Doncaster Community Safety Partnership

Executive Summary

Domestic Homicide Review

Name: Jenny

Died: 2020

Chair and Author: Ged McManus

Date: March 2023

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1 The Review Process

1.1 This summary outlines the process undertaken by the Doncaster Community Safety Partnership Domestic Homicide Review panel in reviewing the death of Jenny, who was a resident in their area.

1.2 The following pseudonyms have been used in this review for the victim, his partner and the perpetrator who was their daughter in order to protect their identities.

Name	Who	Age	Ethnicity
Jenny	Victim	67	White British
David	Jenny's husband	57	White British

1.3 On a day in February 2020, Jenny's husband David[1] 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.

1.4 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[2] and co-codamol. A police investigation concluded that there was no evidence that another person had been involved in Jenny's death.

1.5 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

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

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.

1.6 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)[3]. The Home Office was informed the same day.

1.7 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.

1.8 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.

1.9 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 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.

[3] 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.

1.10 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.

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

1.12 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 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.

2 Contributors to the review

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

3 Members of the Domestic Homicide Review Panel

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

3.2 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.

4 Chair and author of the overview report

4.1 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.

4.2 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.

5 Terms of Reference

5.1 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)

5.2 Timeframe under Review

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

5.3 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.

6 Summary chronology

6.1.1 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.

6.1.2 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.

6.1.3 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.

6.1.4 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[4]. The vehicle had a cherished number plate, which indicated David's name. Jenny's

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

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.

6.1.5 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.

6.1.6 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 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[5].

6.1.7 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.

6.1.8 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.

[5] 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.

6.1.9 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, with signposting to the crisis service as an alternative. Jenny did not contact other services in London and soon returned to Doncaster.

6.1.10 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.

6.1.11 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 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.

6.1.13 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.

6.1.14 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[6] risk assessment.

6.1.15 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.

6.1.16 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 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.

6.1.17 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".

6.1.18 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.

6.1.19 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

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

referral to the community mental health team. Jenny had uncontrolled pain from her medical conditions, and a plan was formulated to address this.

6.1.20 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.

6.1.21 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.

6.1.22 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.

6.1.23 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.

6.1.24 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.

6.1.25 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.

6.1.26 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.

6.1.27 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.

6.1.28 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.

6.1.29 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.

6.1.30 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.

6.1.31 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.

6.1.32 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 Hospital, 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.

6.1.33 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.

6.1.34 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.

6.1.35 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.

6.1.36 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.

6.1.37 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.

6.1.38 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.

6.1.39 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.

6.1.40 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.

6.1.41 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[7]
- 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.

[7] 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.

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.

6.1.42 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.

6.1.43 On 13 September 2019, Jenny made a seemingly sudden decision to leave London and return 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.

6.1.44 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.

6.1.45 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.

6.1.46 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.

6.1.47 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.

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

6.1.49 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.

6.1.50 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.

6.1.51 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.

7 Conclusions

7.1 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 majority of which were never reported to the police although Jenny did contact the police a number of times between 2006 – 2009.

7.2 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.

7.3 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'[8]

7.4 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.

7.5 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.

7.6 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.

7.7 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.

7.8 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).

7.9 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.

7.10 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 in September 2019 and returned home. David picked her

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

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.

7.11 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.

7.12 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.

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

8 Learning identified

This learning arises following debate within the DHR panel.

8.1 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

8.2 Narrative

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

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

8.3 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

9 Panel Recommendations

DHR Panel

These recommendations have been developed in partnership with the panel.

9.1 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.

9.2 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.

9.3 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.

9.4 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).

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

Single Agency Recommendations

9.6 Single agency recommendations are contained within the overview report.