Executive Summary of the Domestic Abuse Related Death Review

In respect of the suicide of 'Jason'[1]

In May 2023

Report produced for Safer Telford & Wrekin by
Paula Harding, Independent Chair and Author

[1] 'Jason' is a pseudonym used to protect the identity of the deceased and his family. It was a popular name in the year of the suicide victim's birth

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Acknowledgements

Members of the review panel offer their deepest sympathy to the family and all who have been affected by Jason's death.

The Chair would like to thank the panel and contributors for their commitment to the review and to improving services for victims of domestic abuse.

1. Background

1.1. This review concerns the circumstances leading to the suicide of Jason, a 37 year old man from Telford in May 2023. As domestic abuse was known to have featured within his previous and recent relationships, this knowledge triggered the statutory requirement for a Domestic Abuse Related Death Review to take place.

2. Summary of Chronology

2.1. Jason was born in Liverpool and, whilst leaving there as a young child, he went back when aged 22 to care for his elderly grandmother. The loss of his grandparents and long bouts of unemployment appeared to have a significant effect on his mental health and problematic alcohol and drug use.

2.2 Jason was first reported to the police for domestic abuse by his mother when he was aged 21 in 2006. Four years later, he was convicted of harassment of his girlfriend, Laura[2], after escalating domestic abuse towards her that included:

- Physical violence including grabbing her by the throat and threatening to slit her throat
- Isolating her from friends
- Withholding her medication
- Threats to self-harm
- Threats to harm pets
- Threats to make false allegations about her parenting to police and social care
- Economic abuse whereby he would constantly harass her for money for cannabis and cocaine
- Significant harassment after separation
- Breaching bail

2.2. He received a suspended sentence and restraining order, but the nature of the sentence meant that he was not supervised by Probation. However, his police records noted warning markers for depression and self-harm which were picked up by police checks during later contact.

2.3 In September 2022, Jason began a short relationship with Sarah[3] who lived in Lancashire. They had met on a dating website but only met in person twice before Sarah told him that she did not want a relationship with him. From the outset, Jason had become attached very quickly. He also talked openly about his depression,

[2] pseudonym

[3] pseudonym

comparing it to that of a celebrity who died by suicide by hanging. He repeatedly told Sarah that he would be dead by the age of 40.

2.4 After the end of the relationship, Jason bombarded Sarah with messages and she reported this to Lancashire Constabulary, providing evidence of more than 300 messages. The police gave him two warnings to stop. They assessed Sarah as facing standard risk and referred Jason to West Mercia Police for investigation.

2.5 Jason' harassment continued but Sarah did not want him to be prosecuted. She only wanted the police to visit him and warn him in person. Thereafter, Jason appeared to evade contact with West Mercia Police who issued two warning letters to him.

2.6 When Jason contacted West Mercia Police he made counter-allegations against Sarah. He was assessed as facing medium risk, and his allegations were referred to Lancashire Constabulary. As Jason had not provided any evidence of harassment, the officer who was dealing with Sarah, considered Jason's allegations to be malicious. Anonymous allegations were also made around the same time to Lancashire Constabulary that Sarah was abusing her children. These were also considered to be malicious complaints.

2.6 Shortly afterwards, Jason entered a new relationship with Eleanor who lived in Nottingham. He went on to report her to the police for coercive control when the relationship ended, but when contacted, he did not want any further investigation to take place.

2.7 In April 2023, Sarah emailed the West Mercia Police Officer who had previously dealt with her to say that the harassment had re-commenced and that Jason had threatened to come up to Lancashire where she lived. The officer was on leave and Sarah did not appear to have received a response thereafter.

2.8 There were no further interactions with agencies noted until Jason's death, the following month.

3. Key Themes

3.1. **Health**

3.1.1. Jason had infrequent contact with his GP and periods on anti-depressants, but he consistently denied any thoughts of suicide. However, when he was seen with suspected weight-loss and mental health concerns, he was not asked about domestic abuse as would have been expected. The Practice has introduced new recording software which prompts clinicians to ask about abuse and record the risk assessment for the patient and others. They have also committed to improve routine enquiry into domestic abuse.

3.1.2. Jason was not signposted to other means of support when he presented with anxiety and sleep disturbance and sought anti-depressants. The GP Practice has since recruited social prescribers who can help access support as well as refer to domestic abuse services.

3.1.3. At times, Jason experienced difficulties in accessing his GP. This was during a time of unprecedented demand and these issues have since been resolved by the Practice.

3.2. **Policing**

3.2.1. Lancashire Constabulary responded to Jason as both an alleged victim and an alleged perpetrator of domestic abuse. They took statements from his victim, who reported being very happy with the response she had received from them. They checked Jason's previous history and found that he had a previous conviction for harassment in 2016 and that informed their risk assessments and led to the reasonable conclusion that Jason was making malicious counter-allegations. However, they found some shortcomings in their lack of supervision and recording; their standards of investigation and in allocating his allegations to the same officer who was responding to Jason as an alleged offender. They have since revised their procedure on allocating cases and provided evidence of the improvements made in investigating domestic abuse, demonstrating that these have led to a doubling of arrests of domestic abuse offenders.

3.2.2. West Mercia Police also responded to Jason as both an alleged victim and an alleged perpetrator of domestic abuse. They considered that they should have made further enquiries with Jason in person about his allegations of abuse.

3.2.3. There were also three occasions when referrals made to other services for Jason were not recorded as received by these services. They have committed to provide evidence of how these systems have improved since, including providing mandatory training on stalking and harassment to all staff.

3.2.4. In the light of Sarah advising that she had not received a response to her email, West Mercia Police have also been called upon to provide assurance that all reports of harassment are robustly investigated including those received by email.

3.3. **Suicide Prevention**

3.3.1. Research has found that perpetrators of domestic abuse were four to five times more likely to die by suicide than those in the prison population (Knipe et al., 2023). Perpetrators of domestic abuse are a group of individuals who are more likely to have experienced many of the risk factors for suicide and calls have been made nationally to include them specifically in suicide prevention strategies.

3.3.2. Whilst the full picture was not known by any agency, Jason had several risk factors for suicide including problematic alcohol and drug use; contact with the criminal justice system; family and relationship problems and he was approaching middle age. However, Jason had relatively little contact with agencies and there was limited opportunity for them to explore his risk of suicide. Although he disclosed mental distress to the police, he denied suicidal thoughts. Likewise, when he sought anti-depressants, he did not disclose self-harm or suicidal thoughts. His risk of suicide was not known in full by any agency.

3.4. Understanding Domestic Abuse

3.4.1. Jason had a history of domestic abuse in his relationships with women and repeated some of his behaviours in his later short acquaintance with Sarah to whom he had become attached unduly quickly.

Learning Point: Repeated Patterns of Abuse

Practitioners need to be aware that perpetrators of domestic abuse often repeat and escalate their behaviours in subsequent relationships.

This case provides the example of how there were clearly repeated patterns of abuse against both victims:

- Threats to self-harm
- Making counter-allegations
- Threats to make/making malicious allegations about child abuse or neglect
- Harassment after separation

3.4.2. The inquest heard how Jason had not taken responsibility for his abusive behaviour in previous relationships. Although there was no evidence that he was a victim, when he made allegations against others, they were taken seriously by the police.

Learning Point: How Perpetrators View Themselves

It is not uncommon for perpetrators of domestic abuse to see themselves as victims of domestic abuse. Respect Guidelines advise:

> *"Whilst all allegations of abuse should be treated seriously, we must be aware that perpetrators might present as victims, some because they genuinely see themselves as victims, and some because by presenting as victims they hope to maintain power and control over their partner… They may not admit responsibility for their abusive behaviours and may try and blame other people or factors for the abuse."* (Respect, 2020:2)

3.4.3. The end of a relationship was clearly a trigger point for Jason and led to his significant harassment of both of his ex-partners.

> **Learning Point: Separation and the Escalation of Abuse**
> A relationship ending, or the fear/threat of it ending, is in the top five most commonly recorded risk factors for domestic homicides/suicides (Hoeger et al., 2024b:45).

3.4.4. Sarah did not think that Jason would harm her and her assessment meant that she was assessed as standard risk. However, she did not know about Jason' history of domestic abuse or conviction for harassment.

> **Learning Point: A victim's perception of risk needs to be informed by knowing their abuser's offending history wherever possible**
> Practitioners rely upon a victim's own perception of risk when formulating our risk assessments. In this case, 'Sarah' did not know that he had a conviction for harassment and had held a knife to his last girlfriend's throat and therefore did not think that he would physically harm her, thereby unknowingly minimising her understanding of the risk.
> A victim's perception of risk can only be as good as the knowledge they have about their abuser's history of violence and abuse.

3.5. **Counter Allegations and Unconscious Bias**

3.5.1. Whilst practitioners need to be aware of any unconscious bias when they consider counter-allegations, particularly from potential male victims, Jason' allegations were considered to be manipulative and unsubstantiated.

> **Learning Point: Counter Allegations of Domestic Abuse**
> A manipulative perpetrator may be trying to draw the police into colluding with their coercive control of the victim. Police officers and practitioners must avoid playing into the primary perpetrator's hands and take account of all available evidence and the history of the alleged perpetrator when making the decision of how best to proceed. This requires careful and considerate professional judgement.

Respect guidance advises that:

"*Whilst all allegations of abuse should be treated seriously, we must be aware that perpetrators might present as victims, some because they genuinely see themselves as victims, and some because by presenting as victims they hope to maintain power and control over their partner."*[4]

3.6. **Action After Sudden Death**

3.6.1. West Mercia Police are currently exploring whether criminal offences should be investigated post-mortem due to this growing awareness of the causal link between suicide and domestic abuse. They have also committed to refer families bereaved by suicide to the local suicide support service, Telford Mind.

4. Concluding remarks

4.1. This review examined the circumstances leading to Jason's tragic death by suicide. Whilst he had relatively little contact with agencies, the review has nonetheless found important learning for individual agencies and for our collective understanding of the increased risk of suicide faced by perpetrators of domestic abuse, stalking and harassment.

4.2. The review panel recognised how difficult it must be for a bereaved family to hear about the abusive history of a loved one after their death. They offer their assurance that exploring this has not been done lightly but done for the purpose of preventing harm to others in the future, whether that harm be to those abused or those abusing others.

[4] https://respectphoneline.org.uk/resources/frontline-workers/guidelines-for-working-with-perpetrators-of-domestic-abuse/

5. Recommendations

5.1 Overview Recommendations

Recommendation 1: Clinical Guidance on Routine Enquiry on Domestic Abuse Where Indicators are Present in Relevant Health Conditions

The Home Office to consider liaising with the Department of Health and Social Care and NICE to ensure that there is consistency across all clinical guidance for routine enquiry into domestic abuse for relevant health conditions which are evidence-based indicators of potential domestic abuse, such as those for depression and anxiety specifically.

Recommendation 2: Primary Care Response to Domestic Abuse

Telford and Wrekin Public Health Team with the ICB, through the Primary Care Networks (PCNs) and GP Safeguarding Leads, to provide assurance to the Domestic Abuse Local Partnership Board that the domestic abuse pathway for primary care, which includes the PCN social prescribers, is effective in identifying and responding to domestic abuse in primary care.

Recommendation 3: Suicide Prevention & Domestic Abuse Perpetrators

Telford and Wrekin Suicide Prevention Action Group, coordinated by the Public Health Team, to ensure that domestic abuse perpetrators, as well as domestic abuse victims, feature within their suicide prevention strategy.

Recommendation 4: Real Time Suspected Suicide Surveillance and Domestic Abuse (Local)

Telford and Wrekin Public Health to liaise with the Coroner and encourage local sign-up with the Real Time Suspected Surveillance System

Recommendation 5: Real Time Suspected Suicide Surveillance and Domestic Abuse (National)

Home Office to liaise with the chief coroner in respect of guidance to coroners to ensure that all coroners are part of Real Time Suspected Surveillance System

Recommendation 6: Suicide Bereavement Service

West Mercia Police and Telford Mind to work together to strengthen links and develop a referral route which will ensure that bereaved families are systematically offered signposting to specialist support services following police attendance at a sudden death.

Recommendation 7: Home Office Leaflets
The Home Office to consider adding to their suite of leaflets for families and friends, leaflets specifically concerning domestic abuse related suicides.

Recommendation 8: Suicide Prevention Specialists on Review Panels
Safer Telford and Wrekin to ensure that a suicide prevention specialist sits on all future Domestic Abuse Related Death Reviews involving suicide in their area

4.2 Individual Agency Recommendations

4.2.1 The GP Practice

- Clinicians to ask about abuse when patients present with depression, anxiety or low mood
- Clearly Identify the reason for a patient seeking medical attention and highlight this to the consulting clinician in case of lack of contact with the patient
- A return to primary face to face appointments

4.2.2 Lancashire Constabulary

- Separate investigators are allocated to cases where both alleged offender and alleged victim make allegations of domestic abuse against each other.
- Provide evidence of improved quality of domestic abuse investigations (completed).

4.2.3 West Mercia Police

- Provide evidence-based assurance that reports of harassment are robustly investigated and victims updated of progress in line with the Victim's Code
- Provide evidence-based assurance that cases of stalking and harassment are adequately supervised and not closed prematurely
- Provide evidence-based assurance on the robustness of referral pathways to support services

Appendix 1: The Review Process

(i) Summary

The decision to undertake a review was made by the Chair of Safer Telford and Wrekin in consultation with the responsible authorities on 14.07.2023. The Home Office was notified of the decision on 08.08.23 and the review was managed in accordance with the relevant statutory guidance.

Paula Harding was appointed as the independent chair and author of the review. Beyond undertaking reviews of this nature, Paula Harding has had no involvement with any agencies in the Telford and Wrekin area.

A review panel was appointed, and its members are listed below. Wider matters of diversity and vulnerability were considered when agreeing panel membership. Cranstoun provided the local domestic abuse service and therefore brought expertise on domestic abuse to the panel. Midlands Partnership NHS Foundation Trust provided expertise on mental health, drug and alcohol misuse and Telford & Wrekin Public Health provided expertise on suicide prevention.

Terms of reference were drawn up and incorporated key lines of enquiry as featured below Agencies participating in this review are featured below as well as those who had no contact.

The review commenced promptly after the inquest on 12.09.2023 with the first panel meeting being held in October 2023 and the panel went on to meet three times.

The panel considered and agreed the draft Overview Report in June 2024 and family members were provided with the opportunity to provide their comments, before the final Overview Report was endorsed by Safer Telford & Wrekin on 17.10.2024.

(i) Review Panel Members

Name	Role/Organisation
Paula Harding	Independent Chair
(redacted)	GP Partner and Safeguarding Lead, (redacted) Medical Practice
Andrea Williams	Service Manager for Telford and Wrekin Domestic Abuse Service, Cranstoun
Claire Histead	Head of Safeguarding, Midlands Partnership NHS Foundation Trust
Jordan Baker	Detective Inspector, Statutory and Major Crime Review Team, West Mercia Police
Lisa Jones	Safeguarding Adults Board Manager, Telford & Wrekin Safeguarding Partnership
Lyn Stepanian	Public Health Practitioner, Telford and Wrekin Council

(ii) Key Lines of Enquiry

The review sought to address both the 'generic issues' set out in the Statutory Guidance, and the following specific issues identified in this particular case:

- How effective were agencies in identifying and responding to the needs and risks faced by the victim?
- How effectively did services respond to disclosures of, or indicators of, domestic abuse? For health services, indicators of possible domestic abuse can be found in NICE Quality Standard QS116[5] And were victims of domestic abuse signposted or referred to specialist domestic abuse services?
- For Police Forces: How did the victim's history of perpetrating domestic abuse influence how his allegations of domestic abuse were responded to? How was the primary perpetrator of abuse determined?
- What opportunities were there to assess the risk of self-harm and suicide?
- What barriers to disclosure and help-seeking were experienced and how did agencies respond to overcome these barriers? To include whether there was any evidence of unconscious bias within the service responses?
- How effectively did services work in partnership to support and protect the individuals concerned? To include the rationale for, and effectiveness of, referrals, to other agencies.
- What good practice can be identified?
- How can services be improved?
    - what lessons can be learnt to prevent harm from suicide or domestic abuse in the future and how will the changes be achieved?
    - what system-wide, multi-agency recommendations do agencies consider need to be made?

(ii) Agency Involvement in the Review

Individual agency reports and chronologies were requested from the following organisations:

- Primary Care
- West Mercia Police
- Lancashire Police

The following agencies were asked to provide briefer information reports to the review:

- West Midlands Ambulance Service
- Merseyside Police in relation to 2016 when the suicide victim was convicted of domestic abuse related harassment

[5] Available at https://www.nice.org.uk/guidance/qs116/chapter/Quality-statement-1-Asking-about-domestic-violence-and-abuse

The following agencies were contacted but confirmed that they had had no involvement with the victim:

- Midlands Partnership NHS Foundation Trust
- National Probation Service
- Nottinghamshire Police
- Robert Jones and Agnes Hunt Orthopaedic Hospital
- Shrewsbury and Telford Hospital NHS Trust
- Shropshire Community Health NHS Trust
- Shropshire Domestic Abuse Service, Cranstoun
- Shropshire Recovery Partnership (drug and alcohol services)
- Shropshire Fire and Rescue Service
- Telford and Wrekin Council Adult Social Care
- Telford and Wrekin Council Children and Young People Service
- Telford Council Housing Services
- Telford Council Neighbourhood Services
- West Mercia Women's Aid
- West Mercia Youth Justice