Waveney District Council
Community Safety Partnership

Domestic Homicide Review
Executive Summary

The death in Lowestoft, Suffolk
November 2014

Report Author:
Mr Gary Goose MBE

Report completed: April 2016

Before formally introducing this Review, the Waveney District Council Domestic Homicide Review Panel would like to express their deepest sympathy to the family involved in this tragedy.

This Review could not have been completed without their challenge and support.

The Independent Chair and author of this Review would also like to thank all those staff from statutory and voluntary agencies who assisted in compiling and reviewing the information culminating in this report.

Table of contents

Waveney District Council Community Safety Partnership
DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Section 1: The Review process

Introduction and agencies participating in the Review.

This summary outlines the process undertaken by the Waveney District Council Community Safety Domestic Homicide Review Panel in reviewing the death of one its residents. That death having occurred on 19th November 2014.

The deceased was an 89-year-old man who was killed by his daughter, 52 years of age at the time of the incident, at the home they shared in Lowestoft, Suffolk.

For the purposes of this Review the deceased will be known as the Victim and his daughter as the Perpetrator.

Whilst the Victim was beginning to suffer a range of age related issues, the Perpetrator had a long history of acute psychiatric illness and was under the care and support of the local mental health trust at the time of the incident, albeit living independently. Their living arrangement provided for a level of inter-dependent care for and by each other.

On the evening of 19th November 2014 the Victim made an emergency telephone call and asked for police attendance saying his daughter was 'trying to hurt him'. Subsequent further calls were made by members of the public who found the Perpetrator outside the address in a distressed state. Police attended and found a number of people in the street struggling with the Perpetrator. Police were joined by a paramedic crew. Whilst in the street the Perpetrator had made, and continued to make, comments about killing her father.

Police and paramedics went into the property in order to check on the welfare of the Victim. They found him slumped in a chair in the living room. He was moved onto the floor in order to attempt resuscitation. CPR proved unsuccessful and he was pronounced deceased at the scene. He was subsequently found to have died from compression of the neck.

This Review has been informed that the issue of the police response to the emergency call made by the Victim at the time of the attack has been scrutinised by the Independent Police Complaints Commission. That investigation is subject of a separate legislative process, its outcome is summarised later within this report.

The Perpetrator was arrested and interviewed by police. Whilst at the police investigation centre it was clear she was ill and was transferred to a psychiatric hospital. As a result of her medical condition no charges were initially brought against her.

The Waveney District Council Community Safety Partnership was notified of the death by Suffolk Constabulary on 29th November 2014. There followed meetings of a Domestic Homicide Review Advisory Panel which took place on 17th December 2014 and 5th January 2015.

As a result of those meetings the Chair of the Community Safety Partnership made decision to undertake a Domestic Homicide Review. The Home Office was notified of the decision and the Review process commenced.

An independent Chair was appointed on 29th January 2015; the Review commenced immediately thereafter. Two initial Domestic Homicide Review Panel meetings were held in this case: 5th March, 12th May 2015. Shortly after the second Review Panel criminal proceedings were instigated against the Perpetrator for the murder of her father.

As a result of the instigation of criminal proceedings the Chair made contact with the Police Senior Investigating Officer in accordance with the Statutory Guidance in order to ensure the Review did not interfere with, or have the capacity to interfere with, the course of justice. Following those discussions, the Chair made the decision to effectively place the Review on hold until the conclusion of those criminal proceedings. The Home Office were informed of this delay.

On 16th December 2015, the Perpetrator pleaded guilty to the offence of Manslaughter on the grounds of diminished responsibility. The Crown accepted this plea. The Judge issued an Order under Section 37 Mental Health 1983 (known as a Hospital Order). No separate criminal sentence was given.

The Review recommenced following the conclusion of the criminal proceedings.

On 4th March 2016 a final Review Panel meeting was held in relation to this case. At the meeting the Chair and Overview Author provided an updated chronology, a summary of the information gathered as a result of the Review and its draft findings. Full discussion followed and, subject to some minor points of detail, the information was agreed as sufficiently detailed to finalise the report and its findings agreed.

The Review was completed in late April 2016.

It was not possible to complete the review within the six month timescales set out within the statutory guidance due to the commencement and nature of the criminal proceedings instigated shortly after the second panel meeting.

The following agencies and individuals contributed to this Review:

- The next-of-kin of the deceased: By way of information to the Review.
- Norfolk and Suffolk Foundation NHS Foundation Trust (Mental Health Services): By way of IMR and Panel membership.
- GP Practice: By way of chronology and written peer review.
- James Padget University Hospital NHS Foundation Trust: By way of IMR and panel membership.
- Suffolk Constabulary: By way of IMR, provision additional information on the murder investigation, interaction with the IPCC and Panel membership.
- HM Coroner: By way of engagement with the review and attendance at panel.
- Suffolk County Council, Specialist Domestic Abuse Advisor: By way of general information, provision of policy and practice. Panel membership.

- Suffolk County Council Adult Social Care Services: By way of IMR and Panel membership.
- East of England Ambulance Service: By way of IMR and Panel membership.
- National Probation Service: By way of Panel membership
- Suffolk Family Carers: By way of information to the Review, personal interview and panel membership
- Suffolk Independent Living: By way of information to the Review and personal interview.
- Suffolk Police and Crime Commissioner: By way of personal interview by the Chair of the Review.
- Waveney Domestic Violence Forum: By way of panel membership
- Suffolk Adult Safeguarding Board: By way of panel membership.

Purpose and Terms of Reference for the Review

Statutory Guidance states the purpose of the Review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted upon, and what is expected to change as a result

- Apply those lessons to service responses including changes to policies and procedures as appropriate

- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working

- To seek to establish whether the events leading up to the homicide could have been predicted or prevented.

Specific purpose and scope of this Review was agreed by the Panel as follows:

<u>Purpose of the review</u>

- Establish the facts that led to the incident on 19th November 2014 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.

- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

- Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident on 19th November 2014; suggesting changes and/or identifying good practice where appropriate.

- Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

Scope of the review

- Seek to establish whether the events of 19th November 2014 could have been reasonably predicted or prevented.

- Consider the period of two calendar years prior to the events, subject to any information emerging that prompts a review of any earlier incidents or events that are relevant.

- Request Individual Management Reviews by each of the agencies defined in Section 9 of The Act and invite responses from any other relevant agencies, groups or individuals identified through the process of the review.

- Seek the involvement of family, employers, neighbours & friends to provide a robust analysis of the events.

- Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

- Aim to produce the report within the timescales suggested by the Statutory Guidance subject to:
    - Guidance from the police as to any sub-judice issues,
    - Concerns of the family, particularly in relation to parallel enquiries, the inquest process and any other emerging issues.

Section 2: Agency contact and information learnt from the Review

The Victim and his wife moved from Bedfordshire to the east coast of England in around 1966 to provide a better, healthier environment. Their then young daughter, subsequently the Perpetrator, moved with them. Their son stayed in Bedfordshire as he had recently begun his working life.

The Victim and his daughter The Perpetrator had lived together since mid-2013. Prior to this The Victim had lived alone following his wife's death in 2009; the Perpetrator had lived in her own home nearby.

The move to live together was done with mutually beneficial intent: The Victim was beginning to develop a range of age related issues and his daughter suffered acute mental ill-health for which The Victim (previously, together with his wife) had provided significant levels of care over many years.

Whilst the victims wife was alive the couple sought support from a local charity; Suffolk Family Carers as they cared for their daughter. Following her death, The Victim gradually withdrew from the using their resource.

The Victim was described as a very private and proud man. At 89 years of age he had only given up cycling a year before his death and had been an active member of a local bowls club and the British Legion.

The Victim and the Perpetrator lived a structured life. Meals were always at a certain time and it helped both to follow routine.

The Perpetrator had suffered acute mental ill-health issues for many years and been subject to significant, consistent and on-going levels of care from her GPs and in particular local mental health services. At the time of the incident she was diagnosed with Affective Disorder; more specifically bi-polar affective, severe depression without psychotic symptoms. She did however, have a long history of 'psychotic' symptoms; these included auditory and visual hallucinations. She reported hearing derogatory voices, seeing 'monsters' around the television, faces at the window. She also reported 'thoughts' that she was being 'chased by demons'.

The Perpetrator's thoughts were reported as being often negative about herself with paranoid ideas that she was going to be harmed, for example, that she was going to be killed in the night or that her medication was going to harm her. There are also references within her medical history of voices telling her to harm her parents.

All of the above contributed to periods of high anxiety and avoidant behaviour, when she relied heavily on the support of her parents (in later years this was her father).

She benefited from financial assistance in the form of benefits enabling her to employ a personal assistant to help her manage day to day living. This financial assistance was due to end at around the time of the incident as a result of her selling her own home and thus being above the financial threshold that afforded her benefits. There is strong evidence that this was a source of increased anxiety, but equally evidence that this individual issue appears to have been resolved in the week leading up to the incident.

The Perpetrator's life was supported greatly by the resources provided by mental health services including day centres and visits by her personal assistant who would take her shopping and for coffee. She also sought comfort with a local independent church mission, somewhere she used to attend with her mother. Religion was regularly referenced as a source of both comfort and agitation in her life and her mental ill-health condition.

Whilst the information before this Review indicates significant levels of health service involvement, other agencies appear to have had very little involvement with either the The Victim or the Perpetrator.

Local GPs, the local hospital and local adult social care staff had some minimal involvement with The Victim and he had been offered a range of support primarily in the form of 'signposting' to various support bodies and groups. He declined these offers.

This review has concerned itself with the level of previous interaction across all agencies. Whether those interactions were reasonable and appropriate in the circumstances and whether lessons can be learned.

Moreover, the review concerned itself with the totality of the situation. Whether those agencies involved took an overview of the whole situation or whether they worked in silo's. It is a fact that a vulnerable elderly man was living with a clearly vulnerable woman, albeit his daughter, both were in receipt of support from separate agencies. Did those agencies work together and were any opportunities to better assess risk missed?

Section 3: Key issues arising from this Review

This Review found itself largely concerned with health and social care providers. In particular, whether those agencies engaged sufficiently with individuals who were clearly becoming vulnerable (in the case of the Victim) and very ill (in the case of the Perpetrator). Did agencies appropriately share the information they held to provide a fully holistic view of the circumstances and risk that prevailed in the household?

In all cases, it found the level of engagement and assessment of risk to be appropriate:

GP's:
The Review finds that on balance the GPs showed a high level of awareness and care for both the Victim and the Perpetrator. They made an appropriate and timely referral for the Victim when his situation demanded it. They also interacted properly with the local mental health trust in managing the complexities and difficulties presented by The Perpetrator's mental and physical health.

The Norfolk and Suffolk NHS Foundation Trust (provider of acute mental health services):
The Trust were engaged for many years with the Perpetrator. They have undertaken a robust internal review of their engagement and fully co-operated and assisted this Review.

As a result of the level of Trust engagement with the Perpetrator, and to some extent the Victim, this Review asked itself four questions about the Trust's involvement:

- Was the risk assessment process in place in this case appropriate in all the circumstances?

Whilst the Trust accepts that the risk assessments on record were out of date, it seems to this Review that the health care professionals involved with the Perpetrator in the days prior to the incident and in the months leading up to it acted accordingly with the information they had and the clinical nature of her presentation. She was well known and to the best of their knowledge there were no incidences of harm to others that indicated a different course of action should have been taken. The Trust accepts that historic information of comments made by the Perpetrator about harming her parents were not part of the most recent risk assessments however this review does not consider that if it had been it would have resulted in any different outcome.

- Was the level of Trust engagement with the Perpetrator appropriate for her level of illness and were care plans being adhered to?

The Perpetrator was well known to the Trust, she benefits from consistent and knowledgeable staff. The Trust accepts that care plans were out of date in accordance with Trust policy, however, this Review takes the view that the level of engagement by the Trust and its staff meant that appropriate levels of care were being provided at the time of the incident.

- Did the Trust respond appropriately when the Victim and the Perpetrator called for assistance the day before the incident?

The Review is aware that the Victim called the Trust as he had concerns for the Perpetrator the day before the incident. He described her as not wanting to leave the house. This Review

comes to the conclusion that the Trust acted quickly and appropriately following the call from the Victim. The telephone call and the actions they took were appropriate in all the circumstances prevailing at the time.

- Was information shared appropriately with other agencies in order that a whole view of the household could be obtained?

There can be a temptation in Reviews such as this to always criticise levels of information sharing. The Review Panel considered and debated this aspect in depth.

It is clear that there was good information sharing between the GPs and the Trust and vice versa. There is also strong evidence that the Trust worked with those others who were supporting, or could support the Perpetrator with issues that were presented. This is evident by the contact between the Trust's staff, Suffolk Independent Living and the Local Authority's financial inclusion team when the financial issues arose during 2014.

However, the join-up between those supporting and caring for the Perpetrator and those who were asked to assess support for her father could have been better. It is clear that when the Adult Social Care staff were tasked with assessing the Victim's situation they were not fully aware of the level of mental ill-health suffered by the Perpetrator; that information being known to the Trust. The question in this case is whether the Trust could or should have made that information available to the Adult Social Care team to enable them to better asses the Victim's needs. This may have led to a more holistic view of the circumstances pertaining within the household rather than one organisation looking at the Victim and one looking at the Perpetrator.

Having discussed this in depth, the Review Panel comes to the conclusion that whilst a professionals meeting may have helped provide a more rounded and holistic view of the household, the fact that one did not take place cannot and should not be subject of criticism in this case for the reasons set out below:

An individual's medical condition and history is rightly protected in law; with exceptions made for specific reasons. In this case, as a result of professional levels of enquiry and care provided by both organisations (The Trust and the Adult Social Care staff) sufficient and appropriate levels of information were known by both to carry out detailed assessments. Where added layers of detail about the extent of the Perpetrator's mental illness made available to the Adult Social Care team it would have probably made minimal or no difference to the level of assessment and support offered. Such assessments were made on the basis of welfare need and not safeguarding need. There is no evidence that the Perpetrator provided such an immediate threat to anyone else, including her father, that would trigger this to have been considered a safeguarding issue by the Trust. Historic comments about harm to her parents were few and the most recent was six years old; the Trust had managed the issues that prompted those comments and nothing suggested they were being revisited.

The Trust accept that there is no evidence to suggest those comments were shared with the Victim. This would have been good practice.

This Review therefore considers that appropriate levels of information were shared in this case by the Trust.

Importantly, this Review is clear that had the Trust shared any of its information that it held about the Perpetrator's medical history with others, either as a result of consent or otherwise, there is no evidence to suggest that different decisions would have been made that would have prevented the tragedy.

No definite root cause of the incident could be identified by the review team.

Suffolk County Council Adult Social Care:
The Review has looked at whether the referral in 2012 from The Victim's GP, followed by his telephone call a couple of weeks later, could or should have been dealt with differently. The Review comes to the conclusion that the Adult Social Care staff and the process by which it gathered and assessed the information were appropriate. Their actions were timely and a personal visit was made to assess the situation which was a good positive intervention.

The issue that requires further mention is whether that member of adult social care staff who carried out that assessment could or should have reasonably been made aware, or have been able to reasonably ascertain, the level of mental ill-health suffered by the Perpetrator. After all, one of the contributing factors for consideration was that the Victim was managing with the help of his daughter. Unfortunately, his daughter was prone to suffering bouts of acute mental ill-health and thus her capacity at times to help look after him was severely impaired. There is no evidence of the offer of a carers assessment for the Perpetrator. Given that the Victim was clear in his refusal of services this is perhaps not surprising but with the value of hindsight such an assessment could have been useful as it may have alerted the ASC staff to the nature of the illness suffered by the Perpetrator; She may, of course, have refused such an assessment in any case. Such disclosure may have led to a professional's conversation or meeting to discuss the holistic picture of the household that existed at the time. However, that illness, at the time was being effectively managed by specialist staff and there were no concerns about her risk to others or her ability to manage in the household with her father in an increasingly caring role.

On balance, this review comes to the conclusion that the involvement of the social care team in this instance was centred, rightly, around the Victims welfare needs, not a safeguarding need. In view of that, whilst a conversation between adult social care and the mental health trust about the Perpetrator's capacity to act as carer would have been preferable, it is not likely to have made any tangible difference to the outcome. The Victim was capable of making his own decisions to decline support and this was not such an acute case where care could be enforced.

Suffolk Constabulary:
Until the incident on 19th November 2014 police involvement had been limited to responding to crime reports and general enquires.

There is no recorded history of violence between the Victim and the Perpetrator.

There was one previous engagement by the police with the Perpetrator where they supported health service colleagues when she was suffering a severe mental ill-health episode. This occurred over eleven years before the death of her father when she was found naked in the street following reports made by members of the public. Police officers and an ambulance attended the scene. The Perpetrator's welfare was considered by the staff in attendance, she was taken to hospital having fallen and hurt herself.

In June 2013 the Perpetrator reported that there had been a burglary at her house. When seen by a police officer she was accompanied by a neighbour, the police officer established that she suffered with mental ill-health issues and that she was upset by the burglary. Some weeks later the officer updated her with the outcome of the investigation. The Perpetrator said it was her intention to sell the property and move in with her father. Whilst the officer had established that she suffered with mental ill-health issues, there was no apparent cause for concern regarding her welfare and no requirement for any referral to be made.

These two issues, over ten years apart were dealt with appropriately by police and this Review does not suggest that any further referrals or action were necessary in the circumstances that prevailed at the time.

The issue of the police response to the emergency call made by the Victim at the time of the attack has been scrutinised by the Independent Police Complaints Commission (IPCC) in conjunction with the Police.

The Chair of this Review has liaised with the Police to ensure that any issues arising from that investigation and relevant to this Review have been identified and incorporated within this report.

As a result of the IPCC investigation it was clear that the call made by the Victim at 8:53pm on the night of the incident was not handled correctly by a police control room operator. Subsequent internal proceedings led to that operator's employment in the police control room being terminated. Given the nature of the attack, in particular that it almost certainly happened at the time of the call made to the police, it is important to note that even had the call been handled differently then it is unlikely that officers would have been able to attend in time to save the victim. Whilst this cannot be said with absolute certainty, it appears to this Review that the victim is likely to have been dead immediately after the call terminated.

The investigation did not find systemic or procedural failings by the police at the time. It did however ask that its findings were included in ongoing work of Suffolk and Norfolk Constabularies to align their call grading system. Since this incident the police have moved to a new method of dealing with each call based upon a more rigorous assessment of the threat, risk and harm posed by each incident.

As a result of the scrutiny of the emergency call made on the night undertaken elsewhere, this Review concludes that that aspect is sufficiently exhausted. This Review has concentrated on the circumstances that prevailed in the months and years leading up to the incident and the appropriateness of agency response and action. The specific response to the incident on the night does not affect the analysis of those prior circumstances.

Other agencies and issues:

The East of England Amublance Service NHS Trust were had been involved previously with both the Victim and the Perpetrator for a range of issues. This Review is confident that the actions taken by the staff of the East of England Ambulance Service Trust were appropriate in all the circumstances scrutinised by this Review. Good communication was made with GPs and other specialist services.

The Victim, his wife and the Perpetrator were provided with support from Suffolk Family Carers (SFC). SFC have a long history within Suffolk and provide information, advice and guidance to family carers of all ages. They provide a range of services to support adult, young and young adult carers across the county including visits in rural locations to provide information and advice to those who are isolated due to their caring role.

Suffolk Family Carers were invited to participate in this Review. They did so fully and the Review would like to formally thank the organisation for its positive contribution to the Review and its findings. They have shown themselves to be a learning organisation and have taken on a number of single agency changes since this incident.

Section 4: Conclusion

This was a truly tragic case where a loving and caring father was killed by his very ill daughter.

Our thoughts are with the family left behind in such difficult circumstances.

The issue of the police response to the emergency call made by the Victim at the time of the attack has been scrutinised by the Independent Police Complaints Commission. This Review has therefore not concerned itself with that aspect as to do so could have the capacity to divert attention from the whole set of circumstances that preceded it. This Review has concentrated on the circumstances that prevailed in the months and years leading up to the incident and the appropriateness of agency response and action.

The issues that comprise this case demonstrate the very real difficulties that exist in managing the risk posed by those people suffering the type of illness as suffered by the Perpetrator.

Whilst properly trained professionals should be expected wherever possible to recognise and mitigate that risk this case exemplifies how it is impossible to completely eradicate it.

This Review concludes that those caring for the Victim and the Perpetrator did what they thought was appropriate in all the circumstances. They used professional knowledge and judgement to make referrals, provide support and reduce the risk that existed from the Perpetrator of self-harm and harm to others.

Whilst there is evidence that the Perpetrator had made previous comments about thoughts of harm to her parents, and that these comments were not available to those who had completed the most recent risk assessments and care plans, the Review does not conclude that if that information had been known any other course of action would have been taken that would have prevented the death of the Victim. Those comments were historic and a symptom of her illness which had been managed effectively in difficult circumstances for many years.

Services were involved with both the Victim and the Perpetrator and each dealt with their respective client. A conversation between professionals to ensure that an holistic view of the household was available would have been helpful, however, given the assessed low level of risk that existed at the time in relation to the Victims age and the Perpetrators illness it is unlikely that it would have made any difference to the services provided.

The Norfolk and Suffolk NHS Foundation Trust and the GPs in this case had significant knowledge of the Perpetrator, her illness, the symptoms that manifested themselves in times of high anxiety and had successfully managed those symptoms for many years. There was nothing in the days immediately preceding the death that was at variance with previous issues of high anxiety and depression. In fact, the work done with her over the preceding weeks and the visit by her brother over the previous weekend seemed to have reduced the anxiety over the immediate financial pressure in the days leading up to the incident. In fact, on the very day of the incident itself there do not appear to have been any signs of what was to come.

One can only come to the conclusion that in the minutes immediately preceding the Perpetrators attack on her father, thoughts had come to her that prompted the attack.

This Review does not consider this could have been reasonably predicted or prevented.

Section 5: Examples of Good Practice, Lessons Learned and Recommendations

Examples of good practice

The use of a Domestic Homicide Review Advisory Panel to provide rigour around early decision making by the Chair of the Community Safety Partnership.

Lessons learnt

Lesson Learned: That risks exist for organisations when migrating systems for recording risk assessments. Care should be taken to ensure that historical recorded risks are included on any new operating system.

Recommendation 1: Risk Assessments by agencies. Consideration and care should be given to the specific factor of historical risk. It should be convenient for all clinicians and staff to document such risks and for a summary to be electronically 'pulled through' and included in all subsequent risk assessments. Even if the risk not considered to be contemporary, a summary will allow future clinicians and staff ease of access to the information, prompt staff to ask about the risk and not allow staff to omit historical risk once it has been identified.

Lesson Learned: That where service users are well known and subject to intensive long-term support by the same staff a risk can exist that the discipline around maintaining regular documented reviews and updated care plans can lapse.

Recommendation 2.
That organisations ensure it is a key role of supervision to ensure the discipline of documenting regular reviews is maintained.

Lesson Learned: That risk assessments should pay particular attention to historic risk assessments in the context of an identified dynamic risk factor and an objective assessment of any signs and/or symptoms present. Highlighting the nature of dynamic risks and the need to monitor them will encourage/support clinicians to assess for these risks and improve the quality and effectiveness of risk assessments.

Recommendation 3.
Risk assessment training – should emphasise the importance of historical risk assessment, in the Timescale: This should be considered as part of the next review of the Trust's risk assessment training programme or within 3 months. Measure: Specific inclusion of the importance of assessing dynamic risks in risk assessment training.

Lesson Learned: The two-tier structure of the Local Authority, the independent nature of Community Safety Partnerships with no direct county-wide oversight, the emergence of the Police and Crime Commissioner and Health and Wellbeing Boards has the potential for making a clear governance structure difficult to achieve. However, it also provides great opportunity for strong partnership arrangements that drive down to a local level. The Chair of this Review has been struck by how many individuals truly want to make a difference. It is therefore essential that organisations agree a clear governance structure for Domestic Abuse in order to harness everyone's undoubted passion for making a difference.

Recommendation 4. That a clear County-wide partnership governance structure be established for the strategic leadership of domestic abuse within Suffolk.