. This was the first of many opportunities to discuss Katherine with the safeguarding team at DGFT. The DGFT noted that although the Human Resources Team were also made aware, they also never involved the Safeguarding Team. This missed opportunity to safeguard Katherine will be considered in the analysis.

52. SM1 did not seek Lester's details. Given the situation, it is unfortunate that SM1 did not investigate or seek advice on attempting to ensure Katherine was safe and well.
53. The remainder of the chronology will describe information provided by Katherine that was shared between professionals but was never verified. There was an apparent lack of professional curiosity, even when Katherine told the DGFT IDVA a very compelling reason for not reporting the assaults to the police. (see paragraphs 48 and 60 below). If, as seems the case, and with the benefit of hindsight, Katherine shrouded many of her disclosure with misinformation, to reassure managers and prevent further questioning, the analysis will consider how an employer should demonstrate respectful uncertainty in relation to DA and seek the employee's permission to share information with other protective and support agencies.
54. In Mid-May 2020, a member of the DGFT team made a referral to Black Country Women's Aid (BCWA)⁹. (All of the contacts with Katherine until her case was closed in August 2020 were over the phone). The referral concerned another assault on Katherine by Lester. They explained that Lester had been in court '*the day before*' and went home to Katherine the same day blaming her for his convictions and '*punched her causing bruising to both her arms, legs and mouth*'. The BCWA in describing the referral in their IMR stated '*whilst in hospital*' that Katherine saw the DGFT IDVA. There is no corresponding HED entry in the DGFT IMR, which suggests she did not seek medical treatment and there was no mention of IDVA involvement in 2020. The WMP IMR makes it clear the police were not involved with Katherine or Lester in 2020 and Lester had no domestic abuse convictions or cautions.
55. Katherine told the DGFT IDVA that there was a non-molestation order in place. (This was not correct- there has been no evidence provided to the DARD to indicate Katherine ever took out a non-molestation order against Lester). It is telling that Katherine was clearly conflicted in her attitude to

⁹ BCWA were operating under COVID restrictions. All contacts were over the phone, unless clients specifically stated they needed an in person meeting which would be assessed by a service manager.

Lester. She described his two sides: caring and kind when sober and abusive and violent when drunk. Katherine acknowledged that she often felt lonely and let him back into her life.

56. In late May, Katherine told the BCWA IDVA (IDVA1) that police had contacted her to say that Lester had been seen in the area and therefore she had been unable to sleep. This does not seem, with hindsight, to be likely as police had no ongoing enquiries with Lester.
57. She also had asked for unplanned '*emergency*' leave on five occasions for '*personal reasons*'. Given that Katherine's experience of domestic abuse was known, a manager well versed in responding to domestic abuse should have recognised the requests for emergency leave may have indicated ongoing abuse.
58. Through June and July 2020, the BCWA IDVA1 was in regular contact with Katherine who said Lester was asking to come over to her house (he was apparently living in Kidderminster with his mother), She would not rule out a reconciliation with Lester '*because she loved him*'. On one occasion BCWA IDVA1 had a strong sense Lester was at Katherine's home as they spoke.
59. The challenge of supporting victims during COVID, when most sessions were on the phone, was a problem experienced by many agencies within the COVID period. Women's Aid compiled a detail report on the impact of COVID restrictions upon DA support '*Shadow pandemic-shining a light on domestic abuse during COVID*'.¹⁰ The report is clear that domestic abuse increased during COVID and the intensity of it worsened for many during lockdowns.
60. BCWA's involvement with Katherine ended in August 2020.
61. During the remainder of that year, Katherine had a period of sickness due to asthma, as well as a presentation to the hospital emergency department with exacerbation of asthma. The DGFT IMR recognised that although Katherine had experienced asthma since childhood, it can be exacerbated by DA, but clinical staff and managers did not appear aware of the link, which could have indicated continuing abuse. This learning will be addressed in the analysis.
62. At the end of March 2021, limited COVID restrictions were still in place across England. Police were called to Katherine's house at round 2am when she reported Lester had broken in and '*turned the bed upside down*'. She told the call handler that Lester had accused her of assaulting him and that he was '*right beside her*'. Although now quite old, the high-risk marker was noted and officers attended relatively quickly. Officers judged both Katherine and Lester to be intoxicated. They were both calm on arrival and were spoken to separately. Katherine said they had both been drinking and an

¹⁰ https://www.womensaid.org.uk/wp-content/uploads/2021/11/Shadow_Pandemic_Report_FINAL.pdf

argument ensued during which Lester grabbed her round the throat. She had gone to bed, but Lester had followed her and tipped her out using the mattress. He had then then kicked and punched her to the legs before throwing a heater at her head causing a scratch. Lester claimed Katherine had hit him over the back with a wine bottle. Although Katherine had bruising and scratching to the legs and head, they were observed to be healing injuries rather than recent. They were nonetheless photographed. It is not unusual in domestic abuse cases where both the primary victim and primary offender have alcohol related disorders for there to be bilateral violence such as occurred here.

63. A DARA risk assessment for Katherine was completed, and she was assessed at medium risk as was Lester, who declined the assessment, but was graded based upon officer judgement which was good practice. Two offences were crimed in relation to the allegation and counter allegation. Supervisors considered both evidence led prosecution and Domestic Violence Protection Notice but felt there was insufficient evidence to proceed.

64. Concerns for Katherine were such that a referral on her behalf was made by officers to what was then called Atlantic Recovery Service (ARCS) an alcohol and drugs team now provided by Change, Grow, Live (CGL). When recovery co-ordinators contacted Katherine to start working with her, she denied she had an alcohol problem and claimed she had not consented to the referral, nor had she been told it was being made. The West Midlands Police IMR indicates that both Lester and Katherine were 'signposted' to alcohol services because attending officers felt they both had signs of alcohol misuse. It is unclear whether officers explained they intended to make a referral or sought consent. If they did not, this was poor practice and a breach of confidentiality. This does not however alter the fact that attending officers' perceptions and professional judgement in 2021 indicated that both Lester and Katherine had possible alcohol misuse or dependency. The Police IMR indicates that as far back as 2018, officers considered that both Lester and Katherine had alcohol misuse concerns. It also notes Katherine denied this and refused support. This concern was apparently disclosed to the Dudley MASH, however records of MASH meetings and MARAC from 2018 have not been retained and therefore there is no evidence this element of Katherine's vulnerability was subject to discussion or action planning.

65. **There were no further relevant calls to West Midlands Police or West Mercia Police made by either party.**

66. In early April 2021 an Emergency Department sister made a safeguarding referral to the Multi Agency Safeguarding Hub (MASH) concerning a history of domestic abuse by Lester upon Katherine. Katherine had presented herself in the emergency department because of the incident described at

paragraph 52. Katherine had said that police had been involved and that Lester had been arrested 3 or 4 times but not convicted. She stated he had been released and had gone on to harm her on each occasion. The DARDR recognised that this could have been one of the reasons that Katherine subsequently claimed to have reported incidents to police when she had not. It will be addressed in the analysis.

67. The Black Country ICB IMR indicated that a GP, In July 2021, noted a safeguarding concern based on information from an attending AED discharge letter which indicated there had been a DA disclosure, yet the clinician missed the chance to engage in further inquiry about the Katherine's safety. These missed opportunities are likely to be a further example of a generally weak understanding of DA by the practice, which at this time had not been trained as part of Identification and Referral for Improved Safety (IRIS) the preferred advocacy service for domestic abuse which was being rolled out over Dudley and the Black Country. They represented a missed opportunity to flag Katherine's records to show domestic abuse was still a factor in her life.
68. The ED sister reported Katherine '*had bruising all over her body*'. (These were the injuries photographed by police a few days before). In a response to screening for alcohol Katherine stated she did not drink. This was a consistent approach when screened for alcohol at the hospital. The DARDR recognised that adults in general are reluctant to acknowledge their alcohol consumption. Katherine was in a patient facing role and may have been concerned it could impact upon her employment status to acknowledge her alcohol use. Issues around domestic abuse and its impact upon victim drug and alcohol misuse will be addressed in the analysis.
69. Katherine agreed to support from the hospital IDVA. She reiterated that she was no longer in a relationship with Lester and wanted advice on safety and help at home. She was referred again to Black Country Women's Aid. Two weeks into April, Katherine told the BCWA IDVA2 that she was still off work because of the injuries from the assault.
70. In mid-April Katherine disclosed to the BCWA IDVA2 that Lester was constantly texting her telling her, '*One minute he loves her and then threatening if she goes to the police, she will lose her job*'. Katherine was clearly worried about this explaining she had a lot of support at work and loved her job. She was reassured that Lester could have no influence over her job security. (It is probable that this tactic used by Lester to control Katherine, was actually very effective, given the lack of reports to police in the following year, despite repeated abuse by Lester). Katherine disclosed Lester was jealous and would accuse her of '*cheating*'.

71. In early May 2021 Katherine was *'in high spirits'* following a visit from her parents. She told the BCWA IDVA2 she was no longer in physical contact with Lester. Towards the end of the month BCWA IDVA2 left and was replaced by BCWA IDVA1, who had previous understanding of Katherine having supported her in 2020. It is a measure of how serious the injuries to Katherine were that she still spoke about them in terms of progressing her recovery. She explained *'she felt stronger and would not consider returning/resuming a relationship with Lester. She was being supported by work and was due to start counselling She did not feel tempted to call Lester and was getting all the help she needed'*. The case with Katherine was closed but she was assured she could contact at any time to renew support.
72. About a week later, at the end of May 2021, Katherine attended ED with mild swelling and bruising to the right forearm on the advice of her line manager (LM2). She did not agree to imaging explaining it felt different to a previous broken arm. (Katherine's daughter was clear that in the past, her mother's arm had been broken by Lester). Katherine declined a referral to the DGFT IDVA. A few days later in early June, Katherine re-presented with recurrent pain in her arm. ED noted visible bruising to her arm. Hospital notes do not indicate whether she was asked direct questions about whether the injury was caused by domestic abuse, but the offer of the DGFT IDVA's support indicates that this was the suspicion even if there was no direct disclosure that Lester was responsible.
73. Two weeks later, in mid-June 2021, Katherine came into ED by ambulance at around 22:00 with an exacerbation of her asthma. (She had been in to ED earlier in the day as well). Staff advised that she should stay in for observations. She was asked about her alcohol use, and she stated she did not drink. The use of alcohol to self-medicate as a response to DA will be considered in the analysis.
74. It is of note that Katherine expressed real reluctance to stay, unless nurses agreed to contact her partner. This must be viewed in the context of national COVID restrictions on visiting patients in hospitals that had only been removed 10 days before. Hospitals were still restricting access, and non-essential visits were not encouraged¹¹. Notwithstanding this, Lester was asked to attend by a nurse, and he agreed.

¹¹ Following the lifting of the national suspension of hospital visiting in England on 5 June 2020, family visits to inpatient settings is subject to local discretion by NHS trusts. The latest guidance from NHS England and NHS Improvement (NHSEI), [Visiting healthcare inpatient settings during the COVID-19 pandemic](#) (dated 13 October 2020), advises that visiting is allowed in inpatient settings, in a very careful and Covid-secure way. This guidance advises on how NHS and other healthcare organisations should facilitate visiting, as far as possible, across healthcare inpatient settings, including mental health, learning disability and autism, children, maternity and hospices. The guidance includes advice on the use of face coverings, social distancing, and virtual visits, as well as additional considerations for visiting at end of life. It also sets out circumstances where patients may be accompanied in hospital where appropriate and necessary to assist patients who need additional support (such as those with dementia). House of Commons Research Briefing prior to a parliamentary debate.

75. (This was a further opportunity to seek his details, but these were not asked for). The DGFT IMR was unable to identify whether Lester attended. Subsequent information revealed to ASC (below) make it clear he was there for several hours. Given the history of repeated physical abuse of their patient by Lester, this decision was questionable. It should have been clearly documented on the safeguarding node of Katherine records that a senior staff member had assessed the risk of inviting in the known abuser to ED to support the victim.
76. In early July 2021, Katherine's GP raised an adult safeguarding referral after she disclosed an incident where her ex-partner Lester had gained access to her house and was '*standing over her*' at 3am and had grabbed her arm. Triaged by MASH, a timely conversation was held with her. It transpired Katherine was talking about an incident that she said happened on a specific date in May 2021. She stated police were aware. It is possible that she was thinking of the March incident, because this was the last police callout to her home, and the facts and time of night the incident occurred are similar. However, it seems more likely that the incident did occur in May, but the claim it had been reported to police was to divert attention.
77. The GP practice had historic records for Katherine that showed domestic abuse with Lester identified as a perpetrator from 2015 and were notified of MARAC involvement in 2018. Even though they were directly aware of domestic abuse in July 2021, there is no recorded evidence from any subsequent appointments or contacts of questioning to identify whether she was still a victim of abuse and needed support. This will be considered in the analysis.
78. Katherine told Adult Social care she was no longer in a relationship with Lester, although she had seen him three weeks before when she went into hospital with breathing difficulties (paragraphs 50-51). He had apparently been 'very supportive' and over a conversation that lasted two hours she explained to Lester how he made her feel when he got angry. She described herself as getting stronger and more independent. She spoke positively about the support she was getting from work and from her GP. The MASH did not seek from Katherine the name of her partner and in this context the DARDR considered this a further missed opportunity to carry out what would be considered a basic safeguarding responsibility. It is noteworthy that no agency beyond the police service and BCWA ever identified Katherine's abuser. Identifying an abuser in any DA concern will be the subject of a DARDR recommendation. **Recommendation Six**
79. Katherine's DGFT line managers were effective at providing support for the consequential impact of domestic abuse and debt, that was an ever-present element of Katherine's problems. She explained her ex-husband had left her with considerable debt. Katherine's shifts were adjusted to

accommodate her. Colleagues offered lifts because she did not drive. She was referred Staff Health and Wellbeing (SHAW) as well as to the BHSF Employee Assistance Programme¹². HR supported her with access to a foodbank.

80. It is extremely unfortunate that arguably the root cause of her poor health and wellbeing; domestic abuse was not addressed as effectively. It seems that 1:1 sessions were insufficiently professionally curious. Manager may have wanted to avoid challenging or difficult conversations, but Katherine's repeat victimisation after claims she was no longer in a relationship should have prompted respectful uncertainty. At the very least managers should have sought advice from safeguarding on appropriate next steps, in view of the pressing need to balance Katherine's right to a private life against a need to address Katherine's risk of serious harm or death.
81. The events that occurred in 2022, described below, whilst reported in the DGFT IMR, were completely absent from the MASH enquiry notes following Katherine's death. Either Katherine's line managers or Human Resources, did not disclose them. Given the seriousness of the allegations (paragraph 60 to 64) this was a significant information sharing opportunity which should have been taken.
82. In the early months of 2022, had Domestic Abuse Stalking and Harassment assessments (DASH) been undertaken with Katherine after any of her DA disclosures, she would have been assessed as high risk and discussed at Dudley MARAC.¹³ That her line managers through January to April 2022 did not ensure that what they were being told by Katherine about reports to the police, were accurate, was regrettable, and meant they had no full understanding of the true level of risk of domestic abuse that Katherine was suffering. That they believed that from April 2022 into 2023 things had '*settled down*' was arguably naïve and perhaps demonstrated a lack of insight concerning health presentations that indicated domestic abuse may be continuing. The safeguarding team, had they been informed of Katherine's history, would certainly have made these links and asked to meet with Katherine.
83. In mid-January 2022, Katherine arrived at work and disclosed her ex-partner had broken her nose. On removing her face mask there were signs of injury. Advised by her line manager (LM3) to go to ED, and report the incident to the police, Katherine stated she had been treated at another hospital and police were informed at the time. This with hindsight appeared to be an effective way of stopping further enquiry. The DARD has established Katherine has not presented at any Black Country

¹² <https://www.bhsf.co.uk/about> BSHF are a health and wellbeing service provider. They provide 24/7 confidential support, tailored to the individual and include health and wellbeing adviser, critical incident advice, telephone counselling and financial debt information.

¹³ A Multi Agency Risk Assessment Conference (MARAC) is a local, multi agency victim-focused meeting where information is shared on the highest risk cases of domestic abuse between different statutory and voluntary sector agencies.

hospital other than her own or any hospital managed by the Worcester Acute Hospital Trust until the illness that led to her tragic death.

84. In February 2022 LM3 left and Katherine's new line manager was LM4.
85. In mid-March 2022 having been off sick for four days, Katherine returned to work but was sent home as unfit. She explained she had seen her GP and was accessing weekly counselling. She said police had arrested her ex-partner, interviewed her and taken photos of her injuries. It does appear from the wording of hospital notes that these were new injuries and a new episode of abuse. Unfortunately, these again had not been reported to police and there is no evidence that the GP had arranged counselling. Katherine had no contact with her GP practice in 2022 and only had contact with out of hours services for an exacerbation of asthma and a facial rash. Out of hours services are sometimes used by service users to avoid questioning in areas they do not want explored.
86. One month later, in April in a 1:1 meeting with her line manager LM4, she had bruising to her left arm. Katherine explained she had been attacked by her ex-partner the previous day while she was outside putting the bins out. Lester had grabbed her and tried to enter the property. He had hit her on the head causing injury. She explained police had attended and taken her to Kidderminster hospital. She said her GP had advised her to inform work. (None of these claims are borne out in the chronologies submitted by the police services, the Worcester Acute Trust for Kidderminster Hospital or the Black Country ICB). She was visibly upset, unfit to work and so LM4 ensured she was driven home. She stated she did not know where her ex-partner was but that there was an exclusion zone around her home. Her manager offered hospital accommodation, but Katherine turned that offer down. The manager was reassured that Katherine had taken positive steps.
87. For the rest of that year, 1:1s held were described by DGFT as being positive, in that Katherine did not mention her partner or attend work with injuries. In the absence of disclosures, it does not appear that line manager made any direct enquiries about domestic abuse. The last recorded conversation between a manager and Katherine that addressed her experience of domestic abuse, was in early April 2022.
88. The absence of family and friend engagement with the DARDR makes it difficult to establish with any degree of certainty, what was happening in Katherine's life from mid-2022, until her death. Immediately after Katherine's death, Katherine's daughter contacted police because she feared Lester had contributed directly to or possibly caused her death. In that context, she was clear Lester had been present throughout this period. She had been contacted by one of Katherine's friends, whose help had been sought by Katherine, after an incident. She said she and others had been sent

photos of her injuries by Katherine after incidents. Her daughter told police that *'she had not seen her mother for a while due to what had been going on'* but she had contacted her mother by phone, and she would say *'everything is OK'*

89. In 2023, Katherine's considerable health difficulties, which were to eventually prove fatal, were addressed without reference to her experience of domestic abuse. It does not seem they were identified as possible indicators of ongoing abuse.
90. From January 2023, colleagues and managers noted a decline in Katherine's appearance and health. In February she was signed off by her GP with breathlessness caused by a chest infection.
91. In early March 2023, in a telephone consultation, Katherine asked for an emergency prescription of antibiotics. Her GP gave *'strong advice'* that he would like to complete a face-to-face examination, but Katherine said she could not go in because she had no one to bring her to the surgery.
92. In early April 2023, a colleague suggested to managers that Katherine smelt of drink and was not behaving in her usual manner. She was spoken to and denied she had been drinking alcohol or that she had a problem with alcohol. She was not asked to take any test that could have confirmed or disproved her assertion. The use of alcohol testing in the NHS and the specific policy of DGFT will be addressed in the analysis. Key staff in line management and Human Resources should have recognised that suspected alcohol misuse could be an indication of enduring domestic abuse and it will be considered in the analysis.
93. In mid-July 2023, Katherine's line manager LM4 had to address the issues linked to Katherine's asthma, and an eating disorder.
94. She was encouraged to present at ED because of concerns about her asthma, but also a decline in her general health. There were also significant concerns about her appearance. Katherine disclosed she had an eating disorder. LM4 asked for blood tests to be taken, but ED declined, and this would have been because Katherine would not agree to them. DGFT in submissions to the DARDR explained; *'Blood results can show many illnesses including infection, poor organ functioning, imbalance in nutrients are some examples. Blood alcohol screening would be a very specific blood test which the manager did not ask for. The manager overwhelming feeling was that Katherine was not well and that blood results may have given the doctor some ideas as to why her general health was deteriorating'*. It is reasonable to assume that Katherine's reluctance was because she may have understood that these tests could have detected the health impacts of chronic alcohol misuse.

95. Clinicians in ED described Katherine as looking well. LM4 would have disputed this assessment. The line manager, interviewed for the DGFT IMR described Katherine as *'having lost weight, and said she looked unwell, frail and her skin was yellow grey in colour'*. Katherine was signed off work and did not return to work before her death. This was five weeks before her death in August 2023, at which point she weighed five stones. Katherine was slight in build, but the only evidence available concerning Katherine's weight in GP records was a telephone review in August 2021, which relied on her 2007 weight noted as 7stone 8 lbs.
96. The eating disorder added a new concern, but one that Katherine minimised. She stated she was already getting support with her eating disorder from her GP. This was not evidenced in the GP notes seen by the reviewer for the ICB IMR.
97. Three days later, LM4 had a 1:1 meeting with Katherine. She was well-presented but said she was not eating well. She stated she was receiving support from her brother who was staying with her and helping with the shopping. LM4 asked directly whether Katherine was experiencing abuse, but Katherine denied it. Walking out with her to the main entrance Katherine did not want to be accompanied to the carpark where her 'brother' was waiting. LM3 suspected this was Lester. Given that Katherine does not have a brother, this is the only credible explanation of the identity of the person waiting for her.
98. LM4 was therefore prompted to hold a long overdue meeting with the safeguarding team. Their advice was to discuss again with Katherine whether she was still suffering abuse and offer support. They suggested the DGFT IDVA should be involved and that they could support if required. LM4 was never able to follow up on this advice.
99. At the end of July 2023, Katherine provided a sick note which the DGFT IMR stated was identifying her eating disorder as the reason she was unfit for work. It was issued when she was in hospital. The Black Country ICB IMR records an in-person consultation the same day, where the brief note described a med-review for a chest infection and gave the reason for sickness as asthma exacerbation. It seems unlikely that Katherine would have looked healthy; only a few days before LM4 had described her condition as worrying and a fortnight later Katherine would be admitted to WRI. There seems to have been little attempt to find out more about Katherine's state of health. There are no notes recorded offering any suggestions for next steps in relation to an eating disorder. As previously noted, the Black Country ICB IMR explained the surgery only became aware of the eating disorder when WRI wrote to the surgery. Thereafter, five days before her death, the surgery was contacted for a sick note by Katherine's mother, EW.

100. In mid-August, Katherine informed her line manager she had been admitted to Worcester Royal Infirmary (WRI). In enquiries following the death it became clear that Lester had taken Katherine to WRI rather than the hospital she worked at, which was considerably nearer her home and where she was known and could be supported. Katherine's daughter believed Lester did this to prevent her and Katherine's mother visiting, because neither drove. It is quite possible that it was Katherine who did not want to present to the ED where she was known. The DARDR was informed by WRI that both Katherine's mother and daughter had managed to attend and were made aware of the prognosis in the days before Katherine's death.
101. Katherine died because of the complex health conditions caused by alcohol misuse and probably exacerbated by her eating disorder, at the end of August. Her cause of death was detailed as pneumonia, spontaneous oesophageal perforation, haematemesis¹⁴ 2 chronic alcoholic liver disease.
102. Although there has regrettably been no detailed involvement with the DARDR by Katherine's family, a certain amount of information was obtained when Lester's sister, raised concerns about the circumstances surrounding the death to the MASH. In the subsequent enquiries a picture emerged of Katherine being isolated from family and friends. Family reported that she had been denied contact with family and friends who had stopped visiting as they described Lester's behaviour as '*weird*' as he would hide their shoes. Significantly Katherine's daughter disclosed witnessing assaults including Katherine having her arm broken.
103. Lester was living with Katherine up to her death. There were allegations that he had control of her bank cards and was exploiting her financially even whilst Katherine was in hospital. Texts had been found on Katherine's phone '*demanding money*'. The home was in a '*filthy condition with loads of stuff everywhere*'. Katherine's daughter later alleged Lester had ransacked the house, and Katherine's jewellery was missing.
104. It is very likely that due to his coercion and control, Katherine could not disclose her experience of abuse and had gone to great lengths to prevent his presence being suspected right up to her death.

7 Analysis and key learning

105. Katherine was subject to continuous coercion and controlling behaviour and serious physical assaults by Lester, for fourteen years. His misuse of alcohol was a factor in almost every incident. Based on the health conditions which caused her death, we now know Katherine also had a long history of

¹⁴ Hematemesis, or vomiting blood, can be a symptom of chronic alcoholic liver disease (ArLD). It's usually caused by oesophageal varices, which are more common in people with ArLD

alcohol misuse. Until 2023, she succeeded in concealing this from her employer, and there is no evidence she sought help. When police officers offered alcohol support, she denied she had a problem.

106. We now know she suffered health conditions, asthma, alcohol dependency and eating disorders that are all known to be linked to or exacerbated by trauma and domestic abuse. There was a generalised weakness across agencies to identify all three comorbid conditions. Whilst her managers would have been clear from the start of her employment with DGFT, that Katherine suffered significantly with asthma, none of the health managers or clinicians showed awareness that exacerbation of asthma could be an indicator of ongoing domestic abuse¹⁵. This is a learning point for current practitioners that should be shared across health. **Recommendation Two**
107. In 2023, Katherine's health was becoming a major concern and DGFT HR were actively managing this in the context of capability to carry out her role. From January to late July 2023, when Katherine was unfit for work and absent until her death, Katherine had approximately forty days of sickness. Alcohol had been raised as a concern, although Katherine denied this when spoken to.
108. Katherine died in August 2023 from chronic health conditions caused by years of alcohol misuse including chronic liver disease. It seems that her GPs had no awareness of this condition. This could be due to the limited face to face and telephone contact Katherine had with the surgery.
109. The absence of reports to her employers or calls to the police from 2022 until her death, should not be viewed as evidence domestic abuse had ended, rather they should be recognised as an indication of the completeness of Lester's control.
110. Katherine's denial that she remained in a relationship with her abuser Lester could have been linked to shame, as victims of emotional abuse often experience feelings of self-hatred or self-loathing. This can lead to the kind of destructive behaviours seen in this review: self-harm, self-neglect, depriving oneself of proper nutrition, addictive behaviours (alcohol, drugs).

7.1 Police investigation of domestic abuse

111. The DARD was aware of documented shortcomings in the West Midlands Police investigation of domestic abuse allegations. His Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) and HM Crown Prosecution Service Inspectorate HMCPSI Review of Evidence led

¹⁵ Awareness of the links between asthma and domestic abuse had been made prior to the events in this DARD. However, the study by Birmingham University which did most to raise professional awareness of the link was published in May 2023- it would not be realistic to expect DGFT to have cascaded this learning by the time Katherine's health had become critical.

Prosecutions in January 2020 recommended *‘Police forces should ensure that training, messaging and guidance is clear that evidence led cases should benefit from the same quality of investigation, early gathering of evidence and supervisory oversight as other domestic abuse cases, particularly in cases where the victim does not support police action. Domestic abuse champions should reinforce this message’* (paragraph 6.9). In the West Midlands Police area that recommendation had not already been achieved, and PEEL assessments in the following years suggested it still was not being achieved.

112. Although the investigation of offences committed by Lester occurred during a period (2018- 2021) when WMP recognised they often missed opportunities for evidence-led prosecutions, the WMP IMR author did not feel there was evidence that this was an issue in relation to Katherine’s reports. There was detailed consideration of evidential opportunities by supervisors and in each case in the light of Katherine’s choice not to pursue allegations, there was insufficient evidence to put to the Crown Prosecution Service.
113. The investigation of DA is recognised by West Midlands Police to be a complex area, and the service has prioritised improvements in this area with Operation Vanguard, overseen by an Assistant Chief Constable. It aims to improve the quality of investigations. Changes in April 2023 now mean that local investigative teams now investigate a broader range of crimes, including neighbourhood crimes. In a recent submission to the Chair WMP noted; *‘This is already having a positive impact on outcomes. In April 2023 the positive outcome rate for total recorded crime was 6.6 per cent. This increased month on month and sat at 9.5 per cent as of September 2023. As of September 2024, this figure is 11.3%. Outcome rates for domestic-based crime sit at 12%.*
114. *The main areas of focus through Vanguard are, response attendance times, the use of investigation plans, delays to investigations, the exploitation of investigative opportunities, the general effectiveness of investigations (including the actions of attending officers responding to calls for service), improvement of the service given to victims in line with victim Codes of Practice, the way crimes are finalised and the overall effectiveness of supervision’.*
115. The DARD was encouraged by WMP’s commitment to improving the quality and timeliness of investigations of DA. If Katherine’s case was an exception, and there were no obvious investigative missteps, why were there no convictions or cautions recorded?
116. Katherine’s case demonstrates a sad reality. She was a victim of domestic abuse at the hands of Lester for around fourteen years. She suffered serious injuries, but none of her reports led to charges or cautions. Katherine’s experience of the criminal justice system response to DA is not unusual, it

remains very common. The Office for National Statistics reported in November 2024 in the National Crime survey that in the year ending March 2024, Police in England and Wales recorded 1.4 million domestic abuse incidents and of these 39,000 resulted in conviction.

117. In many of these cases a victim will chose not to provide corroboration to the initial callout in the form of a statement. It is important to recognise that the initial response of police officers will influence the victim, and a victim's demeanour may influence the willingness of officers (even unconsciously) to 'go the extra mile' in gathering evidence. When officers encountered Katherine, maybe for the first time, they would sometimes find her under the influence of alcohol. It may have appeared in some case to be *'six of one and half a dozen of the other'*, particularly where they recorded bilateral violence.
118. An example would be the incident in paragraph 56 to 59, which occurred in March 2021. It was the last time Katherine reported an incident to the police. Was it that the approach of officers was ill-informed and that thereafter, Katherine did not trust police? The WMP IMR would argue emphatically not. The reviewing officer noted, having watched the body worn video footage that the two attending officers; *'spent much time listening to and reassuring Katherine during their encounter with her, and offered her reassurance and advice in line with her presentation and needs. Neither rushed Katherine, over-talked her or lacked empathy at any point and the way in which they did so in such a professional manner is something to be proud of'*.
119. The chronology noted that the officers went to lengths to refer both Katherine and Lester to alcohol services - an unusual step, and one done with the aim of helping break a cycle, one they probably saw as the root cause of the DA incidents. The DARDR would not suggest theirs was the 'wrong' response, except that it potentially gave the impression to Katherine that officers felt alcohol was the problem, not long-term domestic abuse by Lester.
120. It is important that officers are aware of the use of alcohol as a control mechanism in coercive control, which is addressed at section 7.4 alcohol misuse and domestic abuse. They need to show awareness of alcohol misuse in a victim as a common symptom of domestic abuse, not its' catalyst. They must resist the mindset that the abuser is violent because he is drunk and that if he addresses that problem, his abuse will end. It is possible that Katherine perceived the response to be suggesting she was part of the problem and not the victim of abuse.
121. Trauma informed practice in adult safeguarding is an area that health agencies are increasingly recognising as essential. In policing it is every bit as vital to understand the impact that trauma has

on victims. Gabor Maté¹⁶ in his book describes the impact of trauma. *‘People bearing trauma’s scars almost uniformly develop a negative self-perception most of them are all too conscious of. Among the most poisonous consequences of shame is the loss of compassion for oneself. The more severe the trauma, the more total the loss’.*

122. There is a significant stigma, and sense of shame, attached to alcohol misuse. When that alcohol misuse is connected to, or caused by the trauma of domestic abuse, it represents a psychological barrier to recovery, or escape from abuse, that the criminal justice system alone is not equipped to deal with. The DARD will argue that DA victims like Katherine need not only trauma informed domestic abuse support, but alcohol or drug services that understand DA.
123. The officers in this case were empathetic and caring but were faced with allegation and counter allegation and their supervisor could not see any realistic chance that offences could be prosecuted. This is in many ways a perfect example of the challenge of investigating domestic abuse. Even if this incident was not going to provide the evidence of Lester’s abuse, it was an opportunity to understand Katherine’s long-term experience of coercion and control. For officers to be able to achieve a breakthrough in DA cases, the service needs to continue the crucial work it has started on teaching their frontline officers and supervisors about the mechanisms of coercion and control. They need to routinely take every opportunity to talk to a victim of abuse not just about the current episode, but their experience of abuse over maybe years, such as in Katherine’s case. It requires an understanding of Adverse Childhood Experiences (ACEs) so common in both the history of those with addictions, but also victims of domestic abuse.
124. Gabor Maté describes trauma as *‘perhaps the most avoided, ignored, belittled, denied, misunderstood, and untreated cause of human suffering’*. Trauma is the sad consequence of long-term domestic abuse.
125. Fear of the consequences of reporting domestic abuse is without question one of the principal reasons victims of domestic abuse either do not call police, or having done so, deny there is a problem.
126. Katherine may well have suffered further abuse from Lester in ‘retribution’ for the occasions when he arrested. She told the DGFT IDVA that she had suffered physical abuse by Lester after reporting abuse and that this was why she did not pursue allegations. This is sadly a ‘catch 22’ situation, where

¹⁶ Gabor Maté The Myth of Normal- illness, health and healing in a Toxic culture

a failure to pursue an allegation by both victims and police emboldens the abuser, who having been arrested, leaves custody without caution or charge.

127. Katherine went to lengths to protect herself from Lester by claiming to have support that did not exist, non-molestation orders that were not taken out, or impending prosecutions that were not happening. There is perhaps no area of safeguarding more dependent upon professional curiosity than domestic abuse. It was vital to allow Katherine to make her own decisions about how best to prevent harm from Lester. Yet it was also important that those trying to support her at work understood the true nature of Lester's abuse, coercion and control and the risks to Katherine.
128. Lundy Bancroft has over thirty years' experience specialising in interventions for abusive men and their families. In his book 'Why Does He do that?' In a section entitled 'abusive men and the legal system' he acknowledges the real risk for victims of going to the police. He explains; *'women are noticeably more likely to tell the truth to the police that fifteen years ago. Although the abuser may say 'you put me in jail' the reality is he put himself there, and an increasing number of people are beginning to understand this crucial point. Why should you have to suffer abuse to protect him from the pain or humiliation of being locked up? He knows what he needs to do change in order to keep the police from being called next time. it's on him. I am not recommending that you stand by idly while the police arrest your partner if you fear he may kill you when he gets out. Every woman has to make her own decisions based on what she knows about the status of her own safety; you are the expert on your own partner. You may know from experience that the legal system is not going to be able to control his behaviour and that you will have to seek alternate strategies for safety, such as planning escape'.*
129. If Katherine had this degree of understanding, it would put into context the events of the period from March 2021 when no calls were made to police. Tragically for her, and her family and friends, it does not seem she could find a means of escape either.

7.2 Supporting employees who are victims of domestic abuse

130. The Chartered Institute of Personnel and Development (CIPD) is a Trust that has championed better work and working lives since 1913, when they were founded by a group of people responsible for the wellbeing of factory workers. They are the professional body that have a key role in supporting HR management and personnel managers. Their guidance¹⁷ Domestic abuse: guidance for people

¹⁷ https://www.cipd.org/uk/knowledge/guides/supporting-employees-experiencing-domestic-abuse/nsightplus.bakermckenzie.com/bm/attachment_dw.action?attkey=FRbANEucS95NMLRN47z%2BeeOgEFct8EGQJsWJiCH2WAWHb%2FPDBPVvgqAJGkBPpF7&nav=FRbANEucS95NMLRN47z%2BeeOgEFct8EGQJbuwypnpZjc4%3D&attdocparam=pB7HEsg%2FZ312Bk8OluiOH1c%2BY4beLEAeKrOa4W9JxHM%3D&fromContentView=1

professionals on managing and supporting employees (2020) written in collaboration with the Equality and Human Rights Commission (EHRC) makes an important point; *‘Domestic abuse has an impact at work. Domestic abuse can negatively affect those abused as well as their workplace colleagues. However, importantly, the workplace can often be one of the few places that a person experiencing abuse can be separate from their abuser and experience some independence. This means that work can be the place where people can ask for and access support and feel safe to speak about their experience. It’s essential that employers are knowledgeable about domestic abuse as they are ideally placed to offer key support’.*

131. A vital aspect of domestic abuse support is the effectiveness of employers, managers and colleagues in recognising indicators that their employees are potentially victims of domestic abuse. For some victims, work offers a vital escape from their abuser. It should provide a level of financial security and an opportunity to rediscover their lost identity. At work they are a valued colleague, not a victim. Abusers do not want their victim to be supported or empowered in the workplace and respond by increasing control, often leading to financial abuse (taking control of a victim’s resources and therefore their escape routes) and ultimately encouraging victims to *‘go off sick’* or resign. This case had elements of these features of abuse.
132. Katherine was a long-term victim of domestic abuse and an employee. Her job role was not one which lent itself to working from home during COVID restrictions or thereafter. Her presentation at work on several occasions, with visible injuries, or in a dishevelled state, made it inevitable that in the interests of safeguarding and welfare, questions would be asked.
133. Employers need to create a climate that encourages disclosure but then respond effectively in providing the right support and manage risk. This requires both professional curiosity, respectful uncertainty, and effective information sharing and assessment. It requires an understanding of coercion and control, because fear and control will force many victims to *‘protect’* their abuser. Managers and colleagues need to understand victims will be made to feel the abuse is their fault, often because of their vulnerabilities, which are exploited by their abuser. Victims of abuse will sometimes provide information, which is misleading, only partially true or entirely false. Although this may seem counterintuitive to someone who does not have a grasp of the mechanisms of coercive and control, this reflects a victim’s need to protect themselves, rather than their abuser.
134. Whilst an employer would always need consent to share information with other agencies, they could discuss their concerns with other agencies to ensure an employee is supported and protected with that employee’s consent. If as in this case, an employee states they have reported an incident to

police, that is going to court, or to a GP who has arranged counselling, and that the matter is in hand, it may be appropriate to ask for report numbers or details of the GP. A refusal to allow corroboration of claims made or information to be shared could then alert employers to continuing risk of coercive control if they believe the refusal owed more to domestic abuse, than a desire for privacy. There is an understanding in adult safeguarding that coercion and control can impact a victim's ability to make choices.

135. The DGFT provided evidence that one of Katherine's managers did show professional curiosity when some of the contradictions in Katherine's accounts became evident. When Katherine was asked for a crime number, she complained the manager was trying to access her medical records. This could have promoted a discussion with the safeguarding team around the challenging need to balance confidentiality and safeguarding responsibilities. **Recommendation Six**
136. As an employee of DGFT from January 2020 until her death in August 2023, Line managers and Human Resources at DGFT were aware of Katherine being a victim of domestic abuse and aware that Katherine was experiencing financial hardship. Katherine seemed willing to disclose to her managers some of what she was experiencing, which suggest they created a positive culture. The DGFT IDVA was helpful in referring Katherine to BCWA and this promoted constructive dialogue.
137. Managers across DGFT made referrals and provided support to promote Katherine's welfare and financial security and were accommodating of her need for frequent emergency leave for 'personal reasons'. They offered hospital accommodation. There is therefore no doubt that they were anxious about Katherine and wanted to help her in any way possible. The support offered demonstrated some gaps and did not provide the kind of continuity that would have been helpful. Although clear domestic abuse policies were introduced by DGFT in the period under review, these were not followed by line managers and the HR team, which meant they failed to maximise the potential support that the IDVA or Safeguarding team could offer. There was a naivety and often a lack of professional curiosity when trying to understand Katherine's situation that suggests that staff may not yet understand the tactics by which an abuser exerts control. The DGFT submission identified fifteen missed opportunities in the period under review to enquire whether Katherine's welfare or health issues were linked to DA (2 of these in June and July 2023)
138. With hindsight it is possible to see that Katherine was trying to prevent the true nature and extent of her abuse and vulnerability being understood, by providing managers reassurance that appropriate steps were in place. Whether this was because of coercion or a misplaced loyalty to Lester is uncertain. Abusers will repeatedly tell their victim that their behaviours are the cause of the abuse.

Respecting an employees' right to confidentiality is vital to build trust where domestic abuse has been disclosed. However, demonstrating professional curiosity and showing respectful uncertainty is also desirable. Her managers should have requested from Katherine the name and details of her abuser. That he remained an unidentified assailant right to the end is very worrying. At one stage (paragraph) Katherine claimed there was an exclusion zone around her house. Her manager should have sought the abusers' details because proper safeguarding of a victim of domestic abuse should have suggested a need to alert security to the possibility, he could approach his victim at work putting her and colleagues at risk.

Learning point: where an employee makes a disclosure that they are or have been a victim of domestic abuse, an employer should ensure that the identity of the abuser is discovered, through direct enquiry with the victim or a request for information sharing from other agencies. This is justifiable to ensure the safety of the employee but also of colleagues.

139. A crucial step early in Katherine's employment with the Trust would have been to involve the DGFT Safeguarding Team. That neither line managers, nor the DGFT IDVA, or Human Resources, felt this step would be useful over a period of three and a half years of repeated concerns was a significant missed safeguarding opportunity. It meant that whilst welfare issues were addressed well, the managers did not benefit from 'another set of eyes' offering a more informed perspective which could have led to information being triangulated with other agencies with Katherine's consent. (A refusal to accept this interagency conversation could have been indicative of continuing abuse of Katherine by Lester)

7.3 Primary Care support for victims of domestic abuse

140. It has long been recognised that primary care has perhaps, except for police services, the best opportunity to identify indicators of possible domestic abuse in adults they encounter and offer meaningful and effective support. Since 2016, the National Institute for Clinical Excellence (NICE) has provided best practice guidance on recognising when a patient presents with health indicators that could suggest they are experiencing domestic abuse, which should prompt safe enquiry to encourage a patient to seek help. The NICE quality standards were introduced when face to face consultations were the norm, and they encouraged a low threshold for safe enquiry into potential domestic abuse.

141. In May 2024, in an article for the British Journal of General Practice¹⁸ Dr Vasumathy Sivarajasingam a GP in West London and an Honorary Clinical Research Fellow at Imperial College London and Northwest London Primary Care Clinical Lead, identified what the 2016 guidance suggested was best practice. She sums up the expectations of the guidance. *‘NICE advocates for several key actions to effectively address DA. Firstly, individuals displaying signs of potential DA should be approached for a private discussion to enquire about their experiences, with a priority placed on privacy and safety. Secondly, those enduring such abuse should receive support from staff trained at either level 1 or level 2, underlining the necessity for adequately trained personnel to handle these delicate situations. Moreover, individuals affected by DA should be offered referrals to specialised support services, emphasising the importance of providing comprehensive assistance beyond immediate intervention. Lastly, individuals admitting to perpetrating DA should also be directed to specialised services, showcasing a commitment to addressing the issue comprehensively, including prevention and rehabilitation. These quality statements collectively form a framework for ensuring a compassionate and effective response to DA within frontline services’.*
142. To support GP practices in delivering NICE guidelines, an advocacy and education service, Identification and Referral to Improve Safety (IRIS) has been adopted widely across the UK and is recognised as best practice. The practice Katherine was attending had not yet signed up for Identification and Referral to Improve Safety¹⁹ (IRIS) during the period under review and therefore had not received the training designed to increase awareness of a holistic view of domestic abuse and its’ relevant health indicators. It could be argued however that GPs had had many years to embed best practice in relation to domestic abuse, in the same way as they would be expected to do in relation to other health guidance from NICE.
143. They were supported by Dudley Clinical Commissioning Group (CCG - now ICB) who explained in their IMR *‘we have delivered training to GP practices in Dudley area which has included Domestic abuse and linked the training to the NICE guidance. We continue to share updates and any DA training to both the Practice managers and the Safeguarding Leads Links to the safe and Sound Website to access the DA training offer are sent out when any new training courses are available. GP forum on Domestic*

¹⁸ <https://bjgplife.com/reassessingniceonda/>

¹⁹ Identification and Referral to Improve Safety (IRIS) is a programme of training and support to improve the response to domestic violence and abuse (DVA) in general practice, which has been proven effective and cost-effective in a cluster randomised controlled trial and in the real-world NHS. The IRIS programme provides in-house training for general practice teams, DVA health education materials and ongoing support for practice teams, and a direct referral pathway for patients who are victims and survivors of DVA to a named GP practice-embedded advocate (called the advocate educator, or AE) based within a local, specialist DVA/VAWG service. Training is co-delivered by the AE and a clinical lead, who is a local clinician and a champion for IRIS within the practice. The IRIS Programme is commissioned across areas of England, Wales, the Channel Islands and Northern Ireland, where it is delivered by local IRIS teams.

abuse was delivered by BCWA which was open to all practices'. There was therefore no reason a practice would not have a sufficient understanding of NICE guidance or best practice if they chose to engage with what was offered.

144. IRIS had been funded in Dudley since 2018. (78% of Dudley GP practices are IRIS trained plus 28% partially trained - BCICB IMR). IRIS had been regularly promoted through newsletters, safeguarding forums as well as by the IRIS advocate/educator contacting practices who had not taken up the offer of the service.
145. The practice was aware they had not taken up these opportunities sufficiently quickly. As the ICB IMR made clear, *'All GP practices where sent a GP Safeguarding Self-assessment tool which 88% returned the tool which included a section on Domestic Abuse. The practice involved in the review scored themselves as Amber on this section'*. In this context amber on a RAG rating is an area where some progress has been made but the assessment is that they have not yet reached the standard required.
146. The Black Country ICB IMR considered what this practice knew of Katherine's experience of DA and what should have reasonably been expected of them. *'Despite established flags for domestic abuse and safeguarding in Katherine's records, the clinician team concluded there was no concrete evidence indicating any mental health struggles or any direct disclosures of abuse to primary care practitioners. This lack of visible concern might diminish the impetus for clinicians to ask probing questions during consultations. The absence of clear communication regarding her past experiences may have led to underestimating her vulnerabilities and failing to create a safe space for disclosures. Looking into Katherine's history, the GP practice had recorded DART (Domestic Abuse Risk Assessment Tool) notifications in 2015, 2007, indicating discussions about her case at MARAC (Multi-Agency Risk Assessment Conference 2018). These entries highlighted ongoing concerns about her safety and well-being, yet it seems the protective measures were not consistently integrated into her care. Consequently, the existing alert systems in EMIS might be enhanced to more effectively flag not only current issues but also historic safeguarding and domestic abuse concerns, ensuring that all individuals remain vigilant regarding their patients' safety and health The oversight and analysis of safeguarding notifications related to domestic abuse were ambiguous, creating gaps in the response provided to Katherine'*.
147. Katherine had a history of domestic abuse on the electronic patient record, but the practice did not identify Katherine as a current victim of domestic abuse in their final interactions in 2023, despite having raised an adult safeguarding concern around DA in 2021. The ICB IMR made it clear *'Katherine*

did not disclose any abuse when she attended the surgery and there is no evidence to suggest that any routine questioning occurred during the consultations’.

148. The practice had few engagements with Katherine, and many were telephone consultations:
- **2023 – Four telephone consultations with primary care (including a face-to-face consultation in July 2023)**
 - **2022 - Two contacts with the Out of hours service – Nil with GP**
 - **2021 - Four contacts with the GP practice – Two contact with urgent care and one contact with the red centre²⁰.**
 - **2020 - One contact with primary care**
 - **2019 - Three contacts with primary care.**
149. The BCICB IMR noted, *‘during the COVID-19 pandemic, there were no clear indications that the restrictions significantly affected the care provided to Katherine. She continued to receive support at the RED Centre when necessary, and follow-up contacts were maintained as required. However, it is important to recognize that the pandemic's restrictions may have made Katherine less visible to healthcare professionals. Reduced face-to-face interactions and limited access to services could lead to gaps in observation and support, potentially overlooking crucial signs of distress or danger in her life’.*
150. This DARDR will look at three of Katherine’s health presentations separately below, but a GP practice would be expected to make the necessary connections themselves in relation to a patient. The ICB IMR observed; *Katherine’s minimal visits to the GP practice primarily revolved around brief emergency consultations due to her exacerbation of asthma. This emergency pattern of care often meant she interacted with different clinicians, which limited the development of a continuous care relationship. There was missed opportunities to build a comprehensive understanding of her overall well-being, often overlooking routine enquiries about her physical or mental health plus any potential domestic abuse situations. Therefore, there remained gaps in addressing her specific needs during these fleeting appointments.*
151. These limited opportunities in the context of COVID, or because a patient is not demanding of services, provide some strength to the argument that rather than wait for health indicators to prompt questioning, GPs should ‘ask the question’ routinely. It is a view endorsed in the article previously cited; *‘It is crucial to not only encourage patients experiencing DA to disclose their experiences but also to facilitate an environment where clinicians can ask appropriate questions that encourage survivors to come forward. While the current guidelines encourage clinicians to enquire about DA,*

²⁰ The red centre service is face-to-face consultations for patients with COVID-19 symptoms or other possible contagious illness (respiratory infection, abdominal pain), who are not able to manage their symptoms themselves with analgesia and over the counter remedies

they historically refrain from recommending routine screening in primary care settings. Implementing routine screening is cost-effective and aids in early identification, thereby empowering survivors and preventing crises. It could aid in the early identification of DA cases, empowering survivors and preventing crises’. **Recommendation Five**

152. In January 2025, BCWA who provide commissioned training of IRIS informed the DARDR that the GP practice had commenced IRIS training in November 2024 and will complete it in February 2025. The practice, which had made no DA referrals before the training, have made eleven since it started. This is encouraging and indicates these professionals have taken on board key learning from this case.

7.4 Health conditions linked to or exacerbated by domestic abuse

Alcohol misuse and domestic abuse

‘Alcohol cannot create an abuser and sobriety cannot cure one. The only way a man can overcome his abusiveness is by dealing with his abusiveness.’ Lundy Bancroft²¹

Alcohol Change: alcohol and domestic abuse

153. Alcohol misuse by perpetrators is a common feature of DHRs and DARDRs and also in domestic abuse in general. Alcohol Change (now Alcohol Concern) in 2016 in partnership with Against Violence and Abuse²² carried out a review of learning from DHRs entitled ‘Domestic Abuse and Change resistant Drinkers: preventing and reducing Harm’. They looked at 39 cases and in 15 (38%) both the victim and perpetrator are identified as having a problem with alcohol. (The Home Office Vulnerability Knowledge and Practice Programme (VKPP) Domestic Homicides and Suspected Victim Suicides 2020-2023 Year 3 report across DARDRs noted alcohol misuse by the perpetrator in 32% of cases, but their sample was far larger: 723 cases.
154. There is no indication in any IMRs that Lester engaged with or sought help for his alcohol misuse disorders (AUD) or even acknowledged them. In the absence of evidence that agencies attempted to direct Lester to support (except for one police involvement, where officers raised the possibility of enforced engagement with drug and alcohol services, as an outcome of a criminal sanction) this DARDR will concentrate upon possible reasons Katherine was unable to seek help for her own AUD.

²¹ Why does he do that? Inside the minds of Angry and Controlling Men. Lundy Bancroft
https://dn790007.ca.archive.org/0/items/LundyWhyDoesHeDoThat/Lundy_Why-does-he-do-that.pdf This is a link to a PDF of the entire book.

²²

155. Katherine died from chronic health conditions caused by long-term alcohol abuse. It is not clear when her alcohol use became risky, but there are some uncorroborated indications from submissions to the review, that it was around 2009; the period she started a relationship with Lester. The DARDR did not manage to obtain sufficient information, without family and friend involvement, to understand what caused Katherine's problematic drinking, but it is very probable it was the anxiety and fear caused by repeat domestic abuse. The Alcohol Change study noted factors that might increase the levels of intoxication and minimise her ability to resist abuse. These seem very relevant to Katherine's situation. They include low food intake/dieting increases levels of intoxication - that would be magnified by the anorexia which Katherine reported to WRI. Katherine was of slight build meaning she became intoxicated more quickly.
156. Lester already had a history of alcohol related domestic abuse. Encouraging drug and alcohol misuse in their victims is a common control method used by domestic abusers. Even if Katherine already had a problematic relationship with alcohol before she met Lester, he is likely to have preyed on it and encouraged it. At the very least, he was unlikely to have seen it as a genuine cause for concern.
157. Alcohol Change describing the part alcohol plays in abuse explain *'Living with domestic abuse can be extremely frightening, distressing or exhausting. This can cause some people to drink alcohol to try to cope with the physical and mental health impacts of domestic abuse. Research²³ shows that women who experience extensive physical and sexual violence are more than twice as likely to have a problem with alcohol than those with little experience of violence and abuse. Alcohol use can also leave someone more vulnerable to further abuse, especially if drinking prevents survivors from accessing support or makes their mental health worse'*. The mechanisms of coercive control leave many victims feeling judged by friends, family and colleagues who sometimes offer the apparently simple solution to abuse by saying *'just leave'*, unaware of the web of control mechanisms the abuser has put in place. It is hardly surprising that victims feel they may be even more harshly judged when in addition, alcohol use disorders (AUD) become apparent. Lester used Katherine's fear of losing her job because of alcohol misuse as a powerful control mechanism.
158. It is therefore quite possible that Katherine felt ashamed that she had resorted to alcohol as a coping mechanism, and so keeping this element of her abuse to herself became important to her. There is a significant stigma attached to alcohol misuse. A recent Danish research paper²⁴ published by the

²³ <https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/the-impact-of-domestic-abuse/>

²⁴ Finn, S.W., Mejldal, A. & Nielsen, A.S. Public stigma and treatment preferences for alcohol use disorders. *BMC Health Serv Res* 23, 76 (2023). <https://doi.org/10.1186/s12913-023-09037-y>

British Medical Council explained; *'Alcohol use disorders (AUD) are among the most highly stigmatised medical conditions in the Western world. Individuals with AUD are viewed as more responsible for their disorder and elicit more social rejection and negative emotions compared to other disorders'*.

159. There is a suggestion in early police logs (paragraph 19) that Lester exploited Katherine's alcohol misuse to shame her and diminish her self-esteem. Alcohol Change describe *how 'a perpetrator may exert control over another person by withholding alcohol from them or preventing them from buying it. For someone who is dependent on alcohol, this could be extremely distressing and even dangerous, if they experience withdrawal symptoms'*. This was echoed in the work of the late Evan Stark²⁵ when he researched what he called 'intimate terrorism'. He argued *'that some victims do self-medicate to manage the depression the daily anticipation of violence engenders and that some perpetrators control victims by increasing their dependence on substances before restricting their access to them'*.
160. If Katherine was going to seek help for her AUD from any source, and overcome any stigma, it was crucial that she did not sense she was being judged. Sadly, the decision by her daughter not to engage with the DARDR leaves a gap in our understanding. It is quite likely that over the years Katherine's daughter tried to persuade her mother to accept help but was rebuffed. We know that she did not meet with her mother in the period before her death, and whilst Lester's abuse may have been part of the reason, it is quite possible that her mother's AUD was another significant element.
161. If family support was not effective, then there remained a possibility that Katherine would accept help in the context of employer or agency contacts. Over the years, Katherine denied on every occasion she was asked by professionals, in a health or work context, that she had an issue with alcohol. Her GP had no awareness of Katherine's AUD and surprisingly she never presented with health conditions that would have raised that possibility in the minds of clinicians. In the situations where enquiry was made at work, Katherine chose to deny alcohol misuse and in the absence of evidence, managers felt unable to challenge her claims.
162. Police officers encountered Katherine on several occasions in circumstances that would make it very hard for her to deny that Lester's alcohol use, as well sometimes her own, was a factor in domestic abuse. WMP records show clearly that officers believed Katherine was alcohol dependent and on occasion inebriated. They encouraged her to seek support and made a referral to ARCS (now CGL). She later denied that she was aware of the referral or had consented to it. Even the most skilled

²⁵ Coercive Control: how men entrapment women in Personal life.

professional is unlikely to break down years of stigma and self-hate in a single encounter in moments of high stress.

163. The WMP IMR author was able to offer valuable insight into the demeanour and skills of officers who attended key episodes from viewing body worn camera (BWC) footage. *'It is evident that responding officers were sensitive to the needs of both Katherine and Lester. Each showed compassion, understanding, honesty and integrity, and clearly experienced in primary investigations of domestic abuse and recognised indicators of domestic abuse. They were often professionally curious and sought information from colleagues and WMP systems which they considered when decision-making. Subsequently, the risk assessments were sound, appropriate, and the rationale for such recorded in detail'.*
164. The current Domestic Abuse Risk Assessment (DARA) contains only one question relating to drug or alcohol misuse by the perpetrator /victim. It could be argued that a more nuanced set of questions is needed to understand the part alcohol or drug misuse plays in the lives of both perpetrators and victims. **Recommendation Eight**
165. The Alcohol Change study found whilst perpetrators and victims were often referred into services a significant majority, 80% did not engage (This is also the figure for change resistant drinkers in the general population). The BMC research paper may help us to understand why *'These results indicate that willingness to seek professional help is closely related to stigma, and that a high level of stigma may contribute to a reluctance to, and lower preference for, seeking professional treatment. This is in line with the research on barriers to treatment, which shows that the stigma associated with AUD is an important barrier to treatment-seeking'.*
166. The BMC study already cited was Danish, but there is no reason to suspect that Danes have a higher regard or confidence in their GPs and that it does not have relevance in the UK. The study concluded that GPs were the most likely professional that adults with AUD would seek help from. The study found no evidence that high or low stigma effected this likelihood. *'Regarding preferences for where to seek treatment, the results of the present study showed that both lower and higher stigma scores were associated with a higher probability of a preference for consulting a GP for treatment. In the sub-analyses, when alcohol use was also adjusted for, the association between lower stigma and a higher probability of a preference for consulting a GP was also found. These findings emphasize the crucial role that GP's and primary care play as a cornerstone in Danish health care. It also suggests that the trust in GPs is high, and that GPs are expected to play an important role in addressing and*

treating AUD. Other studies have also found strong support for routinely asking questions about alcohol use in primary care. Thus, GPs play a vital part in recovery from AUD.'

167. The reduction of stigma attached to alcohol use disorders clearly should be a priority for public health in the UK.
168. Katherine was not a frequent attender at her GPs as noted above. However, when Katherine presented to her GP in July 2023, a few days after her manager described her in the terms cited at paragraph 87, and only two weeks before she was to die with acute liver disease, it seems improbable that she could have presented in a way that did not raise a GP's concern, even though she had not been seen for some months. It was only four months before, that the surgery had wisely implored Katherine to attend a face-to-face assessment²⁶ and this was the first opportunity they had had to achieve it. It is sadly the case that it may have been 'too little too late'. Even though Katherine had never disclosed her alcohol use, it is concerning that the surgery stated they had no knowledge (or suspicion) of AUDs given her physical condition.
169. From May to August 2020, and again from April to May 2021, BCWA IDVAS supported Katherine. Whilst it is clear from the BCWA IMR that the part alcohol played in Lester's abuse was discussed frequently between the IDVAs and Katherine, there is no suggestion that she acknowledged or sought help in relation to her own alcohol misuse. The IDVAs seemed to be completely unaware of this aspect of her vulnerability.
170. Had Katherine reached the threshold for MARAC in 2020 to 2022, the BCWA IDVAs would have become aware from information shared, of this aspect of Katherine's vulnerability. Had the incidents of domestic abuse been reported, she would have been seen as at high risk. The IDVAs would have been very well placed to help Katherine understand that as a victim of long-term domestic abuse, she was not alone in resorting to alcohol to cope with domestic abuse. They could have removed the sense of shame, cultivated by offenders, which is so often associated with alcohol and domestic abuse. A specialist alcohol IDVA would have been a very positive additional resource, able to help Katherine address both her domestic abuse but also her AUD. There are alcohol IDVAs at Coventry MARAC and it is recommended that Dudley should explore potential for funding a similar provision.

Recommendation Four

171. The Alcohol Change/AVA study addressed this point; *'The situation with referrals – particularly in relation to victims – is that many services such as A&E and the police now use the DASH²⁷ and will*

²⁶ This related to her chest condition but was a helpful response to her limited engagement.

²⁷ West Midlands Police use the Domestic Abuse Risk Assessment (DARA)

automatically refer high-risk cases to their local MARAC. It is not a perfect system by any means but has resulted in some victims receiving a more proactive response. The difficulty lies with victims that are i) not assessed, or ii) are (correctly or incorrectly) assessed as being at standard or medium risk. In such cases again, there is a tendency to simply signpost. This is unlikely to result in a person self-referring, and even less so when the victim is a change resistant drinker. While this research did not look specifically at referrals to domestic violence services, we would still recommend that these referrals are made. In cases of both alcohol and domestic violence we would encourage speaking to the person being referred about sharing information with those services and supporting joint working between agencies to ensure expertise can be pooled’.

Asthma and domestic abuse.

172. Unlike Katherine’s AUD, which was hidden from all professionals, the GP surgery in this case appeared not to appreciate that exacerbation of asthma could be a potential indicator that domestic abuse was present. The DARDR has noted that the GP had no ongoing awareness of domestic abuse because Katherine was never ‘asked the question’ and never chose to disclose domestic abuse, unprompted. The missing information the GP would have needed to possibly make this connection was held by Katherine’s employers, who would not have been able to share what they knew unless Katherine gave consent, or she had been assessed as at high risk and discussed at MARAC, which she was not.
173. The DARDR has noted that there is a need to raise awareness of the links between asthma and domestic abuse. A study²⁸ by Katina Nash from Oxford University et al. ‘Exposure to Domestic Abuse and the Subsequent Development of Atopic Disease in Women’. Reviewed all known research and found that ‘approximately one-third of individuals with asthma have experienced physical or sexual violence from an intimate partner. They reported that women with documented exposure to domestic violence and abuse face a 52% higher risk of developing atopic diseases, including asthma’.
174. This study also found that those with asthma who reported domestic abuse experienced more frequent asthma exacerbations, increased visits to emergency departments or urgent care, and a greater need for urgent consultations with healthcare providers regarding their asthma. Additionally, these individuals were more likely to state that their asthma hindered their ability to perform work or engage in daily activities. The connection between asthma and domestic abuse whilst known

²⁸ <https://www.jaci-inpractice.org/action/showCitFormats?doi=10.1016%2Fj.jaip.2023.03.016&pii=S2213-2198%2823%2900300-8>

before this study, was not widely discussed across the safeguarding community until late 2023. It would have been rare for professionals to recognise this link in the period under review.

175. This is clearly a finding that needs to be shared with all health professionals because not only would awareness improve treatment options, but it could also lead to more effective questions about domestic abuse. **Recommendation Three**

Eating Disorder and domestic abuse

176. Of the conditions suffered by Katherine, anorexia was the least well understood, although her rapidly deteriorating health finally prompted a disclosure to her managers, although tragically it was too late to offer lifesaving help.
177. With hindsight we can see that her eating disorder may have been caused by her experience of domestic abuse. The BCICB IMR was correct in its' assertion; *'Studies have indicated that domestic violence survivor may engage in eating disorder behaviours as an attempt to establish some sense of control, particularly when their surroundings are chaotic, or that they do not have control over their body or disorder can also develop inadvertently as a way to deal with the overwhelming shame and guilt that is experienced as a result of domestic violence'*.
178. Ione Bretana et al²⁹ contributed a systematic review of evidence and research to a journal Current Psychology concerning 'intimate Partner Violence (IPV) and eating disorders'. They looked at hundreds of articles and research and over 50 that were focused entirely on this area. They concluded; *The results clearly show the relationship between IPV and various eating disorders. Being a victim of IPV, in its different forms (physical, psychological and sexual), has been related to disorders such as anorexia nervosa, bulimia nervosa and binge eating disorder. In general, some studies found differences between men and women in the association of the presence of sexual violence and ED symptoms. In conclusion, EDs may be a form of control that individuals exert over their bodies in response to the control exercised by their abusive partners. Addressing the interpersonal sphere by focusing on the management of violent dynamics within the couple is the key to change in individual coping'*.
179. This case has illustrated that awareness of this link could improve professionals' ability to provide trauma informed care and link the diverse presentations that could be associated with domestic abuse. **Recommendation Two**

²⁹ <https://doi.org/10.1016/j.jpsychires.2013.04.014>

7.5 Patient safety issues raised by this case

180. Katherine was an employee of the NHS, in a patient facing role which was safety critical³⁰. The NHS has a responsibility and duty to monitor clinical incidents and risk. In their own briefing, 'It's a Risky Business'³¹ DGFT explain, *'The NHS treats thousands of people every day. There are risks involved in the treatment of patients, the management of staff and the running of hospitals and clinics. Human error, poor organisation and lack of clarity on management arrangements are all risks. Errors and accidents can cause discomfort, cost money, jobs and in the most extreme cases, lives'*.
181. Hospital managers and their staff must identify when an error or near-miss occurs that could have resulted in damage, loss, or harm to person or property, or a clinical incident which could have or did lead to harm to one or more patients, or a health and safety incident or an assault. Such incidents are reported on the DATIX system within the NHS, and all are subject to review by a manager and supervision and reflection with the employee(s) involved. The purpose is for organisational and individual learning. The DGFT leaflet explains *'Being open about what happened and discussing incidents promptly, fully and compassionately can help patients and staff cope better with the after effects'*.
182. Clearly some incident will be very serious, but many simply require the member of staff to reflect and suggest ways in which they could ensure their practice is less open to a repetition of the same error. A manager could supervise a staff member when they perform the same task in future to ensure they have learnt from the error.
183. The DARDR was aware that a very real direct consequence of domestic abuse is that a victim struggles to function in every aspect of their life, including in the workplace. It can lead to absenteeism, and they become less effective in their role. Particularly when it became increasingly evident that Katherine had responded to her abuse by using alcohol, the DARDR felt compelled to make enquiry of DGFT to identify whether Katherine had made errors during the period under review.
184. The DARDR was informed that between September 2020 and November 2022 Katherine was identified as making seven errors that had been recorded in line with Trust policy and reviewed by a manager. Katherine would have been expected to complete a reflective statement; a self-identified action plan. There is nothing to suggest in submission to the DARDR from DGFT that any of these errors were serious or that they led to actual harm to a patient. The DGFT described them as *'system errors that both Katherine and her managers agreed were down to high demand of work and reduced*

³⁰ This would include any aspect of patient care

³¹ <https://www.dgft.nhs.uk/wp-content/uploads/2014/07/Clinical-Governance-Its-a-Risky-Business-Leaflet.pdf>

capacity within the team and that Katherine was not using systems appropriately to avoid such errors’.

185. The DGFT IMR noted: *‘Katherine’s line manager reported that Katherine’s error rate was no higher than an average person. Most errors were made in 2021, and all were either preceding or following periods of emergency leave, sickness or anxiety/ stress’.* This was also the period when Katherine was suffering repeated domestic abuse. CIPD guidance on Domestic abuse previously quoted states *‘your role as a manager is not to deal with the abuse itself but to address the workplace effects of domestic abuse’.* Errors could have been an unfortunate consequence of domestic abuse.
186. As part of reflective practice, a manager would identify trends or patterns in a colleagues’ errors; these could be attention to detail, concentration, lack of training for example. The manager’s role is to develop and support that individual. In Katherine’s case it would have been entirely reasonable to consider whether domestic abuse was having a direct impact upon Katherine’s performance and provides another compelling reason why managers needed to demonstrate even more professional curiosity. Katherine’s demeanour had changed; the 1:1 meeting notes recorded by managers included concerns that she was *‘rude to staff’*, she had borrowed money from colleagues, she arrived at work with a broken shoe, claiming she had tripped. The managers were aware of emergency leave, twice because of flooding in her house but also for a visit by bailiffs.
187. The DARDR understood the pressure that was placed upon Katherine by her abuser. It meant she struggled to maintain her health and emotional wellbeing. It appeared she responded to her experience of constant domestic abuse by using alcohol and developed an eating disorder, with very real consequent impacts on her physical health, self-esteem and self-worth. In 2021 and 2022 she was having to account for her domestic abuse related injuries to managers and was creating an elaborate smokescreen to deflect attention. In that context, it is reasonable to reflect upon whether her errors were a direct impact of the domestic abuse.
188. The DGFT IMR noted she made no detected or reported errors in 2023. However, concerns around alcohol were first raised at the start of that year. Although a formal report to a manager only occurred once (April 2023) in conversations with some of those managers it was evident colleagues had growing suspicion of alcohol misuse.
189. In a clinical setting, a health professional in any role must be able to perform their duties safely, without the influence of alcohol or drugs. The DGFT would argue Katherine was in a safety-critical role. The risk to patient safety is obvious, if a health professional is unfit due to drink or drugs. The DARDR has considered in the section above why victims of domestic abuse are drawn to alcohol and

drugs as a coping mechanism and the impact it has on their private and personal life. Alcohol misuse can have a very damaging impact on an employee's ability to work effectively and if they are also impacted by low mood caused by their domestic abuse, they are even more vulnerable to errors or accidents.

190. When a colleagues reported in January 2023 to a manager that they felt Katherine could have been drinking and her behaviour was unusual, a manger spoke to her about the concern raised. She denied drinking alcohol. The DGFT IMR suggests that possible alcohol misuse had been raised more than once and was addressed on several occasions; *'Katherine continued to deny she was drinking alcohol despite conflicting reports from colleagues'*.
191. The DGFT policy states, *'that any employee who is suspected of being under the influence when reporting for duty or whilst on duty may be asked to undertake testing by their line manager after consultation with Occupational Health. Employees cannot be made to take a test, however if the employee refuses when an employer has good grounds for testing, they may face disciplinary action'*.
192. The DGFT IMR explained that *'when Katherine was challenged following the concern raised by her colleague that she smelt of alcohol she did not present as being under the influence of alcohol at that time or smell of alcohol'*.
193. Katherine had denied alcohol use consistently to any professional who asked her. In the management review she denied alcohol use. In screening during hospital presentations, she stated she did not drink. In a GP review she stated she drank six units a week. The review has already noted the sense of shame attached to alcohol misuse in domestic abuse victims. Health professionals would suggest stigma, embarrassment and guilt about alcohol consumption are also very common amongst the general population. GPs frequently observe based on a lack of openness around alcohol, that if they ask how much a patient drinks and are told 10 units, they double it in their mind.
194. When Katherine presented to WRI she was very ill. At her initial presentation WRI recorded *'known alcohol dependence'*. The consultant noted *'long standing alcohol excess- one bottle wine/day'*. It is quite possible that even at this final stage, Katherine was reluctant to acknowledge the full scale of dependence.
195. Katherine's case is a sad but extreme example of the personal harm an employee may experience from their alcohol dependence. It is also a measure of the unrecognised risk to patients. If Katherine was drinking to the levels she finally acknowledged, and very possibly sometimes more, then it is likely she was not fit for work quite frequently.

196. This demonstrates the challenge for employers and emphasises dramatically why many see the need for random alcohol screening, as both a deterrent, but also a way of incentivising an employee to be honest about alcohol misuse and seek help. The CIPD guidance recognised that random testing was more common in the private sector than the public sector. 39% of employers with employees in safety-critical roles test for drugs/and or alcohol. In organisations with safety critical roles, 20% test all employees and a further 19% randomly test those in in safety critical roles.
197. Two propositions seem to suggest themselves from the known facts in this case. If Katherine had been subject to a random test there is a reasonable chance, she would have failed it. Given the tragic outcome, urgent alcohol support without blame, in early January 2023, potentially could have set Katherine on the path to recovery.
198. In 2020, The CIPD The published a report³² 'Managing drug and alcohol misuse at work'. The DARDR was struck by the CIPD observations on support for staff; *'When dealing with alcohol or drug misuse at work, employers need to strike the appropriate balance between the need for disciplinary procedures and providing support for individuals. There will be instances where disciplinary action is required, but it shouldn't be the default position just because substance use is identified. We advocate that support and a general concern for the individual's wellbeing is provided, regardless of whatever else is going on. However, when our survey asked employers about their approach to dealing with drug and alcohol misuse at work, we found that around a fifth see alcohol and drug misuse mainly as a performance/disciplinary issue. It's concerning that only around half of employers said they deal with both drug and alcohol misuse as a combined performance/disciplinary and health, safety and wellbeing issue'*.
199. The DARDR has already observed that Katherine's line managers were supportive and offered a good range of welfare options when, for example they identified debt as impacting on wellbeing. Katherine's absence due to asthma was treated with understanding and appropriate return to work processes seemed to have been followed. It may never be clear why Katherine felt unable to seek help for alcohol dependency (and her eating disorder), but it is possible that she feared she might lose the job she loved. The DARDR would recommend that the Dudley Group Hospital trust HR Department review their Drug and Alcohol Policy to ensure that as far as possible it reflects the best practice guidance in relation to staff and manager awareness of spotting the signs and encouraging employees to seek help. **Recommendation One**

³² https://www.cipd.org/globalassets/media/knowledge/knowledge-hub/reports/drug-alcohol-misuse-work-report-1_tcm18-83090.pdf

200. Even if DGFT have a model drug and alcohol policy and welfare orientated approach, or develop one, they did not in this case achieve a disclosure of alcohol dependence in Katherine's case. It is possible that random testing could have achieved a breakthrough, albeit one that would have caused Katherine stress at first. NHS England do not recommend or mandate random drug and alcohol testing; each Trust has the choice whether random testing is introduced across all employees, or safety critical roles, or whether they will only test when they have reasonable suspicion someone is unfit; the DGFT approach. The DARD panel felt this was a possible omission.
201. The DGFT considered the panel's discussion around random alcohol screening but explained that the size of their Occupational Health team and their current responsibilities would prevent them being able to take on this task across a 6,000 strong workforce. They pointed out that many of the staff are registered with professional bodies, such as the General Medical Council, Nursing and Midwifery Council and Health & Care Professions Council that require staff declare drug or alcohol vulnerabilities or risk being struck off the registers³³.
202. DGFT explained that if a testing approach was routine, it would require 24-hour coverage and their Occupational Health team work 8am to 4pm. Testing would not be a task that would be considered sufficiently critical to be covered by Emergency Department.
203. A senior DGFT Human Resources manager explained the Trust will continue to emphasise a supportive approach, focusing on onward referral where drug or alcohol misuse is suspected or disclosed. There will be an emphasis in a redrafted Alcohol and Substance Misuse Policy on raising managers' awareness of how to identify drug, alcohol and substance misuse in staff who may not appear unfit for duty. It will also stress the importance of involving Human Resources and the Safeguarding team. It would be considered as part of the medical or non-medical Concerns Group or the Trust Decision Making group as part of managing allegations process.
204. This process will also be invoked where an employee has been offered support but there are concerns about the level of engagement. However, the Trust will always employ supportive processes to ensure the best outcome for the staff member whilst protecting patients from harm.

8 Conclusions

205. Katherine died because of serious health complications caused in large part by an alcohol use disorder. She had experienced long-term and extensive domestic abuse at the hands of Lester, a

³³ It should be noted that this would not have been a deterrent to Katherine, who was not a 'registered' professional.

serial domestic abuser. His control was such that she felt unable to report abuse in the last two years of her life.

206. Lester had isolated her from friends and family and preyed on Katherine's vulnerabilities, including an alcohol use disorder he in all probability caused, or at least exacerbated with his abuse. He exploited her financially, leaving her in debt. He probably made it hard for her to seek help from her employers, suggesting she would put her job in jeopardy if she did.
207. In the last two years of her life, Katherine's vulnerability was becoming increasingly clear to her colleagues and line managers. DGFT, her employers, had established support structures and a desire to help Katherine that was evident in their efforts to accommodate her needs. Her experience of domestic abuse and her alcohol use disorder needed to be considered together, in a meeting between the safeguarding team, human resources and Katherine. They could have reassured her of their desire to support her, not put her under pressure. She may have felt safe to explain her situation and her choices. DGFT were clear that the absence of safeguarding team involvement from the outset meant DGFT never had a clear picture of the full extent of her vulnerabilities. It is not a situation the Trust will allow to reoccur.
208. Successive managers and colleagues had tried to help Katherine, and her death had a profound impact upon them all. Like so many friends and family of victims of domestic abuse, they have probably asked themselves 'could we have done more?'. It is important to remember the primary aim of an abuser is to stop friends, family, work colleagues offering effective help to the victim. Theirs is not a failure, but rather another tragic example of the power of coercive control. The DARD was clear that DGFT have reflected on the lessons from this case and will raise awareness across the Trust so that colleagues and managers are more aware of the signs of abuse but also the mechanics of coercion and control.

9 Lessons learned and Recommendations

Learning point: In an employment context, the sensitive response to, and management of an employee's experience of domestic abuse, includes an awareness that substance misuse is a common coping mechanism for victims. The review concluded that managers should be aware of the signs of substance misuse and its' link to DA. They should be able to identify potential substance misuse particularly where it does not apparently impact upon fitness to carry out a role.

Recommendation one: The DARDR recommends that ‘Safe and Sound’, Dudley’s Community Safety Partnership seek assurance from the Dudley Group Foundation NHS Trust that their redrafted Alcohol, Substance Misuse Policy raises awareness of how to identify possible drug, alcohol and substance misuse in staff where there are concerns, even though they do not meet the threshold to be considered unfit for duty. Policy should clearly identify the importance of early interventions with Human Resources and the Safeguarding team, to balance the needs for support with the need to safeguard the individual, patients and colleagues.

Learning point: There are common health issues such as eating disorders, asthma, that can be caused and exacerbated by domestic abuse.

Recommendation two: The DARDR recommends that all health agencies provide assurance to ‘Safe and Sound’, Dudley’s Community Safety Partnership concerning how they have raised awareness of the known link between some health presentations, such as eating disorders, or anorexia and asthma, and domestic abuse.

Learning point: MARACs may benefit from having access to an IDVA with specialist drug and alcohol knowledge who could case manage complex cases where substance misuse is a significant risk alongside high-risk domestic abuse

Recommendation three: The DARDR recommends that ‘Safe and Sound’, Dudley’s Community Safety Partnership propose to the DA Board that their Action Plan include assessing the feasibility of funding a substance misuse IDVA at Dudley MARAC.

Recommendation four: The DARDR recommends that commissioners of future DA services and substance misuse services in Dudley align DA provision and alcohol and drug misuse support more directly. Current providers of these services should investigate whether any joint working³⁴/partnerships could in the meantime be established and provide a summary of such arrangements to ‘Safe and Sound’, the Dudley Community Safety Partnership.

³⁴ An example of such possibilities is Sandwell BCWAs co locating an IDVA with Cranstoun drug and alcohol services

Learning point: GPs in this case and more widely are not yet consistently ‘asking the question’ of patients who present with health indicators suggestive of possible domestic abuse. It may now be appropriate to consider making questioning routine by GPs and trained staff in line with other health professionals (Mental health, midwifery, health visiting, emergency departments.)

Out of hours services should also ‘ask the question’ of patients presenting with health indicators suggestive of possible domestic abuse.

Recommendation five: The DARDR recommends that Black Country Women’s Aid, as commissioned providers of IRISi across Dudley and the Black Country, propose to the Director of Programmes and Innovation at IRISi that they consider the feasibility of recommending routine screening for domestic abuse in GP practices and out of hours services and that this be included in all IRISi training packages for health practitioners.

Learning point: Because of coercion, control and fear, victims of domestic abuse may provide unreliable information to managers in work, (and to other agencies) about such things as whether they are at risk from their abuser, or whether they have reported abuse. Professionals should recognise this is often a coping strategy, not dishonesty, and should develop respectful uncertainty to check information, whilst respecting the rules of confidentiality and consent. They should be able to describe the threshold for sharing information without consent.

Recommendation six: The DARDR recommends that ‘Safe and Sound’, Dudley’s Community Safety Partnership seek assurance from the Dudley Group Foundation NHS Trust that their redrafted Domestic Abuse policy includes guidance to managers on when it would be appropriate to share or seek information concerning suspected domestic abuse of a member of the Trust. This should include all aspects of consent and a threshold for sharing without consent if there is a risk of serious harm or death. The policy should make it clear these issues must be discussed with safeguarding team.

Learning point: where an employee makes a disclosure that they are or have been a victim of domestic abuse, an employer should ensure that the identity of the abuser is discovered, through direct enquiry with the victim or a request for information sharing from other agencies. This is justifiable to ensure the safety of the employee but also of colleagues.

Recommendation seven: The DARDR recommends that all agencies remind colleagues that whenever domestic abuse is disclosed or suspected, professionals should seek to identify the abuser by making direct enquiry or seeking information from partner agencies.

Learning point: Alcohol and drug misuse by perpetrators and victims is a common feature of domestic abuse. Understanding its impacts on victims is crucial to effective DA support. Police officers and others who use the DARA risk assessment would gain better insight if the DARA included more questions around these vulnerabilities.

Recommendation eight: West Midlands Police to consider whether Domestic Abuse Risk Assessments (DARA) training and guidance provided to frontline officers should now include recognising that drug and alcohol misuse should be seen as an aggravating factor for not only perpetrators, but also their victims. Drug or alcohol use by a victim may be encouraged by a perpetrator as a technique of control, or be a coping mechanism, due to the trauma of that abuse.