Domestic Abuse Related Death Review[1]

under section 9 of the Domestic Violence Crime and Victims Act 2004

In respect of the suicide of Jason[2]

In May 2023

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

August 2024

[1] The government announced the change in title from Domestic Homicide Reviews to Domestic Abuse Related Death Reviews on 5th February 2024 in online news item: https://www.gov.uk/government/news/fatal-domestic-abuse-reviews-renamed-to-better-recognise-suicide-cases#:~:text=This%20means%20that%20a%20Domestic,and%20emotional%20and%20economic%20abuse.

[2] Pseudonym

CONTENTS

ACKNOWLEDGEMENTS

Members of the review panel offer their deepest sympathy to the victim's family and all who have been affected by his suicide

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.

USE of PSEUDONYMS

It is a requirement of statutory guidance that the reports must be suitably anonymised to protect the identity of the victim and bereaved family (Home Office, 2016: 24). The statutory guidance states that the use of pseudonyms is preferred to the use of other nomenclature, such as initials or letters, because using a pseudonym "humanises the review and allows the reader to more easily follow the narrative" (Home Office, 2016: 18). Therefore in this report, the suicide victim will be referred to as Jason, being popular at the time of his birth.

Reference is made in the report to ex-girlfriends and the following pseudonyms have been used for them, being popular names in the years that they were born:

- The girlfriend from 2010 to 2016 is referred to as Laura
- The woman that Jason sought to start a relationship with during October 2022 is referred to as Sarah
- The most recent girlfriend from December 2022 is referred to as Eleanor

PREFACE

The family will be offered the opportunity to provide a personal statement about their loss and the impact of his death, prior to publication.

1. INTRODUCTION

1.1 Background

1.1.1. This review concerns the circumstances leading to death by suicide of Jason, a 37 year old man from Shropshire in May 2023. As domestic abuse was known to have featured within Jason's previous and recent relationships, this knowledge triggered the statutory requirement for this review to take place.

1.2. Aims and Purpose

1.2.1. This review has been undertaken on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). Statutory Guidance advises that:

> *"Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable." (*Home Office, 2016:8)

1.2.2. The purpose of a review is to:

a) *"establish what lessons are to be learned from the domestic homicide (or suicide) 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 the policies and procedures as appropriate;*
d) *prevent domestic violence and homicide (and suicide) and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated 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."* (Multi-Agency Statutory Guidance 2016, para 7)

1.2.3. As well as examining agency responses, statutory guidance requires reviews to be professionally curious and find the "trail of abuse". The narrative of each review should "articulate the life through the eyes of the victim… situating the review in the home, family and community of the victim and exploring everything with an open mind" (Multi-Agency Statutory Guidance 2016, paras 8 and 9)

1.3. Timescales

1.3.1. The death occurred in May 2023 (date redacted) and Safer Telford and Wrekin was notified by West Mercia Police on 05.06.2023. The decision to undertake a statutory 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.

1.3.2. The review commenced promptly after the inquest on 12.09.2023 with the first panel meeting being held in October 2023. Thereafter, the panel met three times. All panel meetings were minuted and all actions agreed for the panel have been tracked and completed.

1.3.3. The panel considered and agreed the draft Overview Report in June 2024 and family members had the opportunity to provide their comments, which were included in the report before the final Overview Report was endorsed by Safer Telford and Wrekin on 17.10.2024. The report was submitted to the Home Office for approval on 29.10.2024.

1.4. Confidentiality

1.4.1 This Overview Report has been anonymised in accordance with statutory guidance. Whilst the details of each review remain confidential, available only to participating professionals and their direct line management, the report has sought to extract sufficient detail from the suicide victim's narrative for the lessons and recommendations to be understood, whilst balancing this need for confidentiality.

2. Terms of Reference

2.1. Methodology

2.1.1. The review followed the methodology required by the *Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews* (Home Office, 2016).

2.1.2. 20 agencies were notified of the death and were asked to examine their records to establish if they had provided any services to the victim or alleged perpetrator and to secure records if there had been any involvement. 5 agencies were found to have had relevant contact. 15 agencies had had no relevant contact.

2.1.3. Arrangements were made to appoint an Independent Domestic Homicide Review Chair and Author and agree the make-up of the multi-agency review panel.

2.1.4. The coroner provided the Independent Chair with the information that had been made available to the inquest and the outcome of the inquest.

2.1.5. The terms of reference for the review were drawn up by the Independent Chair together with the panel. It was identified that three agencies were to provide Individual Management Reviews (IMRs) and chronologies analysing their involvement and a further two agencies to provide briefer information reports. Briefings were provided for IMR authors by the Independent Chair in order to support report authors in their task and maintain the focus on the key lines of enquiry.

2.1.6. All reports were written by authors who were independent of the delivery of services provided. Wherever possible, report authors presented their findings to the review panel in person and, where necessary, were asked to respond to further questions. The individual agency reports concluded with recommendations for improving their own agency policy and practice responses in the future and informed the multi-agency and thematic recommendations which followed.

2.1.7. The Independent Chair authored the Overview Report and each draft was discussed and endorsed by the review panel before submission to the Community Safety Partnership.

2.2. Involvement of family and others

2.2.1. Jason's parents were invited to engage with the review but did not engage. They were provided with leaflet information[3] from Advocacy After Domestic Abuse and written to again when the review had concluded. The review panel recognised the challenge that families and friends may face when being invited to engage with reviews of this nature and made no judgement on any individual's choice not to do so.

2.2.2. The Independent Chair wrote to Jason's most recent girlfriend, who was the alleged perpetrator of domestic abuse towards him, but she did not respond.

2.2.3. The review was unable to identify any friends of Jason, but the Independent Chair was able to engage with a previous girlfriend, Sarah,[4] who had previously reported domestic abuse from him.

2.3. Independent chair and author

[3] The Home Office leaflet on Domestic Homicide Reviews was not sent to family members, as is normal practice, as it was unsuitable for this domestic abuse related death by suicide
[4] pseudonym

2.3.1 The Independent Chair and Author is Paula Harding. She has over thirty years' experience of working in domestic abuse with both senior local authority management and specialist domestic abuse sector experience. For more than ten of those years she was the local authority strategic and commissioning lead for domestic abuse and violence against women for a large metropolitan area[5] and has been an independent chair and author of domestic homicide and safeguarding adult reviews since 2016. She completed an M.A. (Birmingham) in Equalities and Social Policy in 1997, focusing on domestic abuse and social welfare, and is a regular contributor to conferences, national consultations and academic research. She completed the OCR certificated training funded by the Home Office for *Independent Chairs of Domestic Homicide Reviews* in 2013. She has also undertaken training with Standing Together Against Domestic Abuse and training on the Significant Incident Learning Process, SCIE methodology, Learning Disability Mortality Reviews and the on-line training provided by the Home Office.[6]

2.3.2 Beyond undertaking reviews of this nature,[7] Paula Harding is independent of all agencies in the Telford and Wrekin area.

2.4 Members of the review panel

2.4.1 Multi-agency membership of this review panel consisted of senior managers and designated professionals from the key statutory agencies, and all were independent of the case.

2.4.2 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 and the 'victim's perspective' 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.

[5] Birmingham
[6] Available at https://www.gov.uk/guidance/conducting-a-domestic-homicide-review-online-learning
[7] Paula Harding has undertaken one previous review in Telford and Wrekin and one review in the neighbouring area of Shropshire.

2.4.3 The review panel members were:

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	Partnership Development Officer, Telford & Wrekin Safeguarding Partnership
Lyn Stepanian	Public Health Practitioner, Telford and Wrekin Council

2.5. Time period and key lines of enquiry

2.5.1. The panel agreed that the review should focus on agency involvement with the victim from September 2022, when Jason approached his GP concerned about sudden weight loss until his death in May 2023 (date redacted). The review also considered relevant information relating to agencies' contact outside that time frame. In particular, the review considered the context of domestic abuse within Jason's former relationships from 2016 onwards.

2.6. Individual agency reports

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

- Primary Care
- West Mercia Police
- Lancashire Police

2.6.1. 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

2.7. Agencies without contact

2.7.1 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

2.8 Key Lines of Enquiry

2.8.1 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[8] 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?

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

- 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?

2.9 Definitions

2.9.1 The Domestic Abuse Act 2021 introduced a legal definition of domestic abusive behaviour as consisting of a single incident or course of conduct between two people who are personally connected, each aged 16 or over, and involving 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 (s1: Domestic Abuse Act 2021)[9]

2.9.2 Within this definition, controlling behaviour is understood to be "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." (HM Government, 2016a)

2.9.3 Indicators of domestic abuse can be found, but are not limited to, the following:

- Health indicators of domestic abuse as provided by the National Institute for Clinical Evidence (NICE) Quality Standards[10]
- Economic indicators of domestic abuse as provided by Surviving Economic Abuse;[11]

[9] https://www.legislation.gov.uk/ukpga/2021/17/part/1/enacted
[10] NICE Quality Standard QS116 can be found at https://www.nice.org.uk/guidance/qs116/chapter/Quality-statement-1-Asking-about-domestic-violence-and-abuse
[11] https://survivingeconomicabuse.org/what-is-economic-abuse/

- General indicators of domestic abuse as provided by Women's Aid Federation England [12]

2.10 Parallel reviews

2.10.1 Jason's death was subject to an inquest. There were no other reviews being considered alongside this review.

2.11 Equality and diversity

2.11.1 The review gave due consideration to each of the nine protected characteristics under Section 149 of the Equality Act 2010[13], as well as to wider matters of vulnerability for the victim.

2.11.2 Jason was 37 years old when he died. He was a white British man with vulnerabilities arising from periodic anxiety and depression, long term substance misuse and earlier experiences of self-harm.

2.11.3 Sex and gendered violence were also considered within this review as Jason was a repeated perpetrator of domestic abuse and harassment against women, whilst also considering himself to be the victim of domestic abuse from them.

2.12 Dissemination

2.12.1 The following individuals and organisations will receive copies of this review:

- The victim's family
- Agencies directly affected by this review
- Safer Telford and Wrekin and its agencies
- West Mercia Police and Crime Commissioner
- Telford and Wrekin Domestic Abuse Local Partnership Board
- Office of the Domestic Abuse Commissioner for England and Wales
- The Home Office
- The Coroner for Shropshire, Telford and Wrekin

[12] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/recognising-domestic-abuse/

[13] The nine protected characteristics under the Equality Act 2010 are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation

3. BACKGROUND INFORMATION

3.1 The death

3.1.1 Jason was living with his mother and was last seen by her on a midweek afternoon in May 2023. On the afternoon of the following day, Jason's mother was unable to rouse her son and his bedroom door appeared wedged shut. She was concerned that he may have caused harm to himself as he had been upset the previous day after telling her that his girlfriend, Eleanor,[14] had ended their relationship.

3.1.2 His mother asked neighbours for help and emergency services were called. Paramedics attended the property and with the help of a neighbour broke down the door and found Jason hanging.[15] He was in cardiac arrest and paramedics attempted cardiopulmonary resuscitation (CPR) without success and he died at the scene.

3.1.3 Detectives were dispatched and deemed the death to be non-suspicious and a coronial investigation took place. The Senior Coroner for Shropshire, Telford & Wrekin recorded death by suicide. A toxicology report showed that Jason had taken cannabis and gabapentin at some point prior to his death.

3.1.4 Although Jason's mother was visited again after the death by a police officer, she was not referred to the Suicide Bereavement Support Service, which is a service available to support bereaved families within Telford and Wrekin. The need to ensure that families are offered specialist support is considered further in the report.

3.2 The victim's background

3.2.1 Jason was born in Liverpool where the family lived until he was four years old. He was the elder of two siblings.

3.2.2 His parents divorced when he was aged 18 and Jason was thought to have taken their break-up badly.

3.2.3 The police were aware that Jason was involved in drugs between the ages of 16 and 21. They were also made aware that his mother experienced mental ill-health and problematic alcohol use.

[14] pseudonym
[15] Record of inquest

3.2.4 After college, Jason was unemployed for a few years until his father was able to find him work with him at a machine tool company.

3.2.5 When Jason was 21, he was reported to the police for domestic abuse towards his mother. She talked to the police about her concerns for his behaviour but disclosed no offences and no further action was therefore taken.

3.2.6 At the age of 22 (2007), Jason moved to Liverpool to care for his elderly grandmother. After her death, he began working for a local car manufacturer. The loss of his grandparents, together with long bouts of unemployment, appeared to be significant factors in the decline in his mental health.

3.2.7 At the age of 25 (2010), Jason was referred by his GP to the Community Mental Health Team when he presented with anger management and excessive drinking. He did not respond to their invitations and was therefore discharged.

3.2.8 During that year he began a relationship with Laura[16] which was "on-off" for the next six years. Laura later told the police that during the relationship, Jason had become increasingly verbally and physically aggressive towards her; grabbed her by the throat; threatened to slit her throat; prevented her from taking her medication; isolated her from her friends; threatened to self-harm and threatened to harm her cats. He also threatened to make false allegations about her to the police and social services, threatening to tell them that she was committing benefit fraud and child abuse. She said that Jason would constantly harass her for money for cannabis and cocaine.

3.2.9 After Jason lost his job in 2015, Laura felt obliged to let Jason move in with her but his aggression towards her escalated. In 2016, Laura left her home and reported Jason to the police, and he was arrested for assault and harassment. He denied all allegations but after being bailed, he breached his bail by continuing to harass Laura. Although still denying any wrongdoing, Jason pleaded guilty and was convicted of harassment and possession of cannabis. He received a two-year suspended sentence, and a restraining order was granted by the court in relation to future contact with the victim. The nature of the sentence meant that he was not supervised by probation services for this offence.

3.2.10 Whilst enquiries had been ongoing, Jason was convicted in Telford of driving with excess alcohol, failing to stop when requested to do so by officers and failing to stop after an accident. He was disqualified from driving for 18 months, received a

[16] pseudonym

community sentence of unpaid work and in this circumstance, probation's only involvement was to arrange and supervise this unpaid work.

3.2.11 In the same year, he disclosed occasional thoughts of self-harm to the GP but advised that he had no plans to carry these out. During subsequent consultations, he denied any suicidal ideation or self-harm.

3 CHRONOLOGY

September 2022 –Indicators of Domestic Abuse

3.1 In September 2022, Jason approached his GP as he was concerned about weight loss and fatigue. He advised that he had recently stopped taking his anti-depressants. His last prescription for anti-depressants would have run out in June 2022 and these were therefore removed by the GP from his permitted repeat medication list.

3.2 Once physical causes for any weight loss had been ruled out through blood tests, there did not appear to have been any exploration into potential psycho-social explanations. Whilst his weight had increased slightly at the next consultation, there was no evidence of a planned review thereafter.

3.3 Jason had just begun a short relationship with Sarah,[17] after meeting her through an online dating website. They only met in person twice before Sarah ended the relationship in October 2022. Sarah recalled that from the outset, Jason had become attached very quickly, and, on the second date, she told him to calm down because he had got too intense.

3.4 After this second meeting, Sarah phoned Jason and told him that she did not want to be in a relationship with him but as he responded in a very distressed state, she said that they could be friends. Sarah thought him to be a nice person but recognised that he had mental health issues, and his behaviour was very erratic. Jason had talked openly about his depression describing it as the same kind of depression as experienced by Chester Bennington, the lead vocalist of the rock band *Linkin Park,* who died by suicide by hanging.

3.5 During Jason's everyday conversations, Sarah described how he repeatedly said that he would be dead by the age of 40, and she perceived that he was attempting

[17] pseudonym

to normalise his depression. He told her that he had stopped taking the antidepressants that he had been prescribed.

3.6 Jason also told Sarah about his ex-girlfriend, Laura, in Liverpool describing how she had got him arrested. He said that he was put in a cell overnight but that no charges were brought. Sarah searched online for any record of Jason's arrest but found nothing.

November 2022 - Allegations of Stalking and Harassment

3.7 After the end of the relationship, Jason began bombarding Sarah with messages and she contacted Lancashire Constabulary on **23rd November 2022**. On their advice, she gave Jason a warning that if he did not cease contact, then he would be prosecuted, and she blocked his number. Blocking his number was only partially successful and the next day she received more messages from him and so Lancashire Constabulary took a statement from Sarah; noted his prior conviction for harassment; recorded the current harassment and sent the statement to West Mercia Police for investigation, being the area where the suspect lived.[18]

3.8 An officer from Lancashire Constabulary spoke with Jason on **25th November 2022,** by phone, and gave him a verbal warning to stop contact and to delete Sarah's number from his phone, which Jason agreed to do.

3.9 As time progressed, Sarah went on to receive over 300 unwanted messages[19] from Jason which varied in tone and content from, *"F*** Off"* to, *"You're going to get Karma"* to, *"If you ever need me, I'll be there for you".*

3.10 Sarah did not wish to make a formal complaint against Jason. Whilst she did not think that he would visit her again in person or would physically hurt her, she described feeling unsafe and on-edge.[20] Lancashire Police put an urgent marker upon her address for her reassurance. A DASH was completed, and she was assessed as standard risk. His details were checked with Probation to make sure that he was not open to them.

3.11 On **28th November 2022**, Jason contacted Sarah again using Snapchat and WhatsApp, and she contacted Lancashire Constabulary who gave him a second harassment warning by text, as Jason would not answer his phone. Sarah provided a statement to Lancashire Constabulary documenting all the contact that she had

[18] This is in line with Home Office Counting Rules
[19] As she had tried to block him, approximately two thirds of these went into her spam folder.
[20] She described how she felt at the time when interviewed for this review

received, and this was referred again to West Mercia Police for further investigation.

3.12 Whilst not wanting to pursue a criminal investigation, Sarah wanted a uniformed officer to attend his address and warn him not to make further contact. West Mercia Police tried to contact Jason without success and therefore sent him a letter to his home address warning him about his behaviour. A DASH risk assessment assessed Sarah as standard risk.

3.13 On **29th November 2022**, Jason made an on-line report to West Mercia Police stating that he was the victim of domestic abuse from Sarah, in the form of emotional abuse and threats towards him. He stated that her behaviour and control had since destroyed his mental and physical health, job, relationships with his mother father, sister and two best friends and left him financially ruined. West Mercia Police agreed to contact him for more information

3.14 At some point during December 2022, Jason began a new relationship with Eleanor[21] who lived in Nottingham.

3.15 On **6th December 2022,** Lancashire Police received an anonymous complaint that Sarah was verbally and physically abusing her children and also abused alcohol. After investigation, this was considered to be a malicious complaint and it was suspected, by Sarah, that Jason had made it.

3.16 On that day, Jason contacted his GP requesting to be put back on anti-depressants as a matter of urgency. He had first contacted the GP three weeks prior, but then not answered when the GP tried to call him back on three occasions. This was a particularly busy day, in a particularly busy season for health services, and therefore Jason had a telephone consultation with the Advanced Nurse Practitioner who was working alongside the duty doctor that day. Jason was reluctant to talk to her initially as she was "just a nurse."

3.17 During the consultation, Jason complained that he had anxiety and was not sleeping and requested to resume his anti-depressant, Citalopram, which he had stopped taking six months prior, and Propranol, which he had taken some years prior for his anxiety. The prescription was issued with a low dose sleeping pill, Zopiclone and a plan for a review in approximately 2-3 weeks, or sooner if needed, which Jason agreed to arrange.

3.18 On **8th December 2022,** West Mercia Police tried unsuccessfully to contact Jason, in respect of the harassment allegations, by leaving messages and going to his home address, but he did not return contact and could not be reached after his initial complaint.

[21] pseudonym

3.19 Referrals were made by the police to Adult Social Care who considered that Jason had 'no unmet care and support needs.' A referral was also made to mental health services although they did not appear to have received it. As officers had been unable to contact Jason, a DASH risk assessment was completed using the information that Jason had provided in his on-line report and graded as medium risk, in view of the impact the alleged harassment was having on his mental health. Since the suspect lived in Lancashire, the investigation was transferred to Lancashire Constabulary for further investigation on **12th December 2022.**

3.20 Lancashire Constabulary allocated Jason's allegations of experiencing domestic abuse to the officer dealing with the harassment allegations against him. Jason had not provided any evidence of the harassment, such as through screenshots, texts, emails or calls, and, as it followed warnings made to him where there was evidence of his harassment towards Sarah, it was concluded that Jason's allegations were malicious. His risk was assessed as standard, and the case of his allegations was closed with no further action. Lancashire Constabulary advised West Mercia Police to continue to treat Jason as the suspect of harassment and not as the victim and provided them with a detailed rationale.

3.21 On **19th December 2022**, Sarah contacted Lancashire Constabulary reporting further incidents of harassment by Jason via WhatsApp. Her risk was assessed as standard, and a statement of complaint was taken with the plan to send it to West Mercia Police. Whilst West Mercia Police were notified on the day, the statement did not appear to have been sent. West Mercia Police allocated the investigation to a police officer 5 weeks later.

January 2023 – Review of Medication

3.22 In early **January 2023**, Jason phoned the personal assistant to the GP Practice Manager to request an appointment with the GP as planned, to review his medication. However, whilst he was being transferred to reception to make the booking, he did not stay on the line. Attempts such as this, to bypass reception, were being made by patients at the time because of the difficulties getting through to reception during those exceptionally busy months. However, Jason did not attempt again to request a repeat prescription for another 2 months.

3.23 On **26th January 2023**, the case of the harassment allegations against Jason was allocated to a West Mercia Police officer who contacted Sarah. She said that the messages were continuing, with the last one received two days earlier and a DASH risk assessment was completed, assessing her as standard risk. Sarah reiterated that she did not want to attend court but felt that an officer attending his home

address in person would act as a warning. West Mercia Police asked Lancashire Constabulary to send her statement be sent to them, and she was given the details for DV Assist,[22] which is a national charity assisting victims of domestic abuse to obtain civil non-molestation orders, and Sarah sought advice from them.

February 2023– Allegations of Coercive Control

3.24 In the early hours of **13th February 2023**, Jason reported to West Mercia Police that he was the victim of coercive control from his most recent partner, Eleanor. He said that the relationship had recently ended but that she was suffering from separation anxiety, and she prevented him from seeing any female friends as well as monitoring his contact with them. Having demanded passwords to his social media accounts, he alleged that she took screenshots of any contact he made with other women. He said that if he commented on a social media post, she wanted to know why and that this commonly escalated into arguments. He advised the call handler

> *"...it almost feels like a bullying thing…She picks holes in everything, I have given her the Facebook passwords but it's never enough, I feel like I'm digging myself a hole……. I still want to continue the relationship I'm just worried how much it will escalate if we don't get it under control".*

3.25 Jason advised the call handler that that this was impacting negatively upon his mental health. He said that after speaking with Eleanor's ex-husband, he was concerned about Eleanor's history of domestic abuse. He was given advice about the Domestic Violence Disclosure Scheme by the call taker and a *THRIVE* risk assessment graded the call as grade 2 requiring officer deployment within two hours. The call taker sent Jason a text with the log reference and details of agencies offering support for domestic abuse. As the alleged suspect lived in Nottingham, Nottinghamshire Police were informed of the incident by email.

3.26 Jason contacted the police again two days later asking when an officer would be in touch.

3.27 During this time, the West Mercia police officer investigating Sarah's allegations of harassment against Jason, had made several unsuccessful attempts to contact Jason by telephoning and visiting his home address. As they had been unable to contact him, on **16th February 2023,** West Mercia Police sent a harassment warning letter to his home address. It was not known whether he received the letter. The Force Harassment Procedure at the time encouraged the personal

[22] For more information on DV Assist see https://www.dvassist.org.uk/how-can-we-help-you

delivery of letters to suspects but recognised that it was not always possible to do so.

3.28 West Mercia Police contacted Sarah and, as she had received no further contact, the investigation was filed with no further action.

3.29 The Force's Harm Assessment Unit checked the Police National Computer and found warning markers for Jason for depression and self-harm in the form of cuts to legs. They therefore made referrals for him to Adult Social Care and mental health services, although neither service appeared to have received them.

3.30 On **25th February 2023**, Jason was contacted in respect of his complaint against Eleanor. He told the officer that the situation had calmed down and there had been no further incidents. A DASH risk assessment was completed and assessed as standard risk and Jason was referred to the Victim Advice Line, which is a generic advice service for people affected by crime in West Mercia. Although he mentioned suffering with his own mental health, thinking that both he and Eleanor had Bipolar disorders, he did not disclose thoughts of self-harm or suicide. Jason advised that he did not want any further investigation to take place. He declined to make a statement and only wanted the report logged on police systems as information. The offence was recorded, and no further action taken as requested. The police therefore did not contact Eleanor and it is not known whether Jason made her aware of the allegations that he had made against her. The Harm Assessment Unit reviewed the file before closure, looking only at this incident, and concluded that no referrals to other agencies were then required. This was the last contact that Jason had with the police before his death.

3.31 On **13th March 2023**, Jason received a repeat prescription of his anti-depressant having made and online request three days earlier. As this medication was on his repeat medication list, he did not need to see a doctor or have a review before it was issued. His last prescription had run out in January 2023.

April 2023 – further harassment

3.32 On **4th April 2023**, Sarah emailed the West Mercia Police officer who had dealt with her previously to say that she had received a few more messages from Jason and that evening had a missed call from a private number together with a blocked text asking me to meet with him on Friday and implying he would be coming up to Lancashire. Sarah advised that she did not receive a response from West Mercia Police. The officer was on leave when the email was sent and there was no update on police systems to reflect that any response was indeed made to her.

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

4. OVERVIEW OF AGENCY INVOLVEMENT

This section considers the Individual Management Review and Information Reports completed by individual agencies and the outcomes of discussions with the review panel concerning improvements to services in the future.

4.1 Lancashire Constabulary

4.1.1 The police in Lancashire responded to Jason as both an alleged victim and an alleged perpetrator of domestic abuse. In respect of the allegations of harassment made against him, they took statements from the victim, who reported being very happy with the response she 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 responses.

4.1.2 In response to Jason as a potential victim, Lancashire Constabulary reflected that, whilst it was a reasonable conclusion that Jason was making malicious counter-allegations, there had been no recorded attempts to fully investigate and negate his allegations. They considered that appointing a separate Officer In Charge for this investigation could have prevented the possible conflict of interest of having one officer investigating both sets of allegations. There was also no supervisory oversight recorded within the investigation.

4.1.3 They also found no clear record of investigation recorded and the investigations appeared to 'drift' for both alleged victims by the Officer In Charge. Moreover, there was no record of whether the statement made by Sarah on 19th December 2022 was actually sent to West Mercia Police, or record of the outcome in the case. West Mercia Police did not appear to have received the statement.

4.1.4 The Constabulary advised that during the year before these contacts, improvements had been made to embed minimum standards of investigation incorporating the Victim's Code[23] and aide memoires for domestic abuse offences and stalking and harassment. Quality sergeants had also recently been introduced to ensure that all relevant enquiries are being completed and that rationales for

[23] The Code of Practice for Victims of Crime in England and Wales can be found at https://www.gov.uk/government/publications/the-code-of-practice-for-victims-of-crime

no further action are properly recorded. However, the Constabulary recognised that these standards had not been met on this occasion.

4.1.5 The Constabulary advised that since this time, they have introduced Response Investigation Teams which have significantly improved outcomes for domestic abuse victims. They consider that if these teams had been in operation at the time, they would have provided a more robust response to Jason's allegations. They have also introduced, from August 2023, a new quality testing regime for Inspectors and Chief Inspectors to oversee the quality of cases in the areas of victim centred, suspect focussed, quality of investigation and supervisor reviews.

4.1.6 Lancashire Constabulary have provided evidence of these improvements which have led to a doubling of arrests of domestic abuse alleged offenders.[24]

4.2 West Mercia Police

4.2.1 West Mercia Police also responded to Jason as both a victim and an alleged perpetrator of domestic abuse.

4.2.2 In relation to actions taken in respect of Jason as the alleged victim, although Lancashire Police advised that Jason should be treated as the suspect and not the victim, and provided a detailed rationale for their advice, West Mercia Police considered that they should also have made further enquiries with Jason, preferably in person, and fully established the facts about the allegations he was making and given them the opportunity to assess his vulnerability. Moreover, the decision to take no further action was not reviewed by a supervising officer. Since this time, West Mercia Police Force has reviewed its Stalking and Harassment Policy (September 2023) giving clear instructions in relation to supervision of such cases and will provide assurance on the impact of this review on case closure.

4.2.3 The Force reflected on the delay in contacting Jason to discuss a course of action after his second report to the police in February 2023 about being a victim of coercive control. The delay was initially due to high demand and the prioritisation of incidents of higher risk and followed by difficulty in contacting Jason and securing his availability. On reflection, this may well have been because he was being approached by other officers in respect of the allegations against him.

4.2.4 In relation to investigations against Jason as the suspect of harassment, Jason appeared to evade contact with the police who phoned, messaged and visited him

[24] Evidence provided is included in their action plan

without success. West Mercia Police then issued two warning letters, known as Police Information Notices: the first in November 2022 and the second in February 2023. The Force reflected that they did not know whether Jason received these letters and wondered whether consideration could have been given to making further attempts to locate him in person. This would have ensured that officers knew that Jason was aware that his behaviour was causing distress and enabled action to be taken in the future against harassment should it continue. We have seen that, since this time, West Mercia Police has reviewed its Stalking and Harassment Policy, incorporating coercive and controlling behaviour, and the option to issue a Police Information Notice for the offence of harassment no longer exists. The revised policy, which was published in September 2023, directs officers to gather evidence on coercive and controlling behaviours (course of conduct offences), risk assessment and victim care.[25] Where there is a lack of evidence, or the course of conduct has not been established on two occasions, the officer is required to record the offence and submit an intelligence report to the Police National Database, enabling the specific behaviour of the suspect to be available to other Police forces, which would have been useful in circumstances such as these where the individual lived in a number of police force areas. The revised policy has been accompanied by force-wide, mandatory training for all officers and the Force will provide evidence of the impact of this training on their response to reports of stalking and harassment.

4.2.5 Sarah was able to communicate with a named police officer in West Mercia directly, which was good practice, but when an email was sent to the officer in April 2023 whilst the officer was on leave, Sarah advised that she did not receive a response and the Force could not account for this. At the time, the Force was seen to have improved its response to victims, as evidenced by the inspectorate's report (HMICFRS, July 2023).[26] The review heard how a police officer would devise a contact plan with a victims and are guided to explain to explain to victims that any new complaints or reports of other offences must be made directly via '999' in an emergency, or via the '101' number. Likewise, officers are provided with a voicemail transcript for directing victims to the control room out of hours or an 'out of office' for their email accounts. At the time of writing, West Mercia Police came to national attention for having a Violence Against Women and Girls in-box which was not being monitored, and messages not responded to (BBC, 2024).[27]

[25] See the College of Policing advice to investigators of stalking and harassment for more information on how evidence of the course of conduct can be obtained alongside risk assessment and victim care https://library.college.police.uk/docs/appref/Stalking-or-harassment-advice-for-investigators.pdf
[26] HMICFRS update report available at https://hmicfrs.justiceinspectorates.gov.uk/publication-html/west-mercia-police-revisit-service-to-victims-cause-of-concern/
[27] https://www.bbc.co.uk/news/articles/cy0rlnqk5jyo

The Force were therefore requested to provide assurance that all reports of harassment are robustly investigated, including those received by email, and victims updated of progress in line with the Victim's Code .

4.2.6 There were three occasions when their records showed that referrals had been made to other services for Jason: one to Adult Social Care and two to mental health services. These services had no record of having received the referrals. Referrals by the police are made by the Force's Harm Assessment Unit and West Mercia Police advised that the referral pathway now generates an email receipt from the referee, providing assurance of the robustness of the pathway. The Force has committed to provide the Partnership with progress on the current transformation of the Harm Assessment Unit.

4.3 GP Practice

4.3.1 Aside from the years when he was living in Merseyside, Jason had been registered from birth with the same GP Surgery. He used the Surgery infrequently for various physical issues unrelated to this review, as well as periodically in relation to anxiety and depression. In previous times he had been signposted to various sources of psychological therapy but did not appear to have taken up the suggestions.

4.3.2 The level of demand and pressure on the GP Practice, and all health services, in the winter of 2022/23, meant that it was difficult for patients to seek and gain appointments. On the day that Jason wanted to be seen as an emergency for depression, anxiety and sleep difficulties, the duty doctor's list comprised of 61 telephone and 8 face-to-face consultations, whilst the British Medical Association (BMA) guidelines recommend a maximum of 25 contacts per day. In this context, it was positive that Jason was seen as an emergency by an Advanced Nurse Practitioner who was assisting the doctor and was qualified to do so.

4.3.3 The Advanced Nurse Practitioner was able to reinstate his medication with a plan for a medication review 2-3 weeks later. The review heard that, whilst it was not recorded as such, it was her usual practice to assess risk of self-harm and suicide and Jason was not recorded as being at high risk.

4.3.4 The Practice recognised that this was also a missed opportunity to undertake routine enquiry when indicators of potential domestic abuse were present in Jason's presentation. NICE guidance (QS116) highlights that the symptoms of depression, anxiety and sleep disorders are all indicators of potential domestic

abuse and guides that routine enquiry should be undertaken when presented to them. However, parallel NICE guidance to clinicians on treating anxiety, (CG113) *Generalised Anxiety Disorder* and (NG222) *Depression in Adults*, do not similarly reference the need to ask about domestic abuse, only adverse childhood experiences (NICE, 2022)

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.

4.3.5 The review questioned whether Jason needed a review of his medication before it was put onto his repeat-list. Citalopram, like other anti-depressants, has side effects which can be worse in the first couple of weeks of taking them, hence it would be usual for the medication to be reviewed after this initial period. However, unless someone has been identified as high risk, it is left to the patient to seek the review, and the Practice advised that they did not have the capacity to introduce systems for following up all their patients in this way unless the level of risk required it. There had been nothing in Jason's notes to suggest that he was vulnerable and in need of more pro-active steps being undertaken to monitor his well-being.

4.3.6 The Practice advised the review that there have been significant changes in the intervening times which would have impacted upon the service that Jason received:

- Jason was initially unhappy about seeing the Advanced Nurse Practitioner. An experienced GP now triages all appointment requests.
- Jason experienced some problems getting through to the right person and he rang off whilst waiting to be connected to the right department. Appointment requests can now be submitted online which has meant that the phone lines are less busy and more accessible, particularly to vulnerable people who may not feel able to wait on the call.
- Jason had a telephone appointment when he wanted to go back onto anti-depressants and other medication and routine enquiry on domestic abuse and

signposting to psychological therapies was missed. The Practice has returned to a primary face to face appointment model, although patients can request a telephone call if they prefer. 72% of appointments were face to face in September/October 2023 compared to 58% the year before.

- Jason did not answer when the GP tried on three occasions to return his call. Whilst there was no deficit in this response, the Practice recognised that it did not have a standard policy where contact has failed. The practice policy on 'did not attend' or 'failure to contact' has since been formalised with links to risk assessment and expectations of attempts to contact.

- Jason was not asked about domestic abuse when he presented with either weight loss or mental health concerns. The Practice has introduced new recording software which prompts clinicians to ask about abuse and record the risk assessment for the patient and others.

- Jason was not signposted to other means of support such as psychological therapies or social prescribers when he presented with anxiety and sleep disturbance and sought anti-depressants. The GP Practice has since recruited social prescribers, and the Primary Care Network has made available a mental health nurse who will generally be available to each practice for one day per week.

4.3.7 The introduction of social prescribers was seen as a particularly positive response as all had been offered domestic abuse training, both at basic level and at the ambassador/champion level with the aim being to have an ambassador in each GP surgery. Having identified domestic abuse, the GP would refer the patient to the social prescriber who would complete the DASH and, with consent, refer to Cranstoun, the local domestic abuse service, for ongoing case management. At the time of writing, arrangements were being put into place for the pathway to be monitored by the Domestic Abuse Local Partnership and this was recognised as good practice. However, it was recognised that this pathway was embryonic and as such, the social prescribers in the GP Practice were not yet confident in their role.

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.

4.3.8 The GP Practice has made recommendations to improve its own response through routine enquiry on domestic abuse; strengthened triage and extending its return to face-to-face appointments.

4.3.9 Although it was recognised that it would have been helpful for the GP to know about the allegations of domestic abuse, it was understood that it would not be proportionate or effective to notify GPs of information except in high risk cases.

5. THEMATIC ANALYSIS, LEARNING & RECOMMENDATIONS

5.0 Following on from the analysis of individual agencies responses, this section explores the thematic, multi-agency and system analysis that arises from the circumstances leading to Jason's death by suicide

5.1 Suicide Prevention

5.1.1 Tragically, the method of Jason's suicide, by hanging, is the most common method of suicide for all victims and the number of deaths by hanging have increased almost every year since 2010 (NCIS, 2023:12).

5.1.2 Whilst learning from reviews into domestic abuse related suicides is still relatively new (VKKP, 2021; Home Office, 2022; Dangar et al, 2023), the review panel recognised the growing number of suicides where domestic abuse had been a feature in the person's life, whether as a victim or perpetrator of domestic abuse. Research undertaken for Kent and Medway Public Health showed that approximately 30 per cent of all suspected suicides in their area, over a three-year period, had been impacted by domestic abuse: either as a victim, perpetrator or as a young person affected by the abuse (Woodhouse, 2022). An analysis of the reviews undertaken between 2020 and 2023, has revealed an increased number of suspected perpetrators of domestic abuse who had previously been suicidal, featuring within these reviews (Hoeger at al.,2024:5)

5.1.3 Early research estimated that 25% of men dying by suicide were perpetrators of abuse (Scourfield et al., 2012). A more recent study estimated that domestic abuse perpetrators were four to five times more likely to die by suicide than those in the prison population: a population who were already recognised as being at risk within most suicide prevention strategies (Knipe et al., 2023:7). For those domestic abuse perpetrators considered to be high-risk and high-harm, the rate of suicide has been estimated to be 23 times greater than the highest age-specific suicide rate for males in the general population (ibid). Given these high estimates of the risk of suicide, Knipe et al. (2023) argue that domestic abuse perpetrators should feature in all area's suicide prevention strategies.

> *"In suicide prevention strategies in both England and Wales, whilst there is a focus on victims of domestic abuse, there is no mention of the perpetrators responsible. These constitute a group of individuals who are more likely to have experienced many of the risk factors for suicide during their lifetime, but who are typically overlooked and often elicit unsympathetic responses from the public and services. Yet the needs of this population are complex, and the often chaotic nature of a perpetrator's life means that engaging with mental health care and support may be more challenging – making it even more important that they have access to appropriate services." (Knipe et al, 2023:7).*

Learning Point: Suicide Risk for Domestic Abuse Perpetrators
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)

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.

Assessing the risk of suicide

5.1.4 Jason had relatively little contact with agencies, including the police and GP, and there was limited opportunity for them to explore his risk of suicide. Whilst he disclosed mental distress to police officers, he gave no indication of suicidal thoughts or his intent to self-harm when asked when they completed the DASH risk assessment with him. Nor did he feature as a suspect with a risk of self-harm or suicide in the DASH risk assessments undertaken with his ex-girlfriend. At other times, he did not disclose self-harm or suicidal thoughts to clinicians when he was seeking anti-depressants.

5.1.5 At the age of 37, Jason died when he was approaching middle age. Recent research has found that a history of alcohol or drug misuse, contact with the justice system, family or relationship problems,[28] social isolation and loneliness were common antecedents of suicide amongst middle-aged men (NCIS,2021). Alcohol and drugs, or a combination of both, featured in nearly half the suicides (49%) for men of this age (ibid).

5.1.6 For Jason, the police held historic records about Jason's problems with drugs and alcohol as a teenager, and these persisted into adulthood. During his 20s, he sought support for alcohol problems from his GP, but did not follow through with referrals and the review found no evidence that he had sought help for alcohol or drugs since. Also during his 20s, alcohol and drugs featured in his conviction for harassment, during which he sought money for cannabis and cocaine, as well as a conviction for drink-driving. Whilst it is not known whether his problematic alcohol use persisted, his drug use did, and evidence showed that he had taken cannabis before his suicide. Jason therefore had risks of suicide, but these were not known in full by any agency.

5.1.7 The panel heard how Telford and Wrekin has prioritised suicide prevention within its local strategies. They have made Zero Suicide Alliance training mandatory for all Telford and Wrekin staff within the local authority and highly recommended it for their partner agencies. The links between suicide and domestic abuse have been well established and they are working to have a Domestic Abuse Ambassador and at least one person trained in Applied Suicide Intervention Skills Training (ASIST) in each organisation. It has also actively adopted the Real Time Suspected Suicide Surveillance (RTSSS) system.

Real-Time Suspected Surveillance System (RTSSS) Data in Response to Domestic Abuse

5.1.8 RTSS allows data of suspected deaths by suicide in their area to be shared in real-time, rather than having to wait to receive the coroner's conclusion which can be delayed pending an inquest. This gives more up-to-date information about suicide in an area, as well as nationally, and helps to identify and implement support to prevent suicide, and trends in suicide, in a timelier manner.

[28] The nature of the 'relationship problems' was not delineated in this research.

5.1.9 In Telford, RTSSS is in place and includes data from police and health agencies. It will shortly be rolled out to include wider agencies including domestic abuse services and mental health providers, which was seen as good practice.

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

5.2 Understanding Domestic Abuse

5.2.1 Jason made allegations of experiencing domestic abuse from his last two girlfriends, with the former allegations being considered false. However, Jason also had a history of perpetrating domestic abuse and was first reported to the police for domestic abuse by his mother when he was aged 21.

5.2.2 Jason also had a history of harassment in his relationships with women and had one conviction for harassment of Laura in 2016. She described Jason's domestic abuse towards her, prior to his conviction for harassing her, and this included:

- Physical violence including grabbing her by the throat and threatening to slit her throat
- Isolating from friends
- Withholding 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

5.2.3 Some of these features were allegedly repeated in the short acquaintance, that Jason had with Sarah with whom he sought a relationship, where she described:

- His becoming attached very quickly
- Harassment after separation including bombarding with over 300 unwanted messages
- Threats to self-harm
- An escalation in harassment after warnings by police
- Suspected malicious allegations made against her to the police about child abuse
- Making counter-allegations which were considered by the police to be false

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

Perceptions of Being a Victim

5.2.4 During the inquest, Jason's mother advised that Jason had never taken responsibility for his behaviour in previous relationships. She recalled that her son considered himself to be a victim of a miscarriage of justice.

5.2.5 Although there was no evidence that Jason was himself a victim, it was reassuring to see that risk assessments were undertaken with him when he made allegations against others[29] and the potential for him to have been a victim was taken seriously.

[29] The College of Policing advises that If both parties claim to be the victim, officers should risk assess both (2024).

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)

Harassment

5.2.6 The end of a relationship was clearly a trigger point for Jason and lead 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 5 most commonly recorded risk factors for domestic homicides/suicides (Hoeger et al., 2024b:45).

5.2.7 Whilst warnings were given to Jason by telephone, text and letter, he appeared to evade the several attempts made by the police to warn him in person, as the victim of harassment wanted.

Assessing Risk From Harassment

5.2.8 Jason was assessed as medium risk by West Mercia Police when he made counter allegations against her, in view of his apparent vulnerability.

5.2.9 Jason had a history of, and conviction for, harassment by the time Sarah reported his harassment of her. Sarah was assessed as standard risk each time that she reported the harassment.[30] As she had been clear that she did not think that Jason would physically harm her, or even attend her address, this appeared, on the face of it to be accurate. However, had his previous conviction been included in the formulation, her risk level may well have been increased to medium. However,

[30] except for her last notification in April 2023 which appeared mislaid

the panel heard how this would still have been unlikely to meet the threshold for a disclosure to her of his prior conviction.

5.2.10 The Domestic Violence Disclosure Scheme, often referred to as *Clare's Law*, was introduced in 2014 to set out the procedures the police should use to disclose information about previous violent or abusive offending when there is a reasonable cause to suspect a person would be likely to suffer harm and that disclosure is necessary and proportionate for the prevention of crime.[31]

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.

5.3 Counter Allegations and Unconscious Bias

5.3.1 Whilst many more women experience domestic abuse, stalking and harassment from men than vice versa (Home Office, 2021), there remains a risk that this knowledge may lead to unconscious bias in how practitioners respond to male victims.

5.3.2 After Jason made counter allegations against his former girlfriend, Sarah, Lancashire Police concluded that his allegations were manipulative and unsubstantiated. Indeed, they had good reason to do so as Sarah provided evidence from over 300 messages that Jason had bombarded her with, whilst Jason had not provided any evidence and had a previous conviction for harassment. Nevertheless, both Police Forces concluded that they should have made more attempts to contact Jason and investigate the counter-allegations more robustly as a safeguard against potential unconscious bias.

[31] See the guidance for the full list of factors which need to be taken into account before a disclosure is made
https://assets.publishing.service.gov.uk/media/6489ab97103ca6000c039ea0/Domestic_Violence_Disclosure_Scheme.pdf

5.3.3 Jason's counter-allegations provided an important insight into domestic abuse which all practitioners need to be aware of:

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.

5.4 Action After a Sudden Death

Investigating Domestic Abuse

5.4.1 Whilst West Mercia Police currently attend all sudden deaths, the Force advised that they were currently exploring whether criminal offences should be investigated post-mortem due to this growing awareness of the link between suicide and domestic abuse. Another domestic homicide review in the area (DHR6) has identified the need for the Force to broaden the understanding of officers attending the scene of a sudden death, to consider whether there could be a causal link between suicide and domestic abuse.

Suicide Bereavement Services

5.4.2 Although the suicide victim's mother was visited again by a police officer after her son's death, she was not referred to the Suicide Bereavement Service. This specialist service was launched in 2021 to cover Shropshire, Telford and Wrekin and is provided by Telford Mind. The need for the service was highlighted in the Suicide Prevention Strategy 2023-28 and aims to prevent suicides and its impact on local communities.

5.4.3 West Mercia Police recognised that they had no specific policy direction in relation to referring bereaved families to specialist bereavement services when they attend incidents of sudden death. In response, they are undertaking actions to ensure that officers are familiar with the services available and consistently make referrals in the future.

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.

5.4.4 The review panel were aware that the Home Office has declared its intention to review the statutory guidance for Domestic Abuse Related Death Reviews[32], in order, in part, to strengthen local Partnerships ability to review suicides involving domestic abuse (Home Office, 2022b; 2024) and welcomed this forthcoming guidance.

5.4.5 In the meantime, the Home Office is asked to add to their suite of leaflets, ones which would be suitable for cases of suicide.

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

6. CONCLUDING REMARKS

6.1 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.

6.2 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.

[32] The government announced the change in title from Domestic Homicide Reviews to Domestic Abuse Related Death Reviews on 5th February 2024 in online news item: https://www.gov.uk/government/news/fatal-domestic-abuse-reviews-renamed-to-better-recognise-suicide-cases#:~:text=This%20means%20that%20a%20Domestic,and%20emotional%20and%20economic%20abuse.

ADDENDUM

6.3 In respect of the process of the review, the Independent Chair and Review Panel recognised how important it had been for this review to have a suicide prevention specialist on the panel and made the following recommendation to the Partnership.

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.

7. RECOMMENDATIONS

7.1 Overview & System 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

7.2 Individual Agency Recommendations

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

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).

West Mercia Police

- Provide evidence-based assurance that reports of harassment are robustly investigated, including those received by email, 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

ACRONYMS

AAFDA: Advocacy After Fatal Domestic Abuse
ASIST: Applied Suicide Intervention Skills Training
BMA: British Medical Association
CPR: cardiopulmonary resuscitation
DHR: domestic homicide review
DNA: did not attend
GP: General Practitioner
IDVA: Independent Domestic Violence Advisor
IMR: Individual Management Review
MARAC: Multi-Agency Risk Assessment Conference
MoJ: Ministry of Justice
NICE: National Institute for Health and Care Excellence
PNC: Police National Computer
PND: Police National Database
RTSSS: Real Time Suspected Suicide Surveillance

GLOSSARY

Police National Computer (PNC): Contains information about convictions, warrants, arrests and information markers recorded against persons.

Police National Database (PND): Available to all police forces and wider criminal justice agencies throughout the United Kingdom, allowing the police service to share local information and intelligence on a national basis. The PND supports delivery of three strategic benefits which are to safeguard children and vulnerable people, to counter terrorism, and to prevent and disrupt serious and organised crime, accessing custody, intelligence, crime, child abuse and domestic abuse records.

Domestic Abuse, Stalking and Honour Based Abuse (DASH).
A checklist introduced in 2009 adopted by many agencies to assess level of risk and highlighting those at higher risk. There are 3 categories of (DASH) risk as follows:

- *Standard*: Current evidence does not indicate likelihood of causing serious harm
- *Medium*: There are identifiable indicators of risk of serious harm. The offender has the potential to cause harm but is unlikely to do so unless there is a change in circumstances, e.g. failure to take medication, loss of accommodation, drug or alcohol misuse.
- *High*: Risk of serious harm or homicide. The potential event could occur at any time and the impact would be serious.

Real Time Suspected Suicide Surveillance: This allows a local area to track the number of suspected deaths by suicide in their area in real-time, rather than have to wait to receive the coroner's conclusion which can be delayed pending an inquest. This gives more up-to-date

information about suicide in an area and nationally and helps to identify and implement support to prevent suicide, and trends in suicide, in a timelier manner.

THRIVE risk assessment

THRIVE is the supporting acronym that guides police managers and staff in determining the most appropriately trained department and persons for responding to crime and incidents. The letters stand for 'Threat, Harm, Risk, Investigation, Vulnerability and Engagement'.

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Domestic Homicide Review: DHR 10

Under Section 9 of the Domestic Violence Crime and Victims Act 2004

Multi-Agency Action Plan

Completed actions
Pending sign off as completed by the DHR Oversight Panel

*** *This action plan is a live document and subject to change as outcomes are delivered* ***

'Early Learning' Recommendation 1 **Clinical Guidance on Routine Enquiry on Domestic Abuse Where Indicators are Present in Relevant Health Conditions**						
Ref	**Action (SMART)**	**Scope**	**Target date for completion**	**Lead Agency**	**Monitoring arrangements**	**How will success be measured?**
A	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.			Home Office – via DA Commissioners Office for updates		

'Early Learning' Recommendation 2 **Primary Care Response to Domestic Abuse**						
Ref	**Action (SMART)**	**Scope**	**Target date for completion**	**Lead Agency**	**Monitoring arrangements**	**How will success be measured?**
B	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.		A new Domestic abuse pathway is being developed in partnership with lead safeguarding GP's by the Domestic Abuse Forum. Hopefully complete early 2026	Telford and Wrekin Public Health	Within DA forum escalations to DALP	• Through GP Safeguarding meetings • It must be recognised that with different PCN's there are individual arrangements for social prescribers

'Early Learning' Recommendation 3 **Suicide Prevention & Domestic Abuse Perpetrators – signed off as completed in Domestic Abuse Local Partnership Board on 14.02.25**						
Ref	**Action (SMART)**	**Scope**	**Target date for completion**	**Lead Agency**	**Monitoring arrangements**	**How will success be measured?**

C	Telford and Wrekin Suicide Prevention Action Group (SPAG), coordinated by the Public Health Team, to ensure that domestic abuse perpetrators, as well as domestic abuse victims, feature within their suicide prevention strategy.		Perpetrators and victims are already considered within Suicide Prevention Strategy and will be incorporated into the action plan	Telford and Wrekin Public Health	Through Domestic Abuse forum and SPAG escalations to Domestic Abuse Local Partnership Board	Through monitoring within forum and SPAG

'Early Learning' Recommendation 4 **Real Time Suicide Surveillance and Domestic Abuse (Local) - signed off as completed in Domestic Abuse Local Partnership Board on 14.02.25**						
Ref	**Action (SMART)**	**Scope**	**Target date for completion**	**Lead Agency**	**Monitoring arrangements**	**How will success be measured?**
D	Telford and Wrekin Public Health to liaise with the Coroner and encourage local sign-up with the Real Time Suspected Surveillance System This may involve: • demonstrating successful arrangements in other areas • lobbying national suicide prevention	Local	Review by December 2025.	Telford and Wrekin Public Health	Through SPAG Drug and alcohol forum and regional / national meetings	The Coroner for Telford and Wrekin engages with RTSSS or, if not, national lobbying undertaken for change to national guidance Update June 2025: A new ISA has been put into place to allow information to be shared from

	partnerships to push for national guidance					the Coroner's office.

'Early Learning' Recommendation 5 **Real Time Suicide Surveillance and Domestic Abuse (National)**						
Ref	**Action (SMART)**	**Scope**	**Target date for completion**	**Lead Agency**	**Monitoring arrangements**	**How will success be measured?**
E	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			Home Office – via DA Commissioners Office for updates		

'Early Learning' Recommendation 6 **Suicide Bereavement Service**						
Ref	**Action (SMART)**	**Scope**	**Target date for completion**	**Lead Agency**	**Monitoring arrangements**	**How will success be measured?**
F	West Mercia Police and Telford Mind to work together to strengthen links and develop a referral route which			West Mercia Police Update 15.04.25 - A number of attempts have been made to contact		

	will ensure that bereaved families are systematically offered signposting to specialist support services following police attendance at a sudden death.			Mind via their contact number. Awaiting reply to email sent. Update 12.09.25 - Engagement with Mind management has taken place. Agreed course of action: Mind are going to complete and provide a poster with details of their services and QR code. This will be disseminated to officers both electronically and physically around the policing area. Engagement with the local Problem-Solving Inspector has been undertaken with a view to delivering this locally.		

'Early Learning' Recommendation 7 **Home Office Leaflets**						
Ref	**Action (SMART)**	**Scope**	**Target date for completion**	**Lead Agency**	**Monitoring arrangements**	**How will success be measured?**
G	The Home Office to consider adding to their suite of leaflets for families and friends,			Home Office – via DA Commissioners Office for updates		

	leaflets specifically concerning domestic abuse related suicides.					

'Early Learning' Recommendation 8 **Suicide Prevention Specialists on Review Panels**						
Ref	**Action (SMART)**	**Scope**	**Target date for completion**	**Lead Agency**	**Monitoring arrangements**	**How will success be measured?**
H	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					Suicide lead to be invited to be part of all future panel meetings where suicide is a feature. Individual identified and happy to attend

Individual Agency Action Plans

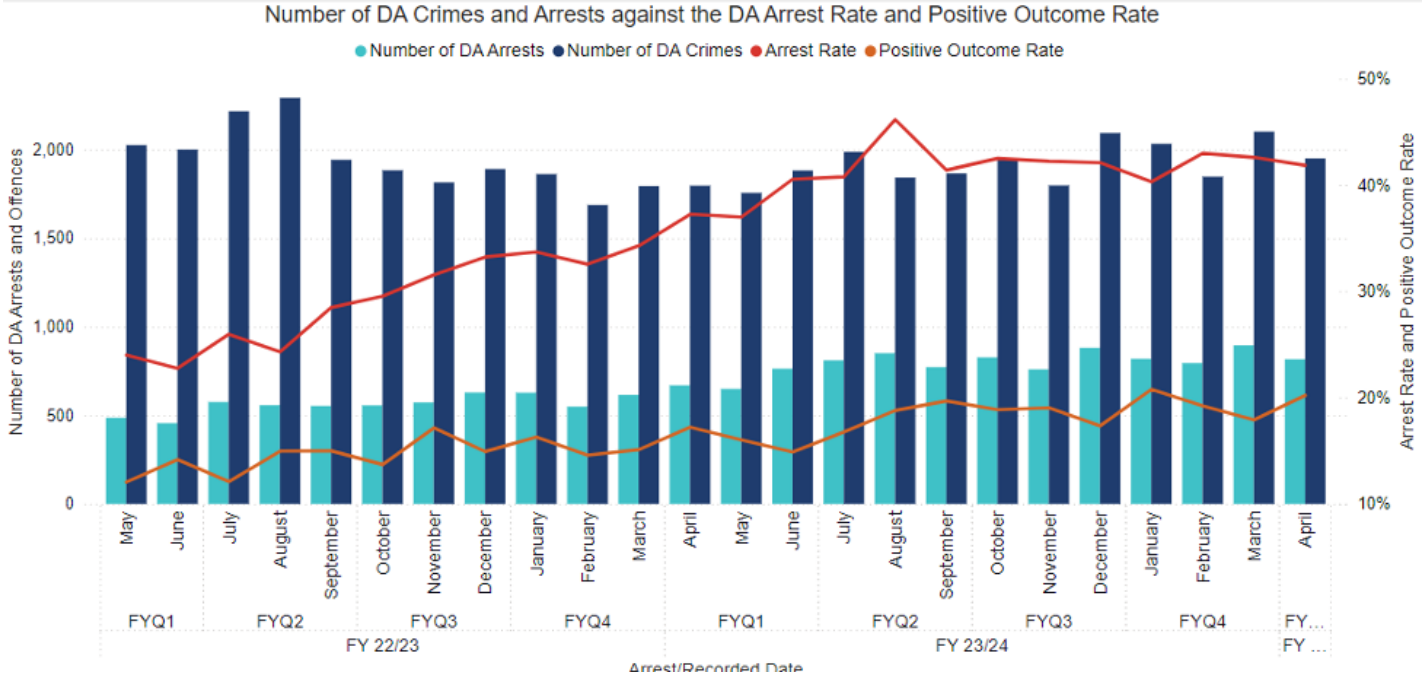
Primary Care - Linden Hall Surgery						
No°	**Recommendation**	**Key actions (SMART)**	**Evidence**	**Key outcomes**	**Lead officer**	**Target date for completion**
1	Clinicians to be reminded to ask about abuse when patients present with Depression./anxiety/low mood	1. Ardens template was installed in April 2023 within the consulting software. This prompts clinicians to a template for recording consultations – which includes the prompt to ask about abuse (as well as recording this and a risk assessment for harm to self and others) surgery systems 2. Clinicians to be encouraged to use the templates as part of their regular consulting – by way of a further educational event within practice. This will be part of a	1. Evidence is that it has been installed and it is available for all to see. 2. To see if team members are using the templates, or otherwise remembering to ask and document about abuse, a random selection of notes problem coded as depression or anxiety, or low mood will be audited to see if the templates are being used and if the questions are being asked and documented	1. PLT held on March 13th highlighting the importance of asking and recording about domestic violence 2. Audit performed in May 2024. An audit of all consultations in April 2024 coded as low mood, depressed mood, depression or anxiety. There were 76 patients with such code (some had been seen more than once that month with the same problems). I reviewed the notes of 20% of those 76 patients. All had been asked about self-harm and suicide and 40% had been asked about domestic violence	Safeguarding Lead	April 30th 2024

		surgery wide PLT event		and had it recorded. This is not as high as I had hoped and further education has occurred, and will occur again in June. Then a repeat audit exercise will be carried out.		
2	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	All appointment requests are triaged and allocated by an experienced GP	Triage forms are available for viewing on our website www.lindenhallsurgery.co.uk/			September 2023
3	A return to primary face to face appointments	As of January 2023 we have returned to face to face being our preferred means of delivering care. 28% of appointments are not conducted face to face but that is at the patients' request or agreed by a GP to be most appropriate (e.g. emergency call after receiving a triage request that	GP Access Data Dashboard reveals that we conducted 72% of appointments face to face in September/October 2023 vs 58% in September/October 2022.			January 2023

		requires immediate attention)				

Lancashire Constabulary						
No⁰	**Recommendation**	**Key actions (SMART)**	**Evidence**	**Key outcomes**	**Lead officer**	**Target date for completion**
4	Separate investigators are allocated to cases where both alleged offender and alleged victim make allegations of domestic abuse against each other to avoid conflict and probable subconscious bias.	• Cascade learning from this DHR to the Senior Management Team (SMT) for the Response Investigation Team (RIT) to inform all RIT staff of the circumstances and learning. • Via RIT SMT, ensure investigations are fully researched prior to allocation to ensure no conflict.	Confirmation received from all RIT team senior managers that learning from this recommendation has been cascaded both electronically and by face-to-face briefings with RIT supervision.	Address issues raised.	Response Senior Management Team	01/07/2024 - COMPLETED

5	Provide evidence of improved quality of domestic abuse investigations.	Introduce Target Operation Model into Response Investigation Teams with improved victim care and engagement, prompt attendance and early arrest	Number of arrests	DA arrests increase from around 400 a month (20%) in 2022, to over 800 a month (42%) in the last quarter of 2023/2024	Response Investigation Teams	COMPLETED



West Mercia Police						
No°	**Recommendation**	**Key actions (SMART)**	**Evidence**	**Key outcomes**	**Lead officer**	**Target date for completion**
6	Provide evidence-based assurance that reports of harassment are robustly investigated and victims updated of progress in line with the Victim's Code	Assurance report to Partnership	Increase in number of reports of harassment leading to arrests since September 2023 Dip sample to be completed and monitoring via the statutory processes.	Reports of harassment are robustly investigated Victims of harassment are regularly updated in line with Victim's Code	West Mercia Police	Force policy around attend, arrest, investigate has been in place for some time. This in order to improve the overall rates of positive action being undertaken in relation to DA incidents. All investigations require intrusive supervision and review by sergeants on a monthly basis. S & H investigations are searched for and captured on a daily business on the daily briefing for scrutiny at the daily management meeting to ensure ownership and progression. Matters relating to DA require review by an Inspector before the matter can be filed.

						Police are mandated by the Victim's Code. Victim code compliance is scrutinised on a weekly basis as a performance indicator and reviewed by local command teams. Repeat noncompliance is dealt with as a performance issue. Investigation quality and VCOP compliance is routinely audited across all crime types force wide. A specific force wide audit of stalking and harassment cases is planned to take place in May/June 2025.
7	Provide evidence-based assurance that cases of stalking and harassment are adequately supervised and not closed prematurely	Assurance report to Partnership	All cases of stalking and harassment are supervised before closure Dip sample to be completed and monitoring via	Cases of stalking and harassment are not closed prematurely	West Mercia Police	All stalking and harassment investigations are now recorded by our IMU (Investigation Management Unit) via a hotline from officers. This is designed to ensure

			the statutory processes.			consistency and compliance with Home Office Crime Recording Standards and prompt review/allocation. All investigations require intrusive supervision and review by sergeants on a monthly basis. S & H investigations are searched for and captured on a daily business on the daily briefing for scrutiny at the daily management meeting to ensure ownership and progression. Matters relating to DA now require review and documentation of decision making on the investigation by an Inspector before the matter can be filed. Investigation quality and VCOP compliance is routinely audited across all crime types force wide. A specific force wide audit of stalking and

						harassment cases is planned to take place in May/June 2025.
8	Provide evidence-based assurance on the robustness of referral pathways to support services	Partnership informed of the progress of review of the Harm Assessment Unit and evidence of referrals that have made is incorporated into that progress report	Numbers of referrals made to Adult Social Care and Mental Health Services Numbers of referrals accepted by Adult Social Care and Mental Health Services	Effective referrals are made in a timely way to Adult Social Care and Mental Health Services.	West Mercia Police	HAU update: Full review has been undertaken of the HAUs across the force. Centralisation of the HAU as one unit will be taking place with the hub being located in Bridgnorth. Intention is to standardise the working practices and pathways being undertaken. Staff have been made aware and plans are underway to complete this change. Bi-monthly meetings are being undertaken with partner agencies in order to progress process and pathway standardisation. Police do not receive feedback from partners in relation to referral acceptance.

Agencies with no individual learning points identified following scoping, IMR's returns and final DHR report:

- Telford and Wrekin Children Services
- Telford and Wrekin Adult Services
- Shropshire Fire and Rescue
- Housing
- Neighbourhood Services
- Probation
- Robert Jones and Agnes Hunt Hospital
- West Midlands Ambulance Service
- Shropshire Community Health Trust
- Shropshire and Telford Hospitals Trust
- West Mercia Women's Aid
- Youth Justice
- Shropshire Domestic Abuse Service
- Midlands Partnership Foundation Trust