Domestic Abuse Related Death Review

Bracknell Forest Community Safety Partnership

Jenny died June 2022

Executive Summary

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Completed - May 2024

Published – February 2025

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Preface

Bracknell Forest Community Safety Partnership (CSP), panel members and the author wish at the outset to express their deepest sympathy to Jenny's (not her real name) family, and we appreciate the engagement from her family throughout this difficult process.

This review has been undertaken in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively in order that lessons can be learnt. This has ensured that we have been able to consider the circumstances of Jenny's death in a meaningful way and address with candour the issues that it has raised.

This report contains details and information of a highly sensitive nature including acts of physical and emotional abuse, substance use, self-harm and suicide that may be distressing to read.

1. Introduction

1.1 This review is a statutory requirement under the Home Office Multi-Agency Statutory Guidance for Domestic Homicide Reviews 2016[1]. The review examined agency responses and support provided to Jenny, her husband Max (not his real name) and her eldest adult son Chris (not his real name) prior to her death. Chris was also alleged to be abusive to his ex-partner Fran (not her real name) during this time which was also reviewed. The Executive Summary summarises the events leading to Jenny's death and the conclusion of the panel's findings. For full analysis into the interaction agencies had with both Jenny, Max, Chris, and Fran please refer to the Overview Report.

2. Timescales

2.1 In June 2022 Jenny died by suicide at her home address, Bracknell Forest CSP received a Domestic Homicide Review referral from Thames Valley Police after there had been reports of domestic abuse from Max and Chris. The decision to carry out the review was made in December 2022; the chair and report author was commissioned in March 2023.

2.2 Paragraph 46 of the Home Office Statutory Guidance, states that the target timescale for completion of the review of 6 months. Due to delays in IMRs being submitted, further information required and meeting the dates for the CSP to agree the final reports, the review was not completed in the expected timeframe, the CSP, panel and Home Officer were kept up to date throughout. There were 5 panel meetings held in total and a presentation to the CSP board.

3. Confidentiality

3.1 In line with paragraph 75 of the statutory and the Data Protection Act 1998[2], to protect the identity of those involved pseudonyms have been used which were chosen by the panel.

[1] Domestic homicide reviews: statutory guidance - GOV.UK (www.gov.uk)
[2] https://www.legislation.gov.uk/ukpga/1998/29/contents

3.2 The sharing of information between agencies in relation to this review was underpinned by the Information Sharing Protocol which is in place to facilitate the exchange of personal information to comply with the requirements of Section 9 of the Domestic Violence, Crime and Victims Act 2004[3].

3.3 Panel meetings were confidential and any sharing of information to third parties was carried out with the agreement of the responsible agency's representative, the panel and chair.

3.4 The findings are restricted to authors of the reports, their managers and panel members. Initial learning identified through the review process has been acted on immediately.

4. Methodology

4.1 Since 2024 Domestic Homicide Reviews (DHR's) were renamed Domestic Abuse Related Death Review's. These reviews became statutory in 2011 under Section 9 of the Domestic Violence, Crime and Victims Act (2004), which states:

A DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by:
a) A person to whom she was related or with whom she was or had been in an intimate personal relationship or
b) A member of the same household as herself; held with a view to identifying the lessons to be learnt from the death.

4.2 Agencies were identified to provide Individual Management Reports (IMRs) after scoping was completed across the Bracknell Forest area. The terms of reference were provided to all agencies completing IMRs, all reports, learning, recommendations, and actions were quality assured by senior members of staff within each organisation.

4.3 Various pieces of research have been used within the analysis and are referenced throughout.

5. Involvement of family and friends

5.1 Jenny's children were informed of the review by letter, including information of AAFDA (Advocacy After Fatal Domestic Abuse). Unfortunately, no contact was made with Jenny's middle or youngest sons. Attempts to contact we made throughout the review.

5.2 Max was contacted, he met the chair and was kept updated throughout the review.

5.3 The chair spoke with the Police and Max to identify any neighbours however, no details were provided.

5.4 The chair was supported by Probation to speak with Chris, he was spoken to on one occasion but unfortunately, this contact was interrupted, and further attempts were unsuccessful.

5.5 Due to the review also reviewing Chris's abusive behaviours towards his Fran, attempts were made to contact her (with the support of the Police and Children's Social Care). This was to

[3] https://www.legislation.gov.uk/ukpga/2004/28/section/9

ensure she was aware of the report and provide her an opportunity to share her experiences. Due to her moving out of the area and there being no further contact with her from Bracknell Forest partner agencies, this was not possible.

6. Contributors to the review

6.1 Panel members and IMR authors were all independent of any support offered and/or provided to those named within the review. IMRs and summary reports were provided and presented by:

- Berkshire Health Care Foundation Trust
- Frimley Health NHS Foundation Trust
- Frimley Integrated Care Board on behalf of Primary Care
- New Hope (Drug and Alcohol Action Team - DAAT)
- Probation
- Silva Homes
- South Central Ambulance Service
- Thames Valley Police
- Berkshire Women's Aid (BWA)
- Bracknell Forest Council Adult Social Care

6.2 The panel comprised of agencies recommended within the statutory guidance, those with specialist knowledge of domestic abuse, older people and suicide. All panel members were required to review all information provided, provide feedback and support the process.

6.3 The review panel consisted of:

Agency	**Representative and role**
Bielec Consultancy Ltd	Katie Bielec – Chair and Author
Berkshire Health Care Foundation Trust	Debra Broderick – Locality Manager
Berkshire Women's Aid	Rachel Murray – Director of Operations
Bracknell Forest Council Adult Social Care	Simon McGurk – Interim Head of Service – ACT & Intermediate Care Services
Bracknell Forest Children's Social Care	Sonia Johnson – Assistant Director: Children's Social Care
Bracknell Forest Community Safety Partnership	Alison O'Meara – Head of Youth Justice and Community Safety Sophie Wing-King – Domestic Abuse Strategic Lead
Bracknell Forest Public Health	Gabriel Agboado – Consultant in Public Health
Frimley Health NHS Foundation Trust	Joanna Bennett – Specialist Children's Safeguarding Nurse Sue Spong – Specialist Nurse in Adult Safeguarding Ablen Dacolos – Adult Safeguarding Named Nurse and Dementia Lead Nurse
Frimley Integrated Care Board	Sharon Ballantyne – Domestic Abuse and Exploitation Safeguarding Lead
Hourglass	Maggie Evans – Director of Operations
New Hope	Sundeep Saundh – Deputy Head of Drug & Alcohol Services

Probation	Lorraine Mansell – South Central Lead for SFO and Complaints
Silva Homes	Tom Mason – Lead Customer Relations Partner (Housing Services)
South Central Ambulance Service	Jackie Osborne – Adult Safeguarding Practitioner
Thames Valley Police	Andy Grahame – T/Chief Inspector, LPA Commander Richard Jarvis – Detective Chief Inspector Paula Searle - Specialist Investigator – Investigation Review Team - Service Improvement.

7. Author of the Overview Report

7.1 Katie Bielec is an independent domestic abuse consultant; she is an accredited chair with AAFDA and SILP[4] and MARAC[5]. She has completed the Home Office Domestic Homicide Review Training, is a member of AAFDA DHR Network, Standing Together Against Domestic Abuse Coordinated Community Response and The Employers Initiative on Domestic Abuse. She is an associate trainer for SafeLives, Surviving Economic Abuse, Rockpool, The Hampton Trust, a guest lecturer at Bournemouth University and an accredited trainer delivering Coercive Controlling Behaviour and Stalking. Katie was previously a Metropolitan Police Officer, is a qualified IDVA, IDVA manager, ISVA[6] Manager and managed domestic abuse services for 11 years.

7.2 Katie is not associated in any way to any agency who have provided information for the review or had any personal or professional involvement with those involved within the review.

8. Parallel Reviews

8.1 In January 2023, the coroner found Jenny died by suicide, no other reviews were carried out during this time.

9. Equality and Diversity

9.1 The chair and panel members considered whether any of the protected characteristics within the Equality Act 2010[7] were relevant within the review. Jenny was a 62-year-old white British female. At the time of Jenny's death, Max was 67 years old, Chris - 38 years old and Fran - 37 years old, all were white British (Jenny's age will be further explored as a victim of domestic abuse within the analysis).

9.2 Women are more likely than men to be victims of high risk or severe domestic abuse: 95% of those heard at MARAC or accessing IDVA services are women. The Office for National Statistics 2023 found that 73.5% of victims were female. The Crime Survey for England and Wales estimated that 1.4 million women experienced domestic abuse between 2022 – 2023. Therefore, due to Jenny and Fran's gender they were at higher risk of being abused.

9.3 Jenny and Max had been married for 25 years, Jenny and Chris claimed this had been abusive throughout. Jenny took her marriage vows seriously and made it clear she would not consider

[4] https://www.reviewconsulting.co.uk/silp-reviews/
[5] MARAC – Multi Agency Risk Assessment conference.
[6] ISVA – Independent Sexual Violence Advocate, support for victims of sexual violence/abuse.
[7] https://www.gov.uk/guidance/equality-act-2010-guidance

divorcing Max. Although Jenny recognised the abuse, after so many years she had tried to manage her relationship and desperately sought to control the abuse she was subjected to. As such this may have created a barrier in her seeking help and support as she had been managing the situation for such a long time.

9.4 Jenny's children were not Max's; however, he had been part of the family since they were teenagers. He has a child from a previous relationship but has no contact with them. Child to Parent violence (of any age) can often be misunderstood and the risks not identified by those who engage with the family. The dynamics within the family where there is abuse from a child shift. The abused parent may feel unable to keep themselves or others safe. They can also struggle with the consequences regarding reporting, not only for themselves but also their child. With these fears it can create significant barriers in the victim seeking support.

9.5 There was no information to suggest Jenny had a disability although she suffered from agoraphobia and experienced mental health difficulties which impacted on her life. At the time of her death, Max was in supported living due to a brain injury caused after he attempted to take his own life approximately 18 months previously. Prior to this there were no known physical disabilities, however he had experienced issues with his mental health. Chris had no known disabilities, although he was known to mental health services.

9.6 Jenny told Police that she would be unable to leave Max due to being Catholic therefore this impacted on her regarding what options she felt she had with regards to the marriage. No information has been provided regarding religious beliefs of any other person involved in this review that had an impact on the circumstances.

10. Dissemination

10.1 Following sign off from the Home Office Quality Assurance Panel, the Bracknell Forest CSP will ensure the documents are disseminated to the Domestic Abuse Commissioner, Office of the Police and Crime Commissioner (OPCC) for Thames Valley, the Chief Executive (or equivalent) for all partner agencies and services represented on the Review Panel, the Bracknell Forest Safeguarding Partnership, and the Thames Valley Domestic Abuse Coordinators Group. Anonymised electronic copies of the Overview Report and Executive Summary will be published on the Bracknell Forest Council website and copies of the report and letter from the Home Office Quality Assurance Panel be provided to the family.

11. Suicide the facts

11.1 At the start of June 2022 Jenny contacted Police after Chris had been verbally abusive and had pushed her against a door. She stated she was frightened and asked for protection from him, officer attended the following day. When they spoke to Jenny, she did not want to support an investigation, a DOM5[8] was completed and she was graded medium risk. A Domestic Violence Protection Notice (DVPN), non-molestation order and referral to the National Centre for Domestic Violence (NCDV) were discussed with Jenny but all were declined.

[8] DOM5 is Thames Valley Police's equivalent to the national DASH (Domestic Abuse, Stalking, Harassment and Honour Based Abuse) Risk Identification Checklist

11.2 A week later, Police attended Jenny's address following a call from her reporting that Chris had turned up at her home. He was arrested for the assault (reported the week prior). Jenny declined to provide a statement and stated the Police were making matters worse and that he would return and beat her. Jenny later called Police stating she wished to pursue a non-molestation order and requested support doing this.

11.3 The following day, Jenny called her youngest son Seth (not his real name) to say goodbye. Due to being concerned for Jenny's welfare he called for an ambulance (he was not at the family home at the time). Jenny was found at her home address having taken an overdose, she passed away in hospital shortly before 21:00 hours that same day.

12. Family and relationship background

12.1 Jenny had 3 children (all of whom are adults), her middle child did not live locally, her eldest child (Chris) stayed with her occasionally and her youngest child (Seth) lived with her on a permanent basis.

12.2 Records from 1980 indicate Jenny worked as a nurse/nursing auxiliary, it is not clear when she stopped working however, she was not working at the time of her death or during the time frame for this review. Max had been working with a nationwide restaurant, he was furloughed[9] during the pandemic, it is unclear when he stopped working but did not work after his overdose/brain injury.

12.3 Max was recorded to have been abusive to Jenny throughout the marriage which was witnessed by Jenny's three children (Max denied any abuse when he met with the chair).

12.4 Max did not have a positive relationship with Chris, and this deteriorated further when Chris assaulted him, which resulted in Max obtaining a restraining order against Chris. This prohibited any contact and impacted Chris's relationship with Jenny.

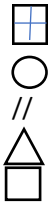
12.5 Chris had a history of violence within his intimate relationships and recorded as a perpetrator of abuse to Fran, he had no children with Fran or any other ex-partner.

12.6 Chris experienced domestic abuse as a child, had a history of substance misuse, mental health and at the time of Jenny's death was working with agencies within the criminal justice system.

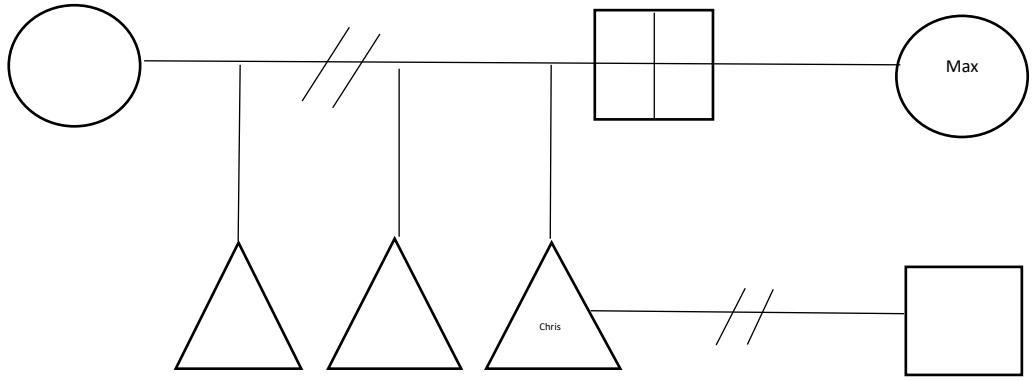
[9] A suspension of work due to the COVID-19 pandemic, payment for employee's were made by the UK Government.

13. Genogram

Key:



Jenny - Deceased
Male ex/partners
Divorced/Separated
Adult children
Fran - Chris's ex-partner



14. Chronology

14.1 There is very limited information regarding Jenny held by agencies, with extensive records for Max and Chris. The review has aimed to be proportionate in the amount of information included to ensure Jenny remains central to the review. As domestic abuse was identified between Jenny, Max, Chris, and Fran outside the dates of the terms of reference, therefore some information was included.

14.2 In 2018 Chris started his relationship with Fran.

14.3 Between 2018 – 2019 records within mental health services indicated Chris had longstanding substance misuse and criminality with violence. Chris appeared to have some 'paranoid' thinking, grandiose ideas and was preoccupied with the notion that Max had abused Jenny and his siblings. During this time Chris assaulted Max and a restraining order was put in place.

14.4 In August 2019 Chris was arrested for assaulting Fran, no further action was taken. In September, Fran engaged with Berkshire Women's Aid (BWA), unfortunately, she stopped engaging with the service.

14.5 The Crisis Resolution and Home Treatment Team (CRHTT) were contacted by Police in mid-December 2019 due to Max taking an overdose after stating he had thoughts of hurting Jenny and wanted to end his life. Over the next couple of days Max spoke to his GP and CPE, within these conversations Max spoke of his struggles within the relationship, Jenny's poor mental health, him having negative thoughts and not wanting to be alive anymore. He called Chris a '*junkie*' and that Chris had beaten Max up twice. Max felt Jenny "*nagged*" him, and he wanted to learn how to deal with this better so he would not become angry with her. Different offers of support were given and accepted; however, he did not engage with these services.

14.6 At the end of 2019 Jenny took an overdose and attended hospital after requiring resuscitation both at home and within the emergency department. She was seen by the hospital Psychiatric Liaison Team and discharged the following day. Within her discharge letter to the GP, it stated:

- Triggered by row with Max where he had stormed out the house and told her he was going to kill himself, he then returned a few hours later.
- Jenny advised that she said to him "*I will show you how to really do it*" and proceeded to take a load of her prescribed medications with the intention to "*prove to her husband that he should not threaten her that he is going to kill himself."*
- Jenny stated she was *"almost regretful of the incident."*
- She felt that what she did would make Max and the rest of her family "*listen more to her."*
- Assessed to be "high risk" of further overdoses due to impulsivity.

14.7 In February 2020 Chris saw his Care Coordinator, he admitted using cannabis daily and alcohol (not daily). He explained the restraining order against him meant he was unable to contact Jenny which resulted in him feeling he had no support and very alone. He reported Max bullied him he was 12 years old, that he loved his mum, described how Max had been violent towards Jenny and told of an incident when Max had grabbed her by the throat and threw her against the door frame. He continued to describe Max as *'a cold-blooded reptile'*. Chris was homeless and had not had a job since he took 'angel dust'[10].

14.8 From 23/03/2020 there was a national lockdown due to the COVID-19 (until June), resulting in Max being furloughed.

14.9 At the end of April 2020, Chris told his Care Coordinator he was living fulltime with his girlfriend (no details provided but believed to be Fran). He was encouraged to engage with Probation and housing to secure his own accommodation, take his medication as prescribed, abstain from illicit drug use and secure a bank account. During a further telephone appointment, Chris talked of a traumatic childhood, that he feared Max, stating Max had been 'sent to destroy', and described a little demon in his head that was constantly proved right.

14.10 Both Fran and Chris were given Acceptable Behaviour Contracts due to continued anti-social behaviour at Fran's home. A few months later in August 2020 Fran's neighbours reported they could hear fighting in the property, which Fran denied. A police partial closure order[11] was affixed to Fran's property in September 2020, both were arrested for breach of the order two days later. Whilst in custody Fran disclosed, she was struggling without Chris and was having suicidal thoughts.

14.11 Fran contacted Police in mid-November 2020 after she fled to a friend and reported Chris had broken her nose, as a result Chris was arrested and bailed. Fran was graded as being at high risk of harm by the attending officer, but this was regraded to medium by DAIU (Domestic Abuse Investigation Unit). Fran self-referred to Berkshire Women's Aid, and disclosed abusive

[10] Angel dust, also known as PCP (phencyclidine), is commonly found as a white powder. This powder may be smoked, eaten, snorted or injected, its powerful dissociative effects and ability to cause hallucinations. PCP is rarely consumed alone today. It's often sold in conjunction with other illicit drugs to create a more powerful high and add an addictive element.

[11] A closure notice prohibits access to the premises for the period specified in the notice. Only the police or a local authority can initiate the process to close premises which are causing antisocial behaviour, if they reasonably believe that there is, or is likely to be either: a nuisance to members of the public or disorder relating to the premises and in its vicinity. In addition, the notice must be necessary to prevent occurrence or re-occurrence of the nuisance or disorder.

behaviours including control, emotional abuse, sexual abuse, strangulation, isolation, threats to kill and use of weapons. She was identified as high risk of harm and referred to MARAC.

14.12 SCAS received a 999 call from Max at the start of December 2020 after an argument with Jenny. He was distressed, stated Jenny had "gone crazy" and he had left the house. He stated he had taken an overdose that evening, the tablets belonged to Jenny, and he wanted to die.

14.13 Fran had informed Silva Homes that at the beginning of December 2020 that Chris had nearly poured a kettle of boiling water over her and was going seek a refuge place out of area. She confirmed with Police the following day that she had ended the relationship, however a week later she disclosed to BWA that she was still in contact with Chris despite bail conditions being in place. By New Year 2021 there were concerns Fran was back at her address with Chris, she was heard at the start January MARAC. Four days after the MARAC Chris was found by Police hiding behind a door at Frans address. He was arrested for breach of bail and coercive control and remanded into custody. Fran fled out of area to a place of safety.

14.14 On two occasions in February 2021 Chris told a mental health practitioner in prison and SCAS that he heard voices telling him to harm himself. Chris was referred for assessment with Criminal Justice Liaison Diversion service for court in April 2021, he reported feeling low, not suicidal but had self-harmed.

14.15 Max was seen by his GP in July 2021; Jenny was with him. Max disclosed increased anxiety over the previous 3 months, which had worsened during the pandemic.

14.16 Reconnect[12] received a referral for Chris from Inclusion (mental health team) at the beginning of August 2021, for support to find accommodation upon release from prison and for his mental health and substance misuse.

14.17 Max called SCAS via 999 in mid-August 2021 stating he had taken an intentional overdose (with Jenny's medication) with the aim to die. Jenny was spoken to by ambulance staff who told them she was frustrated as Max had been fine all day and had then taken the overdose. The following day Max was referred to Psychological Medicine Service he reported he and Jenny had argued, he took an impulsive overdose and wanted the arguing to stop. He told them the relationship was often strained, that he loved his wife but she '*gets on top of him and he feels helpless*'. Jenny was spoken to via telephone, and she disclosed Max was emotionally abusive and controlling. She attributed his overdose to her going out with her son for a few hours, as he would take overdoses to manipulate the situation, however, she loved him, would always have him back and expressed no concern for her safety. Max showed no evidence of mental ill-health, was able to reflect and showed insight into his behaviour and the situation. That same day Jenny booked a call with the GP for Max, she described him as displaying obsessive/compulsive traits and attention seeking behaviour. She gave an example of when he removed all her clothing from her wardrobes so she could not find them. When she questioned him, he told her he did not remember. She explained she found him controlling, for example he told her what to wear and was verbally abusive. Jenny felt "*something was brewing*" as his behaviour was more erratic, but she did not feel at risk from him. She described poor sleep, no alcohol abuse, and that she was housebound.

[12] Reconnect is a service to support people leaving prison to help address health inequalities. They support people to engage with community services then they will discharge.

14.18 Chris pleaded guilty to the assault on Fran and not guilty to coercive control which the CPS[13] accepted. He was issued a suspended sentence and a 10-year restraining order. He was released from prison at the start of September 2021 and began to engage with New Hope.

14.19 During September Max received an initial assessment with Talking Therapies, he stated he felt anxious, irritable and that he was not good enough. He described that he felt he could not do enough for Jenny, wanted to be better and hated himself. He disclosed poor communication with her, claimed she drank a lot of alcohol and that if he '*disappeared*' it would help her. He was provided with a self-help booklet; 'Behaviour Activism and Cognitive Restructuring'.

14.20 Jenny called her surgery at the end of September and spoke to the receptionist, her notes state, "*Jenny called to cancel her Physio Appointment. She was very emotional on the phone reporting that she was unable to leave the house due to her husband's behaviours. She reports she hasn't slept since Sunday and feels she cannot cope anymore. I gave reassurance that we can rearrange the physio appointment and Jenny reported she would call back to rebook when in a more settled frame of mind*." The GP called Jenny who was in tears, she reported Max had bitten her arm and it was swollen and painful and that she had collected Chris from prison. She refused to come in for a face-to-face appointment as she stated she was "*protecting*" Max. The GP explained their safeguarding concerns for her, managed to persuade her to attend the next morning and sent an antibiotic prescription to the pharmacy in the interim. The GP saw Jenny who had a bite injury to her left thumb. She informed them her first marriage failed, that she loved Max, but he would tease her like she was a child until she reacted. The GP explained the safeguarding risks around her situation and deemed her to have mental capacity to make decisions. They discussed a referral to domestic abuse specialist services, but this was refused. She was advised that if she ever felt unsafe to call the Police and an appointment was made for one week later. Jenny attended her follow-up appointment, had a discussion surrounding safeguarding and she told them she was coping better. The GP explained risks of impulsivity and advised her to be careful, she told them that she would '*press charges if anything happened again*'. An x-ray of Jenny's left thumb was requested due to restriction in movement, but Jenny was reluctant to attend, a follow-up appointment was booked for 4 weeks later.

14.21 During a session with Talking Therapies, Max reported Jenny had punched and hit him, he was very scared and had tried to hold her down. He added he had memory problems and did not want to report to the police. He declined a referral to domestic abuse services saying, 'Jenny would go crazy if she found out'. He was told the disclosure would be escalated to the BHFT[14] safeguarding team for advice due to concerns the violence was escalating. This was completed the following day and advice was given to complete the DASH RIC[15] with Max. Max's therapist contacted the GP and advised them they would be completing the DASH RIC due to his disclosure, they raised concerns regarding him being low, self-critical and did not want a management plan and would update them of the outcome. Attempts were made to contact Max to complete the DASH RIC however, these were unsuccessful.

14.22 SCAS received a 999 call mid-October 2021, Max was distressed and stated they had had an argument and 'Jenny *had gone crazy*', he had left the house and taken an overdose of her tablets. He told paramedics Jenny had assaulted him, he wanted to die and was unsteady on

[13] Crown Prosecution Service
[14] Berkshire Healthcare NHS Foundation Trust
[15] Domestic Abuse, Stalking, Harassment and Honour Based Abuse Risk Identification Checklist

his feet. SCAS called Police due to the concern for Jenny's welfare after Max told them she had taken an overdose. Police spoke to both Jenny who confirmed she had not taken an overdose and that Max was playing games. Officers attempted to speak to Jenny about the report of her assaulting Max, she was reported as being dismissive and was arrested on suspicion of the assault. Seth told officers there had been an argument between Jenny and Max, neither had assaulted the other and that Max had been threatening to hurt himself all day and had then left the house. Jenny then told officers she had put up with Max for 25 years and did not want to put up with him any longer, but that she did not want to get him in trouble. Jenny was de-arrested and graded standard risk.

14.23 Jenny later called Police asking why she had been arrested and de-arrested, whilst on the phone she became very upset and stated she had been a prisoner in her home for the previous 11 years. She told them that before they arrived, Max stole her heart medication tablets, punched a wall, and asked her if she "*wanted one next*" and that the situation had made her want to die. Officers attended the home, when they arrived Jenny was described as hysterical, backing away from officers, and not making any sense. During completion of the DOM5 Jenny stated Max had been like this throughout their marriage, but she would not leave as she was Catholic. At the time of completion, Jenny was drunk, and her account was confusing. She said that Max did not allow her to leave the house to see her GP, Jenny was graded medium risk. Chris was present but Jenny kept telling him to shut up when he tried to aid communication.

14.24 Jenny contacted CMHT at the beginning of November requesting Chris's appointment was rescheduled due to Max being in intensive care after a significant overdose. She reported Chris was doing well, had spent most of his time with her, walking the dogs and making her cups of tea. CMHT called Chris a couple of days later and he stated he was trying to support Jenny. 3 days later the GP called Jenny who advised them that Max was in hospital, she alleged he had laced a cup of tea with her prescribed medications and written a note saying his intention was to kill her and himself. A few days later, she contacted the Police and made the same allegations as she had told her GP. Seth also told Police that Max had left a suicide note which said something along the lines of "*see you down the river*." Jenny was graded medium risk, Chris then called Police making the same allegation, no further action was taken.

14.25 In mid-December 2021 Jenny spoke with the Psychological Medicine Service and reported Max had been violent and aggressive all his life. She was aware when she met him that he had a diagnosis of manic depression and had previously had an inpatient hospital stay. She described how things had worsened over the past 3 years with an escalation during the previous 6 months. He had been physically aggressive where she had sustained injuries, he would be very agitated which could last several days, and this was happening every month. She said more recently he was acting strangely, talking to himself, and claimed he could hear voices. She expressed she could not cope with him and would not want him home, however, would support him if he lived elsewhere.

14.26 Chris contacted New Hope on New Years Day 2022 to advise that he had been arrested over the Christmas period (there is no record of this arrest) and had "*fallen off script*"[16]. 3 days later Chris called 999 for an ambulance as Jenny had taken an overdose and had been drinking. Chris was not aware what she had taken and claimed she had hit him whilst he tried to get

[16] This meant that Chris had failed to collect prescriptions.

her medication away from her. Police attended the property, Jenny appeared to be intoxicated, and her mental health was described as poor, however, she was coherent and not lacking capacity. Chris confirmed a verbal argument but denied any assault had taken place and refused to complete the DOM5, which was graded standard risk. The incident was filed, and no further action taken.

14.27 At the start of January 2022 Jenny's middle child called Police (he was in Kent) and reported whilst he was on the phone to Jenny, he could hear a domestic incident between Jenny, Chris, and Seth. Jenny also called police stating that Chris *"was going mental"*, had smashed things up and pushed her. On police arrival both Jenny and Seth disclosed assaults by Chris but did not wish to support police action, declined to complete a DOM5, they were graded medium risk. Whilst on scene officers called SCAS via 999 at 01:47 hours, due to concerns for Jenny. 20 minutes later Police made a further call for an ambulance stating Jenny's medical condition was worsening, she was complaining of pains in her shoulder, had bruising on her shoulder which looked new (she was unable to explain how she had sustained them) and that she had also been experiencing palpitations for the last few days. At 02:22 hours the ambulance arrived, Jenny complained of chest pain radiating into her arm and shoulder and reported to have periods of loss of consciousness. It was noted she had a reduced level of consciousness whilst the ambulance crew were assessing her. She was initially uncooperative and repetitively told the crew that she "*hated men*", she was persuaded to attended hospital. She self-discharged the following day. Chris was arrested for the assaults on Jenny and Seth and further arrested in custody for assaulting an emergency worker. He was bailed for the assault of Jenny and Seth, however, he was charged and remanded to court for assaulting an emergency worker.

14.28 When Chris did not attend a planned phone call with his Care Coordinator a few weeks later, they spoke to Jenny, she spoke of his arrest and recalled how he had started to drink neat alcohol and had "*lost it*" so they had to call the Police. She did not want to support charges and wanted him to come home, so they needed to change the bail conditions. She informed them that although Chris kept asking her for money he was contributing to rent/food and bills. She claimed he was smoking cannabis but was unsure about other drugs.

14.29 Jenny saw her GP at the beginning of February 2022, she told them that Max was still in hospital, he called her every day, and she did not want him home. She was struggling to sleep, was offered medication and had a follow up appointment to check on her welfare. Later that month Jenny informed the GP that Max had moved into the community. The GP spoke to Jenny two days later who described having panic attacks, that she felt guilty about Max, was stressed, and was having flashbacks of the distress she had been through. At the end of February Chris received a further custodial sentence for assaulting an emergency worker.

14.30 At the beginning of March 2022 New Hope closed Chris's case as he was in prison, however, upon his release he re-engaged with the service with specific conditions. The day after his release, Seth called 999 for an ambulance stating Jenny had fallen and sustained a head injury. The call taker reported the scene to sound "hectic", as a result Police were informed, and an ambulance was arranged. Police arrived at Jenny's home where Seth explained Chris had returned to the address, he had heard an argument outside his room and when he came to the door, he found Jenny on the floor and Chris was leaving. Jenny was lying face down complaining that her head hurt, she had a large lump to the back of her head and complained

she could not move. She initially stated that Chris had punched her to the head, but then retracted this saying that she had fallen and hit her head. A DOM5 was refused; however, she was graded medium risk. Police contacted Probation and informed them that Chris was wanted for the assault, they were informed he was due to attend an appointment with them at 14:00 hours that day. 15 minutes after the initial call to SCAS Seth contacted them again stating Jenny had a lump on the back of her head, she was bleeding from her nose and that Chris had hit her. Jenny was heard to say, "*let me die*" and "*don't touch me*" when he tried to help her. As a result of the calls SCAS completed a referral to Adult Social Care. As a result, a social worker made attempts to contact her but there was no answer. The Police called SCAS 1 hour after the original call with concerns for Jenny, Seth then called 2 more times with concerns that Jenny was "*drowsier*", "*cold to the touch*" and a "*deathly colour*", was confused and did not know who anyone was including him and was saying that she wanted to go home even though she was already home. He reiterated that Chris had pushed Jenny, she had hit her head, and he believed that she had cracked her skull. He reported that Police had attended the address but left. An ambulance had already been arranged from the original call.

14.31 4 hours after the original call, an ambulance arrived, it was reported that Jenny had had a period on unconsciousness, but it was unclear how long for. She reported tingling in her legs immediately after the assault/fall, had become confused around 2 hours after the injury and her mobility had not been normal. Jenny was reported to be "*profoundly agitated*", saying she was 13 years old, would like to go home and did not recognise Seth. Jenny complained of a severe throbbing headache, pain to her shoulder and neck, was off balance and a large haematoma with bruising was noted to the back of her head. Jenny was conveyed to hospital where Seth told staff that Jenny presented as confused on purpose as she did not want to press charges against Chris.

14.32 Chris failed to attend his scheduled appointment with Probation, turning up at 17:00 hours.

14.33 That same day Probation issued a Licence Compliance letter[17] to Chris for failure to attend his appointment, they liaised with Police who were concerned Jenny would not engage due to being scared, however, her injuries were recorded on a Body Worn Video camera and the investigation was pending whether an evidence led prosecution would be considered. Chris was wanted by Police, and they felt he should be recalled. Probation explained if he were arrested, he would be released on bail and then there would be a warrant for a recall.

14.34 After Jenny was discharged from hospital, she attended the police station to pass phone details for Chris and told officers that she feared him. Chris was arrested and bailed with conditions for further enquiries to be completed. The following day after her hospital release Jenny was seen by her GP (she was with Seth). She described that Chris had been released from prison and went to her home, he was being loud and drank lots of alcohol. Jenny had gone upstairs to the bedroom where he was sleeping to tell him to leave, he pushed her away and she fell. Seth told the GP that he was "*looking into protection for his mum from Chris, through the Police*."

14.35 Chris failed to attend his scheduled appointment with Probation, a further Licence Compliance letter was sent. As a result of the arrest additional licence conditions were requested, and a text was sent to Chris with his next appointment. He called stating he was unaware of the

[17] A letter to those who are not complying with their licence conditions, the expectations of their engagement, and consequence if they are not compliant.

appointment and agreed that he would report the next day. Chris was arrested the following day for the assault on Jenny and released on bail.

14.36 At the end of March, Chris attended a Probation appointment. He was very hostile and spoke about lack of support, stating agencies would pay as they had failed to support him. He believed agencies had a vendetta against him and it was only going to end in death or him being sent back to prison. A few days later Probation called Police to report they suspected Chris was staying at Jenny's address, which was in breach of his bail conditions and there were concerns for her welfare. She was visited and told officers that she had not been in contact with Chris since the incident in March.

14.37 The following day, Max's Care Coordinator called Jenny who told them of the incident with Max making her a cup of tea which she believed had medication with an aim to harm her. She described "*loving him to bits*" but could not trust him and did not want him home to live with her. Jenny was told that Max would tell workers that he would rather end his life than be without her. Jenny was aware of this as he would tell her the same. The Care Coordinator identified there was concern about the risk of harm to Jenny from Max and the possible intention to end both of their lives.

14.38 The Officer In Charge of the assault on Jenny made a request for the bail to be changed to 'Release Under Investigation' while the investigation continued, this was agreed in mid-April. In the interim Jenny called Police to say that Chris had contacted her by phone and sent her a Mother's Day card. He also told her that he had been looking over the garden fence.

14.39 Max's Care Coordinator and a practitioner from CMHT older adults' team carried out a home visit to him in supported living. Max reiterated he would rather kill himself than be unable to live with Jenny stating that was why he had taken the overdose so he could leave her in peace. He denied attempting to kill anyone else. His residential keyworker felt he was desperate to be back with Jenny, but she would not have him home until he was 'better'. They remained concerned about the risk to Jenny with the allegations of Max putting medication in her tea as well as Max's overdoses.

14.40 At the end of April 2022 Chris was recalled to prison and returned to custody, Chris reported that he purposefully got himself recalled so he could get a good night's sleep and 3 meals a day. Upon his release he told his Probation Officer he was motivated to work with agencies, to get off the street and wanted to stay with a friend in another area, but this was not possible due to licence conditions to remain in Berkshire.

14.41 During a Teams meeting between Max's Care Coordinator and the CMHT Psychiatrist there was a discussion that Max had admitted trying to end Jenny's life as well as his own, however, he then stated he could not remember. He was diagnosed with severe depression and prescribed antidepressants.

14.42 Max was seen by his Care Coordinator to review his mental health and discuss his future living arrangements. Jenny was present for some of the visit and professionals observed them arguing. It was recorded that '*Jenny had little time for his tears, she said he was putting it on and that he had tried to kill her*'. Max's key worker reported that a few days earlier Jenny and Chris had visited Max, Chris's presence had caused Max a huge amount of distress as both had

accused him of trying to kill Jenny. Staff commented that neither Max nor Jenny were good at listening to each other. There was a discussion regarding the couple finances and Jenny was offered support to help sort this, but she declined. It was evident their relationship was of concern and abusive, but staff were unclear who was the primary victim. A Complex Case Discussion was arranged in mid-May, information was shared regarding Max's brain injury, the allegations of domestic abuse and concerns that practitioners were unable to identify who was the primary victim. There continued to be concerns regarding the risk of suicide by Max. Chris was discussed and due to his aggressive behaviour at Max's accommodation he was no longer able to come to the property. The Care Coordinator asked Police if Jenny was at risk of coercive controlling behaviour from Chris as there were concerns Max's money was still going into their joint account. Jenny had also disclosed to the Care Coordinator that she wanted to move; however, repairs would need to be done where holes had been punched in walls and doors. It was agreed Max should remain in supported living as it was not safe for him to return to live with Jenny.

14.43 At the end of May, Jenny requested a telephone call with her GP to increase her anti-depressants. She spoke to a GP (not her regular one) and reported her mood was still up and down on her current dose but did not have suicidal thoughts.

14.44 At the start of June, Jenny called Police and reported Chris was verbally abusive to her and that he had pushed her against a door. Chris walked out of the house and Jenny stated she was afraid of him, needed protection and Seth was with her. Officers attended the following day; Jenny was not supporting an investigation but did complete a DOM5 which was graded medium risk and consented to a referral to NCDV. A DVPN and non-molestation order were discussed but Jenny did not want either. Chris attended New Hope four days after Jenny had called Police. He did not present well (sweating, pale, out of breath) had fallen off script and had not collected since the end of May.

14.45 A week after calling the Police Jenny called again reporting Chris had turned up at her address, officers attended and arrested him for the reported assault seven days earlier. Jenny declined to provide a statement, saying that the Police were making matters worse and that he would return and beat her. Upon arrival in custody Chris appeared drowsy, had slurred speech and was unsteady walking, he complained of blurred vision and nausea, and he had a head wound. An ambulance was called, and he was taken to hospital where no concerns were identified after a CT scan. He returned to custody in the early hours of the following day but was transferred back to hospital after further concerns for the same head injury.

14.46 After officers left Jenny, she called Police saying she wished to pursue a non-molestation order and would require support in doing this, as she was agoraphobic and did not know how to get in touch with the courts. An officer who was due to deal with Chris in custody called Jenny, but she hung up three times, saying that she did not want to live anymore. Due to concerns for her welfare, they arranged for officers to attend her address. However, before this could happen Seth called for an ambulance via 999, reporting Jenny had taken an overdose of unknown medication. He reported that she had called him say goodbye and that she was crying (he was not with her at the time of the call). The call handler called Jenny, she refused to answer any questions and said that she wanted to be left alone. She stated that she had not slept in years and wanted to go to sleep. She told them the front door was locked and that she had drunk a bottle of vodka and "a tonne of pills".

14.47 An ambulance arrived at Jenny's address, initially Jenny refused to answer the front door. The ambulance crew noted that the back door appeared to be open but due to hearing multiple dogs on scene barking, they were not willing to climb over the fence to gain entry. Jenny eventually opened the door and returned to bed, she told the ambulance crew that she was a "*victim of domestic violence from her son and father*" (it is unclear if she meant Max or whether she had also been subjected to domestic abuse as a child). Jenny refused to be assessed and was reported to be verbally aggressive. She stated that she had taken the overdose with the intention of ending her life and refused being taken to hospital. It was deemed Jenny did not have capacity to make decisions due to failing the capacity assessment. Police were requested for assistance to remove Jenny from the address and transport her to hospital. Police arrived at 16:02 hours, despite continuing to refuse to be assessed she eventually agreed to attend hospital with Police assistance. She was conveyed to hospital via ambulance with Police following. A concern for safety report was recorded and an Adult Protection template was completed and shared with Adult Social Care.

14.48 Jenny passed away a short while after arriving at hospital.

15. Effective Practice and Learning

Information Sharing

15.1 Information sharing is essential for individuals to receive the right services at the right time and prevent a need from becoming critical and difficult to meet. When information is looked at in isolation agencies are unable to see the whole picture and are unable to appropriately risk assess and offer the most appropriate intervention.

15.2 Organisations involved with Jenny, Max and Chris were proactive in sharing information and holding different multi-agency meetings. These were all held by those working with Max or Chris with Jenny also being discussed but she was never the central focus. Even though information was shared about Jenny's overdoses, and concerns for her welfare, the domestic abuse appears to have been lost with regards to the causal factor to her presentation. If this had been identified and the risks shared via MARAC, or another multi-agency processes, specialist domestic abuse provision and intervention may have been achieved.

15.3 That said there were examples of positive practice:

- Police were proactive in their referrals to adult social care for Jenny (even though there is no record of receipt from these by social services – this will be further discussed within this section).
- SCAS shared their concerns for Jenny referring her to Adult Social Care.
- Max's Care Coordinator discussed Max at the Complex Need Forum where Jenny and Chris were discussed, and concerns raised.
- Chris's Care Coordinator repeatedly made attempts to engage with him by seeking support through other agencies working with him.
- There were several multi-agency meetings held regarding Chris by Probation ensuring those involved in his support was invited.
- The Prison interacted with the community teams to try and ensure a plan was in place upon his release.

- The hospital and SCAS informed the GP of Jenny's overdoses and concerns for her well-being.
- Silva Homes were able to work with Fran and other services to remove Chris from her property and she was able to find safety in another area.
- The outcomes achieved with Fran during BWA's support were directly linked to consistent, positive multi-agency working. Professionals collaborated to secure space in refuge that met her needs and ensured that the barriers to leaving were mitigated as far as possible. This involved securing a transfer of clinical support to her new local area, securing transport, and working with her to ensure she was fully informed of her rights around her existing tenancy.
- Agencies were also proactive at engaging in support planning, with New Hope and BWA collaborating on a safety plan for Fran to ensure the alarm was raised if she did not attend appointments and how they would manage attendance times for her and Chris.
- BWA led the search for the refuge working closely with New Hope to ensure all support was transferred to the refuge.
- It was also clear that the working relationship Fran gained with the TVP officer promoted positive professional contact and supported her to assess her options and enter refuge.

15.4 However, there were opportunities where information could have been shared and wider discussions:

- The risk to Jenny was never seen as high even when there were high risk factors and the abuse was escalating, this meant she was not heard at MARAC or received an offer of support by an IDVA.
- There was limited interaction by Police with Probation to ensure those working with Chris were aware of the current situation and risk, especially after his arrests.
- No intelligence was submitted in relation to the report from Probation that he was not engaging with his licence and was back at Jenny's property.
- When Chris's Police bail was changed to 'Released Under Investigation', he had already breached his bail conditions, which Jenny had called to inform the OIC. The OIC did not acknowledge or follow up on. Since this Thames Valley Police have implemented Operational Guidance on 'Releasing domestic abuse suspects – Released Under Investigation (RUI)'. To comply with College of Policing guidance, for suspects in custody, before releasing them under investigation (RUI), medium and high-risk cases must have a full rationale documented by a detective inspector. Standard risk cases must have a full rationale documented by the PACE (Police and Criminal Evidence Act 1984) inspector. When converting bail to RUI, medium and high-risk cases must have a full rationale documented by a detective inspector and standard risk cases must have a full rationale documented by an inspector. It is essential therefore that officers ensure that they conduct regular checks of investigation logs to make sure they do not miss information relevant to any decision making especially with regards to safeguarding and domestic abuse.
- When Jenny reported Chris sending the Mother's Day card and peering through her garden fence in April 2022 he had breached the conditions of his prison licence. There is no record that this information was seen by the OIC or shared by Police with Probation. Probation was therefore unaware of this breach of licence conditions. Officers must ensure that they review the content of investigation logs and share information with other

agencies as appropriate as this would have helped Probation gather evidence and make an informed decision whether to recall Chris.

- Chris would have benefitted from being managed under the IOM. Eligibility for the Flex cohort seems to be less understood, and Probation Practitioners need to have confidence in making referrals, challenging refusals, and engaging people on Probation in the scheme. An action will be set for the IOM Strategic Lead to secure management information to provide assurance that relevant cases are being considered.

Record keeping

15.5 Accurate record keeping is a vital part of effective communication within all organisations who work with vulnerable people as it ensures the continued safety of those in need of support. Throughout this process there has been evidence where records were not as detailed as expected. This may have been due to the pressures of workloads and the ability to be able to have recorded conversations and concerns.

15.6 The impact with the absence of detailed records was evident in these circumstances:

- The lack of recording around the decisions not to escalate Chris's case within Probation to support the IOM referral makes it difficult to understand the professional judgements made.
- A recall to court should have been considered by the Probation Practitioner due to Chris's arrest in June 2022 and his lack of engagement with any decisions clearly recorded by the supervising officer. It is unclear why this was never completed.
- Jenny's GP records did not have any problem codes regarding the abuse, self-harm/suicidal, or mental health. There was an opportunity for the GPs to use accurate and appropriate problem codes on the Primary Care Records as well as looking at the use of "warning flags" on the notes to highlight significant issues to all clinicians.
- When Police record 'refused to answer' on their DOM5 or within their notes, they need to be able to detail their observations as well as the victim's responses.

Recognising and responding to counter allegations

15.7 Counter allegations can be difficult for any frontline worker to manage, navigate and respond to. Many of those who abuse will make counter allegations to continue the coercive control over their victims. It enables abusers to create doubt by professionals regarding the victim and seek to control the situation and professionals. All practitioners should be aware of counter allegations and the motivation behind them. It can be dangerous for the victims when there are counter allegations made as risk may not be evaluated appropriately and unsafe referrals may be made.

15.8 Max made counter allegations against Jenny, which resulted in Police arresting and de-arresting Jenny, which caused her distress which was evident when she called the following day to understand the reasons for her arrest. Even so, Max was not spoken to after this allegation and no DOM5 was completed with him. Max was a known victim of violence from Chris and there had been repeated calls to the home, but the allegation was never fully investigated. The Sergeant should have ensured that Max and any other persons involved were recorded correctly, and fully investigated, before filing, to maintain accurate information. This was a missed opportunity to have explored Max's perception of the

relationship as well as speaking with Jenny when she wanted to have further understood of the arrest.

15.9 From 2020, Thames Valley Police commenced the roll out of the SafeLives DA Matters training programme. As part of this, there are now Domestic Abuse Champions throughout the organisation. The training programme helps police to 'understand what is meant by the term coercive control, challenges victim blaming and prompts them to recognise the high levels of manipulation used by those perpetrating it, including in interactions with law enforcement'.

15.10 Other agencies also recorded their concerns regarding both Max and Jenny being victims and perpetrators of abuse and not knowing who and where to go to. Practitioners do not need to be experts in this however, they should feel confident and competent to explore the abuse, appropriately risk assess and seek advice and guidance from domestic abuse specialists. The Bracknell Forest Domestic Abuse Strategic Lead has shared the SafeLives Counter Allegations resource to all panel members to support with their learning and development as well as sharing it with frontline staff.

Professional curiosity

15.11 The term 'professional curiosity' links closely with 'respectful uncertainty', where those working with vulnerable people should attempt to view a situation with a critical eye. Questions should be asked, with inquisitive enquiries to try to establish what circumstances someone is in. Those who are working with vulnerable people should be professionally curious in a respectful way to ensure the person does not feel judged and the relationship between them and the worker is not damaged.

15.12 There was little professional curiosity by any of those who engaged with this family. The DOM5 was utilised by Police however, there does not appear to have been any further enquiries into the impact the abuse was having on Jenny. This would have enabled officers to look at Jenny's situation with a wider lens and considered coercive and controlling behaviour offences by Max and Chris.

15.13 Jenny also shared with Police that her neighbours were witness of the abuse. Many incidents of domestic abuse happen behind closed doors with very few opportunities to have witnesses to these offences. When a victim provides details of witnesses it is essential all lines of enquiries are pursued or eliminated as not doing so may result in a possible loss of available information to inform the investigation and safeguarding.

15.14 Silva Homes dealt with Fran initially for anti-social behaviour and did not consider domestic abuse. It is essential all housing providers understand the complexities and use their unique position as landlords to explore what is happening being closed doors and feel able to assess the risk and offer appropriate interventions.

15.15 Other professionals who worked with Jenny dealt mainly with the presenting issues rather than exploring what was happening for her. Jenny presented with the trio of vulnerability (domestic abuse, mental health, and alcohol misuse). These were mainly dealt with in isolation rather than looking at the whole picture. If the whole picture had been understood and assessed, the interaction and offer of support may have looked different for Jenny.

Exploring risk, safeguarding and interventions

15.16 A noteworthy area of concern with regards to a gap in safeguarding was with Adult Social Care and its process when in receipt of referrals. Police were proactive with much of their attendance to Jenny with completing an Adult Protection template. When reviewing Adult Social Care information as part of this review, they had no record of any of these referrals from the Police and only recorded the two sent by SCAS.

15.17 The chair of this review spoke with the Assistant Community Services Manager from the Adult Social Care Hub (a single point of access for all adults into adult social care) who explained, up to 30/09/2023 Bracknell Forest Adult Social Care Services consisted of several teams, all of whom had their own route into their services:

- Adult Community Team– working with Adults 18+ with physical disabilities and long-term conditions (e.g. Diabetes etc)
- Community Team for People with Learning Disabilities– working with Adults 18+ with learning disabilities and Autism.
- Community Mental Health Team for Older Adults– working with Adults over 65 with Dementia diagnosis.
- Community Mental Health – working with working age Adults 18 – 65 with enduring mental health diagnosis.
- New Hope – Drug and Alcohol Team.

15.18 Most enquiries and referrals were received through a generic adult services email account, which was monitored by administrative staff linked to the Adult Community Team. Individuals would be checked to ascertain if they were known on the system and if known and linked with a team, the enquiry/referral would be forwarded direct to the team for them to action as appropriate.

15.19 The Adult Community Team administration would not be responsible for uploading the referral onto the system if the person were known to another team. If the person were unknown, then this would be passed to the Adult Community Team for a Senior Social Worker to triage and decide who the most appropriate team would be to action. This would then be forwarded directly to the team unless the Adult Community Team felt the referral should be progressed.

15.20 No records would be automatically recorded if the referral were received regarding other teams especially if the person were not on the Bracknell Forest Council computer system. Adult Community Team do not have access to RIO (health systems), therefore would be unable to ascertain if the person were known to health e.g. Mental Health records. They would not have been aware of any actions undertaken by teams following the transfer of the referral as these would not be recorded on the council system.

15.21 During COVID-19, referrals to the Adult Services email account increased significantly and it became apparent that the Adult Community Team were not equipped to manage the requests on behalf of all the other teams and it was recognised there were numerous routes into Adult Social Care Services.

15.22 From the start of October 2023 all referrals/access into Adult Social Care Services go into the Adult Social Care Hub where the team is made up of staff from the Adult Community Team, Community Mental Health Team for Older Adults and Community Team for People with Learning Disabilities. All referrals are recorded onto the system with a decision and rationale recorded as to initial actions. If the person is appropriate for CMHT, the contact would be forwarded to action as per their process. If the person is not on the system, the Hub Seniors will create the person to enable to a record of contact, actions, and input as appropriate.

15.23 As a result, even though Police were proactive with their referrals and sending them to the correct email address they assumed intervention was being taken, but these were never recorded or actioned by any of the social care teams. It is unclear why the two SCAS referrals were recorded (no action was taken which the reasons are not recorded) creating some confusion as to why certain referrals were considered and others not.

15.24 Adult Social Care has reassured the chair that the new system now records every referral received into the Hub and all actions and decisions are recorded within the persons notes. It is concerning for the chair and the panel that there were 1000's of referrals made by agencies to Adult Social Care but due to the old process many were not recorded or taken forward leaving referrers with a false sense of assurance some action had been taken for those vulnerable in the community.

15.25 Risk is dynamic which has been demonstrated throughout this review. Although the Police identified Jenny as medium risk through the DOM5, there were other occasions where different agencies should have been proactive in completing DASH RIC's as well. There was an over reliance on the Police risk assessments, resulting in other agencies taking the opportunity to explore the risks to Jenny at different times and by different workers. Jenny may have made different disclosures to different professionals who she had confidence and trust in. Therefore, all of those who work with people should be aware of the DASH RIC and feel able to complete them when required.

15.26 In the context of Jenny being the subject of previous adult protection referrals and Max being in hospital after an overdose, the OIC should have tasked the Police within the Multi Agency Safeguarding Hub, so they had an opportunity to review whether it was necessary and proportionate to refer on the concerns to Adult Social Care. Additionally, there is no evidence to indicate support services were offered to Jenny regarding mental health, alcohol, or domestic abuse when she was assaulted by Chris.

15.27 The Complex Case Forum correctly identified Jenny would be at risk of harm should Max return home and were able to safeguard her by exploring alternative care options for him. They were also able to discuss the concerns they had for Max when Jenny and Chris both visited him in supported living and the impact Chris's behaviour had on Max. They made positive safeguarding provision to stop Chris attending and were making efforts to support Jenny make the changes to Max's pension and finances.

15.28 The partial closure order on Fran's property enabled Silva Homes to stop Chris coming to the property, however, this meant Fran was also punished when he returned. Victims of abuse are never to blame when abusers use coercion, control, and fear to return to the home. Fran was listed as a perpetrator of Anti-Social Behaviour rather than a victim of domestic abuse;

this was not appropriate and should have been amended as soon as the domestic abuse was known. Additionally, Chris was never listed as a perpetrator linked to the property, this may have been due to him not being a tenant. However, it is possible to add non-Silva Homes tenants to a case, which can be done manually. If Silva Homes are made aware of people who pose a risk to a customer, these records can be flagged for colleagues to be aware of.

15.29 On BWA's contact with Fran in November 2020, a DASH RIC was completed with a score of 19, indicating she was at high risk of serious harm or fatal assault. At the time, BWA's processes were to allocate the case to an outreach worker who would complete the referral to MARAC. Due to the challenges in being able to establish successful contact the referral to MARAC was delayed and was not completed until a month after the initial contact. Whilst several professionals were involved, referrals to MARAC are essential to ensure all agencies are aware of the risks to the individual and can take appropriate steps within their agencies to mitigate these. The delay in referring to MARAC was unsatisfactory as any delay has potentially significant implications for ensuring the safety of survivors identified as high risk.

15.30 BWA's processes were updated in 2021 to ensure that Helpline team members complete a MARAC referral immediately in response to a survivor being identified as high risk. Helpline team members outline the nature and purpose of MARAC and provide the client with the opportunity to provide informed consent, noting however that this can be overridden, in high-risk cases, if the client does not consent.

15.31 In relation to Fran, the BWA worker provided a comprehensive response to ensure all appropriate agencies were informed of the various concerns raised and were able to take appropriate follow up actions, including:

- A referral to Children's Social Care for Fran's children and to Adult Social Care for an unrelated third party about whom they received a disclosure.
- A referral to the Crisis Team and No Woman Turned Away to address Fran's immediate needs.

Experience of staff and increased work-pressures

15.32 There is always the risk that with inexperienced staff there is a higher chance that risks will be missed, and processes will not be followed. This is not to blame those coming into new roles as they require time, training, and supervision. Unfortunately, with increasing caseloads, pressures on time and the lack of mentors to support new staff this can lead to mistakes being made.

15.33 This was especially evident within Chris's case and Probation. He had three different Probation Practitioners all of whom were not experienced to be overseeing a high-risk offender. The new Probation Practitioners had little managerial oversight which in turn impacted on their decision making and their ability to follow organisational expectations, these have been fully explored within the analysis.

15.34 The HM Inspectorate Report on Probation 2022/23 found that within Probation a repeat finding was high number of inexperienced staff and lack of experienced staff. In addition to the under-staffing of frontline roles, the report also found shortages of Senior Probation Officers. Staff interviewed talked about the pressure and responsibilities for line managing

large numbers of Probation Practitioners. They felt this led to a weakened 'first line of defence' against the mistakes that new and inexperienced practitioners could be making, and limited opportunities for reflective supervision and coaching.

15.35 It also found that there was dangerous practice with inexperienced staff holding high risk cases with high caseloads, which in turn impacted the staff's ability to safely manage these offenders.

15.36 To ensure this risk is reduced, new members of staff should be provided with Senior Probation Officers who are confident in their role, are able to provide insightful oversight and guide them with difficult and complex cases.

15.37 Probation is not the only organisation to face these challenges, all statutory services are under extreme pressures with recruitment, retaining staff and demand on services. This can at times be a dangerous cocktail where risks and opportunities to safeguard can be missed. This is in no way to proportion blame on anyone who worked with those involved in this review, but to try and understand the enormous pressure those in frontline services face especially when working with complex vulnerable people.

15.38 All organisations need to be able to allow their staff to complete their roles thoroughly and efficiently, allowing time to engage with clients, self-reflection, and self-care.

Impact of domestic abuse and the risk of suicide

15.39 Research is still limited with regards to domestic abuse and suicide, however, in 2004, Prof Sylvia Walby estimated that 1 in 8 of all female suicides and suicide attempts in the UK were due to domestic abuse. This equated to 200 women taking their own lives a year and nearly 30 women attempting domestic abuse related suicide every day. A Home Office and Police study found in the first year of the pandemic (April 2020-March 2021) there were 38 female domestic abuse related suicides. Within these studies there it is thought that 10 women a week take their own lives due to domestic abuse with 30 attempting it each week, however reporting and recording is still not accurate.

15.40 Domestic abuse has a devastating impact on the victim's health and wellbeing and at times they feel there is no way out. The new national Suicide Prevention Strategy 2023 is clear that every suicide is preventable organisations need to work with those at risk and consider interventions that meet their needs. It is imperative suicide prevention strategies/polices are linked with organisation domestic abuse policies. Staff domestic abuse training needs to ensure it includes the risk of suicide and the high-risk indicator it poses. Bracknell's Domestic Abuse Strategy and Berkshire Suicide Prevention Strategy 2021-26 have been recently reviewed and highlight the links between domestic abuse and suicide. There is a Berkshire Suicide Prevention Group which reviews Police Real Time (Suspected) Suicide Surveillance data including those where there are known/suspected links to domestic abuse (victims and perpetrators), and an East Berkshire Suicide Prevention Strategic Meeting. These groups have a domestic abuse representative present.

15.41 Jenny's suicide attempts at times were seen as a 'mental health episode' and some of the language used was that she was experiencing mental health issues with domestic abuse not

being linked to, considered, or fully explored. Research by Warwick University and Refuge found 96% of those in the suicidal group reported feeling despairing or hopeless, 49% of the suicidal group scored within the severe range of psychological distress and 86% of the suicidal group reported feeling depressed. Jenny had expressed she was feeling all these emotions.

15.42 Practitioners voiced their concerns for Jenny's welfare, and there is evidence of risk assessments being undertaken, however, these were in relation to her mental health rather than the danger posed as the result of her experiencing domestic abuse. Police and SCAS were proactive in raising their concerns for Jenny when they attended the property raising safeguarding referrals but again this was not around the domestic abuse and the link to her suicidal ideation. The hospital could have also used further professional curiosity when she presented with intentional overdoses with regards to domestic abuse.

15.43 When officers attended Jenny's address the day she died, Jenny appeared to have given up on any hope of the abuse stopping, the officers Body Worn Video show her refusing to leave, saying:

- *"I am humiliated… 13 years I haven't left this house," and "I am done."*
- *"30 years of hell, being abused, kicked, money stolen from me."*
- *"Chris beat me. I still got a lump there. It still hurts. He cracked my head on that door, and I tell you what I went down like a sack of shit, and that was 2 months ago, or a month ago. Find I couldn't remember my name."*
- *"Do you know you have signed my death warrant. He said if I called the police again, I'm going to die, and I believe that."*

15.44 Jenny refused medical treatment, she appeared lucid and not intoxicated. She did not present as emotional and spoke clearly and openly, albeit defiantly. She told officers she could not deal with things, saying "Leave me alone. Go." "I have done what I have done." She then went on to talk about years of abuse from Max. Attending officers asked Jenny to let them help her which she replied, "No. I just. Let me go to sleep. I have done it. I do not want this anymore; I want to die." When informed that she could be taken to the hospital by force Jenny stated, "I'll just come back and do it again, and again, and again."

15.45 Jenny on multiple occasions stated she would take overdoses so Max and Chris would listen, or to make the abuse stop. What options did Jenny have to escape the abuse? Did she feel she had anyone to turn to?

15.46 Although Max was no longer living with her there continued to be contact, there was a financial impact with regards to his care and he continued to make the threats of taking his own life.

15.47 Jenny was then being abused by her eldest son, someone she loved and had serious concerns about. All of this would have taken a considerable toll on her which is clear from her final comments to officers on the day of her death.

15.48 Those who consider taking their own lives feel despair and no way out, therefore early intervention is essential when trying to stop them making the decision to die by suicide.

16. Recommendations

Recommendation 1 – Thames Valley Police and Probation
Thames Valley Police to ensure information is shared in a timely way when there is Police contact with people on so that Probation can take appropriate action such as recall.

Recommendation 2 – Primary Care
Add a SNOMED problem code to the patient's primary care record to identify any significant events that may alert the practitioner to review the record for further information. This may then influence how they treat the patient. For this IMR, the relevant SNOMED codes are:

- History of Domestic Abuse
- Victim of Domestic Abuse
- Intentional Overdose
- History of Repeated Overdose
- Vulnerable Adult
- Adult Safeguarding Concern

The SNOMED code should be accurately entered into the patient's health record.

Recommendation 3 – Primary Care
Ensure that all practitioners are aware how to add “Warning Flags” to a patient's primary care record to highlight any significant issues to colleagues.

Recommendation 4 – Primary Care
The learning from this review to be presented at the annual Level 3 Safeguarding Training Autumn/Winter 2023 which is available to all clinicians working in Primary Care.

Recommendation 5 – Primary Care
Promote use of the Ardens Template for “Depression” on the Primary Care Education Management Information System. This contains a specific section on Domestic Abuse Screening with relevant prompts.

Recommendation 6 – Primary Care
To produce a Domestic Abuse Pathway & Flowchart for Primary Care that contains important legislation, processes, pathways, and local information with domestic abuse specialist details for easy referral.

Recommendation 7 - Frimley Health NHS Foundation Trust
Undertake an audit of its domestic abuse practice and pathway and in undertaking this should consider using the Pathfinder toolkit (2020) as a baseline.

Recommendation 8 - Frimley Health NHS Foundation Trust
Review its domestic abuse training offer to include the learning from this review, specifically signposting to alcohol misuse service, referral and utilisation of Alcohol specialist nurses and awareness and utilisation of MARM.

Recommendation 9 – BHFT
Where practitioners are unsure about the best support to offer regarding domestic abuse then advice from BHFT's safeguarding team should be sought.

Recommendation 10 – BHFT
Reminder to practitioners that when disclosures of abuse are made a DASH risk assessment should be completed and a referral to specialist domestic abuse services offered, regardless of whether there is lack of clarity that they are a victim or perpetrator. Should that victim then not engaged with domestic abuse services but there are further disclosures, a repeat DASH RIC should be completed and offer of rereferral to services be made.

Recommendation 11 - Probation
Appropriate decisions are made about recall, the process is adhered to, and decisions are fully documents.

Recommendation 12 - Probation
The communication and enforcement for those on Probation who are homeless is developed in the Bracknell team.

Recommendation 13 - Probation
Appropriate measures are utilised to manage the risk of known victims of domestic abuse, including assessments and the risk of suicide and domestic abuse.

Recommendation 14 - Probation
All relevant cases are considered for IOM, and records are detailed with any decisions ensuring managerial oversight.

Recommendation 15 – Silva Homes
Compulsory Domestic Abuse training should be incorporated as part of the induction process for the Customer Relations Partners.

Recommendation 16 – Silva Homes
All policies within Silva should contain links to the domestic abuse policy.

Recommendation 17 – Adult Social Care
To complete a 6-month review of the new Single Point of Access (Adult Safeguarding Hub) to ensure referrals are entered onto the system, decisions are recorded, and actions are completed.

Recommendation 18 – Bracknell Forest Council
To include Counter Allegations within the domestic abuse training available to services or to offer a separate module to enhance frontline and managerial learning.

Recommendation 19 – Public Health
Suicide Awareness training to include domestic abuse.

Recommendation 20 - All agencies
Ensure Suicide Prevention Policies/Strategies are linked with organisational domestic abuse policies.

17. Conclusion

17.1 The panel and chair are aware this review has included extensive information on Jenny's two alleged abusers rather than her. This has been a challenge due to such little information recorded about Jenny. All efforts have been made to ensure Jenny has remained central to the report and the discussions. Unfortunately, within the multi-agency meetings Jenny was either blamed for the abuse, was not recognised at risk, or was seen as uncooperative with alcohol and mental health issues. This review has highlighted what a difficult and complex situation Jenny was in, and this was also difficult for agencies to navigate.

17.2 The pressure on Jenny having two abusers was evidently creating extreme difficulties managing day-to-day. Max had been abusive to Jenny throughout their marriage with her children witnessing this and even after his overdose and moving out of the home address, he continued to try to manipulate her. Max was never going to stop with his threats to kill himself, which continue to this day.

17.3 It is recognised Chris had been subjected to domestic abuse as a child and this impacted on him. He also had additional complexities he was battling with such as mental ill-health, substance misuse and homelessness. Although he clearly loved his mother, he continued to allegedly abuse her up until her death. The panel hope that he will be supported with his childhood trauma, bereavement, and current situation to reflect, learn, stop offending and using violence to others.

17.4 From her last words to her youngest son and to officers it appears Jenny could not see any other way to make the abuse stop. Bessel Van Der Kolk MD states:

"If a trauma victim is unable to imagine an alternative future, then they have no place to go" and "sometimes after being exposed to a traumatic experience, people feel immobilized and have a hard time finding purpose and pleasure in their current life, and focus, instead, on their traumatic past".

17.5 This may explain how Jenny was feeling, and how she was unable to see an alternative future with suicide as her only option.

17.6 Jenny's other two children were clearly concerned for their mother and made multiple attempts to try and keep her safe and were in an incredibly difficult situation trying to protect their mother from their brother. It is unimaginable the pain and heartache they went through whilst Jenny was subjected to the abuse and since her death and we hope they have the support, love, and care to remember Jenny in their own individual way.

Appendix 1 - Glossary

A&E – Accident and Emergency.
AAFDA – Advocacy After Fatal Domestic Abuse.
BHFT – Berkshire Healthcare NHS Foundation Trust.
BWA – Berkshire Women's Aid - local commissioned domestic abuse service.
Care Coordinator - A trained professional who helps manage the patients' mental health condition and oversees the patients' treatment plan.
CCB – Coercive and Controlling Behaviour
CMHT - Community Mental Health Team.
COPD – Chronic Obstructive Pulmonary Disease.
CRHTT - Crisis Resolution and Home Treatment Team - Short term support for those in mental health crisis, once crisis is reduced onward referral are considered or they may be discharged.
CRS – Commissioned Rehabilitative Services.
CPA – Child to Parent Abuse.
CPE – Common Point of Entry, the 'gateway' to all mental health services, assessing need, and referring to other mental health services or signposting.

CSC – Children's Social Care
CSP – Community Safety Partnership
DAAT – Drug and Alcohol Action Team.
DASH RIC[18] –Domestic Abuse, Stalking and Harassment Risk Indicator Checklist, provides a consistent way to evaluate victims of domestic abuse risk.
DOLS – The Deprivation of Liberty Safeguards Team.
DOM5 – Thames Valley Police's version of the DASH RIC (implemented in 2013).
DVDS - Domestic Violence Disclosure Scheme[19].
DVPN/DVPO – Domestic Violence Protection Notice/Order[20].
EIDA – Employers Initiative on Domestic Abuse.
EPF – Effective Proposal Framework.
EUPD – Emotionally Unstable Personality Disorder.
GP – General Practitioner.
HPDU – Head of Probation Delivery Unit.
ICB – Integrated Care Board.
IDVA – Independent Domestic Violence Advocate, support for high-risk[21] victims of domestic abuse.
IMR – Individual Management Reviews require agencies to look openly and critically at individual and organisational practice.
IOM – Integrated Offender Management.
IPA – Intimate Partner Abuse.
IPT – Intensive Psychological Therapies.
ISVA – Independent Sexual Violence Advocate / Advisor.

[18] https://safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL_1.pdf?msclkid=770463f4ceac11ec8f0466908e13260a

[19] Applicants can make enquiries to the police about their own situation or make enquiries on behalf of others that might be at risk from a current or ex-partner. If a disclosure is made, it is always made to the person at risk. Applicants who are not at risk of harm from the subject can be advised they will not receive the disclosure themselves.

[20] Domestic Violence Protection Notices and Orders can be used to help protect victims of domestic abuse from immediate violence or threat of violence by the perpetrator. They should be used as part of a wider plan to manage the risk to victims so not simply be seen as a solution in themselves. They give victims time and space to consider what to do about the abuse and perhaps seek a non-molestation order to protect themselves longer term. To obtain a DVPN/O, there MUST be evidence of recent use or threat of violence towards the victim. The requirements to apply for a DVPN/O applies immediately following an incident, these are not orders to be requested on retrospective incidents, following Police Bail or in addition to existing orders in place that already provide protection for the victim. Applications must be necessary and proportionate. Although a victim may not want a DVPN, it does not mean one should not be sought, but the court will want to know why one is being sought.

[21] HIGH RISK - There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious.

MARAC – Multi Agency Risk Assessment Conference discusses high risk domestic abuse cases aiming to increase safety, reduce risk and interrupt the abusive behaviour of the perpetrator.
MARM – Multi Agency Risk Management Framework.
MASH – Multi Agency Safeguarding Hub**.**
NCDV – National Centre for Domestic Violence support victims of domestic abuse obtain civil protection orders.
OIC – Officer In Charge.
PNC – Police National Computer.
Police Closure Order - A closure notice prohibits access to the premises for the period specified in the notice. Only the police or a local authority can initiate the process to close premises which are causing antisocial behaviour, if they reasonably believe that there is, or is likely to be either: a nuisance to members of the public or disorder relating to the premises and in its vicinity. In addition, the notice must be necessary to prevent occurrence or re-occurrence of the nuisance or disorder.
PPCS – Public Protection Casework Section.
PPN1 – Public Protection Notice – A police record for all domestic incidents which is shared with partner agencies providing information of the victim and/or the children's safety.
SCAS – South Central Ambulance Service.
SDASH - Stalking DASH designed to identify stalking behaviour when assessing risk.
TVP – Thames Valley Police

Appendix 2 - Terms of reference – Key Issues

- Consider how all forms of domestic abuse are understood by the local community including family, friends, statutory and voluntary organisations. This should also include consideration of coercive controlling behaviour, familial and economic abuse.
- Determine if there were any barriers that Jenny or her family/friends faced in both reporting domestic abuse and/or accessing services. Consideration to be especially given to:
    - The Equality Act 2010's protected characteristics,
    - Mental Health,
    - Alcohol and substance misuse, and
    - Familial Abuse
- Review agency responses, professional curiosity, interventions, care, treatment and/or support provided.
- Consider whether the work undertaken by services was consistent with each organisation's professional standards, domestic abuse and safeguarding policies, procedures, and protocols and whether there was adherence to national good practice.
- Review communication and information-sharing between agencies, services, family, and friends and how this informed risk assessments, decisions, and support.
- Consider what is 'good practice' for agencies to achieve in their response to domestic abuse for both victim/survivors and those who are abusive.
- Consider whether there is consistency in how agencies respond to victim/survivors and perpetrators especially where there is abuse by an intimate partner and family members.
- Explore Chris's intimate relationships and the domestic abuse within these relationships and whether these were inter-linked with the risks to Jenny.
- Consider whether there was any impact of the COVID-19 pandemic on the family or on service response to victim/survivors and those using abusive behaviours.