Swindon Community Safety Partnership

Domestic Homicide Review

Into the death of Theresa (pseudonym)

In November 2017

OVERVIEW REPORT

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Report Completed 3 July 2019

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Section 1: Preface

1.1. The Domestic Homicide Review Chair and Panel wish to express their deepest sympathy to Theresa's family and all who have been affected by her death.

1.2. This Domestic Homicide Review (DHR) is held in compliance with legislation and follows statutory Guidance. Its purpose is to identify improvements, which could be made to community and organisational responses to allegations of domestic abuse, and to try to prevent future incidents.

1.3. DHRs are not disciplinary inquiries nor are they inquiries into how a person died or into who is culpable; that is a matter for coroners and criminal courts, respectively, to determine as appropriate.

1.4. This review has been undertaken in an open and constructive way with those agencies, both voluntary and statutory that had contact with Theresa, entering into the process from her viewpoint. This has ensured that the Review Panel has been able to consider the circumstances of Theresa's death in a meaningful way and address with candour the issues that it has raised.

1.5. The Chair and Panel thank all who have contributed to the review for their time, patience and cooperation.

Section 2 - Introduction

2.1. This report of the Domestic Homicide Review (DHR) examines agency responses and support given to Theresa (pseudonym), a resident of Swindon, prior to the point of her death in November 2017.

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

2.3. A summary of the circumstances that led to a review being undertaken in this case is:

2.3.1. Theresa and Charles (pseudonyms) moved to Swindon from South Africa in 2007 and married in 2009. Theresa's mother, father and brother later followed them to England and settled near them in Swindon. Theresa's brother now lives in London.

2.3.2. In 2016, Theresa whilst receiving medical care for mental health and other medical issues reported that she had been subjected to domestic abuse. Subsequently during the period from September 2016 to November 2017, she made 177 contacts with Swindon Women's Aid and she was referred to Swindon Multi Agency Risk Assessment Conference (MARAC) on three occasions.

2.3.3. On 19 November 2017 Police were called to a Motorway bridge after Theresa had been seen leaning over the bridge. Due to her behaviour, a member of the Mental Health

Control Room Triage Team spoke to her and was satisfied that she was then not at risk of self-harm and she was taken home.

2.3.4. On [redacted] November 2017 Theresa telephoned the Police because she was having suicidal thoughts, the in-house Mental Health Street Triage Team were contacted and subsequently police officers attended Theresa's home address where they found her hanging from a beam in the garage. She was pronounced dead by a paramedic at the scene.

2.3.5. The Police notified the Chair of Swindon Community Safety Partnership of Theresa's death. They informed the Chair that although they believed Theresa had taken her own life, they were of the opinion it fitted the criteria for a Domestic Homicide Review as she had been known to Wiltshire Police, the Multi Agency Risk Assessment Conference (MARAC) and Swindon Women's Aid in relation to alleged domestic abuse.

2.4. The review has considered all known contact/involvement agencies had with Theresa and Charles during the period from 1 January 2015 to the death of Theresa in November 2017, as well as contacts prior to that period which could be relevant to domestic abuse, violence, self-harm or mental health issues. 1 January 2015 was chosen for the commencement of the detailed scope of the review, as it is known that it was during 2015 that Theresa first went to her GP with unexplained physical injuries.

2.5. The key purpose for undertaking Domestic Homicide Reviews is to enable lessons to be learned where there are reasons to suspect a person's death may be related to domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each case, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

Section 3 - Timescales

3.1. The decision to establish a review was made on 8 December 2017 and enquiries were made to enquire if a Mental Health Homicide Review would also be opened. It was not until 24 January 2018 that the Swindon Community Safety Partnership was notified that the circumstances of Theresa's death did not meet the criteria for such a review. Agencies were informed of the review on 25 January 2018 and on the 20 February 2018, the Domestic Homicide Review Panel held its opening meeting.

3.2. The Review was concluded on 3 July 2019. Normally DHRs, in accordance with the National Guidance, would be completed within six months of the commencement of the review. In this case, as police enquiries into reported violence and coercive behaviour only commenced in May 2018, the conclusion of the Review was postponed until the completion of the police investigation. The Home Office was notified of this on 1 May 2018 and agreed to the delay. Theresa's husband and her family were also informed of this postponement and the reasons for it.

3.3. Wiltshire Police notified the review on 28 March 2019 that they had concluded their investigation and that the Senior Investigating Officer having reviewed the case had made the decision that there was insufficient evidence to demonstrate that a crime had been committed.

Section 4 - Confidentiality

4.1. In accordance with statutory Guidance[1], the findings of this review are restricted to only participating officers/professionals, their line managers and Theresa's husband, her mother, father and brother until after this report has been approved for publication by the Home Office Quality Assurance Panel. With the agreement of the Home Office, a copy of the Overview Report has also been provided to the Wiltshire Coroner, the Independent Office of Police conduct and the Wiltshire Police and Crime Commissioner.

4.2. As recommended within the Guidance, to protect the identity of the deceased and her family, pseudonyms have been used throughout this report. The pseudonyms for the deceased and her husband were initially chosen by the Review Panel and later agreed by Theresa's husband and her mother.

4.3. Theresa who was a white South African national was aged 34 at the time of her death. Charles who is also a white South African national was aged 35 at the time of Theresa's death. Their dates of birth and the date of Theresa's death have been redacted from this report to protect their identities and for the privacy of Theresa's family.

Section 5 - Terms of Reference (As set out at the commencement of the review)

5.1. Agencies that have had contact with the deceased, Theresa (pseudonym) and/or her husband Charles (pseudonym) should identify any lessons to be learnt. They should also set out provisional actions to address them as early as possible, for the safety of future suspected victims of domestic abuse, particularly those who are vulnerable through mental health issues and/or substance misuse.

5.2. This DHR which is committed within the spirit of the Equality Act 2010, to an ethos of fairness, equality, openness, and transparency, will be conducted in a thorough, accurate and meticulous manner.

5.3. The Domestic Homicide Review will consider:

5.3.1. Each agency's involvement with the following, from 1 January 2015 to the [redacted] November 2017, (the date of Theresa's death), as well as all contact prior to that period which could be relevant to domestic abuse, violence, stalking, controlling behaviour, self-harm or other Mental health issues:

a. Theresa who was 34 years of age at date of her death.

b. Charles who was 35 years of age at the time of Theresa's death.

5.3.2. Whether there was any history of abusive behaviour towards the deceased and whether this was known to any agencies.

[1]Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews. para 72 (Home Office. December 2016)

5.3.3. Whether there was any history of mental health problems and if so, whether that was known to any agency or multi-agency forum.

5.3.4. Whether family or friends want to participate in the Review. If so, ascertain whether they were aware of any abusive behaviour to Theresa prior to her death?

5.3.5. Whether, in relation to the family members, were there any barriers experienced in reporting abuse?

5.3.6. Could improvement in any of the following have led to a different outcome for consideration:

a) Communication and information sharing between services?

b) Information sharing between services with regard to the safeguarding of adults?

c) Communication within services?

d) Communication and publicity to the general public and non-specialist services about the nature and prevalence of domestic abuse, and available local specialist services?

5.3.7. Whether the work undertaken by services in this case are consistent with each organisations':

a) Professional standards?

b) Domestic Abuse policy, procedures and protocols?

5.3.8. The response of the relevant agencies to any referrals relating to Theresa or Charles concerning domestic abuse, controlling behaviour, stalking, harassment, other significant harm, mental health, or any Safeguarding issue. It will seek to understand what decisions were taken and what actions were carried out or not and establish the reasons. In particular, the following areas will be explored:

a) Identification of the key opportunities for assessment, decision-making and effective intervention in this case from the point of any first contact onwards with Theresa.

b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective?

c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made?

d) The quality of any risk assessments undertaken by each agency in respect of Theresa.

5.3.9. Whether organisations' thresholds for levels of intervention were set appropriately and/or applied correctly, in this case?

5.3.10. Whether practices by agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective individuals and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded?

5.3.11. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner?

5.3.12. Whether, any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services?

5.3.13. If any other statutory Inquiry or Review is established to examine the circumstances surrounding the death of Theresa, the DHR will liaise with the organisations involved to avoid duplication and to take due notice of any findings or recommendations made by such an Inquiry or Review subject to the final shape of the review meeting the requirements as set out in the statutory guidance.

5.3.14. The Review will consider any other information that is found to be relevant.

Section 6 - Methodology

6.1. The method for conducting a Domestic Homicide Review (DHR) is prescribed by Home Office Guidance. Upon receiving written notification of Theresa's death from Wiltshire Police a decision to undertake a DHR was taken by the Chair of the Swindon Community Safety Partnership during consultation with Partnership members on 8 December 2017. The Partnership noted that although it was suspected that Theresa had taken her own life, there were records to indicate that Theresa may have been a victim of domestic abuse and that she had been the subject of Multi Agency Risk Assessment Conferences (MARAC). She had been in contact with the police the day before and on the day of her death. The Home Office was informed of this decision on 21 January 2018.

6.2. Agencies in the Swindon area were instructed to search for any contact they may have had with Theresa or Charles. If there was any contact then a chronology detailing the specific nature of the contact was requested. Those agencies that had relevant contact were asked to provide an Individual Management Review. This allowed the individual agency to reflect on their contacts and identify areas which could be improved and make relevant recommendations to enhance the delivery of services for the benefit of individuals in Theresa's circumstances in the future.

6.3. The DHR Panel considered information and facts gathered from:

- The Individual Management Reviews (IMRs) and other reports of participating agencies and multi-agency forums including the Swindon Multi Agency Risk Assessment Conference (MARAC)
- Wiltshire Coroner
- The Pathologist Report
- Independent Office for Police Conduct

- Interviews and discussions with Theresa's husband Charles, her Mother, Father and Brother
- Interviews with Theresa's friends and neighbours
- Theresa's diaries, notes and available phone records for the relevant period
- [redacted], a Forensic Physician
- Discussions during Review Panel meetings

Section 7 - Involvement of Family and Friends

7.1. Theresa's parents, brother and Charles, her husband, were contacted at the commencement of the Review by letter and by email. The Review Chair spoke to the deceased's mother on the telephone on a number of occasions. During the first of those telephone conversations, the Review Chair explained the purpose of the Review and why it was being held. She responded that the family were aware that Theresa had mental health issues and as she suffered from post-traumatic stress disorder (PTSD), she had on occasions used alcohol as a coping mechanism. She asked what grounds there was to believe that her son-in-law, who was staying with her and her husband, had ever been violent to her daughter? When she had questioned Theresa about visible bruising, she was always told that they were the results of falls, fainting etc. The Chair responded that as the review was at that time at an early stage, he was not in a position to provide details but he confirmed that there were a number of agencies that had notified the review that her daughter had reported to them that she had been subjected to domestic abuse. When reports had been received from those agencies, the Chair would be in a better position to discuss the grounds with the family. It was agreed that Theresa's mother would recontact the Chair with possible dates when they could meet. The deceased's mother agreed "Theresa" would be a suitable pseudonym to be used in the review's reports for her daughter.

7.2. Meetings with the deceased's mother, father and brother and a separate meeting with Charles were delayed, initially as members of the family were abroad, then later postponed, at the request of the Police Senior Investigating Officer, until the conclusion of their investigations. Nevertheless, the DHR Chair provided both Theresa's parents and Charles with the DHR Terms of Reference together with a copy of the Multi-multi-Agency Guidance on the Conduct of Domestic Homicide Reviews.

7.3. After discussions with the Charity, Advocacy After Domestic Abuse (AAFDA) the Review Chair informed Theresa's mother about the advocacy support the family could receive from AAFDA and provided her with an AADFA information leaflet. The family and Charles were also provided with information about the suicide support charity, Survivors of Bereavement by Suicide (SOBS) and the booklet "Help is at Hand" support after someone may have died by suicide, which is published by the National Suicide Prevention Alliance and is available on the Support after Suicide Partnership website.

7.4. The Review Panel had the opportunity to consider information in Theresa's 2015 and 2016 diaries and in her notebook. The Panel also noted the letters that were found by the family after Theresa took her own life. (See Appendix C). It is believed by the family that the letter addressed to her brother had been written prior to an earlier attempt by Theresa as it was located in a drawer in the house and was written on different paper. Charles confirmed to the Review Chair that there was no note specifically addressed to him.

7.5. Wiltshire Police provided the DHR Panel with a copy of a witness statement, which was taken from Charles on 15 February 2018. Charles agreed that this could be used by the review; it is included in Appendix D of this report. In this statement, Charles claimed that he and Theresa rarely argued; that he was never violent to her other than at her instigation during consensual "*rough*" sex, when on occasions she asked him to put a leather collar on her neck. He stated on Friday evenings she would often have bruises as a result of sparring sessions at the gym where she had boxing classes. He also wrote that after attempted burglaries at their home they installed surveillance cameras on the property. In addition, because he regularly worked away from home, he would often message or ring her during the day. They both had a tracking App, so they could see where each other were at any given time. This was an app called "life360". He pointed out that Theresa could have turned that off at any time she wished.

7.6. In rebuttal to some of the comments made in Charles's statement, Theresa's mother requested that specific entries in Theresa's diaries/journals be highlighted in this report. The first, dated 23June 2016 appears to indicate that Theresa had been thinking of leaving Charles and that it was him rather than Theresa who had instigated the rough sex. (See in bold in paragraph 17.19.12) In the second entry, Theresa very movingly described her emotions. (See para 17.19.13.) The third and fourth are lists of what actions could be taken if she decided to leave home and what she should take with her. (See Appendix L).

7.7. Theresa's brother did confirm that he was aware of Theresa's general health issues and her developing mental health struggles. He was of the opinion that this was due to PTSD after witnessing the shooting in South Africa. It was brought back to her when there were burglaries at her house. He added that he also had an app on his phone whereby he could track Theresa and she could track his whereabouts.

7.8. At the conclusion of the police investigation, the DHR Chair met with Theresa's Mother, Father and Brother and had a separate meeting, with Charles on 12 April 2019. They clarified a number of points and provided significant information to the Review. Information provided by the family is included within this report. The family confirmed that there were no barriers stopping them reporting incidents of domestic abuse.

7.9. Charles, after seeing the Overview Report and Executive Summary and being told of the apparent fingermarks on Theresa's arms and footprint on her back clarified that there were occasions when they would *"rough and tumble"* consensually, usually instigated by Theresa. He was asked if it was possible, the Theresa could have been seeing someone else who may have injured her. He replied that she would never do that and in any case, he could know where she was at any time because of the app on her phone. He emphasised that he thought her bruises were probably a result of her going to boxing at "Scrappers" a local Gym. The Club was later contacted by the review but had no record of Theresa being a member and there were no entry in the Gym injury record book of her being at the club and suffering any injury there. The Gym owner confirmed that Wiltshire Police had already made similar enquiries.

7.10. Charles explained that he and Theresa had mutual tracking apps on their mobile phones to give Theresa reassurance as after two attempted burglaries at their home she suffered with nerves when he was away. He was however emphatic that there were no trackers on her car. Whist the police never checked Theresa's vehicle, Theresa had told the Swindon Women's Aid IDVA and separately her GP that she had found a tracker on her car. (Paras 16.59 and 16.60 of this report). She had also discussed this with her brother. (Para 16.45.)

7.11. Theresa's parents and Charles were informed of the findings of the Review on 12 April 2019 and were later provided with electronic copies of the draft Executive Summary and Overview Report to read in private prior to the conclusion of the Review. Theresa's mother, father and brother clarified that when they first came to England they established a registered company in which they and Charles were directors, however they later chose to wind up the company. Theresa was the only member of the family who was involved in Charles' business of which she was a company director. Care has been taken to insure that Charles and Theresa's mother, father and brother's comments are reflected within this final report.

7.12. Theresa's brother stated also pointed out that the family (immediate and wider family in South Africa) were not financially dependent on Charles. His mother was financially in a good place and that she had her own business that was successful. She would send money to South Africa to help cousins and the Grandparents because the social care structure there was not like it is in Britain. He was aware that like himself, Theresa would also send money to the Grandparents. He thought that Theresa was financially ok through her work in Charles business and that he could ask her for money if he ever needed it although he was never in this position.

7.13. After reading the review reports Charles contacted the DHR Chair and stated that whilst he understood that the review was focused on agencies that had contact with his wife, he was concerned that people may believe he had been responsible for Theresa's injuries. It was explained that the review had to consider what his wife had told agencies when looking for lessons to be learnt and addressed. The Chair reminded him that the reports make clear that he had consistently denied ever assaulting his wife and that he had not been convicted of any offence. The Reports would only be published with pseudonyms. Charles acknowledged this and highlighted some corrections to be made. These were addressed.

7.14. At the conclusion of the review Theresa's mother on behalf of the family stated: "We thank the Domestic Homicide Review Panel for providing a voice for our daughter's pain which was not heard during her life. We hope that it will give others in the future the confidence to speak."

7.15. Three of Theresa's friends were initially interviewed by the police and later contacted by the DHR Chair. Their comments are included in this report.

Section 8 - Contributors to the Review

8.1. Whilst there is a statutory duty on bodies including the police, local authority, probation trusts and health bodies to participate in a DHR, in this case the following twenty-four organisations were contacted by the review:

- **Advocacy After Fatal Domestic Abuse (AAFDA):** Was contacted to ascertain if the Charity would be able to act as a support/advocacy service for Theresa's family, whilst her widower (Charles) was staying with the family. The Chief Executive of the Charity confirmed that AAFDA would, if requested, give assistance to the family and the DHR Chair provided AAFDA's contact details and leaflet to Theresa's mother.

- **Alcoholics Anonymous:** Theresa's mother has stated that Theresa had told her that she had attended an Alcoholic Anonymous meeting; The organisation has not been able to confirm this to the review, as they do not require individuals seeking support from them to provide a name.

- **Avon and Wiltshire Mental Health Partnership NHS Trust:** This service provided an IMR in relation to their contacts with Theresa. A senior member of this service who is independent of any contact with Theresa is a DHR Panel member.

- **The Bristol, Gloucestershire, Somerset and Wiltshire Community Rehabilitation Company:** This service had no relevant contacts with Theresa or Charles.

- **Change Grow Live (CGL), Swindon Drug and Alcohol Service:** This service provided an IMR in relation to its contact with Theresa. A senior member of this service who is independent of any contact with Theresa is a DHR Panel member. During this review, CGL's contract was not renewed in Swindon and a senior member of the new service provider, Turning Point, joined the Review Panel.

- **Citizen's Advice Bureau:** This service had no record of any contact from Theresa either locally or nationally.

- **Dorset and Wiltshire Fire and Rescue Service:** This service had one request at 10.30pm on 15 June 2017, to assist the Ambulance Service, to gain entry to Theresa's home but were then not required and therefore had no direct contact with Theresa.

- **Great Western Hospital NHS Foundation Trust:** This Trust provided a chronology of contacts with Theresa and a relevant IMR was completed. A senior member of this Trust, who is independent of any contact with Theresa, is a DHR Panel member.

- **Hometruths:** This small non-statutory service provided an IMR in relation to its contacts with Theresa. [redacted], the IMR author who is also a DHR Panel member) declared her knowledge of and involvement with the deceased at the commencement of the Review.

- **Kiss Gym:** This organisation confirmed to both the Police and to the DHR that Theresa was a member of the Gym. There were no records of her ever being involved in any contact activity. There were no records of her ever reporting any injuries whilst at the Gym.

- **NHS111 (Care UK):** This service provided an IMR in relation to a contact with Theresa. It had no record of any contacts with Charles.

- **National Probation Service:** This service had no relevant contacts with Theresa or Charles. A senior member of this agency is a DHR Panel member.

- **Paladin National Stalking Advocacy Service:** This service had been contacted for advice from Swindon Women's Aid but had no direct contact with either Theresa or Charles.

- **Samaritans:** Whilst Theresa told her GP and NHS111 that she had on occasions contacted the Samaritans as no names are requested or given, the Samaritans were unable to provide any relevant information to the Review.

- [redacted]**:** EMDR Accredited Practitioner and MBACP Senior Accredited Counsellor: The DHR Chair invited [redacted] to take part in the Review, as the deceased's husband had indicated that Theresa had received trauma support services from her. [redacted] responded by letter on 24 May 2018 that she declined the invitation to provide information to the review. (There is currently no statutory requirement for such a private organisation to participate in a DHR). The Wiltshire Coroner has nevertheless directed that the statement she provided to Wilshire Police should be provided to the DHR.

- **Scrappers Boxing Club:** The DHR contacted this club after Charles had informed the review that he thought Theresa might have been a member. The owner of the Club had no record of Theresa having been a member or having attended the club he also checked with all of the Club's coaches and service users. There were no entries referring to Theresa in the club's incident book in which injuries that are sustained on the premises are recorded.

- **South Western Ambulance Service NHS Trust:** This service provided an IMR in relation to a contact with Theresa; it had no record of any contact with Charles.

- **Swindon Borough Council Adult Social Care:** This Department provided an IMR in relation to third party referrals regarding Theresa. A senior member of this Department, who is independent of any contact with Theresa, is the IMR author and a DHR Panel member.

- **Swindon Borough Council Housing Options:** This service provided an IMR in relation to a contact with Theresa. A senior member of this service who is independent of any contact with Theresa is a DHR Panel member.

- **Swindon Clinical Commissioning Group (CCG):** A senior member of this organisation who is independent of any contact with Theresa or Charles is a DHR Panel member. The CCG Safeguarding lead has completed an Individual Management Report in relation to Theresa's regular relevant contacts with her GP Practice.

- **Swindon Multi Agency Risk Assessment Conference (MARAC):** The Swindon MARAC Chair responded to a DHR Memorandum of Agreement confirming that Theresa had been referred to three MARAC meetings. He provided a report setting out his review of those referrals.

- **Swindon Women's Aid:** This non-statutory organisation had relevant contacts with Theresa and an IMR was completed. A senior member of this organisation who is independent of any contact with Theresa or Charles is a DHR Panel member.

- **Victim Support**: This service notified the DHR that it had no relevant contacts to report.

- **Wiltshire Police:** This Police Force had relevant contacts with Theresa and Charles and an IMR was completed. A member of this organisation who is independent of any contact with Theresa or Charles is a DHR Panel member.

8.2. Twelve of those agencies/multi-agency conferences have completed Individual Management Reviews (IMRs) or reports. Other than [redacted], the Hometruths IMR author (see above), none of the Independent Management Review (IMR) Authors have had any

contact or involvement with Theresa or Charles or in the management of staff who had dealt with them.

8.3. The following IMR/Report Authors have confirmed that they are independent of any direct or indirect contact with any of the relevant parties within the Review:

[redacted]: Avon and Wiltshire Partnership Mental Health NHS Trust

[redacted]: Great Western Hospitals NHS Foundation Trust

[redacted]: NHS111 (Care UK)

[redacted]: South Western Ambulance Service NHS Foundation Trust

[redacted]: Swindon Borough Council Adult Social Care

[redacted]: Swindon Borough Council Housing Department

[redacted]: Swindon Clinical Commissioning Group

[redacted]: Swindon Drug and Alcohol Service

[redacted]: Swindon Multi Agency Risk Assessment Conference (MARAC)

[redacted]**:** Swindon Women's Aid

[redacted]: Wiltshire Police

8.4. Theresa's family have also provided information to the DHR.

8.5. The DHR has been given access to the Pathologist's Report and Police statements.

Section 9 - Review Panel

9.1. The DHR Panel consisted of senior officers from the statutory and non-statutory agencies who are able to identify lessons learnt and to commit their organisations to setting and implementing action plans to address those lessons. Only one member of the Panel has had any contact with Theresa or Charles. (See para 8.1. Hometruths)

9.2. The Panel members are:

[redacted]: [redacted], Avon and Wiltshire Mental Health Partnership NHS Trust

[redacted]: [redacted] Adults at risk, DoLS compliance and Adult Mental Health, Great Western Hospitals NHS Foundation Trust

[redacted]: [redacted], Hometruths

[redacted]: [redacted], NHS England

[redacted]: [redacted], National Probation Service

[redacted]: [redacted], Swindon Borough Council Adult Social Care

[redacted]: [redacted]nager, Swindon Borough Council

[redacted]: [redacted], Public Health, Swindon Borough Council.

[redacted]: [redacted], Swindon Borough Community Safety Team

[redacted]: [redacted], Swindon Borough Community Safety Team

[redacted]: [redacted], Swindon Borough Council Housing, and Chair of DA Management and QA Group

[redacted]: [redacted], Swindon Clinical Commissioning Group (CCG)

[redacted]: [redacted]r, Swindon Women's Aid

[redacted], [redacted]: Change, Grow, Live Drug & Alcohol Service

[redacted]: [redacted], Wiltshire Police

[redacted]: Home Office Accredited Independent Chair

Police Initial Investigating Officer: Acting Detective Sergeant [redacted]: Wiltshire Police

Police Senior Investigating Officer: Detective Chief Inspector [redacted]

Review Administrator: [redacted], Swindon Borough Council

Panel Meeting Minute Taker: [redacted], Swindon Borough Council

9.3. Expert advice regarding domestic abuse service delivery in Swindon has been provided to the Panel by [redacted] of Swindon Women's Aid, which provides the commissioned Independent Domestic Violence Adviser (IDVA) Service in Swindon and by [redacted] of Hometruths domestic abuse support service. [redacted] of Avon and Wiltshire Mental Health Partnership NHS Trust has provided specialist independent advice relating to mental health issues. [redacted], Suicide Prevention Lead, Public Health, Swindon Borough Council have provided specialist advice regarding self-harming and suicide to the Panel. [redacted] provided a Forensic Physician specialist opinion on Theresa's injuries to the DHR.

9.4. In addition to a pre-meeting between the Chair of the Swindon Community Safety Partnership, the DHR Chair and the initial Police Investigating Officer; the DHR met formally six times. The schedule of the meetings is:

24 January 201; (pre-meeting) **Swindon Borough Council Civic Offices**

20 February 2018, **Haydon Wick Parish Council Offices**

24 April 2018, **Swindon Borough Council Civic Offices**

5 June 2018, **Haydon Wick Parish Council Offices**

5 June 2019, Haydon Wick Parish Council Offices

3 July 2019, Haydon Wick Parish Council Offices

Section 10 - Chair of the Review and Author of the Overview Report

10.1. The Chair of the DHR Panel is a legally qualified and accredited Independent Domestic Homicide Review Chair. He has passed the Home Office approved Domestic Homicide Review Chairs' courses and possesses the qualifications and experience set out in paragraph 37 of the Home Office Multi-Agency Statutory Guidance (2016).

10.2. He has an extensive knowledge and experience in working in the field of domestic abuse and sexual violence at local, regional and national level. He has provided pro-bono legal work for a Refuge and its residents; been responsible for Government funding and monitoring of the delivery of domestic abuse services across the South West Region of England between 2004 and 2010; was a member of a number of Central Government committees, including those relating to the national funding of local domestic and sexual abuse services, the development of Violence Against Women and Children policies and the national development and implementation of Domestic Homicide Reviews.

10.3. The Chair has no connection with the Swindon Community Safety Partnership and is independent of the agencies involved in the Review. He has previously served as a senior police officer in Avon and Somerset Constabulary and the then Regional Crime Squad until 1999. More recently, he has been the Home Office Criminal Justice System Manager for the South West Region of England. In a voluntarily capacity, he has been the Chair of a substance abuse charity. Since 2011, he has chaired numerous statutory reviews including Serious Case Reviews, Mental Health Reviews, Drug Related Death Reviews and Domestic Homicide Reviews in different areas across the country.

10.4. He has had no previous dealings with Theresa or Charles.

Section 11 - Parallel Reviews

11.1. Coroner's Inquest: In December 2017, the Wiltshire Coroner opened and adjourned an Inquest in order to allow the Wiltshire Police time to gather information relating to the circumstances of Theresa's death. The DHR Panel thanks the Coroner for sharing the information and reports he has obtained for the purposes of the Inquest. The DHR Chair attended a Pre-Inquest Review on 29 May 2019 but at the time of concluding this review, a date for the Coroner's Inquest has not been set.

11.2. Subsequent to the DHR obtaining and considering the Wiltshire Police IMR, on 1 May 2018 Wiltshire Police appointed a senior officer to oversee a criminal investigation

into Theresa's husband Charles. Due to this investigation the Coroner's Inquest, the Independent Office for Police Conduct Investigation and the DHR were adjourned until those enquiries were completed. On 28 March 2019, the Police Senior Investigating Officer notified the DHR Chair that his investigation had been completed and as there would be, no criminal proceedings the papers would be forwarded to the Coroner for the purposes of an Inquest into Theresa's death.

11.3. Wiltshire Police made a "Death or Serious Injury" referral to the Independent Office for Police Conduct (formally the Independent Police Complaints Commission) in respect of the police response to Theresa's contact with the Force prior to her death. Theresa's mother has made further complaints against police to the IOPC. The DHR and IOPC Operations Directorate have liaised and the IOPC Investigation Officer has attended DHR Panel meetings and provided the review with a copy of his and the Decision Maker's final reports. None of the complaints in relation to individual officers were upheld.

11.4. Avon and Wiltshire Mental Health Partnership NHS Trust carried out a Root Cause Analysis Investigation promptly following Theresa's death and provided a copy of the Report to the DHR. The Root Cause Analysis Report and its recommendations were used to inform the AWP IMR Report.

11.5. NHS England was satisfied that Theresa's death did not fit the criteria for a Mental Health Homicide Review; nevertheless, NHS England agreed to be involved in this DHR.

11.6. Swindon Drug and Alcohol Services conducted an Unexpected Death Review into the circumstances of Theresa's death. The following lessons were identified and addressed in that Review:

- Risk of Domestic Abuse not acted upon when information received from GP.
- Disengagement protocol not followed as how the client wanted.
- All clients to be booked Alcohol Nurse Assessments immediately after trigger points on AUDIT/SADQ met.
- Client closure not discussed at Clinical Team Meeting. (See Appendix I).

Section 12 - Equality and Diversity

12.1. The Panel and the agencies taking part in this Review have been committed within the spirit of the Equality Act 2010 to an ethos of fairness, equality, openness, and transparency. All nine protected characteristics in the Equality Act were considered and the Panel was satisfied that services provided were generally appropriate. Theresa's ethnicity, gender and mental health vulnerability were considered to be of particular relevance.

12.2. **Ethnicity:** Theresa had been in the UK for ten years prior to her death and there is no evidence to suggest that her being a white and born in South Africa (although a British citizen though her family ties) was ever an issue for agencies in the manner in which they delivered services to her. However, the Review Panel noted that prior to her move to England, Theresa had witnessed a murder take place in South Africa and due to the perceived stigma around a person seeking counselling in South Africa Theresa did not seek medical help until after September 2015 when she was diagnosed as suffering from post-traumatic stress disorder.

12.3. **Gender:** The Panel, when considering Theresa's vulnerability as a woman, was satisfied that all of the agencies, in particular her GP and the Swindon Women's Aid IDVA recognised and responded with empathy to her vulnerability.

12.5. **Mental Health:** Theresa's GP while treating her anxieties and post-traumatic stress disorder referred her to mental health services. The Mental Health Team concluded that Theresa's problems were situational rather than mental and discharged her. Nevertheless, the service and GP agreed that she had suffered from anxieties, depression and PTSD, which were treated through medication. Theresa's mental health problems are considered in more detail as a key issue, later in this report.

12.6. **Adult at Risk:** The Swindon Council Adult Safeguarding Manager, who advises the Review Panel on Safeguarding issues, was satisfied that the agencies generally provided Theresa with appropriate support services and care but were "hampered by her frequent non-attendance of appointments and her worries about the possibility of Charles discovering her contacts with agencies". (The Panel emphasises that this should not be perceived as blaming Theresa), Whilst Swindon Adult Social Care did not consider that Theresa was in need of Safeguarding as she was receiving support by other agencies, the Review Panel accepted that Theresa could have been considered an 'adult at risk' by virtue of the fact that she had care and support needs in relation to her alcohol abuse, mental health and inability to prevent the reported controlling abuse and violence.

12.7. Whilst there was agreement amongst agencies that Theresa had "mental capacity" within the tests of the Mental Capacity Act 2005, there was a divergence of professional judgement on the issue of choice versus protection. Practitioners were in agreement that she had mental capacity but was choosing to live in a situation where her personal safety was reportedly at risk. They differed on where her right to choose should stop and when their duty of care should start. The Review Panel recognises that the decision is not simple one, in Theresa's case; her GP was also concerned that if she broke Theresa's trust, Theresa would stop all contact and become unsupported and ultimately more vulnerable.

12.8. The Review Panel whilst acknowledging the dilemma practitioners face, highlights that whereas in the past, professionals have been able to rely on the issue of "capacity" as a guide on when to act, the Court of Appeal decision in DL v Local Authorities (2012) has confirmed that legal mechanisms exist to protect those whose decision-making capacity is affected in ways not recognised by the Mental Capacity Act 2005.

12.9. In that case, the Court of Appeal held that the High Court's inherent jurisdiction could fill the gaps left by the 2005 Act. The High Court was able to intervene, and make protective orders, in a case where a vulnerable adult's "ability to make decisions for themselves has been compromised by matters other than those covered by the MCA 2005". Those other matters are that:

- The adult is under constraint; or
- the adult is subject to coercion or undue influence; or
- For some other reason, the adult is "deprived of the capacity to make the relevant decision or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent".

The conditions giving rise to the High Court's powers under the inherent jurisdiction have been dubbed "situational incapacity". It would appear to the Review Panel that Theresa fitted those criteria.

12.10. Charles had only limited contact with any agency and the DHR Panel is satisfied there were no equality issues of concern in the manner those agencies carried out their responsibilities.

Section 13 - Dissemination

13.1. Each of the Panel members, the IMR authors, the Chair and members of the Swindon Community Safety Partnership have received copies of this report. A copy has also been sent to the Wiltshire Police and Crime Commissioner and to the Wiltshire Coroner. In accordance with statutory Guidance[2], the findings of this review are restricted to only participating officers/professionals, their line managers and Theresa's husband, her mother, father and brother until after this report has been approved for publication by the Home Office Quality Assurance Panel.

13.2. Charles, Theresa's parents and brother have been given electronic copies of this report and the Executive Summary to enable them to have the opportunity to read the reports at length and in private.

Section 14 - Background information (The Facts)[3]

14.1. Both Theresa and Charles were brought up in Johannesburg South Africa.

14.2. In [redacted] after witnessing a murder, Theresa became withdrawn and scared to go out. Her family have said that she started to drink heavily and subsequently took an overdose of prescription medication, which resulted in her having her stomach pumped.

14.3. Due to her continual fears about crime in South Africa, Theresa made the decision to move to the UK and Charles emigrated with her in March 2007. They settled in Swindon and married in 2009, moving into a large modern detached house. They had no children. Theresa's parents and brother later joined them in the UK. Her parents purchased a house close to Theresa and Charles's home and her brother settled in London. Charles mother and three brothers also moved to England and settled in Swindon.

14.4. The first recorded concerns about domestic abuse were on [redacted] August 2016. Theresa's GP had noted that Theresa, who was regularly being treated for anxieties and low mood, had presented six times over a short period with injuries she claimed were caused

[2]Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews. para 72 (Home Office. December 2016)

[3] This section sets out the information required in Appendix Three of the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Home Office December 2016)

by falls either during or after exercise. The GP was of the opinion that the injuries were inconsistent with falls and within the context of possible causes, raised the subject domestic abuse. Whilst Theresa denied that she was being subjected to domestic abuse, she stated that her husband was unsupportive.

14.5. Subsequently on [redacted] August 2016, after Theresa had attended an appointment with a LIFT Psychology nurse in respect of head injuries, which she stated, were the result of a fall, she confided to the nurse that her husband was more controlling towards her than she was comfortable with, that he called her frequently, and she had to account for where she was. She was advised to speak to her GP. On 5 September 2016, she was seen at the GP Practice with visible bruising to her left lower arm, but she denied that anyone was inflicting those injuries and blamed clumsiness.

14.6. The notes of Theresa's counselling session on 7 September 2016 with the LIFT Psychology nurse record that she had stated she was not happy in her relationship with her husband but denied his involvement in any of her accidents, she also denied self-harming. She described feeling trapped in her relationship as her husband gave her money to send to her family in South Africa. The following day, her GP spoke to her on the telephone and gave her the telephone number for Swindon Women's Aid, as she was concerned Theresa may be suffering domestic abuse in view of her injuries and no clear explanation.

14.7. On 12 September 2016, Theresa presented at her GP Practice with bruising around her neck and complaining of swallowing difficulties. She told the GP the injuries had occurred during sex with her husband. The GP advised her to report the matter to the police as she was concerned about the risks of further harm to Theresa, but she refused. The GP sought advice from a colleague, but as Theresa was noted to have 'capacity' and had not given her permission for the GP to break confidentiality, the GP did not report it to the police.

14.8. However, in September 2016 Theresa did seek help from Swindon Women's Aid (SWA). From that date to the time of her death, she had 177 contacts with SWA and 3 referrals to the Swindon MARAC (Multi-Agency Risk Assessment Conference). She also had contacts with the charity, Hometruths and with Wiltshire Police in connection with her reports of domestic abuse. It was on the basis of these contacts that the police considered that Theresa's death met the criteria for a Domestic Homicide Review.

14.9. With regard to the history of Theresa's self-harming after her initial drug overdose in 2006, in November 2016 Theresa told the Swindon Women's Aid Independent Domestic Violence Adviser (IDVA) that she had been contemplating taking her own life by taking tablets, which she had been purchasing on the internet. She also told the IDVA of an occasion when she had been thinking of self-harming and had got close to the rail track at a train station and Charles had pulled her back. Later she confirmed to her GP that she was having suicidal thoughts. (Theresa's mother on reading this report emphasised that the one occasion in South Africa that Theresa took an overdose was due to peer pressure and the loss her grandfather.)

14.10. On [redacted] February 2017, the Swindon Women's Aid IDVA made a telephone disclosure to Theresa's GP, that Theresa had told her, that her mental health problems were a consequence of domestic violence and that she hoped that Charles would kill her as that was her only way out. Theresa's GP made a referral to CMHT on the grounds that Theresa was engaging in risk taking behaviour and at times wanted to be killed by her partner.

14.11. On [redacted] April 2017, Theresa received hospital treatment after taking a significant overdose of tablets whilst drinking alcohol. Again, in July 2017 Theresa was referred to hospital by her GP after taking an overdose of Propranolol tablets. She was admitted to [redacted]Medical Assessment Unit where she opened up to staff that her husband had been physically abusing her. Bruises were visible on her left arm.

14.12. On [redacted] September 2017, Theresa told her GP; she had suicidal thoughts and had bought a rope as she was considering hanging herself. She added that she had also stood on a building and considered jumping. A week later Theresa contacted the Swindon Intensive Team asking for help as she felt she could not keep herself safe.

14.13. On [redacted] September 2017, Theresa telephoned the IDVA asking someone to go to her house, as she did not want her family to find her. The IDVA suspecting that she was going to take her own life arranged for the police to attend. They found Theresa in her home garage, with a noose around her neck stepping off a bucket.

14.14. On [redacted] November 2017, Police Officers found Theresa leaning over a Motorway Bridge. She told the officers she was "out for a walk", however it was clear that she was very upset. Due to the officers' concerns, a request was made for a member of the Mental Health Triage team to make a call to talk to Theresa. Although she agreed to speak to a member of the mental health team, she stated that this would not help, as in her words "It never helps whenever I speak to them and something will only happen with their assessments when I turn up dead"

14.15. At 7.45am on[redacted] November 2018, Theresa telephoned NHS111. She stated she had been having suicidal thoughts for approximately one year and had previously dealt with the Crisis Team and the Samaritans. She stated that she had an ongoing problem of being bounced between services. Theresa said she had been diagnosed with mental health problems and had attempted suicide twice a few weeks previously and she was again having suicidal thoughts. She said she had previously been given medication for mental health problems; however, she felt that it did not help and therefore did not renew her repeat prescription. Following an assessment the Health Assessor offered to call an ambulance but this was declined. Theresa replied that she felt others needed it more and stated that she would make her own way to the hospital in a taxi. As per protocol for refused ambulance dispositions a Clinical Advisor called Theresa back at 8am and subsequently contacted the Crisis Team who informed him that Theresa was not currently on their caseload and that she would need to be referred back to her GP. When this was explained to Theresa, she responded that she got that a lot "*that I'm not a risk. I keep wanting to kill myself; I'm not phoning anyone else. Everyone turns me away".* The Clinical Advisor offered to contact the GP for her but she refused the offer. Theresa was recorded as saying: "What *is the point, I will contact my GP who will refer to Crisis, they will take 6-7 hours to get back to me, maybe an appointment tomorrow and they will discharge me. Until one of these attempts works, when they will say that I wasn't under their books. The GP refers me every time. Crisis contact me and tell me I'm not a suicide risk*". After the Clinical Advisor advised her to phone her GP within an hour, the call was terminated. A fax message was then sent to the GP with the details.

14.16. At 12.58pm the same day, Theresa telephoned the police stating she was having suicidal thoughts. She told the operator that she did not want her family to find her, that she had written them a letter and had a rope in her garage, which was the way she intended to take her own life. The Control Room call handler said that she would get her help, but Theresa said that it was too late. Nevertheless, Theresa agreed to hold, while the

call handler contacted the Mental Health Control Room Street Triage Team, however Theresa put the phone down. At 1.01pm, the call handler phoned her back and told her the Triage Team would phone her within one minute. Theresa replied, "*OK, if they don't hear from me just send someone round Ok Thank you*". At 1.02pm, the Triage Team tried phoning Theresa but the call went to voicemail. They continued to try to phone her and at 1.04pm wrote in the "Storm" Log *"IF THEY GET NO RESPONSE LOG MAY NEED TO BE MTI'D (upgraded) FOR UNIT TO ATTEND*"

14.17. At 1.14pm, the Control Room Inspector authorised the dispatch of police officers to Theresa's home. A further three telephone calls were made to Theresa's phone which remained unanswered. The first officers arrived at Theresa's home at 1.23pm. They found Theresa hanging from a rope suspended from a beam in the garage. An Ambulance crew attended and at 1.24pm, it was that confirmed that Theresa was deceased.

14.18. CID officers attended and found a note addressed to her family. A second note addressed to Theresa's brother, which appeared to have been written at a different time was found by the family in a draw in the house. (Appendix C). The officers were satisfied that Theresa had taken her own life and although they were aware that there was a SOP "warning marker" on the premises in respect of reported domestic abuse, no attempt was made to search the premises and a forensic post mortem was not requested.

14.19. The Post Mortem examination report noted that Theresa "*had a number of external bruises which included patchy bruising over the left lower abdomen and extending over the bony proteinic of the left anterior/superior iliac spine. This appeared to be an old bruise, as it was yellowing. Further bruises, which appeared to be more than a few days older, were seen on the lateral aspects of the upper arms on the left, 12x9cm and on the right 10x13cm. Further small bruises up to 1cm in diameter were seen on the inner aspect of the forearms. There was a bruise over the left side of the forehead and extending around the upper cheek on the left side and this measured 5x9cm and was associated with some bruising when the skullcap was reflected. There was a 1mm diameter shallow laceration in the apex of the left external nose. There was no bruising in the mouth and no obvious genital bruising or bruising on the limbs*."

14.20. The Toxicology Report highlighted that Theresa had a history of depression, alcoholism and that she was withdrawing from Sertaline, but that there was no direct toxicological cause of death. There were no tablets in her stomach.

14.21. The Pathologist concluded that the post-mortem examination had identified the direct cause of death as compression of the neck structures by a ligature. He noted that Theresa had been treated for depression and was known to be a "*problem drinker and with visits to alcoholics anonymous*[4]". The Pathologist added that the toxicology showed that *Theresa had consumed alcohol prior to death but the level would likely have only caused "mild" drunkenness*. He went on to state that Theresa was also recently withdrawing from Sertraline which is associated with increased suicide risk. The endometrial appearances suggested secretory and possible premenstrual phase, which may have increased suicide risk.

14.22. In May 2018, after the Chronologies and IMRs from Swindon Women's Aid and from the Swindon CCG in relation to Theresa's GP Practice were received and considered

[4] There is no available record that Theresa visited Alcohols Anonymous but it is known she received limited support from Swindon Drug and Alcohol Services.

by the DHR Panel, Wiltshire Police opened an investigation into Theresa's recorded domestic abuse and injuries. The Police notified the DHR on [redacted] March 2019 that they had concluded their investigation and the Senior Investigating Officer had made the decision that there is insufficient evidence to demonstrate that a crime had been committed.

14.23. One of Theresa's oldest friends told the review that over a period of about three years Theresa had confided in her that she had been having suicidal thoughts. She would often talk about it and a few months before her death Theresa had told her that she thought that hanging would be the best way to end her life.

14.24. At the time of concluding this review, the Wiltshire Coroner's Inquest has yet to take place.

Section 15 - Chronology

15.1. The events described in this section explain the background history of Theresa and Charles prior to the timescales under review as stated in the Terms of Reference. They have been collated from the chronologies of agencies that had contact with Theresa and Charles and from information provided by Charles and Theresa's family.

15.2. Theresa was born in [redacted]; she lived with her younger brother and parents in Johannesburg South Africa until 2007.

15.3. Theresa's family, who now live in the UK have told the police, that Theresa's childhood in South Africa was a good one, she had a solid upbringing and never wanted for anything. Theresa was popular both in and out of school. She did "fairly well" academically, however she excelled in various sports, often being named sportswoman of the year at school. Theresa had a stable set of friends and was described as "*a strong willed and independent girl, determined and persistent in whatever she did*".

15.4. It was at school that she became friends with Charles and he was described by Theresa's parents as, "doting on her and being besotted with her." There were later disclosures by Theresa to a Mental Health counsellor and to the Swindon Women's Aid Independent Domestic Violence Adviser (IDVA) that at school Charles was fixated with her to the point that he was missing classes to wait outside her classroom for her.

15.5. Theresa's parents have recounted that in 2006, when Theresa was twenty-three years of age, an incident occurred which had a serious impact on Theresa's mental health. Notes found after her passing indicated that she was afraid to go out at night but it did not stop her. She still went to see her friends and if she was going to be late in coming home, she would sleep over at her friends.

15.6. One evening in 2006, Theresa was driving to a friend's house in Johannesburg. She had driven into the street and was at the front of her friend's house, waiting for the gate to be opened for her to drive in. At this point Theresa saw two men attempting to "hijack" her friend's neighbour and subsequently witnessed the woman being shot in the stomach. In shock, Theresa initially hid in her car but then realised that the gunmen had seen her. They approached her car and started knocking on the window with the gun they had just shot the neighbour with. Theresa, whilst petrified, managed to put the car in reverse and drive off at speed. The men followed her in the neighbour's car for several miles and only drove off in a different direction when it was clear she was heading towards the police station.

15.7. Having realised she was no longer being followed Theresa returned to the scene of the crime to check on her friend's neighbour's condition. She arrived before the police and ambulance services and saw that the woman was still alive, albeit suffering from a fatal stomach wound. Theresa waited for the emergency services to arrive and gave the local police a statement before going home. She told her parents what had happened and although clearly shaken by what she had seen, she seemed to family and friends to be handling it well at that time.

15.8. Following this traumatic event, Theresa did not go out as much as she had done previously. After her death, her family learnt from her notes that she had been fearful of going out socialising with her friends and that she had been drinking more heavily.

15.9. The shooting incident appears to have been a turning point in Theresa's life. She made a decision to emigrate. Charles, one of her closest friends, had been the victim of a hijacking and was considering leaving the country. They discussed moving to the United States of America, then settled on the United Kingdom due to opportunities for Charles's work, which was in IT. Consequently, in March 2007 they made the move to Swindon.

15.10. Initially, Theresa could not settle in the UK and after three months returned, without Charles, to South Africa. However, she spent only two months in South Africa before realising that the crime rate was still too much for her to cope with and she returned to the UK.

15.11. After returning to Swindon, Theresa's relationship with Charles developed beyond friends to partners and subsequently they married in 2009. Subsequently Theresa's mother, father and brother also moved to the UK.

15.12. In 2012, Theresa and Charles moved to a five bedroomed house in Swindon. Theresa was a director in Charles IT business and their home became the Company's registered office. Charles has stated the business was doing well and giving them, a comfortable life and they were financially secure. This is confirmed by Company House records.

15.13. Charles has told the police that he and Theresa did not have a joint bank account. Theresa had accounts with Barclays (main every day account), Lloyds where she had savings (ISAs) and just prior to her death, she had opened an account with Nationwide, but had not transferred any funds into this. Charles stated, he had little to do with Theresa's individual finances and that she had her own money to do with as she pleased. She had ordered a new car, which she was due to collect the week after her death. Theresa's parents have said that in the days following her death they and Charles had to go into each bank in Swindon with a death certificate to identify where she had accounts, as Charles did not know.

15.14. Charles also stated that in 2015 there was an attempted break in at their house. There was CCTV footage of two burglars attempting to open the garage and the patio doors. Although they never gained access to the house this negatively affected Theresa. In September of the same year there was a second attempted break in whilst Charles was abroad on a business trip. After this incident Theresa became increasingly nervous and had trouble sleeping. Subsequently, to make her feel safer, Charles arranged to have sensor lights installed in the driveway, garden lights that would come on at dusk and sensors would beep in the house if someone came into the garden. They also started arming the house alarm in the evening. He said they discussed moving to a new house, but he was

concerned about Theresa being too far away from her parents who lived within walking distance of their house. Charles said he would often message or ring Theresa during the day when he was working away from home on business. “Normally he would ring or “Face-time” her twice a day at least, but if he was busy then he would text quite a lot.” [5]

15.15. Prior to the period focused on by this Review, Theresa had a number of GP appointments in respect of normal, non-relevant illnesses. However, from September 2015 she increasingly received medical treatment in respect of stress and anxieties.

Section 16 - Overview

16.1. This section summarises what information was known to the agencies and professionals involved in the Review about Theresa and Charles. It also includes relevant information provided by Charles, Theresa’s family and friends.

16.2. In order to present the extent of the information given to agencies by Theresa and their contemporaneous observations, there is significantly more detail in this section than would normally be the case. However, it is emphasised that Charles has consistently denied assaulting Theresa and has explained that he put trackers on Theresa’s phone only to allay her fears when he was working abroad. (See Appendix D). The police investigation into the reported domestic abuse and controlling behaviour, “*found insufficient evidence to demonstrate that a crime was committed*”[6]. Additionally Theresa makes no reference to domestic abuse in the notes she left for her family and brother prior to taking her own life (See Appendix C). Theresa’s parents and brother have told the review that Theresa knowing that the family worried about her mental health, regularly kept them updated about what she was doing, on a “WhatsApp” family group contact.

16.3. On [redacted] October 2015 Theresa saw her GP, complaining of anxiety and stress, which she thought were due to stress at work and difficulties relating to her mother-in-law staying with her, particularly as her husband regularly worked abroad. She was prescribed 5x2 diazepam tablets later she was placed on Bblocker, propranolol 10mg.

16.4. On [redacted] November 2015, Theresa attended hospital with chest pains, which she said she had been suffering for the previous two weeks. She was diagnosed with possible dysrhythmia, a medical condition causing irregular heart rate and with gastro-oesophageal pain, following treatment; she was discharged the following day.

16.5. On [redacted] January 2016 Theresa had a consultation with her GP reporting several fainting episodes in the previous few months, in particular, having fainted twice after sexual intercourse. The Bblocker medication was stopped.

16.6. On [redacted] January 2016, Theresa reported further episodes of fainting during intercourse and she was referred for Neurological examination. Blood test results were normal. On [redacted] February 2016, Theresa had the neurological examination, it was recorded as normal and no diagnosis was made.

[5] From Charles statement to Wiltshire Police (Appendix D and confirmed by him to the DHR
[6] [redacted] Senior Investigating Officer

16.7. During the first seven months of 2016, Theresa regularly attended her GP practice complaining of anxiety and on two occasions reported having thoughts of self-harm. She was referred for sessions with LIFT Psychology [7] and was prescribed sertraline.

16.8. On [redacted] February 2016, Theresa engaged with LIFT Psychology. She attended seven "One to One" sessions and three quarters of a Mindfulness Course. The sessions started on [redacted] March 2016 and the last she attended was on [redacted] July 2016. The assessments showed all mood scores were sub-clinical with the exception of one on 15 June 2016, when she showed moderate low mood, anxiety, and fleeting suicidal thoughts. Further investigation indicated that the anxiety related to the shooting incident in South Africa, which had resurfaced due to an attempted burglary at her home.

16.9. On [redacted] April 2016, Theresa presented, at a hospital emergency department, with intermittent chest pain, numbness to her right hand and the left side of her face. While she appeared well, a request was made for her to have an Urgent Care Centre assessment.

16.10. On [redacted] April 2016, while accompanied by Charles, Theresa was seen at the Cardiac Physiologist Clinic. After a number of tests, she was discharged with a recommendation of adequate hydration pending test findings.

16.11. On [redacted] April 2016, Theresa attended her GP's surgery, reporting a fainting episode after she had "hit the left side of her face during a fall while exercising". Swelling was noted beneath her left eye.

16.12. During the following months, Theresa regularly presented at her GP suffering from anxiety and feeling low, although she denied having any thoughts of self-harm. There were further occasions when she attended her GP with facial injuries, which she stated were caused by falls while or after exercising at home. When questioned, she denied that her husband was violent towards her.

16.13. On [redacted] July 2016 Theresa's GP referred her to Primary Care Liaison Service, (PCLS), in respect of worsening depression and post-traumatic stress disorder (PTSD). She was assessed and signposted to LIFT Psychology with a recommendation to engage with PTSD work. She demonstrated worsening low mood and anxiety, moving from moderate to severe during intervention. During these sessions of contact with LIFT, Theresa described her husband, Charles, as "more controlling than she would like" and that he monitored where she was via her mobile phone. At her contact on 3 August 2016, bruises were observed which Theresa attributed to falling off her treadmill.

16.14. On [redacted] August 2016, during a GP consultation for an injury to her left arm and shoulder, Theresa stated she felt unsupported by her family and had occasional thoughts of self-harm. She said she had reduced her alcohol intake and there was no excess medication in the house. (She had been known to purchase additional medication on the internet) She was tearful and frustrated but denied any domestic abuse.

16.15. Theresa's LIFT counsellor's notes for [redacted] August 2016, record that Theresa had described her family and husband as being unsupportive. She stated she slept badly and had flashbacks to a previous traumatic event when her father had been held at gunpoint in South Africa and her mother had told her not to open the door to help.

[7] Avon and Wiltshire Mental Health Partnership's support service through GP surgeries to people with common emotional, communication and mental health difficulties.

16.16. On [redacted] August 2016, Theresa told the LIFT counsellor that she had excess tablets at home, but she denied having any intentions of self-harm. She did report that she had fallen while exercising and had a head injury. She was advised to see her GP and when she did so, her concerns about her husband's controlling behaviour and her frequent falls were discussed. Although Theresa denied that Charles had physically assaulted her, the GP gave her the contact details for Swindon Women's Aid,

16.17. On [redacted] September 2016, during a contact at LIFT Psychology, Theresa stated that she was unhappy in her relationship but denied that she was subjected to any physical abuse. She described feeling trapped in her relationship as her husband gave her money, which she sent to South Africa to support her grandparents and other family members.

16.18. On [redacted] September 2016 Theresa's GP raised her concerns about domestic abuse in view of the number of Theresa's recurring presentations in relation to physical injuries. Theresa denied that her husband was violent to her, but reported feeling trapped by financial dependency on her husband. While worried about her husband finding out, she gave the GP permission to contact Swindon Women's Aid on her behalf and for the Independent Domestic Violence Adviser (IDVA) to telephone her on her mobile phone.

16.19. On [redacted] September 2106, Theresa was again seen by her GP about her sleep difficulties, bruising to her neck and problems swallowing. Theresa was initially evasive about the cause of the bruising, but admitted it had occurred while she was under influence of alcohol during consensual sexual intercourse. Theresa was advised to contact the police, as the GP felt she was at risk. Theresa said her husband was out of the country and she was not at risk at that time. She denied having low mood or considering self-harm. The GP told Theresa that in view of her disclosure that Charles held her neck during sexual intercourse and caused her to pass out, she believed Theresa was at risk of serious harm and asked for her permission to complete a Safeguarding referral form, Theresa agreed.

16.20. On [redacted] September 2016 Teresa's GP contacted Swindon Adult Safeguarding outlining her concerns about domestic abuse and Theresa's need for care and support. The Safeguarding Enquiry Manager checked if there had been an onward referral to a more appropriate service and if the Police had been made aware of the concerns. The GP informed her that Theresa did not want any police involvement. The referral was assessed and it was later deemed by the enquiry manager that Theresa did not have care and support needs; therefore, no further action was taken.

16.21. At 9.19 am on [redacted] September 2016, Theresa's GP telephoned Theresa, as she had not turned up for an appointment. The GP records noted that during the conversation, Theresa denied any violence from her husband since his return (from working abroad). She also denied having any thoughts of self-harm. She confirmed her throat was still sore but had no swallowing or breathing difficulties. A prescription for fourteen tablets of Sertraline 50mg was issued and Theresa confirmed that she had a counselling appointment planned. The GP offered her a further appointment with Swindon Women's Aid and confirmed that she was aware that a referral had been made to the Adult Safeguarding Team.

16.22. At 12.39pm the same day, Theresa again spoke to her GP on the telephone, asking if she could stop taking Sertraline as she did not think it was helping her mood. She was advised to continue taking Sertraline and warned about stopping medication suddenly.

16.23. That evening, Charles called for an ambulance, after not being able to wake Theresa up, although after a few minutes she did respond. She was taken by ambulance to hospital and she reported taking an accidental overdose of Propranolol. She said she had

been having palpitations since the morning. As she had previously had palpitations and had been prescribed Propranolol to control them, she had impatiently taken too many in a bid to get her heart rate down. Theresa admitted she should have waited and stressed that she had no suicidal ideation. After being observed and given advice she was discharged.

16.24. On 20 September 2016, Theresa was seen by her GP. She denied having intentionally taken the overdose the previous day, stating she had just been careless about the number of Propranolol she had taken. It was recorded in the GP notes that she denied having been subjected to any further strangulation, although she said, her husband had been rougher during sexual intercourse than she was used to or would want. She added that she felt trapped by financial constraints as she was a partner in her husband's business and was sending money to family members in South Africa. There was also a further discussion regarding her posttraumatic stress disorder (PTSD) and Theresa confirmed that she planned to make appointments to see the GP for a review and to see the Psychology Team and LIFT Counsellor.

16.25. On [redacted] September 2016, Theresa made a disclosure to LIFT, of being strangled to the point of unconsciousness during sexual intercourse with Charles. Theresa stated that she was not aware of what he was doing until he began to apply pressure to her neck. The LIFT record shows that she had bruises on her neck. LIFT Staff discussed Swindon Woman's Aid with Theresa and she confirmed that she had previously had a conversation with her GP about domestic abuse. The LIFT counsellor discussed the disclosure with Theresa's GP and informed the GP that she was of the opinion that confidentiality could not be maintained due to the risk to Theresa and therefore she would be making a disclosure to the Police. Theresa was unhappy with this decision and when police officers spoke to her, she confirmed she did not want to take the matter further. She told the police officers that Charles grabbing her neck had been consensual and part of their sex life and that the disclosures to her counsellor had been made with confidentiality in mind.[8] The report was initially graded as STANDARD risk and Charles was not interviewed at Theresa's request.

16.26. Later the same day, the Independent Domestic Violence Adviser (IDVA) from Swindon Women's Aid (SWA) telephoned Theresa to discuss her support needs and to explain the Outreach Support Service to her. Theresa stated she was afraid of engaging and trusting anyone, explaining that when she had spoken to her mental health counsellor, the Police were informed and Theresa then received calls from them, which were difficult for her to answer in front of her husband. Arrangements were therefore made for Theresa to meet with the IDVA at her GP surgery.

16.27. Theresa later met with the IDVA and confirmed that she wished to engage with SWA as her relationship with her husband had deteriorated and she needed support. During the referral process, (which included a DASH risk assessment); Theresa told the IDVA that on one occasion when they were dating, she told Charles she did not want to see him again. Charles had then driven his car into oncoming traffic, saying if he could not have her, no one would. Theresa's brother has confirmed this incident, during his meeting with the Review Chair and Swindon Partnership Domestic Abuse Manager on 12 April 2019, stating he was in the car with them at the time. Theresa's parents stopped her seeing him

[8] See Appendix L. Theresa writes in her diary dated Thursday June [redacted] (2016):"…*the second standout moment was one night during sex I felt his hands around my neck. Something in him was unleashed that night. Progressively sex got rougher and the more I fight back the more he enjoys it. It is like there was this side of him hidden all the years .*"

for a while but they were eventually reconciled and he did not do anything as obviously dangerous again. Theresa said Charles controlled all the money and he had a "tracer" in her mobile phone so that he would always know where she was, when he worked away from home[9]. Theresa said Charles expected swift replies to his emails when he was away on business, but until recently, he had not been physically abusive.

16.28. At that meeting, Theresa explained that things at home had gradually become worse over the previous few months; arguments had escalated to pushing and grabbing. Most recently, her husband had used his belt to strangle her during sex[10] this was not something the couple had discussed before and Theresa was frozen by shock and fear, she passed out. When she awoke, her husband had climaxed and the sexual activity had ceased. Theresa explained that it was this information that her mental health counsellor had contacted the police about, without her consent. Theresa said, rather than being honest, she had minimised what had happened to the police, as she was afraid of the repercussions, the police told her there would be no further action.

16.29. Theresa spoke of feeling trapped in the marriage, her husband was wealthy and paid her approx. £4000 a month to work for him, she could never get that wage elsewhere. She used some of the money to provide for her grandparents in South Africa and to pay for her cousin's son's education in South Africa.

16.30. A further meeting was arranged at the GP surgery, a safe meeting place as although her husband tracked her by her phone, he expected her to attend the GP surgery frequently due to her ongoing low mood, PTSD and accessing counselling. An essential safety plan was set out on what Theresa should do to remain safe at home and how she might leave safely and quickly should she so wish.

16.31. The GP records of the [redacted] September 2016 noted that the LIFT counsellor had contacted the police without Theresa's consent, regarding her concerns about Theresa's revelation that she had been strangled by Charles during sexual intercourse. Theresa had spoken to the police declining to pursue the matter further. The GP contacted LIFT regarding the disclosure to the police and Theresa's next appointment with the counsellor was subsequently cancelled. Later the GP received a telephone call from LIFT reiterating that the information had been disclosed to the police, as it was felt that there was an imminent threat to Theresa's life.

16.32. On [redacted] October 2016, Theresa and the IDVA met again at the GP Surgery. Theresa told the IDVA there had not been any further incidents since they last met but did acknowledge that she now realised how controlling Charles was in the manner in which he monitored her movements. During the week, he had asked for her phone password as she had changed it and she realised that he had also been checking the history of her iPad use. She said she had no access to joint accounts, no idea of their outgoings. She added that Charles monitored all of her spending activity.[11] Theresa stated that she had

[9] Theresa's brother and mother have told the review that they also had contact apps with Theresa with her consent.

[10] Charles has told the review on [redacted] April 2019 that this sexual activity was at Theresa's instigation. When asked by the DHR Chair, he confirmed the on occasions a rope was used and on other occasions a belt. He had kept them for some time after her death, but they were never asked for by the police.

[11] Charles has told the review that Theresa paid household accounts and he paid the business accounts. He stressed he did not know any detail of her finances.

told Charles the police had been called because her counsellor had been worried about her; he did not appear to be worried or concerned.

16.33. Theresa told the IDVA that she had met Charles at school. He was her friend; however, she described him as displaying possessive behaviour towards her from a young age. During school, he would refuse to go to lessons and sat outside her classroom until the teachers became involved.[12] Theresa's education was affected, as she could not concentrate in class. Looking back, she felt she never had a choice about being with Charles, as she has no experience of adult life without him.

16.34. At 8.38 am on [redacted] October 2016, Theresa was seen at her GP surgery. The GP records reveal that Theresa denied having thoughts of self-harm and that she said her mood was "OK". Her GP noticed that she appeared to be in pain. When questioned by the doctor, Theresa stated Charles had injured her the day before, but she was not willing to reveal the details. An examination of her abdomen showed visible tender superficial bruising on the left side. **(*Whilst Theresa's had told the GP that Charles injured her the day before prior to going abroad i.e. the 5 October, she told the IDVA it was the Tuesday or Wednesday i.e. [redacted] October. (See para 16.35 below) Charles had flown to Sweden on 4 October and did not return until [redacted] October 2016.[13]*)** Theresa stated to her GP that she had seen the SWA IDVA on two occasions and had found it helpful and that she was working on an exit strategy from her home and relationship.

16.35. On [redacted] October 2016, the IDVA met with Theresa at her GP surgery. Theresa disclosed a further incident of domestic abuse, she said this took place the previous Tuesday/Wednesday ([redacted] October) and related to Charles questioning her and getting angry about who she was talking to about their home life. She said he had become suspicious after the police had called. An argument ensued during which he started punching her to the left side of her body and ribs. He also kicked her when she was on the floor. Theresa told the IDVA that after Charles had left to go on a work trip abroad, she had seen her GP and told her what had happened. The GP examined her injuries, gave her some pain relief. Theresa told her she had taken photos of the injuries on her phone. Her IDVA completed a further DASH, score 12. As the IDVA believed this was a high-risk case she explained to Theresa that she would be making a referral to MARAC. Theresa was reassured that this was highly confidential and that her wishes and concerns - particularly around anyone contacting her would be heard. A place of refuge was discussed but Theresa said she could not leave, as she felt responsible for her family that Charles helped to financially support. Theresa emphasised that she did not want to report the assaults to the Police, as she feared Charles would lose his job, which required him to have security clearance and a clean criminal record.

16.36. Theresa's personal safety was discussed. She stated the apps on her phone that Charles used to track her with were - Life 360 and Find my friends. She believed he received an email every time she went in and out of the house. Theresa said she could not call the Swindon Women's Aid 24 hour helpline due to the number showing up on her phone bill, but she had called Samaritans in the past and would do so again. Theresa said her parents had visited her at the weekend, they had asked how she hurt herself and she had replied that she had fallen. Theresa was asked if her parents suspected anything, she

[12] Theresa's school friend has confirmed to the DHR that this was the case. Her friends at the time could not understand why Theresa put up Charles behaviour as she was extremely outgoing and popular whilst Charles was very quiet and reserved.

[13] From details of Charles flight records, provided by his solicitor to the police.

said no, they used to dislike Charles but since he had been supporting their family in South Africa they thought, he was wonderful.

16.37. On [redacted] October 2016, Theresa told the IDVA that she was worried that Charles had caught her out lying. He had asked her if she had been to the GP surgery and she replied that she had gone to get a prescription. He then asked her why it had taken one hour seventeen minutes, Theresa had not realised he could track her so precisely.

16.38. On [redacted] October 2016 after the referral from Swindon Women's Aid, the Swindon MARAC considered Theresa's situation. The referral outlined Theresa's isolation, Charles's controlling and stalking type behaviour, along with clear reference to Theresa potentially withdrawing from support if her wishes for confidentiality were not respected. Detailed in the referral was Theresa's withdrawal from mental health counselling after the police had become involved following disclosure and her fear that her husband would find out about the police involvement. The meeting discussed Theresa's situation carefully and noted that Theresa had stated to the police that there was no domestic abuse and that her husband strangling her during sex was part of consensual sexual activity.

The following Risks & Actions were minuted:

"Risks identified: Physical abuse, controlling, alcohol consumption, dangerous driving, monitoring her and bank accounts, isolation, escalating Domestic Abuse and sexual violence, (strangled her), mental health – Post Traumatic Stress Disorder (PTSD), victim overdosed, financial control by perpetrator, minimising to police, non-engagement with police by victim, risks of further physical and sexual abuse, minimising to health.

Actions

- SWA to discuss an Independent Sexual Violence Adviser (ISVA) referral with the victim. (Action completed)
- DAIT (Police Domestic Abuse Investigation Team) to add marker re PTSD and overdose. (Action completed)
- SWA to make referral to Paledin and continue to engage and discuss alarm - Paledin unable to assist as Charles was still living at the family home)"(Action completed)

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16.39. At 11.38am [redacted] October 2016, Theresa saw her GP and reported further physical violence during an argument with Charles the previous evening. Theresa said Charles had tried to strangle her; he had held her by her wrists and had non-consensual sexual intercourse with her. He also hit her around the face and head with a solid object. Theresa told the GP that she did not feel she would ever be able to escape the situation she was in. Although she had no active plan, she was having suicidal thoughts. She said she did not want to go to a refuge. On examination, she was found to have significant bruising to her wrists (4x6cm on her right wrist, 3x6cm on inside of her left wrist and 5x2cm on her back of left wrist) and palms. Theresa expressed her concerns about conceiving after the forced sexual intercourse and requested emergency contraception.

16.40. The SWA IDVA later met Theresa at the GP surgery. It was noted that Theresa was brighter and less tearful than at the previous week's meeting, she was able to move more freely but still in pain from the injuries to her ribs. She admitted to self-medicating, she had pain relief medication and had drunk alcohol to numb the pain and help her sleep. They discussed the MARAC meeting and Theresa said she was interested in talking to Paladin to seek advice regarding the apps on her phone.

16.41. Theresa told the IDVA that she had hidden money in the spare room but Charles had found it. She did not know how he guessed but she felt he was suspicious that she wanted to leave. They discussed if the house was bugged or had cameras Theresa said the outside of the house was clearly fitted with CCTV, so it was possible that Charles had also put cameras inside the house, as it seemed unlikely that Charles would know where to find the hidden money.[14] Theresa added that Charles had said he would reduce her wages for tax purpose, although Theresa believed the real reason was not tax related but rather to restrict her. Charles was going to Belgium with his job the following week and wanted her to go with him, which she did not want to do.

16.42. The following day during a telephone call with the SWA IDVA Theresa disclosed further sexual violence the previous night; she said Charles had had a particularly bad day at work. The IDVA tried to encourage her to consider calling police and/or going into a refuge.

16.43. On [redacted] October 2016, Theresa was referred to PCLS for assessment. She was offered the assessment but cancelled the appointment. However, during triage, she disclosed that she has been involved with the MARAC and Swindon Women's Aid. Her PCLS records show she had stated that Charles tracked her whereabouts using a tracker on her mobile phone. This was known to Swindon Woman's Aid and the MARAC. Although Theresa reported that she was engaging in self-harming behaviours, it was considered that there was no requirement for an assessment for enforced treatment and detention.

16.44. On [redacted] October 2016 after receiving a text from Theresa, the IDVA telephoned her. Theresa told her that she had avoided going to Belgium with Charles, by claiming she felt unwell. She stated he physically assaulted her before he went and she has been left with injuries. Theresa said that they got into an argument and she said that she wanted to leave him. Theresa said she passed out during the attack, as a result of being strangled.

16.45. On [redacted] October 2016, Theresa met the IDVA in the GP surgery; she told her that she had spoken to her brother about the notifications on her mobile phone that she did not understand. He told her, it was because of a car-tracking app, which explained why she has been getting text messages, which recorded where her car was parked.[15] Theresa had not previously been aware of this and wondered if this was because Charles had only recently added the app to her phone. Theresa gave further details about the assault she had suffered prior to Charles leaving for Belgium. She stated that he had put a rope around her neck and strangled her, this left clear marks which although faded were still visible to the IDVA. Theresa said she had a large bruise on her leg and another on her right upper chest, which she showed to the IDVA. Theresa claimed that this assault took place as a result of her "winding Charles up". She said that she wanted to make him angry enough to kill her and that she had passed out due to the strangulation. Since Charles has been in Belgium, he has sent lots of messages about how much he loved and needed her. The support worker again asked if she would go to the police, she said no. Theresa was adamant that she would not engage with them, despite knowing that the assaults were wrong, she felt he had done so much for her family that she could not do that to him. The IDVA tried to rationalise with Theresa but she was firm in her decision and reasoning.

[14] Theresa's mother told the DHR on [redacted] April 2019, that after Theresa's death the family found in one of Theresa's drawers, a scanner that Theresa had purchased for for detecting electronic bugs.
[15] Theresa's brother has told the DHR Chair ([redacted] April 2019) that he could not remember this conversation, but did recall that she had told him that she was concerned as she had found a tracking device on her car.

16.46. Theresa mentioned that things had escalated to high levels of physical violence after she had asked Charles's mother, who had been staying with them, to leave their house as she had been rude to Theresa. Charles who had been away at the time had been furious and had not forgiven her. That was when the assaults started. [16]

16.47. The IDVA asked Theresa to consider going into a refuge but she declined. She said she had spent more time thinking about leaving but was not ready to do so.

16.48. At the request of the IDVA Theresa was seen by her GP, who recorded that Theresa appeared intoxicated, disheveled and unsteady. There were marks on her neck and Theresa told the GP that Charles had put a rope around her neck earlier in the week and had tightened it until she passed out after she had told him she was leaving. She stated that Charles was away on business and that she had drunk a bottle of wine earlier that morning. Theresa denied taking drugs or overdosing other than drinking too much alcohol. With Theresa's permission the GP discussed the situation with the IDVA and advised Theresa to consider leaving home and taking up a place in a refuge. A taxi was arranged by the surgery to take her home.

16.49. Later the same day, during a telephone conversation with the IDVA, Theresa said she had spent the day trying to get more money out of the bank. Although she had previously said she had not wanted to go into a refuge, she was then reconsidering. When she was told there was not a place in the Swindon refuge for a couple of days, she said she would not consider leaving Swindon and would stay in a hotel until the place was available in Swindon. However, when the IDVA said she would book the one bedroom flat at the Swindon refuge for her, Theresa said she wanted more time and would call her back. The IDVA arranged that if Theresa did decide to leave that day, she would be found a two bedroom flat at the refuge until the one bedroom flat was available. Theresa declined the offer saying she had changed her mind about leaving.

16.50. On [redacted] October 2016, the IDVA spoke to Theresa on the telephone and Theresa told her she was still thinking about the refuge place and would decide after speaking to her parents.

16.51. Later, Theresa told the IDVA, she had found out that Charles had called her parents and told them that she was addicted to drugs and alcohol. She was upset and shocked at him for using this tactic and felt that he was painting a picture of her that was not true. Theresa feared this would prevent her parents from believing her if she told them about the domestic violence. Her parents had asked to see her later and while she wanted to tell them the truth, she wass scared of their response. A short time later Theresa again telephoned the IDVA sounding upset, she spoke quietly and said she was putting a stop to everything. She did not need any help or support and everything wass fine. When asked what had happened to make her change her mind she kept repeating, "*I'm fine, everything is fine*." She went on to say that, she had just spoken to Charles on the phone. She would not say what he had said to her but said that she just needed to keep her mouth shut and all would be fine. She added she planned to cancel seeing her parents.

16.52. On [redacted] November 2016, Theresa telephoned the IDVA and told her that after Charles had returned home from his work trip abroad, they had argued and he had physically assaulted her. He was suspicious that she was going to leave him, as he had read a text message on her phone from her Grandmother asking if she was OK. She was once again contemplating leaving Charles and had spoken to an uncle about financial support for her grandparents if she were to leave Charles. How she could safely leave was discussed, as

[16] During his meeting with the DHR Chair, Charles stated he had never assaulted Theresa, in fact been understanding about Theresa asking his mother to leave, as he knew she could be difficult.

a place in the Swindon refuge was then available The IDVA contacted Paladin to discuss Theresa's concerns of tracking devices on her mobile phone and car. Paladin advised that they could not support Theresa due to her still living with Charles. They did however provide advice regarding what Theresa could do in relation to checking her car and phone.

16.53. At 5.14pm on [redacted] November 2016, Theresa went to her GP surgery for a repeat prescription of Sertraline. She told her GP that she had tried to leave her husband, but he had attacked her and physically prevented her from leaving. He had hit her with a metal pole across the left side of her abdomen. She said her husband had telephoned her parents and told them she had drug and alcohol problems. She said she felt unable to confide in them and did not want the police involved. On examination, she was seen to have extensive bruising on the right side of her upper chest, right lower abdomen, left lower ribs, right arm, left lower arm and left upper outer thigh. The GP discussed this with a GP colleague and offered to call the police immediately and arrange for her to go to a place of safety. Theresa acknowledged the GP's concerns for her safety and the risks of further violence but refused and said she wanted to go home.

16.54. On [redacted] November 2016 the IDVA and her supervisor met with Theresa at the GP surgery, Theresa removed her jumper and showed them bruises which were visible on both upper arms, the left arm had grab mark type bruising. Her forearms were also bruised. Theresa said that she had been beaten with a metal pole.

16.55. The refuge place was discussed. As Charles only went out spontaneously, Theresa said it was difficult to plan a safe exit. She was encouraged to call Swindon Women's Aid and leave if a safe opportunity arose over the weekend. The hearts and flowers behaviour that had followed an incident was spoken about, but Theresa said this behaviour had now stopped. Charles seemed less remorseful and did not try to make things up to her. Theresa said she did not have much left in her to cope and the risk of self-harm was discussed. On a scale of 1-10, Theresa has reached 9 in the past week - when she had got close to the rail track at a train station and Charles had pulled her back. She said she now scored herself as 6/7 and said she did not have any plans to harm herself.

16.56. On [redacted] November 2016, the IDVA again met Theresa at the GP surgery. Theresa told her that Charles had gone to Sweden but had not said when he would return. He had however told her that if she left him, he would divulge confidential information about [redacted](A named person close to her), she therefore did not want to go to the refuge. Theresa said she did not know how many more beatings she could take but she was too scared to leave. She could not see a future for herself on her own. The IDVA told her about agencies that would be ready and able to provide her with support her on the path to independence. Theresa added that as Charles had reduced her wages, she had less disposable income.

16.57. On [redacted] November 2016, Theresa telephoned the IDVA and said she wanted to leave home and asked about booking a hotel in a fake name. The IDVA told she could go to a refuge that day. A safety plan was discussed which included, Theresa working until lunch time to avoid making Charles, who was in Sweden, suspicious, packing a bag, buying a new mobile phone and getting money from the bank. She would leave her car in a safe place and at 3.30pm, the IDVA would drive her to the refuge.

16.58. Later the same day, Theresa telephoned the IDVA to tell her that Charles was on his way home from Swindon railway station and she did not know what to do. She was advised to either leave straight away before he got back or to stay and plan a safe exit for another time. Theresa said that she would gather some stuff and leave. Shortly afterwards Theresa phoned the IDVA again to tell her, Charles had arrived home before she could leave. She felt frustrated that Charles always seemed four steps ahead of her. The IDVA

suggested she consider if there is a bug device at home. Theresa told her she would telephone her again if she could safely leave. **(*It is noted that Charles flight records indicate that he took a flight from London Heathrow at 11.45am on [redacted] November 2016 to Gothenburg-Landvetter Airport, this was not a direct flight and Charles changed flights within Amsterdam Airport, prior to arriving at Gothenburg-Landvetter Airport at 2.05 pm.*

On the [redacted] November, Charles took a flight from Gothenburg-Lanvetter Airport at 7.30pm to Amsterdam; Charles then appeared to have remained in Holland until the [redacted] November when he took a flight from Amsterdam to Heathrow landing at 5pm.[17])

16.59. The following day [redacted] November 2016, Theresa met the IDVA by arrangement in a Supermarket. Theresa showed her pictures of a camera that she had found hidden on the bookshelf, behind her desk. She also found a tracker on the car. She was very scared and relived all the phone conversations that she had had in the house and wondered how many of them Charles overheard.[18] They discussed the increased risk and the IDVA suggested Theresa did not return home for her own safety. She said she was too afraid to leave like that and wanted to try to pacify Charles before she left. Charles was due to be away the following week and the IDVA suggested the safest time to leave would be when he was inflight onboard an aircraft. Theresa had bought a new phone, which she would keep hidden, she asked the IDVA to share the telephone number with her GP, as it would be the only safe way to communicate.

16.60. At 12.42pm on [redacted] November 2016, Theresa was seen by her GP, whom she told she had tried to leave her husband the previous week after agreeing a plan with SWA but that Charles had returned home unexpectedly. She told the GP about discovering the tracking devices on her car and the hidden camera at home. She said the previous day, Charles had hit her across her back, her right shoulder and left arm with a solid object. He had also punched her in the face, she had lost consciousness and since then she had been suffering from headaches. **(*See note in para 16.58 above indicating that Charles was out of the Country on that day.)*** An examination revealed bruising and swelling to her left eye and right shoulder. The GP contacted the hospital A&E Department and advised Theresa to attend.

16.61. Following the GP referral, Theresa accompanied by the Swindon Women's Aid IDVA, presented at the hospital emergency department. Theresa reported that during the attack by her husband, she had lost consciousness but was not sure for how long. The hospital records noted that Theresa "while withdrawn and reluctant to give information during the consultation; confirmed she had been assaulted by her partner the previous day but did not want the police notified as Swindon Women's Aid was formulating a safety plan for her. She was discharged after her injuries were x-rayed".

16.62. As Theresa and the IDVA were about to leave the hospital, a receptionist informed them that Theresa's husband had called, stating he knew she was at the hospital and he

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17 The Police investigation highlighted that Charles travel was confirmed by the National Border Targeting Centre. This flight data is also backed up by Charles' usage of his credit/debit cards in the locations indicated on the flight data.

[18] Theresa's mother wrote to the review that it was clear Theresa felt she was being tracked and that the house and car were bugged. When she was packing up Theresa's belongings after her death she found a "bugging checker" (as she called it in her notes). Theresa's mother asked Charles why Theresa had it and he said he did not know. She did not think anything at the time, only once she read Theresa's journals did she piece together why she had it. Theresa's mother stated she also found handcuffs which she was later told by the police, Charles used during sexual activities.

tried to obtain further information. The reception staff neither confirmed or denied her attendance and ended the call. Theresa was panicked by this and told the IDVA : ”He always knows everything, how does he know I am here, I will never get away from him, this is why I haven't come to the refuge, he will never leave me alone". The IDVA reminded her that she had driven to the hospital and that there was probably a tracker on the car. Although the IDVA suggested it might not be safe for her to go home and that she should go to the refuge, Theresa was adamant that she had to go home. She asked the IDVA to look after her phone for her in case Charles found it.

16.63. At 5.04pm,Theresa went to her GP practice in a distressed state reporting that Charles had found out that she had gone to hospital. The GP contacted the IDVA, to inform her that Theresa had attended the surgery and told her that whilst Charles had not been home when she had returned from the hospital, during the time Theresa was at the surgery Charles had called her mobile phone twenty seven times. The GP said that when Theresa had called him back, he said that he knew she had been at the hospital. The IDVA told the GP that she was no longer at work, but all options were open to Theresa. The GP advised Theresa that she was concerned that it might be dangerous for Theresa to return home and suggested she contact the police and go into a refuge. Theresa said she did not want the police involved but would make contact with the refuge herself after her GP consultation.

16.64. On [redacted] November 2016, the IDVA discussed Theresa's situation with a Police DAIT Officer and asked if Theresa could be informed of the types of police engagement available to her, without there being any actions taken without her consent. The officer said she and her detective Inspector would be prepared to meet with Theresa if she was agreeable and explain the legal process and safety measures available. Later that day, at the GP surgery, the IDVA met Theresa. Theresa told her, that Charles had questioned her about her attendance at hospital; he said he knew she had been there and she admitted to getting her arm checked out. He asked her if she was hiding anything and she had replied “No". The IDVA spoke to Theresa about accessing support from her brother, Theresa said he was the best person to go to and agreed that she needed an ally. She said that she would consider opening up to him.

16.65. Theresa consented to the IDVA making a re-referral to the Swindon MARAC, Theresa did ask that her new telephone number was not shared. Her safety was discussed and it was agreed that until she was ready to leave, she would safeguard herself at home by avoiding going to the gym, provoking Charles verbally, threatening to leave or making him suspicious by going out without her phone.

16.66. Theresa cancelled an appointment with the Primary Care Liaison Team as she thought Charles would be suspicious. She did however reveal that she had been having bad dreams, often about being unsafe and she shared another historic traumatic experience she had witnessed when her father had been the victim of an attempted car hijack, which took place on the driveway of the family home. A meeting with the police was discussed and Theresa said she would consider it.

16.67. On [redacted] November 2016, Theresa sent the following text message to the Swindon Women’s Aid IDVA.

“Morning [redacted] Just to let you know I spoke to (Charles) last night and I told him that I never said anything at the hospital but they suspected something was wrong. I told him if it happens again I'm taking it further. I asked him about the cameras and the tracking. He was very calm and said, if I want space he will give me space. Don't know what that means but

I haven't heard from him today yet. Anyway, I'm completely drained and have no fight left in me so I think I'm just going to lay low for a bit. When you speak to Dr [redacted] would you please get her to cancel my appointment next week I made it before I saw her this week and probably won't need it. Thanks again for everything you have done for me I really appreciate it."

The IDVA replied:

"Hi [redacted] I'm concerned that [redacted] calm response to you was calculated because he is out of the UK - if he was aggressive or threatening whilst away you may have left. You know you can call or text me as you need to. I will speak to Dr [redacted] on Thursday. Can I suggest you keep the appointment with her for now, wait until next week and then cancel it if you still feel you don't need it?"

Theresa replied:

"Hey [redacted] Ah I didn't think of it like that I thought I might have gotten through to him finally. You're right that makes more sense."

16.68. On [redacted] November 2016, the IDVA found a text from Theresa stating she had got out safely and covered her tracks, she was being very careful and that she would speak to her the following week. On receipt of the text, the IDVA called Theresa on her safe phone; Theresa told her that she left home on Friday before Charles got back from his trip. She said that she went to a hotel and stayed for the night. The next morning, she went for a run and soon after Charles arrived at the hotel to take her home. Theresa believed that the running app she used, flagged up on her home computer, despite having changed her Apple ID. She said she had gone home with him without a fight. Charles told her not to try and leave again, he would always find her. He beat her again on the Saturday night, using the stick that reaches up to unlock the loft door. She stated she had multiple bruises to her torso, stomach and upper arms. She has an appointment with her GP later that day. Charles had gone to Belgium with work. Theresa had reassured him that she would not leave and she said she would stick to this decision. Theresa would not give her consent for the IDVA to speak to the police.

16.69. The same day Theresa went to her GP surgery and reported the further episodes of violence, during which she said she had been hit with a metal pole on her left arm and lower abdomen. She told the GP that she had left home but that her husband had found her at a hotel. She explained that she was being supported by the IDVA. On examination, the GP saw extensive bruising to Theresa's left upper arm, the centre of her back and lower abdomen. **(See note in para 16.58 above indicating that Charles was apparently out of the Country until [redacted] November.*)***

16.70. On [redacted] November 2016, after telling the IDVA she had been contemplating taking her own life by taking tablets, Theresa saw her GP, she complained of being unwell, having nausea, feeling low and having suicidal thoughts. She told the GP she was suffering more pain from her bruising. She declined further help and the GP stressed the need to be safe. Theresa told her that she was in contact with the IDVA.

16.71. The next day she told the IDVA that she recognised the previous day had been a particularly low day. She said, "I used every resource available to keep myself alive yesterday". On further discussion, Theresa said she had called her GP's surgery and the Samaritans to access support and stop herself from taking the tablets that she had lined up. She

said that she even called her father. He came to visit her with her Mum and Theresa told them that she was struggling with feeling low. She did not however disclose any domestic violence but did say that her relationship with Charles was not as great as it appeared to be. Her father acknowledged that Theresa spent a lot of time on her own and invited her to go and stay with them when Charles was working away. Theresa said she liked this idea and would take up the offer in future.

16.72. On [redacted] November 2016, the GP spoke to the Mental Health Team, who confirmed that Theresa would be discharged at her own request due to difficulties attending appointments. It was confirmed that she would keep contact with the GP and the Swindon Women's Aid IDVA.

16.73. On [redacted] December 2016 during a telephone contact with her GP, Theresa reported further violence after refusing sex with Charles and that she had injuries to her arms, back, chest and legs. Theresa confirmed she was still receiving support from Swindon Women's Aid. The GP offered her an appointment to review her injuries and gave her further advice about staying safe including contacting the police. Theresa declined, stating she wished to stay at home.

16.74. On [redacted] December 2016, Theresa met the IDVA and told her that things had settled down at home due to her being compliant. Nevertheless, the IDVA noticed that Theresa had a large bruise on the left side of her face which she said was caused by Charles hitting her round the face with a TV remote control the previous afternoon before he left for Sweden. Theresa then admitted there had been other assaults and sexual violence on her since they had last met. Theresa did not wish to leave at that time. Her decision was partly due to her not seeing a life without Charles. She said she felt very lonely and isolated, Charles was often the only person with whom she conversed, as she did not want to speak to her parents or brother about what was going on. Theresa believed that Charles would never leave her alone or let her have a life without him. The IDVA spoke about possible protective measures, injunctions and the benefits of reporting to the Police. Theresa was emphatic that she would not go to the Police.

16.75. On [redacted] December 2016, Theresa telephoned her GP requesting Co-codamol for bruised ribs after falling down stairs. During the conversation, Theresa confirmed she had seen the IDVA the previous week as she had been subjected to further violence from her husband, but that she had decided against leaving home. The IDVA had referred Theresa back to the MARAC. The GP advised Theresa to confide in her family and to make further contact with the IDVA to arrange a place of safety. Theresa refused.

16.76. On the same day, the Swindon MARAC meeting considered the referral from Swindon Women's Aid regarding Theresa. The referral highlighted that Theresa's home was "very high tech" and included hidden cameras. Theresa felt she was being subjected to constant monitoring though technology. A discussion took place regarding the escalation in violence. It was again made clear that Theresa did not want police involvement and had declined a meeting with a Police Safeguarding Officer. An additional risk was identified as Theresa would turn off her phone or go out without telling husband when she felt frustrated and this resulted in him being increasingly violent. The meeting considered Theresa's decline in mental health, along with her suicidal thoughts regarding jumping in front of a train or taking an overdose. The meeting heard that Theresa had disclosed to Swindon Women's Aid about being struck by an "object" and being forced underwater during a bath. The meeting heard about the occasion when Theresa had left the marital home for one

night but that Charles had found her. The meeting was also told that Theresa had declined a refuge place and did not see a way out of the relationship. Theresa had told the IDVA she was afraid of her husband but more frightened about life alone. It was agreed that Swindon Women's Aid would keep in contact with Theresa despite the closure of the referral due to her not wanting to exit her relationship with Charles.

16.77. On [redacted] January 2017, Theresa sent the IDVA a text with photos of injuries she said had been caused by Charles, so that she did not have them stored on her phone. (**The DHR Panel have had the opportunity to view these photographs together with twelve others, which show extensive bruising to Theresa's face, neck, arms and body. The additional self-taken photographs had been provided to Wiltshire Police by Theresa's cousin in South Africa. These photographs were not found on Theresa's phone when it was opened during the Police Investigation)**

16.78. At 8.36 am on [redacted] January 2017, Theresa went to her GP surgery, reporting two further attacks by her husband. She said, in one he had hit her with a metal bar, punched, kicked and strangled her with a belt until she passed out. The second was after he listened into a recorded telephone conversation between her and the Samaritans, while he was in his car. He returned home and dragged her from her bath and strangled her with his hands until she lost consciousness. On examination, the GP noted severe bruising to her lower abdomen, right hip, three friction burns on her back. Theresa denied having any thoughts of self-harm. She told the GP, she had sent the IDVA photographs of her injuries. (See Appendix L) She said she would leave her husband next time he was out of the country. The GP reiterated the risks of her staying at home and offered to call the police or a family member. Theresa said she would do it herself.

16.79. At 2.43pm the same day, Theresa returned to the GP surgery in a distressed state with marks around her neck, which were clearly visible to the reception staff. She asked for an appointment with her usual GP. As that GP was not available, she was offered an immediate appointment with the duty doctor but she declined and left the surgery.

16.80. At 5.48pm, her GP spoke to Theresa on the phone. Theresa told her that on returning home from the surgery she had suffered further violence from her husband. He had strangled her until she had passed out. The GP offered her a place of safety, which she declined. Her GP contacted the SWA IDVA and expressed her concerns that the police should be contacted, as she was worried about Theresa's safety. They discussed that Theresa had previously refused to give her consent to the police being informed, that she was of sane mind and did not wish to leave the relationship at this time. They had both made Theresa aware of all the options available to her.

16.81. On [redacted] January 2017, Theresa telephoned the IDVA and told her that, after returning from her routine appointment at the GP surgery the previous day, she and Charles had argued; he had become aggravated, as she had asked about his work. He dragged her upstairs and put a piece of rope around her neck. Theresa said she passed out, when she came around; he was back in his office. After a short while, panic set in and she left the property undetected on foot and had returned to the GP surgery. She said the receptionist could clearly see the marks around her neck. She had left the surgery without seeing the GP and went home, where there were no further incidents. The IDVA discussed safety and emergency exits with Theresa and tried again to persuade her to change her mind about contacting the police. She refused.

16.82. On [redacted] January 2017, Theresa presented at the local hospital emergency department with injuries to her left elbow, forearm and wrist. She stated she had been hit by her husband with a metal pole two weeks earlier. The hospital reported a Domestic Abuse Investigation Team (DAIT) officer spoke to this to the Police and Theresa. She was upset that the Police had been notified, as she did not want her husband finding out. The officer noted that she believed that out of fear, Theresa was minimising the situation. The officer liaised with Theresa's Swindon Women's Aid IDVA, who confirmed she was in contact with Theresa and that an exit strategy and safeguarding plan was being formulated. The officer completed a safeguarding notification, which was considered by the police safeguarding team. A decision was taken not to make further contact with Theresa as this would worry Theresa who was being supported by Swindon Women's Aid. However, four days later Theresa contacted the police, as she was concerned the police would still pursue the matter. She was reassured that the case was filed "No Further Action" (NFA) and unless she changed her mind, no one would see her husband.

16.83. On [redacted] January 2017, the IDVA contacted Theresa by telephone. Theresa said she had not suffered any further physical assaults since returning home from the Police Station. She had not told Charles anything about what actually happened. Theresa expressed her dismay at the course of events that had taken place; she said that she did not want things like that to happen to her. The IDVA empathised with her, but also explained that whilst she was being subjected to high levels of violence and sustaining significant injuries it would be difficult to avoid the Police being involved. She pointed out the police approach and interest, evidenced that they took domestic violence and abuse seriously and that Charles would be held accountable for his actions if she were to engage.

16.84. Later the same day, Theresa sent the following text messages to the IDVA:

"Hi [redacted], thanks again for all your help last. I don't know what I would have done without it. Just to let you know [redacted] and I had a chat at lunch and have decided to split up for a bit, as we are both unhappy. So, I guess it all worked out ok. Thanks again."

16.85. On [redacted] January 2017, the GP telephoned Theresa regarding her painful left arm. Theresa told the GP that the hospital had contacted the police without her consent and she reiterated that she did not give the GP permission to speak to the police. Two days later Theresa wrote to the GP thanking her and the surgery staff for their help.

16.86. On [redacted] January 2017, the IDVA and her supervisor met with Theresa and her GP at the surgery. Theresa told them she was fine, but afraid that the police would take action against Charles if she did not leave him as she had told them she was going to do this. She was advised to contact the DAIT officer if she was concerned. Theresa told them, that she did not know where Charles was or when he would be home, although he had called and texted her regularly each day but had not shared his location or return plans, this kept her on edge. The GP advised Theresa that she was seriously concerned for her safety. The two SWA workers pointed out that public/police intervention could happen again, as she often had severe visible bruising, a black eye or marks around her neck. (These injuries are clear on Theresa's self-taken photographs, which have been viewed by the DHR Panel.) A member of the public could report those injuries to the police and they would take action. The positive police policy was explained her. They again offered her a place in the Swindon refuge but she declined. They then spoke about the couple 'breaking up' the previous week. Theresa disclosed there had been a further sexual assault with violence over the weekend. She refused to go into detail but did state that she had been strangled

but had not passed out. She said that she did not want to leave her home, but feared further police involvement and would therefore go and stay with her brother. She added that she would not tell her brother what had happened, but the IDVA asked how she would prevent him seeing the visible bruising to both of her arms. Theresa said she had not considered this, but said she would still go. At that point, the GP left the room and phone safety, location services and GPS tracking were discussed. The SWA supervisor asked Theresa, if there was anything, she had not told them that was preventing her from leaving. Theresa said there was and became extremely anxious. She said she had a picture on her phone which evidenced the lengths Charles was willing to go to prevent her from leaving. After they reassured her that everything she told them was confidential; she said Charles and his father knew lots of dangerous people in South Africa and said that in December, her cousin's husband was driven off the road and seriously assaulted. She showed them a photo of a man with a bloodied mouth, all of his teeth bar one had been knocked out. Theresa said Charles had implied that he arranged for this to happen. She said that she must stay with him in order to protect her family and she would rather die than have them come to harm.

16.87. The IDVA told her that whilst they were not able to say what protection would be available to her family in South Africa, it would be possible for Police in the UK to put safety measures in place for her family if there was evidence that they were at risk. Theresa said that she believed that Charles was a psychopath, as he does not care what he does. She saw no way out. Again, she declined police intervention, refuge and safety planning. After the meeting had ended, Theresa telephoned the IDVA and told her that she wanted to be honest; she was not going to leave her home. She wanted to stay and would not be going to her brother's home. At 5.46pm, she telephoned her GP to explain she felt unable to leave her husband, as she was concerned it would harm her family. It was noted that she very anxious and aware of the dangers of staying. She denied having any plans to self-harm.

16.88. At 10.29 am on [redacted] January 2017, Theresa telephoned her GP to request more Diazepam. This was refused. Theresa told the GP that Charles had inflicted further injuries on her after she had told him she had spoken to the police. Theresa was unable to remember details of the attack but had a headache and ringing in her ears. She said the police had assured her that they would not take matters any further at that time.

16.89. At approximately 5pm the same day, Theresa attended the surgery and saw her GP. She informed her that there had been a further argument with Charles resulting in him punching her in the left eye and right abdomen. She said, he had put a rope around her neck and tightened it. Theresa said she had felt suicidal and had taken 7x10mg Propranolol with gin, but she had received a telephone call from her Grandmother and changed her mind. On examination, it was noted there was inflammation around her neck, swelling and bruising over her left eye and tenderness over right ribs, Theresa denied having any further active suicide plan and declined any police involvement.

16.90. On [redacted] January 2017. The SWA IDVA received the following text from Theresa.

"Hi [redacted] sorry to text so early. I saw Dr [redacted] yesterday evening she thought it would be a good idea to be seen at A&E to rule out a fractured cheek. Anyway I have just managed to get out now while [redacted] was sleeping and there is a 5-6 hour wait. So, I've decided to leave it and go back home until later today. Is the new lady working yet at hospital? Thanks. Sorry I know my case is closed but Dr [redacted] recommended maybe trying to get somebody from women's aid at the hospital to prevent what happened last time."

Before the IDVA could respond, Theresa telephoned her. The IDVA told her the Health IDVA was not in post at that time. She said that hospital staff would only prioritise her, if she told them how she had sustained the injury.

Theresa reaffirmed that she did not wish to leave the relationship at that time and she knew how to access support via the 24-hour helpline. Theresa added that she had spent the morning visiting a friend and that she confided in the friend about the domestic abuse and said that doing so had felt good. (Previously when completing safety and support plans, Theresa had told the IDVA that she did not have any friends).

16.91. On [redacted] February 2017, Theresa attended her GP surgery and informed her GP that she had not waited in the hospital emergency department as there was a six-hour wait and she would not have been able to give her husband an explanation for being out that long. She told her GP that the IDVA had told her that Swindon Women's Aid could not provide any further help unless she left her husband. She reported that Charles had attacked her the previous night and she had been able to record some of it on her phone. An examination showed bruising on the right side of her chest. The GP advised her to go to the Emergency Department as she had a significant head injury.

16.92. Theresa's GP notes for [redacted] February 2017 reveal that Theresa asked for a GP letter to her College Tutor as she was finding it hard to concentrate. This was done. She said the situation was exacerbated, as Charles had been recording her telephone conversations and had again been violent to her. She told the GP that Charles was away until 23 February 2017 and she had changed the locks but felt unable to leave. On examination, she was found to have bruising on her left arm over the elbow. She said she had no plans to self-harm. The GP continued her prescription Sertaline 100mg and encouraged her to leave, whilst her husband was not there. Theresa continued to refuse police involvement.

16.93. On [redacted] February 2017, Theresa sent the following text messages to the SWA IDVA:

"Hi [redacted]. I am really sorry to have to contact you again and I promised myself I would try not to. But I find myself in a very tough situation and I have no idea what to do about it and was hoping for some advice. I did something about three weeks ago that got me quite a nasty beating. And when [redacted] left last Tuesday I had the locks to our house changed. This has angered him beyond belief and it is safe to say if and when he gets his hands on me I'm in for a world of hurt. I have no idea why I did this as I knew this would only make things worse and I cannot leave and that is why I have not continued speaking with you. Anyway, the problem I am having is I feel my support network has dramatically shrunk to nothing over the past few months. I have repeatedly asked for help when it comes to my mental health but feel I cannot get this help while I am still in this relationship as it has been repeated to me so many times that it is counter-productive and while I understand this, it doesn't take away from the fact that I am in crisis and desperately need help. And I understand where everybody is coming from if I am unable to leave they cannot help and this has led me to do some really stupid things over the past few weeks that has only made things worse for me. Please I need to know where to go from here as I feel without the right help when it comes to my mental health this is going to end badly."

16.94. The IDVA contacted her, to ask for consent to speak to her GP to establish what mental health support options were available. Theresa consented and the IDVA spoke to Theresa's GP. The doctor confirmed she had seen Theresa the previous day and Theresa again said she did not wish to exit the relationship. The GP noted that Theresa had not

had any referrals or contacts with the Primary Care Liaison Team for several months. She would refer Theresa to the Primary Care Liaison Team if that was what she now wanted, however she would want to discuss with Theresa what outcome she was hoping for as a result of the referral; i.e. how would it be beneficial and what did she expect from it.

16.95. The IDVA contacted Theresa and told her to contact her GP to discuss her mental health and any necessary referrals. They talked about how Theresa was at times very scared and compliant and mindful of angering Charles, in case there are repercussions for her family in South Africa. It was acknowledged that this was the threat that kept her compliant and stopped her leaving or engaging with the police. Those concerns for herself and others go out the window at times, such as when she changed all the locks, or goes missing for hours from the house. Theresa recognised that Charles should not be hitting her at all and that he was responsible for his actions; however, she did not feel that she was helping herself to stay safe and could not stop herself. The IDVA asked Theresa to think about what outcome she would like from Mental Health services before contacting her GP.

16.96. The following day the IDVA spoke to Theresa's GP and explained Theresa's worries about her behaviour. The GP asked the IDVA to put in writing what Theresa had told her. She wrote the following letter:

"Dear Dr [redacted]
Further to our telephone conversation today, I write to confirm that I was asked to call you by [redacted] *would like to speak you regarding a referral to CMHT.* [redacted] *is concerned about her mental health and seeks support. She feels that she has occasions whereby she is unable to control impulsive risk taking behaviours.* [redacted] *said that she finds herself doing things which she later regrets, at the time she does not feel able to stop what she is doing.*
Many thanks and kind regards"

16.97. On [redacted] February 2017 Theresa's GP had a telephone conversation with Theresa's IDVA. She told the GP that she had spoken to Theresa and Theresa admitted that her mental health was a consequence of the domestic violence she was being subjected to. Theresa had told her that she hoped that Charles would kill her as that was her only way out. The GP said she was making a referral to CMHT as Theresa was engaging in risk taking behaviour and at times wanted to be killed by her partner. The Freedom Programme was discussed as a possible support option for Theresa although she had declined this in the past. Later the same day the IDVA telephoned Theresa and suggested that she reconsiders the Freedom Programme. Theresa agreed that it was safe for the IDVA to send her the number for Hometruths and to discuss this option further. The IDVA notified the GP of this decision.

16.98. On [redacted]8 February 2017, Theresa contacted Hometruths. She later confirmed to a Hometruths worker that that she had been in regular contact with the Swindon Women's Aid IDVA, that she had a safety plan in place and that her case had twice been to MARAC. However, she had been given Hometruths' details as SWA could not help her further, unless she had a plan to leave her husband.

16.99. On [redacted] March 2017, Theresa's GP again referred Theresa to PCLS. The following day, a CAMHS supervisor and the Swindon Women's Aid IDVA discussed that Theresa believed that she needed a referral to the Mental Health Services, in view of erratic behaviour that she felt she had no control over, which included booking hotels and changing locks. She believed what she was doing put her at additional risk. The CAMHS supervisor

said he would call Lift Psychology and discuss whether they would be able to provide Theresa with Psychological support.

16.100. On [redacted] March 2017, after receiving a request from Theresa for a repeat prescription of Cocodamol, her GP telephoned her and was told that Charles had been violent to her over the weekend causing pain to her right wrist, knee and back. Theresa told her GP she had a Mental Health Team appointment and had been in contact with Hometruths. She was offered but declined a GP appointment and refused to contact the police.

16.101. On [redacted] March 2017, Theresa met with a LIFT Counsellor and told her about further violence by Charles. The Counsellor recorded that during the appointment Theresa appeared to be in pain but was fearful about involving the police. The record noted that Theresa admitted provoking Charles in the hope that he might kill her. She said she had a stockpile of Propranolol and was not prepared to dispose of them, but that she had no plans to overdose or to self-harm. The Counsellor discussed a "keeping safe plan" with Theresa and confirmed that she had the emergency numbers for PCLS and a further appointment was arranged.

16.102. On [redacted] March 2017, Theresa attended the follow-up appointment with the LIFT Counsellor. It was noted that there was no change to the risk level as Theresa had described another serious assault by Charles. She stated she did not want any police involvement due to threats and intimidation made by Charles to harm family members. Theresa had another appointment with Hometruths and a follow-up meeting was arranged for 24 March when a plan was agreed for ongoing support from LIFT Psychology, Hometruths and Theresa's GP.

16.103. On [redacted] March 2017, the SWA IDVA received the following text message from Theresa:

"Hi [redacted]. I just wanted to give you an update. I have an appointment with the mental health team for 24 March. I saw somebody from lift psychology this morning and we discussed the risk-taking behaviour you and I spoke about.[redacted]said in her experience what she thinks is I panic and don't think clearly and fear kicks in and in the moment I do things that are not always rational but she says it is coming from a place driven by fear. Anyway, I just wanted to thank you again for your help and arranging all this for me. I know I am not in a position at the moment or mentally strong enough to even try and leave but [redacted] and I discussed today that she will try and help me get mentally stronger to try leave in the future. So, I hope it's ok if I contact you when that time comes. Thanks again."

16.104. On [redacted] March 2017, Theresa told her LIFT Psychology Counsellor that she had telephoned Swindon Women's Aid at the weekend but had been unable to get emergency accommodation. Theresa described this as being the second weekend in a row when she and Charles had rowed and there had been physical violence towards her. She described feeling surprised that she was still alive.

16.105. On [redacted] March 2017, the Hometruths IDVA met with Theresa at her GP Surgery. Theresa was very low, tearful and distressed. They talked about ways in which Hometruths might assist her. Theresa refused to consider a DASH risk assessment, as she was very resistant to the police becoming involved. She said the last time she had done a risk assessment, the Police were involved and she does not want to get her husband in trouble. She said she did not love him, but he financially supported family members and they would suffer if she reported him. She explained she had moved to the UK

from South Africa with him. His parents, her parents and her brother had all followed. She said she was not close to her family as her husband had isolated her from them. She said she was unwilling to consider going to a refuge as she said the Swindon refuge was full. When it was suggested that she go to a refuge in London, where her brother lived, she immediately turned this down, saying her husband would find her wherever she went. Theresa went on to explain that she had previously planned with the SWA IDVA to leave, but her husband found out. Theresa said she believed that the only way out was if he killed her or if she took her own life. She recognised that she needed help with her mental health and felt the mental health services were helping her at that time. She was encouraged to re-consider going to a refuge and given safety advice, which included reporting to the police, continuing to engage with her GP and the Mental Health team. When it was suggested that she call the Samaritans for support, she replied that she had called them before and knew how to ring them if needed. Theresa confirmed she had the contact numbers for Swindon Women's Aid and the Mental Health Crisis Team and she is seeing her GP regularly. She said she would contact the Hometruths IDVA if she wanted to meet again.

16.106. At 8.34am [redacted] April 2017, Theresa saw her GP and reported that she had had a hypothetical conversation about the sequence of events if police were asked to intervene. Theresa said she was concerned she would not be able to go through with the process of bail or giving evidence, although she admitted that her husband rapes her. Theresa stated she feels her life would be more at risk if the police were involved. On examination, she was found to have bruising on her left upper and forearm, right forearm, upper right arm, lower abdomen and iliac crest. There was a red mark on the left side of her neck. Theresa told the GP that Charles had tried to strangle her. Her GP attempted to contact Swindon Women's Aid in the hospital emergency department but there was no reply. She contacted the Swindon refuge but was informed that there were no places available at that time. Theresa was given the telephone numbers of other refuges and an x-ray appointment was arranged.

16.107. At 10.26 am the same day, Theresa attended hospital for x-rays of her arms. Hospital notes recorded that both arms were bruised. It was noted that Theresa was crying and distressed. She was asked how she got hurt and she replied she had fallen. Hospital staff noted other bruising and asked how she acquired all of the other bruising. To which Theresa reiterated she had fallen down. After consulting her line-manager, the hospital worker advised Theresa that while she should make an appointment to get the results of the x-rays from her GP in a week's time, if she wanted to speak to someone that day about the bruising it could be arranged. Theresa responded that she was fine and left.

16.108. Later the same day, Theresa contacted Hometruths asking for support as she had had a "*tough week*". She was seen the following morning and the options of reporting the abuse to the police and/or going into a refuge were discussed, but Theresa was still reluctant to consider either option. This meeting was followed up three days later at her GP surgery to endeavour to assess motivational change and to find a place of engagement to try to create movement. The IDVA reported that Theresa was despondent and explained that she believed her husband would always find her. She had a complete sense of powerlessness and a resignation that it was inevitable that her husband would kill her or she would take her own life. Although able to logically intellectualise her situation, emotionally she was locked in fear. She talked about feeling she should just tell her husband everything. The counsellor explained the high level of risk associated with this and discussed a DASH risk assessment, which she again declined. Her safety plan was reviewed and Theresa said she would contact the IDVA again if she wanted to talk. There followed a number of

email contacts between Theresa and her Hometruths IDVA in which she discussed her contacts with Lift Psychology and the Mental Health Team.

16.109. On [redacted] April 2017 Swindon Adult Social Care Safeguarding received an alert from the [redacted] Hospital Radiography Department expressing concerns that injuries Theresa sustained were not consistent with her account of how they were caused (a fall). This was assessed as needing further information and to check if Theresa would meet the threshold criteria under section 42 of the Care Act, in light of the fact that this was not the first alert received regarding Theresa. Further enquires by the Safeguarding Team were made to Swindon Women's Aid (SWA) and the Police. SWA confirmed that Theresa did not have care and support needs and she was in contact with them. They also reported that Theresa did not want to speak to the Police. The case was closed pointing to her perceived mental capacity and reluctance for action to be taken.

16.110. The LIFT Psychology contact records show that on [redacted] April 2017, Theresa described having received treatment for injuries resulting from domestic abuse. Her difficulties in leaving the relationship with Charles was discussed, Theresa was again very clear that she did not want police involvement. It was recorded that at this time Theresa reported suicidal ideation as a 7/10 risk, she admitted stockpiling drugs but was not willing to hand them in. She still felt unable to confide in her family. She had self-referred to a PTSD Stabilisation Course with LIFT, but was not offered this as this trauma intervention was not clinically indicated whilst Theresa was reporting a level of risk to herself.

16.111. On [redacted] April 201, Theresa was taken to hospital by ambulance after taking 134 propranolol tablets, which she had bought online. She reported that she was not suicidal but had just had enough. A mental health referral was submitted to the Mental Health Liaison Team and she was admitted to the Emergency Department Observation Unit. She was discharged on [redacted] April and the Discharge letter reported:

"Denies any recent domestic abuse and is still working with Swindon Women's aid and another charity to leave her husband.
Tonight presented with overdose of medication that she bought on the internet knew that it could potentially be a toxic dose but now appears to be denying suicidal intent.
Patient denied taking an overdose before, reported having counselling but has been told there is nothing more they can do for her until she leaves her husband."

16.112. On [redacted] April 2017, the Swindon Intensive Team contacted Theresa and a plan was made for Crisis Management interventions for one week. The Team after liaising with Swindon Women's Aid also made contact with Hometruths as Theresa was not willing to leave her relationship with Charles at this point and would not make a statement to the Police. Theresa discussed plans to possibly leave Charles when he was next out of the country for work but did not know when this would occur. The Police and Safeguarding were informed of this development. Interventions for PTSD in grounding techniques commenced and during the interventions, a joint visit was carried out with Hometruths.

16.113. In view of the concerns for her safety after this overdose, a referral was made by Swindon Mental Health Liaison to Swindon MARAC. As a result of the contact with the Police, on [redacted] April 2017 a Police DAIT Officer spoke to Theresa on the telephone and explained what support was available to her. Theresa agreed to meet with the officer on 10 May to discuss the options available to her.

16.114. At approximately 3pm on 20 April 2017 Theresa's GP telephoned her regarding her admission to hospital for the overdose on 16 April. Theresa told her, she was not currently suicidal and had been seen by the mental health team and had arranged a follow-up appointment. The GP reiterated the options of her leaving home and/or contacting the police. Theresa declined the offer of the GP contacting the police on her behalf, as she was concerned that she would be more at risk if police were involved.

16.115. Later the same day, Theresa contacted Swindon Women's Aid and was told that the refuge was full. She was advised to try the national refuge hotline as she already had this number. Theresa confirmed she was being supported by Hometruths.

16.116. Following this, the SWA IDVA telephoned Theresa, who told her that she had tried to get into the refuge but could not as they were full. Theresa told the IDVA the last time she had called the refuge was before taking an overdose at the weekend. She said she was going to call the National Refuge Hotline to find out where else may have a space. Theresa also said she has met with Hometruths twice and was waiting to be offered a further appointment with one of their support workers.

16.117. On [redacted] April 2017, Theresa's GP telephoned the SWA IDVA and was told that Theresa had been given contact details of refuges and that places had been available, although Theresa had told her GP that none had been offered to her.

16.118. On [redacted] April 2017, Theresa's GP telephoned Adult Social Care Safeguarding re Theresa's situation being considered at the MARAC and gave a summary of her involvement. The GP reiterated her concerns for Theresa's safety and pointed out that she offered to call the police on every occasion she saw Theresa. The GP agreed to attend the MARAC on [redacted] May 2017.

16.119. On [redacted] April 2017, Theresa was reviewed by the Consultant Psychiatrist from the Swindon Mental Health Intensive Team. A recommendation was made for Theresa to continue to engage with LIFT Psychology on trauma-focused work. A discussion with LIFT indicated that due to the level of risk Theresa reported to herself, the need for PTSD work was not indicated. The referral therefore was made to the Swindon Recovery Team for work on more complex trauma. The Intensive Team agreed to continue with contact with Theresa until a Recovery Team Care Co-ordinator was allocated.

16.120. On [redacted] May 2017, Theresa's situation was discussed at the Swindon MARAC following the referral from Swindon Mental Health Liaison after Theresa had taken an overdose of tablets whilst drinking alcohol on [redacted] April. The referral reiterated that Theresa had reported being subjected to emotional and physical abuse. Theresa had stated that she had become isolated, as her husband had convinced her family that she was alcohol and drug dependent and that her contact with them had reduced as a result. The meeting was told that Theresa planned to leave her husband in the immediate future and was seeking support for this; however, she did not want any police involvement. The MARAC considered information from her GP and from Hometruths that Theresa's resistance to change was based in fear and a belief that her husband would always be able to find her and harm/kill her, as he had been aware of her previous attempts when she looked at leaving with help from SWA. An action plan was agreed to try to reassure Theresa that agencies were in a position to assist her to leave her husband and to encourage her to report the abuse to the police. A mental health appointment was made to assess the opportunities to engage Theresa with domestic abuse support services; however, Theresa declined the help offered.

16.121. At 10.05am on [redacted] May 2017, Theresa attended her GP surgery and complained of swelling on her forehead and pins and needles in two lateral fingers on her right hand. Initially she claimed to have walked into a door, but later admitted that her husband had hit her with a metal bar, she said she was too scared to go to the police. On examination, it was found she had significant swelling (4x4 cm) on her forehead, bruises on her right arm. She denied having any thought of self-harm or suicide. The doctor repeated her concerns for her safety and referred her to the hospital emergency department regarding her head injury, but Theresa refused to go.

16.122. By prior arrangement police personnel, visited Theresa at her home on 10 May 2017. Theresa had said she wanted to speak hypothetically about what would happen if she reported Charles and what she would need to do to have the decision taken out of her hands, as she wanted to leave the relationship but was too scared.[19] It was established that she had capacity to make her own decisions and then a plethora of options were laid out to her. Theresa was concerned that Charles had changed people's opinion to be against her and to the extent that she would never be believed. She described Charles as a psychopath, charming one moment and aggressive/abusive the next. Theresa stated that Charles was very intelligent and had designed some software for his work and as such, she felt he was able to track her movements and affect the settings on her phone even when she turned off options such as location settings. Officers did note two webcams at the house. They also saw that Theresa had a large bruise on the inside of one of her arms but when asked about it she would not say how it had occurred. At the end of that meeting, Theresa did not give any indication of whether she would leave and/or make a complaint against Charles. No PPD1 was completed and as such, a MEDIUM risk grading remained.

16.123. On the evening of [redacted] May 2017, the Swindon Women's Refuge received a very hushed telephone call from Theresa, stating she was looking for a space in the refuge; she had tried previously but could not get in due to no space. She was not able to leave that night but had an appointment with her GP at 11am the next morning and would ring from there. It was agreed that a place would be held for her until 3 pm the next day. However, the next day Theresa did not contact the refuge regarding taking the space reserved for her.

16.124. At 11.35am on [redacted] May 2017 Theresa was seen by her GP and reported further violence from her husband, she said he had attempted to strangle her, "thumped" her in the stomach and had hit her right shoulder. She was examined and bruising to her right shoulder was recorded. Theresa told the doctor she had tried to get a place in a refuge, but her husband had prevented her getting there. She was offered a Neurologist referral but declined. A referral was made to Swindon Women's Aid.

16.125. Later the same day during an appointment with the Swindon Intensive Team, Theresa said she intended to leave Charles. She stated that a place had been identified for her at a refuge and that she would enter it that evening. She described Charles as having been "difficult" over the weekend. She disclosed that Charles had put a rope around her neck, strangled her and had sex with her. The Nurse saw marks on Theresa's neck. During the appointment, Charles had sent Theresa a text message, asking why she has parked in a different bay to usual. She worried that Charles knew that she was going to

[19] See Appendix L- In one of Theresa's journals, she lists the possible actions she could take in relation to domestic abuse and catalogues what she would need to do if she left home.

leave him. A plan was made for Theresa to attend an Osteopath appointment and then return to [redacted] for the Swindon Intensive Team to take her to the refuge. Theresa agreed she would not look at her phone, as this would make her anxious. Theresa returned to [redacted] as arranged but had changed her mind about going to the refuge. She stated that Charles had alluded to harming members of her family if she left him. She reported that she had given up and did not care if Charles killed her. A plan was made to see Theresa again the following day and Swindon Women's Aid was informed. Theresa did not want the Police to be informed.

16.126. The following day, [redacted] May 2017, Swindon's refuge received a call from Theresa asking if she could come in to discuss the refuge, as it was unsafe to talk on the phone. At 8pm, Theresa went to the refuge as arranged and discussed what refuge was about and how important it was for her to become safe. Theresa said this was the furthest she had got to coming into the refuge but worried about what would happen next if she did decide to stay. Theresa was also concerned that Charles had contacts in South Africa and would harm her family if she left him. At one point Theresa said, she was open to reporting the assaults and threats to the police. She said she "had lots of images on her new phone of physical bruising etc." She stated she kept these photographs on a memory card and she would delete them from her phone before she went home. While Theresa was thinking through her options, Charles called her mobile; she then became distant and said she would give the refuge a miss this time but that the visit had helped.

16.127. On [redacted] May 2017, Theresa was seen by the Swindon Intensive Team. It was recorded that she appeared to be in pain from her ribs but she refused to go to hospital for treatment. On [redacted] May, Theresa was allocated a Care Co-ordinator from the Swindon Mental Health Recovery Team.

16.128. On [redacted] May 2017, Theresa was seen by Swindon Intensive Team. They saw she had a lump on the left side of her forehead and red under her eye. Theresa was taken to hospital and released after treatment to the head injury, the bruising to her eye and the large mark on her face. Theresa told the hospital staff she did not remember what had happened. The Police were notified and until [redacted] September 2017, they continued their involvement. The issue for the police was deciding whether Charles should be arrested and/or interviewed for the assault on Theresa, whilst bearing in mind that Theresa would not support any investigation. The investigation log shows repeated contact from Theresa by telephone and in person, pleading for the Police not to continue with the investigation and explaining that it had been disclosed to her mental health worker in confidence. There was a reluctance by the Police to drop the case, but although several supervisors were involved, there was a lack of certainty on how best to proceed.

16.129. On [redacted] May 2017, Theresa was contacted by phone by the Swindon Intensive Team; she informed them that she wished to be discharged. Following discussion and based on an assessment indicating no clear role for Mental Health Services for trauma work whilst Theresa remained at risk to herself, she was discharged from both Swindon Intensive Team and Swindon Recovery Team.

16.130. On [redacted] June 2017, the South Western Ambulance Service submitted a Safeguarding referral that Theresa had been picked up at [redacted] (mental health service) following an alleged assault by her husband on the 29 May. The Safeguarding Enquiry Manager confirmed that Theresa was not an inpatient at the Mental Health Unit and he contacted the Police to ascertain that the incident had been reported and recorded and to find

out what support or other actions were in place to support Theresa. A DASH Risk Assessment had been carried out by police and the risks were assessed as medium. The police officer contacted also confirmed a MARAC referral had been made in May 2017 and that the Police had planned to speak to Theresa regarding the incident on [redacted] May. Consideration was given to contacting Theresa, but it was felt that contact might have increased the risk to her, as it was understood that she was reluctant to engage with some agencies and might be reluctant to engage with the Adult Safeguarding Team. The Enquiry Manager therefore closed the case on the understanding that there would be an ongoing police investigation and that an appropriate response was in place from the police and SWA and Hometruths.

16.131. On [redacted] June 2017, Theresa contacted the DAIT Safeguarding Officer to ask "hypothetically" what she would need to obtain a court order to stop her husband from coming near her.

16.13.2. At 4.14pm on [redacted] June 2017, Theresa saw her GP; she told her that Charles had left home after she had spoken to the "Safeguarding Officer at the Police Domestic Violence Unit". She said she was anxious and complained of numbness and pins and needles in her arm. On examination, it was found that she had no neural abnormalities. She was advised to continue to work with the police safeguarding officers and to re-engage with LIFT.
At 6.59pm, Theresa telephoned her GP, stating she felt actively suicidal and she requested a referral to the mental health team. Theresa's GP contacted the Swindon Intensive Team stating she was concerned about an increased risk of overdose. Theresa had stated that Charles, having returned from time abroad had turned up at the gym[20], stating could get to her and she should not take a "protection order" out against him. Swindon Intensive Team attempted to contact Theresa but there was no response.

16.133. On [redacted] June 2017, the Swindon Intensive Team made contact with Theresa and she stated that she was concerned, as she had not seen Charles since the previous day. She believed he thought he had killed her when they last met. She had been trying to contact Hometruths. Swindon Intensive Team contacted Hometruths on her behalf and left a message. The police were contacted and informed of what Theresa had said, although she had not wanted the Police informed. The Police Incident Manager (FIM), an Inspector in the control room, reviewed the information and a decision was taken not to contact Theresa due to her vulnerability and potentially placing her at further risk. The Inspector was satisfied that Theresa had been supported by multiple agencies and was aware that she could report it herself if she wished. On [redacted] June 2017 the Police Civilian Safeguarding Officer sent a text message to a colleague stating she thought Theresa had previously been "*very manipulative when working with* [redacted] *(SWA IDVA) and other agencies and playing one off against the other".*[21]

16.134. On [redacted] June 2017, Swindon Women's Aid received information from a DAIT police officer advising that Charles had left Theresa and she would therefore like to access support. The IDVA telephoned her and was given an update on recent events, which included

[20] The Investigation carried out by Wiltshire Police has found that rather than Charles" turning up" at the Gym, the electronic door entry system indicates that Charles and Theresa arrived at the gym together at6.12am and left together at 7.25am. Only one of their households' vehicles was recorded on the advanced number plate recognition system, so it was considered likely that they had travelled together.
[21] This had not recorded on the Wiltshire Police Niche system, but was found on the officer's mobile phone.

an incident of domestic violence about two weeks previous. Theresa said this occurred when Charles left their home. She said, she thought he left because he believed he had killed her. She said it had been a particularly violent attack, she was strangled until unconscious and he was gone when she came around and he had not come back. Theresa said she had had some contact with him since then, but not in person. She thought he was tracking her, as he seemed to know when she had been to the gym including one day at 3am. The IDVA pointed out that Charles could return to the property at any time, he had key and legal rights. They discussed engagement with the Police, applying for a non-molestation and/or occupation order.

16.135. On [redacted] June 2017, after receiving a number of telephone contacts from Theresa over the preceding days, Swindon Intensive Team decided to offer her a face-to-face assessment in light of the level of support that they have been providing without an open referral. The assessment was completed later that day and Theresa was taken on for home treatment. Contact continued with Theresa, together with liaison with the police safeguarding officer regarding the domestic abuse.

16.136. The following day, Theresa contacted her GP and told her that the Swindon Intensive Service had not been able to contact her on the night of the referral, as she had been sedated and asleep on the top floor. Apparently, the Fire Brigade had been called and had concluded that she was not in. She confirmed that she had a large amount of tablets of Propranolol and Zolpiderm that she had purchased through the internet. She said her husband was still away although he contacted her by telephone. Theresa stated she remained anxious and was using Diazepam. She was advised not to self-medicate but to contact the surgery or Swindon Intensive Service if feeling actively suicidal.

16.137. The same day an e-mail was sent from the Swindon Intensive Team to the Police Domestic Abuse Officers dealing with Theresa's case. Theresa had reported finding the investigation difficult and a request was made on her behalf that it be postponed. The police responded on [redacted] June 2017 expressing concern regarding Theresa’s reluctance to engage with the investigation. Theresa told the Swindon Intensive Team that no one team seemed to be able to offer her the help she felt she needed. Interventions during this episode of care with AWP were mainly about supporting Theresa to manage her risks, thoughts and feelings about the domestic abuse. It was felt that there were no active Mental Health interventions that were appropriate for Theresa at that point but the team continued to support her, due to her risks to herself and risk from others due to domestic abuse. When assessed on [redacted] June 2017, Theresa reported having experienced significant physical abuse from Charles the day before, having been punched, kicked and pulled around. Theresa appeared to be in pain but refused to report the abuse to the Police. Theresa had told Charles she was s considering getting an order and he said he could get her anytime. She was assessed as having the capacity to make the decision that the police should not be informed.

16.138. On [redacted] June 2017, the SWA IDVA contacted Theresa by telephone to establish whether she would like to engage in safety and support planning with a view to safely exiting her relationship. Although Charles was downstairs in the house, Theresa spoke openly on the phone, she said that he had returned home when she switched off tracking/monitoring devices and gave her a ''total beating'. The IDVA urged her to consider her safety and asked Theresa to make contact when it is safe for her to do so. The IDVA notified the police DAIT that Charles was back at the address.

16.139. On [redacted] July 2017, Theresa was seen by the Swindon Intensive Team. Significant bruising to both of Theresa’s arms and what looked like foot-tread prints on both arms

were seen by the team. Theresa discussed telling Charles about her disclosures regarding the abuse. She stated that Charles would kill her if she did this. She also expressed suicidal ideation and that she could take the stockpile of medication she had at home. A telephone call was made to the Police to request an update on their investigation and to inform them of the observations of bruising and the comments made by Theresa.

16.140. On the [redacted] July 2017, a member of the team from Avon and Wiltshire Mental Health Partnership contacted the Adult Safeguarding Team to ask if a member of the team would be prepared to attend a planning meeting about Theresa. It was confirmed that an invitation would be accepted; however, there was no further contact about this meeting.

16.141. At 5.31pm on [redacted] July 2017, Theresa telephoned her GP, reporting being very anxious and that she had taken forty 10mg Propranolol tablets. The GP advised her to go to the hospital emergency department by ambulance. Theresa said she would go by taxi and the GP alerted the emergency department staff. After a short delay, Theresa went to the hospital and was seen to have bruises on her arms, which she attributed to a fall during the weekend. When asked why she had taken the tablets, she replied she "just wanted to chill out". She was admitted to [redacted] Medical Assessment Unit where she opened up to staff claiming her husband physically abused her. Bruises were visible on her left arm. Theresa said that while she was afraid, she wanted to go home and agreed to be seen by the mental health team. The doctors were happy for her to go home, as it was felt appropriate support was in place.

16.142. On [redacted] July 2017 after contacting Theresa's GP and ascertaining that Theresa had been seen the previous day, the Swindon Women's Aid referral was closed due to no further contact from Theresa.

16.143. On [redacted] July 2017, Theresa contacted the Swindon Intensive Team to advise that she wanted to cancel all appointments and wants to sort things out on her own. Later she made further contact and agreed to continue work with the Swindon Intensive Team. Home treatment continued, with Theresa being advised on the [redacted] July 2017 that discharge would be imminent as they were unable to work with her in the long term. Theresa was subsequently discharged on [redacted] July 2017.

16.144. On the morning of [redacted] July 2017, Theresa telephoned the SWA IDVA. She said that she was OK and that Charles was not at home, although she did not know where he was. Theresa confirmed that Charles had attacked her again and that was why she sought support. When asked what had happened she replied '*I'm OK*' and she did not wish to discuss what he had done to her. She said she had texted the IDVA during the attack as all the safety advice she had been given, about silent 999 calls and the emergency service, had gone out of her head. This was the first time that Theresa had reached out for help during an attack. The IDVA asked if she wanted to leave the relationship at this time and she said that she did not know what she wanted to do. She said that she had been in hospital the previous week due to taking an overdose of tablets and had not been feeling great. She had had no contact with her parents recently, they knew about her hospital admission and were not happy, but they did not know about the domestic abuse, they just thought that she was a "lunatic". She had not contacted her brother. When asked what support she had in place, she said that she had an appointment with the Mental Health Intensive Team that morning; she was encouraged to attend this appointment. Theresa talked about wanting to be taken out of the situation. The IDVA emphasised that leaving an abusive relationship must always be the survivor's choice. Nobody would force her to leave against her will. The ethics of supporting survivors, empowering them to make their own decision to leave and the support that would be available to her if she were to do so

was explained. The IDVA told her that this support included civil and criminal protective measures, the Refuge, IDVA support and resettlement support (as required).

16.145. On [redacted] July 2017, Theresa contacted Hometruths by email, stating that her mental and physical health were "*probably the worst it's ever been*". She said she had been discharged from the Crisis Team and had no support. The Hometruths IDVA responded that she was sorry things were not good, that she was aware of the offers of support made by Swindon Women's Aid, the Mental Health team and the Police domestic abuse safeguarding team therefore she was not sure what else she could suggest that had not already been offered. She asked Theresa to outline what support she felt she needed that she could help with. Theresa responded, "*My main goal at this point is getting through each day and trying to process and deal with what I have gone through. I am struggling with the trauma*". The IDVA replied that the fact she was still living in a traumatic situation meant that she would be unable to process or manage her trauma while still experiencing traumatic events. The IDVA outlined the psychological need for safety and being unable to process in fight or flight mode. She stated that until Theresa was able to move to safety she would continue to be in survival mode. She told Theresa she had already explained at their meetings, that she did not know of any way of helping until her situation changed. Nevertheless, she again provided Theresa with the Police and National Domestic Violence helpline numbers and that she could contact the local refuge via SWA or contact her GP or the Mental Health team at any time. Theresa replied that she would do her best to change her situation so that she could move forward.

16.146. On [redacted] August 2017, Theresa saw her GP and during the consultation, she informed the GP that her friend had contacted her brother, as the friend was concerned about her visible bruises. She also said, her husband was not at home and she did not know his whereabouts. Theresa stated she had reduced her alcohol consumption and the GP noted that she had good eye contact.

16.147. On [redacted] August 2017, Theresa rang the Swindon Women's Aid helpline asking if there was a place available to her at the refuge. When she was told that at that time, there was no places available but could they help, she replied "*No I just wanted a space at the refuge*" and rang off.

16.148. On [redacted] August 2017, Theresa left a telephone message at Swindon Women's Aid for the IDVA to contact her on her return from annual leave. The IDVA telephoned her as requested and Theresa confirmed that she was at home alone and it was safe to speak. She asked if there was a refuge place available, as she would like to come in. She explained that she had called the previous week but it was full, however she had not phoned the National Refuge Helpline to seek a space elsewhere. The IDVA said she would check and call her back. The Swindon refuge was full and there was no reply from the Chippenham refuge. The IDVA called Theresa back and established she was safe but had been beaten over the weekend. Theresa said Charles had gone to the Netherlands the previous evening and she expected him back at the end of the week. The IDVA reiterated the safest way to leave would be a planned exit when Charles was away. Theresa stated that she wanted to leave and they discussed the options. Theresa chose to call the National Refuge Helpline to find out where she could be accommodated. She was reminded that she could access support via the 24-hour helpline as required. (The same day at 8.56am, Theresa had sent a text message to Charles stating, *"Thanks for being there for me baby. Just chatting things through with you feels good. We are communicating very well at the moment. Thanks baby. Love you.")*

16.149. On [redacted] August 2017, The SWA IDVA received a telephone call from Theresa. She was concerned that the Police were intending to take action as they had a statement from

a worker at the Mental Health Team. Theresa did not feel it was right that they were not listening to her and felt they were putting her at further risk. Theresa said the police officer would not answer all of her questions, for example, she wanted to know what the statement said and who the officer had spoken to and gathered information from. The IDVA explained the Wiltshire Police positive action policy. Theresa said she felt let down by health professionals who have gained her trust and then reported concerns for her to the Police. The IDVA reminded Theresa that she had made her aware of safeguarding policies that all healthcare professionals were bound by. She also told Theresa that at her request, Wiltshire Police had previously not taken action against Charles, in order to give her an opportunity to safely leave and that she did not leave and had suffered significant injuries as a result of further violence since then. Theresa responded that she was in a good place at the moment, not drinking or abusing prescription medications. She said that she had told her brother she was financially abused and controlled by Charles, but she had not disclosed the physical violence to him. Theresa said that her plan was to move to London to live with her brother. He was in the process of buying a two bedroom property and when the purchase was completed, she would move there with him. She said, she was frustrated that the Police were taking action that she believed would cause her harm when she was in a good place.

Theresa added that she wished she had been sectioned under the Mental Health Act. She said if people were concerned for her then why would they not take her away from the situation. The support worker explained that being sectioned would only give her a brief break from the abuse and that professionals were supporting her to make her own choices regarding leaving. Theresa stated that she was going to tell Charles that he was going to be arrested. The IDVA responded that doing so might place her at further harm and she encouraged Theresa to consider leaving safely while he was still out of the country.

Theresa said that she had called the National Refuge Helpline several times the previous week but no one ever answered the phone. She was encouraged to leave a message and ask them to call her back as soon as possible to discuss her needs. The IDVA also suggested calling refuges directly in any area that she would consider going to, for example, Chippenham as it is close to Swindon or London near to her brother. The IDVA gave her further safety planning advice.

16.150. Shortly after the above telephone call, the IDVA received the following text message from Theresa.

“Hi[redacted]. Thanks for all your effort today and in the past. I have given it some thought and with this arrest coming up I just can't take the stress of this so I have decided to come clean about everything with him, I am hoping a huge weight will be lifted off me. I know you will strongly disagree with me but I am under a lot of pressure. I am not giving the police a statement. Leaving is one thing but I do not support an arrest and the things that will follow that. If the police ask for a statement from you, please I do not give consent for you to disclose anything to them. Thanks and take care.”

The IDVA sent a text message to Theresa, thanking her for the text and reiterating that she would not advise her to say anything to Charles as that could place her at greater risk. She told Theresa to call the 24 hour helpline number if she required any further support or advice.

16.151. On [redacted] August 2017, the DAIT civilian Safeguarding Officer telephoned the SWA IDVA after having received a 4.30am text message from Theresa asked for her help to stop the police from arresting Charles in relation to the domestic abuse allegations. The officer said she was concerned for Theresa and wanted to ensure that she was accessing

support. The IDVA confirmed that she had spoken to Theresa the previous day. Theresa's text read:

"What I wanted to chat to you about is that I think I misunderstood what the service of safeguarding was. I thought it was a general term for protecting vulnerable people with mental health issue like myself. I didn't realise it was only for domestic abuse. I'm sorry to have wasted your time I feel terrible about that. I thought it was for people at risk of self-harm and suicide. There is no domestic abuse going on here, I purely have mental health issues coupled with alcohol and prescription medication problems, which I will see my GP for. Apologies for the mix up and if there are any consequences for me wasting your time I will fully accept them. This was completely my fault."[22]

The same day at 11.30 am, Theresa had the following exchange of texts with Charles:

"Baby do you think I should give my statement while I'm in a good frame of mind. I'm worried seeing you Friday being taken away will upset me and I'll look visually upset if you know what I mean"

Charles replied "*Umm good question. Did they say that they definitely wanted to question you. At the same time it would be good to have the solicitors input on it. But they might not allow you to speak to him if they have me there at the same time"*

At 11.42am, Theresa responded *" Yeah this is what I'm thinking because she said they wanted to question us separately so that I don't get intimidated. But I'm wondering if I do it while you are away they can see there is no pressure on, means its on my terms if you know what I mean. But if you think leave it I will. Just trying to see what the best course action is. I might also be able to see what they actually have."*

16.152. On [redacted] August 2017, Theresa saw her GP and told her that on [redacted] August Charles had packed and left the house and not been home since. She stated she had gone to the Mental Health Crisis Team but had been advised there were no appointments available, she had also gone to the "*DV police unit*" but had been unable to see the safeguarding officer. She had telephoned Swindon Women's Aid, but got no reply. On contacting the Refuge she had been told there were no vacancies, consequently she had 2/7 thoughts of suicide. Theresa told her GP that on [redacted] August she had received a telephone call from a police officer who told her, that following a statement from a member of the Crisis Team, her husband was going to be arrested. She had tried the refuge again but there was still no availability. The next day she had felt anxious and suicidal about the arrest and had called the Crisis Team. She said that on [redacted] August she had contacted the Police safeguarding officer to request information about the disclosure from the Crisis Team, as she had not given her consent. The officer was not able to give her any information at that time and Theresa was anxious about what would happen when Charles returned. She asked the GP to document that she had alcohol problems and mental health issues and had lied about the abuse. The GP contacted the Police safeguarding officer, with Theresa's con-

[22] The officer had not recorded this text on the Police Niche system as required but it was later recovered from Theresa's phone during the police investigation relating to Charles.

sent. She was advised that the safeguarding officer was unable to stop the police investigation. Theresa while denying having any self-harm plans, refused further refuge placement attempts or Crisis Team involvement.

16.153. On [redacted] September 2017, Theresa and Charles attended at the police station together, for Charles to be interviewed. The investigating officer was not on duty but after a review of the case by supervisory officers, a decision was taken that a quick interview would not be appropriate. Eventually after discussion with the Domestic Abuse Investigation Team, a decision was taken not to continue the case and Theresa was informed by text message. Charles was therefore never interviewed about this incident. A PPI was initially graded MEDIUM risk.

16.154. On [redacted] September 2017 Theresa saw her GP and informed her that she and her husband had gone to the police station on 1 September, as she had been advised that her husband would be arrested, however no action was taken by the police and her husband what been allowed to leave. He was now away on business. Theresa said she had suicidal thoughts and had bought a rope as she was considering hanging herself. She had also stood on a building and considered jumping. The GP made a referral to PCLS stating that Theresa had thoughts to end her life in the garage by means of hanging. She reported that she had previously attempted to end her life by means of an overdose and felt unhappy with the Swindon Intensive Team, due to them disclosing information relating to the domestic abuse to the police. Following the telephone contact with Theresa an onward referral was made to the Swindon Intensive Team for assessment. An assessment was completed that evening and Theresa was taken on for home treatment. Later a rope was removed from her possession, which she said she had purchased with a view of hanging herself after speaking with the Swindon Intensive Team and feeling rejected.

16.155. On [redacted] September 2017, Theresa telephoned the Swindon Intensive Team, asking for help and stating she did not feel she could keep herself safe. It was agreed for Theresa to call the team every hour for support whilst she was feeling distressed. A further call was made later that day and Theresa spoke about wanting to drink alcohol but was resisting the urge to do so. She was given support over the phone.

16.156. On [redacted] September 2017, Theresa saw her GP complaining of abdominal pain. She said her husband had returned home, but she denied he had hurt her. On examination she was found to be tender and had bruising on her abdomen, there was also bruising on the right side of her back, which were consistent with fingermarks. (At 10.48am, Theresa sent a text message to Charles stating, *"Baby I am in a queue here just had a blood test now waiting for a scan. There are quite a few people here though. I should have come after you left. Anyway, I'm not sure what time I'm getting out of here. I haven't packed your bag or arranged lunch. You might have to do it sorry baby…*"

Charles replied" *No probs baby I can sort it. Love you*."

At 3.12pm, Theresa sent Charles the following text: ""*Ok I'm out. All good. After all the prob just IBS")*

16.157. On [redacted] September 2017, a member of staff from the police Safeguarding Team together with the SWA IDVA met with Theresa in a Supermarket coffee shop. Theresa told them that Charles was in Germany. She said that the previous day, her GP had sent her to hospital for treatment in relation to the injuries, which she had sustained during an attack at the weekend. Theresa had still not heard from the Police following the statement made by the mental health team. She said that when she attended the Police Station with

Charles she was told that they knew nothing about it. The police-safeguarding officer challenged Theresa about this, as she said she knew it was not true. Theresa said that not knowing what they would do was causing her significant stress. She had sought legal advice but was told that without knowing what evidence the Police had, it would be difficult to predict an outcome. She said she had been unable to speak to the officer in the case due to her odd shifts, Theresa then said she would leave, if a refuge place in Swindon was available. The police officer said that she would look into this for her. After the officer left Theresa told the IDVA that she was surprised that she was still alive, the violence had escalated, she admitted to it being sexually motivated, he had drowned her and beaten her with a metal bar. The IDVA encouraged her to leave, reiterating the risks of staying could be loss of life or serious life changing injury. Theresa said her parents believed she was a junkie and that the bruises and injuries were caused by her falling over drunk.

16.158. After leaving the meeting, the IDVA contacted local refuges and established that Swindon had a three bed flat (which was usually reserved for women with children) and there were possible places in Weston-Super-Mare and Basingstoke. It was agreed with the Swindon Women's Aid Director that Theresa could be offered the three bedroom flat at the Swindon Refuge provided she agreed to engage in 1-2-1 casework to plan a future away from Charles and that she would leave her car and phone at home, as both were used to track her. The IDVA telephoned Theresa and offered her the flat. Theresa asked if going into the refuge would stop the Police from taking their planned action of speaking to Charles. The IDVA answered that she was not aware of anything that would stop the police from carrying out their planned course of action. Theresa then declined the flat. She did not give a reason why, she became quiet and said she had made alternative arrangements. The IDVA asked her what these arrangements were and she would not say. The IDVA felt she was implying that she would kill herself and asked her if she had plans to do so, Theresa said no. The IDVA again asked her what she meant and she would not tell her. Theresa then stopped talking, the IDVA reminded her that she could contact the 24 hour helpline or call the Samaritans if she felt low or at risk of self-harm.

16.159. A short time later, the IDVA received a telephone call from Theresa. She asked the IDVA to send someone to her house. When asked why, Theresa replied, "*I don't want my family to find me*". The IDVA asked if she had taken anything and she said, "*NO*". The IDVA then asked what she was planning to do and she did not answer, however, when asked where she was, she replied that she was in the garage. She would not say what she was planning and the IDVA told her to walk away from the garage into the garden and she said, "*No*" and ended the call. The IDVA was in the process of dialing 999 when her phone rang. Thinking it was Theresa, the IDVA answered but it was the Police safeguarding officer. The IDVA informed her about Theresa's call and that she believed Theresa was going to kill herself. The officer said she knew where Theresa lived and would arrange an immediate response. Shortly afterwards she confirmed that the police and ambulance services were on their way to Theresa's home. The officer continued to telephone Theresa, she answered eventually, and said Police were with her.

16.160. Later, the IDVA was instructed by the SWA director, to ask the Police safeguarding officer to inform Theresa that to avoid future risk, she should have no further contact with the IDVA but that she could contact the 24 hour helpline, the Samaritans or Crisis as necessary.

16.161. The Mental Health Control Room Triage received notification that when the police attended Theresa's address, they found Theresa with a noose around her neck, just stepping off a bucket. The Police left Theresa with her parents and a referral was made to the Swindon Intensive Team.

16.162. On [redacted] September 2017, an assessment was completed by Swindon Intensive Team, although Theresa said she only came for the assessment as her parents made her. She said that the suicide attempt was planned; she fully intended to end her life. She discussed continued alcohol use and explained that she had consumed alcohol prior to the attempt in order to give her confidence. Theresa did not want to engage with the Swindon Intensive Team despite their offer of input. She agreed to a phone call for later that day but was not taken on for home treatment, as there was no identified mental health interventions indicated. Swindon Intensive Team attempted to make contact with Theresa by the phone as agreed but a male answered the phone and stated that she did not wish to talk with them.

16.165. On [redacted] September 2017, the SWA IDVA received a telephone call from Theresa's GP to establish what had happened on 19 September. Theresa had told the doctor that she had been declined a space in the refuge and this led her to feeling helpless and drink whisky before attempting to take her own life. The IDVA told the GP that SWA had offered Theresa a three-bed property in the Swindon refuge. The GP said she had suspected that Theresa had not told her the truth and that she would note the SWA response. Theresa had told the GP that she had been keeping notes of the times that she called for refuge and been refused due to it being full. The IDVA told the GP that the refuge was often full, however women are always offered alternative options to safeguard them, such as an out of area refuge or emergency accommodation via Swindon Borough Council Housing Dept. In Theresa's case as she had access to money and transport, she could arrange an alternative safe place to go to herself if she wished. All of the options had been discussed with Theresa on numerous occasions. The IDVA took the opportunity to inform the GP that she would not be having any further contact with Theresa, but that Theresa could still access support from SWA via the helpline, Community Services Support and the refuge as required.

16.166. On [redacted] October 2017, Theresa attended the Swindon Drug and Alcohol Service run by Change, Live, Grow for a comprehensive assessment.

16.667. At 2.58pm on [redacted] October 2017, Theresa sent the following text to the Police civilian Safeguarding Officer:

"*Sorry (XXXX). I don't know what's wrong with me. I don't know why I keep phoning you. I know if I don't say anything you can't help me. I'm ok I need to pull myself together. I will wait and see what the surgery says about records. I'm just really struggling at the moment with my mental health I think, that's all. (XXX) always told me don't act in panic and that'd exactly what I did today. So just, ignore me. I need to pull it together."*

On [redacted] October 2017 at 8.43am, Theresa sent the SWA IDVA the following text:

"Hi (XXX) I just want to apologise for the last time we spoke. I feel terrible for the position I put you in and I know it was inappropriate. I was not thinking clearly. Its no excuse for my actions but I just want you to know I am really sorry. It couldn't be easy to get a call like that and I didn't think how that would affect you." (Sic)

16.168. On [redacted] October 2017, Theresa made a written request to her GP for copies of her mental health team letters and notes. But, on [redacted] November 2017, Theresa telephoned her GP and said she had been forced under duress by her husband to sign the request for her medical notes. She stressed she did not want Charles to have sight of her records. Theresa told the GP the police had texted her to advise the case against her husband was dropped. The GP checked with the safeguarding lead and was advised that Theresa could view her records in the GP Practice with a chaperone, but paper copies were not to be given.

16.169. On [redacted] October 2017, Theresa attended an Alcohol Harm Reduction workshop run by Swindon Drug and Alcohol Service. This was her final engagement with the service.

16.170. At 2am on [redacted] November 2017, the Swindon Women's Aid Helpline received a call from Theresa. She was crying and asked if there was a space in the refuge. She was told that at that time it was full. She replied it was her own fault as she had been offered a flat previously. She was asked if she wanted to make a new referral into Outreach as the paperwork could be done immediately.

Theresa replied *"No, to just log the call, as all I wanted was to talk to someone"*.

16.171. On [redacted] November 2017 Police were called to a Motorway bridge after Theresa had been seen leaning over the bridge. They found her visibly upset and was dressed only in a jumper and trousers despite the cold temperatures. She told the officers she was "*out for a walk*". She smelt of intoxicants and confirmed to the officers that she had been drinking. Theresa also stated that she used alcohol and prescription drugs, "*as a coping mechanism*". Due to the officers' concerns about Theresa, a request was made for a member of the Mental Health Triage team to make a call to talk to her. Although she agreed to speak to a member of the mental health team, she stated that this would not help, as in her words *"It never helps whenever I speak to them and something will only happen with their assessments when I turn up dead"*. During this call, a plan was made by Mental Health Triage and Theresa that she would make contact with her doctor's surgery the next morning. Mental Health Triage also stated that they were happy for Theresa to return home that evening. She did not disclose to the Triage or officers that she had any intention to harm herself, despite being asked this a number of times, as officers were concerned about her distressed state.

16.172. When talking privately with the police officers, the mental health triage nurse said that looking at Theresa's previous mental health assessments, she seemed to struggle with her mental health when her husband, was away on business. The police contacted Swindon Council Emergency Housing and the Women's refuges in Swindon, Chippenham and Trowbridge in an attempt to find somewhere for Theresa to stay, as she had indicated she would be willing to go, if somewhere was available. All the refuges were full and Theresa stated that she had been trying the same places all week to find somewhere to stay, as her husband was away for the week. Officers gave Theresa several opportunities to disclose anything that she thought they needed to know. Whenever she was asked this, Theresa said that she could not tell them. This led the officers to believe that there was something that Theresa wanted to disclose, but felt she could not out of fear of repercussions. The officers also offered to take Theresa back to the Police Station to allow her to stay safe and speak with officers further. This was declined.

16.173. Theresa asked officers to return her home after a conversation with a Police Sergeant and given that Mental Health Triage were happy for her to do so, this was agreed. She told the officers, her husband who had been away on business was due to return home that evening. Once back at her home address, Theresa was given further opportunities to disclose anything she wanted to the police; however, she continued to decline to do so. Before leaving, the officers told Theresa that, if for any reason she felt scared or in danger when her husband arrived home, she should immediately call 999. When officers informed Theresa that even if she was unable to speak to the call taker when the phone call connected and there were sounds of a disorder in the background, officers would still be sent to her home address to confirm her well-being. Theresa was visibly interested by this, saying that she did not know this was the case. While the officers were with her at her home, her GP telephoned Theresa and was informed of what had occurred at the motorway bridge by one of the officers. The GP spoke to Theresa who initially told the GP she was planning to jump, and then she retracted the statement and refused the GP permission to give any details to the police. The police officers left Theresa at home believing that she had the capacity to look after herself and that she had confirmed she was not intending to jump from the bridge that night or harm herself in any other way.

16.174. On returning to the police station, the police officers telephoned the Swindon Council Housing Department and spoke to the out of hours Housing Options Officer. An

Officer explained what had happened and while emphasising that Theresa had not disclosed domestic abuse to them, they believed there was a domestic violence issue and asked if the housing officer would telephone Theresa as she might open up to her. The Housing Options Officer phoned Theresa and she confided that **s**he had been the victim of domestic abuse over the weekend. She said her husband has just called and was on his way home from the airport. She was asked if she wanted to leave that night, but she said she thought it was too late. She said, *"Things and the situation had escalated a bit quick*". The Housing Options Officer asked if she was sure, she did not want immediate help. Theresa said she was sure and had told the Police this. The Housing Options Officer told her to call the Police if there were any problems and to come to the Housing Office the next day. Theresa did not make any further contact with the Housing Department.

16.175. On [redacted] November 2017, Theresa saw her GP upon the advice of the Police. Theresa denied that she had intended to jump or that she had any plans to harm herself. She said, she had suffered further violence from Charles and said she had been trying regularly but unsuccessfully for a refuge place. She was no longer on Sertraline but had been buying Cocodamol and Diazepam from the internet again. It was recorded, that Theresa was appropriately dressed, her attitude seemed positive, she had good eye contact and rapport. There were however visible bruises, three on the left and one on the right side of her neck. There were no teeth marks or broken skin. Theresa refused to disclose details of how the injuries were sustained.

16.176. Later the same day, Theresa rang the Swindon Women's Aid 24 hour Helpline to ask if there was any space available that night, but she was told that the refuge was fully booked. She said she already had the National DV helpline, so was given the Swindon Homeless out of hour's telephone number. She said she could not say much as her husband was around and they had been arguing as she had left her mobile phone at home when she had gone to the GP surgery and her husband had gone into it to check her messages and calls.

16.177. At 9.05am on the [redacted] November 2017, Theresa turned up at her GP's surgery reception in a tearful state, asking to use a phone to contact the refuge, she said she had left her husband and seemed to be in pain, holding her neck and body. Theresa was taken into an empty consulting room accompanied by the receptionist to use a phone to contact the local refuge and the National Refuge Helpline. Theresa was advised there were no spaces locally and she left a message on the National Refuge Helpline, she then insisted on leaving the surgery as she was worried by the length of her absence from home.

16.178. At approximately 9am on the[redacted] November, Theresa attended at the Police Station to speak to a member of the Public Protection Department (PPD). After a few minutes, the civilian Safeguarding Officer came to speak to her but explained that she was engaged with another issue and would need to leave her for a few minutes. There was a nine minute period when Theresa sat on her own in the Enquiry Office and nobody came back to speak with her. Theresa then told a member of staff at the front desk that she had to leave as she had a doctor's appointment and she left the station.

16.179. At 11.58 am, Theresa attended her GP's surgery in an anxious state. She told her GP that she had suffered extreme violence from her husband. He had used an object to hit her over her head and upper arms, he had trod on her, held her head under bath water, pushed her head into the carpet and attempted to strangle her. He had then left the house and was away. Theresa told the GP that she had gone to the Police Station to see the Police Safeguarding Officer but had been unable to wait for the officer.

It was recorded that on examination, Theresa had bruising and red marks over the left side of her face, her lower abdomen, iliac crest, and both her arms, an ECG was done and a pregnancy test was negative. As her husband had gone away, it was considered that she was not in any immediate danger and that she had full capacity. Her GP nevertheless telephoned the Police Safeguarding team requesting a protection order. She was advised that Theresa should go to the police station or ring 101 and an officer would come around to see her. Theresa told the doctor she had done this and was waiting a call back (there was no indication on Police logs that this was the case). Theresa also said she was making contact with people to obtain a non-molestation order and would continue at home.

16.180. At 2.49pm the same day, Theresa returned to the GP surgery and reported that she had rung 101 and was awaiting a call back. She said she had also phoned the Domestic Abuse Hotline.

16.181. The following day at 3.45am, Theresa sent a text message to the Police civilian Safeguarding Officer stating

"Hi ([redacted]) It's not an emergency but please let me know when will be convenient time to call and speak to you, Thanks"

At 7.45am, Theresa telephoned the NHS 111 to report worsening mental health problems and suicidal thoughts including a plan for a suicide attempt. The NHS 111 Clinical Adviser contacted the mental health crisis team but was advised that they were unable to accept the referral until Theresa had contacted her GP. Theresa was advised to contact her surgery within the hour.

16.182. Between 10.18am and 10.45am, Theresa and Charles had an exchange of short business type texts messages regarding difficulty in making online bank payments. There was no indication in those texts, that she was experiencing any mental problems. However Theresa's mother telephoned Theresa at about 11 15am and Theresa had told her she was having a dark thoughts. Her mother offered to immediately go to see her but Theresa had said she would be alright.

16.183. Later at 12.01pm, A GP from her GP Practice telephoned Theresa regarding the contact she had made with NHS111. Theresa said she was still awaiting police contact after the 101 call to provide a statement. She told the GP that she was having constant suicidal thoughts, regarding hanging or taking medicines. Theresa stated she believed the Mental Health Crisis and Police teams would be unable to act in any meaningful way to help her situation. Her husband was due back in two days-time. She said she has been ringing the local and national refuge lines every day for a place, but no spaces were available. She told the GP she was not taking Sertraline and described her thoughts as "chaotic". Theresa was advised to restart Sertraline. She was clear she did not want specific help or referral to the Mental Health Crisis Team, but then agreed the GP could contact the Crisis Team. The GP then contacted the team and advised them of Theresa's suicide plans and her need for support.

16.184. At 12.58pm the same day Theresa telephoned the police asking for officers to be sent to her house as she intended taking her own life and did not want her family to be the first to find her, When officers were deployed Theresa was found hanging and was pronounced dead by a paramedic after she had not responded to attempts of resuscitation by both the police officers and the paramedic.

Section 17 - Analysis

17.1. Agencies completing IMRs were asked to provide chronological accounts of their contacts with Theresa and/or Charles prior to Theresa's death. In line with the Terms of Reference, the review focused particularly on agencies' contacts from 1 January 2015 to [redacted] November 2017 (the date of Theresa's death), together with relevant information prior to that time. The recommendations to address lessons learnt are listed within the action plans in section 20 of this report. Where there was no involvement or insignificant involvement, agencies advised accordingly. Only one agency has declined the opportunity to provide information directly to the review. (See Section 8 of this report.)

17.2. The Review Panel has checked that the key agencies taking part in this Review have domestic abuse policies and is satisfied that those policies are fit for purpose.

17.3. Twelve organisations have provided Individual Management Reports (IMRs) or reports detailing their relevant contacts. The Review Panel has considered each carefully from the view point of Theresa to ascertain if interventions, based on the information available to them, were appropriate and whether agencies acted in accordance with their set procedures and guidelines. Where they have not done so, the Panel has deliberated if all of the key lessons have been identified and that they were being properly addressed. Consequently some agencies have added to their lessons learnt and reviewed their action plans during the course of this review. Good practice has been acknowledged where appropriate.

17.4. Panel members having read the final IMRs and chronologies and having questioned the IMR Authors are satisfied that the authors have now addressed those points, within the Review's Terms of Reference, which are relevant to their organisations. The following is a summary of the analysis of each report together with the Review Panel's opinion on the appropriateness of the agency's interventions.

17.5. Avon and Wiltshire Mental Health Partnership NHS Trust

17.5.1. The IMR was initially compiled from the Avon and Wiltshire Mental Health Partnership NHS Trust Root Cause Analysis Investigation Report. In conducting her analysis of the contacts with Theresa, the Author considered the following:

17.5.2. **Was Theresa's referral to secondary mental health services properly assessed and an appropriate plan made?**

17.5.2.1. The Author, after reviewing all of the contacts, was of the opinion that Theresa was appropriately referred and assessed by both Primary Care Liaison Service (PCLS) and Swindon Intensive Service (SIS). Generally, the care delivered, and plans made were appropriate; however, there were some areas where this could have been improved.

17.5.2.2. Mental Health Liaison (MHL) did seek advice regarding safeguarding from the Trust Safeguarding Team which resulted in a change in the agreed plan, however prior to this advice the risk management plan (following Theresa's overdose in April 2017) was not robust.

17.5.2.3. A Rapid Access Plan (to enable Theresa to access mental health services without a further GP referral) was in place with Swindon Intensive Service (SIS) and agreed with Theresa; however, this was not clearly shared or understood by all team members.

17.5.2.4. The team managers (at the time) provided good support and comprehensive plans when advice was sought from junior members of staff, however it is not clear if these plans were followed up and outcomes documented.

17.5.3. **Was Theresa's care and treatment appropriate during her contact with services in September 2017?**

17.5.3.1**.** On [redacted] September 2017, Theresa's GP referred her back into PCLS, as her suicidal ideation had increased and Theresa had formulated a plan to hang herself in her garage. She had told her GP that she was reluctant to engage with mental health services and appeared preoccupied with how much information SIS had shared with the police and she also cited the night she rang SIS ([redacted]h August 2017) and was told to contact her GP in the morning. SIS assessed Theresa but the team did not accept her onto the caseload.

17.5.3.2. The suicidal ideation for Theresa continued to escalate and on [redacted] September 2017, she rang Swindon Women's Aid saying that she did not want her family to find her body. The police were contacted and the Mental Health Control Room Triage (MHCRT) updated the log that "police officers attended the home address to find Theresa about to step off a box with her neck in a rope noose". However, there was a discrepancy between the control room log and the SIS entry who states, "That police arrived and (Theresa) had made a noose which she had placed her head through, in order to create a ligature to make an attempt to end her life. When offices approached (Theresa) in her garage, she stepped away from the ligature". Despite, approaching both authors of the RiO record entries, for clarification the report author was unable to gain clear understanding of the RiO differences. Whilst this did not change events for Theresa, it does highlight the need for clear and consistent documentation.

17.5.3.3. The Author was therefore satisfied that the care provided during this time was appropriate, however care needs to be taken to ensure documentation is consistent.

17.5.4. **Was Theresa's care appropriate in her contact in November 2017?**

17.5.4.1. On the [redacted] November 2017, a log was written on RiO by the Mental Health Control Room Triage (MHCRT) stating that Theresa had been identified as standing on the M4 bridge.

17.5.4.2. At Theresa's request, an appointment was made by the MHCRT for Theresa to see her GP. The earliest appointment (with Theresa's preferred GP) was on the 4 December 2017. Theresa expressed concerns this was not early enough, however, she agreed to this appointment because it was her preferred GP with whom she had a rapport.

17.5.4.3. At 7.45am on [redacted] November 2017, Theresa rang NHS111 (the out of hours emergency care provider), stating she felt at risk of suicide and cited she had "been going to and fro between services". It is accepted that the NHS 111 Clinical Adviser contacted Swindon Intensive Team but was told that she would need to be referred by her GP. (See para. 17.5.7.1. below). Subsequently a GP from the surgery referred Theresa to PCLS for mental health support in respect of her suicidal ideation and her plan to hang herself. Theresa reluctantly agreed to see mental health services, stating she had found them less helpful of late.

At 12.58pm, the same day Theresa contacted the police requesting an officer attend her address so her family did not find her body. The police contacted MHCRT to talk to Theresa, but within the twenty minutes it took to escalate the call and dispatch police officers to the home address, Theresa had hung herself in the garage.

17.5.4.4. The Author concluded that the staff at Swindon Intensive Team were not aware of the Rapid Access Plan.

17.5.5. Was **the safeguarding processes followed appropriately in relation to Theresa's reported domestic abuse?**

17.5.5.1. PCLS were made aware of Theresa's domestic abuse (within the GP referral) and that there had been a safeguarding referral by the GP in September 2016. A MARAC meeting had discussed Theresa's circumstances in September 2016 and Mental Health Services were referred to as part of the MARAC outcome. Theresa was followed up appropriately by PCLS.

17.5.5.2. In March 2017, Theresa was again referred to PCLS by her GP who reported that the domestic violence had escalated. At this point, Theresa was already involved with Swindon Women's Aid and had been discussed again within a MARAC meeting.

17.5.5.3. During this time there were further discussions between PCLS and the LIFT Psychology regarding their concerns of not being able to escalate Theresa's reported risk of domestic violence to the police as she was reluctant for them to do so, due to the perceived risk to her (from escalated domestic violence) at home.

17.5.5.4. The LIFT psychologists discussed and agreed that, "If it is just a hit/average assault like that which she experiences regularly" then there would be very little gained. Whilst the views of Theresa should be taken into account, the Author felt it would have been appropriate at this point to report the domestic violence to the police and to make a further MARAC referral.

17.5.5.5. On the [redacted] April 2017, Theresa was assessed in the Accident and Emergency Department by Mental Health Liaison (MHL). Initially the outcome of the assessment did not include any referral to the MARAC, as Theresa did not consent to this. However, later that day, the same nurse in MHL discussed Theresa with the Trust Safeguarding Lead and as Theresa had been identified as "high risk", the following plan was implemented:

1. To complete a MARAC referral, which Safeguarding stated, could be done without the patient's consent.

2. To complete a Domestic Abuse, Stalking and Honour based violence assessment (DASH) based on the information the patient has provided and to clearly state on the MARAC referral that previous contact from professionals has led to violence from her husband.

3. To contact police on 101 to inform them of the situation at the patient's address, so the police are aware if anything else comes through.

17.5.5.6. Following the referral to MARAC, the MARAC team contacted SIS to discuss the recent MARAC referral for Theresa, as it had not been completed with consent. The

MARAC team were advised why this decision had been made and that advice had been sought form the Trust Safeguarding Lead.

17.5.5.7. The DASH score was noted to be eleven on the risk screen, but the MARAC team felt that as the DASH score was eleven without Theresa's contribution, MARAC would have assumed that had Theresa helped populate the risk screen that the DASH score would have been higher. Fourteen and above is considered High Risk, however, a referral could also be made to the MARAC team when the score is below fourteen, based on the practitioner's professional judgement and providing this is articulated on the form. SIS then discussed within the team, when it would be beneficial to inform Theresa of the referral to MARAC and a decision was made that this information would be shared (jointly by SIS and Swindon Women's Aid) with Theresa as soon as possible.

17.5.5.8. Between May and August (2017) there was active involvement with the police to consider if prosecution of Theresa's husband would be taken forward. Despite the escalation of risk in September 2017, no further referrals were made to MARAC by any AWP team. Following discussion with team members, it was evident that SIS team were not aware of the MARAC referral process or the need to make a new referral for every appropriate domestic violence incident.

17.5.5.9. Also, in September 2017, when the SIS team contacted Theresa to check on her welfare, it was reported that a male answered her phone. The nurse (ringing from her own home) stated that she thought she had rung the wrong number and the male said, "Is that the Crisis Team". Despite this reply, the SIS nurse accepted the fact that the male answering, stated Theresa did not want to talk to the caller. The call was ended but there was no further action taken to alert safeguarding or request a welfare check by the police.

17.5.5.10. The Author therefore concluded there were some areas where the safeguarding process was not adhered. Namely:

- Where Theresa reported domestic violence to both PCLS and LIFT psychology (March 2017) this should have been reported to both the police and a MARAC referral should have been made.

- In April 2017 MHL did seek advice regarding safeguarding from the Trust safeguarding team which resulted in a change in the agreed plan, however prior to this advice no plan was in place to make a referral to Safeguarding.

- There was an escalation of risk related to Domestic Violence reported by Theresa in September 2017; however, there was no MARAC referral made.

17.5.6. **Was there an up-to-date risk assessment and corresponding risk management plan?**

17.5.6.1. Risk is a daily consideration for professionals working within mental health services and as a result, changes in apparent risk can lead to immediate changes in the way a patient is supported and managed.

17.5.6.2. The most recent risk assessment was updated on the [redacted] September 2017 and provided a clear and agreed management plan based on the risks identified and Theresa was identified as high risk.

17.5.6.3. All risk assessments for Theresa had been identified as a high risk (apart from the very first assessment) and had been updated on a monthly basis from March 2017.

17.5.6.4. Theresa's risk of suicide or harming herself was discussed regularly within SIS and all of the staff present were in agreement that Theresa's potential risk to self was well known amongst the professionals responsible for her care and treatment and the team knew (and documented) that the catalyst was the return of Theresa's husband from any period away from home.
Talk of suicide was not new for Theresa and her risk level (and corresponding management) had already been determined based on this information. Therefore, no changes would have been made to her management or treatment plan.

17.5.6.5. There was open, collaborative working between Swindon Women's Aid, Hometruths, Theresa's GP and the mental health services involved with her care but the police appeared to have a different view on her risk. (I.e. On the [redacted] June 2017, following a request regarding help with Theresa's ongoing anxiety about police involvement. A police sergeant responded by email stating that they did not feel that Theresa was "high risk of domestic violence" and the police "questioned the validity of Theresa's allegations" and felt that her "mental health issues had influenced her perception of the risk her partner presents to her". It was unclear if Theresa was aware of this shared information).

17.5.6.6. The Author noted that there are examples of progress notes not being validated, across various professional groups (medical, nursing and health care assistants). The importance of completing and validating progress notes in 'real time' is reflected as a lesson (non-causal problem).

17.5.7. **The Review Panel on considering the IMR raised the following issues:**

17.5.7.1. Relating to the need for NHS111 to inform a patient with suicidal inclinations, that they should first seek a referral from her GP to access mental health services.

The IMR Author responded that the reported contact from NHS111 on Theresa's behalf on the [redacted] November 2017 had been reviewed. There is no record of NHS111 calling the intensive team but there is a third hand record made by the Mental Health Control Room Triage Team summarising that Theresa reported she had called NHS111 and that they had called the Intensive Team who advised that Theresa needed to go back through her GP. This is not the advice that AWP would expect to have been given as Theresa had a "Rapid Access Plan" in place and this should have been followed with the team contacting her immediately without the need for a further GP referral. This failure to implement the "Rapid Action Plan" has been acknowledged and has been addressed within the recommendations regarding awareness of rapid access plans relating to Theresa's contact with the service in September 2017. The AWP Care Programme Approach (CPA) and Risk Policy is set out in Appendix J of this report.

17.5.7.2. Regarding the early view that Theresa was not presenting with a significant mental disorder as distinct from a depressed mood due to PTSD and the situation she was living in.

AWP responded that through the first year there was repeated consideration of Theresa's mental capacity with respect to her decision-making, including potential mental health treatment and the question of leaving her husband. Theresa was deemed on more than one occasion to have mental capacity and to have good cognitive health. It was apparent

that Theresa was very fearful of her husband but did not feel able to leave the home for a refuge, to report him to the police, or to stop working for his company. At that stage, it was believed that there was nothing therapeutically possible until Theresa would be out of her situation. Her depression was being treated with medication and could be supported through more mainstream psychology/'listening' services.

After the decision was taken to disclose the violence she was being subjected to, to the police, Theresa made it clear that she felt that her therapeutic relationship with the mental health team was broken and she discharged herself. Nevertheless on [redacted] April 2017 Mental Health Liaison (MHL) received a referral from the local Hospital's Accident and Emergency Department that Theresa had taken (in excess) of 100 x Propanolol tablets. During the following assessment, MHL noted, "the trigger for the overdose was due to the longstanding domestic violence she suffers from her husband and feeling that she had 'had enough of everything.' (Theresa) denies any current active suicidal plans/intentions but given that she is returning to the same environment, with ongoing high risks of domestic violence, ongoing low mood/suicidal thoughts, a lack of support and feeling desperate, risk to self is currently rated as high".

The IMR Author noted that despite documenting this, MHL informed Swindon Women's Aid of Theresa's admission to hospital but did not arrange to see Theresa again and discharged her from the MHL caseload. It may have been more appropriate to refer Theresa into Swindon Intensive Service at this point considering her high level of risk. However, the MHL nurse did discuss Theresa's situation with the Trust Safeguarding Lead and as Theresa had been identified as "high risk", the following plan was implemented:

1. *To complete a MARAC referral, which Safeguarding stated, could be done without the patient's consent.*

2. *To complete a Domestic Abuse, Stalking and Honour based violence assessment (DASH) based on the information Theresa had provided and clearly state on the MARAC referral that previous contact from professionals has led to violence from her husband.*

3. *To contact police to make them aware of the situation at the patient's address so the police are aware if anything else comes through.*

4. *A referral was also made to SIS to home treat Theresa.*

The SIS liaised with Theresa's GP surgery to arrange a safe (neutral) place to meet to be able to assess Theresa's needs. The police kept the Police log open whilst awaiting assessment updates from SIS as Theresa was adamant she did not want police involvement. SIS agreed intensive support of one week, to help Theresa with her suicidal ideation. On [redacted] April 2017, the SIS staff informed Theresa about the MARAC referral (that had been submitted without her knowledge) and she exhibited frustration about this but remained insightful throughout the week working with SIS. She took the knowledge of the MARAC meeting without anxiety and accepted that SIS would refer her care on to Recovery.

The Review Panel whilst accepting the support that was offered to Theresa raised their concerns that there appeared to have been a general lack of understanding of the widely

documented association between exposure to interpersonal violence and suicide among women[23].

AWP acknowledged that Swindon teams need a better understanding of domestic abuse and the MARAC process and this is being addressed within their action plan.

17.5.7.3. AWP was asked if Theresa should have been provide with more consistent, longer term care than she was given and why she was regularly discharged back to her GP.

AWP responded that Theresa was seen almost exclusively by LIFT Psychology or the Swindon Intensive Team during her time with AWP. Neither team is commissioned to deliver care in the long term, LIFT provide time-limited, evidence based psychological interventions in primary care. The Swindon Intensive Team provides care for people in mental health crisis for the duration of the crisis period; again, this is generally short term.

In April 2017 Theresa was referred by the Swindon Intensive Team to the Swindon Recovery Team. This team does provide much longer-term consistent intervention which would include allocation of a Care Co-coordinator who would work closely with the Service User and this referral could have resulted in access, if appropriate, to the secondary care Psychological Therapies Team, who would work with much higher levels of risk and over a much longer time the LIFT. Unfortunately, Theresa declined this support and therefore these teams could not work with her. The Swindon Intensive Team therefore attempted to support Theresa through her periods of crisis but could not keep her on their caseload long term.

17.5.7.4. The Panel asked if either an informal admission or detention under MHA into psychiatric hospital had been considered.

AWP agreed that this issue should be reviewed independently. Later the Panel received the response that no referral to the AMHP service was made by mental health services and no discussions regarding the relative need for this took place, indicative of relative surety on the part of those teams involved that admission would not have been beneficial for her. Whilst it was acknowledged that Theresa could be considered as experiencing on-going low mood, for which she was receiving prescribed medication from mental health services at least some of the time. Her being brought to consider taking her own life was as a consequence of her on-going domestic situation rather than a significant depressive illness which was interrupting her daily operating ability and which necessitated urgent treatment in a psychiatric hospital. Theresa was in receipt of, and accepting of, the mental health treatment deemed most appropriate for her by the inputting team. A hospital admission would have done nothing to alter her chronic domestic situation beyond that which entry to a refuge would have done, which was perhaps the appropriate 'care pathway'. It is true that Theresa could have been detained into hospital, in contrast to her going voluntarily into a refuge or elsewhere, and that this, if happening, would have most probably prevented her hanging herself at that point, but as it is doubtful that she would have presented with a significant mental disorder or a nature or degree necessitating prolonged detention under MHA, and it is unlikely that her domestic situation would have been significantly different at the point of her discharge, or indeed her having leave from hospital. Her

[23]The association between exposure to interpersonal violence and suicide among women: a systematic review: Michael B. MacIsaac, Aust. N Z J Public Health. 2017.

relationship with mental health services was such that she may not have wished for any extensive involvement of professionals, or that she would have remained in psychiatric hospital on a voluntary basis once a detention had been discharged.

The DHR Panel noted this view, that whilst it may have been possible to have detained Theresa under the Mental Health Act, after she had repeatedly shown suicidal ideation, she would have been immediately able to challenge her hospitalisation and walk out, stating she was no longer contemplating suicide and had capacity. On the Panel's behalf, the DHR Chair after consulting with NHS England and Swindon CCG wrote to the Home Office / Department of Health and Social Care to ascertain if a national recommendation could be made to the ongoing Mental Health Service Review regarding broadening detention under the MHA, in relation to a person with situational depression, who has capacity but is choosing to self-harm/suicide rather that accepting support to address their situational problems.

The response received is that Professor Sir Simon Wessely's current mental health service review is considering ways of further reducing numbers needing to be sectioned, rather than looking to downgrade the criteria; therefore the Government would be extremely reluctant to make it easier to detain people "for their own good" under either the Metal Health act or Capacity Act.

17.5.8. The Panel thanked the AWP IMR author and Panel Member for their openness in responding to the concerns of the Panel and for the detailed action plan to address lessons learnt. The Panel members are satisfied that the recommendations now made, when implemented will address the lessons learnt.

17.6. [redacted] Hospital

17.6.1. The IMR Author noted that Theresa had eight attendances at the Emergency Department and one attendance to the Surgical Assessment Unit during the specified timeframe of the DHR Terms of Reference.

17.6.2. Theresa's first two attendances to the Emergency Department related to cardiac symptoms, which were investigated and monitored by the specialist team.

17.6.3. There were three attendances to the Emergency Department relating to mis-use of medication. On the first occasion there was a rational explanation and no further follow up was required. On the following two occasions although Theresa denied suicidal intent, but was acquiring medication via the internet, an appropriate referral was made to the Mental Health Liaison Team to review any presenting risks.

17.6.4. Three attendances to the Emergency Department included physical injury to Theresa and staff documented

Domestic abuse. It is credible that the staff directly questioned Theresa in respect of the origin of the injuries and more specifically domestic abuse. It was also documented that Theresa was known to Swindon Women's Aid. There was evidence of both Swindon

Women's Aid and Police liaison contact in relation to the injuries and historical domestic abuse in respect of information sharing and discharge formulation.

17.6.5. There was however, no evidence of a DASH risk assessment, which may have opened avenues for direct questions to be asked in relation to current domestic abuse and presenting risk. There is also no flag or alert to indicate the number of attendances in respect of physical injury and known history of domestic abuse.

17.6.6. Theresa's last attendance to hospital was to the Surgical Assessment Unit for assessment following discussion with her GP and the assessment area doctor. This attendance was ten weeks prior to her death. Theresa denied any element of domestic abuse at this juncture and no account could be provided for the sustained injury to her stomach. The assessment included epigastric pain secondary to blunt abdominal trauma occurring three days prior to her attendance.

17.6.7. The DHR Panel accepts that hospital staff understood that Theresa did not want the police informed and that she had a safety plan with SWA but on 12 January 2017, a decision was taken to inform the police as staff had fears that she was at risk of potential serious harm. The hospital has now introduced a policy which will assist personnel making such decisions in the future.

17.6.8. The Panel is satisfied that the IMR Author was thorough and open in his review and has identified the key lessons to be learnt and has made appropriate recommendations to address them.

17.7. Hometruths

17.7.1. Hometruths is a non-statutory support service for victims of domestic abuse [redacted] whom had some contact with Theresa. The IMR author, who is a trained Independent Domestic Violence Adviser declared her involvement with Theresa at the commencement of the Review.

17.7.2. The IMR Author completed a detailed IMR and Chronology of contacts. (A summary of those contacts is included in section sixteen of this report.)

17.7.3. Hometruths involvement with Theresa was short term and came on the back of Theresa already accessing support from other agencies. Theresa had been given Hometruths contact details by Swindon Women's Aid, as it had been felt that as she declined to leave her husband there was nothing further SWA could do to help her at that time. Subsequently Theresa self-referred to Hometruths but on assessment, it was clear that other than providing contact and empathy, there was nothing extra that Hometruths could offer that had not already been offered/provided by other agencies. Attempts to re-offer appropriate routes to safety were rejected by Theresa. She declined to engage with police reporting and rejected a refuge placement when one was available. Reporting to the police and leaving her husband were discussed with her at each meeting, as these were the key steps to ensuring her safety.

17.7.4. Theresa presented with the dichotomy of asking for help but being unclear about what help she wanted. She refused to consider leaving home and she said, she did not want to get her husband into trouble by reporting him to the police. In the interactions with her, she demonstrated no motivational change and Hometruths was unable to find a place of engagement with her to be able to move her forwards.

17.7.5. Theresa was accessing her GP, the mental health services and Swindon Women's Aid, which were all services appropriate to her situation. Her case had been to MARAC, so all statutory agencies were aware of her reported high-risk situation. When the case returned to MARAC on [redacted] May 2017, the Hometruths IDVA attended to contribute around the discussion and wider safety planning.

17.7.6. The IDVA accompanied her to a meeting with the Mental Health Team at [redacted] to offer additional support, but after the meeting, Theresa stated there was no additional help the IDVA could provide at that time.

17.7.7. **Theresa's** refusal to engage with a risk assessment made it impossible to consider any additional safeguarding. The Hometruths IDVA was aware of how difficult this case was and sought appropriate help from her colleague. She engaged in discussion with Theresa's GP, with her IDVA from Swindon Women's Aid, with the Police Safeguarding Team and with the mental health workers at [redacted] to ensure she was working in partnership with the other professionals and agencies that Theresa was involved with. At the MARAC, all information was shared fully and formally.

17.7.8. The author concluded that prior to Theresa's death; Hometruths took appropriate positive action on each of the occasions Theresa was in contact with the Charity.

17.7.9. The DHR Panel is satisfied that Hometruths has no lessons to learn or recommendations to make in this case. Hometruths were invited to be co-signatories of the Swindon Women's Aid Referral Pathway Protocol (see Para 17.15.6.) but declined the opportunity.

17.8**. NHS111 (Care UK)**

17.8.1. The Swindon NHS111 service which is operated by Care UK completed an IMR setting out details of the telephone call received from Theresa at 7.45am on the morning of her death.

17.8.2. NHS111 records noted that the call was initially taken by a Health Advisor. Theresa declared that she had diagnosed mental health problems and had previously dealt with the Crisis Team and the Samaritans as she had been having suicidal thoughts for approximately one year. She stated that she had attempted suicide a few weeks earlier and she was again having suicidal thoughts. Theresa told the Health Advisor she had previously been medicated for mental health problems, however she felt that it did not help and therefore had not renewed her repeat prescription. Following an assessment the Health Advisor offered Theresa an ambulance but this was declined. Theresa said she would make her own way to hospital in a taxi. As per NHS111 protocol for refused ambulance dispositions, the call was put into the clinical queue and Theresa was advised that a Clinical Advisor would call her back within twenty minutes.

17.8.3. The IMR recounted that a Clinical Advisor did telephone Theresa at 8am. Theresa confirmed that while she was known to the Crisis Team she had not called them as she believed she would be advised to distract herself and maybe make an appointment. The Clinical Advisor said he would contact the Crisis Team on her behalf and she was put on hold.

17.8.4. On telephoning the Crisis Team, the Clinical Advisor was informed that Theresa was not currently an "open" patient and that she would need a GP referral. The Clinical Advisor informed Theresa and again suggested she attend the hospital Emergency Department or contact her GP. Theresa responded that she was not going to phone

anyone else as everyone turns her away. She then declined the Clinical Advisor's offer to contact the GP on her behalf. The Clinical Advisor asked her what she was going to do and she answered that she did not know but asked that it be recorded that the Crisis Team had turned her away. The Clinical Advisor counselled her that as long as she was not planning suicide at that time, to phone her GP, but if she was planning suicide to go to the hospital Emergency Department. She was also advised to telephone 111 back anytime to which she replied "*What is the point, I will contact my GP who will refer to Crisis, they will take 6-7 hours to get back to me, maybe an appointment tomorrow and they will discharge me. Until one of these attempts works when they will say that I wasn't under their books. The GP refers me every time. Crisis contact me and tell me I'm not a suicide risk*." The Clinical Advisor urged her to phone her GP surgery and speak to her GP within an hour and the call was terminated. The entire transcript of the call was promptly faxed to the GP surgery.

17.8.5. The IMR author was of the opinion that the Health Advisor had completed a thorough NHS pathways assessment and that given the increased skillset required for Theresa, correctly transferred her to a Clinical Advisor.

17.8.6. Whilst the IMR Author was satisfied that both the Health Advisor and the Clinical Advisor were empathetic and made sound assessments he believed that although all available options were considered these were limited as the Crisis Team would not accept Theresa without a referral from her GP.

17.8.7. Nevertheless the IMR Author reflected that whilst the Clinical Advisor correctly contacted the Crisis Team, the outcome of the call may have been more positive had it been handled differently by both parties. The clinician could have queried when Theresa was last known to the Crisis Team, what interventions she had previously had and he could have explained why he felt Crisis Team input was necessary at that time. While trying to manage the situation at the end of the assessment the Clinical Advisor could have told Theresa that he would contact her GP in view of the concerns raised, rather than asking her if she wanted him to do so. The IMR Author did acknowledge that Theresa may still have declined this suggestion.

17.8.8. The IMR Author was able to confirm from their records that there was only the one call made to NHS111 by or on behalf of Theresa.

17.8.9. The Review Panel notes that Care UK is no longer commissioned to provide 111 services by the Swindon CCG. Nevertheless, the Panel is satisfied that after guidance from the DHR Chair, the IMR Author has identified key lessons to be learnt and made appropriate recommendations to address them.

17.9. South Western Ambulance Service NHS Foundation Trust

17.9.1. The Trust provided a chronology of two responses to calls relating to Theresa. The first was on 19 September 2017 when she was conveyed to hospital after an overdose. A safeguarding notification was correctly sent to Swindon Adult Social Care on that occasion. The second call related to her death.

17.9.2. The Review Panel is satisfied that SWAS has no lessons to learn or recommendations to make.

17.10. Swindon Borough Council Adult Social Care

17.10.1. The IMR Author highlighted that on each referral, consideration was given as to whether Theresa had care and support needs under the Care Act. It was determined she did not. However, on each occasions the safeguarding team believed that an appropriate response from the police was ongoing and that Theresa was receiving support from SWA. If the referrals had been taken on as safeguarding concerns, involvement with the Police Domestic Abuse Investigation Team and Swindon Women's Aid may have been the outcome.

17.10.2. On the third referral, there was a greater indication that she appeared to have some care and support needs and at the very least, the team could have made contact with her to determine this. If there was uncertainty about Theresa's willingness to engage, a more creative approach involving the agencies she was engaging with could have been considered. For example, getting a message to her to offer support from Adult Safeguarding or Adult Social Care Services or to arrange to meet in a "neutral" location. Direct contact with capacitated individuals, who are the subject of safeguarding concerns, needs to be the default position.

17.10.3. The IMR Author noted a concern that knowledge about Domestic Abuse was lacking by some staff in Adult Services. An Action Plan is in place to address and remedy this issue.

17.10.4. The Review Panel accepts that the IMR Author has identified the key lessons to be learnt and is satisfied that the recommendations and action plan agreed will address them adequately.

17.11. Swindon Borough Council Housing Department

17.11.1. The IMR Author was of the opinion that the Housing Options Officer, who, during the evening of 16 September 2017, received the telephone call from police explaining their concerns about Theresa, took the correct course of action by promptly telephoning Theresa. After Theresa stated she had been a victim of domestic abuse, the Officer rightly immediately offered her emergency accommodation. However, the IMR author believed that rather than asking Theresa to contact the Housing Department the next day, she should have told Theresa that she would be contacted the next day and referred to a specialist domestic abuse housing options officer.

17.11.2. The DHR Panel acknowledges the prompt response of the out of hours Housing Options Officer and is satisfied that the IMR author has identified a relevant lesson to be learnt and that an appropriate recommendation has been made to address. The Panel is pleased to note the good practice of Swindon Housing Department in employing a specialist domestic abuse housing options officer available to assist victims of domestic abuse.

17.12. Swindon Clinical Commissioning Group

17.12.1. The IMR author is the Swindon Clinical Commissioning Group Safeguarding Lead Doctor. She has no connection with the GP Practice of which Theresa was a patient. The Chronology of Theresa's contacts with her GP were provided by the surgery and have been verified from her medical records. In view of the significance of the relationship, Theresa had with her GP the DHR Chair has decided with the Panel that the detailed analysis provided by the IMR author should be included in full in this section of the Overview Report.

17.12.2. Theresa presented to her GP with multiple medical problems. There were ninety-one entries where Theresa's mental health had been a feature. There were twenty-six disclosures relating to suspected or reported domestic violence, most of which were of significant harm, including strangulation to the point where Theresa lost consciousness. Theresa commented on several occasions that she felt trapped due to financial reasons. She became increasingly suicidal, attempting suicide by way of, an overdose, considering jumping in front of a train, being found on a motorway bridge, saying she had bought a rope, attempting hanging but was found, before eventually succeeding in taking her own life by the method of hanging.

17.12.3. The IMR author noted that the continuity of care for Theresa was excellent, as almost all of the consultations were with the same GP (all except for three occasions). Overall care of the patient by the usual GP was found to be beyond what would be the standard expected care. Analysis of the consultations show the presentations by Theresa were always managed appropriately.

17.12.4. The following had been done for Theresa (this was partly using a review that the GP had done herself in April 2017):

- Adult safeguarding referral made on 12 September 2016. Outcome - Informed - did not fulfil criteria.

- Theresa directed to Swindon Women's Aid (SWA) on every occasion when presented with domestic abuse. There was close liaison by the GP with SWA including a joint consultation and many phone calls.

- Referred when appropriate to the Mental Health Team (MHT).

- Second opinions were sought from the Practice Safeguarding Lead, and another GP, including asking for a review by the other GP.

- Discussed case in practice with colleagues and a Significant Event Audit was completed.

- Referred to LIFT (psychotherapy / counselling) where appropriate.

- Referred to Hospital Accident and Emergency Department (A&E) where appropriate.

- GPs are invited to attend MARACs but not all GPs are able to attend. The fact that this GP did attend, indicates her wish to contribute to the MARAC as fully as she could and to receive the information that was given during the MARAC. This reflects a high standard of care and enabled vital information to be shared.

- Theresa was put in contact with Hometruths through SWA and the surgery was made available as a safe meeting place with Theresa.

- On each occasion, important signposting was repeated to Theresa about the agencies that could help her, even though they had already been discussed many times.

- Where her mood was low, suicidal ideation was always discussed and documented.

- The GP considered whether to phone the police without Theresa's consent and acted in line with current GMC guidance by not discussing her case with the police. (This is discussed further below).

17.12.5. The IMR Author considered the following:

- Were practitioners sensitive to the needs of Theresa and her husband, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a "victim or perpetrator"?

  The IMR author concluded this was done in every consultation with Theresa.

- Was it reasonable to expect them, given their level of training and knowledge to fulfil these expectations?

  The IMR author was satisfied that this was a reasonable expectation.

- Did the GP Practice have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic violence and abuse victims or perpetrators and were those assessments correctly used in the case of this "victim/perpetrator"?

  The Practice had a Safeguarding Adults Policy, which includes domestic abuse. This document is not in line with General Medical Council (GMC) guidelines on confidentiality. (See Appendix C). The GP followed the GMC guidelines, which were given to the GP by the Medical Protection Society (MPS), and therefore the GP

acted reasonably but the IMR author believes that policy needs amending. Specifically, the safeguarding policy (see Appendix E) states, "Where this [gaining of consent] is not possible, or in the case of emergency where serious harm is to be prevented, the patient's doctor will balance the need to protect the patient with the duty of confidentiality before deciding whether to refer. The patient should usually be informed that the doctor intends to disclose information, advice, and support should be offered. Where time permits, the medical defence organisation will be telephoned before action is taken." However, the GMC guidelines current at the time (appendix C) state "It may be appropriate to encourage patients to consent to disclosures you consider necessary for their protection, and to warn them of the risks of refusing to consent; but you should usually abide by a competent adult patient's refusal to consent to disclosure, even if their decision leaves them, but nobody else, at risk of serious harm. You should do your best to provide patients with the information and support they need, to make decisions in their own interests, for example, by arranging contact with agencies that support victims of domestic violence." The new GMC confidentiality guideline does not change this. The exception to the need to keep confidentiality (see Appendix E) is when someone other than the patient is at risk, i.e. a child: "Such a situation might arise, for example, when a disclosure would be likely to assist in the prevention, detection or prosecution of serious crime, especially crimes against the person. When victims of violence refuse police assistance, disclosure may still be justified if others remain at risk, for example, from someone who is prepared to use weapons, or from domestic violence when children or others may be at risk."

- Did the agency have policies and procedures in place for dealing with concerns about domestic violence and abuse? Were these assessment tools, procedures and policies professionally accepted as being effective?

  The IMR Author confirmed that the Practice had an appropriate domestic abuse policy and procedures.

- Did the agency comply with domestic violence and abuse protocols agreed with other agencies, including any information-sharing protocols?

  The IMR Author noted that it seems from the records that relevant information was shared with consent between Swindon Women's Aid and the Practice, the Safeguarding Adults Team and the Practice, and the Mental Health Team (MHT) and the Practice.

- What were the key points or opportunities for assessment and decision making in this case?

  The IMR author was satisfied with each consultation with Theresa, where domestic violence was disclosed; there were twenty-six disclosures of domestic violence towards Theresa, most of which involved significant harm to the patient.

- Do assessments and decisions appear to have been reached in an informed and professional way?

  The IMR Author was of the opinion that this was done on every occasion.

- Did actions or risk management plans fit with the assessment and decisions made?

  The IMR Author was of the opinion that this was done on every occasion.

- Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

The IMR Author was of the opinion that this was done on every occasion.

- When and in what way, were Theresa's wishes and feelings ascertained and considered?

  The IMR author commented that on every occasion Theresa's wishes and feelings were ascertained and considered, by discussion in consultation and thoroughly documented in the notes, including Theresa's rationale and the doctor's rationale on consideration of these.

- Is it reasonable to assume that Theresa's wishes should have been known?

  The IMR Author commented that they were known in detail.

- Was Theresa informed of options/choices to make informed decisions? Were they signposted to other agencies?

  The IMR Author commented that, these were extensively and repeatedly discussed with Theresa during every consultation.

- Was anything known about Theresa's husband?

  The IMR Author commented: Yes, but minimal information. Theresa's husband was a patient at the surgery but he had not been seen regularly. There were no injunctions or protection orders that were, or previously had been, in place.

- Had Theresa disclosed to any practitioners or professionals and, if so, was the response appropriate and was this information recorded and shared, where appropriate?

  The IMR Author commented, yes, the response was always appropriate, considered and involving the SWA where appropriate, including one joint consultation.

- Were senior managers or other agencies and professionals involved at the appropriate points?

  The IMR Author commented: Yes, including referrals to SWA, MHT, and Safeguarding adults' team. The GP also attended a MARAC meeting.

- Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators?

  The IMR Author commented that GPs need further education on the Care Act 2014.

- How accessible were the services for the deceased and her husband?

  The IMR Author commented that the services for Theresa were repeatedly discussed, including being given phone numbers and phoning on Theresa's behalf to services. With regards Charles, following receipt of the MARAC report, should something have been done by any agency to offer support to Charles? This would depend upon how much he knew (if anything) about the MARAC. This point is currently under review by Swindon CCG, as to what advice to give to practices on receipt of information from a MARAC.

17.12.6. The IMR Author was satisfied that procedures were sensitive to the ethnic, cultural, linguistic and religious identity of the "*victim, the alleged perpetrator*" and their families and that consideration had been given for vulnerability and disability necessary. She also noted that Theresa was treated for depression.

17.12.7. The subject of whether to discuss the situation with the police was talked about in every consultation about domestic violence. On each occasion, Theresa declined to discuss the issue with the police and at every opportunity asked the GP not to break her confidence. The GP did not break this confidence, as per GMC guidelines. There were reasons, in addition to the GMC guidance, that Theresa and the GP felt it was not appropriate to contact the police. The GP Practice's Safeguarding Policy is set out in Appendix G).

- It may cause Theresa to be at greater harm as after questioning, the husband would return home. Theresa did find out what the process might be if she did report it, (She had been told; he would be questioned but would be released on bail and then the court case would not be for some time, perhaps a year. She believed that during that time she would be at more risk.)

- Not mentioned in the notes or chronology but believed (through the Author's experience) to be a factor in these decisions is that breaking her confidence would potentially cause a lack of trust in the GP and Theresa may then feel she could not confide in the GP again and would lose this avenue of support.

Each time, not contacting the police was a considered decision, discussed with SWA and Theresa repeatedly, as well as the Medical Protection Society (MPS).

17.12.8. The IMR Author later drew the Review Panel's attention to the following:

The Doctor who wrote the chronology has pointed out some extra General Medical Council (GMC) guidelines, which are relevant and potentially contradictory to the other GMC guidelines. In the GMC guideline: Good Practice in Handling patient information, End Notes, Page 71 number 19 the following is written:

In very exceptional circumstances, disclosure without consent may be justified in the public interest to prevent a serious crime such as murder, manslaughter or serious assault even where no one other than the patient is at risk. This is only likely to be justifiable where there is clear evidence of an imminent risk of serious harm to the individual, and where there are no alternative (and less intrusive) methods of preventing that harm. This is an uncertain area of law and, if practicable, you should seek independent legal advice before making such a disclosure without consent.

This is in contradiction to the other GMC guideline. The IMR author questions whether in this particular case there was an "imminent" risk of serious harm - as Theresa's husband was usually out of the country or Theresa, the patient, had been assessed as safe to go home. There was not a situation where Theresa stated that if she went home that day that she was scared something would happen that day, so the IMR author questions whether this would apply. However, equally it could have been argued that given what had happened to the patient previously, the imminent risk of harm remained should she go home to her husband. Independent advice was sought through the Medical Protection Society (MPS) whose telephone advisers are not lawyers but do follow legal advice and sometimes have legal qualifications - although it was not directly discussed with a lawyer and the practice has said that they do not have this facility - they would rely on the MPS to give advice.

The GP has also found that in addition to this, as described by the GMC in its definition of what "good medical practice is" the following is stated:

Good medical practice describes what it means to be a good doctor.

It says that as a good doctor you will:

Make the care of your patient your first concern

- *be competent and keep your professional knowledge and skills up to date*

- *take prompt action if you think patient safety is being compromised*

Again, this would appear to be in contradiction to the GMC advice in this situation.

17.12.9. The IMR author considered a possible change to law: If GPs were permitted to break confidentiality and could discuss with the police and police could arrest the suspect and use the GPs' notes as evidence and could deny the suspect bail before the trial, then perhaps Theresa may have gone to the police or the police could have acted and arrested the suspected perpetrator without the patient having to be involved. (The Review Panel explained to the IMR author that the legal powers already exist, but the Review will recommend that the Home Office works with other Government Department have to address the ambiguity of existing national/professional guidance on information sharing without consent where there is risk of serious harm or death to any adult).

17.12.10. With regards to the GP referral to Adult Safeguarding, the IMR Author noted the response received from Adult Social Care. The GP notes state on 6 October 2016: *"If patient doesn't need social care then they would sign post to SWA and Domestic Violence Department of Police and as patient doesn't have any social care needs and is now working with SWA and has been contacted by police they wouldn't do anything further."*

This statement, if it was actually said, is not in line with the Care Act 2014. (Appendix F) which states "*274.Subsection (1) provides that the local authorities' enquiry duty applies to adults who have care and support needs (regardless of whether they are currently receiving support, from the local authority or indeed anyone); and who are at risk of or experiencing neglect or abuse, including financial abuse; but are unable to protect themselves. The eligibility criteria that the local authority sets for services and support are not relevant in relation to safeguarding. Safeguarding enquiries should be made on the understanding of the risk of neglect or abuse, irrespective of whether the individual would meet the criteria for the provision of services."*

17.12.11. The IMR author thought it was not clear from the correspondence from the Safeguarding Adults Team, whether a needs assessment was carried out to see if Theresa had care and support needs. Theresa would have had to be involved and this is not mentioned in the notes. Theresa would have fulfilled the criteria for "has needs for care and support" due to her mental health problems and the impact that this had on her and would thus have fulfilled criteria 1a of section 42. She definitely fulfilled 1b and 1c and therefore the decision not to take on her case appears incorrect. In addition, the Author believes Theresa would also fulfil the eligibility criteria, as she fulfils criteria 1, two of criteria 2, (being able to make use of her home safely and developing or maintaining family or other personal relationships) and she fulfils criteria 3. However, as stated above, whether she fulfilled the eligibility criteria was not relevant. Had Theresa been taken on by the Safeguarding Adults Team and as she had been happy for this referral to be made, she may have engaged with this agency and the outcome may have been different.

17.12.12. After the September 2016 referral, the GP made no further referrals to the Safeguarding Adults Team. The IMR author thought that this was not surprising, as the GP had been told that Theresa would not be taken on unless she was needing social care and the GP was aware that she did not need social care. However, perhaps the decision by the Safeguarding Adults Team could have been challenged, if the law had been more clearly understood by the GP. At the time, there was no escalation policy with regards safeguarding adults. One is now in place. A complaint could have been made to the Safeguarding Adults Team by the GP Practice if they had felt that the outcome of the referral was incorrect. However, it would not be standard practice for a GP to know the Care Act 2014 to the level to be able to come to the conclusion that what they had been told was incorrect.

17.12.13. The DHR Panel thanks the IMR Author for her detailed chronology and IMR. The Panel shares the Author's concerns regarding the confusion practitioners are faced with in relation to disclosure of information when an individual refuses consent whilst being at risk of serious harm or death. This is highlighted in a national recommendation in Section 20 of this Report. The issues relating to Safeguarding are addressed in the Swindon Borough Council Adult Social Care recommendations. The Review Panel wishes to commend Theresa's regular GP for the consistently high level of her support of Theresa. (T**heresa's mother has asked the DHR Chair to record the family's thanks to the GP for the consistently high quality care she provided to Theresa over such a sustained period.)**

17.13. Swindon Drug and Alcohol Service (CLG)

17.13.1. Change Grow Live is a non-statutory organisation which until recently provided the Swindon Drug and Alcohol Service. A senior member of CGL completed both an Unexpected Death Review (See Appendix I) and an Individual Management Review for this Domestic Homicide Review. The new service provider "Turning Point" has agreed with the lessons learnt and recommendations made.

17.13.2. The IMR Author highlighted that the client disengaged very quickly after accessing treatment and only attended one structured intervention, which was an alcohol support workshop; the retained notes were not sufficiently detailed to ascertain exactly what issues Theresa had at that time (31 October 2017). This was primarily because Theresa did not engage long enough to have a Recovery Plan Review, which would normally happen six weeks after entry to treatment.

17.13.3. There was no evidence of any follow up of Theresa's actions from the initial Recovery Plan although Theresa did not contact her allocated worker again after the assessment. It is not evidenced if the allocated worker knew about the information that Theresa was known to the MARAC. It was approximately two weeks after Theresa first attended the Service, that a letter was received from her GP, which stated that Theresa was known to MARAC and was at self-reported risk of domestic abuse. There were no contact notes written by the Administration Team, who scanned this notification, to advise the Recovery Worker of its existence and there was an unexplained delay between 18 October 2017 when the document was received and 10 November 2017 when the document was scanned.

17.13.4. The DHR Panel is satisfied that the IMR author has identified the key lessons that can be learnt and that the recommendations made are appropriate to address them.

17.14. Swindon Multi Agency Risk Assessment Conference (MARAC)

17.14.1. The Chair of the Swindon MARAC having received a Memorandum of Agreement from the DHR, provided minutes of meetings and a report analysing the three MARAC referrals relating to Theresa.

17.14.2. The MARAC Chair highlighted that all three MARAC meetings that considered Theresa's situation, were well attended by the relevant agencies and he commended Theresa's GP for attending the third meeting on 2 May 2017.

17.14.3. He believed that the MARAC minutes show that Swindon Women's Aid on two occasions and the Mental Health Service, on the third occasion, provided sufficient detailed information about Theresa to enable the MARAC to consider the options available to assist her, (without breaching her demand that the police take no action), prior to setting action plans, which were all completed.

17.14.4. The Panel asked the Chair of the MARAC to clarify a number of issues including:

1. If advice was sought from the Crown Prosecution Service (CPS)?

2. If consideration was given to a Domestic Violence Protection Notice (DVPN) being issued?

3. If coercive and controlling behaviour was considered by the MARAC?

4. If a Threat to Life notice (previously known as an Osman warning) was considered by the MARAC?

17.14.5. The MARAC Chair responded:

Re 1: At the time of the third and final MARAC ([redacted] May 17), there had been three reports to the Police, all by third parties. Support services had stressed that Theresa's husband was not aware of her disclosures and that the risk to her may increase if he became aware of them. At that time the Police were not in possession of material that could have warranted a Crown Prosecution Service referral (this may have been the case had there been a MARAC after the incident where she made disclosure to mental health staff at Sandalwood court on the [redacted] June 2017 and where a statement was provided by a staff member)

In relation to 2: the MARAC Chair stated DVPNs had been considered but rejected as this would have involved Theresa's husband knowing that she had made disclosures, something that she was clearly anxious about. Whilst a DVPN could be sought without arrest, MARAC is victim focused and would have been going against her wishes causing her to potentially disengage completely from supporting services.

Re 3: Controlling behaviour was listed as a risk at the MARAC on [redacted] May.

In relation to 4: the MARAC Chair responded that he considered two issues, firstly, was the "Threat to Life" an appropriate action and secondly does the "Threat to Life" process assist in domestic abuse cases. He informed the Panel that the Threat to Life national policy states that a threat to life is-

"Where as a result of a deliberate intention or the criminal act of another, the police or another Law Enforcement Agency, has identified a real and immediate threat to a loss of life or to cause serious harm or injury to another".

In the MARAC Chair's opinion, there was no specific information that there was a real and immediate threat to Theresa's life from her husband (the threat from herself does not fall within the scope of the Policy). The Threat to Life letter is meant to relay a specific threat, which the subject may not be aware of, in this case Theresa was fully aware of what was happening. As is clear in the formal Threat to Life letter (below) it would not give any practical advice or help to Theresa in her circumstances. Secondly, the MARAC Chair said he would be uncomfortable with domestic abuse victims being given a letter that states that the police cannot help them any further and if they come to harm it is their own responsibility. He believed this would give a totally wrong message to a victim who is already clearly reluctant to engage with the police and which may actually prevent them contacting the police in future.

The formal Threat to Life letter is:

Mr. /Mrs. /Miss

I am in receipt of the following information, which suggests that your personal safety is now in danger.

I stress that I will not under any circumstances disclose to you the identity of the source of this information and whilst I cannot comment on the reliability or otherwise of the source or the content of this information, I have no reason to disbelieve the account as provided. I am not in receipt of any other information in relation to this matter nor do I have any direct involvement in this case.

Insert here details of the threat

Although (*Insert name of Police force*) will take what steps it can to minimise the risk, the Police cannot protect you from this threat on a day-by-day, hour-by-hour basis.

I also stress that the passing of this information by me in no way authorises you to take any action which would place you in contravention of the law (e.g. carrying weapons for self - defence, assault on others, breaches of public order). Should you be found doing so then you will be dealt with accordingly.

I therefore suggest that you take such action as you see fit to increase your own safety measures e.g. house burglar alarms, change of daily routines, always walk with an associate, carry a mobile phone, install a domestic CCTV door guard system, increase house security measures e.g. locks and bolts. It may even be that you decide that it is more appropriate for you to leave the area for the foreseeable future. That is a matter for you to decide.

If you wish to provide me with full details of the address at which you will be resident I will ensure that the necessary surveys can be undertaken by police staff to advise you regarding the above safety measures. Could you also provide details of someone who the police can contact on your behalf to take urgent messages if you are unavailable.

I would also ask that you contact the Police regarding any suspicions incidents associated with this threat.

17.14.6. The DHR Panel thanked the MARAC Chair's for his responses to the questions raised.

17.14.7. The Panel also noted that the MARAC referrals clearly detailed the serious risks Theresa faced and that those risks were compounded by her reluctance to report the abuse to the police. The Panel acknowledges that the actions available to the MARAC were limited, by the advice from Theresa's GP and the IDVA, that if agencies provided the information required by the police to enable them to take criminal proceedings against Charles, against Theresa's wishes; this would make her more vulnerable mentally and drive her away from the professionals who were still in a position to provide her with support. The Panel therefore accepts that the MARAC had no lessons to learn or recommendations to make.

17.15. Swindon Women's Aid

17.15.1. The IMR Author noted that Theresa had 177 support contact sessions with SWA between [redacted] September 2016 and [redacted] November 2017.

17.15.2. During that time, support was provided to her through an Independent Domestic Violence Adviser (IDVA). Theresa would on occasions seek refuge accommodation but then change her mind. Theresa's last few attempts to access a refuge placement were on the [redacted] and [redacted] November 2017, but on those occasions the Swindon refuge was full and SWA offered her the 24 hour advice line number to access accommodation as she could not stay on the line or be contacted back due to her husband being in the house. Additionally due to attempts to safeguard her, Swindon Women's Aid discussed options such as out of area refuge and emergency accommodation via Swindon Borough Council Housing Department.

17.15.3. The IMR Author highlighted that during the time Theresa received support from SWA she spoke about numerous physical beatings, sexual assaults and that she had been choked and had mentioned that she was surprised she was still alive. She had also said that her husband had convinced her parents that her visible bruises were due to her being a "junkie."

17.15.4. SWA attempted to support her in safely exiting her relationship with Charles, but this was not something that she appeared ready to do, for whilst she would ask for a refuge place she would change her mind or delay when places were offered to her. It was made clear to her that SWA could not continue to support her until she was ready to leave the relationship. SWA did ensure that she was able to receive support from Hometruths, her GP and Mental Health Services.

17.15.5. The Review Panel acknowledges and commends the sustained support SWA provided to Theresa; however, the Panel believes that when a victim of domestic abuse contacts a refuge, if there are no vacancies at that refuge, rather than expecting the vulnerable victim to telephone a series of other local refuges or to telephone the National Helpline, the first refuge contacted should, where safe to recontact her, undertake to make those initial enquiries on behalf of the victim to find suitable vacancies.

17.15.6. The DHR Panel also identified the lack of any clear referral pathway form Swindon Women's Aid to Hometruths. Swindon Women's Aid has consequently agreed to implement the following Referral Pathway protocol. Hometruths were invited to be co-signatories to this Referral Pathway protocol but declined to do so.

Referral Pathway

1. Swindon Women's Aid is a signatory to the Swindon Community Safety Partnership Information Sharing Protocol.
2. If a survivor moves from Swindon Women's Aid to another support agency for whatever reason, Swindon Women's Aid will implement a structured referral pathway to ensure the seamless safeguarding of the survivor.
3. Survivors are currently invited to sign a confidentiality agreement when they first engage with SWA. The confidentiality agreement includes a clause that the agency may share confidential information with other agencies for the purpose of safeguarding the survivor or to address a perceived risk of serious injury or death.
4. If a survivor for whatever reason requests or is advised/recommended to move to another support agency, they will be assured that during the transitional period they can receive support from SWA until they have been properly allocated a named support worker/IDVA by the new service provider. SWA will ensure that the survivor's records are provided to the new service provider to enable the continued appropriate level of support to the survivor.
5. SWA will offer a meeting with the new service provider within 10 working days of the case being passed over. This would include the caseworkers and managers as necessary. This meeting will be formally documented by both agencies to ensure clarity, transparency and accountability. The survivor would be made fully aware of this meeting and confirm their consent to the information sharing.
6. Where appropriate a three way meeting between both agencies and the survivor, should take place as soon as practicable after the agreed decision for the survivor to move. At this meeting the survivor will be informed that their support has been officially handed over to the other support agency.
7. If a meeting cannot be arranged this will be escalated to management.

17.16. Wiltshire Police

17.16.1. The IMR confirmed that neither Charles nor Theresa had any previous criminal convictions.

17.16.2. Theresa first came to the notice of Wiltshire Police in September 2016 following a third party report from LIFT Psychology that Charles had tried to strangle her. When she was spoken to by a member of staff from the Police Control Room she denied that she had been assaulted, stating it had occurred during consensual sex.[24] A comprehensive violence and aggression Standard Operating Procedure (SOP) warning marker was placed

[24] See Para 16.34. Theresa told the SWA IDVA that she had minimised to the police, what had happened as she was afraid of the repercussions.

on her address to alert officers in the event of any further incidents or concerns. It stated "*Should (Theresa) call 999 – It will have taken a lot for her to do this. She has never reported or disclosed information to Police out of fear of repercussions from (her husband) and is extremely fearful of Police turning up at home address. In recent PPD SG (Safeguarding) contact she stated 'If I call come quick'".*

17.16.3. On [redacted] January 2017, there was a further third party report from [redacted]) Hospital that Theresa had presented at the Accident and Emergency Department with injuries to her arms. Theresa informed staff these had been caused by Charles but she did not want Police Officers to contact her. Despite this a Domestic Abuse Investigation Team (DAIT) safeguarding officer persuaded Theresa to go to [redacted] Police station. Upon attendance, Theresa was upset that the Police were involved and informed them she did not want Charles to find out. A PPD1 was completed, which was a difficult task as Theresa would not co-operate, the risk was assessed as Medium due to the DAIT officer not regarding her at risk of immediate harm. The PPD1 was shared with the multi-agency team at the Swindon Multi-Agency Safeguarding Hub (MASH). The arrest of Charles was considered, however, an entry on the investigation log stated that there was a danger that Theresa would withdraw from outreach support if the Police were involved. Theresa spoke to a DAIT officer again a few days later concerned that officers would go to her house.

17.16.4. On [redacted] January 2017, the mental health team at the hospital reported that Theresa had attended the previous evening having taken an overdose. She disclosed to staff that she was a victim of both physical and mental abuse and that her husband was monitoring her movements. She was fearful that the police would go to her house. A DAIT Officer spoke to Swindon Intensive Service (SIS) to discuss ways to support Theresa. An officer spoke to Theresa on the telephone on the [redacted] January 2017; she refused to engage and would not make a formal complaint against Charles. The officer discussed the case with Swindon Intensive Service (SIS) and Swindon Women's Aid and on 10 May 2017. DAIT officers met Theresa. All options were discussed with her including ending her relationship with Charles and making a complaint. The officers noted that she had a bruise on her arm, but she refused to say how this had occurred. She did however say that her husband was stalking her.

17.16.5. The officers could have arrested Charles for assaulting and stalking her in line with the Wiltshire Police Domestic Abuse Positive Action Policy. A prosecution would however have been extremely difficult without her co-operation. It was noted that the case was discussed at the Swindon MARAC on 2 May 2017.

17.16.6. On the [redacted] June 2017, the Police were informed by a Community Psychiatric Nurse that Theresa had presented at [redacted] on [redacted] May 2017 with bruising to her face. She was taken to [redacted] hospital unit, but discharged herself the following day. Theresa contacted the Police DAIT Safeguarding officer to tell her that she had presented at the hospital and she was frustrated that the police had been informed. She said Charles had found out and that her parents had attended at the hospital. She was seen at [redacted] Police station by a uniform police constable on the [redacted] June 2017, but would not disclose how her injuries had occurred. A PPD1 was completed with Theresa who was reluctant to provide information and the risk was assessed as Medium. An entry on the Investigation log by the same officer stated that Theresa was at high risk from her husband, which was different to the DASH risk assessment. The investigation was allocated to a uniform constable, which was in line with the current policy. From the start of the investigation it was apparent that there was a plan in place to arrest Charles with or without Theresa's co-operation. A DAIT

officer was heavily involved in safeguarding and there were numerous discussions with personnel from partner agencies including SWA, the Community Psychiatric Nurse, Mental Health Control Room Triage and the MARAC Co-coordinator.

17.16.7. A statement was obtained from the Community Psychiatric Nurse on 25 July 2017, which did provide some evidence in relation to Theresa's injuries. The statement was poorly written, but did contain enough information for Charles to be questioned regarding the various injuries that Theresa had sustained. By the time the officer in the case requested CCTV from [redacted] it had been taped over thereby destroying any footage of Theresa, which may have shown her facial bruising. Whilst the investigation was ongoing there followed numerous calls and face to face contact between Theresa and the DAIT Safeguarding Officer, with Theresa begging the police to drop the case. A phone call was also received from a GP on the [redacted] August 2017 asking the Police to drop the matter as it was causing Theresa emotional harm and putting her in danger.

17.16.8. The IMR Author felt there was a missed opportunity to arrest Charles on the 1 September 2017 when Theresa and Charles presented at [redacted] Police Station. Theresa informed the Duty Inspector that she believed that her husband was to be arrested. The Officer dealing with the case was not on duty and the Duty Inspector, having listened to Theresa, turned them away, having asserted that the case needed further consideration. He also felt that to arrest Charles without Theresa's cooperation would probably not result in a charge and could put her at an increased risk.

17.16.9. The IMR Author was of the opinion that this was shortsighted as there was a statement on file from the Community Psychiatric Nurse, which did contain some evidence of Theresa's previous injuries. Charles also expected to be arrested, so obviously knew that the police were involved. If Charles had been arrested there would have been an opportunity to persuade Theresa to accept alternative accommodation and offer her continuing multi-agency support. Had Charles not been charged it still would have presented an opportunity for the Police to apply for a Domestic Violence Protection Notice.

17.16.10. The IMR Author commented that the investigation did appear to drift from the original report on the [redacted] June 2017 to the [redacted] September 2017 when a decision was made not to arrest Charles and to close the case. This decision was ratified by a Sergeant.

17.16.11. An entry on the Officer's Enquiry Log (OEL) on 30 August by the DAIT civilian Safeguarding Officer states "I have spoken to (Theresa) this morning; she is an emotional wreck at having had this hanging over her for a prolonged period of time". The decision to close the case was not taken lightly and followed the Officer in the Case taking advice from DAIT supervisors. The detrimental effect to Theresa's mental health was the primary reason for this decision. With hindsight, it may have been preferable to allocate the investigation to a DAIT investigator from the outset. This was not done, as the DAIT generally only investigate high risk cases, but given the history surrounding Theresa this may have proven to be beneficial, as the investigation would have been progressed more swiftly, although the outcome may have been the same. Theresa did however receive considerable support from the DAIT civilian Safeguarding Officer.

17.16.12. The IMR Author thought it was questionable whether the original DASH risk assessment was correctly classed as Medium when the reports implied that she was in fact at High risk from her husband.

17.16.13. On the [redacted] June 2017, Police were again contacted by the Community Psychiatric Nurse who reported that Theresa had told her she had been threatened by Charles.

Theresa had informed the nurse that Charles had moved out of the house, however, he had warned Theresa that he could still find her and not to apply for a protection order against him. The Control Room Inspector appraised himself of the previous history and spoke to the Mental Health Team. They confirmed that Theresa did not want the Police involved. The Inspector noted that Theresa was being supported by several agencies and a decision was made by the police not to contact Theresa. The IMR Author felt a PPD1 could have been completed at that time.

17.16.14. On the [redacted] September 2017, following a call from Swindon Women's Aid, the police Safe Guarding Officer made a "Grade One" call and officers immediately attended at Theresa's home where she was found in the garage attempting to hang herself with a rope. Her parents attended to look after her and the Control Room Triage spoke to the mental health team who arranged to see her the next day. The DHR Panel noted that the prompt actions of the civilian Safeguarding Officer who responded to the information from the SWA IDVA in calling 999 for a Grade 1 immediate deployment to Theresa's address, together with the actions of the officers attending, probably saved her life at that time. It is clear from the IOPC Reports that the two officers who attended dealt with the immediate task of cutting Theresa down efficiently" and professionally considered all of the options available to support Theresa. There is however, no record of the "suicide note" addressed to her brother being found at that time. (See Appendix C).

17.16.15. There was further Police contact with Theresa on [redacted] November 2017 when she was found on a motorway over-bridge. Although she would not disclose what the problem was, the attending officers appraised themselves of the previous history. Theresa was very concerned that the Police would act on any information that she disclosed. Police contacted local women's refuges as Theresa indicated she would go somewhere if there was room available. Unfortunately, there was "*no refuge accommodation available"*. Theresa spoke to the Mental Health Control Room Triage and agreed to contact her GP in the morning; the MHCRT told her they would also contact her in the morning. Officers invited Theresa to attend the police station and remain there whilst accommodation was found through Swindon Emergency Housing. This offer was declined and at her request, she was taken home. Had alternative, safe, accommodation been provided, Theresa may well have made a formal complaint. A PPD1 was completed as High Risk, however, the reviewing DAIT Sergeant wrongly assessed that the incident was not related to Domestic Abuse. Had she read the full history and the narrative on the PPD1 she could not have arrived at this decision.

17.16.16. On [redacted] November 2017, (the day prior to her death) Theresa attended at [redacted]Police Station to speak to the DAIT civilian Safeguarding Officer but left before she could be seen. In addition to informing the Station Front Office staff, she informed the officer by text that she had not stayed because of an appointment with her GP. Due to other commitments, that day the Officer did not reply to the message. The Officer did recall that later that day she received a telephone call from Theresa's GP. The conversation was not recorded anywhere and the Officer is unable to recall the exact words spoken.

17.16.17. The Police "Storm Log" shows that at 12.58pm on [redacted] November 2017 Theresa made a 101 call to the Police Control Room and said that she was having suicidal thoughts. She said she had contacted NHS111 and that she had written a suicide note, had a rope in her garage, and did not want her family to find her. She asked for an officer. to be sent to her home. The Control Room Call Handler said that she would get her help from the in-house Street Triage Team, Theresa responded that it was too late, but then agreed to speak to them. At 1.01pm, the Call Handler told Theresa they would phone her

within the next minute. Theresa replied, "*Okay, if they don't hear from me just send someone round okay thank you*." The Storm log shows that at 1.02pm the Street Triage Team tried to call her but the call went to voicemail. They continued to try to call her and at 1.04pm it was recorded on the log by the call handler "*If they get no response log may need to be MTI'D (upgraded) for unit to attend.*" It was not until 1.14pm that this was done and a unit was deployed.

17.16.18. Officers arrived at Theresa's home at 1.23pm and found her hanging in the garage. She was pronounced deceased at the scene by paramedics. One of the uniform officers then used Theresa's key to check her house to ensure no one else was present.

17.16.19. CID officers, including a supervisor attended the scene and found a "suicide" note, some pills and alcohol. They deemed that Theresa's death was not suspicious and found that there was no evidence of third party involvement. A normal post mortem was later conducted which concluded that death was consistent with hanging and that the marks on the neck were consistent with the ligature found and removed from Theresa.

17.16.20. The IMR Author highlighted the delay from the time Theresa's call was received to the time it took to up-grade it to an immediate response i.e. Sixteen minutes. He is of the opinion that this was too long as she had clearly stated her intention to take her own life by hanging and should have been treated immediately as a vulnerable person. He believes that this was due to a failure to correctly implement Force Policy and Procedure rather than because of any error in the policy itself.

17.18.21. This has been a subject of scrutiny from the IOPC, whose Investigator having considered the statement of the Call Handler and the comments of the Control Room Inspector (see below) was satisfied that the Call Handler's response was in accordance with existing national and force policies, which is set out in Paragraph 17.18. of this report. He quoted:

*The call handler in her response in relation to Theresa's telephone not being answered, stated, "**This then became a concern as it appeared (Theresa) no longer wanted to engage via the phone. Due to this I was about to upgrade the storm log to an immediate response and notify the FIM, (Force Incident Manager) just at the same time the FIM requested the log to be upgraded. I upgraded the log straight away and sent it to dispatch.**"*

*In her statement to the IOPC, the Control Room Inspector commented upon call handlers dealing with people in mental health crisis, "**Call handlers speak to the Street Triage team all of the time and this ensures that people in mental health crisis get the appropriate help they need."***

When commented upon the call handlers actions, she stated:

"The named call handler) did everything right and followed procedure. (Theresa) had agreed to speak to the Street Triage Team, so no officers were deployed at that point. This was the most appropriate action based upon the information at that time and how we would normally deal with this type of call."

17.16.22. The DHR Panel noted that the Call Handler said in her response (above) that when Theresa did not answer the call from the Street Triage Team (1.02pm) she became concerned that Theresa no longer wished to engage. The Call Handler was about to up-

grade the call herself when the Inspector requested the upgrading of the log. **Officers were not deployed until ten minutes later at 1.14pm.**

17.16.23. T**he Panel whilst acknowledging the conclusions of the IOPC remains of the opinion that this was an undue delay. The Panel also questions the view of the Control Room Inspector that directing a person, who had set up a rope and stated she was about to take her own life, to speak to the Street Triage Team without also deploying an immediate officer response was the most appropriate action. Plainly, it was not, as by the time officers were deployed, Theresa had taken her own life. By contrast, on ■ September 2017 when there was an immediate deployment, officers arrived in time to save Theresa's life.**

17.16.24. The IMR Author also noted that the Control Room log contained comprehensive entries in relation to the SOP marker on the address and the history regarding Theresa being the reported victim of domestic abuse at the hands of her husband. The Control Room call handler did not consider this relevant, as the call did not relate to domestic abuse. It is not clear whether the attending officers were informed of this or had appraised themselves of this information, which was readily available. It is noted however that one of the uniform officers, after Theresa was pronounced dead by a Paramedic, did use Theresa's keys to enter and check her house to ensure there was no one else on the premises. (The CID Supervisor who attended later confirmed he was aware of the SOP and "Niche" warning markers but as Theresa's husband was out of the country did not consider them relevant.)

17.16.25. The IMR Author was of the opinion that although CID officers attended, the investigation at the scene of Theresa's death was minimal and was a missed opportunity to gather evidence as it was treated as an uncontentious suicide rather than as a sudden or suspicious death. A search of the property may have revealed the presence of weapons and/or documentation, which may have supported or negated her assertions of domestic abuse. Furthermore, a forensic post mortem, if held, may have revealed more information regarding injuries that Theresa had previously sustained. The police investigation that commenced in May 2018, found no evidence to indicate that a crime had been committed.

17.16.26. It was acknowledged that whilst police officers attended the three MARACs that considered Theresa's situation, the full detail of the abuse and violence that she had reported to other agencies and their contemporaneous observations, was not known to the Police until those participating agencies compiled their chronologies and IMRs for this review.

17.16.27. The Review Panel is satisfied that the IMR Author has identified the key lessons to be learnt and that the recommendations he has made, should when implemented effectively address them. It thanks the IMR Author for his thorough and open report.

17.17. Pathologist's Report

17.17.1. A full forensic post-mortem was neither sought nor carried out.

17.17.2. The Pathologist summarised that the post-mortem examination, which was conducted, identified the direct cause of death as compression to the neck structures by a ligature.

17.17.3. The Report details that "on removal of (Theresa's) clothes there were a number of external bruises, which included patchy bruising over the left lower abdomen and extending over the bony prominence over the left anterior/superior iliac spine. This appeared to

be an old bruise as it was yellowing. Further bruises, which appeared to be more than a few days old, were seen on the lateral aspects of the upper arms on the left 12 x 9 cm and on the right 10 x 13 cm. Further small bruises up to 1 cm in diameter were seen on the inner aspects of the forearms. There was bruising over the left side of the forehead and extending around the upper cheek on the left side and measuring 5 x 9 cm and was associated with some bruising when the skull cap was reflected."

17.17.4. The Pathologist noted that Theresa "had been treated for depression and was known to be a problem drinker and with visits to alcoholics anonymous".

17.17.5. The toxicology has shown that Theresa had consumed alcohol prior to death but the level would likely have only caused "mild" drunkenness. It was also noted that Theresa was recently withdrawing from Sertraline, which is associated with increased suicide risk. The endometrial appearances suggested secretory and possible premenstrual phase, which may have increased suicide risk.

17.18. Independent Office for Police Conduct (IOPC)

17.18.1. The IOPC notified the DHR that Wiltshire Police, as required by law when Police have had involvement in a death or serious injury (DSI), made a referral to the IOPC. Subsequently Theresa's family also made four specific complaints against Wiltshire Police officers/staff, regarding safeguarding aspects of the response to Theresa's 101 call prior to taking her own life and during three previous interactions.

17.18.2. The IOPC terms of reference were to investigate the relevant contacts between Wiltshire police officers and staff and (Teresa) specifically -

a) To identify and examine the actions and decisions of police officers and staff in their interactions with (Theresa)

b) The considerations around safeguarding (Theresa) during each of the incident.

c) To examine whether police actions complied with force and national policies, procedures and guidelines.

17.18.3. The investigation considered whether the officers and staff complied with the applicable guidance and legislation, and whether the existing policies (Summarised below) were sufficient in the circumstances.

17.18.4. **College of Police Code of Ethics**
6.1 According to this standard you must:
• carry out your duties and obligations to the best of your ability
• take full responsibility for, and be prepared to explain and justify, your actions and decisions
• use all information, training, equipment and management support you are provided with to keep yourself up to date on your role and responsibilities.

17.18.5. **Section 136 Mental Health Act 1983**
If a person appears to a constable to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons -

- Remove the person to a place of safety within the meaning of section 135, or

- If the person is already at a place of safety within the meaning of that section, keep the person at that place or remove the person to another place of safety.
  (1A) The power of a constable under subsection (1) may be exercised where the mentally disordered person is at any place, other than— (a) Any house, flat or room where that person, or any other person, is living, or (b) Any yard, garden, garage or outhouse that is used in connection with the house, flat or room, other than one that is also used in connection with one or more other houses, flats or rooms.

17.18.6. **Wiltshire Police Policy and Procedure – Grading and Deployment**

1.1 - Crime and Communications Centre staff will determine the incident grading based on their knowledge, experience and application of the professional discretion framework and consideration of Force values and the Code of Ethics

4.0 – When Command and Control should deploy a resource. “To save life and/or prevent serious injury.”

5.1 - Emergency Contact – “Danger to life”

17.18.7. **Wiltshire Police Vulnerability Strategy**

Key Principle 3.2

“It is crucial that in all encounters with the police, people who are vulnerable should be treated as ‘vulnerability first’. All officers must have regard to their safety, welfare and well-being.”

Key Principle 3.4

“In all situations where vulnerable people come to the attention of police a full understanding of the circumstances should be sought.”

7.18.8. **Wiltshire Police Policy and Procedure - Domestic Abuse 3.10 Medium Assessment of Risk - Definition**

3.10 Medium Assessment of risk - definition
3.11 High Assessment of risk - Definition

17.18.9. **THRIVE + Professional Discretion Framework**

Threat – Harm – Risk – Investigation – Vulnerability – Engagement +

Prevention and Intervention

17.18.10. **National Decision Model**

- Gather information and intelligence.

- Assess threat and risk and develop a working strategy.

- Consider powers and policy.

- Identify options and contingencies.

- Take action and review what happened.

17.18.11. The IOPC Independent Investigation report and Decision Maker's Opinion Template have been provided to the DHR. The Lead Investigator has considered statements from the Wiltshire Police officers and staff together with entries on log records and telephone records and was satisfied that the officers and staff considered their legislative powers and policy responsibilities properly in each of the incidents, which were the subject of complaint. Consequently, none of the complaints were upheld.

17.18.12. The Lead Investigator and Decision Maker have concluded that it is clear from the evidence available that on [redacted] November 2017; (*Theresa*) had made the decision to take her own life and called Wiltshire Police to inform them and ask that they discovered her body rather than being found by her family. (*The Call Handler)* sought to engage the Street Triage Team with (*Theresa*) to which she agreed. However, despite several telephone calls from them, (*Theresa*) did not answer the telephone. Therefore there is no evidence to suggest that WP (Wiltshire Police) caused or contributed to (*Theresa's*) death. This is in contrast to the opinion of the DHR Panel (set out in para 17.16.22. above) that the delay in grading the response to Theresa's call may have contribute to her death at that time.

17.18.13. The Panel thanks the IOPC Lead Investigator for his help and for providing the DHR with the IOPC Reports.

17.19. Wiltshire Police Criminal Investigation

17.19.1. After agencies' information became known to the review and to the Coroner, Wiltshire Police initiated a crime investigation in May 2018.

17.19.2. The investigating officer faced the difficulties of not having the opportunity of questioning Theresa directly or having the results of a forensic post mortem or any evidence from the scene of Theresa's death, nevertheless he carried out a detailed investigation.

17.19.3. Theresa's mobile phone, which the police had to have unlocked by an outside organisation as the PIN could not be ascertained, revealed a vast amount of data, including numerous photographs and short videos. The investigating officer stated the common theme was "*selfie poses*" taken by Theresa showing her kiss Charles on the cheek or lips. All the clips showed them as a happy couple who appeared comfortable in each other's company. There were only three photographs of injuries to Theresa. (These photographs together with several other self taken photographs showing extensive bruises to Theresa's arms, neck, shoulder, body, eyes and swelling to the left side of her face have been viewed by the DHR Panel. The additional photographs, which were given to the Police by Theresa's cousin in South Africa, were not found on the mobile phone unlocked and examined by the police.)

17.19.4. Charles telephone was also examined. The investigating officer stated that conversations were found to be loving and not threatening or controlling. Neither were they

found to be too frequent to suggest harassment. There was nothing in the data to cause alarm or suspicion in relation to any offences.

17.19.5. The DHR has now had the opportunity to read text messages from both Charles and Theresa's mobile phones

In one from Theresa to Charles on 15 June 2017 while she is at hospital, she asks him to bring to the hospital "*her elbow guard thing in case her mom comes to visit so I can cover this bruise. thanks baby*",

In another set of texts on [redacted] July 2017; Charles texts "*Hey my Angel I have just got back to my room. How did your self defence go. Did you manage to get out any of your frustration*"

She replied "*Hey baby it went well thanks. I am just jumping into the shower will phone you when I'm out. We were doing take down moves . As luck would have it took an elbow in the face bit(sic) it wasn't too hard.*"

17.19.6. Charles was interviewed under caution on Monday [redacted] January 2019. He attended the Police Station under invite accompanied by his solicitor. He was interviewed in relation to the offences of manslaughter, rape, assault and controlling and coercive behaviour. Twenty-four separate offences. These alleged offences were disclosed by Theresa to her GP, Mental Health services and [redacted] Hospital and were compiled during the police investigation. During the interview, process Charles gave two prepared statements denying all of the offences put to him. He was advised by his solicitor to reply "no comment" to all questions asked and he adhered to this throughout the interview.

17.19.7. Charles commented in his statement that their love life was fine although Theresa did start to get to a stage where she wanted him to get rough with her during sex. He stated he was never comfortable with that.[25] One time she hit him on the ear during sex, it was painful but he would never fight back and the most he did was hold her arms down so she could not hit him. Another time he remembered that she wanted him to put a collar with a buckle on her around her neck, which he did but did not recall it left a mark on her neck.

17.19.8. Doctor [redacted] LLM MSc(Med Ed) MB, BS, FFFLM, FACBS, FHEA , FACLM ,FRCP, FFCFM(RCPA), DGM ,DMJ (Clin) DAB (Dist), a forensic physician, who has extensive experience in the study and examination of injuries, was given access to witness statements, case notes and Theresa's medical records in order to come to her conclusions.

17.19.9. Doctor [redacted] was aware that Theresa had a history of mental illness, anxiety, depression, post-traumatic stress disorder, alcohol misuse, and several episodes of self-harm (by overdose and previous attempted hanging). That she had taken propranolol for anxiety, she had seen a counsellor, and had also received treatment with antidepressants. She also noted that at no time did the healthcare professionals assessing Theresa come to the conclusion that she lacked capacity. There was never any evidence of psychosis or delusional illness.

!7.19.10. **The Doctor concluded that whilst some of the injuries could be explained by falls onto a hard surface, in her opinion the injuries were typical of repeated**

[25] See para 17.19.12. Diary entry dated Thursday [redacted] June (2016) which appears to rebut this statement.

blunt trauma, such as punches with a fist, or another hard object, and/or repeated kicks. She believed it was highly unlikely that these repeated blunt trauma injuries resulting in bruising and swelling would have been self-inflicted. It was also highly unlikely that the injuries to the abdomen would have been caused by accidental trauma.

17.19.11. Theresa's hand written diaries/journals were discovered by family members after her death amongst her personal possessions. The investigating officer stated, "They *document her obsession with her physical health and recorded her physical symptoms on a daily basis between 2015 -2017. They also document her falls and faints during exercise and in some cases after sex."*

The Avon and Wiltshire Mental Health NHS Partnership Panel Member has clarified that Theresa diary/journal entries relating to her health would have been requested during her treatment programmes:

"Theresa accessed LIFT Psychology Interventions over a 14 month period between March 2016 and May 2017. During this time, she accessed 1:1 interventions and also Mindfulness groups. The purpose of these interventions were to offer skills development to help people manage their intrusive thoughts, feelings and images. A component of all these interventions would be keeping diaries of mood, physical sensations, experiences and thoughts to enable the person to become more aware of their internal experiences and reactions to external triggers as they happen and so gain greater control of their emotions.

Following May 2017 Theresa was regularly under the care of the Swindon Intensive Team and again mood diaries are a very common intervention that the team encourage for someone presenting in the way Theresa did."

17.19.12. The police exhibited the following entries:

- **April 2017** – Theresa is asking questions about her mental health and the treatment she either has received or wants to receive from the mental health services. Sample questions from this document include:

'Do I have the right to access talking therapy (if) I had issues of stress/anxiety from work I'd be able to refer myself. Would I be asked to leave my job? I came to LIFT to discuss suicidal thoughts not issues at home. I've asked numerous times for help with thoughts. Has anybody tried to put themselves in my shoes for a second. I'm doing what I can to survive day to day. I feel like I'm being silenced/left out in the cold because they don't like what I have to say. Is LIFT happy to close the door on me when I have these growing suicidal thoughts?'

'I feel angry, down, anxious, hopeless, all at the same time and I have no idea how to deal with this. My mind goes back to all the bad things and I know my life is great & are so blessed but I can't seem to get out of this funk. I feel so lonely & isolated and have no motivation to expand my circle. Some days I feel there is no point and others think about what would happen if I die & sometimes wonder if it would be better if I did. Turning to alcohol, I feel once I start I struggle to stop then after I take prescription meds. Makes me feel horrible. I feel my husband has no time for me and when he is home he focuses on other things and I'm not a priority. Where did our relationship go so wrong. He never shares his feelings so I walk on eggshells.'

- [redacted]**/16** – *'I feel (Charles) and I are drifting and that's not good. We need to work on it. But it's both our faults.'*

- [redacted]**/16** – *'**So the line keeps moving. What I mean by that was what I thought to be crossing the line has changed over the last 2 years quite considerably. This has almost become the new norm. It started slowly over the years without me even knowing it. Then progressed into more serious things. The way he spoke to me, started getting more condescending. I will never forget the day it all over-flowed and he blew up. Since then my life has never been the same. The second stand out moment was one night during sex I felt his hands around my neck. Something in him was unleashed that night. Progressively sex got rougher and the more I fight back the more he enjoys it. It's like there was this side of him hidden all these years.'***

'*This morning I woke up feeling anxious & thinking about it. Can't stop thinking about – when I do I feel tight in the chest, short of breath, nauseous, light headed. Just terrible physical symptoms. I can't understand how one event can change me so much and terrify me so long after it happened. I often wonder how it could have turned out, what if it was me instead of Carla's neighbour. Why her & not me, could have easily been me. I feel terrible about feeling this way, almost embarrassed as there are people who go through worse things every day.'*

- **In another diary** - Theresa writes about her panic about the events in South Africa that happened ten years before. She struggles to control her emotions, anxiety and impulses. Sheets in to writing her thoughts about suicide and the method she would use. She states that she bought another rope from B&Q in order to end her life by hanging. All the entries are in relation to PTSD and not domestic abuse.

17.19.13. Theresa's mother has asked that the following journal entry is highlighted alongside the above entry dated 23/06/2016, which has been exhibited by the Investigating Officer.

Undated: "***It starts like any other day, the usual morning pleasantries but deep down something doesn't feel right. It can be so subtle but it starts in the body, so tight chest, light headed or just an empty pit in your stomach. To walk round on edge, to constantly question everything you do. To be scared to do the wrong thing. These are just a few things you might feel when living with trauma. Reported trauma picks away at you each day. Each day a little more of you dies. Have you ever been so scared of a person it chills you right to the core. At the same time, you don't have it in you to break the cycle and have the strength to leave. You have become so conditioned that you believe you can't survive outside of the relationship. The cycle begins the same time and time again. The atmosphere in the house changes immediately. There's the outbursts of frustration while during everyday tasks. The tension builds. You feel more and more on edge anticipating something BIG. What are the options? Do you reach out for help? Do you take a drink to try calm yourself or more importantly numb the body and mind. Or do you provoke an attack to get it over before. Well if like me you have tried all of those options you will also be aware how all of those options have their own set of risks. Let's break them down, ok so let's start with the substances to help numb the pain and get you ready for what's about to happen. So you take that first drink but that's not where it stops. One becomes many. You slowly start to care less and less, you think about what you've been through and feel there is no way you can beat this or survive it. Drinking then leads to prescription drugs and before you know it you decide the time has come to***

get this over with. So you know exactly what buttons to push in order to set him off so the tension will disappear. Once it's over there are many feelings mainly; shame, regret, emptiness, pain, fear among others."

17.19.14. Theresa's friends were traced and contacted initially by the Police and later by the DHR.

17.19.15. Friend A had been a lifelong friend of Theresa and remained in regular contact. They would speak for hours on the telephone after Theresa went to the UK from South Africa. She recalled that at school Theresa would spend a lot of time with Charles. She found their relationship strange as Charles was quiet and withdrawn whereas Theresa was the opposite. For the last three years of Theresa's life her physical and mental health declined, messaging about numerous doctors' appointments she had to attend and various diagnoses they had given her. Theresa's mental health appeared to decline massively, in the last year of her life she would message advising that she had taken over-doses and had told mental health professionals that she had wanted to take her life. Theresa appeared to be very unhappy in herself, she would say things such as 'I *don't want to be here anymore*' frequently. Theresa sent photos of bruising she had sustained; these would consist of bruising to her face and body that was very extensive. She would always say that these injuries were due to being so intoxicated she had fallen down the stairs or that she had passed out due to her poor physical health and had awoken with the bruises on her. Theresa's friend B never had reason to question that she was lying about how the injuries were sustained and believed her explanations for the injuries. This friend told the review that Theresa had told hover a period of about three years that she felt very low and often had thoughts of taking her own life. She spoke of this increasingly and a few months prior to Theresa's death she had told her friend that she thought hanging would be the best way. This friend also stated that Theresa had told her about the asphyxia during sex with Charles. She believed that Theresa who had always been the dominant partner had initiated this.

17.19.16. Friend B had known Theresa for 11 years. She described Theresa as a lovely upbeat person but hiding stuff behind a smile. She thought that Theresa was lonely when Charles was working away. She had seen physical injuries on Theresa, notably on her face and her abdomen. Initially Theresa told her that the eye injury had been caused by her falling down the stairs. Yet she also told her that Women's Aid would not help her unless she told them Charles was responsible for the injuries. After time, Theresa told her that Charles had caused the injuries and that she was in a very abusive relationship. Friend A chose to believe her and offered her a room but she declined and said it was ok. The friend stated, she had met Charles on occasions, and was surprised because he seemed a nice person, he was besotted by her. Theresa had shown her photos of the injuries to her eye and body that were on her phone. She said that it was easier to let Charles get on with it so that the assaults would be over quicker. Theresa added that Charles would get angry when she drank but she drank to mask the pain. The friend told the police that she did not believe that the injuries could have been self-inflicted.

17.19.17. Friend C, a neighbour, was aware that Theresa had come to England after witnessing a shooting in South Africa. She described the relationship between Theresa and Charles as being very close physically. She saw a change in Theresa in the last year of her life during get togethers. Theresa would make excuses for not going and would cancel social events. Theresa told her that she thought she had PTSD that she was not sleeping and was having nightmares. The Friend said she never saw any injuries on Theresa.

17.19.18. Theresa's other neighbours claimed that Theresa and Charles kept themselves to themselves and they never heard or saw anything to be concerned about.

17.19.19. [redacted] a Private Counsellor told the Police that she was contacted by Theresa in May 2017 after she had experienced a break in at the home and therapy had been recommended to her. She had experienced unresolved trauma of flashbacks and nightmares. At the beginning of June, she disclosed that she was experiencing symptoms of PTSD from the burglaries and the experiences in South Africa. Sarah House was aware of symptoms including Hyper Vigilance, emotional overwhelm, insomnia, nightmares, flashbacks, loss of interest, sense of hopelessness, loss of a sense of who she was, misuse of alcohol, self-destructive behaviour and suicidal ideation. From May – Nov 2017 there were a total of 20 sessions during which Theresa never disclosed any domestic abuse.[26]

17.19.20. The Investigating Officer ascertained that Charles flight data showed he was abroad on three occasions when Theresa had told her GP she had been assaulted by him. (The review has noted that on one of those occasions Theresa gave the GP a date she claimed Charles had assaulted her prior to going to the airport, which was one day after he had in fact gone abroad. She did however tell the Swindon Women's Aid IDVA that he had assaulted her before going abroad saying it was a Tuesday or Wednesday. He had travelled on the Tuesday.)

17.19.21. The Investigating Officer highlighted in his report that Theresa had never disclosed any offence caused by Charles to the police. She denied that there was any domestic violence when the police enquired. She had also provided conflicting information about how her injuries were caused to both professionals and friends. The Officer pointed out that Charles has no previous convictions in either South Africa or the UK. He is a man of good character and a successful businessman who provided finances for Theresa's family in South Africa. The Officer speculated that Theresa "denied the assaults to police because she knew Charles (sic) did not commit them and genuinely didn't want him to get into trouble for something he didn't commit". The Officer concluded that Theresa "was extremely mentally unwell. She was searching for answers to both her physical and mental health. She was scared because she wasn't in control. I suspect that her thought processes were impaired by the abuse of alcohol and prescription drugs and lack of sleep."

17.19.22. On [redacted] March 2019, the review was notified by the Senior Investigating Officer that the police investigation has reached a stage at which he was satisfied, had exhausted reasonable enquiries. Having reviewed the case, he had made the decision that there was insufficient evidence to demonstrate that a crime was committed.

Section 18 – Conclusions

18.1. The Domestic Homicide Review is not an inquiry into how Theresa died or into who is culpable; that is a matter for the Coroner. The review has focused on identifying lessons learnt from agencies' past actions or inactions and setting service responses to address them. To put the actions and inactions of the participating agencies into context, the review has considered issues, which were key to Theresa's decision making. These include

[26] During Theresa's mother's telephone conversation with Theresa on the day she died; Theresa told her she had seen [redacted] the previous day. Theresa's mother later asked [redacted] about this meeting but [redacted] stated that although it was in Theresa's appointments, it had been cancelled as she was away.

Theresa's mental health, self-harming, alcohol use, physical injuries, reported controlling behaviour, why Theresa was reluctant to leave home and why she refused to report matters to the police.

18.2**. Mental Health**:

18.2.1. Theresa's mother believes the shooting Theresa witnessed in South Africa in 2006 was a turning point for her. In her witness statement to the police, she stated, *"This traumatic event certainly changed (Theresa). In the short to medium term, she was too scared to go out in public places at night. This was exacerbated by other crimes reported in the news and the growing crime rate in South Africa. (Theresa) initially had terrible dreams and feared that the criminals had seen her car license plate and would be able to find her. When she started going out again, she would drink a lot as a means of coping with her thoughts and fears. This period ended with (Theresa) taking an overdose of prescription medication where she had to be taken to the hospital to have her stomach pumped."*

18.2.2. Theresa's mother has told the review that after Theresa arrived in the UK she appeared happy and healthy and it was not until after September 2015 that she started to seek medical help for her anxieties and stress. Her GP treated her with medication and referred her to mental health services.

18.2.3. Avon and Wiltshire Mental Health Partnership (AWP) which provides mental health services in Swindon, found evidence of symptoms of PTSD related to Theresa's experiences in South Africa. However after Theresa disclosed that she had been subjected to domestic abuse and had considered self harming, it was decided that the psychological interventions indicated for PTSD would not be suitable as they are contraindicated with high risk to self-harm or suicidal behaviour. She was prescribed antidepressants but the AWP Psychiatrist was of the opinion that where a person is living in an abusive relationship it is very understandable for them to be exhibiting signs of depression and anxieties. Such symptoms cannot be "medicalised" as it is the situation that needs to change.

18.2.4. The Review Chair drew the Panel's attention to independent research that indicates that intimate partner violence is a common health care issue.[27] The Crime Survey for England and Wales (2017) highlights that women with a long-term illness or disability were more likely to be victims of recent domestic abuse (within the last year) than those without one; to a ratio of 15.9% compared with 5.9%.)

18.2.5. Research was also highlighted that indicates that experiencing domestic violence and abuse is associated with mental health problems including anxiety and depression.

- 40% of high-risk victims report having mental health issues.[28]
- 16% of victims report that they have considered or attempted suicide as a result of the abuse, and 13% report self-harming.[29]

[27] Health consequences of intimate partner violence (Prof. J. C. Campbell published in Lancet 13 April 2002

[28] SafeLives (2015), Getting it right first time: policy report. Bristol: SafeLives)

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

- Domestic abuse has significant psychological consequences for victims, including anxiety, depression, suicidal behaviour, low self-esteem, inability to trust others, flashbacks, sleep disturbances and emotional detachment. [30]

- Domestic abuse victims are at risk of post-traumatic stress disorder (PTSD), as many as two-thirds of victims of abuse (64%) developed PTSD in one study.[31]

18.2.6. It was highlighted in one research document that "these (mental health) issues can make the abusive situation even worse, as the partner or ex-partner may make use of a mental health diagnosis (for example, telling someone that they are 'mad')". (In Theresa's case, she believed that Charles had changed her family's opinion to be against her and as such, she would never be believed. She told the SWA IDVA that Charles had isolated her from her family and that they thought that she was a "lunatic". See paras 16.36, 16.51, 16.20 and 16.143.) In the same research, it was stated: "It can also be difficult for professionals to see beyond the mental health issues and to recognise that an abusive relationship may be at the heart of the problems".[32] There is evidence of this occurring in this case on at least one occasion.

18.2.7. None of the mental health problems Theresa experienced indicated to the mental health professionals that an admission to hospital would have been an appropriate pathway for her. Firstly, the psychological work for PTSD would not normally be delivered within an inpatient setting and again would have been contraindicated with Theresa's self-harming behaviour. Additionally as Theresa was at that time, accepting mental health interventions and engaged with the Intensive Team, detention under the Mental Health Act would not have been appropriate. On two separate occasions, when Theresa had tried to take her own life, Police Officers considered detaining her under the Mental Health Act, but concluded they did not have the power to do so as she had mental capacity within the meaning of the Act and on one of those occasions; she was at her home address.

18.2.8. The Review Panel acknowledged that Theresa was deemed to have mental capacity at the time but questioned if her increasing suicidal ideation could have been considered to be temporarily adversely affecting her mental capacity. Following professional advice, the Panel accepted that this was a professional judgement and in any case may not have been sufficient to detain her in hospital for any significant time against her will.

18.2.9. The involvement of mental health services in Theresa's case was that of providing support to her when she reached out to services asking for help. This involved providing a space for her to discuss her experiences and consider her options, as well as working with her to manage her risks to herself. As the mental health nurse gained her trust, Theresa opened up about domestic abuse and was reassured that her reactions, both, to what she had witnessed in South Africa and to the domestic abuse she described, were normal and to be expected. However when the nurse notified the police of the abuse Theresa spoken to her about, that trust was broken and Theresa never regained her confidence in the service.

30 CTC (2014), Website of the US Centres for Disease Control and Prevention, National Centre for Injury Prevention and Control, Division of Violence Prevention

31 Golding, J. (1999), Intimate partner violence as a risk factor for mental disorders: a meta-analysis in 'Journal of Family Violence', 14 (2), 99-132.

32 http://www.healthtalk.org/peoples-experiences/domestic-violence-abuse/womens-experiences-domestic-violence-and-abuse/impact-domestic-violence-and-abuse-womens-mental-health#ixzz5GbWdgJtL

18.2.10. Significant lessons have been learnt regarding the mental health care Theresa received and these lessons, together with Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) action plan to address them, have been agreed by the DHR Panel.

18.3. **Self-Harming**

18.3.1. Theresa first presented to her GP with anxieties and panic attacks in September 2015 when Charles was working abroad and her mother-in-law was staying with her. Over the following five months, she presented twenty-five times with anxieties and fainting episodes. Initially these were attributed to her mother-in-law's visit and to PTSD relating to the South African shooting incident she had witnessed.

18.3.2. Over the following three months, Theresa regularly saw her GP and when asked, denied having any thoughts to self-harm. The first time she acknowledged having low moods and thoughts of self-harm was on 6 June 2016 when she told the GP, she felt that life was not worth living. She said she had thought about taking an overdose of medication, but said she had no specific plans to do so. She admitted that in the past, she had taken an overdose of her mother's Thyroxine, Paracetamol and Cocodamol tablets. Although she was tearful, on examination, she had good eye contact and rapport. After this initial admission of suicidal thoughts, there were several similar admissions to her GP over the following weeks and she was referred to Mental Health Services.

18.3.3. On [redacted] September 2016, Theresa told the LIFT Psychology nurse that she was not happy in her relationship with her husband. She denied that he had any involvement in her repeated injuries and also denied that she had been harming herself.

18.3.4. Theresa continued to admit to her GP and the SWA IDVA that she was occasionally having thoughts of self-harming. On [redacted] November 2016, Theresa told the SWA IDVA that she did not have much left in her to cope and the risk of self-harm was discussed. On a scale of 1-10 Theresa has reached 9 the previous week (she had got close to the railtrack at a train station and Charles had pulled her back). She said she currently scored herself as 6/7 and said she did not have any plans to harm herself. (Para 16.71.) She later told the IDVA that she had accessed support from the Samaritans, which stopped her taking tablets that she had lined up. She added that she even called her father. He came to visit her with her mother and Theresa told them that she was struggling with feeling low. Her father acknowledged that Theresa spent a lot of time on her own and invited her to stay with them when Charles was working away.

18.3.5. Increasingly during 2017, Theresa told her GP and IDVA that she had thoughts of self-harming and she made several attempts to do so: by taking an overdose of tablets; by walking towards an oncoming train; being found in a disheveled state on a motorway bridge and attempting to hang herself (before later succeeding in doing so). She told those professionals she confided in, that the reasons for her unhappiness with life was because she felt trapped in her marriage and could see no way out, other that by either her husband killing her or her taking her own life. (Paras 16.153, 16.158, 16.169) In February 2017, while worried about what action the police might take after they had received the report about her injuries, she made a plea for help, in a text message to the SWA IDVA stating: *"Please I need to know where to go from here as I feel without the right help when it comes to my mental health this is going to end badly.*" (Para.16.93) yet, in a very moving note addressed to her brother, Theresa that wrote she was in a "dark place" and blamed no one.

18.3.6. Theresa's closest friend told the review that Theresa had confided in her over a period of about three years that she had been having suicidal thoughts.

18.3.7. The Swindon Clinical Commissioning Group IMR Author, made the following summary of Theresa's situation in her report:

"Theresa presented to her GP with multiple medical problems. There were ninety-one entries where Theresa's mental health had been a feature. There were twenty-six disclosures of domestic violence, most of which were of significant harm, including strangulation to the point where Theresa lost consciousness. Theresa commented on several occasions that she felt trapped due to financial reasons. She became increasingly suicidal, attempting suicide, being found on a bridge, saying she had bought a rope, attempting hanging but was found, before eventually committing suicide by the method of hanging."

18.3.8. There are several references in Theresa's journals about taking her own life. On 10 March 2017, she wrote *"….Thoughts about what I am going to do. Wondering how we are going to do about my suicidal thoughts. Mind wondered about it a bit today but not as bad as other days. I wonder how long I can resist the urge to end it all."* (Sic)

18.4. **Alcohol:**

18.4.1**.** In 2017, Theresa told the SWA IDVA that when the family saw her with bruises, they believed these were due to her binge drinking episodes. She explained that this was because Charles had told her parents that she was addicted to drugs and alcohol. She was upset and shocked at him for using this tactic and felt that he was painting a picture of her that was not true. Theresa feared this would prevent her parents from believing her if she told them about the domestic violence she had described to the IDVA. (Para 16.51) Theresa's mother has stressed to the review that she had never witnessed Theresa drinking heavily, but in 2017 Theresa told her, she had a drinking problem and that she would be seeking her for it.

18.4.2. Theresa's mother understand that Theresa attended Alcoholics Anonymous meetings, but as the name implies, no records of the names of persons attending meetings are available for this to be confirmed. However, it is known that in September 2017 Theresa did engage with Change Grow Live at Swindon Drugs and Alcohol Services. After an initial assessment on [redacted] October 2017, she attended only one meeting before disengaging. At the Assessment, she stated she was binge drinking six days out of twenty-eight and her drinks of choice were Champagne and Whiskey. (Appendix I).

18.4.3. The first recorded reference to Theresa's use of alcohol in the UK was on [redacted] August 2016 when it was noted in her medical records that although she was feeling unsupported by her family and was having occasional thoughts of self-harm, she had reduced her alcohol intake and had no excess medication in the house. (Para 16.14) Later, in October 2016 Theresa admitted to the Swindon Women's Aid IDVA, that she used alcohol to numb pain and to help her sleep. (Para 16.40)

18.4.4. There were no other significant agency references to Theresa's drinking until [redacted] Aug 2017 when it was noted in her medical records, that Theresa was concerned about the police considering taking action against Charles and she had asked her GP to document that she had alcohol problems and mental health issues and had lied about the abuse. The GP contacted the Police Safeguarding Officer with Theresa's consent and was advised that the Safeguarding Officer was unable to stop the police investigation (Para 16.151)

18.4.5. Theresa made a number of references in her journal about her use of alcohol as a prop. On [redacted] March 2017 she wrote:"*Turning to alcohol, I feel once I start I struggle to stop*." On 16 May 2017 she wrote:"*Had a rough day, drank almost an entire bottle of whiskey. Called the Crisis Team. Slept at Mum and Dad. I was in a dark space*." (Sic)

18.4.6. After Theresa's death, the Pathologist noted that Theresa "*had been treated for depression and was known to be a problem drinker and with visits to Alcoholics Anonymous"*. However the toxicology report shows that whilst Theresa had consumed alcohol prior to death, "*the level would likely have only caused "mild" drunkenness"* (Paras 17.16.3-4)

18.4.7. Change Grow Live (CGL) who provided Swindon Drug and Alcohol Services conducted an Unexpected Death Review into Theresa's death and their report is set out in Appendix I.

18.5. Physical **injuries.**

18.5.1. Across the period focused on in the DHR Terms of Reference, the reports received from several agencies have revealed evidence, that Theresa suffered repeated physical injuries to various parts of her body. The dates and description of those injuries are detailed in this report.

- Swindon Women's Aid has provided the review with copies of three self-taken photographs of one set of bruises to Theresa's body (see Para16.77[33]). On several occasions, their IDVA and her Supervisor saw marks around Theresa's neck and bruises and wounds on her body (Para. 16.54.) Theresa described to them, how her husband was responsible for the injuries, stating that on different occasions, he punched, kicked, beat her with a metal pole, hit her in the face with the TV remote control, strangled her with a rope and his belt and held her head under water. (E.g. paras 16.81,16.82,16.82)

- Hospital staff who saw and x-rayed injuries to Theresa's head and arms were so concerned that they reported the injuries to the police, as they feared that she might suffer serious injury or death. (Para 16.107). On one occasion, hospital records noted that Theresa "while withdrawn and reluctant to give information during the consultation; confirmed she had been assaulted by her partner the previous day, but did not want the police notified as Swindon Women's Aid was formulating a safety plan for her. She was discharged after her injuries were x-rayed". (Para 16.61).

- Likewise, Mental Health Services, on information from their Nurse, who had seen Theresa's wounds, reported her injuries to the police. (Para 16.25)

- Theresa's GP examined and recorded her injuries on twenty-six occasions. The injuries included, strangulation marks on her neck, deep bruises to her legs, arms, abdomen, ribs, eyes and head. (See Paras 16.53, 16.69, 16.78. 16.121, 16.124. 16.175, 16.177).

[33] The Wilshire Police investigation has noted that Theresa sent these photos her cousin as well as to Swindon Women's Aid. She told her cousin the injuries were caused by a fall but told Swindon Women's Aid they were inflicted by her husband. Theresa's cousin also provided the police with twelve other self taken photographs sent to her by Theresa. These photographs which have been viewed by the DHR Panel clearly show bruising and swelling on Theresa's face, neck, arms and body (See para 17.19.3.)

18.5.2. In January 2016, when Theresa first began presenting to her GP with physical injuries, she claimed they were caused during fainting or falling episodes, during intercourse or during or immediately after exercise. Her GP took blood samples, treated her with medication and made a neurology referral, but nothing unusual was found and no diagnosis was made. Over the following months Theresa's GP questioned her about self-harming but Theresa initially denied she was having any such thoughts. When asked about domestic abuse at first Theresa denied that her husband was violent, but later admitted that he was controlling and that she felt financially trapped as she sent money to members of her family in South Africa, which would stop if she left him.[34] It was several months later (September 2016) that Theresa disclosed that her husband was physically violent towards her. After this she became more trusting of her GP and IDVA and told them further detail of how, she claimed, her husband controlled and assaulted her.[35] Following her confiding in the Mental Health Service that her husband strangled her during non-consensual rough sexual intercourse and their subsequent reporting it to the police[36]; she had become distrusting of new agencies and would refuse to explain how her injuries were caused. (Para 16.25). She told the SWA IDVA, whom she trusted, that she had played down what her husband had done by telling the police, that she had consented to the rough sex. (Para 16.28)

18.5.3. Whilst Theresa had become cautious about explaining how her injuries had been inflicted, she continued to speak openly to her GP and the SWA IDVA. There were times when Theresa turned up at the GP surgery in a distressed state and with visible injuries, which she asserted were a result of assaults by Charles. On one of those occasions, the Practice receptionists saw clear marks around her neck. Theresa told her GP, SWA staff and once to hospital staff, that her husband had used a metal pole to beat her. She stated he would kick her, stand on her and hold her head under the bath water. Her GP notes record that during examinations, (some of which were also witnessed by the practice nurse), she had imprints of a shoe on her body, finger marks on her arms and rope marks on her neck. On 13 December 2016, the SWA IDVA noticed that Theresa had a large bruise on the left side of her face which she said was caused by Charles hitting her round the face with a TV remote control. (Para 16.74) (Undated photographs seen by the DHR show swelling the left side of Theresa's face and a black eye.)

18.5.4. Theresa never told her parents that Charles used violence on her:

- On [redacted] October 2016, Theresa told the IDVA, that her parents had visited her at the weekend, they had asked how she hurt herself and she had replied that she had fallen. Theresa was asked if her parents suspected anything, she said no.(Para 16.36)

- On [redacted] November 2016, Theresa told her GP that she had tried to leave her husband, but he had attacked her and physically prevented her from leaving. He had hit her with a metal pole across the left side of her abdomen. She said her husband had

[34] Although Theresa and Charles sent money to family in South Africa there is no evidence that she ever suggested to agencies that they were the only members of the family to do so. It is known that other members also provided financial support to family in South Africa.
[35] The Police investigation found no evidence of controlling behaviour by Charles on either Theresa's mobile phone or on Charles phone.
[36] It was noted in the police investigation that Theresa had told Friend A that the mark around her neck in a selfie she sent her was caused by Charles putting a collar on her during sex. Theresa said that she had instigated it..

telephoned her parents and told them she had a drug and alcohol problem. She said she felt unable to confide in them and did not want the police involved. On examination, she was seen to have extensive bruising on the right side of her upper chest, right lower abdomen, left lower ribs, right arm, left lower arm and left upper outer thigh. (Para 16.53)

18.5.5. Dr. [redacted] a forensic physician was used as an expert witness by Wiltshire Police and later by the review. After examining photographs of Theresa's injuries and reading medical records, concluded that whilst some of the injuries may be explained by falls onto a hard surface, in her opinion these injuries are typical of repeated blunt trauma, such as punches with a fist, or another hard object, and/or repeated kicks.

She believes it is highly unlikely that these repeated blunt trauma injuries resulting in bruising and swelling would have been self-inflicted. It is also highly unlikely that the injuries to the abdomen would have been caused by accidental trauma.

18.5.6. At the post mortem examination, several bruises were visible on Theresa's body and were detailed by the Pathologist in his report. (Para17.16.2)

18.5.7. After Theresa's death, Charles made a witness statement to the police, in which he denied ever having been violent towards Theresa[37]. He included that once, during sexual intercourse, she had asked him to put a leather collar around her neck and the buckle left a mark on her neck. He added that Theresa often had bruises, as a result of sparring at Friday evening boxing classes. (Appendix D). Charles later provided the DHR with the name of the Boxing Club he thought Theresa attended. That club "Scrappers" was contacted by the DHR and had no record of Theresa having ever been a member. Other Gyms she attended had no record of her taking part in sparring activities or suffering any injury on their premises.[38]

18.5.8. Whilst professionals from several agencies (including the GP Practice, Mental Health Services, Swindon Women's Aid, Hometruths and [redacted] Hospital) saw Theresa's injuries and had early reports from her on how those injuries had been sustained, their different policies, regulatory guidance and understanding of information sharing without consent, when there is a perceived risk of serious harm or death to an adult, resulted in the police not being provided with all of the facts that were available at the time.

18.5.9. The Home Office and Department of Health are responding to a recommendation from this Review, for unambiguous national guidance in respect of information sharing without consent when there is a risk of serious harm or death to an adult.

18.5.10. Theresa's mother after reading this report has asked that the following is added:

"About 2 weeks prior to my daughter's death we were visiting my daughter and the following conversation took place in front of (Charles), myself and my husband just as we were leaving.

[37] Charles provided the Police with a further statement on 19 January 2019 when he reiterated that he had never assaulted Theresa.

[38] Wiltshire Police also made enquiries in relation to gyms where boxing classes took place – Theresa was not a member at any of these – the gyms that were spoken to stated physical contact whilst sparring was rare and that any injuries caused would be recorded. There were no such records. Theresa made numerous diary entries relating to her exercise - running and going to the gym, but there is only one reference of going to boxing. This was on 13 November 2017 10am to 1130am.

(Theresa) – "Mom did I tell what (Charles) said to me".

Me - "No what did he say".

(Theresa) - "(Charles) said that he could snap my neck in a heartbeat, cut up my body and dissolve it in acid and no one would ever find me".

Me - I said to (Charles) "Are you sick? If I don't get hold of my child I will come looking for her".

(Theresa) - "I told you my mother would say that".

(Charles) - "Yes it is easy" and went on to explain how he would do this.

(Theresa) said this in a joking way as she was obviously petrified of him but wanted to let me know.

On leaving, I said to her that we must get together and sort out the Christmas meal and presents. She said that she had already ordered the meats from M&S and that there would be no presents this year (2017). I found this rather strange as (Theresa) loved Christmas and enjoyed spoiling people with gifts.

This was the last time I saw my daughter alive and I now ask myself, was (Theresa) trying to warn me of something."

(**Note:** Proper names changed to pseudonyms by report author).
Note: Charles has responded: "I do not accept (Theresa's mother's) verbatim account of a discussion that happened over 20 months ago. Her recollection of the conversation is somewhat different to what I recall. The conversation was related to a crime drama that we had watched on TV and I don't recall us discussing it in length or in depth as she describes. As she states the conversation was in a "joking way".

18.6. **Reported controlling behaviour**

18.6.1. Charles was described by Theresa's parents and one of her friends as "*doting on her and being besotted with her from an early age*." Theresa told the SWA IDVA that she had met Charles at school. He was her friend; however, she described him as displaying possessive behaviour towards her from a young age. During school, he would refuse to go to lessons and sat outside her classroom until the teachers became involved. Theresa's education was effected, as she could not concentrate in class. Looking back, she felt she never had a choice about being with Charles, as she has no experience of adult life without him. (Para 16.33)

18.6.2. Theresa told the IDVA that during an argument, when they were dating, Charles had driven his car towards oncoming traffic, saying if he could not have, her no one would. (Her brother later told the DHR that he witnessed this incident as he was in the car with them at the time.) Her parents stopped her seeing him for a while but they were eventually reconciled and he did not do anything like that again. (Para 16.27).

18.6.3. On [redacted] May 2017, Theresa, while explaining to police officers why she was afraid to report the assaults, said she was concerned that Charles had changed people's opinion to

be against her and therefore she would never be believed. She described Charles as a psychopath, charming one moment and aggressive/abusive the next. Theresa stated that Charles was very intelligent and she felt he was able to track her movements and affect the settings on her phone even when she turned off options such as location settings. The Officers did see two webcams at Theresa's home. They also noted that Theresa had a large bruise on the inside of one of her arms, but when asked about it, she would not say how it had occurred. (Para 16.122).

18.6.4. Throughout Section Sixteen of this Report there are many reported examples of Charles monitoring Theresa's movements including turning up unexpectedly when she was planning to leave him, questioning her why she had parked the car in a different place, asking why she had been so long at the GP surgery, phoning the hospital when she was there for an x-ray to one of her injuries and later telephoning her twenty-seven times while she was at her GP Practice. (See para 16.63).

18.6.5. On one occasion, Theresa could not understand how Charles had found money she had hidden in the house, only to later discover a camera hidden in her home office. Theresa showed (the SWA IDVA), pictures of a camera that she had found hidden on the bookshelf behind her desk. She also found a Tracker on the car. She said she was very scared and relived all the telephone conversations that she had had in the house and wondered how many of them (Charles) had overheard. (Para 16.59). She thought he was tracking her as he seemed to know when she had been to the gym including one night at 3am. (Para 16.133)

18.6.6. Theresa told the IDVA, that on another occasion she had built up the courage to leave home and had stayed overnight in a hotel. The next morning she went for a run and soon after Charles arrived at the hotel to take her home. Theresa believed that the running app she used, flagged up on her home computer, even though she had changed her Apple ID. (Para16.68).

18.6.7. Theresa claimed Charles had put an app on her mobile phone, which could tell him where she was at any particular time. She said there was a Tracker on the car and surveillance cameras at their home. She told the IDVA that Charles controlled all the money and he expected swift replies to his emails when he was away on business. He would read her text messages and emails; e.g., "He was suspicious that she was going to leave him, as he had read a text message on her phone from her Grandmother asking if she was OK." [39] (Para 16.52)

18.6.8. On [redacted] May 2017, Theresa's situation was discussed at the Swindon MARAC, following a referral from Swindon Mental Health Liaison after Theresa had made a suicide attempt by taking an overdose whilst drinking alcohol on 16 April 2017. The referral reiterated that Theresa was reporting, being subjected to emotional and physical abuse and that her husband was stalking her. The MARAC considered information from her GP and from Hometruths that Theresa's resistance to change was based in fear and a belief that her husband would always be able to find her and harm/kill her, as he had been aware of previous occasions when she considered home. (Para 16.120)

18.6.9. It is emphasised that Charles has never been charged with any criminal offence. He has consistently denied having been violent to Theresa. He has also explained that he had cameras installed at their home because Theresa was worried after two attempted

[39] Charles has pointed out that Theresa was aware of the apps and she could have dispensed with it at any time. It is also known that Theresa's brother also shared such an app with her.

burglaries and that he had apps on both their mobile phones so that they would know where each other were at any given time, as he worked away from home so often he frequently contacted her by text and telephone. (See Appendix D) Theresa's mother and brother also shared family apps with Theresa.

18.7. **Theresa's reluctance to leave home and her refusal to report her injuries to the police.**

18.7.1. The Review Panel acknowledges that Theresa's reluctance to leave Charles and her refusal to report the abuse to the Police whilst perhaps being frustrating for agencies keen to help her, are identifiably common behaviours for a victim of domestic abuse.

18.7.2. There has been indicative research into the reasons women do not leave their abusers. In a study aptly named "Why Doesn't She Just Leave?'" Anderson et al. (2003) investigated exactly that question. Some of the reasons they discovered included financial need, lack of another place to go, as well as reported lack of help from law enforcement. They noted that family and social role expectations may create pressure for the victim to remain in a caretaker role and attempt to repair the relational damage caused by the abuse. They explained that victims who seek to maintain their relationships are motivated to accept apologies from the abuser and promises to change.

18.7.3. In a more recent study, "Perceptions of Domestic Violence: The Effects of Domestic Violence Myths, Victim's Relationship With Her Abuser, and the Decision to Return to Her Abuser", Yamawaki et al. (2012) cite prior research indicating a variety of reasons victims do not leave their abusers, including a cost-benefit analysis weighing relational benefits against the costs of separation. In addition, the reasons victims stay with domestic abusers can change over time. [40]

18.7.4. "The under-reporting of crime to the police is known to be particularly acute for domestic abuse offences, with many more offences committed than are reported to and recorded by the police. Estimates based on those interviewed in the Crime Survey for England and Wales during the year ending March 2015 showed that around **four** in **five** victims of partner abuse (**79%**) did not report the abuse to the police".[41]

18.7.5. In Theresa's case there were several reasons, she put forward as explanations on why she did not want to leave Charles or to see him prosecuted. They included:

- Feeling isolated / Charles was her only contact. (Paras 16.74. 16.105)
- She had no experience of adult life without Charles. (Para 16.33)
- She was too scared to leave; she could not see a future for herself on her own. (Para 16.56)
- Theresa felt she would not be believed. She believed that Charles was very clever and people would always believe him. (Para 16.36. 16.51. 16.143)
- She would be without work/finances. (Para 16.32)

[40] Why Domestic Violence Victims Don't "Just Leave": Wendy L. Patrick PH.D. Psychology Today April 2018

[41] Domestic Abuse: findings from the Crime Survey for England and Wales: year ending March 2017

- She believed he would never leave her alone, he would always find her. (Para 16.62. 16.105)
- Threats of further violence towards her. She described Charles as a psychopath. (Para 16.87)
- Fears for her family financially: Through working in Charles business, she was funding some family members still in South Africa. (Paras 16.24. 16.35)
- Charles threatened violence to family members. (Paras 16.86., 16.95. 16.102. 16.126)
- Threats from Charles that if she left him, he would reveal confidential information, relating to someone she cared about, that could destroy that person's life. (Para 16.56.)
- Theresa felt Charles had done so much for her family that she could not report him to the police for the assaults on her. (Paras 16.46. 16.105)
- If he was prosecuted, Charles would lose his job which required him to have security clearance and a clean criminal record. Her family would then suffer. (Para 16.35).
- She had a lack of confidence in the Police. (Para 15.9)
- The explanation from police officers of what action would take place, if she reported the abuse was not reassuring as they stated he would get bail without explaining how she would be supported or about DVPOs. (Para 16.106)
- Refuge places were frequently not available when she decided she might leave him. (Para 16.151. 16.164. 16.170)

18.8. The PTSD, depression, the violence and abuse, concerns regarding police action, worries about her family and her feelings of resignation that no one could resolve her problems, led Theresa to feel a "mental torture" she could not escape. In her text message to the Swindon Women's Aid IDVA in February 2017, Theresa wrote:

"Please I need to know where to go from here as I feel without the right help when it comes to my mental health this is going to end badly." (Para 16.93)

Also in the note addressed to her brother found after her death, she stated, "the pain of living is too much and no matter what anybody does or says it's all on me. Just know that there is nothing you or anybody could have done to stop this."

18.9. The Wiltshire Police Investigating Officer stated that he suspected that Theresa denied the assaults to police because she knew Charles did not commit them and genuinely did not want him to get into trouble for something he did not commit.

18.10. Whilst it is for the Coroner's Inquest to deliberate on the cause of Theresa's death: the DHR Panel having considered the above factors is of the opinion that the following may have contributed to Theresa's suffering:

- **The cross agency inconsistencies regarding information sharing;**

- **The police failure to take timely positive action in relation to specific domestic abuse reports;**

- **The lack of available local refuge space at critical times for Theresa;**

- **The failure of agencies to recognise the warning signals of the increasing number of attempts by Theresa to self-harm.**

- **The failure of the Swindon Intensive Team to positively respond to the telephone contact from NHS111 on the morning Theresa took her own life.**

- **The length of time it took the Police to send units to response to her telephone call that she was intending to take her own life.**

18.11. Events that occur after a death are normally outside the remit of a DHR, but in this case, the Panel considers that the lack of any investigation by the police officers who attended the scene of Theresa's death was a missed opportunity to search for and secure anything which may have clarified the reasons for Theresa's death or could have supported or negated the information she had provided to agencies relating to domestic abuse. It was also a missed opportunity that a forensic post mortem was not requested. If such actions had been conducted Theresa's family would not have undergone the prolonged stress of the subsequent police investigation, and the Coroner and Domestic Homicide Review would have had more information to assist them.

18.12. The DHR Panel wishes to emphasise that there were many examples of outstanding professionalism shown by individuals in their contacts with Theresa. In particular they commend the consistent high quality of care provided by her GP; the support of the SWA IDVA, the IAPT Practitioner and Psychiatric Nurse who reported their concerns to Safeguarding, and Hospital Staff and the prompt actions and care shown to Theresa by the Police civilian Safeguarding Officer and those officers who attended her on 19 September 2017 and 16 November 2017.

Section 19 - Lessons Learnt

19.1. The following summarises what lessons agencies have drawn from this Review. The recommendations made to address these lessons are set out in the Action Plan template in Section 20 of this Report.

19.2. Avon and Wiltshire Mental Health Partnership NHS Trust

19.2.1. Initially, there was not a sufficiently robust plan in place requiring the Mental Health Liaison to seek the advice of the Safeguarding Team. Staff were not clear regarding DASH and MARAC processes.

19.2.2. The lack of outcomes regarding the robust recommendations made (by senior members of the team) meant that significant information was not known by the rest of the team.

19.2.3. Information recorded in the progress notes was not always consistent when recording police reports relating to Theresa's suicide attempt in September 2017. Care needed to be taken to ensure the documentation was consistent and there was no disparity between teams. Disparity in the documentation can lead to confusion and the possibility of incorrect information being handed over.

19.2.4. Where Theresa reported domestic abuse to both PCLS and LIFT Psychology (March 2017) this should have been reported to the police and a MARAC referral made. Following discussion with team members, it was evident that the SIS team were not aware of the MARAC referral process and the need to make a new referral for every disclosed serious domestic violence incident. This lack of understanding (regarding the MARAC process) meant that the domestic abuse that Theresa had revealed was not reported accurately.

19.2.5. Some progress notes were not completed and validated in real time, as required under the AWP Health and Social Care Records Policy and associated guidance.

19.2.6. Staff were not all aware of rapid accesses processes in the SIS team.
(Not requiring referral from GP) Pressure of time was cited as the primary reason for progress notes not being completed or validated in real time.

19.2.7. The manner in which AWP Mental Health Services responded to NHS111's contact in relation to Theresa revealed a clear lack of clarity in the pathways between the services.

19.3. Care UK.

19.3.1. The Clinical Advisor could have considered an adult safeguarding referral for the caller. The caller (Theresa) had indicated that she was not receiving the care needed and was vulnerable.

19.3.2. There are few options available for clinicians to refer to for patients with mental health problems. Options are often limited to Hospital Emergency Departments or General Practitioners. The availability of mental Health services and the presence of care options on the Directory of Services (DoS) requires system review. (Note Care UK are no longer the 111 service provider in Swindon however the CCG has undertaken to ensure that the new provider signs up to a new care pathway to address this issue.)

19.4. [redacted] **Hospital**

19.4.1. The Hospital documentation demonstrates staff accessed/contacted the relevant services/team/people to protect Theresa. However, attempts to carry out additional risk assessments may have provided further information in respect of current risk.

19.5. Swindon Borough Council Adult Social Care

19.5.1. Members of the safeguarding team did screen the concerns raised regarding Theresa but following communication with the GP and SWA, considered she did not have care and support needs. As a result of each of the alerts, the team confirmed support was being made available from domestic abuse services which appeared to be appropriate in the circumstances. However, more could have been done to obtain Theresa's views directly or to consider different approaches should this appear to be unsafe or difficult. Currently, there is a review of the function of the safeguarding team with a view to improve the responses from the screening/triage function.

19.5.2. With domestic abuse an "abuse type" referred to, in Care Act Guidance, there is a training need on Coercive Control. This is being arranged for all staff in adult services by 18 June 2018. There was also guidance from the Association of Directors of Adult Social Services and the Local Government Association, Adult Safeguarding and Domestic Abuse - A guide to support practitioners and managers. All staff in the safeguarding team have had this document circulated and to consider it as essential reading. Supervision sessions will check this awareness of the content of the document and further training on this subject will be delivered.

19. 6. Swindon Borough Council Housing Department

19.6.1. **Theresa** should have been contacted the day after the original telephone call (if she had agreed) and she should have been referred to the Domestic Abuse Housing Options Officer.

19.7. Swindon Clinical Commissioning Group & GP Practice

19.7.1. There is a lack of clarity for professionals on what course of action to take when they have reason to believe a patient is at risk of serious harm or death but that patient does not give them consent to share the information with the police.
Theresa's GP had concerns for Theresa's safety, but faced with Theresa's refusals to give her permission to share information with the police, she sought advice from the Swindon Women's Aid IDVA, from other GPs at the Practice and later from the Medical Defence Union. She was advised that as Theresa had mental capacity she should follow the GMC Guidelines Confidentiality: Good Practice in Handling Patient Information (2017) (Set out in Appendix E of this Report), which states:

"**As a principle, adults who have capacity are entitled to make decisions in their own interests, even if others consider those decisions to be irrational or unwise. ….. "(**para 57) and **"You should, usually abide by the patient's refusal to consent to disclosure, even if their decision leaves them (but no one else) at risk of death or serious harm. ….**" para 59.

Consequently, the GP did not fully share information with the police, although with Theresa's consent she did inform the Swindon MARAC with the proviso that there would not be any police action against her husband.

Other Health professionals from Mental Health Services and the Hospital following the ICO Codes of Practice did share information with the police without Theresa's consent.

19.7.2. GPs do not necessarily have an in-depth knowledge about the implications of the Care Act 2014. (The Swindon CCG is currently in the process of ensuring that all GP's have this training).

19.7 3. GP Practices in Swindon need to understand what action to take on receipt of a MARAC report in respect of one of their patients.

19.7.4. There is an apparent need for GP Practices to sign up to a Swindon-wide Safeguarding Protocol that would be kept up to date (by CCG) with new legislation.

19.8. Swindon Community Safety Partnership

19.8.1. Swindon Community Safety Partnership identified the need to ensure that domestic abuse practitioners working in the Swindon area fully understood legislation relating to stalking and coercive control coordinated training for Swindon Women's Aid and Hometh-ruths IDVAs and other Domestic Abuse operational personnel relating to technological abuse including the use of security and covert cameras, listening devices, vehicle tracking equipment and mobile phone apps. Recommendations to embed this training into local and national Domestic Abuse Strategies are included within this report.

19.8.2. This review has identified that, due to differing professional guidance and interpretations of Data Protection Act, Information Sharing Codes of Practice and Care Act Safeguarding, in circumstances when consent to share has been withheld; practitioners are faced with critical dilemmas in situations when they have clear grounds to believe that an individual is at serious risk of harm or death if information is not shared. In this case, some organisations shared information with the police without Theresa's agreement, whereas others did not.

19.9. Swindon Drug and Alcohol Service (CGL)

19.9.1. Risk of domestic abuse was not acted upon when information relating to Theresa was received from her GP.

19.9 2. The disengagement Protocol was not followed correctly in respect of Theresa.

19.9.3. Theresa should have been booked an Alcohol Nurse Assessment immediately after trigger points on AUDIT/SADQ were met.

19.9.4. Theresa's closure was not discussed at a Clinical Team Meeting.

19.10. Swindon Women's Aid

19.10.1. When a victim of domestic abuse contacts a refuge and there are no places available the person taking the telephone call should offer to check availability at other refuges and where safe to do so, telephone the victim back rather that expect the victim to make several calls herself. This did not always happen in Theresa's case, although it is noted that she was not always able to receive calls safely.

19.10.2. When Theresa self referred to Hometruths, Swindon Women's Aid did not have in place a structured referral pathway to ensure that Theresa received seamless support.

19.11. Wiltshire Police

19.11.1. Wiltshire Police policies for dealing with domestic abuse are up to date and in line with ACPO guidelines.

19.11.2. The Wiltshire Police policy and procedure on tackling domestic abuse gives guidelines to officers on taking positive action:

- Positive action includes arresting the suspected perpetrator for any offence disclosed. It is the decision of the attending officer whether or not to arrest a suspect and therefore victims should not be asked whether they require an arrest to be made.

- The requirement for ‘positive action’ means that in all domestic abuse cases, officers should consider the incident as a whole, not just the oral or written evidence of the victim.

- Officers must focus efforts from the outset on gathering alternative evidence in order to charge and build a prosecution case that does not rely entirely on the victim’s statement. This is particularly important where at any stage the victim appears not to support a prosecution.

- The victim's views are always to be considered but the decision to arrest remains with the officer even if the victim does not wish to pursue a complaint. All actions will be taken in the interests of the victim in order to take the pressure and responsibility away from the victim.

- It is acknowledged that on occasion, the victim may not agree with the actions taken, however the overriding concern is to keep the victim safe. Only by protecting the victim can we be truly focused on the survivors of domestic abuse.

- Previous withdrawals of support for a prosecution should not adversely influence the decision making in whether to arrest for an offence.

- The Domestic violence definition does not require ‘violence’ to have been used and ‘abuse’ is much wider than any criminal allegations.

19.11.3. This was not an easy case for the Police to resolve, having to balance the need to take positive action with Theresa’s wishes. The reports of domestic abuse on Theresa came to the police thorough other agencies. (Although Theresa did attend a Police Station the day prior to her death but had to leave to keep a GP appointment before being seen). When Theresa was spoken to by Police Officers and DAIT Safeguarding Officers, she stated that nothing had happened and she was not suffering any domestic abuse. She did however say that her husband was stalking her by monitoring her movements with cameras and a tracker. Had evidence been forthcoming, officers could have considered either the specific offence of stalking or the offence of controlling or coercive behaviour in an intimate or family relationship.

a. Stalking: The Protection of Freedoms Act 2012 amended the 1997 Act and created two new offences of stalking:

- Stalking (section 2A) which is pursuing a course of conduct, which amounts to harassment and which also, amounts to stalking

- Stalking (section 4A) involving fear of violence or serious alarm or distress

The offences came into force on 25 November 2012.

b. **Controlling or coercive behaviour :** The offence came into force on 29 December 2015.

An offence is committed by A if:

- A repeatedly or continuously engages in behaviour towards another person, B, that is controlling or coercive; and

- At time of the behaviour, A and B are personally connected; and

- The behaviour has a serious effect on B; and
- A knows or ought to know that the behaviour will have a serious effect on B.

There are two ways in which it can be proved that A's behaviour has a 'serious effect' on B:

- If it causes B to fear, on at least two occasions, that violence will be used against them - s.76 (4)(a); or
- If it causes B serious alarm or distress which has a substantial adverse effect on their day-to-day activities - s.76 (4) (b).

19.11.4. The report by the Community Psychiatric Nurse on 2 June 2017 did trigger a sequence of events that should have led to the arrest of Charles when he presented at [redacted] Police station and this was a missed opportunity. The delay in ultimately filing the police investigation was unacceptable and caused Theresa significant distress.

19.11.5. Theresa's death should have triggered a course of events aimed at gathering evidence; this should have included a forensic post mortem. The IMR Author concluded after having read the various chronologies, particularly from the GP that there were grounds to believe that Theresa had been subjected to repeated violence.

19.11.6. On the day that Theresa took her own life, there was a delay of sixteen minutes from the police control room receiving the call from Theresa to police officers being sent to her house. The call from Theresa had been treated as a call from a person with critical mental health problems rather that one where there was an immediate risk to life.

19.12. Actions re lessons identified prior to the adjournment of the Review in June 2018

19.12.1. National

19.12.1. There are broad principles relating to information sharing without consent set out in the Data Protection Act with an expectation that organisations should treat each case on its merits, in accordance with existing legislation and common law. However, the GMC guidance (which is highlighted in section 17.12 and Appendix G) may inhibit GPs from using their discretion to disclose to the police when a non-consenting patient is at risk of serious harm or death, for fear that they could be criticised or sued for failing to follow GMC Guidance.

19.12.1.2. The Home Office confirmed, on 8 May 2018, that discussions between the Home Office, the Department of Health and Information Commissioner on this issue are continuing and they anticipated to be in a position to provide a plan of action later this year. (2019)

19.12.2. Local

19.12.2.1. On 5 June 2018, the Review Panel notified agencies that although the review would be adjourned to await the outcome of the Wiltshire Police criminal investigation, the recommendations to address lessons learnt should be implemented expeditiously for the safety of future victims of domestic abuse and individuals with mental health issues.

19.13. The DHR Panel's recommendations and up to date action plan at the time of concluding the review on 3 July 2019 is detailed in the template in Section Twenty of this report.

Section 20 - Recommendations and Action Plan

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion
In this DHR professionals from different organisations made conflicting decisions on whether to share with the police information relating to Theresa, without her consent when they believed she was a risk of serious harm or death. Some (including Mental Health Services, and Hospital) ,following the ICO Codes of Practice and Care Act decided to share; others (including Swindon Women's Aid and Hometruths) considered that Theresa had mental capacity to make her own decisions. Another (GP) followed the General Medical Council's Good Practice Guidance on handling Patient information(25/4/2017 onwards) paras 57-59; This divergence of opinion, adversely affected the support Theresa received. The DHR Panel therefore recommends that the Home Office draws to the attention of Dept of Health, NHS England and ICO what happened in Theresa's case and works with those Departments to provide to practitioners clear guidance, which is in line with the ICO Code or Practice.	National	The Home Office agreed to raise the differing professional guidance and practice interpretation of the ICO Codes of Practice on information sharing without consent when there is a risk of serious harm or death, with other Government Agencies including ICO, Dept of Health and NHS England., Proposal sent to HO on 2 May 2018 as the DHR Panel felt that differing practice could put future victims at added risk. **The Home Office provided an update on 4 March 2019 that they are still in discussions with the Department of Health and Information Commissioner on this with a view to strengthening the statutory guidance which they will shortly commence updating with the intention to publish a revised iteration later this year**.	Home Office, ICO, Dept Health, NHS England	Home Office agreed to work with Dept of Health and The. Information Commissioner to review this issue 9 May 2018		Ongoing at date of completion of the this review

That Community Safety Partnerships embed within their Domestic Abuse Strategies that IDVAs and DV practitioners receive training on legislation and practice relating to stalking and coercive control .This training should encompass technical abuse including the use of security and covert cameras, listening devices, vehicle tracking equipment and mobile phone apps.	National	1. Swindon Community Safety Partnership has already completed local training on this issue as a result of this DHR and are in the process of including it within their Domestic Abuse Strategy. 2. Home Office to cascade this nationally to other CSPs	Swindon Community Safety Partnership and Home Office	1 Training provided to Swindon Women's Aid and Hometruths in June 2019		1 Completed in Swindon.
For agencies to be aware of all available civil and criminal justice options to tackle perpetrators of domestic abuse.	National	Swindon CSP to prepare a practitioners guide to using civil powers under the ASB, Crime and Policing Act 2014, as a supplement to police and CPS powers, to tackle domestic abuse.	Swindon Community Safety Partnership Team	1st Draft produced. To be finalised	01/09/18	2 Ongoing
Commissioned Swindon Domestic Abuse Services should have clearly defined processes for supporting victims who may want to stay in relationship and DASS referrals to other support services	Local	1. Swindon CSP and SBC to draft contract variation for approval by Law and Democratic services. 2. Varied contract finalised by Commissioner	Swindon Community Safety Partnership Team		31/12/18	ongoing

For all members of the Swindon Intensive Team to be aware of patients who have a rapid access plan into services and to be aware of its purpose.	Local-AWP	1. Develop locality Safety Alert to highlight this RCA, the process for implementing a rapid access plan and ensuring its dissemination in teams. 2. Disseminate locality Safety Alert and ensure all teams respond to state that the Safety Alert has been shared and understood 3. Deliver brief training sessions on Rapid Access Planning to all staff in SIS team. 4. Develop and implement process to log all Service Users who have a Rapid Access Plan centrally and process to ensure staff check log when Service Users contact the team.	Avon and Wiltshire Mental Health Partnership NHS Trust	**1.** Alert to be sent out as directed. **2.** This will follow from point 1. **3.** The Intensive Team management will arrange deliver brief training at the next Governance meeting. This will be recorded in the meeting minutes. **4.** Completed. Assurance gained that staff continue to log all SU's Rapid Access Plan info on the SIS Discharge Planner.	31 July 2018	1. Due to be sent out 20.03.2019 2. From 1. 3. Senior practitioner to deliver in team Governance meeting 4. **COMPLETED**

To ensure that the Swindon Intensive Team update RiO with any outcomes of multi-agency processes.	Local-AWP	1. Discuss the need to follow up multi-agency advice requests and processes for outcomes in SIS Team Meeting and 1:1 Line Management Supervision 2. Review outcomes of referrals and advice requests in SIS planning meetings and handovers to ensure these are followed up.	Avon and Wiltshire Mental Health Partnership NHS Trust		30 May 2018	**Actions COMPLETED.** Discussion with the team in team meetings has been had in addition to Line Management Supervision. Planning meetings now ensure that referrals and advice requests are now followed up.

Ensure that the Swindon Intensive Team validate progress notes in real time.	Local AWP	1. Discuss need to validate progress notes in SIS Team Meeting. 2. Review progress notes validation as part of IQ Records Management audit.	Avon and Wiltshire Mental Health Partnership NHS Trust	**1.** Complete. Previously discussed in the Intensive Service's Governance Meetings on the 31st August, 21st September and 25th October 2018 - Evidence in meeting minutes. Intensive Team management will reiterate the need for real time validation of progress notes in shift handovers and again in the next Governance meeting. **2**. Progress Notes validation will be/is managed through IQ Records Management Audit by Intensive Team management alongside monthly audit using the five random samples that are generated in line with IQ, Management Team will also check validation of progress notes ad hoc or if indicated.	30July 2018	**COMPLETED.**

Named Professional for Safeguarding Children and Domestic Abuse to work alongside Swindon teams to ensure the use of the DASH risk assessment tool (following disclosure of domestic abuse) and understanding of the MARAC processes.	Local AWP	1. Named Professional to attend Locality Quality and Standards Meeting to deliver awareness raising session on MARAC processes.2. Team Managers to use the Trust Safeguarding Checklist in Line Management Supervision to ensure appropriate Safeguarding processes have been followed where there is reported domestic abuse. 3. Named professional to attend Team Meetings for LIFT, MHCRT, SIS and PCLS to deliver awareness raising sessions on MARAC processes. 4. Carry out audit of records of cases where there is known domestic abuse to ensure appropriate safeguarding processes have been followed.	Avon and Wiltshire Mental Health Partnership NHS Trust	**1.** Completed: Named Professional attended the Swindon Q&S meeting in June 2018. **2.** Intensive Team management will add the Trust Safeguarding Checklist to the staff supervision form as a prompt to discuss any SUs that provide evidence indicating that safeguarding needs to be raised and ensuring this is done in a timely and accurate manner. **3.** Completed: See point 1. **4.** Swindon Quality & Improvement Lead has requested, and the Intensive Team Management team have confirmed, they will audit records of SU's cases where there is known domestic abuse to ensure appropriate safeguarding processes have been followed. Further audits to take place by Swindon Quality & Improvement Lead.	30 November 2018	1. **COMPLETED.** 2. Senior practitioner will complete 3. **COMPLETED.** 4. Ongoing
For teams to ensure that there is no disparity when documenting information regarding the same incident.	Local AWP	Develop locality Safety Alert highlighting this incident and the expected standards of record keeping in progress notes. Disseminate locality Safety Alert and ensure all teams respond to state that the Safety Alert has been shared and understood Monitor quality of progress notes on monthly basis in team though IQ Records Management audit.	Avon and Wiltshire Mental Health Partnership NHS Trust		30 May 2018	Actions **COMPLETED...** Local Safety Alert has been disseminated and progress notes continue to be monitored monthly.

1. Develop locality Safety Alert highlighting this incident and the expected standards of record keeping in progress notes. 2. Disseminate locality Safety Alert and ensure all teams respond to state that the Safety Alert has been shared and understood 3. Monitor quality of progress notes on monthly basis in team though IQ Records Management audit.	Local	3. Named professional to attend Team Meetings for LIFT, MHCRT, SIS and PCLS to deliver awareness raising sessions on MARAC processes.	Avon and Wiltshire Mental Health Partnership NHS Trust		30 May 2018	**COMPLETED.**
Mental Health Services to develop clear pathways to support 111 advisors and clinicians to gain advice and support regarding possible referrals to Mental Health Services and enable appropriate direct referrals without service users in crisis having to go back to the their GP.	Local	The actions associated with this recommendation will be taken forward as part of the project AWP are currently undertaking as commissioned by B&NES CCG to work with Medvivo to develop these pathways. This work is currently in the scoping phase and therefore more detailed actions will arise from the outcome of this.	Avon and Wiltshire Mental Health Partnership NHS Trust	Care UK is no longer the Swindon 111 service provider, however Swindon CCG has undertaken to ensure that the new provider is aware of this pathway and also has a mechanism in place to ensure it is monitored initially.	31 December 2018	Ongoing
1-2-1 supervisor feedback should be provided for clinician involved	Local to the South West call centre	Book feedback session with the CA, listen to the case and get the CA to reflect on their actions.	CARE UK	Room has been booked and interview set up to enable feedback/reflection	1 October 2018	**COMPLETED.** 1 November 2018
Reflective statement addressing current and future practice, with particular attention to adequate safety-netting.	Local to the South West call centre	This will be formulated as a result of the above meeting.	CARE UK	Room has been booked and interview set up to enable feedback/reflection	1 October 2018	**COMPLETED.** 1 November 2018

Clinician involved to ensure up to date with adult safeguarding training.	Local to the South West call centre	Check with training manager on training status and arrange time for CA to complete	CARE UK	CA is currently up to date with training however will be undertaking own CPD on mental health	1 November 2018	**COMPLETED.** 1 November 2018
Clinical lead to raise mental health safeguarding with safeguarding lead to try and identify patterns in referrals. If there is a lack of appropriate referrals or a training need is identified, it will be raised with the national safeguarding lead	Local/National	Meet with safeguarding lead and review past 6 months of mental health safeguarding referral and review cases that have the potential to be safeguarded	CARE UK	Meeting with the safeguarding lead.	1 October 2018	Target **COMPLETED** on1st January 2019
Ensure all staff are up to date with mandatory training - level 2 (health advisors) and level 3 (clinical advisors)	National	This is already reviewed across Care UK monthly and will continue to be monitored	CARE UK	Monthly review	1 October 2018	Ongoing yearly
111 Care UK leads to continue to contribute to discussions at a CCG level regarding the availability of mental health services	Regional	Clinical lead to continue to push the subject of mental health	CARE UK	NA	1 October 2018	**COMPLETED.** 1 November 2018

Consideration of the use of the DASH risk assessment: Where there is a known risk domestic abuse clinical 'alerts' must signpost staff to consider DASH risk assessments	Local	**COMPLETED**	[redacted] Hospital	There was no Trust wide Domestic Abuse policy in place at time of intervention. However, a policy has now been established and ratified and is being rolled out Trust wide from April 2018. When a disclosure of domestic abuse is made this document will clearly guide staff working in the Emergency Department, Minor Injury Units, Urgent Care, and Walk in Centre & Maternity to complete the Safe Lives DASH Risk Checklist which will enable an assessment of the level of risk that the victim is subjected too.	31.05.2018	**COMPLETED. April 2018** Domestic Abuse Policy fully ratified and implemented **03.05.2018 COMPLETE** Domestic Abuse Policy formal launch 03.05.18 all clinical areas, including SWICC were visited that day by Safeguarding Lead (acute) and IDVA (Swindon WA)

Agree 'alert' terminology on the electronic patient record to ensure when relevant, staff consider the use of DASH risk assessment	Local	**COMPLETED**	[redacted] Hospital	A current alert system is in place for all domestic abuse cases referred and discussed at MARAC. However, following investigation it is acknowledged this does not guide staff to consider frequency of attendance and to consider DASH.	31.05.2018	**03.05.2018COMPLETED.** Request discussed with GWH MARAC representative statutory wording agreed. This will guide staff to consider DASH within the MEDWAY alert. This will be applied to <u>all</u> future cases where GWH attend MARAC.

Specialist Safeguarding Supervision for all enquiry managers will include identifying if there has been appropriate involvement of service users in their safeguarding cases, focus on alleged DA and multi-agency arrangements.	Local	Engage supervision to provide specific supervision All adult safeguarding staff to "sign up" for these (mandatory) sessions UPDATE: Since reorganisation of safeguarding arrangements with adult services, this supervision has been extended to key staff acting as Enquiry Managers within the care team	SBC Adult Social Care	>Identify suitably experienced person to carry out sessions >Arrangement of sessions >scope of session to include areas highlighted in review >All staff allocated session and time to attend. [redacted] started this work (with another session planned 3rd May). [redacted] is Regional Association of Director or Social Services (ADASS) project manager, but is working on this role outside of ADASS role.4 sessions set op 23rd April. Another 3 sessions and a group supervision set up for 3rd May. Following feedback from the 2 days, arrangements with future sessions will be made.	23 April 2018	**COMPLETED**. 23rd April 2018 -
Making Safeguarding Personal (MSP): (initiative to ensure service users views throughout the safeguarding process) to be revisited to ensure direct involvement (rather than 3rd party) is a feature of all safeguarding cases – wherever possible	Local and Regional	Regional conference being established to focus on MSP - operational staff to attend.	Association of Directors of Social Services	Conference and workshops within it will have sessions on MSP and how coercive controlling behaviour may influence views held by individuals subject to safeguarding procedures >Report back to Local Safeguarding Board 5 Swindon representatives attended the conference, reported back to LSAB in August 2018	22 June 2018	**COMPLETED**.

Making Safeguarding Personal (MSP): (initiative to ensure service users views throughout the safeguarding process) to be revisited to ensure direct involvement (rather than 3rd party) is a feature of all safeguarding cases – wherever possible	Local	An overview of Coercive and Controlling behaviours along with any other new and emerging themes will be included in the annual Safeguarding Adults Refresher training all staff attend.	SBC Adult Social Care	>Consider suitable trainer >If existing trainer - brief her on current issues >Arrange training event(s) (also, to be included in specialist safeguarding supervision) Training to include other adult care teams as possibility of them managing safeguarding cases New Team manager started 2nd Jan 2019 who is committed to promoting MSP.	30 September 2018	**COMPLETED**.
A full action plan has been drawn up through the Local Safeguarding Adults Board (LSAB) following a Safeguarding Adults Review SCIE Review where Coercive Control was considered to be a factor	Local (but with some Regional learning)	The Head of Social Work has arranged formal training in relation to "Coercive Control & Domestic Abuse" over three dates in May and June 2018, LSAB to include links to related policy/guidance within Safeguarding Adults Procedures, including ADASS 2015 'Adult safeguarding and domestic abuse: A guide to support practitioners and managers'.	SBC Adult Social Care	>all relevant staff to attend training >Policy and Procedures includes ADASS document >safeguarding staff to reread document - for discussion in supervision >LSAB webpage to include this document	30 June 2018 30 April 2018	**COMPLETED.**
Provide training to the Housing Options Team to ensure all cases involving domestic abuse are referred to the appropriate officer and that we should always seek agreement from domestic abuse victims to contact them at a time and via a way that is chosen by them.	Local		SBC Housing	Training provided and completed		**COMPLETED.**

GP's need to be trained in more detail about the implications of the Care Act 2014. The Swindon CCG is currently in the process of ensuring that all GP's have this training.	Local	To include adult safeguarding training in teaching sessions to GP practices. In the interim all GP safeguarding practice Leads will have this training and they will be required to ensure that all their staff are aware of these implications.	Swindon CCG	All GPs receive training about Care Act 2014	May 2018 for direct teaching to practices. Adult safeguarding training will take place on September 25th 2018 and all leads will be asked to cascade information to their staff following this training. (All practices are covered over a year period.)	ongoing

A review should take place on whether the law / GMC guidance should be changed enabling a GP to contact the police if they believe that a patient is at high risk of serious harm or death if they go home to a domestic abuse situation even if no one else would be at risk other than the patient.	National	This is part of the first recommendation of this DHR (see above) but should be supported by a letter to GMC from Swindon CCG. Outcome to be disseminated to all GP practices.	Home Office/ Swindon CCG			ongoing (linked with ongoing Home Office Action above)
Swindon CCG to continue to put together a Safeguarding Protocol that all surgeries are required to sign up to that will be kept up to date (by CCG) with new legislation. This would include domestic abuse information and what actions a GP practice should take on receipt of a MARAC report for one of their patients.	Local	Action already taken: All current safeguarding policies have been requested from GP practices in Swindon. Action to still take: to review and collate to form a unified Safeguarding Protocol following receipt of the practice protocols. To include in the NHSE funded safeguarding development monies on DVA and primary Care	Swindon CCG	Safeguarding protocol for all GP practices launched.		**COMPLETED.**

All personnel should be reminded of the policy that: 1. The "Missed Appointment Matrix" is to be followed for all clients – especially prior to closing. 2. Workers to double check hard copy file for client's preferred method of contact and follow this course of action first. 3. If paperwork received from external partners – the allocated worker to be notified and given the paperwork before admin scan it to the document library to help ensure that potentially vital information is received. 4. A contact note should be put on record indicating a new document has been scanned.	Local		Swindon Drug and Alcohol Service (CGL)	All staff to be notified of this requirement		**COMPLETED.**1 May 2018
When a victim of domestic abuse contacts the Refuge and there are no places available, the person taking the telephone call should offer to check availability at other refuges and if safe to do so, phone the victim back rather that expect the victim to make several calls herself.	Local	Policy agreed and all refuge staff be notified	Swindon Women's Aid	Memo detailed policy sent to all staff on 2 May 2018. discussed at staff meeting on 4 May 2018		**COMPLETED.** 4 May 2018

Swindon Women's Aid require a structured Referral Pathway Protocol for those occasions when a survivor of domestic abuse moves to another service provider.	Local	Draft, approve and disseminate a Referral Pathway protocol	Swindon Women's Aid	Referral Pathway written and disseminated to all staff		**Completed 19 July 2019**
DA offence investigations to only be closed on the written authority of an inspector if the suspect has not been interviewed or arrested.	Local	Where criminal offences have been disclosed in domestic violence cases and the suspect has not been arrested or interviewed, investigations will only be closed on the written authority of an Inspector. The Inspector must satisfy him/herself that positive action has been taken.	Wiltshire Police	This is now written into force DA policy and was communicated to all officers and staff on the 06/03/2019.	1 July 2018	**COMPLETED.**14/03/2019

Evidence led prosecutions audit to take place	Local	Wiltshire Police should review victimless prosecutions to ensure 3rd party material is utilised effectively in the absence of victim testimony.	Wiltshire Police	A number of audits have taken place, mainly around domestic abuse to benchmark our current investigative standard and to identify areas for improvement. Audits have recently led to a force wide campaign to raise awareness of why victims may not engage with a prosecution and how we can build evidence led prosecutions, another audit finding has led to the change in Policy that all DA offences where no interview is to take place must be authorised by an Inspector. All ERO's have had additional training delivered by a former CPS crown prosecutor in relation to evidence led prosecutions, this includes the importance of first response such as utilising BW camera footage, 999 calls, previous history etc., capturing the evidence in terms of witnesses, House to House, CCTV, Digital media etc. understanding Res Gestae, the significance of section 78 of PACE and how documentation a victims fear can help avoid hearsay evidence from being excluded.	31 December 2018	**COMPLETED.** 14032019
Criminal Investigation into alleged perpetrator to be considered	Local	Wiltshire Police should consider the viability of conducting a criminal investigation into offences committed against Theresa by her husband.	Wiltshire Police	Investigation ongoing commenced and being managed by MCIT.	Ongoing	**COMPLETED** 14/03/2019

Consideration to be given to a stalking and harassment clinic.	Local	PPD DA DI to drive forward the potential of a stalking and harassment clinic in both Wiltshire and Swindon at the relevant safeguarding board subgroups.	Wiltshire Police	Stalking and Harassment clinics in Wiltshire and Swindon are being scoped [redacted] who is now the force tactical lead for Stalking and Harassment.	31 December 2018	**COMPLETED** 14/03/2019
All high risk cases should be referred back to MARAC when another incident occurs regardless of whether an offence has been committed or not.	Local	All high risk cases should be referred back to MARAC when another incident occurs regardless of whether an offence has been committed or not.	Wiltshire Police & MARAC	The process of MARAC referrals has been changed so that a professional decision is made by the DACC coordinator if a further DA incident is appropriate to be referred back into the MARAC process.	1 September 2018	**COMPLETED** 14/03/2019
When the police receives a call from a person with critical mental health issues which may indicate a risk of serious harm or death, in addition to referring the caller to the in-house mental health Street Triage Team the call should be treated as a Grade 1 call requiring an immediate response.	Local (Wiltshire Police area wide)	1. Update crisis and negotiator training given to CCC staff to ensure that any suicide concern is dealt with as a priority. 2. Messaging to all CCC staff reminding them of the importance of tasking a unit to suicidal callers before attempting to seek mental health support.	Wiltshire Police	Crisis and Negotiator training is provided to all new crime and communication centre recruits by the Force lead Negotiator. This training already includes support for dealing with suicidal callers in crisis.	1 July 2019	

Appendix A: Glossary of Terms

Avon and Wiltshire Partnership Mental Health Trust

General Practitioner (GP) acts as first point of contact for physical and mental health concerns.

Primary Care Liaison Service (PCLS) Primary Care Liaison Service (PCLS) acts as the single point of access to secondary mental health services. The service provides assessments for adults aged 18 years and above. Following assessment, the service facilitates referrals to secondary mental health services or signposting back to GP or non-statutory services as appropriate.

Mental Health Control Room Triage (MHCRT) is an initiative bringing together local police forces, and the local NHS. It places experienced mental health professionals into the police communications centre to offer real time advice and guidance to support police and fire service officers.

Swindon Intensive Service (SIS) – work closely and effectively with service users in crisis in the community as an alternative to admission to hospital. The service works with referred people and anyone caring for them to help: to work out possible reasons for their difficulties whilst finding the best ways to recover and stay well.

LIFT Psychology – offer primary care psychology services for a variety of issues, ranging from general stress to low self-esteem and anxiety using psycho-educational courses to one-to-one intervention. This can be accessed via GP referral or directly by the patient.

MARAC, or Multi-agency Risk Assessment Conference, is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists.

Swindon CCG

New Journal – detailed notes written by clinicians detailing what has been said during a consultation
MHT – mental health team
SEA – significant event audit
LIFT – psychotherapy /counselling, in house at GP surgery – low level psychotherapy usually not by a psychotherapist
GMC - General Medical Council
Crisis team – The on call psychiatry team for those patients that are at risk of suicide / other severe mental health problem, part of MHT
SIS – intensive mental health team

Wiltshire Police

Abbreviation	Explanation
CPS	Crown Prosecution Service
DASH	Domestic Abuse Stalking and Harassment Risk Assessment model
DVPN	Domestic Violence Protection Notice
DAIT	Domestic Abuse Investigation Team
MASH	Multi-Agency Safeguarding Hub
MARAC	Multi-agency Risk Assessment Conference
NICHE	Crime recording system
OEL	Officer Enquiry log
PPD1	Public Protection Department form
Res Gestae	**Res Gestae** is a Latin word which means "things done." This is the rule of law of evidence and is an exception to hearsay rule of evidence that hearsay evidence is not admissible. It is a spontaneous declaration made by a person immediately after an event and before the mind has an opportunity to conjure a false story.
STORM	Police Command and Control System
SOP	Standard Operating procedure

Appendix B: Bibliography

A study of recommendations arising from serious case reviews 2009-2010 (PDF). [London]: Department for Education. Brandon, M. et al. (2011)
Borderline Personality Disorder: The Nice Guideline on Treatment and Management 2009.

CAADA Responding to Domestic Abuse: Guidance for General Practice.

Care Act 2014

Code of Practice for Victims of Crime (October 2015)

Community Care Inform Adults : Di Galpin

Crime Survey for England and Wales for year ending March 2017

CTC (2014), Website of the US Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention.

Domestic Homicide Review Toolkit.

DL v Local Authorities (Court of Appeal 2012)

Domestic Abuse: findings from the Crime Survey for England and Wales: year ending March 2017

Domestic Violence, Crime and Victims Act 2004.

Equality Act 2010

Factors Associated With Child Sexual Abuse - stacks.cdc.gov
2008; Kaufman & Widom, 1999; Trickett, Noll, & Putnam .Child Abuse & Neglect 2000 24 10 1257 1273 11075694 Trickett PK Noll JG

General Medical Council Guidelines: Confidentiality: good practice in handling patient information (2017)

Good Medical Practice 2013

Guidance to doctors & GPs on the release of medical records into a Domestic Homicide Review. Sheffield Safer & Sustainable Community Partnership.

Guidance on Safeguarding and investigating abuse of vulnerable adults NPIA (2012)

Health consequences of intimate partner violence: Prof Jacquelyn C Campbell PhD

HM Government Information Sharing: Guidance for practitioners and managers.

Intimate Partner Violence as a risk factor for mental disorders: A Meta-Analysis. Jacqueline M. Golding

Mental Health and Domestic Violence: 'I Call it Symptoms of Abuse' Cathy Humphreys Ravi Thiara (2003).

Mental Health Homicide Review: NHS England https://www.england.nhs.uk/south/publications/ind-invest-reports/south-central/avon-wiltshire/

Mental Health and Domestic Violence: 'I call it Symptoms of Abuse' (2003).

Mental health, sexual identity, and interpersonal violence: Findings from the Australian longitudinal Women's health study,

Mortality statistics in England and Wales by sex and age range (ONS) Dec 2015: Laura A. Szalacha, Tonda L. Hughes, Ruth McNair and Deborah Loxton. (BMC Women's Health, 17, 1, 2017).

Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Home Office 2013)

NHS England Standard General Medical Services Contract 2015/6

Nice Guidance on "Domestic Violence and Abuse: How Health Services Social Care and the Organisations they work with can respond effectively". (February 2014)

NICE guideline - depression in adults - recognition and management. (2009)

Police Response to Domestic Violence: Carolyn Hoyle Andrew Sanders

The British Journal of Criminology, Volume 40, Issue 1, 1 January 2000,

Perceptions of Domestic Violence: The Effects of Domestic Violence Myths, Victim's Relationship With Her Abuser, and the Decision to Return to Her Abuser: Niwako Yamawaki, Monica Ochoa-Shipp, Craig Pulsipher, Andrew Harlos, Scott Swindler: Journal of Interpersonal Violence 27, iss. 16, 2012, 3195 – 3212.

Practice guideline for the Assessment and Treatment of Patients With suicidal Behaviours: D.G. Jacobs, et al. (Originally published in November 2003).

Protecting adults at Risk: Good Practice Guide (Social Care Institute for Excellence

Reasons for Reporting and Not Reporting Domestic Violence to the Police: Criminology March 2006

Safeguarding Vulnerable People in the NHS; Accountability and Assurance Framework (NHS England July 2015)

Serious Incident Framework (NHS England Patient Safety Domain March 2015)

Standards of Conduct, Performance and Ethics - Health and Care Professions Council 2016

The Association between Exposure to Interpersonal Violence and Suicide Among Women: a Systematic Review: Michael B. MacIsaac Lyndal C. Bugeja George A. Jelinek. (23 October 2016).

The Mental Capacity Act 2005

Violence, Alcohol, and Completed Suicide: A Case-Control Study

Kenneth R. Conner, Psy.D., Christopher Cox, Ph.D., Paul R. Duberstein, Ph.D., Lili Tian, M.A., Paul A. Nisbet, Ph.D., and Yeates Conwell, M.D. (2001)

Women's Aid, National Survey 2015

Working Together to Safeguard Children, Department for Education (2010)

Why Domestic Violence Victims Don't "Just Leave": Wendy L. Patrick PH.D. Psychology Today April 2018

'"Why Doesn't She Just Leave?': A Descriptive Study of Victim Reported Impediments to Her Safety.": Michael A. Anderson, Paulette Marie Gillig, Marilyn Sitaker, Kathy McCloskey, Kathleen Malloy, and Nancy Grimsby,
Journal of Family Violence 18, no. 3, 2003, 151-155.

WHY DON'T VICTIMS OF DOMESTIC VIOLENCE LEAVE THE RELATIONSHIP? The National Office for the Prevention of Domestic, Sexual and Gender-based Violence.

Appendix C: Text from two notes left by Theresa

Found at her home on the day of her death [redacted] November 2017

Both notes were separate and handwritten:

"To my family, I am so sorry but I just couldn't take it anymore. I know you may not understand this but I just can't explain the dark cloud that is over me. Please don't let this break you but know I am now free. Nothing any of you could have done could have changed this. Please just know that. I love you and please forgive me".

The second was addressed to her brother, [redacted]:

"So if you are reading this then I guess the darkness won. I am so sorry that I did this to you but please try and understand the pain I was in. As I sit here writing this letter the tears are streaming down my face because I know what this is going to do to you. Please find it in your heart to forgive me my brother. I just can't take the mental torture anymore. My mind never switches off and I can't seem to outrun these dark thoughts and trauma I have been through. I know by doing this it may seem like the coward's way out but for me the pain of living is too much and no matter what anybody does or says it"s all on me. Just know that there is nothing you or anybody could have done to stop this. You were all amazing especially you [redacted] you never judged or questioned anything about me and we shared some of the greatest times together and just know that I cherished and loved every second of it. I need you to know how important you are to me and this was the first letter I wrote and I am struggling to get through it. I have watched you grow into an amazing man who I have so much love, respect, appreciation and I absolutely adore you. You hold your head up high little brother and you stay strong you hear me! Sorry about the tear stains on the paper I just can't stop thinking about what this is going to do to you. I love you so much and if it wasn't for you I would never have been able to last this long. Unfortunately it has gotten to a place in my life where this darkness rules everything I do and I am in so much pain. [redacted] please, please, please forgive me but now I can be free. I love you brother, please don't let this break you".

Appendix D: Witness statement made by Theresa's husband Charles on [redacted] February 2018

This statement relates to the life of my wife, [redacted].

[redacted] & I went to the same schools in South Africa (primary and high school), but it was only in high school that we became close friends around 1999. We remained friends after high school.

In 2006, [redacted] witnessed a shooting in South Africa and I believe this seriously affected her mental health. She was visiting a friend and whilst waiting for her friend to open the gate to let her in, two men approached the neighbour who was also arriving in her car. The two men then shot the neighbour in the stomach. [redacted] then hid in her car but realised that the men had seen her, she the fled and the men followed her in the neighbour's car. The men only stopped pursuing her when she turned towards the police station.

Sometime after this, in late 2006, I was hijacked at gunpoint. After that [redacted] and I discussed leaving South Africa, and we both agreed that we would try move to the UK. Shortly after this I managed to get a job offer in Swindon. [redacted] and I moved to the UK in March 2007. We stayed together in the UK and after about 3 months [redacted] was missing home so she went back to South Africa for about 2 months, after which she decided that she wanted to come back to the UK.

In 2015 we had an attempted break in at our house and we had CCTV footage of a 2 burglars attempting to open the garage and the patio doors, although they never gained access to the house this negatively affected [redacted] Then in September of the same year we had a second attempted break in. I was abroad on a business trip and this time 5 men tried to force open one of the windows. After this [redacted]became increasingly nervous and had trouble sleeping.

I tried to help her feel more safe installing sensor lights in the driveway, garden lights which would come on at dusk and sensors which would beep in the house if someone came into the garden. We also started arming the house alarm in the evening. We discussed moving house, but I was concerned about [redacted]being too far away from her parents who lived within walking distance of our house. We also discussed me either looking for a project closer to home or a job where I could work from home more. [redacted]didn't want this and seemed to think this wouldn't really help her.

I work away a lot and as such I would often message or ring her during the day when I was away on business. Normally I would ring or Face-time [redacted]twice a day at least, but if I was busy then I would text quite a lot.

During this time, [redacted] health deteriorated. She began experiencing a wide range of physical symptoms including:

- irregular heart rate (both tachycardia and bradycardia)
- dizziness,
- fainting (vasovagal syncope),
- tightness in her chest
- Numbness in her face and pains on her left hand side.

[redacted] worked with her GP surgery who referred her on to other medical professionals. During this time and leading up to her passing [redacted] kept detailed notes of all her symptoms to help the Doctors with her diagnoses. The wait times for the referrals and specialist would often be very long. The long time it was taking between appointments and the lack

of diagnoses all while she continued to have these physical symptoms contributed towards [redacted]'s sense of helplessness and she writes in her diary of the feeling of wanting to "just give up".

At some, point it the healthcare professionals must have determined that she was suffering from mental health issues. She was referred to many different mental health care departments within the NHS, and she was diagnosed with PTSD from the shooting she witnessed in South Africa. She began working with various teams under the Avon and Wiltshire NHS Mental Health Partnership.

I believe that these teams have seriously failed to help my wife. She diarises many occasions of calling them when in a crisis in the middle of the night and simply being told to go to her GP in the morning. In the days and weeks leading up to her death, she diarises calling and texting members of the Swindon Intensive Services (SIS) and leaving messages not getting called back. On the day of her passing the SIS team called her back and she was simply told to go back to her GP. I find this totally unacceptable that a person in crisis is simply told to go back to their GP.

On another occasion, she diarises being told by a therapist at Lift psychology that she was finding it difficult to handle what [redacted] was telling her, and that if she paid to see a private therapist they would have to listen to her, as she would be paying. In effect I see this as them refusing her treatment as they felt she could afford to pay to see a private therapist.

[redacted] did start seeing a private therapist ([redacted]). [redacted] was helping her process the trauma of the shooting and the attempted break-ins. I felt that [redacted] was really helping [redacted] and in my mind, she seemed to be getting better when she was seeing [redacted] It was the times when [redacted] was away that when she had a crisis she needed to reach out to the Swindon intensive services, which only seemed to frustrate [redacted] and make her mental health crisis worse.

[redacted] also helped [redacted] develop several coping mechanisms. Whenever she would get anxious, she would do colouring in or painting. To help with her sleeping I bought a scented diffuser, which we put on at bedtime. We would also play soothing music in the evenings to help her sleep. She also practiced mindfulness. She made cards that she would keep next to her bed for when she woke up at night, to remind her that she was home and safe. She also attended boxing and Pilates classes to try help with her PTSD symptoms. [redacted] went to boxing classes on Fridays, she enjoyed it but said it could get feisty when there was sparring, I know that since [redacted] bruised quite easily it was clear when she had been sparring. I never pried into [redacted]'s therapy but I just tried to be supportive around it, so I didn't ask specifics about what she was discussing or what was being suggested.

On [redacted] August 2017, I was travelling for business when [redacted] called me to tell me that a PC [redacted] from [redacted] police station had called her and they were going to arrest me under domestic abuse charges. At the time, [redacted] was very distressed and her parents had to come to the house to try to calm her down. [redacted] agreed with PC [redacted] that I would hand myself in as soon as I was back in the UK, PC [redacted] stated that this was ok and that I would just need to report to the front desk at [redacted] and someone would question me. On 5 November, [redacted] and I went to [redacted] police station and reported in. We were told to wait and about an hour later an officer came out and asked why we thought we needed to be questioned, we explained the situation and the officer then said that there was nothing they could find and that they didn't need to question me.

[redacted] was still stressed about this situation and tried to contact PC [redacted] of the coming weeks, but she was unable to contact her or get any further information about the supposed case. I believe this unnecessary stress contributed to her failed suicide attempt on [redacted] September.

On [redacted] September, [redacted] attempted to hang herself. Fortunately, the 999 responders got there in time. I was in Germany on business at the time and her parents called me to tell me. I got the first flight I could get home. I then worked from home for the next several weeks so that I could be with her. During this time, [redacted] had told me that she had told the therapists at the intensive team that she had bought a rope and even set it up as a "trial run". I asked her what they said and she said that they didn't really say anything and that no additional help was offered. I found this very upsetting but at the time I said to her that she needs to concentrate on getting better and that we would make official complaints once she was well.

After this incident on 26 September [redacted] received a text from PC [redacted] stating they would no longer be arresting me, no further information or explanation was given.

[redacted] and I married in South Africa in October 2009. I would say that we had a very happy marriage. Neither of us had many hobbies or interests, so much of our free time was spent together. When working from home in the mornings we would both go to gym together. After I had finished work in the evening, I would join her on the couch where we would watch TV together. On weeks where I was away on business, I would always make a point of calling her at least twice a day. Also, we used one of those family tracking apps, so we could see where we each were at any given time. This was an app called life360, still have it on my phone. [redacted] could have turned that off at any time that she wished.

On weekends we would always try to get out of the house, either looking for an event to attend, visiting her brother in London or just going shopping together. We also enjoyed taking holidays together and in fact, we had booked flights to Thailand for the end of January. Another thing we enjoyed together was dining out, and again we had managed to get reservations at Heston Blumenthal's restaurant in February 2018, and she was particularly excited and looking forward to that.

We did have the occasional argument but I would say less so than any other couple (less than twice a year). I think that [redacted] wished that I would actually fight back, but that's not me and I wouldn't do that. This was never drink fuelled because we didn't really drink that much, we didn't drink during the week together, usually only on Sunday afternoons. During our marriage, I never questioned [redacted] about her drinking because I never suspected there was any sort of issue. We were a happy couple.

Our love life was absolutely fine although [redacted] did start to get to a stage where she wanted me to get rough with her during sex. I was never comfortable with that. One time she hit me on ear during sex, it was painful but I would never fight back and the most I did was hold her arms down so she couldn't hit me. I didn't her hitting me and didn't want her to do it again. Another time I remember that she wanted me to put a collar with a buckle on her around her neck, which I did but I recall it left a mark on her neck. I remember as it was about the time she was seeing a woman called [redacted] from the Intensive Team and I think [redacted] was called in to explain that after that time.

In terms of her career, [redacted] worked for my business ([redacted], an IT company) doing the accounts, paying our salaries and booking my travel. From this, she took a small basic salary (approximately £800 per month) but she also received a 50% dividend share from the business, which would pay out about £3000 per month to each of us.

[redacted] didn't have any specific work hours, which allowed her to study in her spare time. In 2017, I was very proud when she passed her final exam and obtained an honours degree in Combined Social Sciences

Financially I would say we were both very secure. [redacted] kept her own savings accounts (Barclays was her main bank, I think she had an ISA account with Lloyds, plus a new Nationwide account with nothing in it) and paid for her own car, she bought most of the groceries. She had even ordered a new car, which she was due to collect the week after her passing. I never pried into her finances and she was always free to spend her income on whatever she liked. In fact, after her death I had to walk bank to bank on the high street to determine where she had accounts.

Before her death, [redacted] was prescribed Sertraline which she was on for several months. In the weeks preceding her death she had discussed with her GP if the Sertraline where maybe causing her suicidal thoughts. Along with her GP, it was decided that she should come off the Sertraline. Over the course of about three weeks, [redacted] reduced her intake of the Sertraline. At first, this appeared to have a positive impact on [redacted] mental health. I recall her telling me "aren't you glad you have your wife back"

After her death, we also learned from the coroner that they had found tumours on her kidneys. Before her death I did say to [redacted] that maybe her low moods were correlated with her menstrual cycle (I know that [redacted] was so fixated on her health that she even had an app on her phone to track her menstrual cycle, when she was ovulating etc., although we had discussed children and decided not at the moment as we wanted to sort [redacted] health problems out). I now wonder if these tumours somehow impacted her hormones and that would account for her low moods. I also question if these tumours should have been picked up in all her interactions with the various NHS departments.

Further prepared statements to Wiltshire Police on [redacted] January 2019

I, [redacted] wish to state the following:
I have been accused of a number of offences. I am about to be interviewed about my life with Theresa, Theresa's mental and physical health and my mental and physical health.

Before I deal with that, I want to state categorically that I have not caused the death of my wife in any way. I have not had sexual intercourse with her without her full consent nor have I assaulted her. I did not engage in controlling or coercive behaviour towards her at all.

Regarding our relationship, I believe it was a good one. We had a sex life and we very rarely argued. We worked together in our own business. She had full access to her own money and also the business funds. Theresa's parents live but 5 minutes' walk away from our home address. Theresa took part in classes during the week, including boxing classes. I would frequently be working abroad and Theresa would be at home.

I have no physical health issues and apart from depression in my teens, I have no mental health issues.

Theresa had some health difficulties of a physical nature. As far as her mental health was concerned, she was increasingly unwell. I tried to support her as best I could. I always encouraged her to seek medical help. She saw therapists and other professionals to try to help. I did not feel that I was qualified to deal with her problems on my own.
Towards the end, Theresa admitted having dark thoughts. She expressed suicidal thoughts. Again, I made sure she saw suitable health professionals to try to deal with her

problems.
I was and still am completely devastated at my wife's sudden death. However, I was not responsible for it in any way.

Second prepared statement;
I [redacted]wish to state the following;
I have been accused of offences against Theresa between August 2016 and November 2017. I deny the commission of any such offences.

Theresa had her own phone that was paid for by our business.

When I was working at home, there would be little reason for us to speak on the phone as we were often together.
When I was away on business, it would be normal for me to call Theresa in the morning and then we would often face-time each other in the evening. I believe this was reasonable contact between parties. Theresa would be less likely to call me when I was away, it would be more likely for me to call her. The reason for that was Theresa would not want to interrupt my working time - I have to take part in meetings and workshops and it was easier for me to call her after that work had finished or indeed before, it started.
Our mobile phones had mutual 'find my friend' type GPS in case of emergencies.

Following the death of my wife, I have worked fully with the police and the coroner's office. I have provided a face to face statement to a police officer detailing everything I knew about her death. I have also provided the police with all of my phone's messages between us including the day of her death.

Appendix E: General Medical Council Guidance on Confidentiality (2017)

- **Guidance 12/10/2009 – 24/04/2017**

51. It may be appropriate to encourage patients to consent to disclosures you consider necessary for their protection, and to warn them of the risks of refusing to consent; but you should usually abide by a competent adult patient's refusal to consent to disclosure, even if their decision leaves them, but nobody else, at risk of serious harm. You should do your best to provide patients with the information and support they need to make decisions in their own interests, for example, by arranging contact with agencies that support victims of domestic violence.

53. Disclosure of personal information about a patient without consent may be justified in the public interest if failure to disclose may expose others to a risk of death or serious harm. You should still seek the patient's consent to disclosure if practicable and consider any reasons given for refusal.

54. Such a situation might arise, for example, when a disclosure would be likely to assist in the prevention, detection or prosecution of serious crime, especially crimes against the person. When victims of violence refuse police assistance, disclosure may still be justified if others remain at risk, for example, from someone who is prepared to use weapons, or from domestic violence when children or others may be at risk.

- **Guidance from 25/04/2017**

57. As a principle, adults who have capacity are entitled to make decisions in their own interests, even if others consider those decisions irrational or unwise. You should usually ask for consent before disclosing personal information about a patient if disclosure is not required by law, and it is practicable to do so. You can find examples of when it might not be practicable to ask for consent in paragraph 14.

58. If an adult patient, who has capacity to make the decision, refuses to consent to information being disclosed that you consider necessary for their protection, you should explore their reasons for this. It may be appropriate to encourage the patient to consent to the disclosure and to warn them of the risks of refusing to consent.

59. You should, however, usually abide by the patient's refusal to consent to disclosure, even if their decision leaves them (but no one else) at risk of death or serious harm.[19, 20] You should do your best to give the patient the information and support they need to make decisions in their own interests – for example, by arranging contact with agencies to support people who experience domestic violence.[21] Adults who initially refuse offers of assistance may change their decision over time.

65. Such a situation might arise, for example, if a disclosure would be likely to be necessary for the prevention, detection or prosecution of serious crime, especially crimes against the person. When victims of violence refuse police assistance, disclosure may still be justified if others remain at risk, for example from someone who is prepared to use weapons, or from domestic violence when children or others may be at risk.

Appendix F: Care Act 2014 - Section 42

Enquiry by local authority

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

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

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

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

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

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

(a) Having money or other property stolen,

(b) Being defrauded,

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

(d) Having money or other property misused.

Explanatory notes:

Section 42 – Enquiry by local authority

273. This section places a duty on local authorities to make enquiries, or to ask others to make enquiries, where they reasonably suspect that an adult in its area is at risk of neglect or abuse, including financial abuse. The purpose of the enquiry is to establish with the individual and/or their representatives, what, if any, action is required in relation to the situation; and to establish who should take such action. The duty supplements the existing obligations on other organisations to look after the people in their care effectively, or, in the case of the police, to prevent and respond to criminal activity.

274. *Subsection (1)* provides that the local authorities' enquiry duty applies to adults who have care and support needs (regardless of whether they are currently receiving support, from the local authority or indeed anyone); and who are at risk of or experiencing neglect or abuse, including financial abuse; but are unable to protect themselves. The eligibility criteria that the local authority sets for services and support are not relevant in relation to safeguarding. Safeguarding enquiries should be made on the understanding of the risk of neglect or abuse, irrespective of whether the individual would meet the criteria for the provision of services.

275. The local authority has a responsibility to make enquiries if the adult is currently in its geographical area of responsibility (whether or not the person is ordinarily resident there).

276.*Subsection (3)* defines "abuse" to include "financial abuse". The Care Act explicitly refers to financial abuse not because it has a priority status, but for the avoidance of doubt because some definitions of abuse may not ordinarily include this type of abuse.

Safeguarding Policy
Introduction

The purpose of this document is to set out the Practice Policy in relation to the safeguarding of vulnerable adults

Responsibilities

GP lead Dr [redacted]

GP deputy lead Dr [redacted]

The clinical safeguarding lead and the clinical safeguarding deputy lead are responsible for all aspects of the implementation and review of the safeguarding procedures in the Practice.

The Practice will ensure that all staff are trained to an appropriate level and that staff receive training updates periodically. We will endeavour to ensure all new staff will receive training within six months of joining the Practice

What is "an adult in need of care and support"?

The definition is wide, however this may be regarded as anyone over the age of 18 years who may be unable to protect themselves from abuse, harm or exploitation, which may be by reason of illness, age, mental illness, disability or other types of physical or mental impairment.

Those at risk may live alone, be dependent on others (care homes etc.) elderly or socially isolated.

Forms of abuse

- Self-neglect – neglecting to care for personal hygiene, health or surroundings
- Neglect – ignoring mental or physical needs, care, education, or basic life necessities or rights
- Modern slavery – slavery, human trafficking, forced labour and domestic servitude
- Financial or material theft or use of money or possessions, exploitation, misappropriation of property
- Sexual – assault, rape, non-consensual acts (including act where unable to give consent), touching, indecent exposure
- Physical – hitting, assault, rough-handling, inappropriate restraint, pain or misuse of medication
- Psychological – threats, fear, being controlled, taunts isolation, bullying
- Discrimination – abuse based on perceived differences and vulnerabilities
- Organisational or Institutional abuse – in hospitals, care homes, support services or individuals within them, including inappropriate behaviours, discrimination,

prejudice and lack of essential safeguards. It can be neglect or poor professional practice.

- Domestic abuse – psychological, physical, sexual, financial, emotional abuse or honour based violence of someone with care and support needs.

Abuse may be deliberate or as a result of lack of attention or thought, and may involve combinations of all or any of the above forms. It may be regular or on an occasional or single event basis, however it will result in some degree of suffering to the individual concerned. Abuse may also take place between one vulnerable adult and another, for example between residents of care homes or other institutions

Indications

- Bruising
- Burns
- Falls
- Apparent lack of care, including lack of provision of food and drinks
- Nervousness or withdrawn
- Avoidance of topics or discussions
- Inadequate living conditions or confinement to one room in their own home
- Inappropriate controlling by carers or family members
- Obstacles preventing personal visitors or one-to-one personal discussion
- Sudden changes in personality
- Lack of freedom to move outside the home, or to be on their own
- Refusal by carers to allow the patient into further care or to change environs
- Lack of access to own money
- Lack of mobility aids when needed

Where abuse of a vulnerable adult is suspected the welfare of the patient takes priority. In deciding whether to disclose concerns to a third, party or other agency, the clinician will assess the risk to the patient. Ideally the matter should be discussed with the patient involved first, and attempt made to obtain consent to refer the matter to the appropriate agency. Where this is not possible, or in the case of emergency where serious harm is to be prevented, the patient's doctor will balance the need to protect the patient with the duty of confidentiality before deciding whether to refer. The patient should usually be informed that the doctor intends to disclose information, and advice and support should be offered. Where time permits , the medical defence organisation will be telephoned before action is taken.

Due regard will be taken of the patient's capacity to provide valid consent

In assessing the risk to the individual, the following factors will be considered

- Nature of abuse, and severity
- Chance of recurrence and when
- Frequency
- Vulnerability of the adult (frailty, age physical condition etc.)
- Those involved – family, carers, strangers, visitors
- Whether other third parties are also at risk (other members of the same household may be being abused at the same time)

Subject to the local procedures in force, consideration will be given to:

- Multi Agency Safeguarding Adult Referral Form
- Report to Social Services Mental Health Team
- Report to the police
- Report to NHS England Lead
- Police 999 / 101
- Adult Safeguarding Team [redacted]
- Out of Hours Emergency Duty Service [redacted]

PLEASE ALSO SEE Policy and Procedures for safeguarding adults in Swindon and Wiltshire.

Appendix H: Swindon Women's Aid Confidentiality and Information Sharing Agreement.

CONFIDENTIALITY AND INFORMATION SHARING AGREEMENT

INFORMATION FOR SERVICE USER.

The information below outlines how we will treat the information that you give us about yourself, your family and others. It is important for you to read this information sheet and have it explained to you by your caseworker. When you have read and understood the agreement, please sign and date it below.

SWA CONFIDENTIALITY STATEMENT.

2. We will always try and tell you when information is being shared unless it is not safe for you or your children or if we can't contact you.

3. If we have to share information in this situation, we will only share relevant information that will improve you and/or your child[ren's] safety.

4. If we do not have your consent to share information, we will talk this situation through with a senior member of the team and will write on your case file what we have shared, why and who with.

5. You have a right to access your personal file, please contact your caseworker who will advise you of the process.

6. CONSENT/AUTHORISATION.

So that we know you have read and understood this agreement, please answer yes or no to each statement by placing a cross in the box.

The confidentiality and information agreement has been explained to me. Yes, No I understand that information about me will be held confidentially by SWA unless I give Yes No

My permission for it to be shared with others.

I have given my consent to the workers from Swindon Women's Aid (SWA) contacting and exchanging information about me with other agencies, on my behalf, which the project workers deem to be relevant in assessing and providing for my particular needs.

Signature (service user) Date

Signature (SWA caseworker): Date

Guidance for staff where the agreement is being explained over the telephone: If you are taking a referral or having this conversation via the telephone, read the summary information regarding SWA confidentiality statement (in the grey box above) to the service user and sign below to say you have explained it to the service user. On the first opportunity,

you get to meet the service user face to face, go through this agreement again and ask them to sign above.

_____ _____

Swindon Women's Aid (SWA) operates a confidentiality policy in line with the Data Protection Act (a full copy is available on request). Any information you provide SWA will be treated in strictest confidence within the organisation. This means:

1. The information you provide us is confidential unless, you consent to information being shared OR you or any children appear at risk of injury or harm.

_____ __

_____ ☐☐☐☐

_____

_____

_____

_____

Caseworker's signature

Date

_____

_____

SWA Confidentiality and information sharing agreement – version 02.02.16

Swindon Women's Aid sometimes takes part in national research to improve the kind of support women and children receive around domestic abuse.

We are also part of a national research programme run by Women's Aid Federation of England, who are a national charity working to end abuse against women and children. As part of this programme we share anonymised information about our work with Women's Aid to support research into domestic abuse, and to help campaign for more and better services for women and children.

Nothing that could identify you or your children (for example, names, addresses, and birthdays) would ever be shared or made public as a result of this research.

If you would prefer we did not use your information in this way, please tick the box below.
☐ Please do not use my anonymised information for research

I have read, understood and agree for Swindon Women's Aid to use my information

Name:_____ Signed: _____
Date: _____

Appendix I: Unexpected Death Review Report

Unexpected' Death Review Report

The purpose of the death review is to help us understand what needs to be done next to prevent future deaths. The aim of the review is to look for improvements rather than apportion blame.

- The review needs to investigate the facts surrounding deaths that occurred where suicide or overdose (including accidental) is suspected, death is as a result of an accident / untoward incident, cause of death is unknown, or there are unusual features surrounding the death
- The review needs to seek to explain how and why the death occurred including any potential contributory factors;
- The quality of care provided (include good practice and areas identified for improvement) and how well this was recorded should be included as part of the review;
- Based on the learning the report will help identify changes to practice and processes that if effectively applied will prevent future harm to service users and reduce mortality;
- The report should be used to facilitate discussion via the IGTM framework and learning contribute to the Service Quality Improvement Plan;
- The report should help provide a means of sharing learning from the death at a local (including the wider partnership), regional and national level;
- The prompts and format of the report are there to help you complete an effective and efficient report, that if required be easily transposed into a coroner report;
- The more facts you are able to gather the better your conclusions and analysis will be.

It is likely that your findings will highlight some learning and improvement areas. It is also likely that we will never know, if, had all these things been achieved there would have been a different outcome but at least the family would know that everything was done that could have been done.

Définition[42]

An unexpected death has been defined as "any death not due to terminal illness; or a death the family was not expecting" However, patients with chronic or terminal diseases also die unexpectedly.

Although not an exhaustive list for our purposes, criteria for an unexpected death include:

- ➢ Suicide is suspected;
- ➢ Overdose (including accidental) is suspected;
- ➢ Death is the result of an accident/untoward incident;
- ➢ Cardiorespiratory / pulmonary failure, strokes & seizures;

[42] www.endoflifecare-intelligence.org.uk/view?rid=116

➢ Cause of death is unknown;

Service User Profile					
Initials	[redacted]	**Date of Birth**	[redacted]	**Service user ID number**	[redacted]
Gender	**Female**	**Ethnicity**	**White British**	**Datix INF number**	22001
Reason for accessing service	**Alcohol, OTC meds support**	**Primary Diagnosis**	**N/A**	**Dual Diagnosis (provide details)**	Yes
Treatment start date (current episode)			**Treatment end date if not in service and discharge reason**		
21/09/2017			03/01/2018		
Directorate	**South West**	**Service**	**Swindon**	**Team**	Integrated Drug and Alcohol Service

Case overview					
Date of death	**10/12/17**	**Date notified**	**30/01/2018**	**Notified by**	Local Authority
Cause(s) of death	**Suicide**		**Medication prescribed by CGL**	**N/A**	

Date of last risk / recovery plan review	**Last Risk Management Plan: 03/10/2017** **Last Recovery Plan: 21/09/2017**	**Other medication?** **Prescribed by?**	**Sertraline 100mg od** **Prescribed by GP**
Illicit drug use	**Alcohol, Diazepam, Codeine, Propranolol**	**Alcohol use (provide AUDIT score if known)**	**Binge Drinking 6 days out of 28, Champagne and Whiskey.** **AUDIT 30** **SADQ 15**
Date of last medical review	**N/A**	**Date and time <u>last seen by CGL staff</u> prior to death**	**31/10/2017**
External notification required: **Commissioner, CQC, Local Safeguarding Board, HSE**	**Commissioners, Senior CGL Management, PHE**	**Police and / or Coroner involvement** **Coroner report requested**	Domestic Homicide Review invite sent to CGL. Case has been referred to the coroner but unknown if CGL will have to participate yet.
Death classification	Incident	Comments:	
Review Team			

Set out who has been involved in the investigation, whether that be one person or a team. Identify the role of each person both within the organisation and in the review of the death
[redacted] Team Leader – Investigating Manager
Methodology
List the interviews conducted, review at IGTM / MDT, case records, case notes, risk / recovery plan, chronology, other evidence collected and any other methodology used
Hard Copy Paperwork and CRIIS Notes/Document Library
Other agencies involved with the service user – Has additional information been requested to inform this report?
May have been known to AWP Mental Health
Description and Consequences
Concise description of facts surrounding the death (Where, What, When, How?). What was happening for the service user?

The client began accessing support at CGL on 21/09/2017 alcohol, diazepam, codeine and propranolol support. The illicit drug use only started within the last 2 years. The client's GP previously prescribed co-codamol and diazepam, which the client continued to buy online when the GP ceased prescribing. The client also bought propranolol online.

The client's GP fax back identified previous suicide attempts by medication overdose, a history of depression and anxiety, and that the client was an alleged victim of domestic abuse and was known to MARAC.

The client only engaged in one structured intervention since accessing CGL, an alcohol workshop on 31/10/17, and was then sent a disengagement letter advising of our intention to close her as a client, or otherwise explore barriers to treatment to try and support her.

When the client had her comprehensive assessment on 3/10/17 – it was identified that the client had PTSD, and had had no trauma interventions to date. The client also stated that she had sought treatment from the mental health team, but they refused to treat her until she left her husband. She stated she did not understand why this was and identified him as a protective factor and that she would not leave him. The client also identified the damage she felt she was causing her family and she wanted to be abstinent from all substances.

During the single workshop the client attended on 31/10/17, the client checked in as feeling "crap", but otherwise participated well in group and no further concerns were identified. This was the last communication CGL had with the client.

Chronology

The chronology should list, in date order, all significant events and changes during a SUs engagement with the service. Significant would include change of circumstances, risk factors, professional involvement. As the date of death approaches events / changes and actions taken to respond and/or manage become more significant:

- Start the timeline at the first contact or when referral was received and work forwards to last contact;
- Summarise in chronological order the last **6 – 3** months;
- Provide a more detailed chronology for the last 3 months preceding the death;
- For multiple episodes of treatment just detail start and end dates and discharge reason;
  (e.g. Treatment episode x 1: 1st Jan 2014 – 23rd March 2014 – Unplanned exit; Treatment episode x 2: ……..)
- Entries on the chronology should be brief and succinct (do not cut and paste verbatim CRiiS notes);
- Write in the past tense;
- Refer to the title and surname only e.g. Mr. Brown, Ms. Black;
- Specify the date of event, source of information and date information received;
- State facts; do not partake in analysis in the chronology;
- Do not use acronyms (or make sure abbreviations and acronyms are explained when you first reference them);
- Be in neutral language, suitable for professionals and family members to read. Do not insert names of other people involved, just the relationship to the deceased;
- Final entry(s) should be a detailed account of events leading directly up to the death and actions taken immediately after to manage the situation. This would include a record of any de-brief undertaken with staff and / or SUs), contact with family, police, coroner.

Appointments attended or DNA	**Event/intervention**	**Follow up actions if DNA**	**Notes of other agency involvement / referral**
List dates			
21/09/2017	Registration with CGL completed		
25/09/2017	Meet and Greet Attended		
3/10/17	Comprehensive Assessment Completed		Client identified witnessing a shooting 10 years ago as trigger for PTSD. Client stated that something “switched” in her head about a year ago and this was the trigger

for alcohol and drug misuse. She stated her family held a “family conference” to discuss how to support her – she stated she found this both helpful (because of the support), and unhelpful (because of the scrutiny).

Client stated that Mental Health Team would not support her with her PTSD until she left her husband and she did not agree with the decision and stated she needed support with her mental health. Client stated had discussed the mental health with her GP, and she also did not agree with AWP’s decision to not support her. Client agreed to speak again with GP to support her with appealing the decision.

18/10/17 GP Fax Back received

26/10/17 Letter Sent Client had not been attending agreed Alcohol Harm Minimisation Workshop as part of her immediate Recovery Plan. Reminder letter sent of time and dates of workshop.

31/10/17 Alcohol Harm Reduction Workshop Attended31/10/17 Letter Sent Disengagement letter sent advising that client will be closed due to non-engagement unless client contacts CGL to discuss barriers to treatment.The disengagement letter was sent before the Workshop notes had been added to CRIIS. The Case Coordinator therefore was unaware the client had attended the workshop that day.

3/1/18 Client record closed on CRIIS There is an unexplained delay from when disengagement letter was sent and client being closed. It is not recorded if the client was discussed in any team meetings or with a team leader before closing the file. There w

As no recorded welfare, check carried out or calls to the client before closing the file.

30/01/2018 Email received from Local Authority stating client had committed suicide on [redacted]/17, and that CGL were being asked for information for a planned domestic homicide review into the case. CGL were unaware until this point that client was deceased.

Summary of contact
1. Summarise reason for entering treatment. What were the identified needs and what did they require from the project? 2. What risks were identified and how were these going to be managed by the SU and the project? 3. What was outlined in the recovery / risk plan? 4. Compliance with treatment plan and/or prescribing regime

The client entered treatment for Alcohol and OTC medication support. The client's end goal was abstinence from all substances. The immediate identified need was to attend the alcohol harm reduction workshop at CGL, and throw away all her medication she had stored at home. Her progress would be reviewed at her next meeting with her case coordinator.

Risks Identified:

- Polydrug Use
- Previous Overdoses
- Multiple Hospital Admissions
- PTSD

Protective Factors/Mitigating Factors:

- Family Support
- Client to throw away all her tablets at home
- CGL Workshops to help reduce alcohol use
- Husband can take client to hospital
- Re-referral to Mental Health Service by GP

As the client had only just entered the service her initial Recovery Plan was to complete the Entry into Treatment Pathway - Meet and Greet, Comprehensive Assessment and 3 x structured interventions/workshops.

Her immediate goals were to throw away all medication tablets from her home, reduce her alcohol by buying smaller bottles of whiskey, speak to her husband about locking whiskey in cupboard, attend CGL's Alcohol Harm reduction workshop weekly, and to speak to her husband about him attending CGL's carer's group for family and friends of people in addiction.

The client did not immediately comply with the recovery plan for workshop based interventions, but did attend her first and only one on 31/10/17. It is not recorded or known if she complied with throwing away her tablets at home, or had been to the GP for re-referral to Mental Health Services.

Level of engagement with the service

Outline the general level of engagement with the project? What was being done to address disengagement? Was missed appointment protocol followed?
SW1734 attended appointments with her Key Worker or other staff at CGL Swindon between 21/09/2017 and 03/01/2018; she was seen by her Key Worker or other staff on 3 occasions and did not attend on 4 occasions. The missed appointment matrix was not followed or the DNA's recorded from her workshop attendances on any occasions. On the Risk Management Plan – the client had requested a phone call to either herself, her husband or her GP in the event of disengaging with CGL, none of which were completed by the worker who sent a letter instead. There is no evidence of a welfare check being carried out before client was closed to the service.
Last contact
The last contact CGL Swindon had with SW1734 was on 31/10/2017. This was an Alcohol harm Reduction Workshop with SW1734 The service was informed of SW1734's death on 30/01/2018 by The Community Safety Partnership from the Local Authority, as CGL were being invited to give details of engagement with client as there was to be a domestic homicide review regarding her death.
Physical health issues
No issues identified **Possible Victim of domestic abuse – unknown what possible category of abuse**

Mental health issues
Anxiety **Depression** **Suicidal Ideation** **Possible Victim of domestic abuse – unknown what possible category of abuse**
Findings and Analysis

List here what came out of this situation in terms of things that could have been done better, improvements identified and areas where gaps were identified in processes, SOPs. Also highlight areas of good practice

Consider all contributory factors relating to the care and treatment of the service user taking into account:

- **Was there a failure to adhere / apply any CGL policies and procedures? Which ones? What specifically was not followed?**
- **Was the risk / recovery plan reviewed in a timely manner?**
- **Did the recovery interventions relate to the risk / recovery plan?**
- **Where static and dynamic risks identified and responded to?**
- **Was there adequate communication and joint working between relevant partner agencies, GP and family members or carers if relevant?**
- **Did key staff have the appropriate training to do the job well?**
- **Did they communicate and escalate appropriately?**
- **What could we have done differently to potentially prevent this death from happening?**
- **Were there any missed opportunities that may have helped prevent the death (e.g. earlier intervention)?**

See next page for guidance on specific aspects to consider

There is strong evidence that the quality and characteristics of treatment and its management can have as much impact on service user outcomes and mortality as the service user characteristics themselves and indeed may account for more variance. Good quality, evidence-based drug treatment can help service users achieve recovery outcomes and reduce their chances of premature death.

When considering your findings bear in mind the following where relevant:

Harm reduction and risk management

- *Risks are avoidable and can be modified by making changes in personal behaviours. Were protective factors regularly discussed with the SU? Was the SU supported in identifying ways in which <u>they</u> could reduce risk*
- *Regular harm reduction advice tailored to the service user is critical. Is there good evidence that this was happening? Describe the nature of this advice and when it was given?*
- *Was Naloxone provided in this case? Have all staff been trained to distribute Naloxone?*
- *Was a medication safety box provided to the SU if they had contact with children or vulnerable adults?*

Treatment plan

- *There is evidence that receiving an optimal dose of OST results in less opiate use and a reduction in risk behaviours. Was the SU being prescribed the optimal dose for them?*
- *How frequently was the SU drug tested to identify treatment adherence? Was the procedure adhered to? Were self-reports of illicit use quantified? Please describe how 'illicit use on top of script' was being managed.*
- *How was regular alcohol use being addressed? Was the breathalyser used appropriately?*
- *Were regular medical reviews taking place? What did the latest medical review identify and the forward plan.*
- *For SUs who met the high risk profile, were ECG, liver function tests & health screening taking place?*
- *Take home doses should only be given if SU is stable and not using illicit drugs or excessive alcohol. Take home doses should not be given if SUs are suspected of diverting medication, or if there are*

concerns about risk to children. Is there evidence of the Appropriateness of Supervised Consumption Inventory (ASCI) being utilised?

Joint working

- *Describe what joint working and information sharing was taking place with GP, CMHT, Community Pharmacist etc. regarding coordination of care, prescribing practice and risks of poly-pharmacy?*

Recovery interventions

- *How was the service working with the service user to increase and bolster their recovery / social capital (e.g. mutual aid, asset-building interventions to encourage health, well-being and meaningful activity)*
- *How was the family involved in the recovery / risk plan.*

Aftercare planning

- *Is there evidence of robust discharge and aftercare planning + recovery check-ups?*

Recording

- Overall what was the quality of recording? Was it factual, timely and accurate?

Support for staff

- *SV, IGTMs, MDTs are essential forums. If the case met the high risk / complex profile was the key worker supported to present the case? What support was provided to the Recovery Worker to help manage the case?*

The client disengaged very quickly after accessing treatment and only attended one structured intervention which was an alcohol support workshop, the notes were not detailed enough to ascertain exactly what was going on for the client at that time (31/10/17)

The client did not engage long enough to have a Recovery Plan Review, this would normally happen 6 weeks after entry to treatment.

There is no evidence of any follow up of the client's actions from the initial Recovery Plan/RMP as the client was not seen again by her allocated worker since the assessment.

It is not clear if the allocated worker acted on information received from the GP approx. 2 weeks after client first attended CGL, which stated that client was known to MARAC. There was no contact note written by the admin team who scanned this document to advise the Recovery Worker of its existence, and there was an unexplained delay between 18/10/17 when the document was received and 10/11/17 when the document was scanned.

In the client's assessment paperwork and Risk Management Plan – the client listed her husband as a protective/supportive factor and there was no mention of domestic abuse.

The client had not been booked an Alcohol Nurse Assessment after trigger points were hit on both Alcohol AUDIT (30) and SADQ (15)

Lessons learned

Identify key safety and practice issues identified which may not have directly contributed to this death but are significant and will contribute to preventing future deaths.

Risk of Domestic Abuse not acted upon when information received from GP.

Disengagement protocol not followed as how the client wanted.

All clients to be booked Alcohol Nurse assessments immediately after trigger points on AUDIT/SADQ met.

Client closure not discussed at Clinical Team Meeting

Recommendations

This is the learning identified and this is what we need to do as a result.

Recommendations should be numbered and referenced and be directly linked to the learning identified. They should be clear but not detailed (detail belongs in the Service Quality Improvement Plan).

Missed Appointment Matrix to be followed for all clients – especially prior to closing.

Workers to double check hard copy file for client's preferred method of contact and follow this course of action first.

If paperwork received from external partners – the allocated worker to be notified and given the paperwork before admin scan it to the document library to help ensure that potentially vital information is received.

A contact note should be put on record indicating a new document has been scanned.

Conclusion		
Draw out the conclusions linking this back to the introduction and main body discussions		
Immediate Actions taken / to be taken		
Has the immediate risk been assessed for impact and likelihood of re-currence?		
Yes No		
If Yes, what measures if any have been put in place to minimise risk of reoccurrence?		
Measure / Action	**Who is re-sponsible for Action**	**Completed (please mark)**

Investigation report completed by			
Name	[redacted]	**Role and Project**	**P587 CGL Swindon**
Telephone	[redacted]	**Email**	[redacted]**@cgl.org.uk**
Date	**14/2/18**		

Appendix J: Avon and Wiltshire Mental Health Partnership NHS Trust Care Programme Approach and Risk policy

CPA and Risk Policy			
Board library reference	**Document author**	**Assured by**	**Review cycle**
P032	Head of Nursing – Community	Quality and Standards Committee	3 years

This document is version controlled. The master copy is on Ourspace.

Once printed, this document could become out of date.

Check Ourspace for the latest version.

1 Introduction

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) will ensure that service users experience safe effective care and treatment. That provides appropriate support to meet their needs and protect their rights (care and welfare of people who use services CQC Regulation 9; Outcome 4).

The Care Programme Approach (CPA) is the national term used derived from Department of Health Policy guidance and legislation to define a multi-agency framework that supports and coordinates effective mental health care. This is to ensure efficiency and well managed risks in supporting the outcomes of both personal and clinical Recovery. The framework is applied to care of Service Users with severe mental health problems in secondary mental health care services. This personalised approach to mental health care actively promotes Service User involvement and engagement with emphasis on strong communication between multiagency and shared providers in meeting the Service user's needs. Supporting Service Users to engage and undertake an active role in the process. This value is at the heart of AWP approach and its aim of reducing distress, promoting social inclusion thus improving outcomes for Service Users and their families across all domains.

There are 2 levels to the CPA framework.

(New) CPA (formally known as Enhanced) is the level for Service Users with multiple and complex needs and or require their care needs from a range of provider's and multiple agency involvement. This group is likely to be at higher risk and present a greater risk of disengagement from services.

Non CPA (formally known as standard) provides support for individuals receiving care from one agency and who are largely able to self-manage their mental health problem.

When deciding what level of CPA for this group a default position should be considered for ***(New) CPA*** unless assessment of need and risk shows otherwise. ***Non CPA*** (formally known as standard) provides support for individuals receiving care from one agency and who are largely able to self-manage their mental health problem.

2 Policy Statement

CPA is supported through the adoption of the processes described throughout this policy, and through completion of Trust approved forms or the use of RiO, the electronic record. The RiO Clinical Manual outlines the standards for documentation for use with both paper and electronic forms AWP will support people and their families to build a meaningful and satisfying life, as defined by the person themselves, whether or not there are ongoing symptoms or problems, through applying the principles of Recovery and Social Inclusion. This is to ensure that service users receive high quality care based on the range approaches in meeting needs and wherever possible provide choice over their care plan, CPA meetings should be arranged and conducted in active partnership with other agencies working with the service user, and the service user and carer.

3 Purpose or aim

The purpose of the policy is to support staff in the effective implementation of the Care Programme Approach (CPA).

4 Scope

The CPA is the principle framework for providing services to people referred to AWP. AWP will ensure that services are also provided under Non CPA for those people that do not have 'complex' needs and/or where risk assessment indicates a less than significant risk to self or others (DH, 2008).

CPA is underpinned by standardised Procedures for Adult and Older Peoples' Mental Health, and where co-existing problems exist for people with a Learning Disability and / or Substance Misuse. Any person with a person-centred plan or health action plan will be incorporated under CPA.

CPA will operate in all inpatient and community settings and will require good communication with all local organisations, and where people reside in out of Trust placements.

CPA underpins the delivery of care for individuals with mental health difficulties involved in the criminal justice system, in line with the recommendations of The Bradley Report

CPA delivery will be supported in AWP through adherence to clear and robust supervision arrangements as outlined in the Trust supervision policy.

CPA will involve reviewing/re-allocating the Care Cluster, as this demonstrates the changing needs and therefore supports treatment/care plan options

AWP is committed to the fair treatment of all, regardless of their age, disability, gender, sexual orientation, race, ethnicity and religious beliefs.

CPA is a protecting framework for Vulnerable adults – unsettled accommodation significant impairment of a function due to risk mental illness Self-Neglect

Full details of practice guidance and Procedures are accessible via hyperlinks within this document and on the CPA pages of Ourspace.

5 Policy description

5.1. Service Users and Carers

AWP staff will recognise and act upon the expertise that service users and carers bring from living with the challenges of mental distress. The family relatives and carers views need to be considered and involved in the care in the management of risks.

AWP will adopt a shared approach (CSIP, 2008) to ensure that service users and their carers have the opportunity to be actively involved in how they should be treated.

Practitioners will use strengths based approaches that embrace individual aspirations, coping strategies and resiliencies, as well as identifying needs and challenges to promote and support recovery.

Practitioners will work in partnership with service users their relatives and carers to plan and review care. We expect that this will usually involve all parties meeting together. However at times it may be beneficial for the service user and carer to meet a practitioner separately.

The Trust CPA leaflet should be given to every service user who is subject to CPA. This outlines what they can expect from the service and ways to have involvement, including information on how to make a complaint (PALS).

Wherever possible the service user should receive a copy of their care plan and it should be recorded in the Service Users clinical records RiO that this has happened.

5.2. Referrals and Triage

All referrals to AWP are subject to an initial screening by being triaged by an appropriately qualified health care professional.

Referrals which meet the service criteria will be forwarded to the appropriate team who will undertake an assessment.

Referrals not requiring assessment will be returned to the referrer with referral outcome decision and recommendations for further signposting and interventions

All referrals that are accepted will be assessed, completing the electronic record, to determine whether a service is warranted and, if so, whether CPA or Non CPA is appropriate. A Care Cluster will be allocated by the third contact or at the point of transfer into mainstream secondary services, whichever comes sooner

Whether CPA or Non CPA is agreed, the principles and values underpinning CPA will apply; these comprise assessment, planning, intervention and a review with a named practitioner responsible for coordinating their care.

In these instances, where a carer is identified they will be offered a carer's assessment and subsequent plan to meet their needs. See Triangle of Care The details of the carer must be recorded onto RiO.

An appropriate risk assessment will be completed based on the practitioner's assessment and risk scores in the Care Cluster Assessment, in conjunction with service users and their carer/family to address issues written in the care plan. Further guidance on carrying out risk assessment and risk management can be found on the following link: Risk Management

Information regarding the person's history and current difficulties should be sought from family members, where possible.

The role and input of any family members or carers in care and treatment must be articulated clearly in care plans and appropriate arrangements regarding sharing of information by the service discussed with the service user.

Assessments need to fully acknowledge both the current and possible effects on the family due to any mental health problems identified.

This is particularly relevant where there are children in the family, or where there may be a significant impact on other caring responsibilities the person may have. A member of the Trust Safeguarding Children Team will be consulted in all clinical decision making for service users where a risk to a child is identified.

Where further assessments are required, they will be requested and this will be recorded on the care plan.

All assessments will adhere to the principles of recovery, social inclusion, equality of opportunity and diversity.

Any assessment continuing after two appointments will be accompanied by a plan of action and Care Cluster, which may include further assessment.

The completion of all assessments will include allocation to a care cluster.

5.3. People assessed but not requiring a service from AWP

Where a person is assessed but a service from AWP is deemed not necessary, a letter will be sent to the referrer and person, with the referral outcome decision and recommendations for further intervention, including any sign-posting to other services and consideration of any carers needs.

The assessor will be required to complete the relevant electronic record.

Any person felt to require a service from Improving Access to Psychological Therapies (IAPT) or brief intervention from liaison services will be included in this category.

This rule will also apply to person being seen by AWP's autism spectrum disorder and ADHD diagnostic services. Included in this category are those receiving post-diagnostic support

5.4. Service users assessed as needing Non CPA

Those likely to be allocated to Non CPA are those receiving services from:

- Memory Services
- General Hospital Mental Health Liaison Teams
- Care Home Liaison Teams
- Those solely under the care of Specialist Drug and Alcohol Services (SDAS)
- Those attending time limited groups for sessional brief group therapy such as Eating Disorders.

Where a time-limited intervention is provided

- Any service user allocated to Non CPA must still have the principles of CPA applied to their care, as outlined in 5.1.

- All those receiving services under Non CPA will have a Care Coordinator who will take responsibility for organising care, recording appropriate information in progress notes, liaising with the referrer, carers, and others, as appropriate to do so, and organising reviews of the care and the names person responsible for coordinating their care.
- The service user and referrer will be offered a summary of the assessment, including the plan of care.

5.5. Service Users with significant caring responsibilities

The needs of this key group should be considered and explored to ensure that the needs are understood and addressed.

- Parenting responsibilities
- Dual Diagnosis(Substance Misuse)
- A history of violence or self-harm
- In unsettled accommodation

5.6. Service users assessed as needing CPA

This will include anyone where there are:

- Safeguarding issues identified and AWP is the lead organisation, including management or referral under Multi Agency Public Protection Arrangements (MAPPA)
- Anyone requiring admission either to an in-patient unit or to an Intensive Team
- Anyone who is subject to the Mental Health Act, including a Community Treatment Order.
- Anyone being discharged from hospital that is eligible for section 117 aftercare.
- Where the practitioner will be responsible for coordinating the involvement of more than one agency

Those service users assessed as needing CPA will have a named Care Co-ordinator who will take responsibility for coordinating all the functions of CPA.

All service users will have a care plan which will address any areas of risk as identified in the risk assessment. Principles of good care planning within CPA are identified in section 12 below.

Practitioners need to be aware that systems other than CPA may apply to particular service user groups such as MAPPA, S117 arrangements, Mental Capacity Act (MCA) and child protection arrangements

5.7. Safeguarding and Risk

The Trust is committed to delivering effective public protection and safeguarding arrangements to manage care and risk, for service users, their families and carers, and their communities.

Every person referred to AWP will have a risk assessment completed and recorded in RiO.

Procedure to adhere to in the management of risk can be found here

Where a request is received from the Police that an AWP member of staff acts as the appropriate adult for the service user who has been detained by the police the following guidance should be followed: Guidance on Acting as an Appropriate Adult

Where a safeguarding issue has been identified of a sufficient degree to require raising concerns to a partner agency, procedures on the following link will be followed: Safeguarding

5.8. Dual Disorder (co-existing mental health and alcohol and drug problems)

There are increased risks of suicide, non-engagement, non-compliance of medication, of a poorer prognosis, social exclusion and physical related harm for people with dual diagnosis therefore effective detection, support and treatment is essential.

The treatment with the strongest evidence base is an integrated approach. The primary responsibility for care planning sits within mental health services.

Current alcohol and drug use must not exclude people from a full assessment.

If alcohol and drug needs are identified, completion of the relevant RiO fields will be completed, and interventions, including management of risk, identified in the care plan.

5.9. Care planning under CPA

All service users allocated to CPA will have a comprehensive care plan, which must be agreed at the meeting. It is the care co-ordinator's responsibility for maintaining this care plan (though not delivering it all). Wherever possible carers will be consulted on and involved in all stages of developing care plans and reviewing the ongoing care of the service user, including the offer of a meeting alone to discuss any concerns

Wherever possible the care plan will be formed with the service user and carer. It must contain a review date. Where possible it should be signed by the service user. The service user should receive a copy of their care plan. In any instance where this is not possible a reason for this must be recorded in the notes.

Care plans will clearly set out the type of intervention required, the responsibilities of those involved, and the desired outcome.

The care plan should be structured to record those needs that the person can address for themselves and those where support is necessary from AWP, other organisations and family or carers.

The care plan should identify and build on strengths based approaches consistent with the recovery approach, and should reflect the aim of personalised care and social inclusion.

Potential risks and any actions to be taken should be included in the care plan. Positive risk management should underpin any plan of care.

All those recorded on the care plan, including service users and carers, will be provided a copy of the care plan unless specific objections are made by the service user.

Disengagement or non-attendance will always be discussed, action agreed and then recorded in the notes, in accordance with the Access to Mental Health Care Assessment and Treatment Policy and the Care Delivery Procedure

All care plans will include crisis, relapse and contingency plans, and any advanced statements or decisions will include action that is to be taken with regard to any disengagement or non-attendance for appointments.

Crisis Plans

The crisis plan should detail the actions a service user and/or carer could take when they feel there is deterioration in their health and mental wellbeing. A clear plan should outline actions of service response or Service or actions if disengaging with services. The standard of review period for Crisis Contingency and Care Plans should not sit outside of the review and instead be seen to mirror the timeframes of the scheduled review meetings.

The crisis plan should include (but not be limited to) an Out of Hours access arrangement and contact number.

Where possible the service user should be supported to write their crisis plan in the first person.

Contingency Plans

Contingency plans will detail the service/staff response to any deterioration in the service user's health, wellbeing and/or risks.

Details of specific actions to be taken in response to DNAs and non-concordance with agreed plans and treatments should be included in the contingency plan.

There should also be the inclusion of any relevant requirements of a valid Advance Directive and rapid access plan.

5.10. Reviewing care

Reviews of care should take place with the service user and any other relevant people involved in their care.

The Care Coordinator is responsible for ensuring that review meetings take place at the relevant times. **There is a minimal requirement to undertake an annual review** the best practice interval of 6 monthly reviews will be achieved or earlier at whatever time it becomes necessary.

Each review will consider the issue of whether CPA, Non CPA or step down is appropriate, and the appropriate risk assessment undertaken to support any changes made including a decision if discharge from services is required where identified needs and are met or interventions to meet needs are required outside of AWP services.

All CPA must take place in a face to face meeting, agreement will be sought from the service user about whom it is felt needs to be present.

In addition reviews should be undertaken when there are significant changes in need or risks and at transitioning points in the care pathway including:

Internal transfers of care between internal teams e.g.

- Transfers of care to external providers responsible for delivering care under CPA
- Episodes of Intensive home treatment

Discharge from hospital, a review will be undertaken 12 weeks post discharged or as necessary to facilitate putting in place any appropriate plans.

If step down from CPA back to Primary Care is being considered then a full assessment of risk will be undertaken, to include a relapse prevention plan, and instructions on rapid access to care and / or advice.

At the point of step down to Primary Care, all relevant information will be communicated to the GP. GP's to be invited to review meetings when step down is being considered. The GP, service user and any carers will be made aware of circumstances where access to Secondary Care may be appropriate. The care plan will reflect any specific vulnerability of services users leaving hospital and clearly document actions to be taken to provide the requisite level of care in the post discharge period

Section 117 eligibility will be reviewed at each CPA review, including transfers and transitions of care. Each review should ask the following questions:-

a. Do the section 117 aftercare services continue to meet a need arising from or related to the person's mental disorder that led to the original detention?

b. Do the section 117 aftercare services reduce the risk of a deterioration of the person's mental condition?

Do the aftercare services reduce the risk of the person requiring readmission to hospital for treatment for the disorder?

If the answer to all 3 questions is "yes" then the section 117 eligibility **must continue** and this should be recorded on the CPA review paperwork. If any of the answers are "no" then the full multi-disciplinary review should make a decision about whether to formally end the section 117 eligibility. This decision must involve the care co-ordinator, a consultant psychiatrist and the Local Authority, Fully involving the patient and (if indicated) the carer and/or advocate in the decision making process will play an important part in the successful ending of section 117 eligibility. If a decision is made to end section 117 eligibility, then the service user should be informed in writing; the letter should be signed by a consultant psychiatrist and a representative of the local authority.

5.11. Transfer and Transition of Care

In the event of transfer or transitioning care the individual needs of the service user must remain paramount and will not be disadvantaged. Transfer or transition of care.

No duplicate assessments will be undertaken to decide suitability for accepting any transfer request, as this may result in unnecessary delays.

Care will remain with the originating team, until it has been officially transferred through a CPA review or a comprehensive handover meeting in most cases this is expected to be completed in a 12 week timeframe .It is anticipated that this should be completed sooner If this Service User has already moved into the local area to support engagement and treatment needs.

Where it is felt that inappropriate transition requests are being made, the transfer should in most cases still continue. This is to prevent unnecessary disruption to the service users

and avoid delays in treatment, the local arbitration processes will be followed, and where concerns arise these must be escalated to the senior management team in a timely way.

Where teams are utilising Care Clusters, transition will be determined via these procedures.

5.12. Rapid Access

The Crisis, Relapse and Contingency Plan at the point of step down will outline the detail of the circumstances for using the Rapid Access system.

The service user, carer or member of their support network will be able to contact their previous team for rapid access. Every effort will be made to ensure that the previous care coordinator is allocated.

Any service user subject to CPA who is stepped down to Primary Care will be able to make use of a Rapid Access system the discharging team if still relevant to presenting needs will aim to begin initiation of treatment following the guidance in Rapid Access plans written at the discharge CPA and re access arrangements.

The timeframe for Rapid Access will be decided by the care co-ordinator and service user in collaboration with others involved in their care. The date when Rapid Access ceases will be identified in the initial step down crisis, relapse and contingency plan.

Following this period service users will be able to access AWP services through referral routes as identified in Section 3.

5.13. Inpatient and Acute Care

Care coordinators must remain in close contact with ward to on a weekly basis keeping continuity of care and engaging with the Service User throughout all service users will have a review utilising the care planning function of RiO.

Care plans will be updated following any review and as required by service user presentation and or at transitioning points in the team delivering care to ensure that these remain relevant to presenting needs in i.e. an inpatient or community setting.

Standard 72 hour care plan templates will be available for all service users who are admitted.

Further standard care plans will be developed by services, dependent on service and performance requirements.

Upon discharge from a ward, all service users regardless of CPA status will be followed up at 48 hours and 7 day periods.

13. Confidentiality

Service users have a right to understand their rights to confidentiality and the circumstances in which AWP practitioners have a duty to share otherwise confidential information with others.

Multi agency care team and with family, carers and significant others, as detailed in the Trust Data Protection Policy and outlined in Department of Health guidance NHS Code: Confidentiality.

The scope of information to be shared will be discussed with the service user, family, carers, and significant others in order to develop safe and beneficial therapeutic relationships between all those involved with the person. Further guidance can be found on Using and Sharing Information.

14. Roles and Responsibilities

14.1. Executive Director of Nursing and Quality

Is nominated by the Board as the Executive Lead with responsibility for the development and implementation of this policy.

14.2. Service Delivery Units

Are responsible for approving any locality specific process variations, i.e. through the utilisation of specific assessment tools. These will only be utilised following approval through that Service Delivery Unit's Integrated Governance Forums; individual teams / services are not authorised to develop local solutions.

14.3. Team/Ward Managers

All managers will be responsible for:

- Ensuring that this policy is followed and understood as appropriate to each staff member's role and function
- Ensuring that staff acting as care coordinators have the required skills and competencies to carry out the role
- Ensuring that effective case load management and supervision is in place
- Ensuring that cover arrangements are in place for any absence of the care coordinator
- Ensuring that recommendations from audit processes are actioned
- Ensuring that staff attend appropriate training including use of the electronic records system
- Ensuring standards are maintained in line with the balanced scorecards and reinforced through supervision and appraisal

15. Standards

These adhere to national standards, consistent with monitoring and registration through the Care Quality Commission, outcomes 1, 4 and 7.

Contractual requirements related to CPA will be adhered to and are available through Performance and Information.

Further AWP guidance regarding CPA are available on the CPA section of Our Space, and can be accessed through hyperlinks within this document.

Details of any service specific forms and / or assessments to be used must be ratified through the individual locality Governance arrangements, with approval at Trust Governance.

16. Training

Practitioners training for implementation of CPA must be delivered in partnership with service users and carers.

The Trust's overarching policy for training is the Learning and Development Policy and this should be read in conjunction with this policy. Attached policy appendices are the Trust's learning and development matrices. These matrices describe the minimum statutory, mandatory and required training for all staff groups in respect of CPA and Risk.

The Learning and Development Policy also describes the Trust's arrangements for training, in particular how there are processes in place to ensure staff receive the training they require and how non-attendance is followed up. These arrangements are further supported by management supervision and appraisal processes.

The Trust lead for CPA and Risk has agreed the training standard with the Learning and Development Team and training standards have been informed by statutory requirements, professional standards and national best practice.

The Trust lead for CPA and Risk participates in a programme of continuous professional development to ensure they remain up to date and keep abreast of developments in this field.

17. Monitoring and Audit

The Clinical Executive and Associate Directors of Nursing are responsible for monitoring that the standards and requirements of this policy have been met.

Compliance with this policy will be through monthly completion of the Information for Quality System. This will be through record audit, CQC Provider Compliance Assessments and service user and family / carer questionnaires.

The Quality and Standards Committee will receive an annual report in respect of CPA and will take action to address any issues identified.

The annual report will provide information on:

- The adherence to the training requirements outlined on the MLE
- Compliance with use of risk assessment tools and documentation
- Adherence to discharge / transfer indicators

Any issues arising from the review process and monitoring that will aid and inform wider learning will be communicated via the Trust's programme of thematic reviews.

Operational managers are responsible for ensuring the quality of practice of staff, and should regularly review the skills of individuals and their ability to carry out tasks and obligations with regard to the process of CPA.

18. Definitions

Person-centred plan – is an individualised plan as part of the 'Green Light Toolkit' for improving mental health services for people with a learning disability

Shared approach – "is about people who provide services working with service users and carers to find a strong voice that will help them to be understood". (CSIP, 2008 p6)

Step-up – when a service user requires a higher level of intervention from AWP

Step-down – when a service user requires a lower level or no intervention from AWP

19. Associated and Related Procedural Documents

- Appraisal Policy
- Health and Social Care Records Policy
- Learning and Development Policy
- Safeguarding Adults Policy
- Safeguarding Children Policy
- MAPPA Policy
- Risk Management Strategy
- Section 117 After Care Services Policy
- Staff Supervision Policy
- Procedure to Respond to a Request from a Service User for a Change of Service or Professional Staff
- Guidance on Acting as an Appropriate Adult

Appendix K: Response from Home Office re notification of a delay in completing Review.

9 May 2018

Dear [redacted]

Thank you for your email confirming the discussions we had last week in relation to the DHR you are undertaking into the suicide of [redacted] in Swindon.

I note that you are proposing to adjourn the review and have postponed meetings with the family of the deceased whilst the police re-examine the circumstances of the death. However, I understand you intend to continue with a review panel meeting next month so that any essential recommendations can be identified and taken forward before the completion of the DHR.

I can confirm that this is entirely in line with the statutory guidance and the Home Office agrees with your approach.

I also acknowledge the national recommendation identified in the review which relates to information sharing without consent in terms of the risk of serious harm or death to an adult. I am grateful to you for providing the relevant sections of the current and previous GMC guidance on this issue. I can confirm that discussions between the Home Office and the Department of Health on this issue are continuing and we hope to be in a position to provide a plan of action later this year.

Thank you for bringing this matter to our attention and for keeping us updated on progress.

Kind regards,

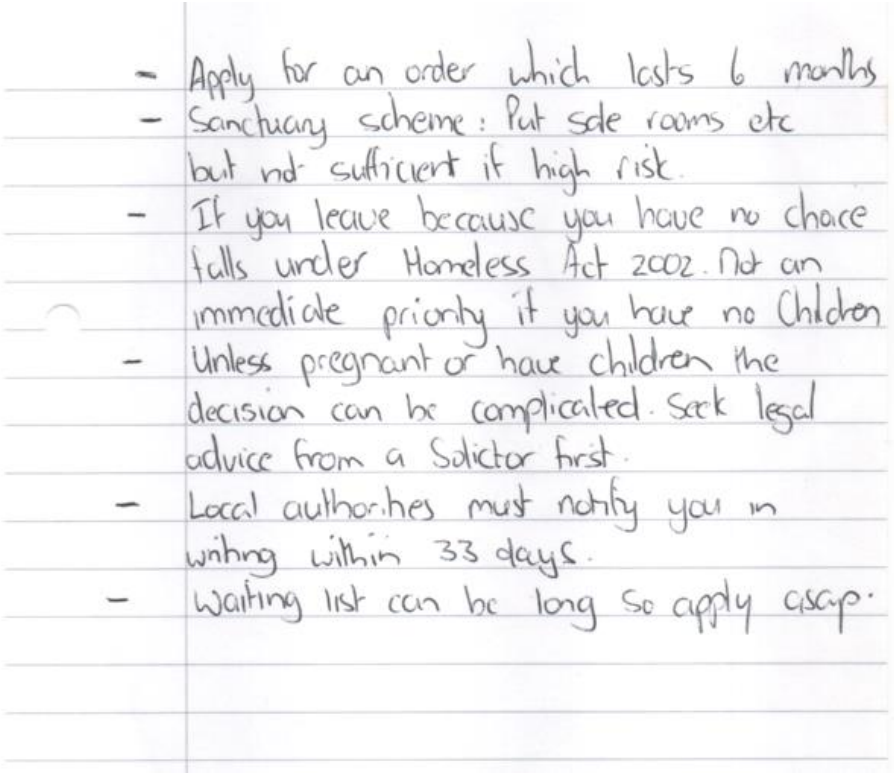
[redacted]

Domestic Homicide Reviews

Public Protection Unit

Home Office

Appendix L : Extracts from Theresa's Journal listing actions re leaving home.



- Apply for an order which lasts 6 months
- Sanctuary scheme : Put safe rooms etc but not sufficient if high risk.
- If you leave because you have no choice falls under Homeless Act 2002. Not an immediate priority if you have no Children
- Unless pregnant or have children the decision can be complicated. Seek legal advice from a Solictor first.
- Local authorities must notify you in writing within 33 days.
- Waiting list can be long so apply asap.

ID - 9872

Bluetooth
Bottom of car
Wheel, bridge
Glove box, under seat
Sunscreens
USB sticks, plugs
Bugging checkers.
Handbag; anything unusual, pen
Create profile on google settings on google
Update Privacy, on Social media.
Location setting (off) facebook.
Get safe online. org
Wipe phone clear.