Executive Summary

SaferCentral
Community Safety Partnership

A Domestic Homicide Review concerning the death of Jane (pseudonym)

(January 2022)

Author – Jackie Dadd

Date completed – January 2023

Family tribute

My daughter grew up a fun loving, full of life, giving, bubbly friendly young girl.

She enjoyed being with her friends and family. She enjoyed so much to visit her Grandad in Dorset and was very close to him. We had holidays, picnics trips with him, walks and her life was happy.

Unfortunately, Grandad passed away when She was 17 and we scattered his ashes at Durdle Door in Dorset. We were all devastated.

At 18, my daughter gave birth to a beautiful baby boy. She was such a good loving mum and so proud of him. She had a normal life and was happy when she was offered a flat for her and my grandson.

At 28 years old, she was diagnosed with an early menopause. Her health took a turn for worse and she was depressed angry and had panic attacks and other symptoms. She started to drink a lot and didn't know how to cope. She was given lots of medication but seemed to get worse, in and out of hospital and a few run ins with previous partners and police.

She was sent to London to see a specialist for hormonal treatment.

For a while, she turned a corner and improved and seemed happier. However, when She was ill, she decided to allow her son to live with his Dad and then missed him dreadfully and didn't seem to have a purpose for anything. She went out with friends and saw her son at weekends which brightened her up and she started having a couple of relationships. One in particular was disastrous. She became unhappy, withdrawn and scared, drinking a lot for fear of this person. At one point though this person was put away and She seemed to brighten up again. We all had a lovely Christmas together last year with my Grandson and family.

Early this year, my daughter took her own life. My beautiful baby has gone. We are all devastated and love and miss her so much. I can't believe I'm not going to see her again. I still see her coming through the backdoor saying 'Hi mum".

Our beautiful girl has gone too soon and her ashes are with her Grandad at Durdle Door.

I just wish there was more that could have been done to keep her safe.

Mum

The Domestic Homicide Review Panel and the members of the Central Bedfordshire Community Safety Partnership would like to offer their sincere condolences to the family of Jane, who have lost their loved one in tragic circumstances, and which has caused this review to take place. They have been left with a huge gap in their lives.

Contents

1. The review process

1.1 - This review is into the death of Jane, a 36yr old female, who was found deceased in January 2022 by Bedfordshire Police at her home address. The Police have investigated the circumstances and have submitted a report to the Coroner with a finding that the death was non-suspicious and the cause was suspected suicide by hanging. The Coroner's inquest has been opened and adjourned awaiting the completion of this review. This will be held on 15th February 2023.

Bedfordshire Police made a referral to Central Bedfordshire Community Safety Partnership on 17th January 2022 due to a history of domestic related incidents involving Jane on their records.

Jane's death was reported to the Coroner by the Police and a file was opened. The report submitted stated that the death was considered to be non-suspicious and was treated as a sudden and unexplained adult death, indicative of a suicide by hanging.

1.2 - A Post-mortem was subsequently held.

The result of that post-mortem examination was: -

1a. Hanging

2. Cocaine and alcohol use

At the time of her death toxicological analysis has identified that the deceased had differing levels of Paracetamol, Sertraline and Zopiclone that were consistent with therapeutic dosing and do not indicate an excess in the hours recently prior to death.

Concentrations of 170 ng/mL of Cocaine and its primary inactive metabolite benzoylecgonine (1600 ng/mL) were found consistent with recreational/binge use or excessive use followed by a prolonged period of metabolism (breakdown in the body).

There is toxicological evidence to indicate that Jane consumed alcohol (100mg/Dl in blood) in addition to having used a number of drugs prior to death. In cases involving rapid death (hanging) it is difficult to determine whether or not excessive ingestion had occurred immediately prior to death.

The only recent injuries found were those of a ligature mark around the neck.

1.3 - A decision was made by the Central Bedfordshire CSP and partners including voluntary and non-voluntary sector, to undertake a Domestic Homicide Review on 10th February 2022 as it was found that the definition in Section 9 of the Domestic Violence Crime and Victims Act (2004) had been met.

The following pseudonyms, agreed by the family, have been used in this review to protect their identities and those of their family members:

Jane - Deceased 36-year-old white British female.

Rosemary – Mother of Jane.

Bobby – Son of Jane. 16 years old when Jane took her life.

David – Most recent Ex partner of Jane who found her deceased. Aged 51 years old.

Paul – Ex partner of Jane, imprisoned for offences against her. White British male aged 45 years old.

Martin – Ex-husband of Jane. Father of Bobby. Aged 35 years old.

Darren – Close Friend of Jane's since school.

Address – Name of area referred to as Central Bedfordshire.

1.4 - Central Bedfordshire Community Safety Partnership (CSP) have the legal responsibility for DHRs within their area. They have commissioned 8 DHRs of which 4 are suicides thus far. In 2018, a quarter of the total of 6507 deaths by suicide registered in the UK were by females. (ONS, Suicides in the UK, 2018 registrations). Domestic Abuse is a factor in around 12.5% of female suicide attempts.

IMR's were requested from the agencies who had significant communication with Jane or held significant information. Selected agencies were asked to submit a summary report to reflect the Terms of reference and provide context to prevalent areas including unconscious bias, suicide and mental health issues. This was to assist in analysing the depth of knowledge and support already in existence and being required in the Central Bedfordshire area.

2. Contributors to the review

The following agencies have contributed to the review: Each of the agency authors is independent of any involvement in the case including management or supervisory responsibility for the practitioners involved.

- East London Foundation Trust
- Bedfordshire Police
- Bedfordshire Integrated Care Board (ICB)
- Bedfordshire Probation Service
- MARAC
- P2R
- Families First
- Bedfordshire Adult Social Care
- Public Protection, Central Bedfordshire Council
- NW Anglia NHS Foundation trust
- BLMK Public Health department
- GP Practice
- Central Beds Community Safety Partnership
- Victim Support/IDVA

- Bedford Women's Centre
- Central Bedfordshire Domestic Abuse Service

3. Review Panel members

The following individuals and agencies/organisations/voluntary bodies have contributed to the Domestic Homicide Review panel:

Name	Area of responsibility	Organisation
Lisa Scott	Safer Communities & Partnership Manager	Central Bedfordshire CSP
DCI Craig Laws	Domestic Abuse Lead	Bedfordshire Police
Jayne Richards	Domestic Abuse Specialist Officer	Children's Services – Central Bedfordshire Council
Tawanda Hakulandaba	Service Manager	P2R – Alcohol services
Dr Joy Jimni	GP practice representative. Doctor	Medical Centre of Jane
Joy Leighton	Senior Operations Manager	Victim Support/IDVA Bedfordshire
Michelle Burnley	Services Manager	East London Foundation Trust (ELFT)
Anna Bruce	Deputy Head of Service	Probation Service - Bedfordshire
Rachael Clifford	Public Health Principal	Public Health Department (BLMK)
Susan Childerhouse	Assistant Director Public Protection	Central Bedfordshire Council
Pushpa Guild	Review Officer	Hertfordshire Police (MCU)
Amy Thulbourne	Service manager Safeguarding and Quality Improvement	Adult Social Care
Nina Page	Team Manager	Central Bedfordshire Domestic Abuse Service

Each panel member is independent of any involvement in the case including management or supervisory responsibility for the practitioners involved.

A total of three panel meetings have been held during this review, excluding the initial meeting to decide on the commissioning. The writing of this report had significant delays whilst Central Bedfordshire CSP found an available Chair and author. There was a further delay awaiting the Police submission due to capacity issues. The Home Office were kept informed throughout. The completed report was handed to the Central Bedfordshire Community Safety Partnership on 1st February 2023.

4. Author of the overview report and Chair

4.1 - The chair of the review panel and author of this report is Mrs Jackie Dadd, an independent consultant who is independent of the organisation and agencies contributing to this report. She has no knowledge or association with any of the subjects in this report prior to the commissioning of this review. She is a retired Detective Chief Inspector with Bedfordshire Police since January 2021, with vast experience of safeguarding and domestic abuse related issues and has been involved in the DHR process since its inception in 2011. She has undertaken a number of DHR's having completed the Home Office online training, the CPD accredited AAFDA DHR Chair training and is a member of the AAFDA DHR network, regularly attending the monthly forums for CPD and discussion.

4.2 - The independency of Mrs Dadd was thoroughly explored prior to her undertaking this work due to her previous links with Bedfordshire and Mrs Dadd, Central Bedfordshire CSP and the review panel were all satisfied that the transparency, independent nature and integrity of this report was assured from its outset.

5. Terms of Reference

5.1 - Terms of reference were discussed and agreed upon during the first panel meeting on 1st September 2022.

It was agreed that the main areas of focus would be based on:

1) If domestic abuse in any form had been the causation or a contributory factor to Jane taking her own life
2) The availability and effectiveness of services and agencies provisions for those contemplating taking their own life and those with complex needs within Central Bedfordshire
3) The response of services when a victim has previously been a perpetrator and whether this creates barriers in process
4) Considerations and actions available to appropriately support and safeguard domestic abuse victims

It was agreed by the panel that the review and research dates would take place from 2009 as this was the known year that the relationship issues became known to multiple agencies, but any relevant information held prior to that should be included until the date of her death.

5.2 - The full Terms of Reference are below:

- The date parameters under consideration for documentation are from 2016 to the 2022. However, if relevant information is held prior to this, can a summary be provided to provide context.

- This is to be reviewed as a suicide based on the investigation by appropriate authorities. The purpose is to establish if DA was a cause or contributory factor in the death of Jane.
- Ensure the review seeks to involve the family in the process and takes account of who the family may wish to have involved as lead members. Identify any other people the family think may assist or be relevant in the review process.
- Seek the involvement of employers and friends to provide contextualised analysis of the events.
- How accessible were the services and pathways for referral for the deceased.
- Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and whether these were acted upon. Recommend any changes following the review process.
- Establish accessibility of services for those contemplating suicide and whether training has been received in relation to the effects DA may have towards this.
- What provisions are available for those suffering from alcohol misuse? Were appropriate referrals made when it was established this was a factor with Jane?
- Establish the response to Jane's Mental Health and establish:
  Was it appropriate?
  Was DA considered by the professionals and spoken about with Jane?
  What sharing information processes and referrals are in place when multiple complex needs are identified and did these occur in Jane's case?
- Identify the processes and risk assessing that Housing associations have available in relation to domestic abuse victims and perpetrators and whether they are effective.
- Were procedures sensitive to the ethnic, cultural, linguistic, and religious identity of the deceased and her ex-partner? Was consideration for vulnerability and age necessary? Were any of the other protected characteristics relevant in this case?
- Identify and highlight good practice for wider sharing
- Panel to have a parallel action plan for expedited implementation where practicable during the review
- Establish what processes are in place to record appropriately, decision make and provide support when it may be unclear who the victim and the perpetrator are within the relationship.
- Establish if there is unconscious bias with professionals because victim has previously been recorded as an offender
- What processes are in place to inform victims ahead of a perpetrators release. What safeguarding plan is put in place and who holds responsibility for this.
- Has Covid had an impact on patients/clients in relation to lack of face-to-face contact and difficulty in contacting for assistance.

6. Summary Chronology

6.1 - When Jane was 18 years old, she met Martin and began a relationship with him. A year later, she fell pregnant and they had a baby boy, Bobby, who was born in July 2005. The

relationship broke up when Bobby was about 18months old and Jane and Bobby moved back in with her mum until she was allocated a house.

Following the separation, Jane began to drink alcohol more frequently and in 2006, the Health visitor recorded that she was suffering from post-natal depression, describing her as vulnerable and prone to depression and she was offered counselling. Her GP reports that she was prescribed anti-depressants and sleeping tablets as she complained of insomnia.

6.2 - The first recorded domestic abuse incident for Jane was recorded in 2012, when her partner at the time had too much to drink and had become aggressive. This was recorded as a verbal only incident.

In January 2015, Jane complained of mood swings, panic attacks and suicidal thoughts. She attempted to take her own life for the first time and repeated this within a year. Her son, Bobby, was in the house at the time. Jane had been referred to a psychiatrist and during that year, was found to have obsessive intrusive aggressive thoughts of self-harm and harming others. She continued to drink heavily which was thought by medical professionals, to be the reason she began to have fits and panic attacks during that year.

6.3 - At 28 years of age, Jane was diagnosed with premature ovarian failure and was subsequently placed on HRT. This had a negative impact on her mental health. She remained under the psychiatrist and the gynaecologist. Over the next couple of years, Jane took several overdoses and threatened to harm herself in which the Police, Children Services and the ELFT were all involved. She was detained under S136 of the Mental Health Act 1983 on more than one occasion.

6.4 - In 2019, there were several incidents involving Jane and the police due to an escalation in her mental health issues. One of these saw her prosecuted for assaulting her then partner by using a telephone cable to tighten round his neck. She pleaded guilty to ABH.

In total, ELFT (Mental Health Team) have nine separate records of Jane attempting to take her own life between 2019 and 2021. She had seven admissions to mental health wards between June 2018 and October 2019.

6.5 - Jane met Paul in early January 2020 and although initially appearing happy, Paul soon caused her mother concern by his controlling behaviour, constantly phoning and questioning Jane whilst she was on a trip to Brighton with Bobby and Rosemary. A short while later, Rosemary found Jane cowering in her bedroom during an argument with Paul one night and she banned him from the house.

On numerous occasions of trying to end the relationship, Paul would go out ‘drinking’, park his van outside and leave flowers at the gate. He would send Jane large quantities of texts via differing social media formats and make multiple phone calls.

Jane would constantly go back to him and when her mum asked her why, she would reply,

‘It’s easier than not being with him as I then get a bit of peace’.

6.6 - In December 2020, Jane made her first report to the Police in relation to harassment from Paul due to constant calls and messages and visits to her mother's home, even though she had broken off the relationship. She was unwilling to support any police action at that time and the case was closed due to evidential difficulties.

6.7 - Early January 2021, the police recorded a kidnapping of Jane by Paul. Paramedics reported concerns for Jane's welfare, having responded to a suicide attempt made by Jane, by hanging. She was conveyed to hospital for treatment and disclosed she felt trapped in an abusive relationship. Paramedic described the abuse comprised of controlling and coercive behaviour from Paul.

The Police assisted Jane through the NCDV to apply for a non-molestation order. Paul continued to stalk and harass Jane in breach of this. She attempted suicide at her home address where she lived with her mother. Jane said that a contributory factor to this suicide attempt was Paul's incessant calls and text messages.

Paul went on to locate Jane whilst she was in refuge and then glue the locks to her new home when she left there as a way of letting her know he knew where she was.

6.8 - Jane reported three separate breaches of the non-molestation order to the Police during 2021. Near the end of October, Jane was at home one evening when she received a phone call from Paul from a withheld number. He called her a 'bitch' and said that she had ruined his life, caused him to lose his job and not be able to see his children. He then went on to contact her a further 9 times the same evening. Jane reported this to the police and made a statement.

Within two days, Paul had been arrested, admitted his actions and was charged with the latest breach of the NMO and remanded in custody. He was sentenced to a 10-month custodial sentence in November 2021 in which Jane was at the Court to hear this. Following this, Jane told ELFT that she was feeling a bit more settled but was worried for when he would get released.

6.9 - She had begun a new relationship in the same month with David. Rosemary states that David seemed normal when he first got together with Jane, but then Jane discovered that he looked at perverted sites on the internet and although he promised he would stop, he didn't which led to arguments. Jane ended the relationship. David continued to contact her.

6.10 – Jane had a good Christmas with her family and was in good spirits on a day in mid-January when she had rung her Mum. The next evening, David went to her flat and entered through the front door as it was unlocked. He found Jane hanging from an internal door with a white dressing gown cord tied around her neck. David rang 999 and the ambulance and Police arrived shortly afterwards. He attempted CPR, as advised by ambulance control until the paramedics took over from David. However, they were unable to revive her. At 6.58pm, Jane's death was declared.

The following notes (transcribed) were found at Jane's home:

'I'm really sorry. I couldn't cope. I was lonely and I'm scared for when Paul comes out of prison. I'd rather kill myself than him kill me. I love David but I was never good enough for him or anyone. I failed my whole life. (Star is born). I'm just a disappointment to everyone, not even got a relationship with my brothers.

Next page

'I'm really sorry but I'm not coping well, I live on my own and sad + lonely.
I would rather kill myself before Paul will. I'm living in fear. I love my family but sad my brothers never had a relationship with me. I'm sorry for my behaviour but my menopause and balance took over. I'm gutted not one of you tried to understand.
Tell Bobby I'm proud and he's an amazing young man. You r the best thing I'm proud of. Please don't cry or get angry.'

There were no signs of third-party involvement or criminality. This incident was treated as a sudden and unexplained adult death, indicative of a suicide.

6.11 - The panel have concluded that the differing forms of domestic abuse that Jane received from Paul was the significant contributing factor of Jane taking her own life and that her mental health issues accentuated her decision making.

7. Key issues arising from the review

7.1 - Communication between organisations to work holistically to enhance support and safeguarding.

There is good evidence of referrals being made between organisations throughout this review in order to assist and provide support for Jane with her multi complex needs including domestic abuse, alcohol issues and mental health issues. However, there is a lack of communication in order to assist each other and thus enhancing that support.

Jane's mother has told the review of the frustration Jane felt when she called the crisis team and someone different would attend each time with no prior understanding of the history, making Jane have to explain it on multiple occasions. Resourcing and capacity issues are understood within Mental Health teams but there should be an expectation for them to review the history notes of the patient prior to attending. CMHT record information in several formats, utilising WhatsApp for an easy communication method, weekly clinical Multidisciplinary team meeting notes are in a shared folder and then their official electronic RiO system. This means that the information is not stored in one location and can be overlooked or not officially recorded. This is not the official protocol but is utilised by operatives.

Both the IDVA service and P2R received referrals and both attempted to or contacted Jane via the phone and she declined or ignored their services. However, if they had met her face to face, utilising an introduction from an agency that had already established a relationship with her, then the approaches may have been accepted in a different way by Jane as she had multi complex needs and may have reacted to this introduction more favourably.

The Police had several investigations ongoing against Paul in relation to breaches of his non-molestation order but partly due to lack of communication with the CPS and internally, they were not presented as one overall case to be considered, thus losing the opportunity to charge further offences and potentially obtain a larger term of imprisonment, thus providing reassurance and safeguarding for Jane for a longer period.

Housing was contacted out of hours via email whilst Jane was in crisis. The email was not read until over 48hours later and was not identified as a safeguarding issue. No referrals were made. This information was only disclosed to the panel by the Coroner on reading a draft version of the Overview report as Housing had responded with a nil return during the scoping request.

(Recommendations refer)

7.2 - Lack of understanding between the correlation of domestic abuse and mental health

Training of domestic abuse as a safeguarding area is now delivered to many organisations across the Country including each organisation involved within this review. However, it has been identified that it is still not widely understood or recognised in regard to the correlation between mental health issues and domestic abuse. This can be whether or not the domestic abuse is the causation of the mental health, vice versa or whether on exacerbates the other but they are still, more often than not dealt with in isolation of each other.

ELFT comment on disclosures made to them from Jane in one instance that she wanted to harm an ex-partner but no safeguarding referrals were made. They also identify the degree of disconnect in the Care Coordinators approach when Jane disclosed domestic abuse to him and he did not connect this with a risk to her self-harm and suicidal thoughts/intent.

This is the first DHR that public health will have been a panel member for Central Bedfordshire and this will now be best practice going forward for all DHR's involving suicide. Public Health do not collate specific data in relation to domestic abuse and suicide at this time and do not have a domestic abuse specialist on their suicide prevention steering group.

Panel members agreed on behalf of their agencies that training specifically in this subject area was required in their organisations for both front line staff and managerial positions.

(Recommendations refer)

7.3 - Unconscious bias when victim has previously been recorded as a perpetrator

Panel members have discussed in depth how support services and the MARAC process are often cautious over offering support and disclosing support mechanisms that only victims

would be told, such as locations of refuge if they were recorded previously as a perpetrator. This is due to previous experiences where perpetrators have manipulated the system in order to gain knowledge and to present themselves as victims to mask their abusive behaviour and discredit the other party.

The IDVA service initially received a referral at the start of January 2021 and recorded the reason for the decision not to support her as being a perpetrator from a previous matter. They also incorrectly recorded that she was receiving support from Families First and Bedford Women's Centre who have confirmed they were not. A further referral in April of the same year saw support for Jane declined again on the basis that there was a counter allegation involved from the incident and previous information in regard to her offending behaviour. In October, the same year, a further referral for Jane was received and contact was made via phone. Jane declined support but wanted help to make her front door more secure and after receiving the details, stated that she would contact them directly if needed. There is no record as to why on this occasion, support was offered in comparison with the earlier referrals. Jane was supported at the Court process in November by the Court IDVA.

Jane was referred to MARAC on three separate occasions in 2021, but it does not appear that any definitive decisions were made on how best to safeguard her. MARAC has no statutory authority which leaves them with no jurisdiction when tasking actions which are then not completed.

There is a toolkit available to assist with risk assessing when a victim has previously been a perpetrator but the MARAC action for this to be completed by ELFT does not appear to have occurred. It is difficult to state whether the actions from MARAC or the IDVA service were that of unconscious bias as it is understandable that caution has to exist but when removed from the situation, the information and series of events make it clear that Jane was genuinely a victim of Paul ad required support and safeguarding.

(Recommendations refer)

8. Conclusions

Jane was raised by a loving sole parent in her mother and had three older brothers who she was initially close to and were protective of her. She was told of the fact that her father had been imprisoned for offences of paedophilia when she was fourteen years old, which affected her mental health to a degree but did not become apparent how much this had bothered her until later in her life when she disclosed triggers to her mental health workers and referred to this.

At 19 years old, Jane gave birth to a son and suffered from post-natal depression due to her ongoing mental health issues, she agreed custody with his father would be safest in 2019 after several incidents of drunkenness and attempts to take her own life whilst he was in the house with her.

At 28 years old, Jane was diagnosed with early onset menopause which affected her physically and then mentally, having a huge impact on her wellbeing, relationships including that with her son and her happiness. Jane had several relationships following the diagnosis which were all volatile and had police involvement. Jane was recorded as the offender for an incident in one relationship in 2019 where she punched her partner in the face and tried to strangle him with a cable. Both had been drinking. Jane was recorded as a victim of domestic abuse with two separate partners and her mother describes all her relationships as similar and that Jane always 'chose the wrong man'.

Jane has nine separate incidents of attempting to take her own life recorded with authorities between 2016 and 2021. She had seven admissions to mental health wards between June 2018 and October 2019. ELFT have 82 entries on their recording system and now employ an IDVA from Victim Support to provide guidance, support and work closely with people experiencing domestic abuse which is good practice.

Unconscious bias is present throughout the agencies in a number of forms. Processes are embedded for risk assessment and to provide safeguarding guidance but this can create unconscious bias due to the information provided prior clouding the ability to be able to assess the current situation. Police arriving at domestic incidents that Jane had called in would attend already aware that she had previously been recorded as a perpetrator and would then learn of her mental health issues and at times, unwillingness to support a prosecution which may all be factors in creating unconscious bias and not taking her whole vulnerability state into consideration. However, the information provided is required for risk assessing. Bedfordshire Police have embedded Cultural Intelligence training for all staff to assist with a wider holistic awareness that incorporates how to perceive persons and needs to ensure that even with information provided, they must look and risk assess holistically without pre-conceived thoughts. (Recommendation refers)

A toolkit has been devised to assist with decision making and risk assessing when a victim has previously been a perpetrator but there is still uncertainty from Support services and MARAC as to what support can be offered as there have been previous experiences of them exploiting the system and learning safeguarding mechanisms to assist there offending behaviour. These reasons were recorded as to why Jane was not offered support from the IDVA service on the first two referral occasions. All authorities and agencies are fully aware of unconscious bias and deliver training on the subject but this does not prevent it from happening.

The Police assisted Jane with obtaining the NMO to assist with safeguarding her in the absence of support services which was a positive action. However, the investigations into the breaches of the NMO were dealt with in isolation and there were missed opportunities to prosecute more offences due to prosecution time limits expiring, delays in the investigations and lack of a coordinated approach. When the police obtained charges and Paul was prosecuted, he pleaded guilty and received a sentence of 4 months imprisonment, affording Jane some peace of mind at that time. The police are satisfied with the processes that they have in place but need to ensure that they are adhered to.

The absence of relevant legislation, processes and responsibility for informing victims of domestic abuse when a perpetrator is released from prison has been identified as a gap that can impact greatly on a victim with the unknown and uncertainty, particularly in a case such as this where the stalking behaviour of the ex-partner led to Jane living in fear. If the legislation was in place and outlined responsibilities within the process for all domestic abuse victims to be informed prior to their perpetrators release, this would have enabled further engagement with Jane and her family for the purposes of revising the safeguarding measures /plan, ensuring they were sufficient to mitigate the risks, and to commensurate to the threats posed. It would also provide Jane with the knowledge rather than the unknown.

Training is required amongst professionals to understand the correlation between domestic abuse and Mental Health and also, how to address multi complex needs to ensure they are all responded to which will prevent overshadowing. Agencies must work more holistically together in utilising existing 'formed' relationships in order to gain introductions to those victims that are harder to reach.

The voice of the child has not been possible during this review as the choice of the child (currently 17yrs old) not to engage was respected. Children's services were engaged with Jane and her son from 2012 to 2019 and received no referrals throughout that period from any agencies including school or health relating to concerns over Bobby. However, it may have been beneficial for Bobby to access support for his emotional wellbeing as a child of a parent with significant mental health needs.

Throughout the time of 2020/21, whilst in a relationship with Paul and after, when Jane had ended this, Jane suffered physical injuries to her face and legs, stalking and harassment with Paul turning up at locations, constantly texting and calling and also emotional abuse by way of gluing the locks to her door. Paul exercised coercive and controlling behaviour over Jane from the beginning of the relationship when she went to Brighton for the weekend with her mother and son and he constantly called her, questioning her movements and whereabouts. These early incidents were not reported to the police. This behaviour continued throughout the relationship. The police have reviewed all reported/attended incidents and have identified occasions where controlling and coercive behaviour should have been considered, investigated and recorded and was not.

The inadequate reviewing of Housing records during the course of this DHR would have led to a number of learning points being omitted had the Coroner not provided information and evidence that had not been disclosed to the panel.

Jane's history of mental health issues and her medical condition of premature ovarian failure caused her to attempt suicide on a number of occasions throughout her life which her mother thought was a cry for help. However, Jane had not been admitted to a mental health ward since October 2019 and had not attempted to take her own life since January 2020. Jane was specific in the notes that she left of the fear and would rather take her own life than let Paul take it.

The panel have concluded that the differing forms of domestic abuse that Jane received from Paul was the significant contributing factor of Jane taking her own life and that her mental health issues accentuated her decision making.

9. Lessons to be learnt

Overshadowing

Jane had multi-complex needs with her mental health issues being the most prominent in the situations where she would have to speak with agencies/authorities.

Assistance in one area can sometimes lead to overshadowing by professionals as they are faced with multi-complex needs and will revert to the issue that is either already being addressed and has support in place or is potentially the easiest to address. If a victim is not in the frame of mind to support a prosecution or receive specialist support, then often, the domestic abuse is put to one side and the mental health issues are addressed which does not eradicate the abuse that will then continue. Jane had a number of recorded mental health crisis calls logged prior to any domestic abuse incidents. This information, although required for risk assessing prior to arrival may sometimes form an opinion in the responder's mind before they have even met or spoken to the person.

Training is required amongst professionals to understand the correlation between domestic abuse and Mental Health and also, how to address multi complex needs to ensure they are all responded to which will prevent overshadowing.

Effects of Covid

The review identified that the Dunstable CMHT was short of staff for a significant period during 2021. The team was heavily reliant on agency staff who changed frequently which also led to increased responsibility and pressure on the permanent staff within the team. High caseloads with increasing complexity. ELFT was receiving increased police referrals and an increase in safeguarding cases in relation to domestic violence. The pandemic led to an increased rate of referrals to CMHT's with reductions in staffing capacity. Jane's mother states that the frustration endured by Jane with different responders and having to inform them what is wrong rather than them already having the required background knowledge.

Victim Support, P2R, GP practice and Adult Social Care offered a reduced level of face-to-face appointments with clients over the Covid lockdown and surrounding period, but many were unable to receive this and also, declined this due to their own fears of contracting the virus. Jane declined a number of offers of support from different services over the phone without the benefit of face to face, of which her mother has stated would have assisted due to Jane's multi complex needs.

This is a wider issue to review separately, but worthy of note that it was identified by panel members and was the period of time during 2021 when she suffered constant domestic

abuse by the way of stalking and harassment from Paul and reached a low point, prior to ending her life.

Recommendations

National

1. **A review of legislation to reflect all domestic abuse victims are informed of a perpetrator's impending release from Prison following any length of custodial sentence. This must include a stated process and organisational responsibility.**
   A change in legislation of this kind will provide the opportunity for further safety planning and risk assessment, knowledge to the victim to prevent fear of the unknown and complete the cycle of victim engagement and focus from the beginning of the Criminal Justice system to the end.

2. **As a safeguarding function, it is strongly recommended that the MARAC should be placed on a statutory footing.**
   This would enable robust management, reporting, action ownership and accountability at the outset.

Local

3. **An interim local process to be agreed between Probation, Police and Support services to inform victims of domestic abuse of the imminent release from prison of their perpetrators following a custodial sentence whilst the National review takes place.**
   This will ensure that the matter is addressed expeditiously for the short term and keeps victims informed whilst the National review takes place.

3a. **Clear lines of responsibility need to be determined in relation to ownership, management and sharing of information specific to prison releases of domestic abuse perpetrators, notification to victims and reviewing safety plans.**
This will provide specifics within an agreed protocol to ensure there is no confusion as to who completes what action, negating any omission that may impact on the victim or their safety. This is a subsidiary recommendation to Recommendation 2.

4. **Bedfordshire Probation to include reminder information on managing domestic abuse cases in their communications to staff, focusing on the importance of pre-release planning and multi-agency working.**
   This will assist as a reminder and any necessary training provided with the cases that fall under The Domestic Violence Crime and Victims Act (DVCVA) 2004, which the Victim Liaison team are responsible for. Also, for information sharing with other agencies when it does not.

5. **Discussion for pre-release domestic abuse intelligence checks to be requested by Probation for a 12-month period where there are known cases of domestic abuse.**
   This would provide additional information to assist with safety planning and identification of victims that require contact and potential support.

6. **Ensure minimum of annual meetings between Probation Head of Service and Police Lead for Public Protection to discuss collectively our approaches to domestic abuse cases.**
   This will provide a collective approach and strategy and maintain the focus on the area of domestic abuse.

7. **Public Health to devise a bespoke training package for agencies enabling them to identify and understand the correlation between domestic abuse and mental health issues.**
   This will assist with policy writing and protocols on a strategic level and also for front line, public facing professionals on an operative level. It will increase knowledge and awareness amongst the workforce to assist in:
   - Identification of suicide indicators
   - Interpretation and identification of risks to individuals at the earliest opportunity
   - Enable effective interventions to be considered at the earliest possible stage.

8. **BLMK Public Health to integrate a domestic abuse specialist from the local region to sit on the Suicide Prevention Steering Group.**
   This will provide representation and specialist advice in the area of domestic abuse within this group.

9. **Agencies to improve on a collaborative approach to supporting those who require safeguarding, particularly with multi-complex needs including:**
   - **Fostering relationships**
   - **Utilising existing multi-agency meetings for planning**
   - **Improving communication between agencies**

   This will ensure that agencies who have trouble contacting 'hard to reach' victims via phone to introduce themselves have the opportunity to meet with them through already trusted professionals which may enhance the support and provide specialist support in other areas that they may not have had.

10. **Bedfordshire Police to integrate a system of flagging or alerts created on the Athena database to highlight and prioritise summary only offences where the STL may be applicable.**
    This will provide an additional layer of assistance to notify the investigating officer in order to complete files and communicate with the CPS to ensure a decision is made on prosecution prior to this date and it does not expire.

11. **Bedfordshire Police are to re-emphasise the importance of following policies and processes that have been implemented for the recording, investigation and prosecution of domestic abuse related offences to their staff and officers of all ranks.**
    This will ensure that, if adhered to, it will expedite investigations so that the statutory time limits do not expire in the future and eradicate investigations being investigated in isolation when there is a repeat victim or perpetrator.

12. **MARAC within Bedfordshire to identify a local interim process for the escalation of non-completed actions whilst awaiting the outcome of the National recommendation at 2.**
    Actions are tasked for a reason and this will ensure a review that they are completed and provide an escalation process for non-compliance whilst MARAC remains non-statutory.

13. **Domestic abuse training by ELFT IDVA to be implemented as compulsory for all Care Coordinators.**
    This will enhance knowledge of those working directly with clients in order to correlate domestic abuse with their mental health issues and risk assess appropriately on disclosure.

14. **ELFT to review the Bedfordshire and Luton Directorate induction programme to incorporate suicide prevention training and domestic abuse and for this to be delivered to all community, crisis, and inpatient staff and Care Coordinators.**
    This will provide awareness and early integration of the two matters across a range of staffing roles.

15. **CBC Housing to ensure all staff provide an out of office automatic reply on their emails and phone messaging service to include hours of work and provide support service information for those in crisis.**
    This will provide clarity for those contacting in an emergency that they will not receive an immediate reply and provide an immediate pathway for support.

16. **CBC Housing to ensure the requirement for immediate referrals are written into their policy and procedures where there is an immediate safeguarding issue or immediate risk of harm.**
    This will negate any delay in referrals whilst the officer is trying to make contact with the client and make other agencies aware in a timely manner.

17. **CBC Housing to revise procedures to ensure that all data from each department within Housing is researched on request during a DHR.**
    This is to ensure all relevant information is forwarded when requested in order to be reviewed appropriately by the panel prior to the completion of the overview report.

18. **Bedfordshire Police to ensure that the Cultural Intelligence training is delivered to all staff and officers and is on-going. Part of this delivery is to include the awareness of overshadowing and unconscious bias with multi-complex individuals.**
    This will ensure that all staff and officers have the required awareness to act holistically and take all information into consideration when risk assessing and dealing with individuals who may have mental health issues, be suffering from domestic abuse, medical issues or substance abuse and ensure that they are all considered when determining the most appropriate response and support.

19. **Suicide Prevention group of Public Health BLMK to coordinate and collaborate with partners on a consultation process to implement a working agreement between agencies for professional discussions to take place following agreed trigger points of multiple attempts to die by suicide.**
    This is to provide a practical collaborative approach to prevent those who have attempted to die by suicide on more than one occasion, an individual plan to support their individual needs and complexities.

20. **ELFT to review the ongoing support services for those discharged from hospital following multiple attempts to die by suicide.**
    ELFT state that changes in service provisions and offers that differ from patient to patient may prove difficult to change as it will mainly be based on budget and capacity but this is an area that need to be explored as to what can practically be implemented and can dovetail into recommendation 19.

21. **ELFT to communicate to Crisis workers that the notes should be read whenever practicable prior to speaking to a patient and how asking an open question or them to repeat their history may impact on them.**
    This will ensure they have an informed approach when speaking to a patient and potentially conducting a risk assessment but may be able to ask the questions in a manner where the patient knows that they have shown due diligence in reading their notes prior to the meeting.

22. **Bedfordshire Police to increase awareness of the Home Office Crime Recording Rules in relation to investigating all crimes and considering Coercive and Controlling behaviour for those DA cases that are graded at medium or standard risk. Also, to ensure there is a review procedure to ensure this is being correctly addressed.**

    This will bridge the gap for those cases that are not high risk but require equal consideration and investigation of all relevant crimes in addition to the principal crime.