Overview report

Central Bedfordshire Community Safety Partnership

SaferCentral
Community Safety Partnership

A Domestic Homicide Review concerning the death of Jane (pseudonym)

(January 2022)

Author – Jackie Dadd

Date completed – January 2023

Family tribute to Jane

My daughter grew up a fun loving, full of life, giving, bubbly friendly young girl.

She enjoyed being with her friends and family. She enjoyed so much to visit her Grandad in Dorset and was very close to him. We had holidays, picnics trips with him, walks and her life was happy.

Unfortunately, Grandad passed away when She was 17 and we scattered his ashes at Durdle Door in Dorset. We were all devastated.

At 18, my daughter gave birth to a beautiful baby boy. She was such a good loving mum and so proud of him. She had a normal life and was happy when she was offered a flat for her and my grandson.

At 28 years old, she was diagnosed with an early menopause. Her health took a turn for worse and she was depressed angry and had panic attacks and other symptoms. She started to drink a lot and didn't know how to cope. She was given lots of medication but seemed to get worse, in and out of hospital and a few run ins with previous partners and police.

She was sent to London to see a specialist for hormonal treatment.

For a while, she turned a corner, improved, and seemed happier. However, when She was ill, she decided to allow her son to live with his Dad and then missed him dreadfully and didn't seem to have a purpose for anything. She went out with friends and saw her son at weekends which brightened her up and she started having a couple of relationships. One in particular was disastrous. She became unhappy, withdrawn and scared, drinking a lot for fear of this person. At one point though this person was put away and She seemed to brighten up again. We all had a lovely Christmas together last year with my Grandson and family.

Early this year, my daughter took her own life. My beautiful baby has gone. We are all devastated and love and miss her so much. I can't believe I'm not going to see her again. I still see her coming through the backdoor saying 'Hi mum".

Our beautiful girl has gone too soon and her ashes are with her Grandad at Durdle Door.

I just wish there was more that could have been done to keep her safe.

Mum

The Domestic Homicide Review Panel and the members of the Central Bedfordshire Community Safety Partnership would like to offer their sincere condolences to the family of Jane, who have lost their loved one in tragic circumstances, and which has caused this review to take place. They have been left with a huge gap in their lives.

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Preface

The key purpose of any Domestic Homicide Review (DHR) is to examine agency responses and support given to a victim of domestic abuse prior to their death and to enable lessons to be learnt where there may be links with domestic abuse. For these lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. The victim's death in this case met the criteria for conducting a DHR according to Statutory Guidance1 under Section 9 (3)(1) of the Domestic Violence, Crime, and Victims Act 2004. The Act states that there should be a "review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death".

The Domestic Abuse Act 2021 and the Home Office defines Domestic Abuse as:

Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if—

(a) A and B are each aged 16 or over and are personally connected to each other, and

(b) the behaviour is abusive.

Behaviour is "abusive" if it consists of any of the following—

(a) Physical or sexual abuse

(b) Violent or threatening behaviour

(c) Controlling or coercive behaviour

(d) Economic abuse

(e) Psychological, emotional or other abuse

and it does not matter whether the behaviour consists of a single incident or a course of conduct.

"Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to—

(a) Acquire, use or maintain money or other property, or

(b) Obtain goods or services.

For the purposes of this Act A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child).

Controlling behaviour is:

A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is:

An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. The term domestic abuse will be used throughout this review as it reflects the range of behaviours encapsulated within the above definition and avoids the inclination to view domestic abuse in terms of physical assault only.

Recommendations will be made at the end of this report, however, there has been an ongoing action plan introduced by the panel, parallel to this review to ensure that the areas that can be immediately addressed have not incurred unnecessary delay.

A glossary is available at appendix B at the end of this report which will provide explanation to the acronyms used throughout.

Section 1 - Introduction

1.1 The commissioning of the review

1.1.1 - This review is into the death of Jane, a 36yr old female, who was found deceased in January 2022 by Bedfordshire Police at her home address. The Police have investigated the circumstances and have submitted a report to the Coroner with a finding that the death was non-suspicious and the cause was suspected suicide by hanging. The Coroner's inquest has been opened and adjourned awaiting the completion of this review. This will be held on 15th February 2023.

1.1.2 - Bedfordshire Police made a referral to Central Bedfordshire Community Safety Partnership on 17th January 2022 due to a history of domestic related incidents involving Jane on their records. A decision was made by the Central Bedfordshire CSP and partners including voluntary and non-voluntary sector, to undertake a Domestic Homicide Review on 10th February 2022 as it was found that the definition in Section 9 of the Domestic Violence Crime and Victims Act (2004) had been met.

1.1.3 - Contributors to the review

Agency	Contribution
Bedfordshire Police	IMR, Panel member
Victim Support/IDVA	Summary report, Panel member
Central Beds Community Safety Partnership	Relevant data, Panel member
P2R	Scoping, Panel member
Families First	Scoping
BLMK Public Health	Summary report, Data, Panel member
Children's services	Scoping, Panel member
MARAC/Central Beds Domestic Abuse Service	Scoping, Panel member
Adult Social Care	Summary report, Panel member
Bedford Women's Centre	Scoping
Public protection, Central Bedfordshire Council	Panel member
East London Foundation Trust	IMR, Panel member
Bedfordshire Probation Service	IMR, Panel member
GP practice	Scoping, Panel member
Bedfordshire Integrated Care Board	Panel member

1.1.4 - Review Panel

Central Bedfordshire CSP initially found it difficult to find an available Chair and author to complete this review and informed the Home Office of this to keep them updated.

At the outset of this review, it was identified that Public Health had not been invited as a panel member. Central Bedfordshire immediately saw the importance of their inclusion and

identified a suitable representative who will now sit on all DHR panels of Central Bedfordshire CSP that involve a death by suicide.

1.1.5 - The panel comprised of the following:

Name	Area of responsibility	Organisation
Lisa Scott	Safer Communities & Partnership Manager	Central Bedfordshire CSP
DCI Craig Laws	Domestic Abuse Lead	Bedfordshire Police
Jayne Richards	Domestic Abuse Specialist Officer	Children's Services – Central Bedfordshire Council
Tawanda Hakulandaba	Service Manager	P2R – Alcohol services
Dr Joy Jimni	GP practice representative. Doctor	Medical Centre of Jane
Joy Leighton	Senior Operations Manager	Victim Support/IDVA Bedfordshire
Michelle Burnley	Services Manager	East London Foundation Trust (ELFT)
Anna Bruce	Deputy Head of Service	Probation Service - Bedfordshire
Rachael Clifford	Public Health Principal	Public Health Department (BLMK)
Susan Childerhouse	Assistant Director Public Protection	Central Bedfordshire Council
Pushpa Guild	Review Officer	Hertfordshire Police (MCU)
Amy Thulbourne	Service manager Safeguarding and Quality Improvement	Adult Social Care
Nina Page	Team Manager	Central Beds Domestic Abuse Service

1.1.6 - All members of the panel and authors of the IMRs have complete independence from any subject in this review. Following careful consideration by the Chair and review panel, it was agreed that reports, chronologies, IMRs and other supplementary details would form the basis of the information provided for the overview. Thanks goes to all who have assisted and contributed to this review with their valued time and cooperation.

1.1.7 - Author of the Overview report

The chair of the review panel and author of this report is Mrs Jackie Dadd, an independent consultant who is independent of the organisation and agencies contributing to this report. She has no knowledge or association with any of the subjects in this report prior to the commissioning of this review. She is a retired Detective Chief Inspector with Bedfordshire Police since January 2021, with vast experience of safeguarding and domestic abuse related issues and has been involved in the DHR process since its inception in 2011. She has undertaken a number of DHRs having completed the Home Office online training, the CPD

accredited AAFDA DHR Chair training and is a member of the AAFDA DHR network, regularly attending the monthly forums for CPD and discussion.

The independency of Mrs Dadd was thoroughly explored prior to her undertaking this work due to her previous links with Bedfordshire and Mrs Dadd, Central Bedfordshire CSP and the review panel were all satisfied that the transparency, independent nature and integrity of this report was assured from its outset.

1.2 Purpose of the review

The purposes of a DHR are to:

a) Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

b) Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

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

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

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

f) Highlight good practice.

DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for the Coroner and criminal courts, respectively, to determine as appropriate. DHRs are not part of any disciplinary inquiry or process. Part of the rationale for the review is to ensure that agencies are responding appropriately to victims of domestic abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and domestic abuse. The review also assesses whether agencies have sufficient and effective procedures and protocols in place which were understood and adhered to by their staff.

This review will ascertain whether domestic abuse could have been the cause or a contributory factor to the death of Jane. It is not to apportion blame, but to view the circumstances through her eyes.

1.3 Timescales

1.3.1 - Bedfordshire Police made a referral to Central Bedfordshire Community Safety Partnership on 17th January 2022 due to a history of domestic related incidents involving Jane on their records. A decision was made to undertake a Domestic Homicide Review on 10th February 2022.

The Home Office were informed of the decision to commission a DHR on 1st March 2022, but Central Bedfordshire CSP then struggled to find an available chair and author. Mrs Jackie Dadd was commissioned to provide an independent chair and author for this DHR on 1st July 2022. Three separate panel meetings then took place. The completed report was handed to the Central Bedfordshire Community Safety Partnership on 1st February 2023.

1.3.2 - Home Office guidance states that the review should be completed within six months of the initial decision to establish one. The writing of this report had significant delays whilst Central Bedfordshire CSP found an available Chair and author. There was a further delay awaiting the Police submission due to capacity issues. The Home Office were kept informed throughout.

1.3.3 - Timeframe of Review process

17/01/22	Police referred incident for consideration of DHR to Central Bedfordshire CSP
10/02/22	Decision to commission a DHR made by Central Beds CSP and partners
01/03/22	Home Office notified of decision to commission DHR
01/07/22	Mrs Jackie Dadd commissioned as Chair and Author
01/09/22	First panel meeting
15/11/22	Second panel meeting
20/01/22	Third panel meeting
01/02/23	Completed report handed to Central Beds CSP by Author

1.4 Terms of Reference

1.4.1 - The full Terms of Reference can be found in Appendix A at the conclusion of this report. The Terms of reference were discussed and agreed upon during the first panel meeting on 1st September 2022.

1.4.2 - It was agreed that the main areas of focus would be based on:

a) Has domestic abuse in any form been the causation or a contributory factor to Jane taking her own life?
b) The availability and effectiveness of services and agencies provisions for those contemplating taking their own life and those with complex needs within Central Bedfordshire

c) The response of services when a victim has previously been a perpetrator and whether this creates barriers in process
d) Considerations and actions available to appropriately support and safeguard domestic abuse victims

1.4.3 - It was agreed by the panel that the review and research dates would take place from 2016 as this would reflect the most recent relationship issues and mental health issues prior to Jane taking her own life, but any relevant information held prior to that should be included until the date of her death.

1.5 Subjects of the review/Family and friends' involvement

1.5.1 - In accordance with Home Office guidelines to ensure confidentiality, pseudonyms have been utilised throughout this report for the following:

Jane – Deceased 36-year-old white British female.

Rosemary – Mother of Jane.

Bobby – Son of Jane.

David – Most recent Ex partner of Jane who found her deceased. Aged 51 years old.

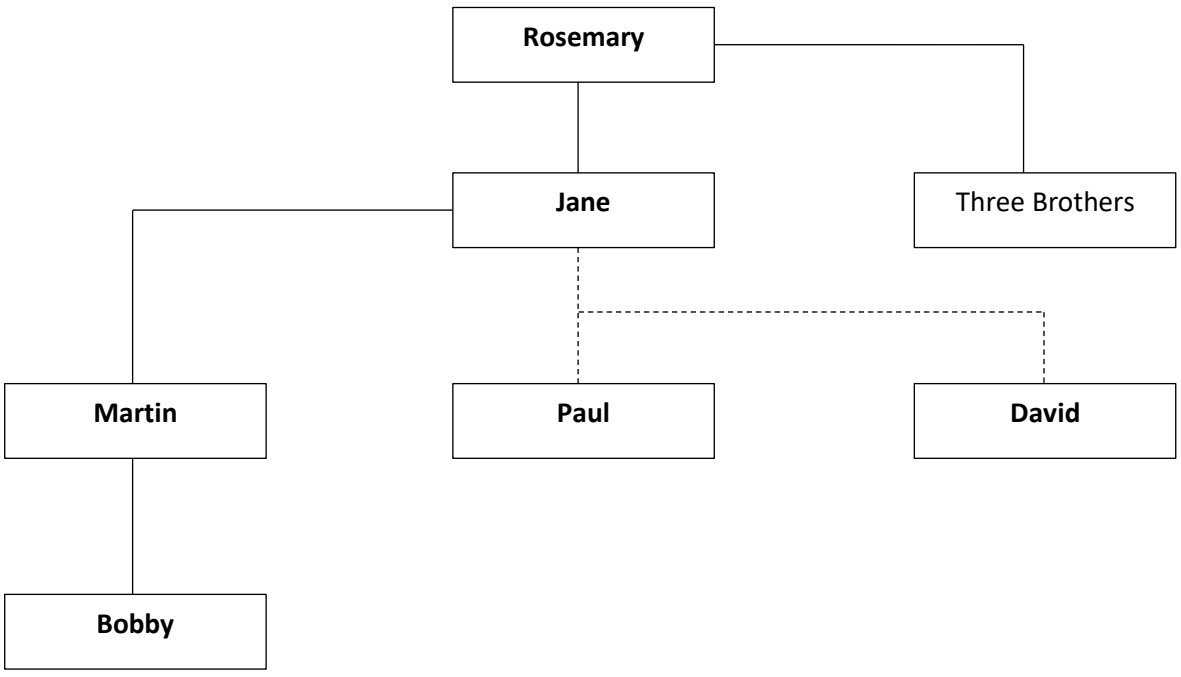
Paul – Ex partner of Jane, imprisoned for offences against her. White British male aged 45 years old.

Martin – Ex-husband of Jane. Father of Bobby. Aged 35 years old.

Darren – Close friend of Jane's since school.

Address – Name of area referred to as Central Bedfordshire.

1.5.2 - Genogram



1.5.3 - The Mother of Jane wished to be fully engaged with the review and the author would like to express their gratitude for the significant contribution and assistance provided throughout. The pseudonyms used in this report were agreed by Rosemary as suitable and Rosemary chose the name for her daughter to be referred to in this report.

Rosemary, as next of kin was sent a letter from Central Bedfordshire CSP shortly after the commissioning of the DHR to inform her of the review and provide details of AAFDA for support. She was then visited by the Author at her home address and during this time, was provided with a leaflet and had the advocacy of AAFDA fully explained and an offer for referral was made. Rosemary declined this at that time and it was revisited on each occasion the Author spoke, emailed or met with her. Rosemary may contact AAFDA following the Coroner's inquest. Rosemary was also offered to attend a panel meeting if she wished and declined as was happy to be updated by the Author.

Martin, the father of Jane's child was spoken to and provided his information over the phone. Martin offered to speak to his son to see if he was willing to speak to the author as he felt he would know more than he did and it was agreed he would be the most suitable person to do this. Martin has not made any further correspondence with the author when contacted, so it has to be assumed that Bobby did not want to speak.

Darren, a close friend of Jane's who she had known since school was also spoken to and provided his knowledge and thoughts based on what Jane had confided in him.

1.6 Parallel reviews

Coroner

1.6.1 - The Coronial process is taking place parallel to this review.

Jane's death was reported to the Coroner by the Police and a file was opened. The report submitted stated that the death was considered to be non-suspicious and was treated as a sudden and unexplained adult death, indicative of a suicide by hanging.

A Post-mortem was subsequently held.

The result of that post-mortem examination was: -

1a. Hanging

2. Cocaine and alcohol use

1.6.2 - At the time of her death toxicological analysis has identified that the deceased had differing levels of Paracetamol, Sertraline and Zopiclone that were consistent with therapeutic dosing and do not indicate an excess in the hours recently prior to death.

Concentrations of 170 ng/mL of Cocaine and its primary inactive metabolite benzoylecgonine (1600 ng/mL) were found consistent with recreational/binge use or excessive use followed by a prolonged period of metabolism (breakdown in the body).

There is toxicological evidence to indicate that Jane consumed alcohol (100mg/Dl in blood) in addition to having used a number of drugs prior to death. In cases involving rapid death (hanging) it is difficult to determine whether or not excessive ingestion had occurred immediately prior to death.

The only recent injuries found were those of a ligature mark around the neck.

The coroner has suspended the coronial investigation pending the outcome of this review and the Pre-Inquest review hearing has been set.

1.7 Equality and Diversity

The review gave due consideration to each of the protected characteristics under Section 149 of the Equality Act 2010. All concerned are defined as white British. The relevant legislation that provided the context for the panel was The Disability Act 2016 and The Equality Act 2010.

Key considerations for the panel were whether Jane's gender and mental health condition influenced how the various agencies dealt with Jane and influenced the support that they offered.

It was considered that Jane's sex was relevant to the review as 3-10 women each week die of suicide where they have suffered domestic abuse and in 2017, eighty-three per cent of victims reporting coercive control to the police were female.[1] Jane had a previous conviction for a domestic abuse related offence and particularly as a female, it was considered whether this caused unconscious bias when she then approached authorities for help and support as a victim.

Disability is relevant to this review due to the mental health struggles that Jane suffered with throughout her adult life partially, if not mainly caused by the early onset of menopause (premature menopause)

Research by women's health website 'Health and her' found that nine per cent of women going through perimenopause have thought about suicide, while 86% admitted they had suffered mental health issues as a result of their experiences with perimenopause.[2]

The World Health Organisation[3] state that symptoms associated with menopause include changes in mood, depression and anxiety which may have had an influence on her actions/behaviour following being abused and the Police not understanding or being able to take this into account when they attended.

The panel also considered whether the effects of her medical condition and mental health overshadowed the DA matters that she disclosed when speaking with health professionals,

[1] Office for National Statistics, 2017
[2] Prima Team 07/10/21 mental health women survey
[3] World Health Organisation – Menopause – 17/10/22

preventing her from obtaining specialist support in this area. Domestic Abuse is a factor in around 12.5% of female suicide attempts.

Equality is about ensuring everybody has an equal opportunity and is not treated differently or discriminated against because of their characteristics. **Diversity** is about taking account of the differences between people and groups of people and placing a positive value on those differences.

1.8 Dissemination

Recipients who received copies of this report prior to publication:

Panel Members (listed in 1.1)

Members of the Central Beds Community Safety Partnership

Coroner's office

Rosemary, Jane's mother

1.9 Contextual background

1.8.1 - Central Bedfordshire is a unitary authority serving a growing population of around 274,000, with 27,500 of these being females between the ages of 30-44. It is a rural area with over half the population living in the countryside and the rest in a number of market towns.

Central Bedfordshire Community Safety Partnership (CSP) have the legal responsibility for DHRs within their area. They have commissioned 8 DHRs of which 4 are suicides thus far.

1.8.2 - This report will refer to Situational couple violence (SCV) (situationally provoked violence). This is violence that occurs where the couple has conflict which turns into arguments that can escalate into emotional aggression and possibly physical violence. SCV often involves both partners. (ref: Johnson A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and ... - Michael P. Johnson - Google Books)

1.8.3 - It will also refer to overshadowing. This is defined as a lived experience of mental illness is associated with compromised physical health and decreased life expectancy. Mental health consumers face greater barriers to accessing treatment for physical illnesses and are less likely to receive appropriate physical care than those without mental illness. Physical illnesses may go underdiagnosed and undertreated in mental health consumers because clinicians tend to focus on the mental illness to the exclusion of other health problems, a phenomenon called diagnostic. (ref: 2021 - Molloy, Renee1,2; Munro, Ian1,2; Pope, Nicole) https://journals.lww.com/jbisrir/Fulltext/2021/06000/Understanding_the_experience_of_diagnostic.7.aspx)

Following National research, a recent report (2022) has found that among people who had attempted suicide in the past year, half (49.7%) had experienced intimate partner violence. (SSRN-id4052660.pdf)

1.8.4 - Bedfordshire has seen an increase in suicides in 2022 which, if they remain on the same trajectory, will exceed last year which had doubled from the previous year. It still remains lower than the national average at this time (ONS).

1.8.5 - Research has shown (ref: Cambridgeshire County Council DASV Partnership (cambsdasv.org.uk)):

1. Domestic Abuse is a factor in around 12.5% of female suicide attempts
2. 25% of those in Domestic Abuse services have felt suicidal due to the abuse
3. Domestic Abuse victims are 8x more at risk of suicide than the general population
4. 50% of Domestic Abuse victims who attempt suicide will undertake further attempts within a year
5. 20% of DA Victims attempting suicide are pregnant
6. A third of female suicides are subject to domestic abuse
7. "Suicidal acts…… are more likely where feelings of defeat and entrapment exist alongside beliefs that neither rescue nor escape are possible" Williams (2001)
8. 3-10 women a week die by suicide where they have suffered domestic abuse

Section 2 – The Facts

2.1 Background information

2.1.1 - Jane was born in the Central Bedfordshire area in the Mid 80's. Her mother, Rosemary, was single at the time and was already raising her three elder brothers. Rosemary had been in a relationship when she fell pregnant with Jane. During this pregnancy, her partner was imprisoned for offences relating to paedophilia and she immediately broke off the relationship and never saw him again. Jane did not find this out until she was 14yrs old and never met her father or had any contact with him.

Jane had a normal family life and was a happy little girl with protective brothers. The family always lived in the same area. During her last year of school, Jane became rebellious, missing odd days at school and getting tattoos. This was put down to it just 'being her age.' She went to college in Luton to study a travel and leisure course, whilst working at Dunelm on a Saturday in the same store her mum worked.

2.1.2 - It was around her 18th birthday that she first started showing an interest in boys and in bar work. During this year, she met Martin and a year later, when 19 years old, she fell pregnant and they had a baby boy, Bobby, who was born in July 2005. The relationship broke up when Bobby was about 18months old and Jane and Bobby moved back in with her mum until she was allocated a house.

Following the separation, Jane began to drink alcohol more frequently and in 2006, the Health visitor recorded that she was suffering from post-natal depression, describing her as vulnerable and prone to depression and she was offered counselling. She was living on her own with her son at the time and was on the verge of eviction due to rent arrears. Her GP reports that she was prescribed anti-depressants and sleeping tablets as she complained of insomnia.

2.1.3 - The first recorded domestic abuse incident for Jane was recorded in 2012, when her partner at the time had too much to drink and had become aggressive. This was recorded as a verbal only incident by the police.

Jane continued to receive medication as her depression appeared to gradually get worse over the next few years, frequently seeing her Doctor.

2.1.4 - In January 2015, Jane complained of mood swings, panic attacks and suicidal thoughts. She attempted to take her own life for the first time and repeated this within a year. Her son, Bobby, was in the house at the time. He was asleep upstairs. Jane asked the ambulance crew to be as quiet as possible so that they didn't wake him. Jane had been referred to a psychiatrist and during that year, was found to have obsessive intrusive aggressive thoughts of self-harm and harming others. She continued to drink heavily which was thought by medical professionals, to be the reason she began to have fits and panic attacks during that year.

Jane was referred to ELFT (East London Foundation Trust) who would provide support for her mental health issues for the remainder of her life. A safety plan was put in place for Bobby by Early Help in which Martin and her mother were fully involved. Jane attended parents' evenings at school and Early Help described Bobby as a happy, mature person. He would have been 12 years old at that time.

2.1.5 - At 30 years of age (confirmed in medical records), in December 2015, Jane was diagnosed with premature ovarian failure and was subsequently placed on HRT. This had a negative impact on her mental health and Rosemary states that although they tried numerous types of medication, nothing worked and the thought that she could never have another baby used to get Jane down and there were times she would not get up during the daytime. She remained under the psychiatrist and the gynaecologist. Over the next couple of years, Jane took several overdoses and threatened to harm herself in which the Police, Children Services and the ELFT were all involved. She was detained under S136 of the Mental Health Act 1983 on more than one occasion.

2.1.6 - In 2019, several reports were made to the Police about Jane from residents in relation to graffiti. She was detained under s136 Mental Health Act 1983 due to actively trying to hang herself with a dressing gown and in the September, she called the police as she had knives and wanted to harm herself and her 14-year-old son who was with her. There had been an escalation in her behaviour due to her mental health issues during the year with frequent Crisis team and Children's services intervention. A referral was made to the complex needs service in September 2019 but they responded that they did not have capacity at that time and would re-visit this at a later date when their demand had reduced.

and due to this, Jane agreed with Martin that Bobby should go and live with him as it was for the best. Jane would continue to have supervised access. Bobby was transferred to Hertfordshire Children's Social Care as that was where he was now living and received support from Hertfordshire Children's Social Care. Some of which was undertaken and some that was declined by Bobby.

2.1.7 - Later the same month, the Police were called by Jane's partner who she had recently began a relationship with as she was trying to strangle him. Both were intoxicated and he was also currently off work sick due to mental health issues of his own. Whilst playing poker together, Jane had become agitated, and after slight goading, she punched him in the face which split his lip and made his nose bleed. Jane then used a phone cable to tighten around his neck which she admitted causing him to 'pass out.'

Jane was initially dealt with in relation to attempted murder and was on bail following charge. Jane reported to the crisis team that the thought of going to prison made her feel suicidal and took an overdose, becoming an informal patient in the Mental Health Unit. She was found not guilty at trial and pleaded guilty to ABH.

2.1.8 - One night in early January 2020, Jane went out for a drink down the pub and met Paul, who she began a relationship with. Rosemary states that they seemed really happy for a month, but then she began to notice things that did not sit right with her. Rosemary and Jane took Bobby to Brighton for the weekend and Paul rang her the whole time they were there, questioning what she was doing and arguing with her. Rosemary told Jane of her concerns.

On returning home, Rosemary wanted to meet him as Jane was living with Rosemary at the time. He started coming round regularly until one night, Paul and Jane were arguing and Paul's language was awful. Rosemary went into the bedroom where she saw Jane cowering in the corner of the room so she kicked him out and never allowed him back in her house. Rosemary contacted the police once he had left but they did not then attend until three hours later at 2o'clock in the morning and Jane was so frustrated and tired by then, that she refused to engage or make a complaint and was abusive towards the attending officers. (Rosemary's recollection).

2.1.9 - A pattern then developed where Paul would go out drinking, then park his van outside and leave flowers at the gate. He would follow her and send her many texts and messages. Jane would constantly go back to him and when her mum asked her why, she would reply,

'It's easier than not being with him as I then get a bit of peace.'

2.1.10 - In December 2020, Jane made her first report to the Police in relation to harassment from Paul due to constant calls and messages and visits to her mother's home, even though she had broken off the relationship. She was unwilling to support any police action at that time and the case was closed due to evidential difficulties.

2.1.11 - Early January 2021, the police recorded a kidnapping of Jane by Paul. Paramedics reported concerns for Jane's welfare, having responded to a suicide attempt made by Jane,

by hanging. She was conveyed to hospital for treatment and disclosed she felt trapped in an abusive relationship. Paramedic described the abuse comprised of controlling and coercive behaviour from Paul. Despite efforts to end the relationship, he reacted by harassing Jane and her family. She felt the only means of escape was suicide, hence she attempted it again, resulting in her hospitalisation. Jane was found unconscious by her mother.

2.1.12 - Jane stated that a verbal argument occurred between her and Paul at his home address resulting in Jane's anxiety levels increasing to the point she wanted to leave. However, Paul locked the doors to prevent Jane leaving, he threw her mobile phone and shoes outside at which stage Jane struck Paul, resulting in him throwing her out of the property, using such excessive force, that she collided with the side of his van.

Jane attempted suicide at her home address where she lived with her mother. Jane said that a contributory factor to this suicide attempt was Paul's incessant calls and text messages.

2.1.13 - Two days later, Jane contacted the police in a hysterical state to report constant harassment from Paul and that she was dissatisfied with the lack of police action, to date. Jane claimed Paul was making calls from withheld numbers to deceive her into thinking the calls were from medical specialists, who would also usually call from withheld numbers. Jane stated she could no longer endure Paul's behaviour.

2.1.14 - Police officers attended. Jane's demeanour was described as hostile and uncooperative. No specific offences were further disclosed and no further action taken. Safeguarding advice was given. There were a number of occasions when Paul would harass Jane and even caused her physical harm at times, but Jane did not always contact the Police as she became frustrated that they were not doing enough and sometimes took a long while to see her after she had called.

2.1.15 - A further report of stalking was recorded in March 2021 and the Victim Engagement Officers from the Police assisted Jane with obtaining a Non-Molestation Order (NMO) through the NCDV (National Centre Domestic Violence) forbidding Paul to threaten violence, intimidate, harass or pester Jane and was served on Paul via a process server acting on behalf of Jane's solicitors which he acknowledged. The same day, he contacted the Police to re-open allegations he had previously made against Jane as he was upset about the Non-Molestation Order.

2.1.16 - During April 2021, Jane made three separate reports of breaches of the Non-Molestation Order to the Police with constant harassment and abuse from Paul in public and via messaging and calls from multiple communicative methods. One of these incidents saw Jane jump from a moving car that Paul was driving as she feared for her safety, injuring her legs. Paul was arrested on the last day of April but then granted bail. All reports including those with assaults were all risk assessed as medium risk. Due to the increasing risk of harm that was posed to Jane, she went into refuge for her own safety. Rosemary states that Jane struggled with the isolation of the refuge from her family and usual surroundings and hated it. She became aware of a car driving back and forth and then Paul turned up at the refuge. He had found her, potentially from 'Find my Phone'.

Rosemary states that Jane lived in fear of receiving calls from Paul or him turning up which accentuated her mental state of anxiety. Due to Paul knowing her whereabouts, Jane was allocated a flat in the September. On trying to move some of her belongings in on the first day, whilst with a friend she had known from school, she found the locks had been glued preventing her access.

She later reported to ELFT that Paul's actions affected her mental health a great deal. She said she was constantly worried he was coming to get her and was afraid to go out on her own. Jane said this was worsened when she found super glue in her door keyhole and had to call a lock smith to fix it. She said she suspected it was him and this was supported by her neighbour's testimony that the description matched the person that was at Jane's door.

2.1.17 - At the beginning of October 2021, Paul turned up at Jane's address unannounced. She answered the door and he asked for a glass of water. Jane walked to the kitchen and passed Paul a glass of water. Whilst he has been stood in the doorway of the property, he has shoved a hard plastic cup into Jane's face causing her nose to bleed and water to spill over her top and onto the floor. He then left and Jane contacted the Police.

Near the end of October, Jane was at home one evening when she received a phone call from Paul from a withheld number. He called her a 'bitch' and said that she had ruined his life, caused him to lose his job and not be able to see his children. He then went on to contact her a further 9 times the same evening. Jane reported this to the police and made a statement.

Within two days, Paul had been arrested, admitted his actions and was charged with breach of the Non-Molestation Order. He was remanded in custody.

2.1.18 - November 2021 was a month of mixed emotions for Jane. She began a relationship with a male named David who she had met down the pub which initially made her happy. Sadly, Jane also lost a close friend who she had known since her school days which she confided in another friend, Darren, had affected her badly.

Jane attended Paul's Court hearing which was conducted via video link. He received 10 months imprisonment for the offences he committed against Jane to breach his Non-Molestation Order. Jane told ELFT that she was feeling a little bit settled now he was in custody but worries for when he gets released although the police have a safety plan for her.
Rosemary states that David seemed normal when he first got together with Jane, but then Jane discovered that he looked at perverted sites on the internet and although he promised he would stop, he didn't which led to arguments. Jane ended the relationship but David continued to contact her.

2.2 Circumstances of the death of Jane

2.2.1 - Jane spent Christmas, 2021 with her family. It was an enjoyable time and the last time her mum saw her happy.

In the early hours of New Year's day 2022, Jane was arguing with David when he grabbed her by the throat and they have both fallen onto the living room sofa. David was shouting his love for her and kissing her during this time. Jane contacted the police but did not want to support any action.

2.2.2 - One day in mid-January 2022, Jane was in Luton when she rang her mum. She had met up with a friend who she had worked with years ago and had a nice time. She sounded really happy on the phone. She rang again later when she had been home for a while. She told her Mum that her friend had gone back with her to put up a curtain track and David had popped round with a bunch of flowers. She said that he was going to come back later to pick up some of her belongings.

2.2.3 - The next evening, David went back to the flat and entered through the front door as it was unlocked. He found Jane hanging from an internal door with a white dressing gown cord tied around her neck. David rang 999 and the ambulance and Police arrived shortly afterwards. He attempted CPR, as advised by ambulance control until the paramedics took over from David. However, they were unable to revive her. At 6.58pm, Jane's death was declared.

2.2.4 - There were no signs of a disturbance, insecurity, third-party involvement, or alcohol/drugs misuse. A handwritten note consisting of more than one page was found, indicating an intention to die by suicide. The notes were confirmed to be in Jane's handwriting by both David and her mother. It appears that Jane was trying to find the right words. A transcript can be found at appendix C.

It is not known when either were written.

2.2.5 - Next of kin, (Jane's mother) was also notified of her daughter's death that evening, as was her son. David provided a statement to officers that evening, confirming that he had been in a relationship with Jane since June 2021 and he had been attempting to make contact with her via phone throughout that day however, there was no response. He was due to pick Jane up for a dinner date that evening, hence he called at the flat approximately 6:40pm but there was no answer. He last saw Jane the previous evening, when she appeared to be in good spirits and looking forward to their weekend.

The Police submitted a Coroners file that stated that the death was considered to be non-suspicious and was treated as a sudden and unexplained adult death, indicative of a suicide by hanging.

2.2.6 - Sadly, neither Jane or Rosemary were aware that Paul had already been released on a home detention curfew to his address in Central Bedfordshire three days earlier and there is no evidence to suggest he tried to contact Jane during this time. (see appendix C).

2.3 Individual management reviews (IMR's)

2.3.1 - Jane's contact with numerous organisations was constant throughout her life from 28 years old which was when her mental health and medical issues first came to light.

2.3.2 - Probation

Involvement with Jane

Probation (at this point the Community Rehabilitation Company - CRC) became involved with Jane because of her being subject to a Community Order for an offence of Assault Occasioning Actual Bodily Harm against her partner at the time. It became clear from the conversations with Jane that there were a number of presenting issues for her during this period including managing her mental and physical health issues in relation to the early menopause; mental health issues including suicidal ideation, self-harm, depression, PTSD; alcohol misuse; anger issues. These issues were frequently addressed within her probation appointments. Considerations were given to these needs, including a level of flexibility around appointments, especially when she was feeling unwell. This is what would be expected given the presenting needs and issues.

Jane appears to have had a positive relationship with her Responsible Officer. They met in person on 4 occasions prior to the COVID pandemic which led to a change of service delivery for the CRC. The change in delivery meant there was strict criteria as to which individuals could be seen face to face. Jane did not fit into these criteria and therefore from 26/03/20 until 24/08/20 any contact with her Responsible Officer was completed via the telephone. Jane entered a new relationship in October 2020 and it was decided that based on the index offence, there was a potential for increased risk and her reporting changed to a blend of face to face and telephone appointments. This followed the COVID service delivery model of the time and was an appropriate decision based on the information known to the Service.

Jane engaged positively in all sessions and it appears she was open about her feelings. Jane did not own a smart phone during this period of telephone contact and therefore there was no way to check for physical cues in Jane's appearance, which may have given additional indicators to any issues she was experiencing at the time. There was a sense from her Responsible Officer that she may have been minimising her alcohol use during this period, but this was unable to be verified due to the contact being by phone. It is also understood that Jane lived with her mother and was not always able to say all that she wanted on the phone as she did not wish to be overheard. This is an unfortunate consequence of the exceptional operating model and COVID, but in line with the policy at the time.

Information was appropriately shared by Probation, especially when there was a decline in her mental health, for example, there were regular liaison/check ins with Jane's Community Care Co-Ordinator, especially when there were concerns that she may have stopped engaging. Information was shared with Police including a request for a safe and well-check

when her Responsible Officer had received a text message suggesting that Jane may be self-harming. Information was also shared with housing providers.

Jane's involvement with P2R was seemingly closed during this period. Whilst Jane reported a reduced level of alcohol consumption, her Responsible Officer continued to discuss this with her within her supervision sessions.

In October 2020, Jane reported being involved with a new partner, now known to be Paul. Face to face reporting was appropriately re-instated due to her index offence and the potential for risk to her new partner. No issues were reported in relation to this relationship until December 2020 which followed the text message to her Responsible Officer stating that she could not cope with life. Probation acted on this immediately and requested a safe and well check from the police. It was at this point that Jane disclosed a sexual assault by a friend of Paul's and she also disclosed this to the police. Correctly there was a strong focus from this point on in her supervision about this assault and her emotions regarding it as her mental well-being seemed to decline following this incident.

Probation was also involved in a safeguarding vulnerable adults strategy meeting in January 2021 where decisions were made regarding a referral to MARAC as it was disclosed in this meeting that Jane had attempted suicide as she was in a domestically abusive relationship with Paul. This was the first point that Probation was aware of abuse in the relationship and due to the completion of her Order, there were no subsequent appointments with Jane for any further exploration of this issue to be had.

Based on the information known to Probation, every action that would have expected to have been taken, was taken.

Jane's chronology of pertinent appointments:

27/01/20 - Attended for PSR appointment. Short format PSR completed. Previous suicidal concerns raised within the report. Highlighted within the report that Jane is pre-menopausal and this is causing her a hormone imbalance which is impacting upon her emotions.

13/02/20 - Sentenced at Court. Received a 12-month Community Order with 20 RAR days and a 12-month Mental Health Treatment Requirement.

05/03/20 - Attended probation appointment. Jane reporting having a panic attack in town as she was running late. Said that she had visited the victim of her index offence as she wanted to give him his things back. Reported no arguments, they both apologised for what had happened and she left. Discussed the triggers to the offence which she states were his jealousy making her angry, alcohol and mental health issues. Discussion regarding Jane's low self-esteem.

18/03/20 - Attended probation appointment. Jane is engaging with care coordinator. Her presenting needs are anger and low mood. Discussion regarding a referral to Stepping Stones for counselling. Jane had seen her son and was finding it difficult after seeing him. She turns to alcohol to deal with this.

26/03/20 to 23/04/20 – Telephone appointments held. Jane isolating with her Mum. She is worried that she will not be able to see her son until lockdown is lifted. Reported mental health to be struggling as she has nothing to look forward to.

14/05/20 to 15/06/20 - Jane feeling positive. Big shift from previous calls. Reports she is doing well on her MHTR and engaging with her care co-ordinator. Most mentally stable she has felt in a long time.

28/07/20 - Telephone probation appointment. Reported that her mental health has declined and she has been self-harming and attempted to hang herself. She is not sure why. Risk increased due to mental health decline - mental health related to index offence.

Jane's mental health is directly linked to her index offence. Jane said that she has been avoiding seeing people because she is worried that she might commit another offence which she does not want to do.

13/08/20 - Jane said that she had a fight with victim of index offence. He was constantly calling her and getting through on a private number. He told her he was going to kill himself because of her, she drove to his house and when she got there, he was fine. She told the officer that she got so upset and overwhelmed that she slapped him. Spoke about what Jane can do if this happens again.

14/10/20 to 06/11/20 - Attended 3 x telephone probation appointments and a face-to-face (F2F) appointment. First known contact with Paul**.** Jane reported that she is feeling the best she has in a long time. Disclosed a new partner, dating for around 2 weeks. Reported that he makes her feel special and he is not a drinker which helps.

Probation re-assessed the risk due to Jane having a new partner and previous DA concerns and asked Jane to come in for a F2F appointment. Jane reported reduced drinking, she recognises that drinking makes her more likely to become violent. Work completed around relationships and the risk of DA.

30/11/20 - Jane not feeling great. Struggling with her menopause which is causing her to feel more depressed, sweat more, lack energy. Physical health deterioration impacting on her mental health. Discussed some coping mechanism to help her mental health. Still only drinking 2 cans every other night.

08/12/20 – Several communications – Jane text stating she couldn’t cope anymore and had nothing to live for. A police welfare check took place, actioned by probation. Jane’s Mum reported that Jane had been drinking last night and then slit her wrists. She feels this was due to Jane seeing a man called Paul. She reported that he was not a very nice man and would often called Jane a 'c*nt'. Paul had a friend who appeared at Jane’s house yesterday evening. Jane invited him in and the friend is reported to have 'come onto Jane'. Jane asked him to stop and kicked him out of the house. Jane told Paul about this and he didn't believe her and said that she was lying and that she must have instigated it.

Mum reported big concerns for Jane and feels that she is going backwards. She also reported that Jane is drinking a lot in the evenings and she uses alcohol as a coping mechanism.

Jane stated she had been under a lot of stress lately. Leading her to cutting her wrists last night. Explained that the friend of Paul's put his hands down her trousers last night which also led her to self-harm – she told police about the incident.

21/01/21 - Safeguarding vulnerable adults strategy meeting. Meeting arranged after Jane tried to hang herself in a suicide attempt on 03/01/2021.

Jane said that she attempted the suicide as she was in a DA relationship. It was physical, he locks her in the house, he has threatened her and her family, she is scared of him. She could not see any way out of it other than suicide. She was taken to A&E.

Jane is drinking a lot of alcohol but she is not eating. Jane has now reported that she is back with the male. When staff from CMHT went to complete a DASH form, Jane denied that there was any violence in the relationship. A MARAC referral is going to be put in on professional judgement decision as it is felt that she was underscoring because she was back in a relationship with him.

Is having contact with care coordinator at least once a month but at the moment it is weekly. She has had a previous referral to the complex needs team but did not engage. A referral for DBT has gone in.

12/02/21 – Probation Order ends. No further contact.

2.3.3 - Involvement with Paul

Probation was first made aware of Paul when he was sentenced to a 10-month custodial sentence for common assault and breach of a Non-Molestation Order on 17/11/21. He was sentenced without a Pre-Sentence Report. He was allocated to a community Probation Officer on 23/11/21 and police intelligence checks were requested for a backdated period of six months, returning information relating to the assaults against Jane for which he was convicted. Only domestic abuse incidents relating to six months prior were requested and received, therefore at this time Probation did not have the full picture in relation to the extent of previous domestic abuse. Further checks were completed to support the completion of the OASys risk assessment and additional information regarding domestic abuse was provided on 27/01/22.

Paul was eligible for Home Detention Curfew and was released on 12/01/2022 to his father's home address. No issues or concerns were raised in relation to the suitability of this address. This was an appropriate assessment.

This case did not meet the criteria for the Victim Contact Scheme, therefore correctly, no Victim Liaison Officer was allocated in the case. There was no information available to Probation to suggest a discretionary referral to the scheme was warranted.

Paul was fittingly assessed as medium risk of harm as part of the case allocation process (note: the target for completing a full risk assessment is 15 days post release, and therefore at the time of Jane's death, an initial OASys risk assessment had not been completed but was in progress as per our national standards. At the point it was completed, the risk remained appropriately assessed at medium).

In every case where domestic abuse has been identified as a relevant factor, the Probation Officer should request additional licence conditions requiring the individual to notify their supervising officer of any developing intimate relationships. This was unfortunately not included in this case. Consideration should also be given to imposing a licence condition to undertake an accredited or non-accredited programme if this has not been undertaken in custody. This was also not imposed in this case. Given, that Paul was subject to a Non-Molestation Order, it should be expected for a non-contact condition to have been imposed on the licence. This was also not included. These appear to have been oversights in this case which were subsequently rectified following a management review of the case.

Paul's offending was such that he did not meet the criteria for inclusion on the Management of Domestic Abuse Perpetrators panel (MDAP). Equally, the criteria for inclusion on the Integrated Offender Management Scheme (IOM) had changed nationally to focus on acquisitive offenders, and therefore, he was appropriately, not considered for this panel.

It is the expectation that all Responsible Officers managing a domestic abuse case should ascertain whether a case has already been discussed at a MARAC; ensure they attend or feed into MARAC meetings in line with local arrangements; complete actions arising from MARAC meetings and inform the MARAC co-ordinator when actions have been completed. Unfortunately, in this case a MARAC check was not completed by the allocated officer and therefore they were unaware of the history of MARAC referrals relating to Paul and Jane. Whilst there would not have had any direct contact with Jane, this information may have contained details to an IDVA or equivalent working with Jane with whom contact could have been made regarding safe-guarding and release plans.

Records indicate that there were no actions for Probation following the MARAC meeting held in December 2020 regarding Jane.

There is no record on the probation case management system of any other partner agency contacting Probation regarding Jane and the pending release of Paul.

2.3.4 - <u>Chronology for Paul</u>

11/10/21 - Paul appears at Luton and South Bedfordshire Magistrates Court. Sentenced to a 10-month custodial sentence for common assault. No Pre-Sentence Report prepared for this hearing. Paul was assessed as medium risk of harm and registered on our system as a domestic abuse perpetrator. First offence. Case not eligible for VLO involvement.

25/11/21 to 08/01/22 - Seen in prison for 1-1 session by prison staff on 6 occasions. No issues raised.

12/01/22 - Paul is released from prison and attends his initial probation appointment. Conditions of licence explained to him, probation induction completed. Paul states he will be getting a new phone number and has no intention of contacting his ex-partner.

14/01/22 - Paul attends his second appointment. Paul showed some victim empathy but denied the assault and kept referring it to as "accidental ABH". He accepted all parts of breaching non mol twice and explained the circumstances behind this.

2.3.5 - Terms of reference response

How accessible were the services and pathway referral for the deceased.
During the period that Probation was involved with Jane, the service was highly accessible in terms of telephone contact, however within the context of the exceptional delivery model (operating at the time as a result of COVID), face to face appointments were limited.

Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and whether these were acted upon?
The domestic abuse towards Jane was only made known to Probation at the end of her Order. There are appropriate policies and procedures in place to respond to domestic abuse (HMPPS Domestic Abuse Policy Framework) and we participated in a strategy meeting in order to share relevant information. It was in this meeting that decision was made to complete MARAC referrals (action not allocated to Probation who were no longer working with Jane).

What provisions are available for those suffering from alcohol misuse? Were appropriate referrals made when it was established this was a factor with Jane?
Jane was not engaging with alcohol services during the time Probation were involved with her, however her alcohol misuse was discussed with her regularly in her 1-1 sessions, particularly exploring the link between alcohol misuse and her aggression and mental health.

What sharing information processes and referrals are in place when multiple complex needs are identified and did these occur in Jane's case?
There was regular liaison between Probation and the Care Co-Ordinator regarding Jane's mental health. When there appeared to be a deterioration, Probation would contact the care co-ordinator to inform them of concerns and to check that she was accessing their service. A safe and well check was requested when Jane appeared to suggest she had nothing to live for. Domestic abuse with Jane named as the victim was not highlighted as an issue until the end of her Order, but there were regular conversations regarding domestic abuse both generally and triggers for Jane as the instigator when her emotions became too much.

Establish what processes are in place to record appropriately, decision make and provide support when it may be unclear who the victim and the perpetrator are within the relationship.
The Offender Assessment System (OASys) risk assessment tool is used to identify whether an individual is or has a history of being a domestic abuse victim or perpetrator and this

information is used to determine the risk management and sentence planning. Alert flags are also updated on our case recording system to allow for risks and vulnerabilities to be readily identifiable. We would complete regular police intelligence checks, especially when incidents have been self-reported to clarify the information received and ascertain the victim/perpetrator status.

Establish if there is unconscious bias with professionals because victim has previously been recorded as an offender.
Jane was known to the service as a domestic abuse perpetrator and there were no indications of her being a victim until towards the end of her Order when she disclosed a sexual assault. At this point she was supported around actions she could take to report abuse and supported around her feelings regarding this. Her supervision was trauma informed and no evidence to suggest a bias in her management.

What processes are in place to inform victims ahead of perpetrators release. What safeguarding plan is put in place and who holds responsibility for this.
There are clear processes in place when a victim is eligible for and involved with the Victim Liaison Officers. Similarly, through the MARAC process, actions and risk management plans would be completed ahead of release and actions attributed to the relevant agency.

In this case, Jane was not eligible for the victim scheme. The allocated officer had not completed MARAC checks and there are no records to suggest that any agency involved with Jane had contacted Paul's Responsible Officer post-sentence to share any concerns Jane had regarding his release. The expectation would be that any actions to inform victims ahead of a perpetrators release and subsequent safeguarding plan would be identified at MARAC and actions shared with the appropriate partners.

There is no process in place for Probation to contact a central point of contact (such as police Emerald team) to inform them of pending releases of domestic abuse perpetrators.

2.3.6 - Good practice/Reflective considerations:

During the time that Jane was involved with Probation there is evidence of effective partnership working between Probation and mental health services. There is clear evidence of good practice in terms of appropriately and swiftly responding to reports of crisis from Jane.

More comprehensive planning should have been completing in preparation for Paul's release from prison, including the inclusion of appropriate licence conditions to additionally safeguard Jane (non-contact) and to address Paul's offending behaviour (inclusion on a domestic abuse accredited or non-accredited programme).

The Responsible Officer should have completed MARAC checks prior to release to assess whether any victim agency was working with Jane and contact made to discuss release plans if applicable.

2.3.7 - Bedfordshire Police

Prior to writing this report the author has undertaken the below actions, to ensure a good understanding of the incidents is gained, and to provide a comprehensive review. This review has been conducted by means of:

- Examination of Bedfordshire Police computerised records and databases, including MODUS, Athena, crime, non-crime, case administration tracking system (CATS), which contains details of children and adults at risk, domestic abuse incident management, command and control system (STORM), intelligence and Enterprise search systems
- Review of recorded crime reports
- Review of DASH assessments
- Review of Adult at risk referrals
- Review of Child at risk referrals
- Discussion with key staff and written or verbal responses from other relevant staff
- Review of the Coroner's report and associated documents
- Review of Bedfordshire Police policies and procedure, in particular domestic abuse, adults at risk and safeguarding
- Review of legislation and legislative changes over the prescribed period
- Review of staff and organisational changes over the prescribed period
- Review of partnership practice, policy, and guidance

Bedfordshire Police databases contain details of both, incidents attended by Police Officers and recorded as crimes, relevant to the date parameters of this review.

The Mental Health Street Triage (MHST) is a collaborative service, between mental health professionals, paramedics and police officers, governed by the Bedfordshire Mental Health Hub. MHST functions 7 days per week, between the hours of 13:00 and 23:00. The purpose of MHST is to deliver an appropriate response, patient experience and outcome when responding to emergency mental health crisis calls across the county of Bedfordshire.

2.3.8 - MHST will take referrals from both the Bedfordshire Police and EEAST control rooms, and both paramedics and police officers directly. Referrals cannot be accepted from other services however information sharing is welcome regarding people likely to come into imminent contact with emergency services. Incidents that are assessed as high priority, requiring an immediate response, will be prioritised by the team. MHST will also provide advice and guidance to police and paramedics who have concerns about the mental health of an individual at an incident.

When the team are referred an incident, they will make a joint decision on the course of action to take. This could include a face-to-face assessment, the giving of advice to other professionals, decline, etc. There will be occasions where more than one incident occurs simultaneously. On such occasions, MHST will decide which incident they are going to deploy to, depending on where there is the most risk and where they believe they can make

the most impact. Where MHST declines an incident for any reason, it will be the responsibility of the relevant control room to ensure the incident is resourced.

The Force's Emerald team are notified of high-risk cases and will take ownership of those, depending on the domestic abuse history and levels of risks. The Emerald team is responsible for the investigation and the drive for an increase in positive outcomes for victims of domestic abuse. The team sits under the crime umbrella, alongside serious and complex crime, and operates from two hubs: one in the north and one in the south of the county. The team's key priorities are to ensure first-class service to domestic abuse victims, supporting those who are vulnerable and high risk, and focusing on targeting the most prolific and repeat offenders.

Supported by a team of Victim Engagement Officers (VEOs), the Emerald team will ensure that the victim receives a high level of tailored support. In order to achieve this, the team will strive to utilise orders wherever possible and look at new and innovative ways to implement them, as well as work in conjunction with partners across the three local authorities.

PPU (Public Protection Unit) monitor and review domestic abuse cases daily, for onward referrals to relevant specialist departments and agencies.

2.3.9 - In mid-January 2022, Police were alerted by Ambulance control to the sudden and unexpected death of an adult female at her home address in Central Bedfordshire. Ambulance control had been contacted via a 999-call made by David, upon discovering the deceased. David identified the female as his partner, Jane, aged 36 years who he discovered hanging from an internal door. Officers were deployed to the address and instigated the sudden death protocol. It was established that the front door to the first floor flat had been left unlocked, enabling David to gain access. He attempted CPR, as advised by ambulance control until the paramedics took over from David. However, they were unable to revive her, and Jane's death was declared at 6:58pm that evening.

Amongst the numerous items that were seized by officers from the flat, were the following:

- Ten different types of prescribed medication
- Three mobile phones and a Tablet
- Keys to the flat
- Handwritten note consisting of three pages, indicating an intention to die by suicide. The note was confirmed to in be in Jane's handwriting by both her partner and mother

There were no signs of a disturbance, insecurity, third-party involvement, or alcohol/drugs misuse. Jane was known to be the sole occupant of the flat, having been relocated to that address from a refuge, since October 2021.

The local 'on call' Detective Inspector was notified, and a supervisor attended the address to assess the scene, circumstances, and specialist resources. No suspicious or unexplained

circumstances were revealed at that time; hence an investigation was commenced on behalf of HM Coroner, directed by the attending Supervisor. In compliance with policy, a scenes of crime officer was deployed to the location to secure any scientific evidence.

Next of kin, (Jane's mother) was also notified of her daughter's death that evening, as was her son aged 16 years. David provided a statement to officers that evening, confirming that he had been in a relationship with Jane since June 2021 and he had been attempting to contact her via phone throughout that day however, there was no response. He was due to pick Jane up for a dinner date that evening, hence he called at the flat approximately 6:40pm, but there was no answer. He last saw Jane the previous evening, when she appeared to be in good spirits and looking forward to their weekend.

Jane was known to have a history of mental health issues during the period of the review parameters and was diagnosed with numerous conditions including, the onset of early menopause, personality disorder, anxiety, depression, and unexplained seizures. She was open to Central Bedfordshire mental health services and her medical conditions were medicated.

Prior to meeting David, Jane had been in an abusive and controlling relationship with Paul for approximately twelve months. At the time of Jane's death, Paul was the subject of a Non-Molestation Order and had been released from HMP Peterborough just three days previously. Neither her mother nor Jane were aware that Paul had already been released on a home detention curfew to his address.

Ownership of the investigation remained with the local policing teams as opposed to officers from the Beds/Cambs/Herts Major Crime Unit, as is the policy with suspicious/unexplained or sudden deaths. As a result of the police investigation and evidence gathered on behalf of HM Coroner, no unlawful acts or culpability on the part of any individual, have been uncovered, suspected, or alleged to date, that directly contributed to Jane's death. Although, there was a history of domestic abuse between Jane and Paul, which necessitated intervention by professionals/agencies involved in the review process, relevant to the review parameters.

2.3.10 - Summary of chronology

Since Jane had been in a relationship with Paul, Bedfordshire Police recorded at least 11 separate incidents of harassment, stalking and assaults between December 2020 and December 2021. Paul was named as the perpetrator and with each incident, the behaviour described was becoming more fixated, obsessive, and persistent. The impact on Jane's psychological and emotional well-being was detrimental to the extent that, she was living in fear and sought refuge in a safehouse. Jane was supported by the IDVA[4]/VEO service and eventually relocated in October 2021, to the flat where she was found deceased. Jane

[4] Independent Domestic Violence Advisor

suspected Paul had knowledge of this address, although there was no direct evidence or information to corroborate her suspicion.

2.3.11 - Pertinent chronology (inc. direct copies from reports for context)

The following is a separate submission by the Police from DCI Gresswell having fully reviewed the investigations involving both Jane and Paul.

10/04/2021 Stalking/Harassment/DV

Entry made on the 10/04/2021 - On the stated date and between the stated times the IP received a text on what's app at approximately 7pm at night showing a court order of a Non-Molestation Order. The offender then followed texting the IP on What's app 20 times and texting through messenger 15 times and calling the female 20 times. All this caused the IP distress and she texted back fuck off .
When officers arrived at location at 2230 hrs the offender was still calling and texting the IP and sending pictures
The IP and Offender were in a relationship but they were separated due to previous domestics.
The IP has applied for Non-Molestation Order and she is awaiting paper but its active which was seen by officers on civil legal aid certificate .
Action taken:
Safeguarding advice
Dash completed
Negative statement
referral
Outstanding task: Victim to receive the paperwork for Non-Molestation Order from solicitors

21/04/2021 - OIC contacted Jane over the telephone she is currently at home and is a bit shaken over what happened at the weekend. I have informed her that Paul is wanted for arrest, and we will be trying to arrest him for the offences in this coming week. She states she understands. Safeguarding advice given including 999/101 advice and not to go to locations where it is known Paul is or Paul frequents.

The supervisor allocated this to the same OIC who was responsible for other existing reports on 31/07/21.

15/09/2021 - Spoken to Jane, she states there has been a further breach on non mol by suspect, I asked her to report this by 999 or 101. She states she is not feeling good in refuge and does not like it there, council are not helping her quickly enough to find a house. Told her FI work has been completed and case will be with CPS shortly.

30/10/2021 - This investigation is to be filed Outcome 17. STL has expired 09/10/2021. Summary offence recorded. CPS have been approached for alternative linked report offences. Suspect currently on remand for similar more recent investigations. Final THRIVE added, closing report and gatekeepers' decision log.

Comments and observations by DCI Gresswell in relation to this incident: This investigation was not progressed in a timely manner, meaning that the time limits expired, before the OIC had submitted the case to CPS. What is concerning is that whilst the OIC was speaking to the victim on 15th September 2021, the victim discussed further offending. The OIC should have taken a report, attended the address of the suspect and gone to CPS with all the offences. Instead, the victim was let down and told to report to 101/999. This was a missed opportunity as there had been no reports of breaches of the Non-Molestation Order since the three reports in April 2021 and no further reports were made until October 2021. The breach which was clearly mentioned was never recorded and actioned upon.

19/04/2021 Assault without Injury

Incident location is a public house in Central Bedfordshire.
On stated date and time IP has attended location with her friends she was aware her ex-partner was going to be there; IP has a Non-Molestation Order against ex-partner.
Once at the location offender has been shouting and swearing at IP saying things such as "YOUR A CUNT....YOU HAVE BROKEN MY HEART....YOU TREAT ME LIKE SHIT". IP has told her friends to go home as she did not want them to see this, offender has then carried on before IP has gone to leave. It was then that IP noticed her mobile was dead meaning she could not call a taxi, as a result she accepted the offer of a lift home from the offender. During the drive back to her home address offender has been shouting at her and driven past her home address, leading to IP becoming very panicked and jumping from the moving car. IP has landed on the grass verge where members of the public came to help and tell the offender to leave.

19/04/2021 - IP stated that she had a Non-Molestation Order in place against Paul, she was unable to provide a copy of this only an application form. Upon searching on PNC there is no molestation order in place.

IP is victim to ongoing domestic violence from offender who is constantly messaging her and trying to speak with her. They have been split up for several weeks and on and off for several months prior to that. IP is dealing with anxiety, depression, and historic suicidal thoughts, she also stated that she is an alcoholic but trying to handle that by not drinking until tonight due to stress.
IP is speaking with a counsellor for numerous reasons, but she does not consent to any further victim support, her mother who also lives at location strongly believes she would benefit from this help. she has stated that she is feeling trapped and helpless because of the situation with her ex-partner (offender) and him not leaving her alone. she has been seeking a Non-Molestation Order but believes this to already be in place.

03/05/2021 - Suspect was arrested 30/04 at 17:55pm at address for BREACH OF NON-MOLESTATION ORDER. DP (detained person) was under the influence of drugs and cocaine. The allegation was that on 29/04/2021 it is alleged that the DP has attended address, Houghton Regis which is the address of ex-partner Jane which is in breach of his non molestation order currently in place. It is alleged that the DP has also contacted Jane numerous times once of which was in the presence of Police. This is also in

breach of the Non-Molestation Order in place. An interview was conducted at 09:43am on 01/05/2021 whereby the suspect partially admitted/ partially denied his involvement in the breaches of the Non-Molestation Order but stated that the victim has also been contacting him, inviting him to her house and locations such as the pub and 'tricking' him into breaching the non-mol order then reporting him to the police for it. Suspect's phone has been booked into property for downloading in reference to all the linked reports and victim has provided her phone for download also.

03/05/2021 – Closing report
I have assessed this investigation and due to the victim stating she voluntarily went with the suspect into the vehicle as well as attended a location where she knew he was going to be present and arranged to meet with a friend who invited the suspect there and she was aware of this as stated in her MG11. I am not satisfied she has been victim of a common assault as the suspect simply applying breaks in the car and her subsequently hitting her head on the interior of the vehicle, we are not going to be able to prove the breaks being used was done maliciously and if the IP was not wearing a seatbelt it is reasonable that she did jolt forward and hit her head. I am not satisfied we can prove that any offence has taken place and at the time of the incident there was no non-molestation in place. Even though a non-molestation was not in place the victim has voluntarily conversed with the suspect after consuming alcohol, known he was to be in the same location as her and travelled with him inside a vehicle. For these reasons there is no realistic possibility of points to prove being made out for any specific crime. There are many other crime reports in relation to the suspect and victim referring to Harassment and breach of non-molestation whereby the points to prove may be easily met and proven with some protracted enquiries. Victim is still receiving victim support for these instances.

03/05/2021 – Suspect related entry
Decision: Conditional Bail Authorised
This is an investigation into several reports including a BONM, assault and stalking. The victim has provided evidence in relation to these matters.
The DP has admitted in part to some of the breaches and states this is a strained relationship between both parties, but she has contacted him on several occasions and asked him to attend, almost tricking him into a breach, by inviting him to the pub or to her house to take drugs. None of which is mentioned in her statement.
There are further enquiries which include re-visiting the victim to ask if this is the case and to download her mobile. I know it is the suspect who should follow the order but if it is shown she has tricked him this can undermine her credibility.
Suspects mobile phone to be downloaded.
Please release on conditional bail

04/05/2021 – Victim related entry
OIC spoke to victim, and she agrees this report to be filed NFA due to her being with the suspect by choice at the same pub and accepting a lift home etc. Fortunately, she sustained no injuries and is happy for the investigations which we have more evidence of a clear and definite breach with no undermining evidence to be progressed instead of this one.

Comments and observation by DCI Gresswell: There is confusion as to whether there is a Non-Molestation Order in place and this in part together with the account provided by the suspect and the statement from the victim led to the report being filed by the OIC. Ds Stonnell rejected the decision to file the crime report, stating that the suspect should be released on conditional bail and for the suspects phone to be downloaded. The day after the comments have been made by DS Stonnell, the OIC has spoken to Jane see the comments dated 04/05/2021, whereby the report has been filed contrary to the supervisor's direction.

30/04/2021 BREACH OF NON-MOLESTATION ORDER

IP has Non-Molestation Order taken out against Suspect since 24/03/2021. On the material date in between the material times the Suspect has called the IP 45 times on her mobile phone and left seven voicemail messages and attended the address twice, banging hard on the door repeatedly and calling through the letter flap for the IP to answer the door and come outside. IP is still receiving medical treatment from injuries caused by Suspect.

30/04/2021 – Investigation summary
IP has shown officers a copy of a Non-Molestation Order issued on 24/03/2021 which expires in 1 year. The order names the Suspect and gives clear instructions not to contact the IP, come within a certain distance of the IP's address and not to commit violence or intimidate the IP. On 29/04/2021 between 11:39 and 19:19 hours the Suspect has called the IP 45 times on her mobile phone using a withheld number leaving 7 voicemail messages. IP answered the phone once at 13:57 hours and heard the Suspects voice. Suspect has appeared at the IP's address and banged on the door, calling through the letter box for the IP to answer the door and come outside. Suspect has then left for approx. 20 minutes, come back to the address, and tried a softer approach by knocking and calling through the letter flap again. Whilst taking a statement from the IP the Suspect called the IP and she put the call on loudspeaker so officers could record the call on BWV. IP is extremely frightened of Suspects behaviour and is fearful she cannot go out as the Suspect will appear.

30/04/2021 Evidential review
This appears to be part of a course of conduct that has not been 'gripped up' as a series of incidents.
Timeline:
- 18th of March - Reports stalking (exhibits are uploaded on 07/04/21. There is no statement)
- 26th March - Non mol is issued
- 09th April - Harassment where the DP has been texting & calling her following the service of a non mol. A neg statement has been taken.
- 19th April - Common assault where the IP has been in a pub with her friends. DP has been there too. Argument has ensued. Her phone battery died so she has accepted a lift from him. Further argument, he has slammed on the brakes, and she has hit her head.
- 29th April - He attends the house and is banging on the door shouting through the letterbox.
- 30th April - He attends again and calls her.

There are several outstanding enquiries that need to be completed. The timelines in relation to contact are still unclear. It is unclear whether there has been reciprocal contact or whether it has been all one-sided. The IP has given us her phone voluntarily for it to be downloaded. Response officers have been asked to re-attend given that there are several unanswered questions and errors in the statement taken by officers earlier in the day. I have asked for the items below to be clarified:?1) Exhibits 1-15 in relation to 18th of March to be exhibited
2) Details of friends that she was at the pub with?3) Having a frank conversation with IP about being transparent about the contact between them since non mol was issued (& prior)?4) Statement to cover the previous harassment and clarifying timeline?5) Handover form?6) Form for consent to take her phone to be completed? 7) Non mol states there was a further date - asking about this and whether IP has any paperwork. Exhibiting non mol in statement?8) Checking whether DP has messaged on any social media etc.

DP is in custody but is drunk and high on cocaine. He states that he is a functioning drug addict however officers arresting & officers booking him into custody describe extremely volatile and fluctuating behaviour. He is happy and then sad, crying hysterically and then fine. Considering this I have asked for a full HCP assessment prior to interview.

02/05/2021 Supervisor review
Decision: Conditional Bail
This is an investigation into several reports including a breach of Non-Molestation Order, assault and stalking. The victim has provided evidence in relation to these matters.
The DP has admitted in part to some of the breaches and states this is a strained relationship between both parties, but she has contacted him on several occasions and asked him to attend, almost tricking him into a breach, by inviting him to the pub or to her house to take drugs. None of which is mentioned in her statement.

03/05/2021 Workload note***Actions***
1) Download phones for evidence
2) Approach CPS for charging decision

07/05/2021 Victim related entry
VEO: Visited IP at home address and provided her with a temporary phone whilst her phone is being downloaded. Spoke to IP briefly, no concerns raised

31/05/2021 Victim related entry
Telephoned Jane w/c 24/05 discussed her getting her phone back. I explained I had not had the chance to download it yet and Jane said that she has had no direct contact with suspect, but he does drive past her house sometimes. I gave her 999/101 advice.

30/09/2021 – Case submitted to CPS for advice

12/02/2022 – Closing report
Please see MG3 added from CPS on advice. No prosecution for suspect. Ip is now deceased. No VCOP to complete, Suspect informed of NFA decision.

Comments and observations by DCI Gresswell: This is the first report that has confirmation about the Non-Molestation Order and it is recognised by another officer that there has been a cause of conduct and the series of reports have not been 'gripped up.' There are concerns on how long it took for the OIC to complete a MG3 and submit this to CPS for them to complete the investigation. There was no necessity for delaying submitting the MG3 to CPS, just because the FI enquiries had been completed, we had the phone evidence.

Also, of concern the first time a Detective Inspector undertook a review of the investigation was on the 7th of December 2021 which goes against the standards of Inspectors reviews being every 100 days.

04/08/2021 Assault Common and battery, victim not making a complaint and filed

02/10/2021 999 call report of a suspicious incident - that Jane has returned to the locality after being away for about 5 months, and she has found a note on her vehicle which was parked outside her mother's address and believes superglue has been put in the key lock. The attending officers stated no evidence, and it was suspicious circumstances and not harassment or stalking and this was filed.

25/10/2021 – Breach of Non-Molestation Order

Between stated times on the date this incident occurred. The suspect at 2130 hours contacted the IP from a withheld number. The suspect called the victim a 'bitch' and stated over the phone to the victim that shed ruined his life and caused him to lose his job and not be able to see his children. The suspect then continued to call the victim a further 9 times on both a withheld number and the suspects work number. This is in breach of the suspects Non-Molestation Order causing the victim to feel harassed, intimidated and pestered.

27/10/2021 – Offender charged. This is a high-risk domestic breach of non mol. The victim has provided am MG11 that she has received several calls from the defendant which is in breach of the order. The suspect has been arrested and interviewed and admitted the offence and that he was aware of the order. The case was taken to CPS for a charging decision which as authorised. Defendant remanded into custody.

19/11/2021 PVP – Making adult safeguarding personal
After speaking to IP today I have offered to do a referral for counselling. Ip was feeling anxious still and feel the sentence is not long enough - 10 month/5 on good behaviour. IP feels the counselling will really help. I have made a note to contact her in Feb 2022 to discuss the renewal of the non mol before he is due out.

Comments and observations by DCI Gresswell, although at this time, the officer dealing with this differed to the other cases above and they recognised the risk and were successfully able to secure a charge and a remand. The concern is on this case is why did not the officer dealing with this case or the custody sergeant who booked the offender into custody release that the offender/suspect was named on other reports. They could have gone to CPS on all outstanding matters, although no consideration on this.

12/01/2022 - Intelligence

Paul was released from HMP Peterborough with various curfews and conditions.

15/01/2022 - Report of death of Jane

Comments and observations by DCI Gresswell: I have been unable to find any communication or notes on any of the incidents that Jane was updated by the police and any further safeguarding measures had been undertaken.

2.3.12 - Response to relevant Terms of reference

Establish the response to Jane's Mental Health and establish:
Was it appropriate?
Was DA considered by the professionals and spoken about with Jane?
What sharing information processes and referrals are in place when multiple complex needs are identified and did these occur in Jane's case?
The THRIVE framework is increasingly used across the force together with the National Decision Model, Code of Ethics, and existing risk management tools to provide a consistent, standardised, ethical, and robust approach to risk management.
The THRIVE framework reminds officers and staff of the importance of considering Threat, Harm, Risk, Investigation, Vulnerability and Engagement in all key decision making and is applicable from the initial incident reporting phase through to the finalisation stage of the investigation.

Specific Safeguarding teams are responsible for reviewing all referrals submitted to them, for accuracy and assessment, in the light of changing circumstances. In Jane's case, officers had consistently completed adult at risk and child at risk referrals where appropriate, in addition to the DARA/DASH documents. Risk assessments were also completed when both Paul and Jane were in custody and held in police detention, which enabled them to access healthcare professionals, liaison and diversion services, mental health professionals and adult social care services. In Jane's case, the majority of referrals were shared with ELFT, adult social care and CMHT[5], in compliance with the force's information sharing protocols.

Due to his relentless efforts in harassing Jane and as a result a stalking incident reported on 19/03/21, Jane successfully applied for a Non-Molestation Order against Paul, with the assistance of the National Centre Domestic Violence (NCDV). The interim order was issued on 26/03/21 by Luton Family Court and electronically served on Paul on 01/04/21, with a full order issued on 14/04/21. Thereafter, Jane reported breaches of the NMO on 09/04/21, 18/04/21 and 30/4/21 and on each occasion, officers were unable to locate the NMO on police databases or Police National Computer (PNC)[6]. As with most civil orders, best practice dictates that Forces should update PNC with details of such orders, once served upon the respondent. Copies of the NMO are also retained on the NCDV database, which is accessible to law enforcement agencies. It has not been possible to explain the absence of the NMO or establish the cause of police systems not being updated hence, Jane forwarded a copy of

[5] Central Mental Health Team
[6] Police National Computer

the order to Force Control Room (FCR) staff, herself. Paul was released on bail with conditions for the stalking and harassment matters, pending advice from the CPS.

Bedfordshire Police implemented the Domestic Abuse Risk Assessment (DARA) in 2020. Analysis and comparisons with the DASH have not shown much change in terms of number of cases identified as High, medium or standard risk. This has been integrated within the relevant policies and procedures.

All Bedfordshire Police staff and officers received a day's input on awareness of Unconscious bias several years ago. As this area has evolved with research, to assist with self-awareness and awareness of others, Bedfordshire Police are now providing a Cultural Intelligence programme to allow staff to consider inclusion and how everyone may express emotions or communicate their wellbeing and stresses. Leading Inclusively with Cultural Intelligence seminars provides detailed information about individual cultural identities and their preferences, how to identify these in yourself and in others and how to adapt, when necessary to be equitable to the needs of the individual.

This can be utilised not only with colleagues but also stakeholders and partner agencies and the community they encounter. Understanding that different people will display and seek help differently, going beyond emotional intelligence and developing ways to recognise the different ways people want to be supported.

The Cultural Intelligence delivery is to develop individuals to become Culturally Intelligent and is something which requires intentional effort. This is being supported by the Senior Leadership Team and all staff and officers will receive the training, regardless of their rank or role. They are currently halfway through this programme which embarked in January 2023.

2.3.13 - Good practice/Reflective considerations:

The initial police response and investigation of each incident adhered to the force's domestic abuse policies in existence at that time, in terms of the following areas:

- Completion of DASH/DARA
- Completion of risk assessments
- Safeguarding advice/measures/plans
- Positive action
- Victim support and safety
- Recording of crimes and compliance with NCRS in general terms
- Activating Body WORN Video (BWV)
- Securing and preserving evidence
- Compliance with the sudden death investigation policy and Coroner's protocol

Whilst recognising that Jane was a repeat victim (albeit unwilling to support any police action), there was a requirement for officers to take a holistic view of Jane's circumstances. The escalating levels of risks that Jane and her family were potentially exposed to, coupled with the domestic abuse history, were driving factors for wider consideration and safety

planning. However, each incident was treated in isolation and there appears to have been a failure to take positive action to adequately address and manage these risks, by means of, prevention, intervention, enforcement, or review. Paul was arrested on numerous occasions for breaching a Non-Molestation Order (NMO)[7]. He was released on conditional bail until 26/10/21 when he was further arrested for yet another breach of the NMO. Paul was remanded in police custody to appear before the court on 28/10/21, when he was eventually remanded to prison, due to his repeated offending and flagrant disregard for the conditions imposed by the Magistrates Court, and those contained within the NMO. He next appeared at Luton Magistrates Court on 17/11/21 and was further remanded to prison until 15/12/21, (having pleaded guilty to assault and breach of Non-Molestation Order), pending compilation of a pre-sentence report.

2.3.14 - East London Foundation Trust (ELFT)

ELFT has 'Domestic Abuse and Harmful Practices Policy' - last reviewed September 2019 next review September 2022 in place which is accessible to all staff on the intranet. The policy is to ensure that ELFT adopts a safe, consistent and quality approach to domestic violence and abuse in line with current legislation, local and national guidance, the policy is underpinned by the Department of Health (2017) Responding to Domestic Abuse: a resource for health professionals and the Working Together to Safeguard Children (2018) documents.
The policy also includes responsibilities of staff:
Complete DASH Risk Identification Checklist (DASH-RIC) with survivor consent
Refer to MARAC using MARAC referral form when DASH-RIC indicates High Risk (over fourteen ticks, potential for escalation or professional judgement).
If survivor does not consent to DASH-RIC consider completing referral to MARAC on professional judgement.
If perpetrator under 16, refer to Children's Social Care as per local guidance. Think Family!
Establish immediate safety of survivor, children and others.
If risk of immediate significant harm call 999
Provide survivor with contact details for local support services.
Consider additional risk factors such as mental health, mental distress, older adults, disability, pregnancy and LGBT+ and include in assessment.
Liaise with other professionals as required
Document in Patient Electronic Records as per ELFT Health Records Policy.

2.3.15 - Jane

Jane had a primary diagnosis of recurrent depressive disorder and Ovarian failure with Emotional Unstable Personality Disorder (EUPD) and misuse of alcohol. Jane also had a history of seizures. Biological, psychological (including thoughts, emotions, and behaviours), and social (e.g., socio-economical and socio-environmental) factors, all play a significant

[7] Non-Molestation Order

role. Each interconnect with complex interactions and impact on Jane's health and wellbeing.

In total, ELFT have nine separate records of Jane attempting to take her own life between 2019 and 2021. Methods include overdose with the last serious attempt in January 2021.

Jane was under the care of the Dunstable Community Mental Health Team (CMHT) from 2015. She was initially open to the medical caseload with review appointments averaging every 6 months. She was referred to the team psychologist for treatment which ended in 2016.

In early 2016 Jane accessed the Accident and Emergency (A and E) department, psychiatric liaison service (January), this was the only occasion in 2016. In early 2017 Jane attended A and E and it is during this contact she reported the end of a relationship she had with a man who was homeless who had stolen from her, potentially drugged her and threatened her. No safeguarding referral was made or onward referral regarding DV.

Following the A and E attendances Jane was seen at the CMHT by a doctor. Jane reported her thoughts regarding wanting to kill the ex-partner which were reported to the police. No safeguarding referral made. Jane attended A and E on three occasions' during January 2017, with intervention provided and referrals back to the CMHT (second occasion referred to crisis team who closed the same day).

In June 2018 Jane attended A and E following a disclosure that her mother's partner was a 'paedophile' which brought back memories of her father's history and imprisonment for child sex offences. Jane attempted to take her own life by jumping off a balcony (stopped by partner) and overdose. Jane was admitted into hospital.

May 2019 Jane attended A and E following the police being called to the family home. Jane was reportedly violent towards her family with recent self-harm and an attempt on her life. Jane's mother reported she was drinking excessively and had 'slapped' her son. Children's safeguarding referral sent by PLS staff. Later that month Jane was arrested for graffiti on her ex-partners door, adult caution given. In June 2019 Jane was admitted to hospital on section 2 following self-harm and section136. Jane disclosed she had allowed a friend she had met in hospital into her home who had stolen from her. Safeguarding alert raised, Jane did not wish to share any further details or take this forward.

September 2019 - Mental health street triage contact with reported thoughts of harming herself and son. On the 20/9/19 Jane was arrested for ABH and charged with attempted murder. Released with additional mental health support from the crisis team. Jane had a brief admission to hospital. Unable to identify any referral for perpetrator of DV for Jane. Two days after plea hearing (also anniversary of brother's death), Jane attended A and E. Jane had planned to kill herself. She had waited for her mother to go to sleep, cut her throat and took an overdose. Mother found her. Safeguarding alert raised with recommendations for ongoing support, Jane was admitted into hospital. Following discharge from hospital CC discussion with Clinical Director regarding the risk and complexity of Jane's circumstances and presentation. Agreed referral to the complex needs service which was sent.

Unfortunately, the complex needs advised they had no capacity to offer Jane any intervention at that point and would revisit when capacity enabled. (Complex needs service provides assessment and therapeutic intervention for those individuals with personality disorder with significant risk behaviour)

January 2020 - A and E attendance by Jane and crisis support offered. Hearing date for ABH was February. Jane reported she attempted to take her own life. Intoxicated on attendance to A and E.

December 2020 - Jane reported to her CC via text a sexual assault from her ex-partners friend, debt and alcohol consumption with self-harm. Appropriate P2R referral discussed and agreed, no discussion regarding accessing support in relation to sexual assault or debt concerns identified (sexual assault had been reported to the police).

January 2021 - A and E attendance following attempt to hang herself which Jane stated was due to stress which resulted from her controlling and overbearing ex-partner. Safeguarding referral made and section 42 enquiry allocated to the CMHT – student allocated enquiry officer with senior oversight and management of the enquiry. Open to victim support and sigma in place. MARAC referral completed. Discussion with IDVA senior and enquiry lead officer. IDVA advised they could not provide Jane with support as there was a risk she may use the safety strategies that IDVA support against/harm others in the future. This risk was identified as high as she recently assaulted her ex-partner 6 months prior. IDVA advised Bedford All Women's centre, Stepping Stones and Family First could provide support. No identification in records that these referrals were made. Jane had been referred by probation to Independent Sexual Violence Advisor for Survivors. P2R discharged due to non-engagement. A key risk was identified as part of the section 42 enquiry in relation to domestic abuse:

''lives in her mother's property as a measure to reduce impact of difficulties in her intimate relationship and to manage her mental health and risky behaviours, she is eligible for her own accommodation and being supported to bid. However, moving into her own accommodation without support and plan to manage the risk may increase Jane's vulnerability both to domestic violence and her own self injurious acts'

March 2020 - Further reports of DV between Jane and her partner. Jane was arrested after reportedly having a fight with her partner and Jane was in possession of a knife when police attended, Jane sustained injuries. Central Beds Local authority requested review of risk assessment and protection plan regarding DA. It is not evident in the records that this was reviewed with Jane by the CMHT.

In April, Jane reports a further DA incident of her ex-partner trying to run her over in a vehicle. This was after he turned up at a location where she had met a friend and he just joined them on the table. MARAC identified as high-risk agreement for DA service to liaise with CC for engaging in extra DA support, working with Emerald team (police).

October, Jane reported her ex-partner knocked on her door and as soon as she opened the door, he hit her on her face with a plastic bottle and she fell over and started bleeding form

her nose. She then rang the police and reported the incident and he was arrested for assault and for breaking his non molestation order. She reported he appeared in court and it was adjourned to the 15/12/21 and he was released on bail.

The ex-partner was calling whilst out on bail breaking conditions and arrested to appear in court November 17th.

Jane moved into her own accommodation in November which had been indicated in risk assessments as an increased risk to DA and self-harm/suicide attempts. There is no record of any discussion between the CC and Jane regarding this risk with a contact report with Jane stating she was mentally well.

December – MARAC. No actions for ELFT.

2.3.16 - Good practice/reflective considerations

There is a degree of disconnect in the CC's approach to DV. He worked with the safeguarding enquiry lead in 2021 and Jane communicated with him directly about DV but little evidence of the CC connecting the DV being a risk in relation to Jane's self-harm and suicidal thoughts/intent. The mental health risk assessment indicates the increased risk to self-harm and DV with Jane living alone and the CC visits Jane at her new independent home when she reports a further DV incidence.

The review established that the Dunstable CMHT made documentation following discussions that are not recorded on RiO (electronic system). For example, the weekly Clinical Multidisciplinary (MDT) team discussion is documented on their shared folder but not on RiO, WhatsApp messages (a recognised way of communicating in the CMHT)

The risk is not explored and no evidence of discussion regarding Jane's protection plan is within the records. Jane did report feeling mentally well.

The review has not been able to identify if the CC had accessed any DV training or the trust suicide prevention training. ELFT staff are able to access Local Authority DV courses and in May 2021 ELFT employed an IDVA (employee of Victim support honorary contract) for a period of 6 months to work closely with CMHT's, to provide guidance, support and work directly with people experiencing DV.

Jane had good access and response to her mental health when in crisis inclusive of PLS in A and E, crisis team, 111 option 2, mental health street triage and the court liaison and diversion service. She received appropriate medical and psychological interventions whilst under the care of the CMHT. The DBT skills group Jane attended in 2021 was a 6-month course which included providing SU's with tools to support distress tolerance, emotional regulation and interpersonal effectiveness. Jane ended her attendance prematurely due to not having a phone with a camera (held with police for evidence). The team offered alternative ways to support Jane to continue her attendance which she declined.

The review identified that the Dunstable CMHT was short of staff for a significant period during 2021. The team was heavily reliant on agency staff who changed frequently which

also led to increased responsibility and pressure on the permanent staff within the team. High caseloads with increasing complexity. ELFT was receiving increased police referrals and an increase in safeguarding cases in relation to domestic violence. The pandemic led to an increased rate of referrals to CMHT's with reductions in staffing capacity. Jane's CC was a permanent CC within the team.

2.4 Summary of reports

In addition to the IMRs, certain agencies/organisations were requested to provide supplementary information into processes and provisions to provide context of the services and support available and where there may be barriers cross referenced with the Terms of Reference.

Adult Social Care

2.4.1 – Bedfordshire has a Safeguarding Adults Board that has policies that cover Luton, Bedford Borough (BB) AND Central Beds Council (CBC). There is a documented history of Mental Health crisis, suicide attempts and safeguarding allegations relating to domestic abuse from 2016-present all information was shared with the Mental Health trust as the primary support service to Jane.

Jane is not known and has never been to Adult Social Care as she has been open to Community Mental Health Teams with diagnosed Mental Health needs including depression, anxiety, emotionally unstable personality distress disorder and early onset menopause.

There are twelve safeguarding alerts on record between 2016-2022 in which five are related to attempt suicides. January 2021 was the first occasion Jane had cited the reason for this attempt was to escape an abusive partner as this was the only option.

2.4.2 - Safeguarding Adults Process Overview.

The Safeguarding Team in each council area has responsibility for:
- Receiving safeguarding concerns
- Collecting initial information on the concern.
- Determining whether a safeguarding enquiry or alternative other action is required.
- Referring concerns to local authority or other agency staff for enquiry. (In this case ELFT Safeguarding team and Community Mental Health teams under S75 delegated functions.) Providing advice, guidance, direction, and monitoring during the enquiry phase.
- Ensuring that Central Beds Council (CBC) S42 enquiries are completed within the required timeframes and to the required standards.
- Ensuring that the objectives of the enquiry are achieved including effective risk assessment, protection plans and reviews.
- Auditing of safeguarding activity.

• Providing support to the Safeguarding Adults Board including management reports and analysis of trends and themes, specialist advice and management and administration of its agenda and sub-groups.

2.4.3 - Safeguarding Adults Board joint policy and procedures. (CBC/BB/Luton)

The Care Act 2014 states that local authorities must make enquiries, or cause others to do so, if they reasonably suspect an adult with care and support needs is or is at risk of being abused or neglected.

A Safeguarding Enquiry under section 42 of the Care Act will be undertaken when the concern meets all elements of the three-stage test:

• A person has care and support needs
• They are experiencing or at risk of abuse
• As a result of their care and support needs is unable to protect themselves

An enquiry is the action taken or instigated by the local authority in response to a concern that abuse, or neglect may be taking place. An enquiry could range from a conversation with the adult, or if they lack capacity, or have substantial difficulty in understanding the enquiry, their representative or advocate, prior to initiating a formal enquiry under section 42, right through to a much more formal multi-agency plan or course of action.

Whatever the course of subsequent action, the professional concerned should record the concern, the adult's views and wishes, any immediate action has taken and the reasons for those actions.

In Luton, Bedford Borough and Central Bedfordshire, an informal enquiry is made by the safeguarding teams on receipt of a concern, to establish whether the three-stage test has been met. The local authorities may also initiate a non-statutory enquiry.

A formal enquiry under section 42 of the Care Act 2014 may either

1. be coordinated by the local authority (previously known as a safeguarding investigation) or
2. be requested to be undertaken by another agency using formal procedures most relevant to the concern.

When such a request is made to a provider or partner under section 42 of the Care Act 2014, there is a duty to cooperate and respond.

2.4.4 - Safeguarding Adults and Mental Health Trust. (Delegated functions)

The Mental Health Trust (ELFT) provides services for people with serious Mental Health problems, including adult social care services on behalf of Bedford Borough Council and Central Bedfordshire Council.

The delegated responsibilities include carrying out Safeguarding enquiries.

ELFT has dedicated safeguarding adult leads with nominated leads who are cited to all referrals from the local authority safeguarding team. The leads can support with escalation, joint audit, thematic reviews and are active members of the safeguarding adult's board.

Safeguarding enquiries are then allocated to the most appropriate Community Mental Health team or departments such as P2R (drug and alcohol) and safeguarding leads have oversight of enquiries.

ELFT have an Associate Director for Safeguarding and Domestic Abuse in position who is responsible for Safeguarding Adults. ELFT also has a Director of Social Work practice to oversee compliance with statutory social work functions.

ELFT have robust quality assurance practices in place and are resourced to ensure governance and practice scrutiny is built into team practices.

Community Mental Health teams are responsible for carrying out safeguarding enquiries in line with these procedures including assessment, risk management, protection planning, service commissioning, planning, and review.

Community teams are also responsible for assessment and care management of people with care and support needs and in these roles have responsibility for being vigilant to the potential for abuse and for opportunities for prevention.

Other Mental Health Trust services and health care staff in close daily contact with adults will ensure that they provide support and care, in line with the Care Quality Commissions guidance to prevent the potential for abuse to occur. They have a responsibility to recognise and respond to abuse. Staff and volunteers need to be aware of safeguarding procedures and who to concern if they have any concerns.

The Mental Health Trust operates local arrangements such as serious incidents (SI Reviews) to ensure that clinical governance systems and Adult Safeguarding are fully integrated to provide openness and transparency about clinical incidents, learning from safeguarding concerns that occur within the NHS, clarity on reporting, and more positive partnership working.

2.4.5 - Terms of Reference response

How accessible were the services and pathways for referral for the deceased. Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and whether these were acted upon. Recommend any changes following the review process.

Central Bedfordshire Council has robust policies and procedures for Domestic abuse including a well-attended comprehensive suite of training for practitioners via the BDAP website. This suite of training is also available for partner agencies to attend including Mental Health trust practitioners.

A domestic abuse responder training scheme is in operation meaning that all areas of the council have staff trained to signpost, advise and direct people experiencing abuse to help and assistance.

From the perspective of pathways being followed, Jane was known to MARAC and her situation was discussed on numerous occasions indicating that the appropriate referrals and processes did occur. The MARAC is attended by all key partners including the Mental Health Trust, Central Bedfordshire council and other agencies.

Establish the response to Jane's Mental Health and establish:
Was it appropriate?
Was DA considered by the professionals and spoken about with Jane?
What sharing information processes and referrals are in place when multiple complex needs are identified and did these occur in Jane's case?
In relation to information sharing, any intelligence received by the adult safeguarding team was automatically shared with the Mental Health trusts safeguarding team and frontline community Mental Health teams who were responsible for delivering care and support and case management in accordance with the Care Act 2014 as a delegated function under a S75 agreement.

An agreement made under section 75 of the National Health Services Act 2006 is between a local authority and an NHS body in England.
Section 75 agreements can include arrangements for pooling resources and delegating certain NHS and local authority health-related functions to the other partner(s) if it would lead to an improvement in the way those functions are exercised.

Central Bedfordshire council have delegated assessment and care management functions as detailed within the Care Act to ELFT where the persons primary need is a Mental Health condition or crisis.

In practice this means ELFT have registered social workers and allied professionals within their frontline teams who can assess and provide an equivalent service to that of a social worker in a frontline adult social care team. The benefit being that as they are located within a multi-disciplinary specialist Mental Health team so are likely to have additional knowledge, expertise and easy access to health professionals who are involved in the person's Mental Health care.
This ensures that whilst the primary need of a diagnosed Mental Health condition or substance addiction (in case of P2R) is being met the social work intervention can be met at the same time avoiding the need for multiple team input and duplication.
Social Workers within Community Mental Health teams have access to training on safeguarding, domestic abuse and would have the required skills to converse with a person about safeguarding them in situations of domestic abuse. The social workers and relevant frontline community Mental Health team are also delegated S42 enquiries under the Care Act and they will be requested to lead a safeguarding enquiry and risk/protection planning for a person whose primary need is Mental Health and who is already under their care.
Outcomes of safeguarding should be recorded on the local authority social care database (swift) on closure as overall responsibility for Safeguarding Adults remains with the LA.

Has Covid had an impact on patients/clients in relation to lack of face-to-face contact and difficulty in contacting for assistance.
Safeguarding Adult responses and enquiries maintained the request for face-to-face visits for risk assessment and sensitive discussion in relation to any allegations or ongoing enquiries.
Any request for a S42 enquiry led by the Mental Health trust or follow up as a result of alerts being received would have expected a face-to-face welfare check and visit to assess and

review the safeguarding risk assessment and protection plan with each individual person. This was expressed in DMT instructions (safeguarding response) provided by the CBC Adult Safeguarding team to the Mental Health trusts safeguarding team and allocated workers for Jane within the appropriate Community Mental Health team.

2.4.6 - Good practice/Reflective considerations:

Since 2020, within Central Bedfordshire council, the safeguarding team, housing, and frontline social work teams each have specialist DA worker roles who can lead on DA cases and advise and support other frontline practitioners to ensure a robust response. These workers liaise closely with the MARAC, IDVA service and the domestic abuse partnership. The advice and guidance this service provides has been reported as highly beneficial to peers and practitioners.

During Covid restrictions, safe spaces and IDVA coaching sessions were arranged for social workers undertaking enquiries. All initiatives are open across agencies.

2.4.7 - Public Health

Public Health for Central Bedfordshire also cover Bedford, Luton and Milton Keynes and are referred to as BLMK. Each day in England, twelve people get to the point where they have no other choice but to take their own lives. BLMK Public Health have a five-year suicide prevention strategy with an action plan running alongside this with the aim to reduce the number of suicides in these areas over this time. The BLMK Action Plan will be reviewed in line with the new national ten-year plan due to be published later this year, of which there will be a section on domestic abuse.

The Suicide Prevention Steering Group had identified domestic abuse as an emerging risk factor in our real time surveillance earlier this year and applied to the Local Government Association sector led improvement programme for specialist support in this area, which was successful. There is currently an expression of interest for an allocated consultant who will facilitate a local action plan later this year. At this time, there is no domestic support specialist who sits on the steering group.

The Suicide Prevention Pathway Service is provided by Mind across BLMK and provides support for individuals who have mental health/wellbeing needs and may have accessed medical, clinical or emergency services. BLMK have funded several programmes across the areas. One being the Stay Alive app which is commissioned through the suicide prevention transformation fund. Also, See the Signs suicide awareness training which is free and available to all professionals working across BLMK. This is a rolling programme. Zero Suicide Alliance training is a free resource which is being signposted as part of the ‘shining a light on suicide’ campaign which was launched on Suicide Prevention Day.

2.4.8 - Good Practice/Reflective considerations:

The Suicide Prevention Strategy is going to refresh its 'hard to reach' priority groups and DA has been outlined as one of these groups going forward. This will provide more focus and specific actions in this area.

Central Bedfordshire will now have a BLMK Public Health representative as a panel member on all DHR's commissioned involving suicide.

2.4.9 - IDVA/Victim Support (VS) - Bedfordshire

Victim support provide the IDVA service for Bedfordshire. At the point of first referral in January 2021, Victim Support ran two 'high risk' IDVA teams, one covering Luton and the other covering Bedford Borough and Central Bedfordshire, taking risk referrals made into the 3 MARACs. Referrals were made into MARAC and the Senior IDVAs would pick these up from MARAC agendas. Mid 2021 (July) there was a successful bid for additional funding to secure additional five roles, Court IDVA, Hospital IDVA for Luton & Dunstable Hospital, Stalking Advocate, a Health & Communities IDVA and a Senior IDVA. These roles were to support around standard to medium risk predominately. Referrals are made by emailing a referral form into the service. During the latter part of 2021, there was further additional funding for two additional IDVAs to work alongside housing and social care.

During and since Covid there has been an increase in the complexities of cases and the possibility of situational violence. Referrals are dealt with on a case-by-case basis. Where there are concerns about counter allegations, the IDVA will speak to the Police and/or referring agency to gather further information, this would be reviewed and take into consideration a variety of factors including present/previous types of offences, was this part of same or previous relationship. When speaking to clients, the Respect Toolkit will be completed where there are concerns about the possibility about perpetrating behaviour.

Previously, if there were concerns about any referrals and after speaking to Police and/or referrer, the process would be to await the MARAC to gather information from partners prior to making contact with the client. Referrers would always be notified of the intention to wait until the MARAC. However, VS now attend the 'weekly response' meeting at Central Beds. The meeting comprises of a number of core MARAC partners to review queries/concerns about referrals, to determine if they are meeting the threshold or not. If as a result of this meeting where there is still ambiguity the case would go into MARAC for further information from partners, however this does not always lead to a definitive answer. Where referrals are received for both parties, unless it is clear who is the victim, VS would default to the response meeting and/or MARAC prior to contacting either party.

Jane was referred to the IDVA Service on three occasions, the first of which being on 26.01.2021. During contact with the referrer on 27.01.2022 signposting information was provided for them to discuss with the client, including support available from Families First and Bedford Women's Centre. Upon the third referral received for Jane contact was made with her on 02.11.2022 and the support options explored. She was initially uncertain if the IDVA Service could provide her with support she required and so an information leaflet on

the IDVA Service was emailed to her and information was provided on the Bobby Scheme. Jane later declined support on 04.11.2021, at which point she also confirmed she did not wish for the IDVA Service to make a referral to the Bobby Scheme. She would contact them directly.

2.4.10 - Chronology of pertinent dates

26/01/21 - Referral into IDVA Service from Bedfordshire Health. Jane as the victim (Paul is the alleged perpetrator) Email sent to referrer asking to discuss the referral.

27/01/21 - Spoke to referrer to explain we would not be supporting Jane due to her being heard as a perp on another case (serious assault and strangulation) in 2019 and a further assault on the same male. Jane was being supported by ISVA and provided information to ELFT for Bedford Women's Centre and Families First. Case closed.

15/04/21 - Re-referral from Beds Police with Jane as the victim – Alleged Perpetrator was Paul – Jane was brandishing weapon, counter allegations. Decision made not to contact her due to counter allegations from this incident and previous information around her offending behaviour. Referrer updated to say we would not be contacting at this time but would keep the case open until the MARAC for any further information.

2.4.11 - Central Bedfordshire Domestic Abuse Service – MARAC

MARAC stands for a Multi-Agency Risk Assessment Conference. Central Bedfordshire MARAC is delivered by the Domestic Abuse Service which sits within the Children's Services Directorate of Central Bedfordshire Council but works across the whole of Central Bedfordshire Council.

The role of the Domestic Abuse service is to create and oversee an effective service response to domestic abuse at every level, which supports those affected by domestic abuse, this includes:

- Commission Domestic Abuse services for victims, young people, families, and perpetrators
- Provide professional advice – in a professional capacity or with friends/family
- Communication and engagement with professionals, partners, and residents to raise awareness of and help prevent Domestic Abuse
- Hold partners to account for the way in which Domestic Abuse is dealt with through Child Safeguarding Practice Reviews, reflective practice, and Domestic Homicide Reviews
- Support BDAP – Bedfordshire Domestic Abuse Partnership working with Bedford Borough Council, Luton Borough Council and voluntary organisations to raise awareness of Domestic Abuse and promote training and good practice across the three local authorities

- Deliver the Central Bedfordshire, Domestic Abuse MARAC aims to review and coordinate service provision for clients at high risk of experiencing domestic abuse.

2.4.12 - MARAC Governance

Central Bedfordshire MARAC aims to, monitor, and evaluate effective information sharing to enable appropriate actions to be taken to, increase public safety, safeguard victims, any children involved and to put appropriate measures in place to intervene and disrupt perpetrators.

CBC MARAC is governed by the Pan Bedfordshire Steering group and delivered in accordance with the following protocols:

- Pan Bedfordshire MARAC Operating Protocol
- Central Bedfordshire Operating Process and
- Central Bedfordshire MARAC Information Sharing Agreement

These documents have been provided to the chair of the DHR as part of the review process.

2.4.13 - MARAC Actions:

In respect of the governance and oversight of MARAC actions there is a clear audit pathway which includes:

1. MARAC representatives reminded to complete all incomplete actions one month after actions are allocated and two weeks after the assigned action deadline date.
2. MARAC Coordinator completes an action audit on a quarterly basis, looking at the incomplete, unable to complete and ongoing actions. Agencies are contacted again directly to complete and/or update outstanding actions
3. When a second quarterly audit is completed, and actions remain outstanding they are escalated to the agencies operational lead via the Pan Bedfordshire MARAC Steering Group.

Where there are challenges and barriers for agencies in completed actions the MARAC coordinator and/or Domestic Abuse Specialist liaises closely with the MARAC Action owner and operational leads to ensure actions are completed and updated.

In this case, in addition to the usual MARAC action audit process the concerns were such the MARAC actions assigned to mental health and adult safeguarding agencies were followed up separately and on more than one occasion. Further to this, additional meetings were arranged with adult safeguarding and ELFT leads ahead of MARAC meetings to revisit and update on actions and then again afterwards, where actions were not completed within agreed timeframes.

MARAC actions are recommendations only. There is no statutory duty to complete MARAC actions and where agencies are experiencing significant operational demands and competing priorities it can be challenging to take any further action to ensure actions are completed.

In order to add weight to statutory agencies capacity to undertake MARAC actions there would need to be a change in the status of MARAC nationally to ensure allocated actions are able to be prioritised with core statutory service.

2.4.14 - Counter Allegations

Where there are counter allegations in a high-risk MARAC case and there is uncertainty around who the primary perpetrator is, professionals are advised to complete the Respect Male Victim toolkit which explores counter allegations and aims to identify where significant risk lies.

In this case a recommendation was made to complete the toolkit and the Domestic Abuse Specialist attempted to contact the Care Coordinator on a number of occasions to offer advice and guidance. These were not responded to by the care coordinator and subsequently raised with the Adult Safeguarding MARAC Representative.

Unfortunately, on this occasion despite being clear on the safeguarding needed during the MARAC meeting discussions and the subsequent assigned actions, the statutory limitations of MARAC reduced the impact of those safeguarding decisions and measures put in place

Central Bedfordshire MARAC has seen an increase in complex cases, frequently involving counter allegations. Initially this trend appeared to be driven by COVID 19 lockdown restrictions, limiting all agencies capacity to complete direct work with both parties in cases of counter allegations. Since the lockdown measures have eased Central Bedfordshire MARAC has seen a continuation of referrals involving complex cases and counter allegations.

It appears that in these cases, there is a gap in specialist commissioned services, who historically would refuse to work with victims where there have been previous allegations against them. This will be addressed with commissioned providers through the contract procurement process to ensure specialist support is offered to all victims referred to CBC MARAC in future.

It is of concern that counter allegations have been a factor in at least three other cases of suicide recommended for DHR decisions over the last 12 months in Central Bedfordshire. There is a considerable amount of work being undertaken to understand the impact of domestic abuse on suicidal ideation in Central Bedfordshire, in collaboration with BLMK Public Health and the Suicide Prevention Board. Further consideration will be given to the management and safeguarding of high-risk cases of domestic abuse, where there are counter allegations and history of suicidal ideation as part of this work.

2.4.15 - Housing

During the scoping exercise of this review, CBC Housing responded with a nil return, stating the did not have any information in relation to Jane. Further scoping was conducted with Clarion housing who are a Housing Association providing accommodation locally and this was also a nil return. There were no representatives in relation to Housing that sat on the panel.

During the final stages of the review, the coroner forwarded the author information in relation to housing that had not previously been received. The property Jane lived in was not a CBC property but was a private tenancy being supported the Lets Rent team in Housing.

This team inspect the properties every 3 months, to ensure all is well, and Jane's property was visited a short while prior to her death when all was found well in terms of the condition of the property, and she was happy living there.

Jane had a contact officer within the department whom she emailed in October 2021 to ask for assistance as someone had put superglue in her locks. The locks were changed following a phone call to the Landlord.

There were further communications in relation to other matters over the next couple of months and then in early January 2022, her contact officer completed an inspection of the property. On speaking with Jane, she told her how she had a brilliant Christmas with her son visiting. This was the last time her contact officer saw Jane.

A few days later at 01.18hrs on a Saturday morning, Jane sent the following email to her contact officer:

> Hi,
>
> I need some help or advise please.
>
> As you know I have mental health problems specially my anxiety.
>
> When I moved to this flat, I loved it I'm so happy here and want to stay,
>
> My ex put me in a safe house as he was a danger for beating me. He's in prison since September and due out march or April time. I've been so wrapped up in moving in and spending Xmas with my son. But now I've hit rock bottom. the police have advised me to move again but I don't want to and why should I, it's not fair.
>
> I'm so scared and worried when he's free I feel I need to kill myself before he comes out and kills me, as he is obsessed by me and I know he will turn up one day, I just don't know what to do.
>
> Please can you call the policeman that contacts me and helped me with my case and find out when Paul is free, (phone number provided) please. Sorry can't remember his name.
>
> I hate living in fear.
>
> Can't stop crying and so scared I don't know what to do please help me. Sorry to ask
>
> Thank you

This was received at 08.35hrs the following Monday morning when the contact officer returned to work. She immediately replied, asking for consent to contact Victim Support.

The following morning, when she had not replied, the contact officer tried to ring her with no reply. Later that morning, she was informed of Jane's death by a colleague who had heard the information from a neighbour of Jane's. On phoning the number provided by Jane of the Police Officer, he confirmed this. The contact officer then informed her manager.

Good practice/Reflective considerations:

There is now in place an online Tenant Support and Wellbeing Service (TSWS) that was launched at the latter part of 2022. All residents and tenants in managed properties are provided with contact details. The TSWS is available 24hours a day all year round where they can obtain support for health and well-being, relationships, family matters and other matters that cause stress. Signposting for additional support is available and also counselling.

The Lets Rent properties that are managed on behalf of other landlords do not have an out of hours emergency service, except for repairs calls. Jane's property was one of these managed properties, so the arrangements in place are only for out of hours repairs.

The team have received up to date safeguarding training, in view of the learning from this case.

Section 3 - Analysis

3.1 Family and friends' perspective

3.1.1 - Rosemary

Rosemary remembers her daughter as a fun-loving young girl whose personality changed considerably when she began early menopause when she was about 30 years old. She started drinking more which didn't help as she was on medication for her depression and anxiety but nothing worked.

She sometimes did not get up in the daytime and each time she attempted suicide felt like a cry for help due to her medical condition. The thought of never having another baby used to get her down. Rosemary knows Jane was not perfect, but she always used to pick the wrong man and when she asked Jane why she kept going back to them, she stated it was easier than not being with them as it gave her a bit of peace as she didn't feel safe on her own due to the constant harassment and stalking.

Rosemary felt that the police could have done better. They didn't always attend straight away and Jane would wait up into the middle of the night and be so frustrated by the time they got there she would say 'What's the point' and this would lead to her not supporting prosecutions along with the fear she felt.

Rosemary knew that a great source of frustration for Jane was if she had a set back and rung the crisis team. They always came out quickly and were really nice people but there would be two or three of them and were always different people. They would ask 'How are you?' and How can we help?' and Jane did not want to have to explain everything over and again.

Although Jane could be difficult due to her condition, with Paul, it was definitely more him than her and Jane wasn't to blame for what happened in that specific relationship. The fear of Paul harming her was clearly the reason Jane took her own life.

Rosemary has had the opportunity to read this report and is happy with the accuracy, content and portrayal of her daughter.

3.1.2 - Martin

Martin first met Jane when she was 19 years old and describes her as outgoing and cheeky. He states that she did have a temper at times, never physical, but she seemed all right in herself. Her grandad passing affected her and she could never talk about it and got angry when it was. She never dealt with it properly.

Martin says that she tried her best for their son, Bobby. She was not a perfect mum but she wasn't a bad one. He describes Bobby as similar to Jane in the fact that neither open up about their feelings. Bobby has never told him that he witnessed any arguments in his mums' relationships but Martin states that this does not mean that he didn't.

Martin is happy with the response and support he received from Children's Services in both Bedfordshire and Hertfordshire and the offers to assist him, but Bobby declines to open up. He feels that Bobby has grown into a sensitive balanced individual with a positive outlook on life.

3.1.3 - Darren

Darren was a close friend of Jane's since school and she often confided in him. She often told him that she was sick of the way people treated her which caused her anxiety.

She told him how Paul stalked her and always seemed to find out where she was. When Darren helped her move into the last flat that she lived in, nobody had known the location yet Paul had managed to find out and glued all of the locks together which he later admitted. This worried her about living there before she had even moved in properly. Darren advised her to get CCTV as she had told him of the injuries Paul had inflicted on her many times before including being run over.

Darren is aware of the issues Jane had in her life but believes that being a victim of domestic abuse was the major part in why she took her own life.

3.2 Terms of reference areas

3.2.1 - Has domestic abuse in any form been the causation or a contributory factor to Jane taking her own life?

Whilst analysing this area, the panel took full account of a number of factors in Jane's life that cannot be ignored:

- The effect of learning about her father at an early age
- Post-natal depression and long-standing depression
- Diagnosed mental health issues that affect her behaviour
- Medical condition of premature ovarian failure causing menopause at an early age

Her medical condition had a detrimental effect on Jane's mental health, leaving her feeling depressed and isolated at times causing her to be vulnerable. This vulnerability was exploited by the men that she came into contact with and then went on to have relationships with. Due to her mental health issues and the commonality of alcohol misuse with her partners, there were incidents of situational violence with her partners with evidence of them goading her in certain circumstances. This accentuated the symptoms of Jane's mental illness from her diagnosis in 2015.

During Jane's relationship with Paul, he was violent and controlling towards her which was witnessed by her own mother. Although she broke the relationship up numerous times, she remained with him as it 'gave her some peace.' The constant phone calls and harassment when she was not with him wore her down to the point that it was easier to be with him than not.

Following Jane completely breaking off the relationship, Paul went on a campaign of constant phone calls and messaging with tirades of abuse. He would follow Jane as she went about her personal business, turning up at her home and in public places such as pubs. He tracked her to the refuge where she had gone to seek solace and isolated herself for the sake of her safety.

Paul exploited her vulnerability by making it known to her that he was watching her, glued her locks to her new home before she moved in all to cause emotional abuse and instability to her mental health.

Jane lived in fear of Paul for the last year of her life, never knowing if he was watching her or if he would turn up at any time. The only peaceful time she had from him was whilst he was in prison and even then, Jane voiced her fear of what would happen when he was to be released.

The notes she left specifically commented on the effect that Paul' release and behaviour had on her stating that she would rather kill herself than Paul kill her in both notes. She clearly felt the abuse would continue when he was released from prison.

It has been noted that there are conflicting accounts as to why David attended the flat the night he found Jane as told by David at the time and the account that Rosemary has stated in recollection of her conversation with Jane. However, the matter has been investigated and this is seen as an anomaly.

3.2.2 - The availability and effectiveness of services and agencies provisions for those contemplating taking their own life and those with complex needs within Central Bedfordshire.

Public Health provide free training and a 'stay alive' app that provides essential suicide prevention for everyday life. The Suicide Prevention Steering Group has identified domestic abuse as an emerging risk factor and are employing specialist support in that area. However,

there is no domestic abuse specialist currently sitting on the group to advise and discuss which would assist with any decision making on progression. (Recommendation refers)

The panel considered the fact that there had been nine suicide attempts by Jane and the lack of collaboration surrounding this. Reliance by agencies where there is DA identified is on the MARAC process, however, if this is not identified when treating someone who has attempted to take their life on more than one occasion, there should be a trigger point where agencies can come and collaboratively work together to support that individual and address all of their needs. There is no legislation at this time to govern this and would therefore have to be a local agreement for professional discussions. (Recommendation refers)

Healthcare and support needs will vary for each individual. It is now well accepted that abuse (both in childhood and in adult life) can be a main factor in the development of depression, anxiety, and other mental health disorders, and may lead to sleep disturbances, self-harm, suicide, and attempted suicide, eating disorders and substance misuse. Professionals have received training and recognise this.

The Mental Health Street Triage team is a collaborative service that provides advice to emergency mental health crisis calls and collaborates the Police and paramedics directly with mental health professionals. This is good working practice. However, there remains a gap in relation to front line operatives identifying mental health issues and suicidal tendencies if it is not already known. Training in relation to this and specifically in incidents involving domestic abuse and understanding the correlation is required to bridge this gap. (Recommendation refers)

Assistance in one area can sometimes lead to overshadowing by professionals as they are faced with multi-complex needs and will revert to the issue that is either already being addressed and has support in place or is potentially the easiest to address. If a victim is not in the frame of mind to support a prosecution or receive specialist support, then often, the domestic abuse is put to one side and the mental health issues are addressed which does not eradicate the abuse that will then continue. Jane had a number of recorded mental health crisis calls logged prior to any domestic abuse incidents. (Recommendation refers)

Jane had a permanent Care Coordinator with ELFT which provided her with continuity, although in times of crisis, if not available, in order to respond in a timely manner, those who were on duty would attend with little information which caused additional frustration in having to explain her own issues when asked how she was. Jane disclosed domestic abuse to her Care Coordinator on more than one occasion, but there is little evidence of him connecting that this would be a risk in relation to her self-harm and suicidal thoughts. It cannot be established if he received any domestic abuse training. It did establish that due to there being several ways the Care Coordinator communicated and meetings documented, the main computer system (RiO) did not hold all of the information from which a risk assessment on Jane would rely on. Since this has been identified, ELFT have reviewed their

recording protocols and are content they are sufficient and the issue is with non-compliance. Communication has been sent to all staff as a reminder of recording procedures and will be monitored by supervisors going forward. As this has been addressed, a recommendation has not been made from this review.

Jane contacted her housing support officer on a weekend, out of hours and the message was not read until she returned to work. There was not an out of hours message for where support could be obtained or that the message would not be immediately received. On receiving the email, the support officer responded immediately but did not acknowledge the serious tone, make any immediate referrals or raise the issues outlined in the email further. The wording of Jane's email was not identified as an immediate safeguarding issue. The Lets Rent Team have a communal email address but this is not monitored at weekends or evenings. (Recommendations refer)

3.3.3 - The response of services when a victim has previously been a perpetrator and whether this creates barriers in process.

The Police receive information prior to attending a domestic abuse incident which is required to enable them to assess risk and prepare them to an extent on the history of the situation. However, this information may give them preconceived ideas and cause unconscious bias if they arrive at an incident, knowing one party has previously been recorded as a perpetrator. Due to the layered processes where checks are made, any initial decision making based on this should be identified by another on review prior to finalisation, but this is not always the case. There were a number of omissions made within the investigations between Paul and Jane, some of which resulted in the expiring of statutory time limits negating the possibility to prosecute and some that did not meet the requirements for a prosecution set by the CPS. There was also the lack of collectiveness and analysis to unite the individual incidents by either the Police or the CPS. Both also identified the statutory time limits and did not work within them.

It cannot be known whether this was bias either in relation to Jane previously being an offender, her not wishing to support certain prosecutions or her mental health issues that affected the service offered to her as a victim. (Recommendation refers)

Jane's mother, Rosemary highlight two issues that were barriers with Jane. One being the length of time that it takes the police to respond, by which time Jane has disengaged due to her lack of patience which was an affect of her early onset of menopause. The police were mostly contacted after the event when Paul had left the location which then has consequences in relation to the risk assessment determining the priority of the call. With the perpetrator no longer at the location, the response time would not be determined as immediate. This is based on demand and priority and therefore a recommendation has not been made to change this.

Rosemary also spoke about the changes in Jane's Care Co-ordinator due to employing agency staff and different crisis workers attending who did not know her history. Agency staff and turnover were an issue during Covid which has now settled with more permanent staff which addresses the issue surrounding Care Coordinators. Crisis workers may not always read the notes of a patient prior to speaking to them which can affect the overall risk assessment as they are not totally informed and this can have an adverse effect on the fact that the patient has to constantly repeat their history. ELFT have stated that this approach is made by some Crisis workers even if they had read the history in order to hear it from the patient without leading them which would prevent unconscious bias. (Recommendation refers)

Panel members have discussed in depth how support services and the MARAC process are often cautious over offering support and disclosing support mechanisms that only victims would be told, such as locations of refuge if they were recorded previously as a perpetrator. This is due to previous experiences where perpetrators have manipulated the system in order to gain knowledge and to present themselves as victims to mask their abusive behaviour and discredit the other party.

Jane was referred to MARAC on three separate occasions in 2021, but it does not appear that any definitive decisions were made on how best to safeguard her.

The IDVA service initially received a referral at the start of January 2021 and recorded the reason for the decision not to support her as being a perpetrator from a previous matter. A further referral in April of the same year saw support for Jane declined again on the basis that there was a counter allegation involved from the incident and previous information in regard to her offending behaviour. In October, the same year, a further referral for Jane was received and contact was made via phone. Jane declined support but wanted help to make her front door more secure and after receiving the details, stated that she would contact them directly if needed. There is no record as to why on this occasion, support was offered in comparison with the earlier referrals. Jane was supported at the Court process in November by the Court IDVA.

There is a toolkit available to assist with risk assessing when a victim has previously been a perpetrator but the MARAC action for this to be completed by ELFT does not appear to have occurred. It is difficult to state whether the actions from agencies within MARAC were that of unconscious bias as it is understandable that caution has to exist but when removed from the situation, the information and series of events make it clear that Jane was genuinely a victim of Paul and required support and safeguarding which was not implemented. (Recommendation refers)

3.3.4 - Considerations and actions available to appropriately support and safeguard domestic abuse victims.

A Non-Molestation Order was in place against Paul, but during the course of this review, it has not been established why the NON-MOLESTATION ORDER was not recorded or accessible on any of the police databases including PNC. This situation necessitates a review

of existing policies to ensure that civil orders relating to domestic abuse perpetrators, are accurate and accessible to all officers and staff.
This is an area of high organisational risk for Bedfordshire Police in terms of managing high risk perpetrators and delivering an enhanced level of service to vulnerable victims, exposed to high risks of harm. This is currently part of a National Super Complaint and internal processes are being reviewed with a task and finish group being led by the College of Policing. Due to this, it is felt that a recommendation from this review is not required as it is in the process of being addressed at this time.

The initial obtaining of the order was seen as good practice by the Police; however, Non-Molestation Orders are only effective if they are acted upon appropriately and in a timely manner. Orders of this kind can provide the ability for authorities to safeguard the vulnerable who are sometimes unable to safeguard themselves. In this sequence of incidents, the Police dealt with each incident in isolation to a degree, presenting evidence separately to the CPS of a poor quality, causing the statutory time limits to exceed in some cases and finalising certain reports when evidence was available and could have been utilised in the overall case presented to the Court if not as charges in their own right. Taking a phone from a vulnerable victim such as Jane and not returning it for four weeks having informed her of the contrary and not allocating an investigation for over three months after it was recorded does not provide an appropriate level of service to the victim.
(Recommendation refers)

All incidents reported to the police were reviewed and no Controlling and coercive behaviour was identified, recorded or apparently considered. At the time of these incidents the National Crime Recording Standards (NCRS) specified the principal crime rule introduced in 2017 and often referred to as double counting (so record the conduct crime plus the most serious of any offences being reported at the same time – i.e. Kidnap and Controlling and Coercive behaviour). Therefore, crimes of controlling and coercive behaviour were not recorded or investigated when they should have been.

As part of a review by the National Police Chief's Council (NPCC) in May 2023, the Home Office Crime Recording rules were simplified. Officers and staff are now required to only record one crime. The principal crime will be recorded and any other crimes identified will be recorded as included classifications.

The general rule is one crime for each specific intended victim and the guidelines for offences likely to be linked to DA are:
Application of this rule does not mean that other crimes should be forgotten. There is still an expectation that all crimes will be documented within the crime record and investigated fully.
In cases where the conduct crime is not recorded as the principal crime, any subsequent referral of the case to CPS must include a clear reference to the fact that a conduct crime has been disclosed.

Stalking and harassment was prevalent and this was recorded and investigated with observations on the effectiveness of these investigations made throughout this report.
During the course of the writing of this report, Bedfordshire Police now has the role of a

stalking coordinator and a process for triage of all stalking reports. Although only 50% of stalking offences relate to domestic abuse, all reports will sit with the Emerald domestic abuse Team to provide specialist response and oversight. The triage process will consider Stalking Prevention Orders.

Bedfordshire Police now have additional scrutiny at sign off stage for rape and high-risk DA if they are filed no further action. However, this does not provide reassurance that Controlling and coercive behaviour is identified and investigated in those cases where it is risk assessed as medium or standard. These are also the cases that will lack multi-agency information sharing. (Recommendation refers)

Intelligence was received from HMP Peterborough to Bedfordshire Police confirming Paul's release on 12/01/22. This intelligence was not shared with anyone. The police report shows that Jane was informed that she would be contacted prior to his release, but no such contact is recorded or any further risk assessment of safeguarding needs. It is not clear that the police were aware he had even been released.

Probation has a small team of Victim Liaison Officers (VLO's) who are governed by the below legislation:
The Domestic Violence Crime and Victims Act (DVCVA) 2004 lays out the statutory boundaries of the VCS, and the victims who statutorily qualify for the VCS. These are:
Victims of offenders who have been sentenced to 12 months or more in custody for a specified sexual, violent or terrorism offence, even if the offence was committed before the relevant provisions of the DVCVA 2004 concerning the VCS or the forerunner scheme to the VCS came into force (1 April 2001) although it is understood that we cannot trace all pre-2001 victims.

Victims of offenders who have been made subject to a hospital order with restrictions for a specified sexual, violent or terrorism offence, under the Mental Health Act (MHA) 1983 (restricted patients).

Victims of offenders who have been made subject to a hospital order without restrictions for a specified sexual, violent or terrorism offence, under MHA 1983 (unrestricted patients).

The next of kin or close family member(s) of a victim, as specified in one of the above categories, who died as a result of the offence; and

The parent, guardian or carer of a child or vulnerable adult who was a victim as specified in one of the above categories (unless this is not considered to be in the victim's best interests). Once the child turns eighteen, contact should be provided to them directly.

This legislation did not cover for the circumstances of Jane and therefore, they did not inform her. The police held the information in their intelligence system with no requisite to inform her or pass the information on. Jane had no support services engaged due to her previous offending and declining assistance and therefore they would not have enquired in order to inform her. This is not covered in the updated DA Charter in 2021 and is a concerning gap that requires attention.

As no organisation or agency had responsibility, this led to Jane living in fear of the unknown or not knowing whether he would turn up on her doorstep, as she did not know when Paul was due to be released. If legislation covered this scenario, this would have allowed for further risk assessment and safeguarding measures being implemented where necessary. The knowledge that Paul had been released three days earlier to when Jane took her life may have given her peace of mind if a risk assessment and safeguarding plan had been discussed with her. (Recommendations refer)

A number of support services including P2R and Victim Support (IDVA service) have protocols in place to manage their workloads whereby they will make a certain amount of phone calls to a referred client and if this is not answered then the file will be closed to them. This client, and in the case of Jane, may have multi complex needs and therefore already have a built relationship with another service e.g., Crisis Team or VEO from Police that could be utilised as a face-to-face introduction. This may have enhanced the possibility of Jane engaging with either of these services and therefore, accessing additional, vital support. A similar collaboration used to take place under the dual diagnosis group but this no longer exists. (Recommendation refers)

On leaving refuge, Jane was provided a flat within the same region as her family and friends as she had not dealt well with being away and isolated from them which was detrimental to her health. Her wishes were adhered to although the review has not identified any risk assessment or advice for her not to return to the area. On Paul's release from prison, he returned to the same area into privately rented accommodation and as he did not reach the criteria for MAPPA intervention, there was no restriction on where he could live, albeit that he didn't make contact with Jane during the short time he was released. However, this would not have negated them 'coming across' each other in public places whilst socialising or going about their daily business.

The MARAC for Central Bedfordshire has a number of processes and protocols in place that attempt to address the non-compliance of organisations who do not complete the actions they are tasked with during a meeting. Records show that the action regards the toolkit given to ELFT was addressed by the Central Bedfordshire Domestic Abuse Service with contact being made on several occasions with no response. Without any statutory duty, agencies lack accountability for the non-completion of actions which sit outside their own statutory obligations. Actions are tasked in MARAC to assist with the safeguarding of victims and the non-completion of these actions with no accountability can create risk. (Recommendations refer)

3.3 Other areas for analysis

Effects of Covid

The review identified that the Dunstable CMHT was short of staff for a significant period during 2021. The team was heavily reliant on agency staff who changed frequently which also led to increased responsibility and pressure on the permanent staff within the team.

High caseloads with increasing complexity. ELFT was receiving increased police referrals and an increase in safeguarding cases in relation to domestic violence. The pandemic led to an increased rate of referrals to CMHT's with reductions in staffing capacity. Jane's mother states that the frustration endured by Jane with different responders and having to inform them what is wrong rather than them already having the required background knowledge.

Victim Support, P2R, GP practice and Adult Social Care offered a reduced level of face-to-face appointments with clients over the Covid lockdown and surrounding period, but many were unable to receive this and also, declined this due to their own fears of contracting the virus. Jane declined a number of offers of support from different services over the phone without the benefit of face to face, of which her mother has stated would have assisted due to Jane's multi complex needs.

This is a wider issue to review separately, but worthy of note that it was identified by panel members and was the period of time during 2021 when she suffered constant domestic abuse by the way of stalking and harassment from Paul and reached a low point, prior to ending her life.

Section 4 – Conclusions and Recommendations

4.1 Conclusions

4.1.1 - Jane was raised by a loving sole parent in her mother and had three older brothers who she was initially close to and were protective of her. She was told of the fact that her father had been imprisoned for offences of paedophilia when she was fourteen years old, which affected her mental health to a degree, but did not become apparent how much this had bothered her until later in her life when she disclosed triggers to her mental health workers and referred to this.

At 19 years old, Jane gave birth to a son and suffered from post-natal depression due to her ongoing mental health issues, she agreed custody with his father would be safest in 2019 after several incidents of drunkenness and attempts to take her own life whilst he was in the house with her.

4.1.2 - At 28 years old, Jane was diagnosed with early onset menopause which affected her physically and then mentally, having a huge impact on her wellbeing, relationships including that with her son and her happiness. Jane had several relationships following the diagnosis which were all volatile and had police involvement. Jane was recorded as the offender for an incident in one relationship in 2019 where she punched her partner in the face and tried to strangle him with a cable. Both had been drinking. Jane was recorded as a victim of domestic abuse with two separate partners and her mother describes all her relationships as similar and that Jane always 'chose the wrong man.'

Jane has nine separate incidents of attempting to take her own life recorded with authorities between 2016 and 2021. She had seven admissions to mental health wards

between June 2018 and October 2019. ELFT have 82 entries on their recording system and now fund an IDVA from Victim Support to provide guidance, support and work closely with people experiencing domestic abuse which is good practice.

4.1.3 - Unconscious bias is present throughout the agencies in a number of forms. Processes are embedded for risk assessment and to provide safeguarding guidance but this can create unconscious bias due to the information provided prior, clouding the ability to be able to assess the current situation. Police arriving at domestic incidents that Jane had called in would attend already aware that she had previously been recorded as a perpetrator and would then learn of her mental health issues and at times, unwillingness to support a prosecution which may all be factors in creating unconscious bias and not taking her whole vulnerability state into consideration. However, the information provided is required for risk assessing. Bedfordshire Police have embedded Cultural Intelligence training for all staff to assist with a wider holistic awareness that incorporates how to perceive persons and needs to ensure that even with information provided, they must look and risk assess holistically without pre-conceived thoughts. (Recommendation refers)

4.1.4 - A toolkit has been devised to assist with decision making and risk assessing when a victim has previously been a perpetrator but there is still uncertainty from Support services and MARAC as to what support can be offered as there have been previous experiences of previous perpetrators, now victims, exploiting the system and learning safeguarding mechanisms to assist their offending behaviour. These reasons were recorded as to why Jane was not offered support from the IDVA service on the first two referral occasions. All authorities and agencies are fully aware of unconscious bias and deliver training on the subject but this does not prevent it from happening. It is up to each individual to take responsibility for ensuring that any unconscious bias does not affect their decision making or professional judgement.

4.1.5 - The Police assisted Jane with obtaining the Non-Molestation Order to assist with safeguarding her in the absence of support services which was a positive action. However, the investigations into the breaches of the Non-Molestation Order were dealt with in isolation and there were missed opportunities to prosecute more offences due to prosecution time limits expiring, delays in the investigations and lack of a coordinated approach. When the police obtained charges and Paul was prosecuted, he pleaded guilty and received a sentence of 4 months imprisonment, affording Jane some peace of mind at that time. The police are satisfied with the processes and policies that they have in place that should negate this occurring but need to ensure that they are adhered to.

4.1.6 - The absence of relevant legislation, processes and responsibility for informing victims of domestic abuse when a perpetrator is released from prison has been identified as a gap that can impact greatly on a victim with the unknown and uncertainty, particularly in a case such as this where the stalking behaviour of the ex-partner led to Jane living in fear. If the legislation was in place and outlined responsibilities within the process for all domestic abuse victims to be informed prior to their perpetrators release, this would have enabled further engagement with Jane and her family for the purposes of revising the safeguarding

measures /plan, ensuring they were sufficient to mitigate the risks, and to commensurate to the threats posed. It would also provide Jane with the knowledge rather than the unknown.

4.1.7 - Training is required amongst professionals to understand the correlation between domestic abuse and Mental Health and also, how to address multi complex needs to ensure they are all responded to, which will prevent overshadowing. Agencies must work more holistically together in utilising existing 'formed' relationships in order to gain introductions to those victims that are harder to reach.

4.1.8 - The voice of the child has not been possible during this review as the choice of the child (currently 17yrs old) not to engage was respected. Children's services were engaged with Jane and her son from 2012 to 2019 and received no referrals throughout that period from any agencies including school or health relating to concerns over Bobby. However, it may have been beneficial for Bobby to access support for his emotional wellbeing as a child of a parent with significant mental health needs.

Throughout the time in 2020/21, whilst in a relationship with Paul and after, when Jane had ended this, Jane suffered physical injuries to her face and legs, stalking and harassment with Paul turning up at locations, constantly texting and calling and also emotional abuse by way of gluing the locks to her door. Paul exercised coercive and controlling behaviour over Jane from the beginning of the relationship when she went to Brighton for the weekend with her mother and son and he constantly called her, questioning her movements and whereabouts. These early incidents were not reported to the police. This behaviour continued throughout the relationship. The police have reviewed all reported/attended incidents and have identified occasions where controlling and coercive behaviour should have been considered, investigated and recorded and was not.

4.1.9 - The serious nature of stalking and harassment as to the mindset of the perpetrator and what their ultimate aim is can often be overlooked or diminished. The requirement to obtain a Non-Molestation Order is proof that Jane did not want to be constantly contacted by Paul and the breaches of this where he showed a blatant disregard for the safeguarding measure affected Jane's mental health and she informed those close to her and professionals of how she lived in fear for her life and him turning up at any point.

Jane's history of mental health issues and her medical condition of premature ovarian failure caused her to attempt suicide on a number of occasions throughout her life which her mother thought was a cry for help. However, Jane had not been admitted to a mental health ward since October 2019 and had not attempted to take her own life since January 2020. Jane was specific in the notes that she left of the fear and would rather take her own life than let Paul take it.

4.1.10 – The inadequate reviewing of Housing records during the course of this DHR would have led to a number of learning points being omitted had the Coroner not provided information and evidence that had not been disclosed to the panel.

4.1.11 - The panel have concluded that the differing forms of domestic abuse that Jane received from Paul was the significant contributing factor of Jane taking her own life and that her mental health issues accentuated her decision making.

4.2 Lessons to be learnt

Overshadowing

Jane had multi-complex needs with her mental health issues being the most prominent in the situations where she would have to speak with agencies/authorities.

Assistance in one area can sometimes lead to overshadowing by professionals as they are faced with multi-complex needs and will revert to the issue that is either already being addressed and has support in place or is potentially the easiest to address. If a victim is not in the frame of mind to support a prosecution or receive specialist support, then often, the domestic abuse is put to one side and the mental health issues are addressed which does not eradicate the abuse that will then continue. Jane had a number of recorded mental health crisis calls logged prior to any domestic abuse incidents. This information, although required for risk assessing prior to arrival may sometimes form an opinion in the responder's mind before they have even met or spoken to the person.

Training is required amongst professionals to understand the correlation between domestic abuse and Mental Health and also, how to address multi complex needs to ensure they are all responded to which will prevent overshadowing. (Recommendations refer)

4.3 Recommendations

National

1. **A review of legislation to reflect all domestic abuse victims are informed of a perpetrators' impending release from Prison following any length of custodial sentence. This must include a stated process and organisational responsibility.**
   A change in legislation of this kind will provide the opportunity for further safety planning and risk assessment, knowledge to the victim to prevent fear of the unknown and complete the cycle of victim engagement and focus from the beginning of the Criminal Justice system to the end.

2. **As a safeguarding function, it is strongly recommended that the MARAC should be placed on a statutory footing.**
   This would enable robust management, reporting, action ownership and accountability at the outset.

Local

3. **An interim local process to be agreed between Probation, Police and Support services to inform victims of domestic abuse of the imminent release from prison of their perpetrators following any length of custodial sentence whilst the National review takes place.**
   This will ensure that the matter is addressed expeditiously for the short term and keeps victims informed whilst the National review takes place.

3a. **Clear lines of responsibility need to be determined in relation to ownership, management and sharing of information specific to prison releases of domestic abuse perpetrators, notification to victims and reviewing safety plans.**
   This will provide specifics within an agreed protocol to ensure there is no confusion as to who completes what action, negating any omission that may impact on the victim or their safety. This is a subsidiary recommendation to Recommendation 2.

4. **Bedfordshire Probation to include reminder information on managing domestic abuse cases in their communications to staff, focusing on the importance of pre-release planning and multi-agency working.**
   This will assist as a reminder and any necessary training provided with the cases that fall under The Domestic Violence Crime and Victims Act (DVCVA) 2004, which the Victim Liaison team are responsible for. Also, for information sharing with other agencies when it does not.

5. **Discussion for pre-release domestic abuse intelligence checks to be requested by Probation for a 12-month period where there are known cases of domestic abuse.**
   This would provide additional information to assist with safety planning and identification of victims that require contact and potential support.

6. **Ensure minimum of annual meetings between Probation Head of Service and Police Lead for Public Protection to discuss collectively our approaches to domestic abuse cases.**
   This will provide a collective approach and strategy and maintain the focus on the area of domestic abuse.

7. **Public Health to devise a bespoke training package for agencies enabling them to identify and understand the correlation between domestic abuse and mental health issues.**
   This will assist with policy writing and protocols on a strategic level and also for front line, public facing professionals on an operative level. It will increase knowledge and awareness amongst the workforce to assist in:
   - Identification of suicide indicators
   - Prevent overshadowing and unconscious bias
   - Interpretation and identification of risks to individuals at the earliest opportunity
   - Enable effective interventions to be considered at the earliest possible stage.

8. **BLMK Public Health to integrate a domestic abuse specialist from the local region to sit on the Suicide Prevention Steering Group.**
   This will provide representation and specialist advice in the area of domestic abuse within this group.

9. **Agencies to improve on a collaborative approach to supporting those who require safeguarding, particularly with multi-complex needs including:**
   - **Fostering relationships**
   - **Utilising existing multi-agency meetings for planning**
   - **Improving communication between agencies**

   This will ensure that agencies who have trouble contacting 'hard to reach' victims via phone to introduce themselves have the opportunity to meet with them through already trusted professionals which may enhance the support and provide specialist support in other areas that they may not have had. It will also ensure that a holistic approach for more than one agency to prevent overshadowing and unconscious bias.

10. **Bedfordshire Police to integrate a system of flagging or alerts created on the Athena database to highlight and prioritise summary only offences where the STL may be applicable.**
    This will provide an additional layer of assistance to notify the investigating officer in order to complete files and communicate with the CPS to ensure a decision is made on prosecution prior to this date and it does not expire.

11. **Bedfordshire Police are to re-emphasise the importance of following policies and processes that have been implemented for the recording, investigation and prosecution of domestic abuse related offences to their staff and officers of all ranks.**
    This will ensure that, if adhered to, it will expedite investigations so that the statutory time limits do not expire in the future and eradicate investigations being investigated in isolation when there is a repeat victim or perpetrator.

12. **MARAC within Bedfordshire to identify a local interim process for the escalation of non-completed actions whilst awaiting the outcome of the National recommendation at 2.**
    Actions are tasked for a reason and this will ensure a review that they are completed and provide an escalation process for non-compliance whilst MARAC remains non-statutory.

13. **Domestic abuse training by ELFT IDVA to be implemented as compulsory for all Care Coordinators.**
    This will enhance knowledge of those working directly with clients in order to correlate domestic abuse with their mental health issues and risk assess appropriately on disclosure.

14. **ELFT to review the Bedfordshire and Luton Directorate induction programme to incorporate suicide prevention training and domestic abuse and for this to be delivered to all community, crisis, and inpatient staff and Care Coordinators.**
    This will provide awareness and early integration of the two matters across a range of staffing roles.

15. **CBC Housing to ensure all staff provide an out of office automatic reply on their emails and phone messaging service to include hours of work and provide support service information for those in crisis.**
    This will provide clarity for those contacting in an emergency that they will not receive an immediate reply and provide an immediate pathway for support.

16. **CBC Housing to ensure the requirement for immediate referrals are written into their policy and procedures where there is an immediate safeguarding issue or immediate risk of harm.**
    This will negate any delay in referrals whilst the officer is trying to make contact with the client and make other agencies aware in a timely manner.

17. **CBC Housing to revise procedures to ensure that all data from each department within Housing is researched on request during a DHR.**
    This is to ensure all relevant information is forwarded when requested in order to be reviewed appropriately by the panel prior to the completion of the overview report.

18. **Bedfordshire Police to ensure that the Cultural Intelligence training is delivered to all staff and officers and is on-going. Part of this delivery is to include the awareness of overshadowing and unconscious bias with multi-complex individuals.**
    This will ensure that all staff and officers have the required awareness to act holistically and take all information into consideration when risk assessing and dealing with individuals who may have mental health issues, be suffering from domestic abuse, medical issues or substance abuse and ensure that they are all considered when determining the most appropriate response and support.

19. **Suicide Prevention group of Public Health BLMK to coordinate and collaborate with partners on a consultation process to implement a working agreement between agencies for professional discussions to take place following agreed trigger points of multiple attempts to die by suicide.**

This is to provide a practical collaborative approach to prevent those who have attempted to die by suicide on more than one occasion, an individual plan to support their individual needs and complexities.

20. **ELFT to review the ongoing support services for those discharged from hospital following multiple attempts to die by suicide.**
    ELFT state that changes in service provisions and offers that differ from patient to patient may prove difficult to change as it will mainly be based on budget and capacity but this is an area that need to be explored as to what can practically be implemented and can dovetail into recommendation 19.

21. **ELFT to communicate to Crisis workers that the notes should be read whenever practicable prior to speaking to a patient and how asking an open question or them to repeat their history may impact on them.**
    This will ensure they have an informed approach when speaking to a patient and potentially conducting a risk assessment but may be able to ask the questions in a manner where the patient knows that they have shown due diligence in reading their notes prior to the meeting.

22. **Bedfordshire Police to increase awareness of the Home Office Crime Recording Rules in relation to investigating all crimes and considering Coercive and Controlling behaviour for those DA cases that are graded at medium or standard risk. Also, to ensure there is a review procedure to ensure this is being correctly addressed.**
    This will bridge the gap for those cases that are not high risk but require equal consideration and investigation of all relevant crimes in addition to the principal crime.

Appendices

Appendix A

Terms of reference

- The date parameters under consideration for documentation are from 2016 to the 2022. However, if relevant information is held prior to this, can a summary be provided to provide context.
- This is to be reviewed as a suicide based on the investigation by appropriate authorities. The purpose is to establish if DA was a cause or contributory factor in the death of Jane.
- Ensure the review seeks to involve the family in the process and takes account of who the family may wish to have involved as lead members. Identify any other people the family think may assist or be relevant in the review process.
- Seek the involvement of employers and friends to provide contextualised analysis of the events.
- How accessible were the services and pathways for referral for the deceased.
- Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and whether these were acted upon. Recommend any changes following the review process.
- Establish accessibility of services for those contemplating suicide and whether training has been received in relation to the effects DA may have towards this.
- What provisions are available for those suffering from alcohol misuse? Were appropriate referrals made when it was established this was a factor with Jane?
- Establish the response to Jane's Mental Health and establish:
  Was it appropriate?
  Was DA considered by the professionals and spoken about with Jane?
  What sharing information processes and referrals are in place when multiple complex needs are identified and did these occur in Jane's case?
- Identify the processes and risk assessing that Housing associations have available in relation to domestic abuse victims and perpetrators and whether they are effective.
- Were procedures sensitive to the ethnic, cultural, linguistic, and religious identity of the deceased and her ex-partner? Was consideration for vulnerability and age necessary? Were any of the other protected characteristics relevant in this case?
- Identify and highlight good practice for wider sharing
- Panel to have a parallel action plan for expedited implementation where practicable during the review
- Establish what processes are in place to record appropriately, decision make and provide support when it may be unclear who the victim and the perpetrator are within the relationship.
- Establish if there is unconscious bias with professionals because victim has previously been recorded as an offender
- What processes are in place to inform victims ahead of a perpetrators release. What safeguarding plan is put in place and who holds responsibility for this.
- Has Covid had an impact on patients/clients in relation to lack of face-to-face contact and difficulty in contacting for assistance.

Appendix B

Glossary

AAFDA: Advocacy After Fatal Domestic Abuse

CMHT: Community Mental Health Trust

CBC: Central Bedfordshire Council

CRC: Community Rehabilitation Company (Probation)

CSP: Community Safety Partnership

DA: Domestic Abuse

DARA: Domestic Abuse Risk Assessment

DHR: Domestic Homicide Review

ELFT: East London Foundation Trust

FCR: Force Control Room

FRS: First Response Services

GP: General Practitioner

IDVA: Independent Domestic Violence Advisor

IMR: Individual Management Review

MARAC: Multi Agency Risk Assessment Conference

MASH: Multi-Agency Safeguarding Hub

MCU: Major Crime Unit

OIC: Officer In Case

PPU: Public Protection Unit

PVP: Protecting Vulnerable Persons

STL: Statutory Time Limit

THRIVE – Threat, Harm, Risk, Investigation, Vulnerability, Engagement

VCS: Victim Contact Scheme

VEO: Victim Engagement Officer

Appendix C

Transcript of note/letter left by Jane found following her death:

'I'm really sorry. I couldn't cope. I was lonely and I'm scared for when Paul comes out of prison. I'd rather kill myself than him kill me. I love David but I was never good enough for him or anyone. I failed my whole life. (Star is born). I'm just a disappointment to everyone, not even got a relationship with my brothers.

Next page

'I'm really sorry but I'm not coping well, I live on my own and sad + lonely. I would rather kill myself before Paul will. I'm living in fear. I love my family but sad my brothers never had a relationship with me. I'm sorry for my behaviour but my menopause and balance took over. I'm gutted not one of you tried to understand.
Tell Bobby I'm proud and he's an amazing young man. You r the best thing I'm proud of.
Please don't cry or get angry.'

Appendix D

Home Office

Interpersonal Abuse
Unit 2 Marsham
Street London SW1P
4DF

Tel: 020 7035 4848
www.homeoffice.gov.uk

Lisa Scott
Safer Communities & Partnership Manager
Safer Communities & Partnership Team
Community Safety, Parking and Programmes
Central Bedfordshire Council
Priory House, Monks Walk,
Chicksands, Shefford,
Bedfordshire,
SG17 5TQ

8th February 2024

Dear Lisa,

Thank you for resubmitting the report (Jane) for Central Bedfordshire Community Safety Partnership to the Home Office Quality Assurance (QA) Panel. The report was reassessed in January 2024.

The QA Panel noted there was positive engagement from family and friends in the DHR process, particularly from Jane's mum, Rosemary. Her beautiful tribute to Jane at the beginning is very moving. Condolences are offered to the family regarding the loss of Jane, which is good practice, as is the use of pseudonyms for her and the connected persons within the DHR, with Jane's pseudonym chosen by her mother. There is a strong sense of Jane as a person throughout the review.

There is good evidence of engagement with public health, including representation on the DHR panel. It might also have been helpful to have had a third sector representative. There is extensive detail of each agency's engagement and significant themes are identified: stalking, coercive and controlling behaviour, situational couple violence (SCV) and 'overshadowing', unconscious bias, and the impact of enduring mental ill health. This was positive to read however could have be probed in greater depth.

The QA Panel noted that most of the issues raised in the previous feedback letter following the first submission have now been addressed.

The view of the Home Office is that the DHR may now be published.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel

Appendix E

	Recommendation	Scope of recommendation	Action to take	Lead Agency	Key Milestones achieved in enacting recommendation	Target Date	Completion date and outcome
1	A review of legislation to reflect all domestic abuse victims are informed of a perpetrators impending release from Prison following any length of custodial sentence. This must include a stated process and organisational responsibility.	National	Contact with relevant committee. Outline of proposal. Identification of process, relevant authority responsibilities and blockages to overcome. Consultation and implementation.	DA Commissioner			
2	As a safeguarding function, it is strongly recommended that the MARAC should be placed on a statutory footing.	National	Review of existing statutes to confirm necessity. Assign level of prioritisation against competing subjects. Identify relevant existing Bills to be incorporated into. Proposal papers drafted and submitted.	DA Commissioner	19/01/23 – DA Commissioners office contacted and agreed that it is an issue that is being looked at for progression.		

3	An interim local process to be agreed between Probation, Police and Support services to inform victims of domestic abuse of the imminent release from prison of their perpetrators following a custodial sentence whilst the National review takes place.	Local	Task and finish group to be initiated, Meeting between leads of probation, police and support services. Identify process for Probation obtaining prisoner release information and any barriers. Process to be identified on timely transference of information. Communication and training package to be devised for staff. Implementation of process.	Police	16/01/23 – Start and finish group lead identified.		
3a	Clear lines of responsibility need to be determined in relation to ownership, management and sharing of information specific to prison releases of domestic abuse perpetrators, notification to victims and reviewing safety plans.	Local	Identify each stage of process and establish actions required to be taken by each agency at each stage. Examine how to overcome any barriers identified.	Police	17/01/23 – Scoping exercise begun for relevant organisation to notify victims.		

			Outline a process document with clear direction of the delegation of responsibility. Identify a recording system to analyse outcomes.				
4	Bedfordshire Probation to include reminder information on managing domestic abuse cases in their communications to staff, focusing on the importance of pre-release planning and multi-agency working.	Local	Reminder to be placed in the weekly newsletter and repeat on a minimum quarterly basis. All staff required to complete mandatory adult safeguarding training with review by managers in supervision sessions. Regular case audit review process to be utilised for analysis of compliance and effectiveness.	Probation			
5	Discussion for pre-release domestic abuse intelligence checks to be requested by Probation for a 12-month	Local	Dissemination of information to all probation staff or requisite for 12	Probation			

	period where there are known cases of domestic abuse.		months intelligence request on DA cases rather than 6 months. Head of Police intelligence to allow and communicate to intelligence department that DA will be twelve months. Probation to work alongside identified Police Lead to share information to safeguard and risk assess victims of all DA subjects within Probation criteria				
6	Ensure minimum of annual meetings between Probation Head of Service and Police Lead for Public Protection to discuss collectively our approaches to domestic abuse cases.	Local	Head of PDU at Probation to arrange and diarise annual meetings with Police head of PPU. Ongoing review as to whether they should be more frequent. Minutes and action log to be recorded ad actioned where appropriate.	Probation			

7	Public Health to devise a bespoke training package for agencies enabling them to identify and understand the correlation between domestic abuse and mental health issues.	Local	Obtain commissioning. Devise training programme. Timetable for delivery. Communication plan for organisations/ agencies.	BLMK Public Health			
8	BLMK Public Health to integrate a domestic abuse specialist from the local region to sit on the Suicide Prevention Steering Group**.**	Local	Identify the most relevant DA specialist. Ensure inclusion on Suicide Prevention Steering Group meeting invites and documents.	BLMK Public Health			
9	Agencies to improve on a collaborative approach to supporting those who require safeguarding, particularly with multi-complex needs including: • Fostering relationships • Utilising existing multi-agency meetings for planning	Local	Identify appropriate reviewing delegation of implementation and ongoing practice. Buy-in of organisational/ agency executives. Awareness package. Dissemination to operative staff via executives.	Central Bedfordshire CSP			

	• Improving communication between agencies		Review/analysis method identified for scrutiny.				
10	Bedfordshire Police to integrate a system of flagging or alerts created on the Athena database to highlight and prioritise summary only offences where the STL may be applicable.	Local	Scope for feasibility. Authority gained by Police executives. Application to relevant IT governance.	Bedfordshire Police		September 2023	
11	Bedfordshire Police are to re-emphasise the importance of following policies and processes that have been implemented for the recording, investigation and prosecution of domestic abuse related offences to their staff and officers of all ranks.	Local	Communication package to be disseminated through intranet. Consideration of re-training at all ranks if required. Policy documents to be accessible to all. Regular dip sampling at each rank structure. Evaluation by Investigation Standards Board.	Bedfordshire Police			
12	MARAC within Bedfordshire to identify a local interim process for the escalation of non-completed actions with	Local	Identify an audit process. Decide on non-compliance criteria	Central Beds Domestic Abuse Service	17/01/23 – Audit process, non-compliance criteria and governance		

	accountability whilst awaiting the outcome of the National recommendation at 2.		or timeframe to be addressed. Identify governance structure for escalation of findings. Identify process and method of escalation. Implement an overall review structure for effectiveness.		structure for escalation suggested. To be taken to Bedfordshire MARAC Steering group for agreement to present to PAN Beds DA Strategic Group.		
13	Domestic abuse training by ELFT IDVA to be implemented as compulsory for all Care Coordinators.	Local	Relevant training programme identified. Timetable for delivery. Process for supervisors to review patient completed documentation for one-to-one questioning for check and balance.	ELFT			
14	ELFT to review the Bedfordshire and Luton Directorate induction programme to incorporate suicide prevention training and domestic abuse and for this to be delivered to all	Local	Utilise current suicide prevention programme on a rolling programme. Induction review to include staff being booked onto course	ELFT			

	community, crisis, and inpatient staff and Care Coordinators.		as part of induction by managers. Managers to book staff onto DA training as part of induction plan. Outcomes assessed during supervisory reviews.				
15	CBC Housing to ensure all staff provide an out of office automatic reply on their emails and phone messaging service to include hours of work and provide support service information for those in crisis.	Local	Primary message and support network to be agreed for all staff. Communication to staff. implementation	CBC Housing	February 2023 – Review of current processes undertaken		
16	CBC Housing to ensure the requirement for immediate referrals are written into their policy and procedures where there is an immediate safeguarding issue or immediate risk of harm.	Local	Policy and procedure Review. Re-write for inclusion of this process. Communication to staff Implementation. Reviews of cases to ensure compliance in staff one to ones.	CBC Housing	Summer 2022 – Up to date Safeguarding training delivered to Lets Rent Team		
17	CBC Housing to revise procedures to ensure that all data from each department	Local	Process identified for receipt of scoping request.	CBC Housing			

	within Housing is researched on request during a DHR.		Identify suitable recipient who will have access to all information or obtain all information. Check List of all systems and data to be checked and returned with scoping.				
18	Bedfordshire Police to ensure that the Cultural Intelligence training is delivered to all staff and officers and is on-going. Part of this delivery is to include the awareness of overshadowing and unconscious bias with multi-complex individuals			Bedfordshire Police			
19	Suicide Prevention group of Public Health BLMK to coordinate and collaborate with partners on a consultation process to implement a working agreeing between agencies for professional discussions to take place following agreed trigger points of multiple attempts to die by suicide			Public Health			

20	ELFT to review the ongoing support services for those discharged from hospital following multiple attempts to die by suicide				East London Foundation Trust			
21	ELFT to communicate to Crisis workers that the notes should be read whenever practicable prior to speaking to a patient and how asking an open question or them to repeat their history may impact on them.				East London Foundation Trust			
22	Bedfordshire Police to increase awareness of the Home Officer Crime Recording Rules in relation to investigating all crimes and considering Coercive and Controlling behaviour for those DA cases that are graded as medium or standard risk. Also to ensure there is a review procedure to ensure this is being correctly addressed.				Bedfordshire Police			

SaferCentral
Community Safety Partnership

DHR Action Plan – Jane – Central Bedfordshire CSP

	Recommendation	Scope of recommendation	Action to take	Lead Agency	Key Milestones achieved in enacting recommendation	Target Date	Completion date and outcome
1.	A review of legislation to reflect all domestic abuse victims are informed of a perpetrators impending release from Prison following any length of custodial sentence. This must include a joined up approach and organisational responsibility.	National	Contact with relevant committee. Outline of proposal. Identification of process, relevant authority responsibilities and blockages to overcome. Consultation and implementation.	DA Commissioner			
2.	As a safeguarding function, it is strongly recommended that the MARAC should be placed on a statutory footing.	National	Review of existing statutes to confirm necessity. Assign level of prioritisation against competing subjects. Identify relevant existing Bills to be incorporated into.	DA Commissioner	19/01/23 – DA Commissioners office contacted and agreed that it is an issue that is being looked at for progression.		