Working together for a safer county
SAFERNORTHUMBERLAND

Statutory Review following the death of Jane in January 2019:
Executive Summary

produced by Kath Albiston – November 2020

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1. THE REVIEW PROCESS.

This summary outlines the process undertaken by Safer Northumberland Partnership (SNP), following the death in January 2019 of Jane, who was a resident in their area.

The following pseudonyms have been in used in this review for the victim and perpetrator (and other parties as appropriate) to protect their identities and those of their family members:
Jane – deceased, aged 20 years.
John – Jane's partner at the time of her death.
Mark – Jane's ex-partner.

There were no criminal proceedings following Jane's death. There was an inquest in which the coroner provided a verdict of suicide, stating that Jane, whilst suffering mental health problems, took her own life through hanging.

The Safer Northumberland Partnership (SNP) was notified of Jane's death on 24/01/19 by Northumbria Police. A Review Core Panel took place and as a result a recommendation was made to the SNP that a DHR be undertaken. The decision to undertake a review following the death of Jane was based on the circumstances in which the victim took her own life. These were that:

- She had reported to the police two historic rapes by an alleged perpetrator, with whom she was previously in a relationship, and in which she had also disclosed being subject to other forms of abuse.
- The victim was informed in December 2018 that the allegations of rape were not to be pursued, and took her own life by hanging within one month of being given this information.

Following ratification by the Chair of the Partnership, the Home Office was notified in writing, on 11/03/19, of the intention to undertake a Review.

2. CONTRIBUTORS TO THE REVIEW.

As part of the review process Individual Management Review (IMR) reports were completed by six agencies where it was identified that significant contact had taken place with Jane within the specified time period. IMR reports were received from the following agencies:

- Northumbria Police
- Northumberland Tyne and Wear (NTW) NHS Foundation Trust
- Northumberland Clinical Commissioning Group (CCG)
- Northumbria Healthcare NHS Foundation Trust (NHCFT)

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- North East Ambulance Service NHS Foundation Trust (NEAS)
- South Tyneside Women's Refuge

Additional information in the form of summary reports was also provided by Gateshead Housing Company, Harbour, Rape Crisis Tyneside and Northumberland, Victims First Northumbria, and CTP Future Horizons (Employment Service - Ministry of Defence). The reason full IMRs were not completed was either due to the very limited nature of contact with these services i.e. referral only, or due to the fact that their involvement either did not become evident until the later stages of the review, or no responses were received upon request for information and had to be further pursued by the Chair of the Review.

Northumberland and North Tyneside Adult Services also provided information to clarify that they had no face to face contact with Jane and conducted no assessments.

All IMR authors, were independent i.e. they were not directly involved in the case and had no direct line management responsibility for any of the professionals involved.

3. THE REVIEW PANEL.

As with IMR authors, all Panel members were independent i.e. they were not directly involved in the case and had no direct line management responsibility for any of the professionals involved. The review panel membership was as follows:

Kath Albiston	Independent Overview Report Author
Deborah Brown – Community Safety Academy Manager	Northumberland Fire & Rescue Service
Patrick Boyle, Senior Manager, Specialist Provision Services	Northumberland County Council (NCC) Children's Services
Dave Cookson - Commissioner for Secondary Education + Post 16	Northumberland County Council (NCC) Wellbeing - Education & Skills
Anna English – General Manager, Adult Social Care	Northumberland County Council (NCC) Adult Services
Jan Grey - Associate Director Safer Care	Northumberland Tyne and Wear (NTW) NHS Foundation Trust
Fiona Kane, Head of Quality & Patient Safety, Adults	Northumberland Clinical Commissioning Group (CCG)
Kathryn McClafferty	South Tyneside Refuge

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Eric Myers - D/Inspector Rape/MARAC,	Northumbria Police
Paula Shandran. Professional & Operational Lead Safeguarding Adults & Children	Northumbria Healthcare NHS Foundation Trust (NHCFT)
Philip Soderquest – Head of Housing and Public Protection	Northumberland County Council (NCC) Strategic Community Safety
Julie Stewart, Strategic Housing Manager,	Northumberland County Council (NCC) Strategic Housing
Lesley Storey	Independent Chair
Jane Stubbings - Named Lead Professional for Safeguarding Adults	North East Ambulance Service NHS Foundation Trust (NEAS)
Margaret Tench, Designated Nurse Safeguarding Children	Northumberland Clinical Commissioning Group (CCG)
Karen Wright – Strategic Safeguarding Manager	Northumberland County Council (NCC) Adult Services
Robin Harper-Coulson, NSSP Business Manager	Northumberland County Council (NCC) Wellbeing-Safeguarding
Liam Howley, Community & Environmental Health Manager	Northumberland County Council (NCC) Environmental Health
Paul Weatherstone, Head of North of Tyne Cluster :	Northumbria Probation Service
Dorothy Chambers. Senior Manager Specialists Services	Northumberland County Council (NCC) Front Door MASH

Following the appointing of an Independent Chair and Author an Initial Review Panel meeting took place on 09/04/19 when the draft terms of reference for the review were set.

Following this, a further meeting took place to review the chronologies and finalise the terms of reference on 14/06/19; with a subsequent meeting taking place with both IMR authors and Panel members on 08/10/19, with the purpose of reviewing the Independent Management Reviews (IMRs) and discussing key learning identified for inclusion in this overview report.

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The draft overview report was circulated on 29/11/19 and a further Panel meeting to review this took place on 12/12/19. Within this it came to light that various further pieces of information were needed from agencies. In addition following the sharing of feedback received by the Chair, a strategy was agreed for approaching the victim's family. Due to the time needed in relation to the above, a further Panel meeting was scheduled for March 2020 to sign off the final report. However this could not be held due to restrictions in place in relation to Covid-19. This final sign off occurred on 12/10/20.

4. CHAIR AND AUTHOR OF THE OVERVIEW REPORT.

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Lesley Storey, the Independent Chair, is a consultant with over 25 years' experience working in the field of community safety working to reduce the impact and incidence of crime on communities. As lead of the Community Safety Department in the North of England, her portfolio included addressing high impact crime such as counter-extremism, anti-social behaviour, violence against women and girls, hate crime, serious and organised crime, reducing re-offending and modern-day slavery. She is an experienced Domestic Homicide Review Chair and report writer and has overseen 15 DHRs. She is Home Office accredited and has significant expertise of working with families during reviews, ensuring they are represented and their contribution to reviews is integral to the process.

The Chair has a BSc degree in Sociology and Social work, a post-graduate diploma in child protection and in Quantitative Research Methodology, statistics and change. She is a qualified youth and community practitioner and has worked directly with perpetrators of abuse within commissioned services. She has worked nationally as an expert on domestic abuse, advising on ad hoc national panels and round tables, most recently she advised cabinet ministers on care pathways for child victims of domestic abuse.

Kath Albiston, the Overview Report Author, is a qualified Probation Officer, and prior to leaving the Probation Service worked within a joint Police and Probation unit acting as Chair for Multi-Agency Public Protection (MAPP) meetings. Working independently as a consultant and trainer since 2006 she has undertaken a variety of roles within the domestic violence and Safeguarding arena, working with statutory and voluntary sector agencies around the writing of risk assessment tools, policy and procedure, and the training and clinical supervision of staff. She has also undertaken service reviews and scoping exercises in relation to provision of domestic violence services and is also rostered trainer for the Working With Perpetrators – European Network (WWP-EN). The Author also acts as an 'expert witness', writing domestic abuse risk and vulnerability assessments for public and private law cases, as well as having undertaken over 18 Domestic Homicide Reviews, Safeguarding Adults Reviews and Serious Case Reviews in the North East.

5. TERMS OF REFERENCE FOR THE REVIEW.

In addition to the standard areas for consideration outlined in the Statutory Guidance for the Undertaking of Domestic Homicide Reviews, the Panel agreed the following areas for specific consideration by agencies in this case:

- What supports were put in place/action taken by your agency following the MARAC meetings? Do you feel that the MARAC process was helpful in supporting the victim/managing the risk?
- To what extent were your agency aware of concerns regarding the victim's emotional wellbeing and her experience of domestic abuse? How were these addressed?
- Regarding the victim's disclosure of alleged rape and the process that followed, including the decision not to proceed with charges, to what extent were your agency involved with the victim in relation to this? Was the impact of this disclosure and subsequent events recognised? How was the victim supported regarding this?
- Was there any indication that the victim was experiencing any ongoing coercive control?
- Is there any information that has come to light since the victim's death that you were not aware of at the time and you feel should have been shared with you previously? Or is there any information that you feel your agency should have shared previously?

The time period for consideration within the Review was agreed as from 18/01/18 to the date of Jane's death; this time period begins when she was known to have moved in with her with her ex-partner, subsequent to which the allegations of domestic abuse came to light. In addition, all agencies were asked to include within their IMRs any previous relevant information that would assist in understanding the circumstances of Jane's death.

6. SUMMARY CHRONOLOGY

Information from agency records provided a limited picture regarding Jane's background. According to such records Jane had disclosed that her mother had been in an abusive relationship and that as a child she had heard the physical and verbal abuse that her mother was subject to. Jane has two sisters, and a brother who died when she was 14 years old; the circumstances of his death are unknown to the Review. Jane was known to have joined the army but information from Future Horizons (Employment Service - Ministry of Defence) suggests she left after three months in training; reference is made to a knee injury, however information from other agencies also refer to Jane reporting having been bullied. Jane had support from an

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Employment Advisor at Future Horizons from May 2017 to May 2018, when contact ceased as she had found employment as a security guard.

In January 2018, Jane moved in with her then partner, Mark, taking a joint tenancy in the Gateshead area. At this time, she also registered with a new GP practice in the area and reported a long history of anxiety and depression going back to her teenage years. In relation to more recent problems she disclosed bullying within the army, then isolation and poor support upon leaving. She also reported that she had just moved into the area with her partner, who was supportive, although went on to disclose that the relationship was strained due to her illness. She stated that she had friends but no close family support. The GP prescribed medication as well giving Jane the telephone number for Talking Therapies.

Jane had four more face to face appointments at the GP practice in Gateshead from January to May 2018. Two of these were physical health related, whilst two were for low mood.

In April 2018, Jane renewed contact with her Employment Advisor from Future Horizons and reported that she needed to get out of her accommodation as she felt very unsafe with her boyfriend; this included reporting that he had tried to 'force himself on her'. The Employment Advisor then contacted the Armed Forces Outreach Service (AFOS) at Gateshead Housing Company and advised them of the situation. AFOS then made a referral to the Domestic Abuse Support Service at Gateshead Housing Company, informing them that Jane wished to end the relationship and re-locate to Newcastle due to domestic abuse; it was confirmed the same day that Jane had been awarded priority for rehousing on the basis of being ex-armed forces.

A worker for the Domestic Abuse Service at Gateshead Housing Company contacted Jane who further confirmed she was experiencing domestic abuse from Mark and that it was her intention to end the relationship once she had her own tenancy to move to. A MARAC (Multi Agency Risk Assessment Conference)[1] referral was made by the worker based on the information shared by Jane, which had identified her as being High Risk on the SafeLives DASH Risk Indicator Checklist[2]. Within this information a high level of coercive control by Mark towards Jane was reported and she reported significant impact in terms of feeling isolated and depressed and that she was having a lot of thoughts around ending her life as she couldn't face being in the relationship

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[1] A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors. After sharing all relevant information they have about a victim, the representatives discuss options for increasing the safety of the victim and turn these into a co-ordinated action plan. The primary focus of the MARAC is to safeguard the adult victim.

[2] Domestic Abuse Stalking and 'Honour Based' Violence checklist to use with those experiencing domestic abuse in order to identify the risk, and assess whether they meet the criteria for a referral to MARAC.

any longer; she also disclosed a number of previous attempts to kill herself, both at home and at work.

Jane also disclosed that on a number of occasions Mark had forced himself on her when he wanted sex, even though she had said no. As a result of the disclosure of rape the Gateshead Housing Company made a referral into Northumberland and Tyneside Rape Crisis Centre for Jane, who was offered an appointment, but did not attend.

Comprehensive safety planning, support identification, and information sharing was then undertaken by the Domestic Abuse Worker. At this stage JANE declined temporary accommodation but was told she could access this at any future point either by contacting the Domestic Abuse Worker or the housing options team.

Jane then presented as homeless at North Tyneside Council and requested a refuge and her MARAC case was therefore heard in North Tyneside on two occasions - in May and August 2018.

In May Jane contacted NTW's Initial Response Service (IRS) reporting increased feelings of harming herself. As a result of this she was offered a face to face assessment, following which she was directed to her GP to have her medication increased, as well as to be referred into Talking Therapies. She then saw her GP on four occasions from May to July 2018 in in relation to her anxiety and low mood.

Throughout May six more attempts were made by the Domestic Abuse Worker to contact Jane, with only the final one being successful. At this stage Jane was living in a South Tyneside refuge, made no disclosures about any ongoing domestic abuse issues, and stated she had sufficient support and was looking forward to moving to her own property. She was advised that she could contact the Domestic Abuse Worker in the event of any change of circumstances, and that she should also report any future incidents or concerns directly to the Police or any local authority employees who may be supporting her.

Within the MARAC meeting in May 2018, one of the action points was to ensure that all offences noted on the MARAC referral were recorded as crimes, which resulted in Northumbria Police creating a crime log for the offence of Rape of a Female. This was later recorded as undetected as JANE did not wish to proceed with the complaint.

In June 2018, Jane made further contact with NTW's Initial Response Service, seeking advice as she felt she needed to talk to someone about her difficulties. She had a Talking Therapies appointment the following week and was advised to get further medication from her GP; no further role for NTW services was seen at this time. It does not appear that Jane attended the appointment with Talking Therapies.

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In July, Jane moved to her own tenancy in North Tyneside, and at this time also changed GP practice. At some stage since her separation from Mark in April 2018 she had begun a new relationship with John, whom she was still in a relationship with at the time of her death.

In July 2018 Jane called police reporting that Mark had phoned her on numerous occasions and claimed to know her address. This incident was attended by the domestic violence car, with an outreach worker from Harbour present; Jand agreed a referral to Harbour's IDVA support services but then failed to attend an initial appointment, resulting her case being closed. The allegations were recorded as Harassment by the Police, but the case was later closed in December 2018 as undetected[3].

In July 2018 a referral was made into Victims First Northumbria (VFN) by Northumbria Police, the case was marked as HARRASSMENT WITHOUT FEAR. VFN made no contact with Jane and the action was recorded as Rejected – High Risk DV; this is a policy position of VFN as the service does not support high risk victims.

Around this time, Jane also made contact with NTW's Crisis Team complaining of having suicidal thoughts, of feeling anxious, struggling to be around people, feeling irritable, and getting frustrated with colleagues. She also disclosed having had contact with her ex-partner over the weekend, who called her names and wished bad upon her; she felt her mood had dipped as a consequence.

The following day when speaking to officers regarding the alleged harassment, Jane disclosed two historic rapes by Mark, the first occurring in February/March 2018 and the second just nine days previously at her new address. Victims First Northumbria received a further referral from Northumbria Police for Jane in relation to this, marked RAPE OF FEMALE 16 OVER. On this occasion the case was accepted into the service. VFN subsequently contacted Northumbria Police and asked for clarification regarding the Achieving Best Evidence (ABE) interview. It is not usual practice for VFN to contact a victim of rape before this interview takes place and the staff wanted to establish this before they contacted Jane.

The next day, Jane was seen at her new GP practice, who noted her long-term problems with anxiety and low mood. She described how she had started self-harming again recently by cutting herself and had had previous suicidal thoughts, but none lately; although this can now be seen to contrast the contact with the Crisis Team two day earlier. Jane also reported that she was no longer in an abusive relationship and

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[3] Information supplied by Northumbria Police clarified that when a recorded crime is formally closed it is graded as either detected or undetected; if a crime is closed as 'undetected', as with this case, this usually means that there hasn't been a positive outcome for the crime.

that she was continuing to work. The GP started her back on her medication, which had run out a few weeks previously, and advised her to return in two weeks' time.

At the end of July Jane was interviewed in relation to the allegations of Rape. Following the interview, she was reported to have gone into crisis and to have told a police officer that she could not cope anymore; she disclosed that the previous night she made an attempt to kill herself by tying a cord round her neck. Jane reported having no support in place having fallen out with her family and friends following this report of rape. The police contacted Street Triage, the police and mental health team, who attended the Police Station and completed a face-to-face triage. Following this assessment, the outcome was for Jane to discuss medication with her GP and to work with the Harbour domestic violence worker; this appointment was scheduled for two days later and it is now known that Jane did not attend.

Following the ABE interview, the OIC managing the case contacted VFN and confirmed this had taken place. The OIC highlighted the vulnerabilities and mental health issues that had been observed in the ABE interview. VFN then held a case discussion regarding JANE, the records examined highlighted that VFN understood the priority for Jane was support around her mental health. The ISVA who had been allocated the case, and her supervisor, decided that as JANE had been referred to her GP and Talking Therapies "*this was the best place to start and that she has the details for the crisis team which is great".* The OIC was emailed and advised that if Jane felt well enough to access the ISVA services specifically around issues to do with the rape, she could get in touch at a later date. A few days later, VFN held a further case discussion and decided to close Jane case.

In mid August Jane reported to a GP that her mood had not been good over the previous couple of weeks with ongoing thoughts of self-harm. She was described as tearful but having good eye contact and holding a reasonable conversation. Her medication was increased and she was given numbers for Talking Therapies and the Crisis Team, as well as a 'Fit Note' to remain off work.

A few days later following a call to 999 from JANE's mother, in which she reported that JANE had attempted to hang herself, JANE was seen at A&E reporting low mood and two recent attempts to hang herself. She discharged against medical advice, and her mother told A&E team that they would contact the Crisis Team at home for ongoing support. A&E Medics told the Liaison Psychiatric Team that they felt Jane had had capacity to consent to the discharge.

The next day, Jane was seen at her GP practice for an emergency appointment, which she attended with her mother. In this appointment she described getting closer and closer to committing suicide over the last few months. She detailed how the day before she had a rope around her neck and one foot off the chair she was standing on, when her boyfriend rang as he had worked out from her messages to him that she was going

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to commit suicide. She described that she fluctuated between wanting to commit suicide with periods of feeling alright. She also reported that she was struggling with sleep problems and therefore was started on different medication for this. The GP referred her to NTW's Community Treatment Team (CTT), requesting a 'Soon Assessment', and also asking to be notified if they did not intend to either offer further investigations or acute management in the short term, so that the GP could review further. As a result of this referral, JANE was reviewed at an Multi Disciplinary Team meeting within NTW's CTT, and it was agreed to offer a routine assessment for October 2018.

Jane attended A&E on towards the end of September having ingested 10 cyclizine tablets; she reported having been out drinking and having taken the medication that she did not think would be fatal; she told her boyfriend immediately and attended hospital with him. She denied any current suicidal ideation and expressed that she wanted to leave. Jane was assessed as having capacity to choose to leave; she was said to be future oriented and said that she had an upcoming appointment with mental health services in October which she planned to attend. They felt that Jane was currently of low risk and were happy for her to be discharged without assessment from the Psychiatric Liaison Team.

At the beginning of October Jane attended her GP practice once more in relation to her anxiety and depression. She stated that she was seeing the Community Treatment Team that same week and that she'd regretted the overdose. However, Jane then missed her appointment with NTW's Community Treatment Team, stating she had forgotten; she was offered a further appointment for November. Jane attended this appointment and was seen by a Nurse Specialist and Mental Health Social Worker. Following this assessment, a plan was put in place that she should continue to work with Harbour, ask her GP about starting back on medication which she reported having stopped, and be referred to Talking Therapies by her GP if needed. The referral was then closed to the Community Treatment Team and a letter was sent to the GP outlining the outcome of the assessment; it does not appear however that this letter was typed until 17/01/19 and was not received until 28/01/19, after Jane's death.

In relation to the contact with Harbour, Jane had been offered an initial assessment in August 2018 following the MARAC meeting, she did not attend however, and this resulted in her case being closed.

At the end of November the OIC contacted VFN and raised that Jane had had no contact from the ISVA service and that she was very vulnerable and needing support. On the same day VFN emailed the OIC back to inform her they had emailed the OIC previously to ask what support was needed but the OIC stated she had "missed this email". The following day, VFN made telephone contact with Jane. Jane picked up the

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phone and said now wasn't a good time to talk and requested VFN call back; a further 4 calls were made and went unanswered

In December 2018 Jane was informed by a phone call from Northumbria Police that the case relating to the allegations of Rape was to be discontinued; it does not appear that any specific support was put in place around this.

At the beginning of January VFN called again and were able to speak to Jane, the records from the conversation gave an insight into the pressures Jane was experiencing and the ISVA suggested a referral was made into Northumberland Tyneside Rape Crisis (NTRCC) for counselling. Jane was then contacted by NTRCC and offered an appointment for counselling; she was given the telephone number of the out of hours crisis service which NTRCC operate and informed she would be contacted again with the date and time of her first counselling session.

Approximately two weeks later, Jane was seen at her GP practice with anxiety and depression. This was the last appointment prior to her death. She was seen with her partner and described worsening symptoms including suicidal thoughts and that she was self-harming again. She was finding that her medication was not effective and was making her sleep too much. She was already on the waiting list for Talking Therapies so the GP recommended starting on a different medication. The records did not indicate that the GP informed Talking Therapies of her worsening symptoms to try and get her seen sooner.

Tragically, Jane was found dead at her home five days later, having hung herself. On the day of her death Jane had been alone at her home address whilst her partner, JOHN, was at work. John received a text during the day stating 'I love you' and made numerous attempts to respond but got no reply. When he returned home later that day he found Jane hanging from the garage ceiling and called 999. Emergency treatment was delivered by Ambulance Service staff on scene and continued on route to the emergency department, where Jane was tragically pronounced dead. The notification completed at the hospital stated she had died as a result of asphyxiation secondary to hanging.

Jane's death occurred one month following her having been notified by Northumbria Police that historic rape allegations she had made against her ex-partner, Mark, were No Further Actioned.

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7. KEY ISSUES ARISING FROM THE REVIEW

In the undertaking of this Review, areas of good practice in relation to work undertaken with Jane by agencies were seen, particularly around responses to the presenting issues, and referral and signposting to further assessment and support. This was particularly apparent following Jane's initial disclosure of abuse, when staff at Future Horizons made contact with the Armed Forces Outreach Service in Gateshead, who in turn referred to the Domestic Abuse Service. Contact by the Domestic Abuse Worker then led to a detailed assessment of the current situation, Jane's access to a refuge, the GP being informed of concerns, and a referral to MARAC, thus informing other agencies. Information available to the Review demonstrated how the immediate risk relating to the domestic abuse was addressed and support put in place for Jane around this.

In addition to such good practice however it has also emerged there are areas of practice where lessons could be learned in order to improve services. To assist in understanding these fully it was useful to consider the issue of coercive control. Within JANE's disclosures to staff, particularly those informing the MARAC referral and process, such coercive control was apparent in relation to the behaviours which she described having experienced. When reviewing Jane's presentation and agencies response to it, while we cannot make assumptions about the causes of such presentations, in being aware of the potential long term impact of living with coercive control and abuse, we can perhaps better understand the overall picture.

7.1 Investigation and response to allegations of Harassment and Rape

It was identified within the IMR completed by Northumbria Police, that their involvement with Jane in response to the allegations made of harassment and rape addressed each of these in isolation. They were therefore not considered as part of the broader picture that was available from the MARAC information which suggested patterns of coercive control. This impacted on the way in which the risk was viewed around each of the allegations, with a focus upon physical risk and contact with Jane, as opposed to wider implications of emotional impact and accompanying risk. In addition, this has been identified as directly impacting in terms of the pursuance of charges.

In relation to the above, there was no evidence of any active consideration of pursuing charges of coercive control, or any evidence to indicate why it was not progressed or recorded as a crime; this was despite Northumbria Police having received extensive training around coercive control. It was also not clear as to what extent the evidence relating to both the allegations of Harassment and Rape were considered against the context of coercive control, and whether decisions around whether to pass these to the CPS for charging could have been altered by this i.e. would Jane's actions relating

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to having contacting Mark have been viewed differently in light of evidence of coercive control. While it was impossible to conclude from the information available that the decision taken not to pass this case to the CPS for review would have in any way changed had the broader context more fully considered, or indeed that passing it to the CPS would have led to a different charging decision, it did however raise the question of whether more robust measures, such as review by the CPS, would be beneficial in cases in which alleged crimes such as Rape take place in a domestic abuse scenario.

Northumbria Police also identified that such limited consideration of the broader picture led to the lack of a coordinated victim strategy. This was seen to have led to Jane being informed of the discontinuation of charges with no consideration being given to the emotional impact of this upon her, and thus no coordination with appropriate support agencies. This was particularly concerning in light of the reported history of abuse, suicidal thoughts which she had acted upon, and her previous expression that she felt unable to cope as she did not feel she was being believed.

It was also highlighted that JANE did not receive the support of an ISVA as she should have. This was in part due to a miscommunication between Victims First Northumbria but also highlighted that no direct contact attempt was made by them with Jane.

It became clear throughout the Review that the support offered to Jane in relation to her allegations of rape was insufficient; rape is one of the most traumatic and invasive crimes and for a woman with clear vulnerabilities and mental health issues the impact would have been significant. A joined-up victim support strategy coordinated by one service would perhaps have ensured Jane received a coordinated appropriate response for each segment of her journey through the criminal justice system.

The lack of a victim strategy also meant that no other agencies with whom Jane had been in contact with were aware of the court case having been discontinued, and therefore also unable to pro-actively identify, and put in place, plans to support her in dealing with the impact of this. NTW did identify that prior to this, in October 2018, Jane had informed them of the court case and as part of their plan referenced her continued work with Harbour to support her around this. However, no contact with Harbour was made to discuss this, thus resulting in NTW being unaware that Jane was no longer engaged with them.

7.2 <u>Limitations of responses to Jane's worsening mental health presentation and the lack of a coordinated robust approach</u>

In considering the identified lack of a coordinated victim strategy, this also highlighted an issue that ran throughout the Review; namely the lack of any significantly coordinated or robust approach to address Jane's repeated presentation and reports of mental distress, including suicide attempts.

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Over the course of the review period Jane presented at her GP on at least nine occasions expressing feelings of low mood, anxiety or depression; as well as raising these at contacts with other agencies. In addition, from April until the point of her death there were four occasions on which Jane directly reported suicidal thoughts, with additional direct references to three recent suicide attempts. It was also noticeable that during this period Jane contacted her GP or '111' services on a number of occasions presenting with physical health symptoms; while no conclusions can be drawn from this, it does perhaps however raise the question of whether these were also indicators of Jane's worsening emotional state and attempts to access support.

While each individual incident was seen to have been appropriately responded to, with either further assessment, referral, or changes in medication, what does not appear to have happened during this time was Jane's access to services to explore these in any more in-depth or sustainable way. What was seen instead was constant reference to her being referred back to the GP and awaiting Talking Therapies. Indeed it was difficult to ascertain from information available to the Review exactly what was happening with the Talking Therapies referral, as there are numerous different references to this in which it was said that it is that she had either been given the number for self-referral, was still required to complete the self-referral, or that she was on a waiting lists, or awaiting assessments. What was clear however is that this was constantly referenced as one of the ways in which to address Jane's presenting concerns, including the risks around suicide, yet she did not appear to have accessed this service and there was little evidence of this being followed up or clarified.

Alongside the above, there were occasions when Jane herself reports working with other agencies such as NTW or Harbour, and this was included in plans to address risks around her mental health. In reality, she did not always attend these appointments or indeed, as was the case with Harbour, was never actually open to them for ongoing support.

This highlighted gaps in information sharing and coordination between agencies, resulting in the absence of any robust plan being put in place. Without this, agencies had no clear overview of the wider picture, which became apparent as a result of this Review. Within this it was seen that Jane was repeatedly accessing services and expressing concerns about her own mental and emotional health, alongside disclosing ongoing alleged harassment and rape from someone with whom she reported having been in a coercively controlling relationship. The key moments within this can be seen as those in which she disclosed the alleged harassment and historic rapes, the point at which she was interviewed in relation to these, and the point at which charges were discontinued.

In considering the above, a number of areas of learning arose. Firstly, the need for agencies to pro-actively clarify reported engagement with other services, and provide

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such services with information around concerns, when such attendance is seen as forming part of a plan to address support needs and risk. Secondly, the need to further update agencies to whom referrals have been made when there is a further presentation or increasing concern, so that prioritisation can take place and access to services occurs. Thirdly, the need to consider the broader risks related to coercive control, and it's long term emotional impact, including any links to suicide risk.

When considered together Jane's presenting mental health concerns, alongside her reports of abuse and ongoing involvement in the investigative process, highlighted a high level of potential vulnerability that should ideally have led to consideration of the need for a more coordinated strategy. MARAC meetings took place earlier on, and were focused primarily on issues of physical risk, with limitations also seen in relation to the information shared, due to the MARAC having moved from Jane changed areas. In addition, only one Safeguarding referral was made throughout the period considered by the Review. This latter referral was made by the police in July 2018 but was not advanced further as it was felt that having been seen by Street Triage, appropriate support was already in place due to Jane's ongoing contact with her GP and Harbour; which we now know was not the case. While it was impossible to know if a multi-agency meeting would have impacted on any subsequent outcomes in this case, what it would have done is provide the broader picture that became available to this Review. This picture has identified a pattern of crisis and referral, with Jane receiving no longer term or more in depth intervention.

8 CONCLUSIONS

In cases where a victim takes their own life, it is very rare that definitive conclusions can be drawn about exactly why this has occurred, and indeed it was not the purpose of this Review to attempt to do so. However, the Review did consider the events leading up to Jane's decision to end her life in order to identify lessons that can be learned in relation to how we support those who have disclosed abuse, and are living with the impact of this.

Within the Review a picture was revealed of JANE as a vulnerable young woman, with a number of previous life stressors referred to, including having witnessed abuse as a child, having lost her brother at a young age, and having been subject to bullying both at school and in the army. Through her report to agencies, Jane's account of her previous relationship was clear and she described a high level of coercive control, sexual abuse and ongoing harassment. Her repeated reports of anxiety, low mood, depression and suicidal ideation and attempts, indicated a deterioration in her mental and emotional well-being, and it was difficult to separate this from the ongoing issues in relation to her ex-partner, and her experiences in the pursuance of criminal charges. While there was evidence of good practice in responding to Jane's presentation, learning was identified in relation to the need to better understand experiences of

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abuse, the impact and interaction of this in terms of any ongoing mental health difficulties, and the need to thus fully recognise the potential level of vulnerability and risk. This could in turn help to better facilitate a coordinated and robust multi-agency approach, rather than responding to the management of each presentation or incident in isolation.

9 LESSONS TO BE LEARNED

This case highlighted some key lessons learned that translated both to general and single agency recommendations; it was also recommended that they be disseminated more widely within agencies in order to facilitate learning and improvements in practice. These were:

- The value of considering reported experiences of abuse outside of individual incidents in order to help recognise overarching issues of coercively controlling behaviour.
- The need to consider charges that may be pursued against alleged perpetrators in relation to coercive control, despite differently presenting original allegations.
- The need for a robust trauma informed and coordinated response to victims/survivors ensuring timely access to appropriate support services.
- The importance of considering the emotional impact of such abuse upon the victim, particularly when combined with presenting mental health concerns, including risks relating to suicide.
- The viewing of repeated presenting mental health concerns as part of a pattern, and the taking of a coordinated multi agency approach that facilitates access to specialist services; this should reduce the potential for people to get trapped in a cycle of referral between services with lack of meaningful intervention.

10 RECOMMENDATIONS FROM THE REVIEW

Community Safety Partnership

- The Community Safety Partnership to collate information from all other local reviews arising from the suicide of a victim of domestic abuse in order to consider the learning as a whole, to identify any further actions needed, and to identify ways in which disseminate overall learning to agencies and practitioners across the partnership.

All agencies

All agencies involved in this Review to provide evidence to the Community Safety Partnership that:

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- Procedures and guidance are in place to ensure that where contact with other agencies forms a key part of either a management plan or a decision to close a case, relevant information sharing and clarification takes place with the identified agencies known to be working with the person;
- Procedures and guidance are in place that in cases of alleged abuse where the victim identifies coercive control and/or police investigations, this prompts consideration of any increased vulnerability and risk, including the impact on the emotional wellbeing of the victim and their presenting mental health concerns; and that this is then reflected through consideration of appropriate referral to multi-agency procedures such as MARAC or Safeguarding.
- Learning from this Review to be disseminated to staff in all agencies and agencies to evidence that identifying risk and vulnerability around coercive control, including the links to suicide risk, is incorporated into ongoing training and that such training is reflected in practice.

Northumbria Police

Identified within the IMR:

- Victim strategies must be used for domestic abuse victims were a single victim has numerous investigations running at the same time. Investigators must coordinate their updates and consider the impact of these updates as a whole and the potential impact on a victim. Were an update or series of updates is identified as posing a potential to negatively impact on a victim's health steps must be taken to reduce this impact and to support the victim.

- Commissioned research or a review of any current academic work into 'The links and risks to victims of suicide, where allegations of domestic rape are alleged' needs to be carried out with the aim of providing training to raising understanding of any established risk of suicide in respect of victims from domestic abuse and domestic related rape to ensure that safeguarding is addressed and potential risks are identified.

Additional arising from the Review:

- Northumbria Police to identify methods to review whether coercive control charges are being actively considered in cases of domestic abuse that present first as other crimes; if such a review indicates this is not the case, to identify strategies will be put in place to address any gaps in awareness or implementation among staff.

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- Northumbria Police to identify whether procedures in place around reviewing the evidential threshold for passing a case to the CPS sufficiently reflect an understanding and awareness of coercive control and whether a safeguard is needed in these cases that would prompt the CPS' advice to be sought in all such cases.

- Northumbria Police to review existing polices and protocols in relation to supporting victims of rape and sexual assault who are also victim of domestic abuse

Victims First Northumbria

Arising from the Review:

- VFN to review policies/procedures regarding initial contact with victims.

Northumberland Tyne and Wear (NTW) NHS Foundation Trust

As the following recommendations were included in the trust Serious Incident process, all have been completed.

- The assessment documentation was not completed in a timely manner, meaning that the GP did not have access to the plans following assessment until after the incident. (The documentation had been completed and sent prior to the incident on January 17th). *Within trust Serious Incident Review process, this was a recommendation that has been actioned and completed in April 2019 with individual staff seen and a team protocol developed.*

- It was felt that further communication could have been made with Harbour, with the patient's consent, to discuss the agreed plan following assessment and identify when the court case may be given that the court case was likely to increase the patient's distress and risks. *Within trust Serious Incident Review process, this was a recommendation that has been actioned and completed in May 2019 via the learning from the SI in team meetings.*

- Jane had admitted to being in a new relationship, however given the domestic abuse she had experienced it was felt that it may have been advantageous to have identified even a first name of the 'partner' she was discussing or who was accompanying her to appointments on occasion to clarify that it was not the ex-partner. *Within trust Serious Incident Review*

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process, this was a recommendation that has been actioned and completed in July. Trustwide via Safer Care Bulletin of coercive control/DHR and reference to Domestic Abuse Policy re same. Also incorporated in to Clinical Risk to Others training in May 2019.

Northumberland Clinical Commissioning Group

- Where a patient is currently on a waiting list for mental health services and their condition is noted to have deteriorated, the clinician should consider informing the service to assist them in prioritisation or escalate concerns to the Crisis service if deemed appropriate.

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