SAFER TORBAY

Domestic Homicide Review
Executive Summary

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

Review into the death of Jane
in March 2021

Independent Chair: Gary Goose MBE

Report Author: Christine Graham
February 2024

Preface

The Safer Torbay Partnership and the Review Panel wish at the outset to express their deepest sympathy to Jane's (pseudonym) family and friends. This review has been undertaken in order that lessons can be learned.

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

This review was commissioned by Safer Torbay Partnership on receiving notification of the death of Jane in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

Contents

1 The Review Process

1.1 This summary outlines the process undertaken by the Safer Torbay Partnership Domestic Homicide Review Panel in reviewing the death of Jane, who was a resident in their area prior to her death in the Spring of 2021. Jane's deceased body was found by police after they responded to an email that she had sent them the previous evening which appeared to outline her plans to take her own life.

1.2 Jane was only 36 years old when she died. She had struggled with mental ill-health since childhood. The symptoms of her condition, including episodes of significant self-harm, resulted in her spending her teenage years in the care of the local authority. In later life she disclosed significant incidents of childhood trauma. As an adult, her struggles with mental ill-health continued but she developed an independent lifestyle, living in a flat owned by her father.

1.3 In more recent years Jane had disclosed further information about her early life trauma and had been able to develop intimate adult relationships. The most recent of those relationships was with a local man. The police were called on a number of occasions to domestic abuse incidents involving Jane and her partner and had, in the months prior to her death, issued a Domestic Violence Protection Notice to the man in an effort to prevent escalation of abusive behaviour by him towards her.

1.4 The following pseudonym's have been used within the review:

'Jane' has been used for the deceased. This name has been chosen by her mother.

The man with whom Jane had been in a relationship for between 12-24 months, and had separated from prior to her death, will be known by the pseudonym, 'Richard'. This pseudonym was chosen by the report author.

1.5 A police investigation found insufficient evidence to bring criminal proceedings against any third person in relation to Jane's death.

1.6 At the time of publication, an inquest is still pending.

1.7 It is within this context that this review is set.

1.8 The process of review began on 21st April 2021 when the Safer Torbay Safety Partnership (the CSP) was advised by Devon and Cornwall Police of Jane's death. On 25th May 2021 the Domestic Homicide Review Multi-Agency Core Group met and, having considered the circumstances of Jane's death agreed that the criteria had been met and that a Domestic Homicide Review would be held. An Independent Chair and Author were appointed in June 2021.

1.9 Jane's family were informed of the Review by the CSP in July 2021 and all agencies were asked to secure and retain any files relating to Jane.

2 Contributors to the Review

2.1 The following organisations contributed to the Review by way of an Individual Management Report:

- Devon and Cornwall Police
- Devon Partnership Trust
- Jane's GP
- Torbay and South Devon NHS Foundation Trust

2.2 The independence of all IMR authors was established through the panel process.

2.3 In addition, members of Jane's family engaged with the review, supported throughout by an advocate from AAFDA.

2.4 The review considered how best to engage with the man with whom Jane had previously been in a relationship. Given the particular circumstances of this incident it was impractical to do so.

3 The Review Panel Members

3.1 The members of the Review Panel were:

Gary Goose	Independent Chair	
Christine Graham	Independent Report Author	
Simon Hester	Head of Safeguarding	Ambulance Service
Philip Leonard	Detective Sergeant, Criminal Case and Serious Case Review Team	Devon and Cornwall Police
Nicola Seager	Detective Chief Inspector, Local Investigation	Devon and Cornwall Police
Alexandra Doughty	Director of Intelligence[1]	Devon and Cornwall Police
Robin Scoville	Locality Practice Lead, Adult Services Directorate	Devon Partnership Trust
Collette Eaton-Harris	Interpersonal Trauma and Violence Lead	Devon Integrated Care Board
Louise Arscott	Head of Devon and Torbay Probation	Probation Service
Di Pooley	Area Services Manager (South West)	Sanctuary Housing
Deborrah Kelly	Chief Nurse	Torbay and South Devon NHS Foundation Trust
Jane Schofield	Clinical Nurse Manager, Devon Sexual Health	Torbay and South Devon NHS Foundation Trust

[1] Job title at the time the review was commissioned was DCI for South Devon

Simon Acton	Torbay Drug and Alcohol Service	Torbay and South Devon NHS Foundation Trust
Louise Stevens	Safeguarding and MCA Lead	Torbay and South Devon NHS Foundation Trust
Victoria McGeough	CSP Manager	Torbay Council

3.2 All the panel members were independent of any direct involvement with Jane.

3.3 The panel met three times with additional single agency meetings to clarify various issues that arose during the process.

4 Domestic Homicide Review Chair and Report Author

4.1 The Independent Chair for this Review was Gary Goose MBE. The Overview Author was Christine Graham.

4.2 Gary and Christine have completed, or are currently engaged upon, a number of Domestic Homicide Reviews across the country in the capacity of Chair and Overview Author. Previous Domestic Homicide Reviews have included a variety of different scenarios: male victims; suicide; murder/suicide; familial domestic homicide; a number which involve mental ill health on the part of the offender and/or victim; and, reviews involving foreign nationals. In several reviews, they have developed good working relationships with parallel investigations/inquiries such as those undertaken by the IOPC, NHS England, and Adult Care Reviews.

4.3 Neither Gary Goose nor Christine Graham are associated with any of the agencies involved in the review, nor have, at any point in the past, been associated with any of the agencies.[2]

4.4 Both Christine and Gary have completed the Home Office online training on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing overview reports, as well as DHR Chair Training (Two days) provided by AAFDA (Advocacy After Fatal Domestic Abuse). Details of ongoing professional development are available within the Appendices of the Overview Report.

5 Terms of Reference

5.1 The Domestic Homicide Review set out, in particular, to explore the following areas:

- Consider the impact of COVID-19 lockdown on Jane's mental health.
- Consider the impact of domestic abuse on Jane's mental health and whether any potential impact was recognised and whether she was supported.
- Consider the impact of Jane's mental health on her ability to seek help in relation to the domestic abuse she had experienced.

[2] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (para 36), Home Office, Dec 2016

5.2 As the review evolved and more information was revealed, it looked further in depth at the following areas:

- What was known about Jane's background
- The vulnerabilities she faced
- The evidence of any trail of domestic abuse in this case
- The impact of trauma, its recognition and the approach of local agencies
- Suicide and Domestic Abuse

5.3 The full Terms of Reference can be found within the appendices of the full overview report.

6 Summary Chronology

6.1 Jane was only 36 years old when she was found deceased in the flat where she lived alone. Whilst an inquest has yet to be held, it appears that she had overdosed on a number of different drugs.

~~6.2~~ She had sent an email to the police via a non-emergency contact route in the early hours of a morning shortly before her death. The email said: *'I've taken 30 amnisuperid, 40 diclofenac sodium, 5 diazepam, 30 naproxen and 60 propanalol. I have two cats. The key is on the doorstep'*.

6.3 Jane was a woman who had struggled with a number of vulnerabilities since childhood. She had lived in Devon since childhood. Her parents separated when she was 8 years old. At the age of 11, the local children's services became involved subsequently leading to her becoming a looked after child. The circumstances relating to her moving to the care of the local authority are known to the review panel and remain private. However, they have been considered in relation to any learning that has arisen.

6.4 It was between the ages of 13 to 17 that she was looked after in local authority care and had support and treatment from mental health services. She had been known to mental health services since 1997 and was first admitted to hospital at the age of 12. She was admitted to hospital frequently under both civil sections and Section 37 of the Mental Health Act. Jane's dysregulated behaviour as a child in care was of such a level that at times, she was the sole resident of a premises with multiple members of staff required to look after her and keep her safe.

6.5 As she grew into adulthood, Jane had a diagnosis of Emotionally Unstable Personality Disorder (EUPD)[3] and had a long history of deliberate self-harm (DSH). She was also diagnosed with Fibromyalgia[4]. When she was particularly ill Jane was described as someone with a history of serious attempts on her life (most recent December 2014) and serious self-harm in the past. It was identified that she could present with fixed beliefs regarding being evil and that she would not get better. She had spent her adult life within the mental health system and found it hard to believe that she could exist outside of this system. She lacked a

[3] https://www.mind.org.uk/information-support/types-of-mental-health-problems/borderline-personality-disorder-bpd/about-bpd/
[4] https://www.nhs.uk/conditions/fibromyalgia/

weekly structure and purpose to her life. She had a chronic level of suicidal ideation and at times actively investigated ways to end her life. She also suffered chronic low mood and lack of motivation. Jane's mother also recalls her being diagnosed with schizoaffective disorder. The family want to make it clear that this was an additional chronic mental health condition that affected her for life.

6.6 Jane continued to be in regular contact with her GP and mental health services throughout her life.

6.7 Jane's vulnerability as an adult was exploited by some of those she came involved in relationships with. At different times she told of being bullied, raped, financially abused and threatened with the exposure of explicit images.

6.8 In more recent years she became involved in a relationship with a man, Richard. There is clear evidence that this relationship was abusive. Examples of a range of different types of abusive behaviour have been identified by this review.

6.9 Police were called on a number of occasions in the year before Jane's death to incidents involving Richard. Whilst none could meet the required level of evidence required to prosecute Richard, a Domestic Violence Protection Notice and Domestic Violence Protection Order were utilised in attempts to better protect Jane.

6.10 It is clear however, that the relationship between the two continued, with Richard being at Jane's address on various occasions up to a week before her death. On the last occasion, police attended and found Richard with his bags packed waiting for a friend to collect him as he was leaving the address. Police waited with Jane until he had gone.

6.11 In addition to the reports of domestic abuse in her relationship, police were also alerted by Jane, and others to some of her more unusual incidents and events undoubtedly caused by her level of mental ill-health. These included sending over 50 emails to a local school, fixation on religion and a belief that she had been kidnapped and her body tissues removed.

6.12 The review has also looked at the impact of COVID 19 regulations upon Jane. The review is aware that Jane regularly stayed with her father during times of increased mental illness. During COVID 19 this did not happen as she was concerned about the impact upon her father's health should she contract the illness. During the period she stayed at her own flat, increasing her level of vulnerability to any potential abuser.

6.13 It is within this context that organisations sought to support and safeguard Jane.

7 Key issues arising from the Review

7.1 A Domestic Homicide Review is tasked with identifying a trail of domestic abuse within a relationship and identifying learning to better protect others. This review has looked at the evidence that exists of domestic abuse primarily in the relationship between Jane and Richard. The review has looked carefully at the actions taken by professionals, and those organisations within which they worked, who received any of those reports and has considered additional information provided by the family of Jane.

7.2 Through no fault of her own, Jane presented a range of complex behavioural issues for varying organisations. Much of her behavioural and mental health issues may have been as a result of childhood trauma, in particular perhaps her later disclosure of being raped as a child.

7.3 It is clear that Jane was subject to a range of different forms of abusive behaviour. These are set out within the overview report.

7.4 The review has looked at whether those charged with safeguarding Jane recognised those issues and acted accordingly. The review has considered how her disclosures of historic sexual offences were managed and what learning can be drawn from those. The review has also looked at whether agencies worked together by sharing information to protect and safeguard Jane.

7.5 In relation to her relationship with Richard, there were issues identified with the correct use of police DASH risk assessment completions, the consideration of the use of the Domestic Violence Disclosure Scheme, the notification of incidents to social care teams, the recognition of strangulation as a specific 'red flag' and an understanding of the recognition of potential abuse by Jane's GP.

7.6 The review is aware that a number of changes have been made by organisations that have addressed issues that are either historic or have changed as a result of this case.

7.7 The review has also identified some areas of good practice that are highlighted within the main report.

7.8 Given that there is evidence that Jane was affected by childhood trauma the review has looked at what work is being undertaken locally to move to a greater understanding of the effect of trauma on people's lives, their vulnerability and its recognition within those supporting or safeguarding them.

7.9 Whilst the review has applied a suicide timeline to this case and looked at the local suicide strategy, that is not intended in any way to pre-empt any decision of HM Coroner, but it does however feel appropriate that the review looks at Jane's death through this lens given all the circumstances that prevail in this case.

7.10 The review has made six recommendations that the panel believes will make others safer in the future.

8 Conclusions

8.1 This is a truly tragic case in which a young woman's life has been taken as a result of an overdose of drugs. Whether that overdose was intentional or otherwise is a matter for HM Coroner alone to determine. What is clear is that a combination of domestic abuse, the unintended consequences of COVID-19 regulations upon Jane's state of mind and Jane's long-standing mental ill-health and thus her vulnerabilities, all probably contributed to her death, intentional or otherwise.

8.2 A delay in the police responding to an email sent by Jane in which she detailed the tablets she had taken and that she had two cats, is rightly being reviewed by the Independent Office for Police Conduct (IOPC), this review should not comment upon that investigation. It will make its own recommendations. However, this review does not find that Devon and Cornwall Police dealt with Jane in anything other than a sensitive and considerate way in all their previous dealings with her.

8.3 Learning has been identified as a result of the scrutiny of this case and the review believes the six recommendations will contribute to making life safer for others in the future

9 Lessons Identified

9.1 When a Domestic Violence Protection Notice is issued, the time should be used to provide the victim with details of support services that can help them.

9.2 In December 2020 Devon and Cornwall Police did not take the opportunity to share concerns about Jane's vulnerability with partner agencies.

9.3 The DASH risk assessment, whilst including a question about strangulation, only allocates one tick as with every answer. The review believes that this does not reflect the high risk that non-fatal strangulation poses.

9.4 Suicide risk is not linear, it is constant and repeated. It would be best practice to ensure that whenever engaging in a conversation about suicide with a patient/client, to assess an individual, mitigate the presented risk and reassess during the next contact or share information with a relevant service for this to be continued.

9.5 Jane's family believe that in person contact would be most effective when assessing suicide risk.

10 Recommendations

10.1 **Devon and Cornwall Police**

10.1.1 That the force uses this incident (anonymised) as an example of the type of individuals and circumstances that should attract a PPN (Public Protection Notice). This should then be shared through local learning bulletins.

10.2 **Devon Partnership Trust and Jane's GP practice**

10.2.1 That Devon Partnership Trust and the GP practice reassure the Community Safety Partnership that they have mechanisms in place to ensure that this approach is embedded into services[5].

[5] Suicide risk is not linear, it is constant and repeated. It would be best practice to ensure that each time a patient or client speaks about suicide, this is discussed with them to assess and mitigate the risk at that time. Information should be shared with any relevant service. The risk should be reassessed during the next contact.

10.3 **Home Office**

10.3.1 That the Home Office instigates a review into DASH risk assessments to ensure where strangulation is a factor the risk is rated as high regardless of the other answers given.

10.4 **Torbay Mental Health and Suicide Prevention Alliance**

10.4.1 That the work of the Torbay Mental Health and Suicide Prevention Alliance pays attention to the research and needs of those who are, or have, experienced domestic or sexual abuse.

10.4.2 That the real-time surveillance pays attention to the link between suicide and domestic and sexual abuse.

10.4.3 That the suicide prevention training includes reference to the links between domestic/sexual abuse and suicide.