Doncaster Community Safety Partnership

Domestic Homicide Review

Overview Report

Jenny

Died February 2020

Chair and Author: Ged McManus

Date: March 2023

INDEX

Family Tribute

One of Jenny's daughters wrote the following tribute on behalf of her family, and it is the family's wish that it is included in this overview report.

Our Mum

Recently I saw a quote, which perfectly encapsulated my mum's philosophy on life:

"The world is like a book, and those who do not travel read only one page"

Immediately I thought of my mum, because she was bookish, had a curious mind and a real sense of adventure. She often spoke about how one should explore the world and would recount the travels that she had had. In particular, the trip to see her uncle in America and the teeny tiny bikini she wore which certainly raised an eyebrow or two! The experiences she had in America stayed with her for life - mum would surprisingly describe in detail stories from the crevices of her mind. Once, when I spoke about taking Friday Night Dinner Shabbat with my husband's parents, she told me of the time when she had a similar experience of with friends of her uncle's. She recited in vivid detail the dinner and the people with whom she shared it.

It's these stories that epitomise my mum - her intelligence, her curiosity and real love of life, and although she may have been unable to explore the world in recent years, her sense of adventure never left her. Mum's curiosity couldn't be hampered by her sometimes-limited means - she would take us on adventures, sometimes morbid, to explore Bluebell Woods, Roach Abbey, Gainsborough Hall, Tickhill Castle, Loch Lomond and *St Michael's Graveyard* to name but a few! Exploration and learning did not have to be on foreign shores - there was so much to see in our locality - all you had to do was open your eyes and really look at the world around you. Why is that building like that, who lived there, how did that happen? These are the questions she taught us and will stay with me always. Mum loved to dance - many a time we would dance around the kitchen to the tame Heartbeat soundtrack or finger dancing to techno music during my wild Gatecrasher days in the nineties and noughties. She instilled a fire in me and my sister- to live life the fullest, to love, to travel, observe the world around you, ask questions, and read as much as possible!

Reading was a real passion of my mum's – she read everything from the scandalous to the mundane; she refused to leave a book unfinished irrespective of frustrating syntax or it being ridiculously verbose! She loved to learn, at the age of thirty six

determined to learn more and expand the parameters of her life she returned to study, eventually becoming a qualified therapeutic counsellor. I shall never forget her tapping away on her electric typewriter at her makeshift desk - our dining table! Education was so very important to my mum, something that she instilled in us her daughters; mum ensured we went to a good school, we read often, and *did our homework.*

Sat in what we called her "cockpit"- her favourite armchair, mum would enthusiastically review our homework, no matter how tedious. Her favourite story of this, was of reading my A-Level essay on Soil Horizons; you can't get drier than that! Mum simply saw it as her parental duty, her way of ensuring that we learned, had an excellent education, so we could be afforded opportunities and succeed in life.

My mum personified her values - she could often be found sat reading an anthology of Shakespeare's Sonnets or flicking through a compendium of art - her favourite being that of the Pre-Raphaelite era. For many years, a print of 'The Lady of Shallot' hung in pride of place in our living room, and her books filled the numerous bookcases scattered around our home.

The people my mum admired were like her in a way, they rebelled from the norm of their time and they were a 'little bit naughty'- she loved Black comedy - which evoked her wicked, cackling laugh, loud and proud at the taboo. One of my fondest memories of my mum is when we shared an evening, her sat semi-recumbent in her 'cockpit', continuously cackling at a deeply dark Helena Bonham Carter comedy.

Mum had real joie de vivre for many years of her life, and it is in this joy that she should be remembered.

1 Introduction

1.1 This report of a Domestic Homicide Review (DHR) examines agency responses and support given to Jenny[1], a resident of Doncaster, prior to her death. The panel would like to offer their condolences to Jenny's family on their tragic loss.

1.2 On a day in February 2020, Jenny's husband David[2] contacted the ambulance service reporting that he had found Jenny unconscious in bed. On attending at the family home, ambulance service staff found that Jenny had passed away. The police were contacted and initially found nothing to indicate a cause of death. Consequently, a routine sudden death report was completed by the attending officer, and Jenny's body was taken to the local mortuary. No crime scene investigation was requested and there was no input by a supervisor or detective. This was, at the time, the routine procedure in a non-suspicious sudden death.

1.3 During a post-mortem examination, a note was found inside Jenny's pyjamas that indicated that Jenny had taken her own life. The note made reference to historic sexual abuse, mental and physical health problems, and domestic abuse. Toxicology tests indicated that it was likely that there had been a fatal excess use of trazadone[3] and co-codamol. A police investigation concluded that there was no evidence that another person had been involved in Jenny's death.

1.4 In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community, and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

1.5 The review considers agencies' contact and involvement with Jenny and David from 1 January 2017 until Jenny's death in February 2020. This time period was chosen because concerns were raised for Jenny's welfare during 2017, and the panel wished to capture any potential information that may be relevant in the months leading up to those concerns. In coming to this decision, the panel was aware that there may have been domestic abuse throughout Jenny and David's married life. The panel was also aware of significant changes to services in Doncaster and to partnership arrangements over the years and thought that the

[1] A pseudonym agreed with the victim's family.
[2] A pseudonym agreed with the victim's family.
[3] Trazodene is an antidepressant medicine that works to balance chemicals in the brain.

three-year period chosen was proportionate and likely to produce relevant learning for contemporary services in Doncaster. Background information prior to 1 January 2017 is used in the report for context.

1.6 The intention of the review is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources, and interventions, with the aim of avoiding future incidents of domestic homicide, violence, and abuse. Reviews should assess whether agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.

1.7 **Note:**
It is not the purpose of this DHR to enquire into how Jenny died. That is a matter that will be examined during the coroner's inquest, which had not been concluded when the DHR process was finalised.

2 Timescales

2.1 This review began on 4 August 2020 and was concluded on 23 February 2023. See paragraph 5.2 for more detailed information.

3 Confidentiality

3.1 The findings of each review are confidential until publication. Information is available only to participating officers, professionals, their line managers and the family, including any support worker, during the review process.

3.2 Pseudonyms were agreed with the victim's family to protect her identity and the identity of others referred to in the report.

4 Terms of Reference

4.1 The purpose of a DHR 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 on, and what is expected to change as a result;

Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

Contribute to a better understanding of the nature of domestic violence and abuse; and

Highlight good practice.

(Multi-Agency Statutory guidance for the conduct of Domestic Homicide Reviews 2016 section 2 paragraph 7)

4.2 Timeframe under Review

The DHR covers the period 1 January 2017 to Jenny's death in February 2020.

4.3 Case Specific Terms

Subjects of the DHR

Victim: Jenny, aged 67 years

Jenny's husband: David, aged 57 years

Specific Terms

1. Did colleagues in your agency clearly understand and follow referral arrangements, both when making and receiving referrals?

2. Were relevant assessments completed in line with procedural guidelines and within relevant timescales? Did these assessments inform plans of action?

3. What risk assessment models / tools were used by colleagues in your agency?

4. What indicators of domestic abuse, including coercive and controlling behaviour, did colleagues in your agency identify in this case?

5. Did colleagues give appropriate consideration and weight to other potential risk and vulnerability factors in this case (including, but not necessarily limited to the deceased's experiences of childhood sexual abuse, chronic pain, depression, and previous suicide attempt)?

6. Did colleagues consider the inter-relationship between the experience of domestic abuse and compromised emotional and mental well-being in this case, and how this inter-relationship might increase the vulnerability of Jenny?

7. Did your agency give sufficient consideration and weight to the risk of suicide in this case?

8. What support is given to staff in your agency to recognise and assess the risk of suicide, including the inter-relationship between para-suicide and vulnerability to domestic abuse?

9. Did colleagues consider the 'lived experience' of Jenny and David in this case? In particular, their economic and social circumstances, access to the support of family and friends, and the impact of racial, cultural, linguistic, faith, disability or other diversity issues, on their circumstances and their capacity to access support?

10. Were colleagues aware of David's alleged abusive behaviour? If so, were steps taken to assess this, or to refer to another agency for support to minimise this behaviour and potential harm?

11. How effectively did your agency communicate to Jenny, and those whom she authorised (e.g., her daughters), the outcomes of assessments and services offered?

12. How effective was information sharing and co-operation in respect of Jenny and David? Was information shared with those agencies who needed it?

13. On the occasions that Jenny moved to her daughters' homes to escape domestic abuse, how effectively did your agency work with Jenny, her family, and other agencies to support her safe return to her home area?

14. Were single and multi-agency policies and procedures followed? Are those procedures understood by colleagues and embedded in practice?

15. Are there examples of innovation and service improvement in your agency that may warrant wider implementation, or examples of exceptional individual practice that contribute to professional excellence?

16. As a result of completing this Independent Management Review, what learning has been identified for your agency? Please make recommendations in relation to professional practice, agency procedures, management oversight, or other organisational systems, as informed by identified learning.

5 Methodology

5.1 Following Jenny's death in February 2020, a delayed referral was made to Doncaster Community Safety Partnership by South Yorkshire Police on 2 June 2020. The reason for the delay was an initial delay in identifying that Jenny had taken her own life and a further delay in making an internal referral to the South Yorkshire Police safeguarding team – as it was not recognised by local officers that the circumstances may have been appropriate for a Domestic Homicide Review. Information has since been provided by South Yorkshire Police to their officers in order to reduce the chances of such a delay in future.

5.2 On 17 June 2020, the Safer Stronger Doncaster Partnership agreed that the circumstances of the case met the criteria and agreed to conduct a Domestic Homicide Review (para 18 Statutory Home Office Guidance)[4]. The Home Office was informed the same day.

5.3 The start of the process was delayed as a result of agency work pressures in the Covid-19 pandemic and the need to source and commission an Independent Chair and Author. The first meeting of the DHR panel took place on 4 August 2020. Significant further delays were experienced because the CCG was unable to complete an IMR until 1 March 2021, due to work pressures.

5.4 On 25 February 2021, the Chair was informed by South Yorkshire Police that evidence in the case was being reviewed in order to establish if there should be a further investigation. At a DHR panel meeting on 2 March 2021, a decision was made to suspend further work on the review, which may involve family contact, until such time as the police review was complete. On 15 April 2021, it was confirmed to the Chair that the police would be reopening their investigation. A panel meeting took place on 5 May 2021, where the panel decision to suspend further work was confirmed. Panel members agreed to continue to develop actions to address areas of learning that had been identified at that point.

5.5 In August 2022, the Independent Chair was informed that following the submission of a file of evidence to them, the Crown Prosecution Service had made a decision that there was insufficient evidence to bring any criminal

[4] Where a victim took their own life (suicide) and the circumstances give rise to concern, for example, it merges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.

charges against David. The decision was appealed by Jenny's family, but the appeal was unsuccessful, and it was confirmed that there would be no criminal charges. A request was made to the police for sight of witness statements created during the further police investigation, and these were subsequently provided in September 2022.

5.6 In November 2022, the Chair of the review met Jenny's daughters, who were assisted by their AAFDA advocate and their solicitor. Following this meeting, an advanced draft of the overview report was provided to Jenny's daughters so that they could provide feedback. Their feedback, which was provided in December 2022, is incorporated into the report.

5.7 Panel meetings resumed in January 2023. Some of the original panel members were no longer in post for various reasons, such as retirement, and were replaced by new panel members. This is detailed at paragraph 8.1.

5.8 In total, the panel met eight times, with the final meeting taking place on 23 February 2023.

5.9 At the conclusion of the review it had not been possible for logistical reasons for the family to meet the DHR panel. Arrangements are to be made for a special DHR panel meeting in order for the family to meet the panel and discuss the report and recommendations.

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

6.1.1 Jenny had two daughters, Margaret[5] and Sarah[6], who had both supported her during the timeframe reviewed by the DHR. Jenny's daughters and their partners wanted to be involved in the review and had contacted AAFDA[7] to enquire about support before a decision was made by the Community Safety Partnership that the circumstances of the case met the threshold for a Domestic Homicide Review.

6.1.2 Margaret, Sarah, and their partners agreed to speak to the Chair and Author of the review, using video conferencing. This was made necessary as a result of measures in place regarding Covid-19. They were supported by an advocate from AFFDA.

6.1.3 Jenny's daughters were able to provide a significant amount of information to assist the review. This information appears throughout the overview report and is attributed appropriately. They also provided information about Jenny's life and relationships, which is set out in the following paragraphs.

6.1.4 Jenny was born in Belfast and moved to Doncaster with her family as a young child, when her father found work locally in the mining industry.

6.1.5 As a child, Jenny suffered from a number of medical conditions, including severe asthma and eczema. As a result of her medical conditions, she missed a lot of her early school life. She suffered from sexual abuse as a child and later received counselling for this. Later in life, Jenny was diagnosed with scoliosis[8].

6.1.6 At 19 years of age, Jenny moved to London to start nurse training. It was there that she met her first husband and the father of her daughters. The couple married and settled in Doncaster where their children were born. In 1987, the marriage broke up after Jenny's husband had an extra marital relationship. Following a financial settlement, Jenny was able to buy her own house outright and continued to live in Doncaster with her daughters.

[5] A pseudonym agreed with Jenny's daughter.
[6] A pseudonym agreed with Jenny's daughter.
[7] Advocacy After Fatal Domestic Abuse: a charity that supports the families of victims of fatal domestic abuse.
[8] Scoliosis is a condition where the spine twists and curves to the side.

6.1.7 Jenny met and formed a relationship with another man, which lasted for around ten years. Margaret and Sarah described this as being a happy time, and they have fond recollections of family gatherings and holidays. Jenny enrolled at college to study for a degree in psychology. She enjoyed studying and reading, and her house was filled with many books.

6.1.8 In 1999, Jenny suffered from a mental health crisis and was a hospital inpatient for a month. Despite this, she continued with her studies and went on to be a voluntary counsellor. Margaret and Sarah say that keeping herself busy, learning, and meeting new friends, gave her lots of confidence and improved her mental health.

6.1.9 In 2002, Jenny met David. The couple got married the following year, and David moved into Jenny's house. Both Margaret and Sarah describe many incidents of domestic abuse, which began soon after the marriage. These included physical assaults as well as other intimidating behaviour. On one occasion in 2006, Sarah made a 999 call to the police, as David had pinned Jenny against a wall and was choking her. Sarah says that she genuinely thought David was going to kill Jenny. On reading the final draft of the report Sarah reflected that she though David was strangling Jenny. David was arrested. He was later released without charge as Jenny declined to provide a statement and there was insufficient evidence to prosecute. The majority of incidents were never reported to the police. Section 70 of the Domestic Abuse Act 2021 introduced the offences of non-fatal strangulation and non-fatal suffocation. The offences came into force on 7 June 2022 and are not retrospective.

6.1.10 The daughters also described other controlling behaviour perpetrated by David, examples included:

- Giving and then taking back presents, as Jenny 'didn't deserve them'.
- Running up debts, which were secured against Jenny's house.
- Monitoring Jenny's telephone calls by insisting she placed the phone on loudspeaker.
- Preventing Jenny from using her car and giving it to a relative to use.
- Objecting to Jenny reading. Removing books from the house.
- Jenny kept a diary in which she documented the abuse, but these were sometimes taken from her room whilst she was out.
- Ripping up Mother's Day cards.
- Selling Jenny's mobility scooter.

6.1.11 In addition to the family home, Jenny and David also owned a caravan at a holiday park on the east coast. They spent time there together but often David

spent time there on his own during the week, returning to Doncaster at the weekend.

6.1.12 Latterly, the couple had separate bedrooms in the house. Jenny had a lock fitted to her door and told her daughters this was to give her some privacy and a sense of safety because she feared what David might do in a violent or abusive outburst. The lock was replaced several times as it had become damaged, but there is no evidence as to the cause of the damage. Jenny's daughters say that David moved all of Jenny's belongings into her room, and she was not allowed to have things in the rest of the house.

6.1.13 In the year before her death, Jenny had spent time living with her daughters, following significant incidents that are detailed later in the report. In September 2019, she returned home to live with David.

6.1.14 On the day before Jenny's death, Margaret visited her at home. Jenny was in good spirits and enjoyed playing with her granddaughter. She seemed happy and spoke about plans for the coming year, including exercises to help her back pain. When Margaret left, Jenny was happy and smiling. She later texted to say thank you for the birthday present Margaret had brought – as it was Jenny's birthday the following day.

6.1.15 Jenny was found deceased the following morning – her birthday.

6.2 **David**

6.2.1 Prior to the suspension of the DHR to allow for the police enquiry, David agreed to speak to the Chair and Author of the review, and a conversation took place by video call. David was supported by one of his adult daughters.

6.2.2 David said that he was Jenny's main carer and that he was in receipt of carer's allowance. He said that he found this very hard and was not aware of any help that might have been available to him, for example, he did not know that he would have been entitled to a carer's assessment (Care Act 2014).

6.2.3 The Chair discussed with David that the reason a Domestic Homicide Review had been commissioned was because there was evidence that there had been domestic abuse in his relationship with Jenny. David denied that there had ever been any abuse in the relationship although he acknowledged that as a couple, they did argue and sometimes he said things in the heat of the moment. He said that he loved Jenny but that she was a very negative person and sometimes this was difficult to deal with. For example, he sometimes needed to encourage her to get up and dressed because he thought it would make her feel better, but she resented this.

6.2.4 Where specific issues were discussed, David minimised his involvement or blamed Jenny. For example, in relation to the 2006 incident when he was arrested, he said that Jenny had attacked him and then lied that he had attacked her, causing him to be arrested.

6.2.5 David said that there could not have been any abuse in their relationship because Jenny came back to him after periods of separation, and she would not have done so if he had been abusive. For example, when Jenny returned home in September 2019, he met her at the railway station, and they went to their caravan at the east coast, which David said they both enjoyed. Jenny's daughters say that Jenny told them that she felt isolated at the caravan, so they find this difficult to reconcile with David's view that on this occasion, Jenny enjoyed her time there.

6.2.6 In relation to finance, David said that Jenny was not short of money and had more money than he did. He said that Jenny did not like driving and was affected by previous accidents that she had been involved in. She therefore did not drive her car very much and preferred to be driven by others. For example, he took her to almost all her doctor's appointments but waited outside for her in the car.

6.2.7 David said that Jenny complained that it was difficult to access help when she needed it. On the day that Jenny died, she woke David up at approximately 2 am asking for help. David said that he did not know exactly what Jenny needed or how to help her and told her to go back to bed. He found Jenny deceased later in the morning when he took her a cup of tea.

6.2.8 The panel acknowledges that David's views can be seen as victim blaming, and his views have not been challenged. The panel, however, made a decision that it was important that the report contained David's views, as they made an important contribution to the overall context of the review.

6.2.9 David agreed to the DHR having access to relevant information held by his GP.

6.2.10 David was arrested and interviewed under caution by the police in September 2021. He provided a written statement in which he denied any abusive or controlling behaviour towards Jenny. He said that the allegations being made were a vendetta against him by Jenny's family.

7 Contributors to the Review / Agencies Submitting IMRs[9]

7.1.1	**Agency**	**Contribution**
	Doncaster Adult Social Care	IMR
	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	IMR
	South Yorkshire Police	IMR
	Rethink Mental Illness (Provider Doncaster Crisis House – The Haven)	IMR
	Rotherham Doncaster & South Humber NHS Foundation Trust	IMR
	Nottinghamshire Healthcare NHS Foundation Trust	IMR
	Doncaster CCG	IMR
	Doncaster Domestic Abuse Caseworker Service / Domestic Abuse Hub	IMR
	Yorkshire Ambulance Service	IMR
	Nottinghamshire GP Practice	IMR
	London GP Practice	IMR
	St Leger Homes	IMR

7.1.2 As well as the IMRs, each agency provided a chronology of interaction with Jenny and David, including what decisions were made and what actions were taken. The IMRs considered the Terms of Reference (TOR) and whether internal procedures had been followed and whether, on reflection, they had been adequate. The IMR authors were asked to arrive at a conclusion about what had happened from their own agency's perspective, and to make recommendations where appropriate. Each IMR author had no previous knowledge of Jenny or David, nor had any involvement in the provision of services to them.

[9] Individual Management Reviews (IMRs) are detailed written reports from agencies on their involvement with Jenny and/or the perpetrator.

7.1.3 The IMR should include a comprehensive chronology that charts the involvement of the agency with the victim and perpetrator over the period of time set out in the 'Terms of Reference' for the review. It should summarise: the events that occurred; intelligence and information known to the agency; the decisions reached; the services offered and provided to Jenny and David; and any other action taken.

7.1.4 It should also provide: an analysis of events that occurred; the decisions made; and the actions taken or not taken. Where judgements were made or actions taken that indicate that practice or management could be improved, the review should consider not only what happened, but why.

7.1.5 The IMRs in this case were of good quality and focussed on the issues facing Jenny. They were quality assured by the original author, the respective agency, and by the panel Chair. Where challenges were made, they were responded to promptly and in a spirit of openness and co-operation.

7.1.6 The CCG IMR was significantly delayed due to other work pressures and was not received by the Chair until 1 March 2021.

7.2 Information About Some of the Agencies Contributing to the Review

7.2.1 Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust is a provider of acute health care, serving the population of Doncaster, Bassetlaw, and the surrounding areas.

It has a total of over 700 inpatient beds over 3 hospital sites and provides outpatient services over several sites across the area.

The Trust provides inpatient care, outpatient services, and day surgery. It has a minor injuries department and 2 emergency Departments with 24hr care provision.

7.2.2 Rethink Mental Illness

The Doncaster Crisis House, aka The Haven, is commissioned directly by the NHS (RDaSH) and is owned and run by Rethink Mental Illness. The Haven provides short-term (up to 7 days) accommodation and bespoke support for people experiencing a mental health crisis.

The service is for people aged 16 and over, with no upper limit on age. We are registered as a care home with the Care Quality Commission (CQC) for 5 beds. This service provides the following:

- An alternative to hospital admission in a therapeutic, calm environment
- Emotional and practical support to help achieve desired individual outcomes
- Signposting to, and information on, appropriate agencies
- Support in identifying triggers to crisis and developing new coping strategies
- Support with medication and prompting of personal care
- To initiate applications for alternate housing, where required.

7.2.3 Rotherham Doncaster & South Humber NHS Foundation Trust (RDaSH)

Rotherham Doncaster & South Humber NHS Foundation Trust (RDaSH) provides extensive health services across the South Yorkshire and North Lincolnshire area, as well as community nursing services in Doncaster for adults and universal services for children. RDaSH employs approximately 3700 members of staff across the organisation. The Trust engages with a diverse population across three significant urban areas – Doncaster, Rotherham, and Scunthorpe.

7.2.4 Nottinghamshire Healthcare NHS Foundation Trust

Nottinghamshire Healthcare provides integrated healthcare services, including mental health, intellectual disability, and physical health services. Over 9000 dedicated staff provide these services in a variety of settings, ranging from the community through to acute wards, as well as secure settings. The Trust manages two medium secure units: Arnold Lodge in Leicester and Wathwood Hospital in Rotherham; and the high secure Rampton Hospital near Retford. It also provides healthcare in prisons across the East Midlands.

7.2.5 St Leger Homes

St Leger Homes is a limited company that is wholly owned by Doncaster Council. The company manages Doncaster Council's 21,000 homes and provides a range of services including the Housing Options and homelessness advice services.

7.2.6 **Doncaster Domestic Abuse Caseworker Service / Domestic Abuse Hub**

The Doncaster Domestic Abuse Service Domestic Abuse Caseworker (DAC) team is a Doncaster local authority support service for victims of domestic abuse, aged 16 and over, who are assessed as being at standard or medium risk of harm from domestic abuse.

The DAC service provides support and assistance in a number of ways, offering practical advice and assistance around safety planning, supporting clients with legal applications through criminal and civil court proceedings, supporting clients in liaison with other services that offer assistance in relation to housing, health and wellbeing, and a variety of other support services in Doncaster and sometimes beyond.

The DACs support clients with referrals to therapeutic support provided by other services and, if appropriate, applications to refuge and safe housing away from the perpetrator. The role of the DAC is to support clients to reduce risk from domestic abuse. The DAC workers can only provide support with consent from the client. The Doncaster Domestic Abuse team is not a statutory service.

7.2.7 **Doncaster Adult Social Care**

Adult Social Care is about providing personal and practical support to help people live their lives. It's about supporting individuals to maintain their independence and dignity. There is a shared commitment by the Government, local councils, and providers of services to make sure that people who need care and support have the choice, flexibility, and control to live their lives as they wish.

7.2.8 **Doncaster CCG**

The CCG is a membership organisation: members are the 39 local GP practices based in the borough. It has responsibility for purchasing and structuring healthcare services for over 320,000 patients in Doncaster, with a budget of over £500 million, and our aim is to provide the best possible care. Alongside GP practices, it has over 190 members of staff working on management projects or healthcare.

8 The Review Panel Members

8.1	Ged McManus	Chair and Author
	Tim Staniforth	Domestic and Sexual Abuse Theme Manager – Doncaster Metropolitan Borough Council
	Andrea Hamshaw	Workforce Development Officer Domestic Abuse Service – Doncaster Metropolitan Borough Council
	Jo Wade (replaced by Calise Martin January 2023)	Case Review Officer, South Yorkshire Police
	Charlie Cottam (replaced by Kim Goddard January 2023)	Professional Lead (Safeguarding), Rotherham, Doncaster and South Humberside NHS Foundation Trust
	Sarah Smith	Public Health Improvement Co-ordinator (Public Mental Health & Suicide Prevention) – Doncaster Metropolitan Borough Council
	Pat Johnson (replaced by Amanda Timms January 2023)	Lead Professional for Safeguarding Adults, Doncaster Bassetlaw Teaching Hospitals NHS Foundation Trust
	Angelique Chopin (replaced by Angela Meredith January 2023)	Safeguarding Adults Board Manager, Doncaster Metropolitan Borough Council (representing Adult Social Care)
	Vesta Ryng	Phoenix Women's Aid
	Julie Jablonski	Safeguarding Lead, St Leger Homes
	Julie McGarry	Domestic Abuse and Sexual Safety Lead, Nottingham Healthcare NHS Foundation Trust

Barry Cooper	Manager, The Haven, Doncaster Crisis House
Ian Boldy	Head of Individual Placements and Designated Nurse Safeguarding Adults, Doncaster CCG
Cal Lacy	Doncaster Domestic Abuse Service

8.2 The review Chair was satisfied that the members were independent and did not have any operational or management involvement with the events under scrutiny. The exception was Adult Social Care, where the original panel member had managed one of the services involved.

9 Author and Chair of the Overview Report

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 sets out the requirements for review chairs and authors. In this case, the Chair and Author were the same person.

9.2 Ged McManus was chosen as the DHR Independent Chair and Author. He is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adult Reviews. He was judged to have the skills and experience for the role. He has experience as an Independent Chair of a Safeguarding Adult Board (not in Doncaster or an adjoining authority) and has chaired and written previous DHRs and Safeguarding Adult Reviews. Ged served for over 30 years in different police services in England. Between 1986 and 2005, he worked for South Yorkshire Police (a contributor to this review), before moving to another police service. The commissioners of the review were satisfied of his independence given the length of time since he had any involvement with South Yorkshire Police. He has completed online Home Office training for DHR chairs and has attended accredited training for DHR chairs, provided by AAFDA.

Ged was the Author of a previous DHR in Doncaster.

10 Parallel Reviews

10.1 An inquest was opened and adjourned immediately following Jenny's death. The inquest had not been concluded when the DHR was completed.

10.2 Rotherham Doncaster & South Humber NHS Foundation Trust [RDaSH] has undertaken a serious incident review and investigation. The results of the investigation informed the IMR submitted to the DHR panel.

10.3 A DHR should not form part of any disciplinary inquiry or process. Where information emerges during the course of a DHR that indicates disciplinary action may be initiated by a partnership agency, the agency's own disciplinary procedures will be utilised: they should remain separate to the DHR process. There has been no indication from any agency involved in the review, that the circumstances of the case have engaged their disciplinary processes.

11 Equality and Diversity

11.1 Section 4 of the Equality Act 2010 defines protective characteristics as:

- **age** [for example an age group would include “over fifties” or twenty-one year olds. A person aged twenty-one does not share the same characteristic of age with “people in their forties”. However, a person aged twenty-one and people in their forties can share the characteristic of being in the “under fifty” age range].
- **disability** [for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act].
- **gender reassignment** [for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully ‘passes’ as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act].
- **marriage and civil partnership** [for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic].
- **pregnancy and maternity**
- **race** [for example colour includes being black or white. Nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be “black Britons” which would encompass those people who are both black and who are British citizens].
- **religion or belief** [for example the Baha’i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism

and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be].

- **sex**
- **sexual orientation** [for example a man who experiences sexual attraction towards both men and women is "bisexual" in terms of sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So, a gay man and a lesbian share a sexual orientation].

Section 6 of the Act defines 'disability' as:

(1) A person (P) has a disability if:
  (a) P has a physical or mental impairment, and
  (b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.

11.2 Jenny had a number of long-term medical conditions that limited her mobility and affected the things that she was able to do in her day-to-day life. She was in receipt of Disability Living Allowance (later Personal Independence Payment) – a benefit linked to the severity of her medical conditions. The panel was in no doubt that she was disabled within the meaning of the Equality Act. Jenny was able to access medical and other appointments, sometimes with the support of her daughters. Whilst the panel thought that her restricted mobility could have been a barrier to accessing services, there is evidence that Jenny attended many appointments independently. David told the Chair of the review that he drove Jenny to most medical appointments and waited for her outside in the car. Jenny did miss some appointments when she said she had not received letters.

11.3 Jenny also sought support for her mental health and sometimes disclosed suicidal ideation, as well as domestic abuse. She was diagnosed with anxiety and depression. There was no other mental health diagnosis.

11.4 The panel acknowledged that research on domestic abuse and older people suggests that 'older women's experiences of domestic abuse are markedly

different from those in younger age groups and that these differences have not been adequately acknowledged or accounted for'[10].

11.5 A report by Safelives, 'Safe later lives: Older people and domestic abuse' highlights that women aged 61 (40%) or over are more likely to experience abuse from a current partner than younger women (28%). They are also more likely to be living with the perpetrator after getting support. 32% for women 61 or over, 9% for younger women.

11.6 Research has indicated a significant number of domestic abuse victims suffer from suicidal ideation. A study[11] in 2019 estimated that between 20 – 80% of victims of domestic abuse had suicidal ideation. This is discussed further at paragraph 14.3.7.

11.7 Jenny's daughters say that she had a deep Christian faith although she did not attend church or subscribe to a particular denomination. She would always finish a conversation with them by saying: "God bless".

11.8 All subjects of the review are white British. At the time of the review, they were living in an area that is predominantly of the same demographic and culture.

[10] www.reducingtherisk.org.uk/cms/sites/reducingtherisk/files/folders/resources/victims/Domestic_abuse_and_older_women_McGarry_and_Simpson.pdf 'Domestic Abuse and older women: exploring the opportunities…' page 2

[11] From hoping to help: Identifying and responding to suicidality amongst victims of domestic abuse[11] [*Vanessa E. Munro & Ruth AitDavid]*

12 **DISSEMINATION**

Jenny's family
Home Office
Doncaster CSP
Doncaster Clinical Commissioning Group
South Yorkshire Police
South Yorkshire Police and Crime Commissioner
Doncaster Safeguarding Adult Board
Rethink Mental Illness
St Leger Homes
Nottingham Healthcare NHS Foundation Trust
Doncaster Bassetlaw Teaching Hospitals NHS Foundation Trust
Rotherham Doncaster & South Humber NHS Foundation Trust (RDaSH)
Domestic Abuse Commissioner

13 Background, Overview and Chronology

13.1 This part of the report combines the Background, Overview and Chronology sections of the Home Office DHR Guidance overview report template. This was done to avoid duplication of information. The information is drawn from documents provided by agencies and material gathered by the police during their investigation, following Jenny's death. It is supplemented by information provided by Jenny's daughters. Events are reported here without commentary. Analysis of events during the time period of the review appears at section 14. Information prior to the review period is included for context and is not subject to detailed analysis.

13.2 Jenny had a number of medical conditions, including scoliosis, asthma, anxiety, and depression. She had many GP and other medical appointments. Only those appointments that are felt to have a direct bearing on the review, are referenced.

13.3 Jenny's daughters recall that when they were growing up, the house was always busy with visitors and family members or friends who would often call to see them. Jenny was very social and had many good friends in the village. She had joined baking clubs and exercise groups and also had an interest in the church, where she helped out. When David moved in, this declined a lot and pretty much stopped altogether soon after. If friends or family came round to see her, he sat in the room: Jenny's daughters felt that this restricted the conversation.

13.4 Between 2006 and 2009, Jenny contacted the police on seven occasions. Jenny sought advice on dealing with David and his sometimes-aggressive behaviour but did not report any physical assault. Jenny indicated that the couple were seeking a divorce and that she was consulting a solicitor. At times during this period, Jenny indicated that the couple were still living in the same house; however, at other times, she indicated that they were apart. Appropriate referrals were made, and Jenny indicated that she was in contact with support services. These matters were not recorded as domestic abuse.

Jenny's daughters recall that in November 2006, David assaulted Jenny, causing a cut to her eye. It does not appear that this was reported to the police, but Jenny did seek treatment from her GP.

13.5 It is known that Jenny was engaged with Doncaster Women's Aid at about this time. This organisation later ceased trading and although some archived records have been traced, Jenny's records are not amongst them. The DHR traced a worker who supported Jenny between approximately 2007 and 2009, and they agreed to talk to the Chair of the review. The worker told the Chair that they could remember Jenny

and that she was a lovely person. They were unable to recall much detail given the passage of time and the fact that no notes were available. However, they could recall that Jenny related constant emotional abuse from David, with abusive language and insults being interspersed with prolonged periods of 'silent treatment'. Jenny was supported to access a solicitor. Enquiries with the Family Court have shown that there was an application for an occupation order. This was not granted because David gave an undertaking to the court, in June 2009, to stay away from the house. The Family Court no longer holds any further details of the case.

13.6 When Doncaster Women's Aid ceased operations, a different organisation (South Yorkshire Women's Aid) was set up and began providing similar services. This organisation was short-lived, and it has not been possible to trace any written records. Attempts were made by social media to contact a person who was believed to have worked with this organisation and supported Jenny, but this was unsuccessful.

13.7 During the review period, Jenny was in receipt of Disability Living Allowance, part of which funded the use of a car on the Motability Finance Scheme[12]. The vehicle had a personalised number plate, which indicated David's name. Jenny's daughters say that David treated this car as his own. He would sometimes take Jenny to see Margaret and would smoke in the car, which affected Jenny's asthma. The couple also had an older small car, which Jenny used. Jenny told professionals that David had taken the car from her and let a family member use it. This is something that has also been asserted to the Chair of the review by Jenny's daughters. David denied this, stating that Jenny did not like driving and preferred others to drive. For example, he often drove her to medical appointments.

13.8 David was in receipt of carer's allowance, in respect of the care that he provided to Jenny. In order to claim for carer's allowance, a person must assert that they provide at least 35 hours care a week. Jenny's daughters say that he did not provide that much care to Jenny and often spent time at their caravan on his own.

13.9 On 6 February 2017, during a telephone triage appointment with her GP, Jenny reported that she had been assaulted by David the previous night, when he pulled her hair, pushed her to a wall, put a glass on her face, and was trying to hit her with beer cans. She said that she didn't dare call the police as David had threatened to

[12] https://www.motability.co.uk/about/

kill her. Jenny said that they had now arranged for grandchildren to stay with them, and this was a protective factor. Jenny was prescribed diazepam[13].

13.10 On 3 March 2017, Jenny saw a GP. It was recorded that: 'Threatened again by husband. [a third party] smashed window frame other day. She won't go to the police because he has threatened if she does. Husband bad when drinks. Says has nowhere to go, daughter lives a long way off. Husband gave her car to his daughter. It is her house but she believes if she leaves it she will not get back'.

Jenny was given contact numbers for domestic abuse support services and encouraged to report issues to the police.

13.11 On 28 April 2017, Jenny saw a GP: she was feeling unwell with her heart racing and feeling anxious. Jenny said that David was verbally, but not physically, abusive and was drinking excessively. She was in touch with a domestic abuse service and was planning to stay with her daughter for a few days.

13.12 In May 2017, Jenny attended an appointment at a London GP practice whilst she was staying with Sarah. A referral to mental health services was made but was rejected, as Jenny did not meet the criteria for secondary mental health services, with signposting to the crisis service as an alternative. Jenny did not contact other services in London and soon returned to Doncaster.

13.13 On 12 June 2017, during a routine appointment, Jenny disclosed to her Doncaster GP that she felt very isolated and was receiving verbal abuse from David all the time but no physical abuse. Jenny said it didn't seem to work out in London with her daughter, and she was feeling isolated. The GP ensured that Jenny had contact numbers for a domestic abuse service and adult safeguarding.

13.14 On 21 June 2017, Jenny disclosed to her Doncaster GP that she was receiving no help from David, and even though he was being paid carer's allowance, she had to pay all the bills.

13.15 On 12 July 2017, at an appointment with Psychological Therapy Services (an RDaSH service later renamed Improving Access to Psychological Therapies), Jenny disclosed further information about her relationship with David. Jenny said that there had always been problems in the marriage, and that the couple had separated in the

[13] Diazepam, first marketed as Valium, is a medicine of the benzodiazepine family that acts to reduce anxiety. It is commonly used to treat a range of conditions, including anxiety, seizures, alcohol withdrawal syndrome, benzodiazepine withdrawal syndrome, muscle spasms, trouble sleeping, and restless legs syndrome.

past. She added to information given previously, for example, stating that David had heard her criticising him and had 'gone mad', and that he was verbally abusive to her very often. Records indicate that the RDaSH practitioner contacted domestic abuse services, and it was agreed that Jenny would contact them the next day – as the service would only accept a self-referral. The RDaSH practitioner checked that Jenny had contact numbers for a range of support organisations.

13.16 From 14 June 2017 to 17 July 2017, Jenny had a period of contact with the Adult Social Care and Wellbeing service, after Jenny had contacted them. On 17 July, Jenny disclosed that she had been a victim of domestic abuse for several years. Jenny said that David had taken her car and given it to one of his daughters. The wellbeing officer encouraged Jenny to report the issues to the police.

13.17 Jenny contacted the police the same day. She reported that she was suffering ongoing domestic abuse from her husband. He was meant to be her carer, but he had been away at the caravan on the east coast all week. She went on to say that he was going there all the time, that he was not looking after her, and that she had been living on microwave meals. As a result of the call, a police sergeant attended to see Jenny. The sergeant recorded that Jenny was not at risk, the house was clean and tidy, and Jenny had access to food. Jenny spoke of historic domestic abuse incidents, which appeared to have been dealt with previously. Jenny was signposted to Victim Support but did not consent to a referral to any other agency. No further action was taken. South Yorkshire Police have recognised this as a missed opportunity to complete a DASH[14] risk assessment.

13.18 On 22 July 2017, David contacted the police reporting that Jenny was trying to goad him into an argument. An appointment was subsequently made, and David attended a police station on 27 July 2017. David said that he was having problems with Jenny, who was drinking a bottle and a half of wine a day and mixed with strong prescription medication. He acknowledged that he had been arrested for assaulting Jenny some years previously but said that she was now trying to goad him into an argument so that she could call the police and have him arrested. He was advised to contact a family law solicitor or counselling service. A DASH risk assessment was completed, showing David as the victim: this was graded as standard risk. Jenny was not spoken to.

13.19 On 26 July 2017, at a further appointment with Psychological Therapy Services, Jenny said that the police had not been very helpful. It was concluded that the most

[14] Domestic Abuse Stalking and Harassment (risk assessment) www.savelives.org.uk

appropriate service for Jenny's mental health was the Doncaster Women's Centre – for counselling regarding domestic abuse. Contact was made with the centre. A request for information was made to the women's centre on behalf of the review, but there was no trace of Jenny in their records.

13.20 On 30 July 2017, Jenny contacted the police to ask for advice in relation to an issue relating to David's daughter's partner. During the conversation, Jenny told the operator that she "had been having issues with her own husband but they were now sorted".

13.21 On 16 August 2017, at an appointment with Psychological Therapy Services, Jenny said that she was working with two people from the domestic abuse service and was in regular contact with them. Jenny said that counselling had not begun at the women's centre as they had put her in touch with a domestic abuse worker. The IAPT practitioner contacted the women's centre, and it was agreed that Jenny would call back to arrange counselling in the next two weeks. She was discharged from the service as it was felt that the women's centre was a more appropriate service.

13.22 On 11 December 2017, at an appointment with her Doncaster GP, Jenny disclosed that she had suicidal thoughts, but her family were a protective factor. She said that she had been to counselling in the summer but it was a waste of time. Jenny was anxious and tearful and was offered, but declined, a referral to the community mental health team. Jenny had uncontrolled pain from her medical conditions, and a plan was formulated to address this.

13.23 On 31 December 2017, David contacted the police reporting that he had received a series of threats from his daughter's partner. The incident was resolved the following day when a DASH risk assessment was completed: it recorded David as the victim. Due to evidential difficulties, no action was taken in relation to criminal offences. There is no evidence that Jenny was involved in this incident, but she was living in the home at the time, and it could therefore have impacted upon her.

13.24 On 6 March 2018, at an appointment with her Doncaster GP, Jenny disclosed that David drank alcohol excessively and was verbally abusive. Jenny said that her daughters were supportive but didn't live locally.

13.25 On 22 May 2018, at an appointment with her Doncaster GP, Jenny said that she had been spending time at the family caravan and was going there the following day. Jenny told the GP that her relationship with David was now much better.

13.26 On 7 December 2018, at an appointment with her Doncaster GP, Jenny was tearful and anxious. She said that things had been fine over the summer whilst staying at the caravan, but that David was always angry and shouting since they had come back to Doncaster. She said that there was no violence or physical aggression and declined an offer of counselling.

13.27 On 10 April 2019, at an appointment with her Doncaster GP, Jenny disclosed that David was drinking every day, shouting at her, and being verbally abusive. Jenny said that she had fleeting suicidal thoughts and had been having them for years but "knew that they were silly" and would not act on them. David had gone to their caravan the previous day.

13.28 On 22 April 2019, whilst at the family caravan on the east coast, Jenny contacted the ambulance service reporting that she had taken an overdose of prescription medication. David took over the call and said that he would take Jenny to hospital, so an ambulance was not required. Jenny did not arrive at hospital. This prompted further action to follow up the call, but the address of the caravan could not be traced. No follow-up action was taken. Yorkshire Ambulance Service has identified this as a missed opportunity to submit a safeguarding concern. David told the Chair of the review that Jenny had contacted him whilst he was out and that he had returned to the caravan to see her. He thought that Jenny was fine and did not need to go to hospital. He recalled arguing after this incident and said that he told Jenny, in anger "he would buy her the tablets next time", although he did not mean it and it was said because he was angry and frustrated.

13.29 On 24 April 2019, Jenny again contacted the ambulance service: this time from home. She said that she had taken an overdose a few days previously and was unwell. Jenny disclosed to ambulance staff that David was controlling and could be verbally aggressive, constantly swearing, and demeaning to her. He drank alcohol excessively every day, and she was feeling isolated and alone. She said that David had told her that the next time she took an overdose, she should do it properly. David was not at the property when the ambulance service arrived, and Jenny was taken to Doncaster Hospital. The ambulance service staff made a safeguarding referral with Jenny's consent. On arrival at hospital, Jenny was seen by a triage nurse and arrangements were made for her to be seen by the mental health liaison team (RDaSH). However, Jenny left before she could be seen and went home. Jenny later returned to the hospital and was seen by clinicians in relation to her physical and mental health.

The mental health practitioner completed a full needs assessment. The assessment stated that Jenny:

'is the victim of domestic abuse from her husband. He verbally abuses her and has threatened to damage her property. He has systematically destroyed her sense of self confidence and access to people outside of their home'.

A suite of specific documentation was completed, including a Functional Analysis of Clinical Environment (FACE) risk assessment. This highlighted that Jenny had experienced 16 years of systematic verbal and emotional abuse from her husband; and that her husband had a previous history of abuse within previous relationships. The risk management plan details her intention to move to Newark.

There is no evidence within clinical records that a further safeguarding concern was considered at this time. The police were not notified of the concerns reported.

13.30 Following the safeguarding referral from the ambulance service, there was a period of telephone contact with Doncaster Adult Social Care until 19 May 2019, when the case was closed. A referral was then made to Nottinghamshire Adult Social Care, as Jenny was then resident in their area. Nottinghamshire Adult Social Care has responded to an enquiry from the review: they have no knowledge of Jenny and did not receive a referral.

13.31 On 26 April 2019, at an appointment with his GP, David said that he was suffering from low mood because of problems with his wife, who was causing a lot of stress. He said that his wife also had mental health problems and it was a difficult relationship. He was prescribed an antidepressant and declined a referral for counselling.

13.32 On moving to Nottinghamshire, Jenny registered as a temporary patient at a local GP practice. She was referred to local mental health services provided by Nottinghamshire Healthcare NHS Trust. Jenny was seen promptly. Her first contact with the Trust was on 10 May 2019, and she then had five face-to-face appointments before her case was closed on 26 July 2019, as she had moved back to Doncaster.

13.33 On 14 July 2019, Jenny spoke to the Doncaster mental health crisis team by telephone. Jenny said that her psychologist at Nottinghamshire Healthcare NHS Trust would complete a referral to Doncaster on return from leave, but she felt that was too long and she needed some support in the interim. She was being supported

by Women's Aid in Doncaster. Jenny said that David had been staying at their caravan for the last 10 weeks, and he planned to remain there. She felt well overall but was concerned that without support, her mental health might deteriorate. Jenny's concerns were reported back to her GP.

13.34 On 22 July 2019, following a referral from her GP, Jenny spoke to the Doncaster community mental health team. She said that she had been depressed for two years and said this was in response to feeling physically unwell. She said she returned to Doncaster to live with her husband, and he had been supportive. She had been living with her daughter in Nottinghamshire but had decided to return home because she did not want to continue living with her daughter, as she could not fully settle in someone else's home. She said that she had been seen by CMHT in Newark and felt that she was making progress but had to return home. She said that she had felt anxious the previous week and contacted her husband who was spending time at their caravan at the coast. He returned home to provide her more support, and she said he was now more supportive. The referral was downgraded from urgent (contact patient within 4 hours) to non-urgent (to be seen within forty days), as the CMHT recorded there was no evidence of urgency.

13.35 Between 22 – 26 July 2019, Jenny contacted the community mental health team on three occasions, seeking support for her mental health. Jenny said that she did not have suicidal ideation but felt abandoned with regard to support for her mood and feelings. A home visit was agreed for 28 July 2019, and a scheduled IAPT (Improving Access to Psychological Therapies) appointment was brought forward from 11 August to 29 July.

13.36 On 27 July 2019, Jenny contacted her daughter, Sarah. As a result of the call, Sarah was so concerned for Jenny that she drove from London to help her. Sarah took Jenny to Doncaster Royal Infirmary, as Sarah felt that Jenny needed help and was advised to do so after calling 101 for advice. Jenny was assessed by the mental health liaison team (RDASH) and was admitted the same day to The Haven (also known as The Crisis House). This is a facility operated by Rethink Mental Illness, providing short-term accommodation and support for people suffering mental health crisis.

Sarah contacted Doncaster Adult Social Care, and a safeguarding concern was recorded.

13.37 Jenny was visited by David. However, after the visit, she made it clear that she did not want to see him again. Jenny's daughters say that this was because David was attempting to interfere with her care. For example, he wanted to attend a

psychology assessment with her, but Jenny felt that this was an attempt to prevent her from making disclosures about the abuse she suffered.

13.38 Jenny stayed at The Haven until 9 August 2019. During this time, she was visited by Adult Social Care (safeguarding team) and mental health services. Attempts were made to find refuge accommodation; however, nothing could be found in Doncaster, and Jenny did not want to go to a refuge outside Doncaster. Jenny's daughters say that attempts to offer Jenny accommodation were very limited because her disability meant that refuge accommodation was unlikely to be suitable.

13.39 The safeguarding team social worker contacted the Doncaster domestic abuse case worker service. Following receipt of a referral, a worker from the service spoke to Jenny and Sarah, by telephone, and it was established that Jenny was going to stay with Sarah in London. The worker asked Sarah to recontact her when new accommodation was found for Jenny in Doncaster, so that support could be provided.

13.40 On 9 August 2019, Jenny left The Haven and went to stay with Sarah in London. The intention of this was to provide some respite whilst a permanent solution could be found in Doncaster.

13.41 Prior to leaving Doncaster, Jenny attended an appointment with IAPT on 9 August 2019. Jenny said that the main problems were emotional abuse in her relationship with David. She said that she had had this for many years, that it was this that had caused depression and anxiety, and that she felt worthless and hopeless. She said that she had no confidence and felt frightened and depressed constantly. David had 'encouraged her to kill herself and said that he would buy her the medication to overdose with'. Jenny wanted to leave to go to London with Sarah, and it was agreed that she would contact the service again on her return from London.

13.42 Following the involvement of Adult Social Care (safeguarding team), Jenny's case was passed to a social work team for assessment. The intention was that an assessment, under the Care Act 2014, would take place. The case was placed on a waiting list for allocation and was not allocated to a social worker until 6 February 2020. The allocated social worker made a number of attempts to contact Jenny by telephone, but all were unsuccessful.

13.43 On 13 August 2019, at an appointment with his GP, David said that he was struggling with anxiety and depression, following a hard breakup from his wife. His

antidepressant dose was increased, and he was given a limited supply of medication to assist with sleep.

13.44 On 19 August 2019, Jenny registered as a temporary patient at a London GP surgery. She was referred to the local mental health service and was seen by the crisis team, accompanied by Sarah. The assessment concluded that there was no suicidal ideation and hospital admission was not necessary to maintain Jenny's safety. There was no further plan for treatment.

13.45 Whilst in London, both Sarah and Jenny were in contact with services in Doncaster to try to resolve Jenny's position – so that she could return to Doncaster safely. Examples include:

- Adult Social Care sent information in relation to Extra Care housing[15]
- A domestic abuse caseworker rang Sarah, on 21 August, to see if Jenny had been rehoused in Doncaster and offered some practical advice when Sarah said that she had not.

Sarah feels that this was a very difficult time for them. She says that once her mother was safe in London, it felt as if services in Doncaster were no longer interested in supporting her, even though she made it clear that this was a temporary situation and that Jenny's goal was to return to Doncaster.

13.46 On 27 August 2019, following contact from Sarah and Jenny and an assessment, St Leger Homes accepted a duty to help prevent Jenny from becoming homeless (Housing Act part 7, as amended by the Homelessness Reduction Act 2017). The personal housing plan completed, stated that Jenny required a one-bedroom ground floor adapted property and included Jenny's preference for a particular site.

13.47 On 13 September 2019, Jenny left London and returned home to Doncaster. Whilst Sarah was out, Jenny was in contact with Margaret by telephone and seemed panicky and anxious. She said that she wanted to go back to her home, and this seemed very important to her. When Sarah returned home, Jenny said that she wanted to leave, and she got a taxi to the railway station. David told the review Chair that Jenny had contacted him via a WhatsApp call, as his number had been barred in her phone. Jenny wanted to come home, and he picked her up from the railway station in Doncaster.

[15] Assisted living (also known as extra-care housing) is a type of 'housing with care', which means people retain independence whilst being assisted with tasks such as washing, dressing, going to the toilet or taking medication.

13.48 On 31 October 2019, Jenny made contact with the Doncaster IAPT service, and an appointment was arranged on 2 December 2019. The case notes from this appointment indicate that Jenny had felt 'trapped and uneasy' when she was staying in London.

13.49 On 24 December 2019, a Doncaster domestic abuse caseworker rang Jenny and left a message on her mobile number, asking if she still needed support. No reply was received, and no further contact was made.

13.50 On 30 December 2019, at an appointment with her Doncaster GP, Jenny said that David was being verbally abusive to her but was not physically abusive. Jenny said that she was in touch with other services, including Doncaster Women's Aid. She had support from her daughters and did not need anything further from the GP.

13.51 On 8 January 2020, the IAPT assessment was completed. The assessment considered Jenny's history as well as the relationship dynamics within her life. It identified themes of childhood sexual abuse, which impacted significantly on her life. Jenny did not wish to address historical issues but wanted counselling to explore family relationships. Symptoms of anxiety and depression were identified. The outcome was that counselling was to be arranged. On 20 January 2020, an IAPT practitioner phoned Jenny to discuss her care, but there was no reply.

13.52 Jenny continued to have contact with her GP for routine medical issues but did not raise further concern about her relationship with David.

13.53 On 6 February 2020, Jenny's case was allocated to a social worker in order to conduct an assessment. The social worker contacted Sarah, who said that her mum had returned to live with David in Doncaster in September 2019. The social worker then attempted to contact Jenny by telephone three times but was unsuccessful

13.54 Around a week before her death, Jenny surprised Margaret by driving to Margaret's home for a family event. Jenny had not driven for some time and was pleased and positive that she had managed to do so.

13.55 After leaving London, Jenny was not in touch with her daughter, Sarah. However, she did keep in touch with Margaret, who visited her occasionally, including the evening before her death. David had earlier started an old motorbike in the house and the fumes had bothered Jenny because of her asthma. Margaret says that David laughed about this. The purpose of the visit was to give Jenny a birthday card and present, as it was her birthday the following day.

14 Analysis

14.1 Did colleagues in your agency clearly understand and follow referral arrangements, both when making and receiving referrals?

14.1.1 There is good evidence, throughout the IMRs completed for this review, that referrals were made appropriately for Jenny, on many occasions, and that those referrals were then acted upon appropriately by the recipient organisations.

14.1.2 On some occasions, Jenny asked that referrals were not made. For example, when visited by the police on 17 July 2017, Jenny asked that no referrals were made to other organisations. She was, however, provided with contact details for organisations that may have been able to offer support.

14.1.3 The ambulance service response to events on 22 April 2019, when Jenny took an overdose, was finalised without ensuring that Jenny was safe. After Jenny had initially called the emergency services, David took over the call and said that he would take Jenny to hospital. This did not happen. As a result, the ambulance service made enquiries with the caravan site that Jenny was believed to be staying at, but she was not recorded as being there. Contact was also made with the police to see if they had any recent calls from Jenny, which could contain information on her location. Again, this was unsuccessful. A further review of the information, recorded that there were no 'red flag' issues, which suggested that Jenny was at imminent risk if medical attention was not sought. An ambulance was not dispatched, and the call was referred back to the 111 service. The DHR panel thought that the actions taken were proportionate and reasonable. Other options that could have been considered, such as a physical search for Jenny on the large caravan site during the night or a request to the police for a live time trace on Jenny's mobile phone, were not considered by the panel to be practical or proportionate in the circumstances. Yorkshire Ambulance Service has identified this incident as a missed opportunity to raise a safeguarding concern.

14.1.4 Yorkshire Ambulance Service staff did raise a safeguarding concern two days later, when Jenny contacted the ambulance service and was taken to Doncaster Hospital. This concern resulted in a period of telephone contact

with Adult Social Care. This was finalised on 19 May 2019 when a referral was sent from Doncaster Adult Social Care to Nottinghamshire Adult Social Care, as Jenny was then staying with Margaret in Nottinghamshire. This point is further discussed at paragraph 14.2.4.

14.1.5 Jenny's move to stay with Margaret in Nottinghamshire, which was known about on her discharge from hospital, did not result in a referral from mental health services in Doncaster (RDaSH) to the appropriate Nottinghamshire service, which should have taken place. Jenny was contacted by a member of RDaSH staff to check that she was able to access appropriate services. This is a single agency learning point for RDaSH. Instead, a referral was made after Jenny attended a GP appointment in Nottinghamshire. This referral resulted in a period of support from a community psychiatric nurse and a psychologist who then referred Jenny back to her own GP in Doncaster on 22 July 2019. The GP referred Jenny back into the community mental health team. The panel thought that despite the potential complexities of moving areas, there was evidence of a good initial response – from the Nottinghamshire GP and local mental health services (Nottinghamshire Healthcare NHS Foundation Trust) – to Jenny's needs.

14.1.6 Soon after this, Jenny attended at Doncaster Hospital on 27 July 2019 and subsequently was accommodated at The Haven for two weeks. During this period, a number of services were involved, in particular Adult Social Care (safeguarding), following a safeguarding concern raised by Sarah. A safeguarding social worker spoke to mental health services (RDaSH), who visited Jenny and also spoke to the domestic abuse service. A worker from that service spoke to Jenny on the telephone. Discussions took place with appropriate services regarding refuge accommodation, but nothing could be found in Doncaster. When Jenny then left The Haven to move temporarily to London, the safeguarding social worker ensured that an appropriate referral was made, internally, with Adult Social Care for an assessment under the Care Act 2014 to take place.

14.1.7 Referrals were not made to services in London where Jenny was moving to temporarily. This was because Jenny was thought to be moving on a temporary basis and would soon be back in Doncaster. The panel heard that had Jenny been a high-risk MARAC victim, then a MARAC to MARAC transfer would have taken place. The fact that a DASH risk assessment was not conducted by any service after July 2017, was a barrier to understanding the level of risk that Jenny faced from domestic abuse.

14.1.8 In August 2019, Jenny saw a London GP and was referred to the local mental health crisis team, where she was seen and assessed quickly. The panel

thought that the facilitation of appointments and referrals for Jenny as a temporary patient, both in Nottinghamshire and London, was good practice.

14.1.9 There is good evidence that Jenny's Doncaster GP made appropriate and timely medical referrals to other agencies, in particular mental health services. Jenny disclosed domestic abuse to her GP on a number of occasions and was signposted to Women's Aid as early as 2 June 2006. Notes from subsequent consultations indicate that Jenny was accessing this service.

14.1.10 There were a number of opportunities for Jenny's Doncaster GPs to consider direct referrals to MARAC, safeguarding, the police, or the domestic abuse caseworker team. There is no evidence that potential referrals were considered. This is a learning point for the GP surgery / ICB.

14.2 Were relevant assessments completed in line with procedural guidelines and within relevant timescales? Did these assessments inform plans of action?

14.2.1 There is good evidence that physical and mental health assessments were completed promptly and in line with guidance. In some instances, this did not result in the immediate provision of a service. For example, on 22 July 2019 when an urgent referral was made to the Doncaster community mental health team by Jenny's GP, the referral was downgraded following a telephone triage assessment conducted the same day – as the assessment concluded that Jenny's case was not urgent. The triage included speaking to the referrer and team manager, which is considered by RDaSH to be good practice.

14.2.2 The panel saw that assessments conducted by health professionals in Nottinghamshire and London, had been conducted within appropriate timescales.

14.2.3 It is clear that Jenny relayed her 'lived experiences' to health practitioners on a number of occasions at the commencement of contact with health services. She was clear that she was suffering from emotional and economic abuse. Whilst her 'lived experiences' relating to domestic abuse are acknowledged within the assessments and risk assessments, they did not lead to clear plans of action in supporting Jenny to deal with the abuse that she was suffering. There is no evidence that a health professional considered or completed a DASH risk assessment, for example. Despite the abuse that Jenny clearly outlined, it was a safeguarding concern raised by her daughter, Sarah, that triggered the involvement of Adult Social Care in July 2019.

14.2.4 Adult Social Care had a number of contacts with Jenny during which there were opportunities for assessments to be completed.

- Wellbeing Team – 14 June 2017 to 17 July 2017. Jenny discussed the issues facing her and outlined the services that she was involved with. Jenny was encouraged to contact the police, which she did.
- Integrated Support and Assessment Team (ISAT). This team was allocated Jenny's case following the first safeguarding concern raised by Yorkshire Ambulance Service in April 2019. After liaison with other services, where it was clear that it was Jenny's intention to return to Doncaster, a social worker spoke to Jenny and then referred her case to Nottinghamshire Adult Social Care for an assessment. The panel thought that more could have been done to ensure that an assessment was conducted for a vulnerable Doncaster resident who was seeking to return to Doncaster. Doncaster had no feedback and no knowledge of whether the referral was received by Nottinghamshire. Nottinghamshire has responded to the review that they had no knowledge of Jenny and did not receive a referral. This is a single agency learning point for Doncaster Adult Social Care
- Safeguarding Adults Hub – 30 July 2019 to 8 August 2019. Following the safeguarding concern of 27 July 2019, a safeguarding enquiry was conducted under Section 42 of the Care Act 2014.

  This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)—

  (a)has needs for care and support (whether or not the authority is meeting any of those needs),

  (b)is experiencing, or is at risk of, abuse or neglect, and

  (c)as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

  (2)The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.

  (3)"Abuse" includes financial abuse; and for that purpose "financial abuse" includes—

  (a)having money or other property stolen,

(b)being defrauded,

(c)being put under pressure in relation to money or other property, and

(d)having money or other property misused.

- The allocated social worker visited Jenny, assessed her immediate needs, and liaised with other services. The social worker recorded that Jenny's desired outcomes were met. [see paragraph 14.12.7]. The case was passed to an area social work team for assessment on 1 August 2019. This was the correct course of action as the safeguarding social worker's role did not extend beyond the initial safeguarding enquiry to ensure that Jenny was safe at that time.
- Adult Social Care South Team (area team). Following receipt of the request for an assessment under the Care Act 2014, Jenny's case was risk assessed. Jenny was not considered to be in crisis as she was currently safe. She was placed on the priority one waiting list for allocation to a social worker. The case was not allocated to a social worker, for the assessment to be conducted, until 2 February 2020, and an assessment did not take place before Jenny's death. During the first few weeks of this period, there were contacts with Sarah – who was acting on behalf of Jenny – when advice on housing and other matters was offered. Requesting an assessment by the relevant London authority was considered and rejected because it was thought that would be ineffective.

The panel was told that during the relevant time, the team had a particularly demanding workload with a high number of people presenting in crisis, and Jenny's case was one of many awaiting allocation. The service does not have a set standard in relation to the waiting time for an assessment. Whilst the panel understood that and were not in a position to question the relative merits of other cases, they thought that such a waiting list should be managed dynamically. There is no evidence of this in Jenny's case. This is a single agency learning point for Doncaster Adult Social Care.

14.3 What risk assessment models / tools were used by colleagues in your agency?

14.3.1 South Yorkshire Police

South Yorkshire Police have used the widely adopted DASH risk assessment since 2012.

- On 17 July 2017, when Jenny was visited by a police sergeant, the information that Jenny gave about domestic abuse was thought to be historic and the issues were dealt with by ensuring that Jenny's welfare needs were being met. South Yorkshire Police recognise this as a missed opportunity to complete a DASH risk assessment.
- On 22 July 2017, when David complained to the police that Jenny was trying to goad him, a DASH risk assessment was completed – showing him as the victim.
- On 31 December 2017, when David complained about receiving threats from his daughter's partner, a DASH risk assessment was completed – showing him as the victim.

Both assessments, in relation to David, were graded as standard risk and did not generate further action. After the incident of 17 July 2017, South Yorkshire Police did not have contact with Jenny in circumstances in which a DASH risk assessment, in relation to her relationship with David, would have been appropriate.

The panel noted the following information prior to the Terms of Reference period of the review: that between 2006 and 2009, Jenny contacted the police on seven occasions. Jenny sought advice on dealing with David and his sometimes-aggressive behaviour but did not report any physical assault. These matters were not recorded as domestic abuse and were before South Yorkshire Police began routinely using the DASH risk assessment.

The panel thought it relevant to include the information as it shows that issues in the relationship happened over a long period of time.

14.3.2 During Yorkshire Ambulance Service interactions with Jenny on 24 April 2019, staff were concerned about her disclosures, to the extent that they raised a safeguarding concern using their professional judgement. Yorkshire Ambulance Service staff do not currently have access to the DASH risk assessment. This is something that is being reviewed currently by the service; therefore, there is no separate recommendation on this.

14.3.3 **RDaSH**

The Trust utilises a standard 'full-needs assessment' when engaging with service users in receipt of mental health services. This is a holistic needs-based assessment that considers the biological, psychological, and social

needs of an individual. This assessment is accompanied by a Functional Analysis of Clinical Environment risk assessment (FACE), which is a holistic tool and considers identified risks (both historical and current), ranging from risks of suicide, exploitation by others, risks to others, etc. Towards completion of the assessment, clinicians are then prompted to summarise the risks and identify an appropriate risk management plan. There is evidence that FACE risk assessments were completed appropriately during Jenny's contacts with RDaSH services.

14.3.4 Nottinghamshire Healthcare NHS Foundation Trust

When Jenny was referred to Nottinghamshire Healthcare NHS Foundation Trust in May 2019, a structured risk assessment was completed at initial assessment. This risk assessment did make reference to domestic abuse, but domestic abuse was not part of the risk formulation. The risk of domestic abuse was identified but no structured assessment of the risk was completed. The risk of ongoing suicide was assessed using the basic risk assessment. The assessment indicated that Jenny was no longer experiencing suicidal thoughts, and her family were a protective factor.

14.3.5 Rethink Mental Illness

Rethink Mental Illness use their ISSP (Integrated Support and Safety Planning) documents across their services.

The Haven utilised the following elements of the ISSP system:

- Safety Management Plan
- First Look at My Situation
- My Support Plan
- Reviewing My Situation
- Discharge Safety Management Plan

14.3.6 The panel noted that Jenny had disclosed domestic abuse repeatedly during appointments with health professionals but that a DASH risk assessment had not been completed at any time by a health professional, despite clear records of Jenny's disclosures. On reviewing the information within agency IMRs, it is clear that Jenny disclosed emotional and economic abuse and said that there was no physical abuse. Reflecting on this, the DHR panel thought that the absence of physical abuse may wrongly have diverted health professionals from completing a domestic abuse risk assessment. This is a multi-agency learning point. [Panel learning 1].

14.3.7 The panel was made aware of the research cited at paragraph 11.4. The link between suicide and domestic abuse should have been a further signal to health professionals after Jenny's suicide attempt in April 2019. This is a multi-agency learning point. [Panel learning 2].

14.4 **What indicators of domestic abuse, including coercive and controlling behaviour, did colleagues in your agency identify in this case?**

14.4.1 During the period of the review, Jenny disclosed, to many agencies, that she was being abused. These agencies included:

South Yorkshire Police
Doncaster GP
RDaSH
Yorkshire Ambulance Service
Doncaster Adult Social Care
Nottinghamshire GP
Nottinghamshire Healthcare NHS Foundation Trust
Doncaster Teaching Hospitals NHS Foundation Trust
Rethink Mental Illness (The Haven)
London GP and Crisis Team
St Leger Homes

14.4.2 Jenny sometimes told professionals that she was being supported by Doncaster Women's Aid. It is possible that this gave them some assurance that Jenny was receiving specialist support. This organisation has now closed. The remaining records from Doncaster Women's Aid are stored in the Doncaster Council Archives. The records have been searched and there are no records available relating to Jenny and the support she was given. Jenny's daughters do recall that she received support from Women's Aid and had been told to maintain a diary of the abuse that she suffered. Jenny's daughters disclosed that Jenny's diaries were sometimes removed from the bedroom whilst Jenny was out, but she continued to record her thoughts in a diary. Jenny's current diary was not found after her death. Her daughters believe that her diary was in her bedroom and would have been found if Jenny's death had been treated as other than a routine sudden death.

14.4.3 The disclosures that Jenny made to all of the agencies involved are consistent, in that she said David was verbally abusive and threatening towards her. She also said that she was suffering from economic abuse in a number of ways. For example, David had blocked access to her car (funded

by Disability Living Allowance / Personal Independence Payment) and allowed his daughter to use it. Jenny also said that she had to pay all the bills for the household whilst David did not contribute. Jenny's daughters told the Chair that Jenny had originally owned the house outright but that she had been persuaded to secure David's debts against it.

14.4.4 In addition, there was evidence that David may have tried to prevent Jenny from receiving medical treatment after her suicide attempt in April 2019, when he declined an ambulance saying that he would take Jenny to hospital but did not do so. David told the review Chair that he did not think Jenny needed to go to hospital. Jenny was at least to some extent reliant on David, for example, he was in receipt of carer's allowance: this can only be claimed by someone who is providing at least 35 hours of care per week[16], although Jenny told others that he often did not provide any care.

14.4.5 As early as 2007, a code of domestic abuse was added to Jenny's Doncaster GP medical records, which allows the records to be searched. Domestic abuse can also be added as a problem in the medical records or flagged to ensure that it is visible in future consultations, without the need to go back many years in the records. This may have assisted with continuity and providing context of the abuse, as it appeared at times from the records that individual GPs were unaware of the previous abuse that may have altered their risk assessment and management. This is a learning point for the GP surgery / ICB.

14.4.6 Records from an IAPT appointment on 9 August 2019, show that that Jenny said David had "encouraged her to kill herself and said that he would buy her the medication to overdose with". This is a clear statement relating to a potentially criminal act. Section 2 of the Suicide Act (1961), as amended by Section 59 and Schedule 12 of the Coroners Act (2009), applies. In these cases, it must be proved that:

- The suspect did an act capable of encouraging or assisting the suicide or attempted suicide of another person; and
- The suspect's act was intended to encourage or assist suicide or an attempt at suicide.

This incident was not reported or considered in the context of safeguarding, nor was further support, guidance, or advice sought. The panel thought that the disclosure should have been reported or advice sought. The panel noted

[16] www.gov.uk/carers-allowance/eligibility

that Jenny had been upset at this appointment, that she was particularly keen to leave to go to London with Sarah, and they thought that knowing that Jenny was going to be safe in London, had affected the RDaSH practitioners' considerations. This is a single agency learning point for RDaSH.

14.4.7 The panel considered whether there was evidence that David had subjected Jenny to coercion and control and, in doing so, referred to the Crown Prosecution Service's policy guidance.

14.4.8 The Crown Prosecution Service's policy guidance on coercive control, states:

'Building on examples within the Statutory Guidance, relevant behaviour of the perpetrator can include:

- Isolating a person from their friends and family
- Depriving them of their basic needs
- Monitoring their time
- Monitoring a person via online communication tools or using spyware
- Taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep
- Depriving them access to support services, such as specialist support or medical services
- Repeatedly putting them down such as telling them they are worthless
- Enforcing rules and activity which humiliate, degrade or dehumanise the victim
- Forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities
- Financial abuse including control of finances, such as only allowing a person a punitive allowance
- Control ability to go to school or place of study
- Taking wages, benefits or allowances
- Threats to hurt or kill
- Threats to harm a child

- Threats to reveal or publish private information (e.g. threatening to 'out' someone)
- Threats to hurt or physically harming a family pet
- Assault
- Criminal damage (such as destruction of household goods)
- Preventing a person from having access to transport or from working
- Preventing a person from being able to attend school, college or university
- Family 'dishonour'
- Reputational damage
- Disclosure of sexual orientation
- Disclosure of HIV status or other medical condition without consent
- Limiting access to family, friends and finances

This is not an exhaustive list and prosecutors should be aware that a perpetrator will often tailor the conduct to the victim, and that this conduct can vary to a high degree from one person to the next'.

14.4.9 The panel thought that there was clear evidence that Jenny had been subjected to coercion and control. It is also clear that despite Jenny's multiple disclosures, little was done to directly address the issues that she disclosed.

14.4.10 Despite all of Jenny's disclosures, no DASH risk assessment was completed, and a referral to a domestic abuse specialist was not made (this may have been complicated by Jenny's assertion on some occasions that she was in touch with Women's Aid).

14.4.11 The Serious Crime Act 2015 received royal assent on 3 March 2015. The Act created a new offence of controlling or coercive behaviour in intimate or familial relationships (Section 76). The new offence closed a gap in the law around patterns of controlling or coercive behaviour in an ongoing relationship between intimate partners or family members. The offence carries a maximum sentence of five years' imprisonment, a fine, or both. The offence, which does not have retrospective effect, came into force on 29 December 2015. The legislation was therefore effective for the whole of the period under review.

14.4.12 There is evidence from agency records, that Jenny complained of behaviours that amounted to coercive control. There is no evidence that these behaviours were recognised as potentially criminal acts, which could have led to a criminal investigation if reported to the police. The panel thought that this indicated a lack of understanding of this legislation, which must be addressed. This is a multi-agency learning point. [Multi-agency learning 1].

14.4.13 The panel also discussed the impact of potential financial and economic abuse on Jenny. Surviving Economic Abuse[17] provides the following definitions:

Financial abuse
Controlling finances, stealing money or coercing someone into debt

Economic abuse
Financial abuse plus restricting, exploiting or sabotaging other resources such as housing, food, property, transportation and employment.

14.4.14 Jenny's daughters say that when Jenny met David, she owned her own house, which was mortgage free. During the course of Jenny and David's relationship, her daughters say that a mortgage was taken out to fund an extension, and David's debts were secured against the house. Another example is the use of Jenny's Disability Living Allowance to fund a car. Jenny's daughters say that she was not allowed to use this car, and David used it as his own.

There is no evidence that issues surrounding economic and financial abuse were known to agencies prior to Jenny's death.

14.5 **Did colleagues give appropriate consideration and weight to other potential risk and vulnerability factors in this case (including, but not necessarily limited to the deceased's experiences of childhood sexual abuse, chronic pain, depression, and previous suicide attempt)?**

14.5.1 The police were unaware of the childhood sexual abuse allegations, which only became apparent to them when Jenny's note was found after her death. Officers were concerned about Jenny's disabilities and medical conditions, and these were highlighted in the contact with the police on 17 July 2017. The

[17] Surviving Economic Abuse (SEA) is the only UK charity dedicated to raising awareness of economic abuse and transforming responses to it.

sergeant recognised welfare issues around Jenny's inability to have free movement due to her disabilities. In order to check that Jenny's wellbeing was not at risk, the sergeant attended the home and checked that she had sufficient food and was not living in dangerous conditions. The sergeant was satisfied that she had spoken with Jenny in detail and offered appropriate advice Paragraph 14.3.1 has already outlined that this was a missed opportunity to complete a DASH risk assessment.

14.5.2 RDaSH provides evidence that, from reviewing accessible clinical documentation, including the completion of full-needs assessments and FACE risk assessments, RDaSH practitioners gave due consideration to other potential risk and vulnerability factors within this case. Assessments completed, were holistic in nature and considered appropriate risk factors.

14.5.3 In her interactions with Nottinghamshire Healthcare NHS Foundation Trust, Jenny told the psychologist of her experiences of childhood sexual abuse: this was not added to the risk assessment. There was evidence in the record that Jenny experienced physical illness when stressful life events occurred, and she described this as feeling sick or unwell. Chronic pain related to fibromyalgia and curvature of the spine was also discussed, but there is no evidence it was considered in relation to increased risk of suicide. Initially, there was a high level of concern in relation to her suicide risk; however, actions at time of discharge, suggest this concern had reduced, as direct referral into local mental health services was not made. On the initial risk assessment, Jenny reported that her family were a protective factor. The Nottinghamshire Healthcare NHS Foundation Trust practitioners continued to use this protective factor (even when her family relationships later became strained, and she reported feeling that she was a burden to her family). Leaving her husband was also considered to be a protective factor. When Jenny moved back to the family home in Doncaster, a summary letter was sent to her GP, requesting that they refer to the local mental health team, despite her not having completed her planned care. This letter described many of the risks outlined but there was no analysis of the risk or suggestion about what the risks moving into the future might be. There is no evidence that risk was considered as increased due to the apparent loss of her two protective factors: she felt a burden to her family so was no longer in contact with them, and she was returning to the home she shared with her husband but said that she would not be resuming the relationship.

14.5.4 Staff at Rethink Mental Illness are trained to pick up on risk and other vulnerability factors. They are aware of the relationship between abuse and

childhood social or sexual trauma, combined with chronic pain, depression, and prior suicide attempts. In their opinion, it is likely that Jenny's admission to The Haven in July 2019, prevented a suicide attempt at that time.

14.5.5 Adult Social Care took account of Jenny's vulnerabilities in their dealings with her, to the extent that appropriate referrals were made to other agencies. Whilst a practical approach was taken in enlisting the support of other agencies, no risk assessment tool was used to assess these risk factors. The panel was told that a risk management policy and tool for Adult Social Care staff (Strength-based risk taking for positive outcomes) was developed and published in July 2019: this is now in use.

14.5.6 The Association of Directors of Adult Services publication, 'Adult safeguarding and Domestic Abuse, a guide to support practitioners and managers 2015', contains the following information on the impact of domestic abuse on people with care and support needs:

What might be the additional impacts of domestic abuse on people with care and support needs?

- increased physical and/or mental disability
- reluctance to use essential routine medical services or to attend services outside the home where personal care is provided
- increased powerlessness, dependency, and isolation
- feeling that their impairments are to blame
- increased shame about their impairments (for example, in relation to needs for personal care).

Research has mainly been carried out with women, and this has shown that: being disabled strongly affects the nature, extent, and impact of abuse. Research has shown that people's impairments are frequently used in the abuse. Humiliation and belittling were an integral part of this and were particularly prevalent. Many abusers deliberately emphasise and reinforce dependency as a way of asserting and maintaining control. Sexual abuse appears to be proportionately more common for disabled than for non-disabled women, perhaps reflecting particular vulnerabilities. The impact of domestic abuse is often especially acute where the abusive partner is also the carer, the carer has considerable power and control, and the victim relies on them. Perpetrators often use forms of abuse that exploit, or contribute to, the abused person's impairment.

14.5.7 The panel recognised some of the features, described by the publication, in Jenny's consistent reports to professionals. The panel thought that these impacts could reasonably have been expected to be recognised and acted upon by professionals in Adult Social Care who dealt with Jenny's case.

14.6 Did colleagues consider the inter-relationship between the experience of domestic abuse and compromised emotional and mental well-being in this case, and how this inter-relationship might increase the vulnerability of Jenny?

14.6.1 Jenny had many detailed consultations with her Doncaster GPs, where domestic abuse and her emotional and mental well-being were discussed. This was particularly the case before the timeframe of the review, when there was more continuity in which doctor Jenny saw. In more recent years, there was less continuity but there were appropriate referrals regarding her mental health and support and follow-up from the GPs.

14.6.2 During the interaction with Jenny in July 2017, the police identified both Jenny's emotional and mental well-being and her increased vulnerability. As a result, an electronic tag was placed on the police computer. This would highlight to the police operator, the risk of domestic abuse associated with the location and phone numbers, so that officers would be aware of the risks in the event of future calls.

14.6.3 During Jenny's interactions with Nottinghamshire Healthcare NHS Foundation Trust, the impact of domestic abuse was considered to have a significant impact on her mental health. The fact that Jenny was staying with her family (Margaret) and had split from David, were recorded as protective factors. After initial personal appointments, the allocated psychologist kept in touch with Jenny throughout June 2019, despite her moving back to Doncaster. The panel thought that this was good practice in a complex set of circumstances. However, the potential for increasing risk as her protective factors were removed, does not appear to have been considered. [see paragraph 14.5.3]

14.6.4 Rethink Mental Illness staff at The Haven, realised that they needed to give Jenny time and space to express herself coherently. She was assessed as having capacity to make informed decisions about her care and support upon admission and had a positive discharge plan predicated upon a move to London to stay with her daughter, Sarah.

14.6.5 Adult Social Care (safeguarding) was aware of Jenny's vulnerabilities and made appropriate referrals to other agencies. One referral made was

internally to the Adult Social Care South Team (area team), which was then responsible for conducting a care and support assessment. [discussed at paragraph 14.9]. At the time the referral was received, it was established that Jenny was staying with Sarah in London, and it was therefore assessed that she was in a safe place away from the alleged perpetrator. The subsequent delay in allocating the case for assessment and the fact that there was no communication from Adult Social Care to Jenny after August 2019, meant that they were not aware that Jenny had moved back to Doncaster in September 2019 to the family home, and she was no longer in a safe place.

14.6.6 The RDaSH Full Needs Assessment (FNA), which was completed in April 2019 when Jenny attended at the Emergency Department at the Doncaster Royal Infirmary, acknowledged that she had experienced low mood for many years, detailing the circumstances of the abuse that she had experienced. It described how it is was unclear what was mental illness and what was the result of sustained long-term abuse from her husband, clearly stating that she was the "victim of domestic abuse from her husband. He verbally abuses her and has threatened to damage her property. He has systematically destroyed her sense of self, confidence and access to people outside of their home."

14.6.7 This assessment indicated that she was leaving her husband to live in Nottinghamshire with her daughter. The assessment was conducted out-of-hours, and it was good practice that the nurse consultant for Older People's Mental Health Services, contacted Jenny's daughter (the following day) to discuss a plan for follow-up with Nottinghamshire mental health services.

14.6.8 The circumstances of the complexities of the inter-relationship between the experience of domestic abuse and compromising of emotional and mental well-being, were again explored when Jenny attended at the Emergency Department at Doncaster Royal Infirmary in July 2019 (this facilitated an admission to The Haven). Although the formal Full Needs Assessment and risk assessment were not completed at this time, which would have been expected practice, there is evidence of the impact that domestic abuse was having on Jenny in relation to her emotional and mental wellbeing. Jenny presented as agitated, experiencing fleeting suicidal thoughts, isolated, and lonely. The clinical entry acknowledged that she was in an emotionally abusive relationship.

14.6.9 Jenny was seen by a social worker from the Older People's Mental Health Team the following working day, and a comprehensive and holistic Full Needs Assessment was completed. This took into account the circumstances of the admission into The Haven, along with other complex stressors in her life,

including considering both the difficulties and impact of the relationship. The social worker discussed the impact of previous coercive and controlling behaviours exhibited by her husband. Jenny said that she was not frightened to return home.

14.7 **Did your agency give sufficient consideration and weight to the risk of suicide in this case?**

14.7.1 In April 2019 when Jenny attended at Doncaster hospital having taken an overdose three days earlier, she left the hospital prior to treatment. This caused a high level of concern, and a number of actions were taken to trace her. She was found at home and agreed return to the hospital with ambulance service staff, where a full needs assessment and risk assessment were conducted by the mental health liaison team (RDasH).

14.7.2 RDaSH assessments completed on a face-to-face basis, considered the risk of self-harm / suicide. Actions were taken to mitigate the presenting risks and stressors, for example, admission to The Haven (July 2019).

14.7.3 After the April 2019 episode and Jenny's subsequent referral to Nottinghamshire Healthcare NHS Foundation Trust by a Nottinghamshire GP, there was a quick response to what was considered high risk. For example, after initial telephone contact, Jenny was seen at home by a community psychiatric nurse on 10 May 2019. However, when she left the area and returned home, it does not appear that the potential increase in risk was recognised – as a full risk assessment was not completed, and a full risk formulation was not shared with the GP.

14.7.4 During Jenny's admission to The Haven, full consideration of the risk of suicide was given. It was assessed that Jenny's increasing thoughts around suicide as a possible way out, had been increasing prior to admission. However, within hours of being admitted and being away from the domestic situation that was triggering suicidal ideation, she self-reported the following: 'I feel safe now … I have no intentions of taking my life …' (Safety Management Plan 27/07/2019).

14.7.5 When Jenny left The Haven and went to Sarah's home in London, there was a view taken by Adult Social Care that Jenny was being supported by her daughter, was away from the alleged perpetrator, and she was therefore safe at that time. No formal risk assessment was completed in relation to the risk

of suicide whilst being displaced from home and awaiting a Care Act assessment.

14.7.6 Jenny's Doncaster GPs clearly documented that a risk assessment for suicide had taken place in the majority of consultations regarding mental health. However, the last two consultations with GPs on 7 February 2020 and 13 February 2020, when Jenny complained of low mood and poor sleep, have no record regarding suicidal thoughts, and no risk assessment was recorded.

14.7.7 The police response to Jenny's death did not take into account the possibility that her death could be suicide. The panel noted that in July 2017, an electronic tag was placed on the police computer. This would highlight to the police operator, the risk of domestic abuse associated with the location and phone numbers, so that officers would be aware of the risks in the event of future calls.

The Vulnerability Knowledge and Practice Programme (VKPP) report – Domestic Homicides and Suspected Victim Suicides 2021 – 2022 Year 2 Report (December 2022) – contains the following recommendations, which are pertinent to this case.

Recommendation 14 [to the police]: We recommend that initial police enquiries in unexpected deaths or suspected victim suicides should: (1) record all persons present in the household at the time of the death; (2) record any known history of domestic abuse associated with the victim, address or persons present in the household at the time of the death; and (3) contact close associates and others who may have information material to a history of domestic abuse, including family, friends and neighbours. Any relevant information uncovered about domestic abuse could be included in the 'circumstances of death' section in the death report to Coroners.

Recommendation 15 [to the police]: When attending the scene of an unexpected death or suspected suicide, police must always apply professional curiosity and an investigative mindset to test the obvious explanation. Attending officers should be alert to any signs or disclosures of a history of domestic abuse, especially of coercive or controlling behaviour. Forces should develop mechanisms to check that learning is captured from key cases and that the College of Policing's guidelines for Recognising and Responding to Vulnerability-Related Risks (which focus on professional curiosity) are being implemented effectively.

Recommendation 16 [to the police]: When there is an unexpected death or suspected suicide, reasonable and prompt system checks should be made for any known history of domestic abuse crimes and non-crime incidents by appropriate officers or staff. Where possible, this should be done prior to the attending officer leaving the scene and/or within initial enquiries. Slower-time searches for domestic abuse history should then be conducted to inform the investigation, for instance on call-handling, intelligence, and public protection systems. Considering that domestic abuse is often not reported to police, these slower-time searches should also consult local partners who may have knowledge of an undisclosed history of domestic abuse, including domestic abuse services.

Recommendation 17 [to the police]: In line with forthcoming guidance from the College of Policing on unexpected deaths, a PIP 3 Senior Investigating Officer (SIO) (minimum detective inspector or police staff equivalent) should be appointed to provide oversight of all unexpected death investigations. This should include providing advice and direction to the officer in the case, reviewing investigations Domestic Homicides and Suspected Victim Suicides 2021-2022 121 and conclusions. Oversight review should consider any evidence of domestic abuse history.

Recommendation 18 [to the police]: We recommend that police officers should be made aware of the possibility of domestic abuse perpetrators attempting to manipulate the narrative and processes after a death, especially where they are next of kin.

The panel acknowledged that the VKPP report was published after Jenny's death but thought that the learning and recommendations bore a direct relation to Jenny's case.

DHR panel recommendation: That South Yorkshire Police provide the Community Safety Partnership with a presentation on how they have implemented the recommendations from the VKPP report.

14.8 What support is given to staff in your agency to recognise and assess the risk of suicide, including the inter-relationship between para-suicide and vulnerability to domestic abuse?

14.8.1 South Yorkshire Police

In 2012, The College of Policing was established as the professional body for everyone working for the police service in England and Wales. The purpose of

the college is to provide those working in policing with the skills and knowledge necessary to prevent crime, protect the public, and secure public trust. The college utilises the Managed Learning Environment (MLE), an online secure platform, which hosts the suite of learning products for policing.

There are five e-learning modules regarding recognising and managing suicide for officers' development and understanding. The course is not mandatory, but it is part of the recommended training options for officers to complete.

Gatekeeper training[18] is a concept that has been looked at in the UK, to better equip officers to recognise suicide and use interventions where possible. Marzano et al. (2018) alludes to the idea that training in suicide prevention appears to have been well received and to have had a beneficial impact on officers' attitudes, confidence, and knowledge. Further research is needed to assess its longer-term effects on police attitudes, skills, and interactions with suicidal individuals, and to establish its relative effectiveness in the context of multilevel interventions

In relation to the linkage between para-suicide and domestic abuse, all police and staff members are required to carry out the training regarding 'Public Protection – Initial Response'. This is the first module in the Public Protection Level 1 Core Learning program of e-learning. The module covers general awareness issues surrounding 13 core areas of public protection. It also covers information ranging from signs and indicators, risk identification and assessment, intervention, partner agencies, prevention, and police powers. This training is aimed at all operational police officers and police staff and is a prerequisite for further training in specialist public protection roles. The initial training is followed by an e-learning course in 'Public Protection – Abusive Relationships'. The e-learning course for Public Protection is delivered over five modules. This is a scenario module covering the following specific core areas of public protection: Domestic Abuse, Stalking and Harassment, Child Abuse. The course includes a scenario that covers general awareness of definitions, legislation, and positive action issues around public protection. The courses do not cover a specific section on para-suicide per se, but it covers trigger points for officers and staff to look for that indicate abuse within a relationship. The responsibility of undertaking these initial training programs and the subsequent follow-up training modules, is the responsibility of each officer and staff member to complete these. The action planning of

[18] Marzano, L., Smith, M., Long, M., Kisby, C., & Hawton, K. (2016). Police and suicide prevention: Evaluation of a training program

this continual development lays with the direct supervisor of the said SYP member and is managed through the PDR[19] process.

14.8.2 Rethink Mental Illness

Staff at The Haven are fully supported by the MH professionals from the local Access Team (RDaSH), who retain the clinical risk and oversight of their patients during their stay at The Haven. Comprehensive RDaSH assessments are received, which contain details and references to the current level of suicide risk.

Successful suicide prevention services use a combination of crisis centres, home visits, and emergency phone lines[20]. The Haven is not set up specifically as a specialist suicide prevention service, but it shares aspects of those services. Staff are trained in suicide prevention, mental health first aid, and how to deal with emotional crises. Home visits are undertaken by the relevant NHS mental health team. Also, Rethink runs a 24-hour helpline from The Haven, which is a freephone and confidential service.

Jenny's daughters say that she used the ReThink 24-hour helpline on a number of occasions. The helpline is a confidential service, and no records of calls are retained.

14.8.3 Yorkshire Ambulance Service

Yorkshire Ambulance Emergency call handlers and NHS 111 call handlers are trained in national ambulance call pathways, which enables them to identify the risk of suicide. Clinicians are able to further assess the risk. YAS and NHS 111 only provide short episodes of care, which do not allow the time to build a therapeutic and trusting relationship. Therefore, it is difficult to be able to explore the inter-relationship between para-suicide and vulnerability to domestic abuse.

14.8.4 Nottinghamshire Healthcare NHS Foundation Trust

All staff receive a full safeguarding update every three years. This update includes domestic abuse and the link between domestic abuse and increased

[19] Personal Development Review
[20] Joy Hibbins 'suicide prevention techniques 2018'

rates of suicide. However, this training has only included information specific to suicide since August 2020.

All staff are expected to undertake suicide awareness training every three years. This training focuses on understanding and assessing the risks of suicide. All staff also have access to specialist safeguarding practitioners who can offer specialist advice in relation to domestic abuse and risks associated.

14.8.5 **Rotherham Doncaster and South Humberside NHS Foundation Trust**

Staff within RDaSH receive training relating to risk, which is commensurate to the role that they undertake. Clinicians within the Access Team (including Hospital Liaison), have access to STORM training (Skills Training on Risk Management), which considers the risks of suicide, along with the exploration of existing support networks and crisis / contingency planning. The IAPT service is a primary care-based service, and if significant risk issues were to be identified during the course of a clinical contact, then the service-user would be referred through to either secondary mental health services or the Access Team. IAPT practitioners do receive training relating to risk assessment as an adjunct to their role, but this is not a requirement stipulated by IAPT's national team.

Mandatory training relating to clinical risk assessment is undertaken for all patient-facing staff in the Older People's Mental Health Team, which considers the risk of suicide (although not a specific suicide-risk assessment course). Informal training through team teaching sessions, also considers recognising and assessing suicide risks; however, there is no formal or specific training relating to suicide that is offered to OPMHS staff.

14.8.6 **Adult Social Care**

The response from Adult Social Care acknowledges that whilst some staff have received training in suicide risk and prevention, as well as domestic abuse, other staff have very limited knowledge in this area.

14.8.7 **Doncaster Clinical Commissioning Group**

All staff were given the opportunity to take part in training on www.zerosuicidealliance as part of World Suicide Prevention Day in 2019.

14.8.8 The panel recognised the significant efforts of some agencies in providing training for staff in this area but thought that more could be done across the partnership. The panel was made aware of a number of free training

resources available to all agencies across the health and social care sector: this information was provided by the panel member who is the lead for suicide prevention in Doncaster. For example: https://www.zerosuicidealliance.com/training

This is a multi-agency learning point. [Multi-agency learning 3].

14.8.9 **Doncaster Domestic Abuse Service**

In collaboration with the suicide prevention lead in Doncaster, staff from the Doncaster Domestic Abuse Service, Riverside (Commissioned service), Doncaster Children Young People and Families, and Aspire Drug and Alcohol service, attended suicide bereavement training in June 2021.

14.9 **Did colleagues consider the 'lived experience' of Jenny and David in this case? In particular, their economic and social circumstances, access to the support of family and friends, and the impact of racial, cultural, linguistic, faith, disability or other diversity issues, on their circumstances and their capacity to access support?**

14.9.1 Jenny's GP records document that her relationship with David was abusive but the complete picture could only be seen by going back through the records to 2006. Jenny tended to comment on the current state of abuse rather than the past abuse, which meant that individual doctors did not always have a complete story in consultations. The panel acknowledged that GPs have a limited amount of time to see patients and thought that more comprehensive 'flagging' of domestic abuse on systems may have helped.

14.9.2 David also told his GP that he had been badly affected by problems in his relationship with Jenny (in 2019) and was prescribed antidepressant medication as well as medication to help him sleep.

14.9.3 RDaSH practitioners who engaged with Jenny, did listen to her 'lived experience' and acknowledged the disempowerment that the experience of domestic abuse within her relationship had on her. Assessments undertaken were holistic and explored the impact that her relationship was having on her, particularly the impact on her mental health, which would in turn impact on elements of her day-to-day life such as going out or having contact with friends. A stark record of Jenny's 'lived experience' is provided within clinical records in April 2019, with these stating that she 'is the victim of domestic abuse from her husband. He verbally abuses her and has threatened to

damage her property. He has systematically destroyed her sense of self, confidence and access to people outside of their home'.

14.9.4 Jenny was living with Margaret during her contact with Nottinghamshire Healthcare NHS Foundation Trust. There is evidence within the record that Jenny was supported in managing this relationship. She was clear with workers that she did not feel ready to start accessing support around becoming more independent: she was fully supported in her choice regarding this. Nottinghamshire Healthcare NHS Foundation Trust practitioners were aware of Jenny's decreased mobility, and they adapted suggestions based on this.

14.9.5 Rethink staff utilise a Recovery Star methodology to determine 'lived experience' of all service users. The star has ten points: Managing Mental Health, Self-Care, Living Skills, Social Networks, Work, Relationships, Addictive Behaviour, Responsibilities, Identity & Self-Esteem, and Trust & Hope. During her stay with Rethink, staff recorded positive gains in managing mental health, self-care, and relationships. Scores in Identity & Self-Esteem and Trust & Hope diminished.

The ISSP paperwork also considers issues of diversity, as listed above, where they may present barriers to recovery or where they may positively impact strength-based support.

The NHS (RDaSH) assessments also consider, in detail, the 'lived experiences' of their patients.

Rethink certainly reflected upon Jenny's 'lived experience' during her stay at The Haven.

14.9.6 During Adult Social Care's interactions with Jenny, there was a mixed understanding of her 'lived experience'.

- The Wellbeing Team, which was in touch with Jenny from 14 June 2017 to 17 July 2017, completed an action plan that incorporated elements of Jenny's 'lived experience'.
- The Integrated Support and Assessment Team had a short period of telephone contact with Jenny prior to making a referral to Nottinghamshire Adult Social Care. There is no evidence that detailed information about Jenny's 'lived experience' was gathered during this period, or that information available from earlier records (Wellbeing Team) was checked.

- Safeguarding Adults Hub – 30 July 2019 to 8 August 2019. The allocated social worker visited Jenny. These contacts included an element of understanding Jenny's experience. Particularly, in relation to domestic abuse.
- Adult Social Care South Team. Having been passed the case for assessment, there was some initial contact with Jenny and her daughter, Sarah. However, as discussed in previous paragraphs, a full assessment that would normally be expected to take full account of Jenny's 'lived experience', did not take place.

14.9.7 There were a number of aspects of Jenny's life that meant that the situations facing her were quite complex. Her physical and mental health issues have been documented throughout the report. Her home life with David and the effect that his behaviour had on her, have also been discussed. However, other factors must have impacted on Jenny during the review period. For example:

- There were a number of incidents of threats and other concerns reported: these involved other family members and are not included in this review.
- A child of the family died suddenly.

14.9.8 Jenny also reported to some professionals that she was feeling under pressure from her family. They encouraged her to start divorce proceedings to end her marriage to David, although she was not ready to do so. On one occasion whilst staying briefly with another relative, Jenny was asked to leave following a disagreement.

14.9.9 There was a common understanding amongst agencies of the domestic abuse and medical issues facing Jenny. Other issues were not commonly understood and no one agency contributing to the review, had a full picture of Jenny's life and experiences. An effective care and support assessment (Care Act 2014) could have drawn all of that together.

14.10 Were colleagues aware of David's alleged abusive behaviour? If so, were steps taken to assess this or to refer to another agency for support to minimise this behaviour and potential harm?

14.10.1 During 2017, there were two reports to the police of abusive behaviour: one by David and the other by Jenny. On both reports, officers discussed with them the need to seek advice and support from external agencies such as

Relate[21] or family law / divorce solicitors. Jenny was also given the contact number for Victim Support[22]. Neither Jenny nor David welcomed referrals being made to appropriate agencies by the police, but they were open to being offered contact numbers for other agencies for self-referrals.

14.10.2 During her stay at The Haven, Jenny had initially listed David on her named visitors list. However, following a mental health appointment on 29 July 2019, which he attended, Jenny made it clear to staff that she did not want to see him again, and he was thereafter denied entry.

14.10.3 Most agencies contributing to the review, saw their role as supporting Jenny: they had little or no contact with David.

14.10.4 Both Jenny and David were registered at the same GP practice. In 2019, David sought help for his mental health, citing a breakdown in his relationship with Jenny as a cause. As patient records are separate and confidential, the link between the couple and potential domestic abuse was not recognised

14.10.5 A domestic abuse perpetrator education programme was available in Doncaster from 2014. An evaluation report[23] published in September 2017, shows that there were a total of 17 referral routes recorded on the programme. Major sources of referral included children's services, social services, South Yorkshire Police, Probation, and voluntary agencies. The majority of clients (45.6%) self-referred themselves to the service.

Had David been referred by any agency or encouraged to refer himself, then it is likely that a space on the programme would have been available. However, in light of David's denial that his behaviour was abusive, it is unlikely that he would have been accepted onto a programme – as participants need to acknowledge their abusive behaviour.

14.11 **How effectively did your agency communicate to Jenny, and those whom she authorised (e.g., her daughters), the outcomes of assessments and services offered?**

14.11.1 RDaSH records show that there was clear communication with Jenny regarding assessments, outcomes, and appointments. Records also indicate

[21] Charity providing relationship support throughout the UK. Services include counselling for couples, families, young people and individuals

[22] Independent charity dedicated to supporting victims of crime and traumatic incidents in England and Wales.

[23] https://www.sheffield.ac.uk/polopoly_fs/1.743694!/file/Final_Report_17-9-17.pdf

some conversations with Jenny's daughters, e.g., a conversation with Sarah about the safeguarding referral she made for Jenny.

14.11.2 When Jenny stayed with Margaret and her mental health care was with Nottinghamshire Healthcare NHS Foundation Trust in 2019, records evidence a good level of communication between staff, Jenny, and Margaret. Trust staff kept in touch during a brief visit to London and on Jenny's return to Doncaster, before referring back to Jenny's Doncaster GP.

14.11.2 Jenny's contact with Adult Social Care was across four separate teams.

Wellbeing Service: Jenny discussed health issues and home life, and she had already made contact with other agencies as required. The Wellbeing Service practitioner completed an action plan; the details of which were communicated with Jenny on the telephone. Jenny's family were not involved.

Integrated Support and Assessment Team: This team was involved after the first safeguarding concern in April 2019. Staff spoke to Jenny by telephone and then passed her case to Nottinghamshire Adult Social Care. Jenny did not give consent for her family to be involved on this occasion.

Safeguarding Adults Hub: The safeguarding social worker met Jenny and Sarah whilst Jenny was staying at The Haven. The social worker was in touch with both Jenny and Sarah to ask for consent for referrals to other agencies and to explain the process.

Adult Social Care South Team (area team): Once Jenny left Doncaster on 9 August 2019, there was limited contact with her and Sarah. Sarah called the team twice asking for information about housing assessments. A team leader called Sarah on 19 August to ask for an update on Jenny's situation. There was no further contact beyond this. Mangers accept that, on reflection, the team could have kept in touch with Jenny or Sarah regularly. This would have picked up the fact that Jenny left Sarah's home in September to return to Doncaster, which should have then generated further actions.

14.11.3 Whilst Jenny was staying in London, Sarah contacted St Leger Homes on her behalf and completed the necessary processes to register Jenny's need for housing. As described at paragraph 13.3.3, St Leger Homes accepted that they had a duty to help prevent Jenny from becoming homeless. On 16 October 2019, St Leger Homes contacted Jenny by phone, when it was established that she was living back in Doncaster with David and no longer required support. The housing application was withdrawn. Although Sarah had dealt with the initial application, she was not told that it had been

withdrawn. The panel heard that this was the correct process, at that time, as Jenny was not relying on Sarah for support and was able to deal with the matter independently.

14.12 **How effective was information sharing and co-operation in respect of Jenny and David? Was information shared with those agencies who needed it?**

14.12.1 There is evidence from agency records that information was shared by way of formal referrals and that detailed information was provided in order to inform assessments. What did not happen for the most part though was professionals speaking to each other or working together. For example, Nottinghamshire Healthcare NHS Foundation Trust did not liaise with agencies in Doncaster, beyond referrals and letters. The same position is reflected between agencies in Doncaster for most of the review period.

14.12.2 Whilst Jenny was staying at The Haven, agency records indicate that there were a number of conversations between agencies, primarily instigated by the safeguarding social worker. It is clear that all of the agencies involved, understood the nature of the domestic abuse issues that Jenny had reported and what the effects on her were.

14.12.3 After Sarah's contact with St Leger Homes on Jenny's behalf, St Leger Homes contacted Adult Social Care in order to gather information about Jenny's case. This information was shared appropriately.

14.12.4 Although there is evidence of formal information sharing through referrals and letters, some opportunities were either not considered or not explored. For example, although Jenny consistently reported domestic abuse, no agency contacted the police or asked the police for information.

14.12.5 There is no evidence that a multi-agency meeting was considered in order to discuss Jenny's case and develop a multi-agency action plan. Given the number of agencies involved, the DHR panel thought that this would have been appropriate and helpful. Adult Social Care (safeguarding) thought that a multi-agency meeting was unnecessary as Jenny's desired outcomes had been met. [see paragraph 14.12.7].

14.12.6 The Care Act guidance includes the principles of Making Safeguarding Personal (MSP), which involves asking the adult at risk what they would like to happen.

The aim of Making Safeguarding Personal is to:

- engage people throughout the process, with a focus on outcomes for the Adult at Risk
- make people feel safe
- make people feel empowered and in control
- an asset-based approach to help identify individuals' strengths and networks.

14.12.7 Jenny's desired outcomes from the safeguarding process were recorded as:

1. Independence back and did not want to return home to her husband.
2. To be referred for a Care Act assessment in order to be considered for supported living accommodation.
3. To stay with her daughter, Sarah, until some accommodation in Doncaster was found.

14.12.8 Jenny's desired outcomes were met, in part, on the basis of her being safe – when she left The Haven, she went to London to stay temporarily with Sarah. It was clear that this was only a temporary arrangement. There was no plan to keep Jenny safe beyond this and no plan for her safe return to Doncaster. Adult Social Care's future involvement relied on a care and support assessment requested by the safeguarding social worker; however, as discussed in previous paragraphs, this was never completed.

14.12.9 Several agencies knew that Jenny had returned to Doncaster to live with David. These included St Leger Homes, RDaSH, and Jenny's Doncaster GP. Although Jenny had returned to exactly the same situation that had prompted her stay at the The Haven and a safeguarding concern in July 2019, this did not prompt any agency to share information or make further checks on Jenny's safety. Adult Social Care, for example, was unaware that Jenny had returned to Doncaster until notified of her death.

14.13 **On the occasions that Jenny moved to her daughters' homes to escape domestic abuse, how effectively did your agency work with Jenny, her family, and other agencies to support her safe return to her home area?**

14.13.1 Nottinghamshire Healthcare NHS Foundation Trust knew that Jenny had moved back to Doncaster after her stay with Margaret in Nottinghamshire and a brief visit to London. Indeed, their staff kept in touch with Jenny

through that period. However, when she returned to Doncaster, a letter was written to her GP rather than a direct referral being made: this would have been good practice given the risks of self-harm and the loss of her identified protective factors. [Previously discussed at 14.5.3]. On her return, the nurse practitioner and GP saw her quickly for mental health symptoms and referred urgently to specialist mental health services.

14.13.2 As outlined at 14.12 – when Jenny left Doncaster for a second time in July 2019, for the sanctuary of Sarah's home in London – there was no effective plan for a safe return to Doncaster.

14.13.3 Sarah supported Jenny's contact with services in Doncaster, for example, with a housing application and contact with RDaSH. She remains angry and frustrated that supporting her mum at such a difficult time, felt extremely difficult. From Sarah's point of view, once Jenny had gone to London, services in Doncaster effectively "washed their hands" of her, despite it being made clear that it was only a temporary arrangement. Sarah feels that services in Doncaster were not interested in helping Jenny and that every contact with services "felt like a battle" to achieve anything.

14.14 Were single and multi-agency policies and procedures followed? Are those procedures understood by colleagues and embedded in practice?

14.14.1 South Yorkshire Police followed the established procedures that were relevant at the time of their contact with Jenny (save for not completing a DASH on one occasion).

Since 2018, instructions contained within the Mental Health Took Kit ensure all officers are trained in respect of the Vulnerability Assessment Framework (VAF), and when encountering a member of the public, they will follow the procedure to carry out a vulnerable people's assessment. In 2017, this process was not in place to guide an officer in considering the submission of a CID 70[24]. Therefore, those officers who attended Jenny and David's home, would not have had access to this tool kit.

The P-ABCDE guidance

P- Pre-encounter factors that shapes operational response and management of a person's mental health needs

[24] The Vulnerable Adult Form replaced by the vulnerable adult application.

A- Appearance of a person
B- Behaviour of a person
C- Communications, what are they saying, how it is said, does this give cause for concern?
D- Danger to self, person, or public
E- Environment, nature of situation and source of information available within it.

The CID 70 Vulnerable Adult form (The CID 70 has been replaced with the vulnerable adult application [App], which is completed and submitted on an officer's personal handheld device), contains a risk assessment, which is the trigger for additional safeguarding and protection via a multi-agency response, where appropriate. This may be needed when one or more of these risk factors are involved, in order to ensure the continued protection and care of the Adult at Risk. South Yorkshire Police have provided front-line officers with the information and tools required when encountering vulnerable members of the public. Normal practice would be that the App automatically emails a copy of the form to the relevant Child or Adult Social Care.

14.14.2 Nottinghamshire Healthcare NHS Foundation Trust's policy in relation to domestic violence and abuse, was not followed in this case. Nottinghamshire Healthcare NHS Foundation Trust practitioners did not follow the 'recognise, respond, refer, record' process set out in this policy. The risk of abuse was recognised, but there was no response to further assess the risk, referral or liaison with appropriate agencies was not carried out, and the recording of disclosures was limited. This policy has been in place for a number of years and is well utilised within the Trust.

There is no policy within the Trust that relates directly to transfer of outpatients to geographical area, but accepted practice is to complete a transfer of care to the local mental health team. This was not done in this case.

14.14.3 There is little evidence to show that RDaSH staff explored Jenny's disclosures of domestic abuse within the context of safeguarding. Domestic abuse is a domain of abuse within the Care Act 2014, and safeguarding statutory guidance provided by the Act, indicates that individuals have the right to live safely – free from abuse or neglect. However, in 2019 when Jenny was receiving input at The Haven from RDaSH, there was evidence of good communication and liaison with appropriate services surrounding domestic abuse. Further support, guidance, and supervision could have been sought from the safeguarding team within RDaSH – around the development of

safeguarding protection plans and the consideration of Trust staff submitting a safeguarding concern.

RDaSH has a robust clinical policy relating to domestic abuse. This was ratified in August 2019 and is due to be reviewed in 2022. This is a comprehensive policy that is accessible to all staff within the organisation. The policy provides clinicians and practitioners, in each and every setting, a guide / framework by which they can engage with individuals who are experiencing domestic abuse or violence – or where there may be instances of domestic abuse or violence.

RDaSH has recently updated its safeguarding adults and children's policy and combined this into a safeguarding manual. This is also accessible to all staff across the organisation and has comprehensive hyperlink to relevant multi-agency policies and procedures, depending upon the local authority.

14.14.4 During interactions with Jenny, Adult Social Care followed established procedures across the four teams involved. The Adult Social Care South Team (area team) adhered to the Care Act 2014 statutory guidance, locally agreed practice standards, and the Strengths Based Risk Taking (Policy for adult social staff). Jenny was assessed as high risk, and information, advice, and signposting was provided regarding alternative options that could be considered whilst waiting for a Care Act assessment (for example, contacting private sector landlords). When Jenny returned from London to live in the family home with David, this clearly increased the risks; however, as outlined earlier in the report, the move was not known to Adult Social Care.

14.14.5 Health professionals did not complete any DASH risk assessments despite that option being open to them. The panel was told that GPs are not expected to complete a DASH risk assessment due to their limited appointment times but that they should make appropriate referrals.

14.14.6 Adult Social Care did not use the DASH risk assessment despite Jenny's case being very clearly one of domestic abuse. In the absence of a risk assessment, it is difficult to understand the level of risk that a professional is dealing with and therefore formulate a plan to deal with it. This is a learning point for Adult Social Care.

14.15 **Are there examples of innovation and service improvement in your agency that may warrant wider implementation, or examples of exceptional individual practice that contribute to professional**

excellence?

14.15.1 The panel did not identify such innovation and service improvement. However, the panel did recognise the care and support provided to Jenny by the Nottinghamshire and London GPs and Nottinghamshire Healthcare NHS Foundation Trust. There were examples of good practice in providing access to services when a client unexpectedly moves areas.

14.15.2 Adult Social Care has recognised that regular contact with people on the waiting list for a Care Act assessment, has the potential for better informing risk assessments. Whilst this did not happen in Jenny's case, it has now been acted upon and regular contact is made.

14.16 **As a result of completing this Independent Management Review, what learning has been identified for your agency? Please make recommendations in relation to professional practice, agency procedures, management oversight, or other organisational systems, as informed by identified learning.**

Note. All single agency recommendations are contained within the Action Plan at Appendix A.

14.16.1 **South Yorkshire Police**

The police officers who attended the initial report of Jenny's sudden death, followed the correct 'Non-suspicious Sudden Death Protocols', set out by the district they were policing. However, when told by David that Jenny had previously tried to take her own life, other options could have been considered, including contacting a supervisor or CID for advice and calling a crime scene investigator. This would have ensured that all relevant evidence was recovered.

In response to this, a briefing note has been prepared and circulated (force-wide) to response teams: highlighting and reminding officers that on attending a sudden death, it is imperative that they keep an 'open mind'; assess all available information; and use 'professional curiosity' in order to secure and preserve any evidence available. This should ensure that anything pertinent is secured at the time.

14.16.2 **Adult Social Care**

The social worker in February 2020, could have sought advice from the Domestic Abuse Service or mental health worker, to identify an appropriate

approach to contacting Jenny – given that she was not contactable by telephone and knowing that she was back in a vulnerable situation.

14.16.3 **Nottinghamshire Healthcare NHS Foundation Trust**

Since the time frame under review, the Trust's domestic abuse training now contains specific detail and awareness raising about domestic abuse and the risk of associated suicide. The Trust's approach to domestic abuse training is broad and aims to give practitioners an understanding of the heterogeneity of domestic abuse, including the prevalence among older age groups. It is important, therefore, that this is emphasised in all training.

14.16.4 **RDaSH**

Within the clinical records, there are multiple references to Jenny experiencing abuse from her husband. Whilst she was mostly provided with information regarding self-help / self-referrals, there is little evidence to suggest that she acted upon this. The local authority fed back that she was not subject to a MARAC (Multi-Agency Risk Assessment Conference). Had a DASH risk assessment been completed with her, this may well have informed practitioners regarding pathways into formal safeguarding processes, such as a MARAC.

It is clear that clinicians identified the reports and impact of domestic abuse and captured the 'lived experiences' of Jenny, within clinical records. However, there is a requirement for all clinicians and practitioners, across the organisation, to be reminded that domestic abuse is classed as a domain of abuse under the Care Act 2014, and thus should be considered within the context of safeguarding. Whether it remains for the case to continue to be managed within a safeguarding arena is dependent upon the specifics of that case.

Domestic abuse, and the 'lived experience' of domestic abuse, is often complex and multi-faceted. It requires objectivity, and in highly complex cases, the support from safeguarding professionals within the organisation. There is no evidence that members of any clinical team sought safeguarding advice from the Trust's own safeguarding team. A further notification will be sent to all staff as a reminder of the need to access appropriate supervision and support when engaging with these situations.

14.16.5 **Rethink Mental Illness**

Staff undertake comprehensive safeguarding training with both Rethink and the local authority, but there was no specific course on domestic abuse. This has now been addressed and therefore does not lead to a recommendation.

14.16.6 **Clinical Commissioning Group**

Improving Record Keeping in Primary Care, related to domestic abuse.

Primary Care Training to raise awareness of domestic abuse presentation and response. Planned for May 2021.

Consider suicide awareness training if not covered for all of Doncaster in 2019.

Developing a Doncaster Domestic Abuse Protocol and Guidance for Primary Care.

15 Conclusions

15.1 Jenny and David were married in 2003, with David moving into Jenny's home in Doncaster. Her family say that there were many domestic abuse incidents: the vast majority of which were never reported to the police although Jenny did contact the police a number of times between 2006 – 2009.

15.2 The review focusses on the period from January 2017 onwards. Jenny told professionals, on many occasions, that she was experiencing domestic abuse from David. On most occasions, she said that the abuse was emotional but there was one occasion, in 2017, when she disclosed physical abuse to her GP.

15.3 The DHR panel was mindful of information from Jenny's family that David may have had a controlling influence on Jenny and recognised that many domestic abuse incidents are never reported. One report, for example, states:

'On average victims experience 50 incidents of abuse before getting effective help'[25]

15.4 Throughout this period, it is thought that Jenny was receiving help and advice, in relation to domestic abuse, from Doncaster Women's Aid. Unfortunately, this organisation no longer exists, and it has not been possible to access records of the specialist help that Jenny may have received.

15.5 Although there was only one report of domestic abuse to the police during the timeframe of the review, Jenny disclosed domestic abuse to medical professionals on many occasions. None of these disclosures resulted in a domestic abuse risk assessment being conducted, even though the DASH risk assessment is available to many medical professionals.

15.6 Jenny sought respite on occasions by spending time at her daughters' homes: they both lived separately away from Doncaster. This was the case on two occasions in 2019.

15.7 On the first occasion, Jenny stayed in Nottinghamshire where she received good support from local mental health services before moving back to live with David.

[25] SafeLives (2015), Insights Idva National Dataset 2013-14. Bristol: SafeLives

15.8 In July 2019, after moving back to Doncaster, Jenny suffered a mental health crisis and was admitted to The Haven (a facility providing short-term accommodation and support for people in crisis).

15.9 A safeguarding enquiry (Section 42 Care Act 2014) took place whilst Jenny was in The Haven. This was concluded as Jenny's desired outcomes were met. These were:

1. Independence back and did not want to return home to her husband.
2. To be referred for a Care Act assessment in order to be considered for supported living accommodation.
3. To stay with her daughter, Sarah, until some accommodation in Doncaster was found.

15.10 Jenny moved to London to stay with Sarah. There was no plan put in place for her safe return to Doncaster and although her family tried to help, there was little progress made in trying to find alternative accommodation in Doncaster. Jenny left London suddenly in September 2019 and returned home. David picked her up from the railway station, and they went back to living together. The hoped-for Care Act assessment was never completed; Jenny's case having been placed on a waiting list.

15.11 Jenny died in February 2020, and her death was initially treated as a routine matter until a note was found by a mortuary assistant some days later. This meant that Jenny's bedroom, where she was found, was not searched by the police and medication and her diaries were not recovered for examination. Her daughters say that Jenny's diaries contained comprehensive information about her life and the abuse that she endured.

15.12 For his part, David denies any abuse. He told the Chair of the review that Jenny would not have come back home if he had been abusive.

15.13 The Review Panel has identified a number of areas of learning and recommendations, which are set out in the following paragraphs.

16 LEARNING

This learning arises following debate within the DHR panel.

16.1 Narrative

Jenny disclosed emotional and economic abuse to a range of professionals; however, she said that there was no physical abuse. The behaviours that Jenny complained of amounted to coercive control. This did not result in professionals completing a DASH risk assessment or referring the issues to the police.

Learning

Professionals may have been wrongly diverted from conducting appropriate risk assessments by the absence of physical abuse.

Panel recommendation 1

16.2 Narrative

The link between domestic abuse and suicide is not well known or understood amongst professionals.

Learning

Knowledge of the link between domestic abuse and suicide will enable professionals to formulate appropriate risk assessments and risk management plans.

Panel Recommendation 2

16.3 Narrative

Training for staff on suicide prevention is inconsistent across the partnership.

Learning

The availability of free training resources to agencies should enable them to provide information and advice to staff on suicide prevention.

Panel Recommendation 3

17 Recommendations

DHR Panel

17.1 All agencies involved in the review should provide Doncaster Community Safety Partnership with evidence of the training provided to staff in recognising and acting upon coercive and controlling behaviour.

17.2 All agencies involved in the review should provide Doncaster Community Safety Partnership with evidence that information has been provided to staff on the links between domestic abuse and suicide.

17.3 All agencies involved in the review should provide Doncaster Community Safety Partnership with evidence of the training and information provided to staff on suicide prevention.

17.4 South Yorkshire Police should provide the Community Safety Partnership with a presentation outlining their implementation of recommendations 14 – 18 of the Vulnerability Knowledge and Practice Programme (VKPP) report – Domestic Homicides and Suspected Victim Suicides 2021 – 2022 Year 2 Report (December 2022).

17.5 The learning from this review should be shared with Doncaster Safeguarding Adult Board.

Appendix A Action Plan – Jenny DHR Doncaster Community Safety Partnership

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
1	All agencies involved in the review should provide Doncaster Community Safety Partnership with evidence of the training provided to staff in recognising and acting upon coercive and controlling behaviour.	Local	Coercive Control Training is part of the DA Training Offer from City of Doncaster for multiagency attendance. The training schedule is promoted through the Safer Stronger Doncaster Partnership, DA and SA Theme Group, MARAC Steering group and DA Newsletter and DA Champions network.	City of Doncaster Council	Coercive and Controlling Behaviour. Is part of the package of DA training delivered by City Of Doncaster Council Workforce Development Officer. It is delivered via Microsoft Teams. Available to the multi agency workforce of Doncaster and Rotherham. Police officers and staff and Domestic Abuse Service staff and some Childrens Social Care staff have been trained in "DA Matters". "DA Matters" features Coercive Controlling behaviour throughout. St Leger Homes; as part of the DAHA accreditation deliver DA awareness training to all staff. The % that have completed this training is 98.9%. Doncaster Bassetlaw Teaching Hospitals Trust. Trust Level 2 (joint adult and children's) and Level 3 Children's Safeguarding	October 2020.	October 2020. The training is provided on a regular basis in an annual timetable for a multiagency audience. Detail of attendees is held by the Workforce Development Officer and Buy Doncaster. Doncaster Bassetlaw Teaching Hospitals have 2 dedicated commissioned domestic abuse liaison officers, providing support to DBTH colleagues.

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
					training covers domestic abuse and coercive control as part of the wider safeguarding topics. In addition, the domestic abuse champion training covers this in detail. Safeguarding Huddles provide further opportunities for targeted discussions across emergency department, paediatric areas, and targeted adult areas. **RDaSH have a Domestic abuse training package that covers coercive and controlling behaviour including identification and response. The package is attached for reference and includes case study examples, and video clips to further emphasise the impact of these behaviours. The Domestic abuse act 2021 and previous learning/recommendations from other DHR's were used as the foundation for all**		They provide bespoke training around the subject of domestic abuse across Trust areas which includes recognising and acting upon coercive and controlling behaviour. Coercive Control is also included in the Safeguarding Adults and Children level 2 statutory training for DBTH staff.

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
					information contained within the training. Domestic Abuse training package new		
2	All agencies involved in the review should provide Doncaster Community Safety Partnership with evidence that information has been provided to staff on the links between domestic abuse and suicide.	Local	The links between domestic abuse and suicide is part of the DA Training Offer from City of Doncaster for multiagency attendance. The training schedule is promoted through the Safer Stronger Doncaster Partnership, DA and SA Theme Group, MARAC Steering group and DA Newsletter and DA Champions	City of Doncaster Council	In collaboration with Public Health Colleagues the Workforce Development Officer has included suicide awareness in the training which does include links to DA. Public Health promote the link New-Suicide-Report2c-Refuge-and-University-of-Warwick.pdf (nspa.org.uk) and the training link that I encourage everyone to do is www.zerosuicidealliance.com/training DWP Data sharing relating to suicides now in place so we can identify further themes and learning opportunities	December 2023	The training has been provided on a regular basis in an annual timetable for a multiagency audience. Detail of attendees is held by the Workforce Development Officer and Buy Doncaster. May 2024

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
			network. Domestic Abuse Awareness training includes this information and also provides the link to the Zero Suicide Alliance Free training.		YAS Evidence for DHR 02 2020.docx A Homicide and Suicide Timeline training webinar, delivered by Professor Jane Monkton Smith is being commissioned by City of Doncaster Council and the other local authorities in South Yorkshire for multiagency participation. The provisional date for delivery is 14th October 2024. Completed October 2024. This training is promoted via the monthly DA Champions network newsletter, The DA and SA Theme Group, MARAC Steering Group and DA Strategic Board. DA Champions is a multi agency	October 2024	14th October 2024. Training delivered via a webinar to 460 + delegates. Doncaster DA DASH (Domestic Abuse Stalking

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
					Network across Doncaster, members of the network have completed DA Awareness training provided by the Local Authority. Articles/links are attached. Doncaster and Bassetlaw Teaching Hospitals Trust. The link between DA and suicide is highlighted in above training, however following the https://nspa.org.uk/wp-content/uploads/2021/04/New-Suicide-Report2c-Refuge-and-University-of-Warwick.pdf report the DA liaison officers are reviewing this report content with a view to making further amends to training content. The links between domestic abuse and suicide has been included as information in		and Harassment) and MARAC (Multi Agency Risk Assessment Conference) training includes links between DA and Suicide. The DASH document has three questions about suicide and suicidal ideation by the victim and the alleged perpetrator. Currently there are over 400 domestic abuse champions within DBTH . Champions have access to 6 weekly updates and are

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
					articles and with links to other sources within the Doncaster DA Champions Network news letter in September 2021, October 2021, December 2021, September 2022, December 2022, January 2023, March 2023, May 2023, July 2023, August 2023, September 2023, November 2023, January 2024 and April 2024.  DA and SA Newsletters DA and s The links between domestic abuse and suicide will continue to be regular subject matter in future editions. **In the RDASH training package clear examples of**		provided with resources and links to external Local authority training which includes links between domestic abuse and suicide.

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
					real cases associated with suicide attempts and completion are covered. Highlighting that a patient presenting with suicidal plan, intent, ideation could be subject to domestic abuse including honour-based abuse. A DHR example is used in the training to discuss further the consideration of suicide being associated with domestic abuse.		
3	All agencies involved in the review should provide Doncaster Community Safety Partnership with evidence of the training and information	Local	This forms part of the domestic abuse training Offer from City of Doncaster for multiagency	City of Doncaster Council	Public Health promote the link New-Suicide-Report2c-Refuge-and-University-of-Warwick.pdf (nspa.org.uk) and the training link that I	December 2023	The training is provided on a regular basis in an annual timetable for a multiagency

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
	provided to staff on suicide prevention.		attendance. The training schedule is promoted through the Safer Stronger Doncaster Partnership, DA and SA Theme Group, MARAC Steering group and DA Newsletter and DA Champions network. Domestic Abuse Awareness training includes this information and also provides the link to the Zero Suicide Alliance Free training.		encourage everyone to do is www.zerosuicidealliance.com/training This training is promoted via the monthly DA Champions network newsletter, The DA and SA Theme Group, MARAC Steering Group and DA Strategic Board. • DWP has a complex needs toolkit containing links to local organisations who can help and provide appropriate support to those who require it. • Comprehensive guidance is available for officials on how to support customers who discuss or imply that they intend to harm themselves. When a threat of self-harm is identified, staff follow a six-point plan that helps them take the appropriate action;		audience. Detail of attendees is held by the Workforce Development Officer and Buy Doncaster. May 2024

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
					this could include alerting the emergency services where appropriate. A Domestic Abuse Homicide and Suicide Timeline training webinar, delivered by Professor Jane Monkton Smith was commissioned by City of Doncaster Council and the other local authorities in South Yorkshire, plus South Yorkshire Police, for multiagency participation. The Training was delivered on 14th October 2024. Attached link to the 'Preventing Domestic Abuse Related Homicides and Suicides' document by Professor Jane Monckton-Smith. 11360-Monckton-Smith-(2022)-Preventing-domestice-abuse-related-homicides-report.pdf (glos.ac.uk) For further	October 2024	Completed on 14th October 2024. Over 460 people from multiple agencies received the training via a webinar. October 2024.

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
					information on the training providers, or to contact directly, please follow the link below: Home | Homicide Timeline City of Doncaster Council has commissioned 50 licences for Multi Agency Staff to subscribe to Professor Monkton Smiths DA Homicide and Suicide training package. The training is available to multi Agency staff within the Community Safety Partnership. Information on the suicide support service, Amparo and suicide awareness training available: Has been shared across the Community Safety Partnership by the Doncaster DA Service.		October 2024 October 2024

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
					• Amparo confidential service that offers support to **anyone affected by suicide**. If you are a professional who wants to learn more about Amparo service and the support they offer, then book onto one of the FREE briefing sessions here. • ZSA Training -Suicide Awareness FREE online courses that teaches you the skills and confidence to have a potentially life-saving conversation with someone you are worried about. • South Yorkshire is a free and The Doncaster Suicide Surveillance Panel has multiagency representation.		

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
					Yorkshire Ambulance Service front-line staff are required to complete Level 2 Mental Health Awareness Training delivered in person by the YAS academy. Part of this session looks at suicidal thoughts but is generally more about mental well being and how to look after ourselves including staff, not just patient specific. It covers services available that can support when a person is feeling suicidal. YAS are currently providing a full day in person training 'Responding to Suicide Training' provided by Suicide Bereavement UK. The Safeguarding Team are all booked to attend this. Doncaster and Bassetlaw Teaching Hospitals Trust. There is currently an item that is being explored on our vulnerable		

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
					patients steering group to consider what actions are required. However we have Mental health crisis workers support and refer in for mental health assessment for emerging concerns and risk assessment. **RDaSH have clinical risk training where the assessment of all risks, including suicide is explored. Although RDaSH don't currently have a specific suicide prevention or awareness training. This is a recognised area of development for RDaSH and is currently being reviewed for future implementation.**		
4	South Yorkshire Police should provide the Community Safety Partnership with a presentation outlining their implementation of recommendations 14 – 18 of	Local	South Yorkshire Police are in the process of collating a presentation to outline how as a force we achieve		Preparation of this presentation is currently underway and will be shared with the Partnership when complete.	April 2023 Completed.	Recommendation 4 VKPP Action.pdf

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
	the Vulnerability Knowledge and Practice Programme (VKPP) report – Domestic Homicides and Suspected Victim Suicides 2021 – 2022 Year 2 Report (December 2022).		recommendations 14 – 18 of the VKPP report. It is noted that some of these recommendations outline processes that we already follow as a force.				
5	The learning from this review should be shared with Doncaster Safeguarding Adult Board.	Local		Safeguarding Adults.	Sent to the Doncaster Safeguarding Adults Board for sharing with the membership.	June 2023	31st May 2023 Information shared for dissemination.

Agency – Doncaster Domestic Abuse Caseworker Service							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
1	Domestic Abuse Case closure information should be shared with referring agencies, with consent from the client.	Local	Embed in practice.	Doncaster Domestic Abuse Caseworker service.	Staff to undertake relevant action in these circumstances.	January 2021	Adopted as standard practice. January 2021

Agency – Doncaster Domestic Abuse Caseworker Service							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
2	Withdrawal of consent to support by clients, should be communicated to the referring agencies.	Local	Embed in practice.	Doncaster Domestic Abuse Caseworker service.	Staff to undertake relevant action in these circumstances.	January 2021	Adopted as standard practice. January 2021

Agency – Doncaster Adult Social Care							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
1	To ensure all staff in Adult Social Care have received domestic abuse training, including risk assessment, within the past 3 years.	Local	To establish a programme of training and awareness sessions.	ASC	An establish programme of training has been developed with some examples below: - Basic awareness - DASH and MARAC - Stalking and Harassment - Coercive and Controlling Behaviour	December 2023	January 2022. All staff access DA Training Programmes provided by The City of Doncaster Council Workforce Development Officer.

Agency – Doncaster Adult Social Care							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
					- Supporting Older Victims of domestic abuse and those with care and support needs. Domestic Abuse Strategy- Multi-agency domestic abuse champions network – with a member of each locality team attending and feeding back to their teams.		
2	To ensure all people waiting for Care Act assessments are contacted on a regular basis to inform risk assessment.	Local	Each locality team RAG rate all incoming referrals using their priority tool. Red – high priority, Amber – medium risk, Green – low risk.	ASC	This was introduced as part of managing service demand during COVID and remains in place. Each team's desktop management & risk assessments are overseen by the team leader or advanced practitioner. Face-to-face contact – facilitated by locality team social care worker (frequency depending on needs & risks) • Telephone check in – tasked to communities	April 2023	The RAG rated system remains in place. We are expanding our locality approach to maintaining individual's safety and wellbeing. Individuals supported by the Adult Social Care locality teams are vulnerable due

Agency – Doncaster Adult Social Care							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
					(frequency depending on needs & risk) • Door drop – facilitation of door drop of essential items where there are no other support networks available.		to numerous factors, including fragility, physical disabilities, dementia, and multiple core morbidities. The following systematic approach will be utilised to identify the support that individuals required during the pandemic and remains in place. Each individual will be given a RAG rating to identify the nature and frequency of contact that services will provide.

Agency – Doncaster Adult Social Care							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
3	To share the lessons learnt from this DHR with Adult Social Care staff, to highlight any missed opportunities.	Local	To discuss with senior managers, to agree best method of sharing such actions. Confirm what is required and why. Including 1-1s, PDRs and/or practice forums / awareness and open discussion or formal training.	ASC	Lessons learnt shared for dissemination across the workforce.	June 2023	31st May 2023. Lessons learnt shared for dissemination across the workforce.

Agency – Rethink Mental Illness (Provider Doncaster Crisis House – The Haven)							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
1	Haven staff to undertake domestic abuse training.	Local	Discussion with Rethink's L&D department around provider.	Rethink	All staff to have domestic abuse training recorded as complete on the Training Matrix.	Jan 2021	**2021** Domestic abuse training was rolled out in 2021 and is completed by all staff as an integral part of safeguarding knowledge and awareness. This training became mandatory in English care homes from April 2021 and supports compliance with Regulation 13 'Safeguarding service users'. Suicide training was improved and rolled out – also early 2021. This made clear the correlation between

Agency – Rethink Mental Illness (Provider Doncaster Crisis House – The Haven)							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
							coercive controlling behaviour and suicide. This is a mandatory course for all workers.

Agency – Rotherham Doncaster & South Humber NHS Foundation Trust							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
1	Where an individual is in receipt of secondary mental health services and moves to an area outside of the Trust boundaries, they should be referred to local services by the original Trust	Local	All staff to be reminded regarding this practice.	RDaSH	Discussion at Care Group Quality meetings	Nov 2021	10.11.2021

Agency – Rotherham Doncaster & South Humber NHS Foundation Trust							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
2	All staff are to be reminded of the domains of abuse which may be experienced in domestic abuse (i.e. psychological).	Local	RDaSH Safeguarding Team to produce a 7 minute briefing relating to the experiences of domestic abuse.	RDaSH	Discussion at Care Group Quality meetings	Nov 2021	10.1  Domestic Abuse - 7 Minute Briefing LB.ppt
3	Explicit dialogue within the 7 minute briefing relating to the links between domestic abuse and suicide should be evident.	Local	As above.	RDaSH	Actions documented above.	Nov 2021	10.11.2021
4	Where there are explicit threats or statements made in relation to the encouragement or assisting of a suicide, advice	Local	As above. Inclusion in 7-minute briefing.	RDaSH	Actions documented above.	Dec 2021	10.11.2021

Agency – Rotherham Doncaster & South Humber NHS Foundation Trust							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
	should be sought from the Safeguarding Team.						
5	Recognition of domestic abuse and then subsequent actions to take / referral onto appropriate services or agencies.	Local	All RDaSH staff are to be reminded of the need to consider onward referral when domestic abuse is identified.	RDaSH	This will be considered within the 7 minute briefing that is to be developed. The briefing will also consider other risk assessing tools, such as the DASH risk assessment, that should be utilised.	Dec 2021	10.11.2021 DASH included in L3 Safeguarding Training Promoting staff to ask the question regarding relationships as part of full assessment.
6	All staff will be reminded of the need to consider domestic abuse within the context of safeguarding, including seeking guidance from the Safeguarding Team and utilising protection planning.	Local	All Trust staff will be reminded of the presence of the Domestic Abuse policy (although will be reviewed in line with the Domestic Abuse Bill). All Trust staff are	RDaSH	Inclusion within the 7-minute briefing.	Dec 2021	10/11/2021 Domestic Abuse Policy has been reviewed and ratified in July 2022

Agency – Rotherham Doncaster & South Humber NHS Foundation Trust							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
			to attend mandatory safeguarding / domestic abuse training commensurate to their individual role.				

Agency – NHS South Yorkshire ICB (Doncaster)							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
1	Training for primary care staff to include learning from previous DHRs.	Local		ICB	This was delivered at the Primary Care training Sessions last year. There were two held, with attendance approximately of around 120 staff. The sessions covered the recent DHR's plus some reference to previous cases. Included was discussion regarding processes.	May 2021	12th and 26th May 2021.

Agency – NHS South Yorkshire ICB (Doncaster)							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
					Additionally, the Health Safeguarding Lead also attended to cover the process when the safeguarding elements to concerns.		
2	Review of provision and uptake of suicide awareness training for primary care staff.	Local		ICB	Public Health promote the link New-Suicide-Report2c-Refuge-and-University-of-Warwick.pdf (nspa.org.uk) and the training link that I encourage everyone to do is www.zerosuicidealliance.com/training Information received 28th October 2024. • The practice use an e-learning platform for suicide prevention – this continues to be promoted and accessed.	December 2023	

Agency – NHS South Yorkshire ICB (Doncaster)							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
					• Public Health has provided information from a public health perspective around suicide prevention across the system • Public Health will be attending Target to promote the group training offer that she can deliver (suicide safer community project) • Public Health to provide the ICB with some dialogue around Suicide Prevention for inclusion in upcoming ICB newsletters that goes out to primary care. Update received 26th November 2024.	October 2024. Date to be arranged	October 2024 Newsletter information to raise awareness of the training, encourage staff to use as good practice and as a refresher around the prevention of suicide.

Agency – NHS South Yorkshire ICB (Doncaster)							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
					suicide awareness training is being done through www.zerosuicidealliance.com and all staff must carry out the training.		
3	Developing Domestic Abuse Guidance for Doncaster primary care staff.	Local		ICB	This was delivered at the Primary Care training Sessions last year. There were two held, with attendance approximately of around 120 staff. The sessions covered the recent DHR's plus some reference to previous cases. Included was discussion regarding processes. Additionally, the Health Safeguarding Lead also attended to cover the process when the safeguarding elements to concerns.	May 2021.	12th and 26th May 2021.

Agency – Yorkshire Ambulance Service							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
1	Review the referral process for domestic abuse and scope the potential to use the Domestic Abuse, Stalking, Harassment and Honour-Based Violence (DASH) risk assessment tool to drive quality practice and provide a referral mechanism to the Multi-agency Risk Assessment Conference (MARAC) process.	Regional (in that YAS covers the whole of Yorkshire)		Yorkshire Ambulance Service (YAS)	The business case for a specialist Domestic Abuse worker has progressed through Gate 2 of YAS's internal process and has been presented to the Trust Management Group. Funding was approved job. The description is awaiting approval and grading at YAS's job matching panel (likely to be May 2023). The business case for a specialist Domestic Abuse worker has progressed through Gate 2 of YAS's internal process and has been presented to the Trust Management Group. Funding was approved job. The description is awaiting approval and grading at	End of the 23/24 financial year.	

Agency – Yorkshire Ambulance Service							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
					YAS's job matching panel (likely to be May 2023). UPDATE FEB 24: The Specialist Domestic Abuse Practitioner (SDAP) was appointed and joined the YAS Safeguarding Team September 23. The SDAP is currently scoping the use of the DASH risk assessment within YAS and how this can be implemented. This is being reviewed alongside the Health Pathfinder guidance from Standing Together. Since being in post, the SDAP has been able to review some of our DA related call outs, which has resulted in a referral being made to Doncaster MARAC (Feb 24) after paramedic's identified a female as high risk of serious domestic abuse and homicide. The referral process in relation to domestic abuse has been reviewed. This has been strengthened as outlined		

Agency – Yorkshire Ambulance Service							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
					below as it is included in our training and readily available on the domestic abuse intranet page for all staff to view. It has also been included in our draft Domestic Abuse Policy.		
2	Develop training and learning material to support staff around recognition of, and response to, domestic abuse and the referral options, to improve staff knowledge and confidence in supporting victims.	Regional (in that YAS covers the whole of Yorkshire)	Identify key staff for first wave of Level 3 Safeguarding training. Identify appropriate external training offers from multi-agency partners and funding/com	Yorkshire Ambulance Service (YAS)	480 - Key staff identified and captured in the 2022-2023 training needs analysis and plan. ESR online modules to be reviewed and adapted jointly by safeguarding and YAS academy. 000 North: Domestic Violence Basic Awareness Level 1, 000 North: Domestic Violence and Abuse Level 2 being considered and final agreed content to be	End of the 23/24 financial year.	Completed April 2025.

Agency – Yorkshire Ambulance Service							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
			missioning implications.		live against identified job roles April / May 2023. All frontline smart phones have been installed with the Bright Sky App – which provides practical support and information on how to respond to domestic abuse. This app has been in use since the end of 2021 262 members of YAS staff are now compliant at level 3 safeguarding (March 2023). This figure is recorded on the Trust's ESR portal and marks a compliance of 52.4%. The remaining 238 have been provided with the relevant details to complete the		

Agency – Yorkshire Ambulance Service							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
					training over the next year. Internal communications used to publicise work on domestic abuse and key messages via weekly staff update and social media channels with a reach of 2000 employees per day – see attached document for examples. 480 - Key staff identified and captured in the 2022-2023 training needs analysis and plan. ESR online modules to be reviewed and adapted jointly by safeguarding and YAS academy. 000 North: Domestic Violence Basic Awareness Level 1, 000 North: Domestic		

Agency – Yorkshire Ambulance Service							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
					Violence and Abuse Level 2 being considered and final agreed content to be live against identified job roles April / May 2023. All frontline smart phones have been installed with the Bright Sky App – which provides practical support and information on how to respond to domestic abuse. This app has been in use since the end of 2021 262 members of YAS staff are now compliant at level 3 safeguarding (March 2023). This figure is recorded on the Trust's ESR portal and marks a compliance of 52.4%. The remaining 238 have been		

Agency – Yorkshire Ambulance Service							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
					provided with the relevant details to complete the training over the next year. Internal communications used to publicise work on domestic abuse and key messages via weekly staff update and social media channels with a reach of 2000 employees per day – see attached document for examples. UPDATE Feb 24: YAS has now developed, approved, and launched Domestic Abuse E Learning. This is currently mandated to any member of staff with line management responsibilities. We are hoping this will be expended to all staff as the training plan / budget is developed for the next financial year.		

Agency – Yorkshire Ambulance Service							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
					The DA E-Learning covers recognising domestic abuse, indicators, making a domestic abuse enquiry and how to respond to disclosures and referrals pathways. The SDAP is currently promoting this training to all staff across YAS via our internal communications (staff update) that this can be accessed voluntarily. The DA E-Learning was launched to the organisation as part of our 16 days of Activism Campaign against gender-based violence (Nov 23). This also coincided in us launching our domestic abuse Intranet Page. All YAS staff have access to this page which contains information around domestic abuse, different forms of abuse, barriers in making disclosure, domestic abuse enquiry, referral pathways including		

Agency – Yorkshire Ambulance Service							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
					tools & resources to refer to local services. The SDAP has worked with IUC (111 team) to develop and enhance their domestic abuse training which is provided to all staff as part of their in person staff induction. This training has now been updated to reflect the changes within the Domestic Abuse Act, highlights coercive and controlling behaviour, highlights high risk factors including strangulation & pregnancy, indicators of domestic abuse and how to respond and ask about this (DA inquiry) and referral pathways and support available. UPDATE MAY 2025: The E-Learning referenced in our previous update (Feb 24) was approved to be rolled		

Agency – Yorkshire Ambulance Service							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
					out to all staff in patient contact roles as part of the 2024-25 training needs analysis. We currently have a 93% compliance rate. The Safeguarding Team have developed a series of 5 Agency – Yorkshire Ambulance Service No Recommendation Scope local or regional Action to take Lead Agency Key milestones achieved in enacting recommendation Target Date Completion Completion Date and Outcome minute guides which are available to all staff via the Trust intranet. There are several relating		

Agency – Yorkshire Ambulance Service							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
					to domestic abuse which include: recognising & responding to domestic abuse, coercive & controlling behaviour, links between alcohol and domestic abuse, domestic abuse experienced by older people, Clare's Law, Non-fatal strangulation & stalking. The Safeguarding Team has delivered a programme of CPD training events this year which have been well attended and supported. 10 sessions were provided at different venues across our region. Each session covered awareness of non-fatal strangulation within the context of domestic abuse, professional		

Agency – Yorkshire Ambulance Service							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
					curiosity and how to make an effective referral which included a patient case study. In addition to this we provided a Best Practice Day (26/02/25) which had a host of external Agency – Yorkshire Ambulance Service No Recommendation Scope local or regional Action to take Lead Agency Key milestones achieved in enacting recommendation Target Date Completion Completion Date and Outcome guest speakers which included domestic abuse. We had a female with lived experience		

Agency – Yorkshire Ambulance Service							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
					speak of her lived experience of coercive and controlling behaviour and a presentation from IDAS regarding older people's experiences of domestic abuse. We are currently reviewing our CPD funding budget and learning themes from our statutory reviews in order to plan our CPD training sessions for 2025/26. YAS have taken part in several awareness initiatives including Domestic Abuse Awareness Month October 2024 and provide a series of lunch and learn webinars. YAS promoted National Stalking Week April 2025 and provided a stalking awareness briefing		

Agency – Yorkshire Ambulance Service							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
					for YAS staff to access and we are already planning events as part of the 16 days of activism against gender-based violence for November 2025.		
3	This will be evidenced by audit of the quality and volume of referrals in respect of domestic abuse.	Regional (in that YAS covers the whole of Yorkshire)		Yorkshire Ambulance Service (YAS)	YAS Evidence for DHR 02 2020.docx An audit of adult safeguarding referrals where domestic abuse is highlighted as a type of abuse was undertaken by the Safeguarding Team October 2024.	End of the 23/24 financial year.	Completed October 2024.
4	Review and update the YAS policy 'Domestic Abuse: Management Guidance', to reflect the strengthened pathways for assessment and referral.	Regional (in that YAS covers the whole	Policy will be reviewed taking into account	Yorkshire Ambulance Service (YAS)	Update 20/01/2023 All of the actions in relation to this recommendation will be progressed once the	End of the 23/24 financial year.	Completed November 2024.

Agency – Yorkshire Ambulance Service							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
		of Yorkshire)	learning from DHRs and the implications of the new domestic abuse bill. Immediate changes to be considered for any areas of significant concern.		Specialist Domestic Abuse Worker is in post. The business case has now progressed through Gate 2 of YAS internal process and received full support to be presented to the Trust Management Group for funding. Evidence of Gate 2 meeting and agenda attached. Update Feb 24: The SDAP is currently reviewing this guidance. The SDAP has drafted a DA Policy which will reflect and strengthen pathways for assessment and referral. We are hoping to start the ratification process internally in the next financial year. UPDATE MAY 2025: Completed: the YAS Domestic Abuse Policy &		

Agency – Yorkshire Ambulance Service							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
					Management Guidance was approved November 2024. Copy attached. YAS DA Policy and Management Guidanc		

End of overview report 'Jenny'