DARDR EXECUTIVE SUMMARY
FOR JULIE
MAY 2024

Gloucester Community Safety Partnership in conjunction with Safer Gloucestershire

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The Review Process

This summary outlines the process undertaken by the Gloucester Community Safety Partnership Domestic Abuse Related Death Review (DARDR) panel in reviewing the suicide of Julie who was a resident in their area.

The Victim's own name is not used in the Report in accordance with the Family's wishes. The pseudonym used in the report is Julie and was chosen by the family. Julie was 41 years of age, Female and White British.

The pseudonym used in this report for the perpetrator was Damon. Damon was 44 years of age at the time of the fatal incident, and a White British male.

The process began on the 4th of June 2024 when this case was considered by an expert panel. The panel made a recommendation to the Community Safety Partnership (CSP) and on the 16th July 2024 the CSP made its decision and informed the Home Office of its decision to commission a DARDR for Julie. Panel members were duly notified and informed about the DARDR. All agencies that potentially had contact with Julie and Damon prior to the point of death were contacted and asked to confirm whether they were involved with them.

Ten of the Fourteen agencies contacted confirmed contact with the victim or perpetrator and were asked to secure their files.

Contributors to the Review

Gloucestershire Constabulary - IMR
Gloucestershire Health and Care NHS Foundation Trust - IMR
Gloucestershire Hospitals NHS Foundation Trust - IMR
South Western Ambulance Service NHS Foundation Trust - IMR
Gloucestershire Domestic Abuse Support Service - IMR
ICB (on behalf of GP) - IMR
Gloucestershire City Homes - IMR
Gloucestershire City Council - Short Report
Change Grow Live (CGL) - Short Report

Department of Work and Pensions - Short Report

All IMR and report authors were independent and had no direct contact or connection with Julie or Damon.

The Review Panel Members

Shona Priddey - Independent Chair
Rachel Williams- Assistant to Independent Chair
Sophie Jarrett - Gloucestershire Office of the Police and Crime Commissioner
Jeanette Welsh - Gloucestershire Hospitals NHS Foundation Trust
Samantha O'Malley - NHS Gloucestershire Integrated Care Board (ICB)
Jonathan Newman - Gloucestershire Health and Care NHS Trust
Lisa Ratcliff - South Western Ambulance Service NHS Foundation Trust (SWASFT)
Tessa Davis - Gloucestershire Domestic Abuse Support Services (GDASS)
Sue Smith - Gloucestershire Drug and Alcohol Support Service
Hazel Mitchell - Gloucester City Council
Nikki Smith - Gloucestershire County Council
Caroline Lucas-Mouat - Strategic Housing Partnership
Nicola Bullock - Gloucestershire City Homes
Louise Missen - Gloucestershire Constabulary
Katie Lewis – Nelson Trust Women's Centre
Sarah Hawker - Department of Work and Pensions
Minesh Patel - Change Grow Live

None of the Panel members had direct involvement in the case nor had line management responsibility for any of those involved.

The Independent Chair and the Assistant to the Chair are both independent, ensuring no conflict of interest.

The Panel met on four occasions. Further meetings took place with individual Panel members where it was necessary to do so.

Author of the Overview Report

Shona Priddey was appointed by Gloucester Borough Council, Gloucestershire County Council and Gloucestershire OPCC on behalf of Safer Gloucestershire as the Independent Chair and Author for this DARDR in August 2024. Shona acts as an Independent Chair and Author for DARDRs. She has completed the Home Office approved course for Domestic Homicide Review Authors provided by AAFDA. Her background is within the Criminal Justice System both academically and professionally. She is a justice of the peace in both criminal and family courts and holds the position of trustee for a domestic abuse charity (SUTDA). Shona is independent of all the agencies involved in this case and has never worked in Cheltenham or Gloucestershire or for any of its agencies.

Terms of Reference for the Review

Statutory Guidance (Section 2.7) states the purpose of the DARDR is to:

- Establish what lessons are to be learnt from the domestic suicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- Identify clearly what these 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.
- Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
- Prevent domestic violence and homicide and improve service responses for all victims of domestic violence and abuse, by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to at the earliest opportunity.
- Contribute to a better understanding of the nature of domestic abuse.
- Highlight good practice.

Specific terms of reference set for this review

Agency response

- Did agencies share information and if they did, what did they share?
- Did any agency join the dots? If they did was it done correctly and in a timely manner?
- What more could have been done by agencies?
- Could improvement in any of the following have led to a different outcome:

  - Communication and information sharing between services?
  - Information sharing between agencies regarding the safeguarding of adults?
  - Communication within services?
  - Communication and publicity to the public and unknown specialist services about the nature and prevalence of domestic abuse and available local specialist services.
- Was the work undertaken by services in this case consistent with each organisation's professional standards and any domestic abuse policy procedures and protocols?
- Has any learning already been identified? If so, has anything been implemented since Julie's death.

Summary Chronology and Key Issues Arising from the Review

Julie was a 41-year-old woman who had Ocular Albinism affecting her vision and had a diagnosis of Schizotypal personality disorder. Julie lived in a flat in Gloucester and died from falling from a roof at the block of flats where she lived; it is unknown whether she jumped or fell, and it will remain unknown. Julie had been in a domestically abusive relationship with Damon for approximately five years. Damon did not officially live with Julie, but he often stayed in her flat and was abusive towards her. Damon was not with Julie at the time of her death.

Julie had struggled with her mental health since her teens and had used both prescription drugs and illicit drug use and alcohol to cope. Julie was known to the Police and the Courts for her own criminality. Damon had been in prison prior to his relationship with Julie but not for anything DA related. Damon was also reported to be an illicit drug user.

Julie was known to multiple agencies over many years; the review looked at agencies' contact and involvement with Julie from 1st January 2019 - May 2024. However, for a variety of reasons Julie was never able to engage with them in a meaningful or constructive manner. Agencies tolerated more than was acceptable on multiple occasions trying to help Julie and give her the support she had previously asked for when making the initial contact. Julie was largely estranged from her family due to her behaviour towards them. The key issues for Julie were DA, mental ill health, primarily her personality disorder, and substance misuse including both drugs and alcohol.

Conclusions

Julie had a tremendous amount of engagement with agencies and professionals, yet she was not able to engage with them in a proactive way once she was given the help she had asked for. It is evident that all agencies saw a vulnerability in Julie as they all tolerated more from Julie than they would have normally accepted in their roles as professionals.

Julie had complex needs. Julie struggled with her mental health and was diagnosed with a personality disorder. Julie had addictions to drugs and alcohol and was a victim of DA.

There is reference to Julie's childhood and early physical relationships, and both of these will have impacted what Julie perceived as acceptable behaviour within a relationship.

One of the purposes of a DARDR is to prevent domestic abuse and homicide and improve service responses for all domestic violence and abuse victims and their families by developing a coordinated multi agency approach to ensure that domestic abuse is identified and responded to effectively and at the earliest opportunity. The panel will identify lessons and make recommendations accordingly.

Lessons to be Learned

This section will summarise what lessons are to be drawn from the case and how those lessons should be translated into recommendations for action. It will also evidence any early learning identified during the review process and whether this has already been acted upon.

GHFT employed a Substance Mis-use Specialist Nurse in February 2023 and many of the more challenging aspects of Julie's care would now have the benefit of that nurse's oversight. With the progress made in this area since the post started, this would now mean a more nuanced bespoke patient management plan than the GHFT plan of December 2022.This would be written with clinicians and those known to already be involved. This would include advice to GHFT staff on known "normal" behaviour and known prescribed medications so that they have an objective record of what had or had not been prescribed and could check with pharmacies whether this had been picked up.

GHFT now have body worn cameras for the Nurse- in- Charge of ED and the Violence and Aggression team lead, which enables later review of incidents to better understand the level of abuse being experienced by staff and assist with forming a view of whether a person had capacity at the time of the incident. Only people with capacity at the time of an abusive incident are dealt with by the Behaviour Standards Panel. Those thought likely to lack capacity are addressed via the clinical team with the greatest expertise in the patient's diagnosis.

GCH recognised Julie's vulnerabilities and her lack of engagement during her tenancy and as a result sometimes went over and above what a landlord/GCH would do, for example delaying or not taking any action re ASB or tolerating her abusive language either at all or soon enough.

SWASFT recognised that on occasion, opportunities to make safeguarding referrals were missed due to not having consent when mental capacity should have been considered. Capacity was noted on EPCRs, but this could be questioned by her presentation at times. When heightened, agitated, aggressive or refusing to engage, establishing capacity would have been challenging. Julie often refused ambulances after calling or refused the offer of attending ED and whilst capacity was usually noted, further exploration of fluctuating capacity may be relevant. Capacity was usually assessed for the decisions regarding treatment and not necessarily regarding her own care and safety.

It is worth noting the changes to the safeguarding department since May 2024: following an independent review recommendation, the safeguarding department within SWASFT now have a new management structure and dedicated safeguarding specialists for each geographical locality covered by SWASFT, as well as a dedicated training professional. The specialists provide a link between external local partners, SWASFT as an organisation and operational staff. The dedicated safeguarding trainer provides bespoke training and invaluable input into the content of SWASFT clinical yearly training days.

SWASFT have invested in a training programme whereby clinicians are having an increased mandatory face to face four and a half hours on safeguarding which has domestic abuse as a specific topic this year and Operational Officers are being offered Level 3 safeguarding training. There is also a current programme being rolled out geographically on further

training on capacity assessments for clinicians. This is a topic often covered on yearly training days, however, this bespoke training is in addition to this.

ICB (GP) Better liaison is required between primary care and secondary/tertiary care, this might have provided a more co-ordinated approach to managing Julie's complex health needs. A mental health worker/advocate attending appointments with Julie would have been helpful for Julie.

ICB (GP) Keeping a complex patient on if the registration with another practice is only going to be temporary and within the County.

ICB (GP) did not receive any information from police about welfare checks or MARACs undertaken for Julie. If they had done, they would have followed the RCGP guidance for recording relevant and proportional information about the patient's vulnerabilities or DA status.

GHC Mental Capacity Assessments need to be clearly documented as per policy to evidence the basis of the assessment and the decision.

GHC Staff can use the trust MCA specialists for advice and guidance on complex cases where continued unwise decisions are made, and the person is at risk of serious harm. This is to ensure all options are considered.

GHC Safeguarding adult reflective supervision on complex cases can help to explore complex cases and support staff in their practice.

Police recognised that opportunities to arrest Damon for breach of injunction were missed and that citing lack of victim complaint as a rationale not to proceed isn't acceptable for DA cases. The amount of NFAs has been reflected on and there is more oversight on DA cases now following a force wide DA improvement plan being implemented following the roll out of DA Matters. Custody Sgts are no longer authorised to make a NFA decision in relation to DA cases and this must now be considered by an inspector.

As part of the ongoing focus to improve the police response to DA, breach of bail or breach of other preventative orders for DA are now expected to be treated as a new incident with the potential for new crimes being committed. Breaches of conditions are indicative of rising risk within an abusive relationship and should be treated as such.

Dealing with incidents in isolation despite Julie frequently making the same allegations has been recognised and controlling and coercive behaviour would be considered now and there is a concerted effort to look at the bigger picture to join incidents together to show a pattern of wider offending. This has been covered in the DA Matters training rolled out across the force and made mandatory for all officers.

In addition, following the DA Matters force 'health check', Gloucestershire Police have stopped the use of Negative Pocketbook entry since December 2023 and are now directed to consider opportunities for ELP and other investigative avenues, rather than relying on the victim to decide as to further police action.

VISTs for DA must always be completed by an officer face to face unless exceptional circumstances apply (implemented already).

Clear directive has been issued in the constabulary that Body Worn Video must be used when capturing first accounts or completing the VIST with DA victims and must be used when attending all DA incidents.

Recommendations from the Review

When attending a multi-agency meeting, the GCH officer attending should request a follow-up meeting be scheduled and a date agreed at the meeting.

GCH will always look to support vulnerable customers and any enforcement action for ASB would always be a last resort. Whilst each case will always be dealt with on a case-by-case basis GCH should be aware of the impact of any ASB on the neighbour(s) and take this more into account during ASB case reviews; not forgetting however the separation between ASB and DA and the acknowledgement that DA requires a different response to ASB even when identified as ASB by neighbour(s).

ICB (GP) Discuss complex cases in regular clinical governance meetings.

ICB (GP) The consideration of a PCN safeguarding care coordinator, they could be utilised in future cases such as this.

ICB (GP) Complete a GDASS referral to obtain better support for a patient experiencing DA (this was offered to Julie, but she had declined). Promote attendance at GDASS training which will raise awareness of GDASS support at the practice.

ICB (GP) recommend not deregistering patients when they are moving temporarily and still within an acceptable distance to the surgery.

GHC The safeguarding adult supervision offer is being relaunched from the 20th of January 2025. Practice reminder to go directly to recovery and AOT team managers to ensure it is considered for domestic abuse and safeguarding concerns - GHC safeguarding adults' team to action.

GHC and GDASS to agree MHIDVA relaunch in the trust - GHC Head of Safeguarding, GHC Named Lead for Safeguarding Adults and GDASS health lead.

GHC Practice requirements regarding recording of Mental Capacity Assessments and use of MCA specialists for consultation to be addressed through targeted plan with Recovery and AOT Teams - MCA leads.

GHC Targeting AOT Teams, specific domestic abuse training update to be delivered at the whole service away day April 2025- GHC safeguarding adults' team to action. Representation from each AOT to be secured for the Trust Domestic Abuse Champions Network.

Police to ensure investigations to begin at first point of contact, and from then on receive timely and robust supervision to drive activity to improve standards. Officers attending DA incidents must seek to investigate and not just focus on safeguarding responsibilities. This could be communicated to officers through divisional training days or via "team talks".

Officers should be reminded to treat DA as a pattern of behaviour, rather than as a series of isolated incidents. They should be reminded of the importance of recording partner agency referrals on the VIST and incident reports and to consider all domestic assaults as serious offences. All of these behaviours should be addressed through initial training to new recruits and ongoing CPD or divisional training days for existing officers.

Gloucestershire has already joined the Making Every Adult Matter (MEAM) network with the aim of improving outcomes for people facing multiple disadvantages. As multiple disadvantages are a systemic issue, the overarching aim is that learning from the MEAM approach will influence systems change in Gloucestershire. The approach in Gloucestershire will explore themes of safeguarding and complex emotional needs. The intersection of mental ill health and domestic abuse are represented within the work and learning to lead to systems change.