Keeping Bexley Safe

BEXLEY COMMUNITY SAFETY PARTNERSHIP DOMESTIC HOMICIDE REVIEW

Overview Report into the death of Jenny

August 2020

Independent Chair and Author of Report: Danielle Davis

Associate Standing Together Against Domestic Abuse

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STANDING TOGETHER against domestic abuse

1. Preface

1.1 The incident

1.1.1 Jenny[1] lived in Bexley with her husband Adam[2] and their five year old child (Child A). They were married at the time of her death. The author and panel offer our condolences to her friends and family and hope this review reflects this throughout.

1.1.2 The day prior to Jenny's death in August, Adam left the house to take Child A on a day trip to the beach. Jenny did not go with them due to a tooth ache for which she attended an emergency dentist appointment to be checked. Jenny called them whilst they were on their way to say she was upset they had left without her, so they returned home. Adam stated that when he returned that Jenny did not want him in the house and wanted to separate. He left with Child A and they stayed in a hotel for the night. During the night Adam received text messages from Jenny as well as a call stating she was going to hang herself. Adam stated that this was something Jenny had done before and so he did not take her threats seriously. When he returned the following day, he found that Jenny had died having hanged herself from the kitchen door.

1.1.3 A police investigation at the time of death was conducted by the Metropolitan Police Service (MPS) who concluded that the death 'whilst unexpected had no suspicion of third-party involvement'. The coroner held an inquest which did not require police attendance. The finding of the coroner was that, "The deceased hanged herself from a door handle at her home being found dead by her husband in the morning of August 2020. She had a considerable amount of alcohol in her blood when she did this act and this may have coloured her thinking. Her intent to die is not found proven in the circumstances". The conclusion of the coroner as to her death is recorded as, "Died having hanged herself".

1.1.4 The Review Panel expresses its sympathy to the family, and friends of Jenny for their loss.

1.2 Introduction

1.2.1 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004 and should be conducted in accordance with the December 2016 Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (hereafter 'the statutory guidance').

1.2.2 The *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews* (2016) states that: "Where the victim took their own life (suicide) and the

[1] Pseudonym

[2] Pseudonym

circumstances give rise for concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken…Reviews are not about who is culpable" (Para 18). The Bexley Community Safety Partnership (CSP) Board and partner agencies decided that the circumstances of Jenny's death warranted the commissioning of a DHR.

1.2.3 This Domestic Homicide Review (hereafter 'the review') examines agency responses and support given to Jenny, a resident of Bexley prior to the point of her death by suicide at her home in August 2020.

1.2.4 The review will consider agencies contact/involvement with Jenny and Adam from September 2010, a year prior to the first known significant incident, until the date of Jenny's death.

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

1.2.6 The key purpose for undertaking DHRs is to enable lessons to be learned from a death by suicide where it is known or believed that they previously experienced domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.2.7 This review process does not take the place of the criminal or coroner's courts nor does it take the form of a disciplinary process.

1.3 Timescales

1.3.1 This review was commissioned by the Bexley Community Safety Partnership. Having received notification from the Clinical Commissioning Group (CCG) on the 7th September 2020, a decision was made to conduct a review in consultation with Bexley Community Safety Partnership on 8th October 2020. Subsequently, the Home Office was notified of the decision in writing on 20th October 2020.

1.3.2 Standing Together Against Domestic Abuse (hereafter 'Standing Together') was commissioned to provide an Independent Chair (hereafter 'the Chair') for this review in November 2020. The completed report was handed to the Bexley Community Safety Partnership (CSP) on 13th May 2022. In May 2022, it was tabled at a meeting of by the Bexley Community Safety Partnership and signed off, before being submitted to the Home Office Quality Assurance Panel in May 2022. The completed report was considered by the Home Office Quality Assurance Panel. In December 2022 the Bexley Community Safety Partnership received a letter from the Home Office Quality Assurance Panel detailing the report for publication. The letter will be published alongside the completed report.

1.3.3 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. Following the Home Office notification in October 2020, Standing Together were commissioned by the Bexley CSP to conduct the review in November 2020. Summaries of engagement were collected from agencies with the initial panel meeting on 16th February 2021. At the initial panel it was agreed given the pandemic, of which we were in the third lockdown at the time, there was a significant burden on agencies, and they would require additional time to complete the necessary research and IMRs. As such the second panel took place in June 2021. A similar challenge was noted at this meeting as health organisations remained under capacity due to the roll out of the national vaccine roll out and required additional time to review draft reports. As such the final panel meeting took place at the end of September 2021.

1.4 Confidentiality

1.4.1 The findings of this review will remain confidential. The panel recommendation will be to only publish the Executive Summary of the Overview Report once it has been approved for publication by the Home Office Quality Assurance Panel. In the interim information has been available only to participating officers/professionals and their line managers.

1.4.2 The decision to not publish the full Overview Report is due to the nature of the case and as the perpetrator of the domestic abuse was not the perpetrator of a homicide. As the victim of domestic abuse died by suicide it is possible that the information provided within this report may not be appropriate for the perpetrator of the domestic abuse to see in full. The perpetrator of the domestic abuse was clear that he did not want to engage in the review process and the panel believe further contact, or indeed publishing the Overview Report, could cause unintended harm or consequence to the child of Jenny. We also feel as a panel there is a need to protect both family members and their privacy.

1.4.3 This review has been anonymised in accordance with the 2016 statutory guidance. The specific date of death and the sex of the child removed (with anonymity further enhanced by the child being referred to as Child A). Only the independent Chair and Review Panel members are named.

1.4.4 The following pseudonyms have been used in this review to protect the identities of Jenny, her partner, child and those of their family members:

Name	**Relationship to victim** (of domestic abuse, the death was suicide she was not the victim of homicide)
Jenny	Victim
Adam	Husband
Child A	Biological child

1.4.5 Due to Jenny's family choosing not to engage as of the point of writing, these pseudonyms were chosen by the Chair in consultation with the panel and deemed to be culturally appropriate. Agencies have checked that these names were not meaningful within the family as known, although due to the limited agency contact this was decided with the information known only, and neither the police or children's services had any engagement with wider family members.

1.5 Equality and Diversity

1.5.1 The Chair and the Review Panel have considered the protected characteristics under the Equality Act 2010 of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation during the review process.

1.5.2 Throughout the review, the Review Panel considered the following protected characteristics:

- ***Sex*****:** Jenny was female and Adam was male. Analysis of domestic homicide reviews reveals gendered victimisation across both intimate partner and familial homicides with females representing the majority of victims and males representing the majority of perpetrators.[3] This characteristic is therefore relevant for this case, the deceased was female and perpetrator of previous abuse is male. In considering the links between domestic abuse of suicide in women, it is estimated that more women take their own life as a result of domestic abuse than those that are killed by their intimate partner. Studies have shown that almost 30 women attempt suicide every day as a result of experiencing domestic abuse. It is also estimated that that every week three women take their own lives.[4]
- ***Ethnicity*****:** Jenny identified as White British and there is no evidence to suggest this impacted her experience of domestic abuse or access to services. Adam was also White British.
- ***Age:*** Jenny was 49 at the time of her death, she was due to turn 50 soon. There is no evidence to suggest that this was significant, but it is a milestone birthday and so we cannot know what that might have meant for Jenny. The Crime Survey for England and Wales (CSEW) year ending March 2020 found a rate of 7.7 per 10,000 of the population for domestic abuse experienced between the ages of

[3] "In 2014/15 there were 50 male and 107 female domestic homicide victims (which includes intimate partner homicides and familial homicides) aged 16 and over". Home Office, "*Key Findings From Analysis of Domestic Homicide Reviews*" (December 2016), p.3. and Analysis of the London DHR sample (n=84) reveals gendered victimisation across both types of homicide with women representing 83 per cent (n=70) of victims (including one trans-female) and men ninety per cent of perpetrators (n=76)". Montique ,B. "*Domestic Homicide Review (DHR) Case Analysis and Review of Local Authorities DHR Process*" (November, 2020).

[4] SafeLives, How widespread is domestic abuse and what is the impact? https://safelives.org.uk/policy-evidence/about-domestic-abuse/how-widespread-domestic-abuse-and-what-impact (accessed 16 February 2021)

45-54. Adam was around a year younger so there was not a significant age gap between the two.

- ***Disability:*** Neither Jenny nor Adam had a disability.
- ***Gender Reassignment:*** Both Jenny and Adam were the same gender as assigned at birth.
- ***Pregnancy and maternity:*** During the review period Jenny was pregnant between October 2014 to June 2015. Around 30% of domestic abuse begins during pregnancy, while 40–60% of women experiencing domestic abuse are abused during pregnancy.[5]
- ***Marriage and Civil Partnership:*** Jenny and Adam were married. For the year ending March 2020, the Crime Survey for England and Wales showed that adults aged 16 to 74 years who were separated or divorced were more likely to have experienced domestic abuse than those who were married or civil partnered, cohabiting, single or widowed. Being married in Jenny's case may have limited her options in terms of leaving Adam, which could have intersected with her role within the home as she had no independent form of income aside from Adam's salary.
- ***Religion or Belief*:** There is no reliable information regarding Jenny or Adam's religion or belief.
- ***Sexual Orientation:*** Both Jenny and Adam identified as Heterosexual/Straight.

1.5.3 The following considerations have also been identified as pertinent to the lived experiences of Jenny:

- **Mental health:** Jenny died by suicide in August 2020. Prior to this she had attempted suicide nine years prior, in 2011. SafeLives spotlight[6] on mental health and domestic abuse found that people with mental health needs were more likely than victims of domestic abuse without mental health to experience a higher number of forms of domestic abuse including; physical abuse, harassment and stalking, jealous and controlling behaviour and sexual abuse. Contributing to Jenny's mental ill-health was the death of her mother in 2016, which on some occasions she had expressed to professionals was the cause of her depression. The same research found that a higher proportion of victims experiencing domestic abuse were likely to also experience problematic substance use with 14% reporting problematic alcohol use compared to only 4% of victims without mental health needs.
- **Substance use**: As discussed above, victims with mental health needs are more likely to experience problematic substance use. There were occasions

[5] Friend. J (1998), 'Responding to violence against women: a specialist's role', Editorial, Hospital Medicine, September, Vol 59, No. 9, pp 98-99. https://safelives.org.uk/policy-evidence/cry-health/idvas-maternity-units (accessed 7 April 2021)

[6] https://safelives.org.uk/sites/default/files/resources/Spotlight%207%20-%20Mental%20health%20and%20domestic%20abuse.pdf

throughout agency interactions with Jenny when her alcohol use was referenced. Although she never discussed her alcohol use with professionals as being problematic, or sought support for this from substance use services, it is evident that there were occasions where alcohol was a feature in her life. On the one occasion known to professionals when domestic abuse was reported to the police following Adam physically assaulting Jenny, both Jenny and Adam had consumed alcohol. It is important to acknowledge that alcohol use is never the cause of domestic abuse, it is always the perpetrator's choice to harm. However, research has found that alcohol use increases the occurrence and severity of domestic violence[7] whilst other research shows that men who use alcohol are up to six times more likely to be abusive to their partner[8].

- **Economic Abuse/ Socioeconomic Status:** We have no information about Jenny's work before having a child, but we know from the information agencies did have that she was a stay at home parent. It was likely therefore that she relied on Adam's salary with no independent income that we are aware of. This would have limited her options in terms of access to some services and her ability to leave the relationship. We also know from agencies including Children Services that the family appeared to be, and were described as 'affluent' and this may impact on unconscious bias. National evidence highlights that many victims of domestic abuse make attempts to leave abusive relationships prior to doing so, SafeLives found that 68% of high-risk victims try to leave in the year before getting effective help, on average 2 or 3 times each[9]. Jenny's socioeconomic status may have been a barrier to leaving, or, a reason for returning.

1.5.4 The Review Panel took an intersectional and ecological analysis approach to better understand the lived experiences of both Jenny and Adam and of the domestic abuse within the relationship. This means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand an individual's journey and experience with local services and within their community. As stated by Kimberlé Crenshaw, "If you don't have a lens that's been trained to look at how various forms of discrimination come together, you're unlikely to develop a set of policies that will be as inclusive as they need to be."

- An ecological analysis considers someone's identify and lived experiences at an individual, relational, community, and societal level. It is about how individuals relate to those around them and to their broader environment.

- An intersectional analysis considers the complex ways in which differing aspect of someone's identity and lived experience can combine or intersect in the context of

[7] fs_intimate.pdf (who.int)

[8] Mental disorders and intimate partner violence perpetrated by men towards women: A Swedish population-based longitudinal study (plos.org)

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

structural discrimination to create heightened and persistent forms of inequality, marginalisation, disadvantage and powerlessness.

1.5.5 Taking an ecological and intersectional approach can help identify the factors that create, sustain or exacerbate someone's risks and needs. An ecological and intersectional approach can also identify the barriers someone may have faced in recognising or reporting domestic abuse, their options for safety and protection available, and considers any conscious or unconscious bias or privileging by agencies and or society.

1.6 Terms of Reference

1.6.1 The Terms of Reference are included at **Appendix 1**. This review aims to identify the learning from this case, and for action to be taken in response to that learning with a view to preventing homicide or domestic related deaths and ensuring that individuals and families are better supported.

1.6.2 The Review Panel was comprised of agencies from Bexley, as the family were living in that area at the time of Jenny's death. Agencies were contacted as soon as possible after the review was established to inform them of the review, invite their participation and request them to secure their records.

1.6.3 At the first meeting, the Review Panel shared information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from September 2010 to the date of the death. This timeframe was chosen because the first significant contact noted within the initial scoping with agencies was an overdose Jenny had taken in September 2011. The panel agreed that it would be beneficial for agencies to continue twelve months prior to that in an attempt to establish any events relevant to that, particularly due to the limited contacts and information that was known to agencies during initial scoping. Agencies were asked to summarise any relevant contact they had had with Jenny, Adam, or Child C outside of these dates.

1.6.4 *Key Lines of Inquiry:* The Review Panel considered both the generic issues as set out in the 2016 statutory guidance and identified and considered the following case specific issues:

- Analyse the communication, procedures and discussions, which took place within and between agencies.
- Analyse the co-operation between different agencies involved with Jenny or Adam [and wider family].
- Analyse the opportunity for agencies to identify and assess domestic abuse risk. In particular the role of enquiry.
- Analyse agency responses to any identification of domestic abuse issues. In particular incidents of first time reporting and how this impacts assessment of risk.
- Analyse organisations' access to specialist domestic abuse agencies.

- Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.
- Analyse the intersectionality of Jenny's experience of mental health (depression), bereavement, alcohol use and domestic abuse. In particular how this may have impacted Jenny's ability to be identified by agencies, or seek support in relation to domestic abuse.

1.6.5 To address specific issues in this case (including in relation to equality and diversity as identified in 1.5) the following agencies were invited to be part of the review due to their expertise even though they had not been previously aware of the individuals involved:

- Mind in Bexley
- Solace Women's Aid

1.7 Methodology

1.7.1 Throughout the report the term 'domestic abuse' is used interchangeably with 'domestic violence', and the report uses the Domestic Abuse Act (2021) statutory definition of domestic abuse which achieved Royal Assent on 29th April 2021 and is included here to assist the reader, to understand that domestic abuse is not only physical violence but a wide range of abusive and controlling behaviours. The definition states:

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

- *A and B are each aged 16 or over and are personally connected to each other, and*
- *the behaviour is abusive.*

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

- *physical or sexual abuse;*
- *violent or threatening behaviour;*
- *controlling or coercive behaviour;*
- *economic abuse (see subsection (4));*
- *psychological, emotional or other abuse; and it does not matter whether the behaviour consists of a single incident or a course of conduct.*

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

- *acquire, use or maintain money or other property, or*
- *obtain goods or services.*

For the purposes of this Act A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child).[10]*"*

1.7.2 A total of 19 agencies were contacted to check for involvement with the parties concerned with this review. Of these 8 had contact and were asked to submit Individual Management Reviews (IMRs) and a chronology. A combined narrative chronology was also prepared. We did not ask any agencies for a short report.

1.7.3 *Independence and Quality of IMRs:* All IMRs were written by authors independent of case management or delivery of the service concerned. Most IMRs received were comprehensive and enabled the Review Panel to analyse the contact with Jenny, Adam, and Child C and to produce the learning for this review. Where necessary further questions were sent to agencies and responses were received.

1.7.4 *Documents Reviewed:* In addition to the above information, the Chair reviewed individual organisation's domestic abuse policies and procedures and relevant past DHRs in the area.

1.8 Contributors to the Review

1.8.1 The following agencies were contacted, but recorded no involvement with Jenny, Adam, or Child C:

- Probation (NPS and CRC)
- Solace Women's Aid
- Mind in Bexley
- Pier Road Project (Drug & Alcohol Service)
- Victim Support
- Education Services
- Multi-Agency Risk Assessment Conference (MARAC)

1.8.1 The following agencies and their contributions to this review are:

Agency	Contribution
Metropolitan Police Service	IMR and Chronology
London Ambulance Service	IMR and Chronology
Bexley Children's Services	IMR and Chronology
Oxleas NHS Trust	IMR and Chronology
Lewisham and Greenwich NHS Trust	IMR and Chronology
Gravesham and Dartford NHS Trust	IMR and Chronology
Bromley Healthcare	IMR and Chronology

[10] Domestic Abuse Act 2021: overarching factsheet - GOV.UK (www.gov.uk)

The GP[11] Surgery	IMR and Chronology
The Hurley Group	IMR and Chronology

1.8.2 We are aware that on the day of Jenny's death she visited her dentist for an emergency department. Throughout the review we sought to establish which practice she attended to engage them in the review. As Adam chose not to participate in the review and no other health organisations on the panel were able to check we were unable to establish which dental practice she attended. We wrote to the Coroner to request any information they had on the practice attended but did not receive a response.

1.9 The Review Panel Members

1.9.1 The Review Panel members were:

Name	Job Title	Agency
Danielle Davis	Independent Chair and Author	Standing Together
Althea Cribb	Observer – Mentor Chair	Standing Together
Angela Helleur	Chief Nurse	Queen Elizabeth Hospital (QEH)
Belinda Chideme	Children's Lead	Lewisham & Greenwich Trust
Amy Glover	Area Manager	Solace Women's Aid
Clare Hunter	Designated Safeguarding Lead for Children	Bexley Clinical Commissioning Group (CCG)
Dawn Mountier	Safeguarding Officer	London Ambulance Service
Deborah Simpson	Domestic Abuse and Sexual Violence Manager	London Borough of Bexley Community Safety Partnership
Emma Thompson	Manager	NHS - Urgent Care Centre
Lauren Ovenden	Deputy Director	Bexley Education
Lorraine Latteman	Named Nurse - 0-19 Services	Bromley Healthcare
Malcolm Bainsfair	Head of Safeguarding Adult	London Borough of Bexley
Natalie Beltramo	Adult Safeguarding Advisor	Queen Elizabeth Hospital (QEH)
Nicki Shaw	Head of Service	Bexley Children Social Services

[11] Specific GP surgery has been anonymised throughout the report and will be referred to as 'the GP surgery'

Philippa Uren	Designate Nurse for Adult Safeguarding in SE	Bexley Clinical Commissioning Group (CCG)
Rachel Lanlokun	Named Nurse Safeguarding Children,	Oxleas NHS Trust
Russell Pearson	Specialist Crime Review Group	Metropolitan Police Service (MPS)
Samantha Swift	Detective Inspector - Public Protection SE BCU	Metropolitan Police Service (MPS)
Samina Shah	Safeguarding Lead GP	GP Surgery
Sarah Burchell	Service Director Bexley Care	Oxleas NHS Trust
Sarah Connelly	Deputy Medical Director for Unscheduled Care	The Hurley Group - Urgent care centre
Sharon Fernandaz	Director of Operations	The Hurley Group
Sue Govier	Safeguarding Lead	Dartford and Gravesham NHS Trust
Susan Webb	Service Manager	Bexley Children Social Services

1.9.2 *Independence and expertise*: Review Panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case.

1.9.3 The Review Panel met a total of three times, with the first meeting of the Review Panel on the 16th February 2021. There were subsequent meetings on 16th June 2021 and 30th September 2021.

1.9.4 The Chair wishes to thank everyone who contributed their time, patience and cooperation to this review.

1.10 Involvement of the Jenny's Family, Friends, Work Colleagues, Neighbours and Wider Community

1.10.1 The Review Panel sought to involve Jenny's family, friends, work colleagues, neighbours and the wider community. However, the only contact the review panel had access to was Jenny's husband, Adam, who did not want to be involved in the review process in any way. We sought to identify wider friends or family such as through the coroner's office but were unsuccessful. As Jenny was a stay at home parent, she did not have a place of work to be contacted and we had no details of wider networks.

1.10.2 Once the decision to conduct the DHR had been confirmed in October 2020, Bexley CSP notified Adam, Jenny's partner, of this decision in November 2020: a letter was sent, along with the Home Office leaflet, and information on Advocacy After Fatal

Domestic Abuse (AAFDA)[12]. A call was also made to Adam by the CSP to explain the process in end November 2020. During the call, the process of learning lessons from Jenny's death was discussed, which prompted Adam to state that 'he could answer that already' and that it was due to Jenny's mother dying in a car accident four years prior, and that although she had anti-depressant medication, she did not take it. He suggested that the dentist medication may have been a factor as well. He stated that she had not reached out to anyone for support. He stated that 'even her best friend said how selfish it was to commit suicide when you had a child'. Following this, the Chair also wrote to Adam about the process, including additional information on the DHR process.

1.10.3 As no response was received to these letters the Chair sent a text message to him in May 2021 to confirm receipt of the letters and offer the opportunity to meet to discuss the review. Adam declined this offer and confirmed he did not want to be involved in the review, but did state to the Chair that he agreed with the coroner's verdict that the death 'was in no way premeditated and just done in a moment of madness after drinking whilst upset'.

1.10.4 Given the panel's main contact was through Jenny's husband, who had previously been the perpetrator of domestic abuse, the panel would have had to go through him to access her wider networks which did not seem appropriate. Additionally, as Adam himself had been clear in his wishes to not be involved in the review it would also not have been appropriate to continue contact in mapping Jenny's friend and family networks through him. Checks were also completed with AAFDA who confirmed that they were not supporting anyone else who self referred in relation to her death.

1.10.5 The panel discussed re-engaging with Adam at the draft report stage to ensure he was able to contribute, however as he was the perpetrator of domestic abuse within the relationship, it was decided that the engagement as a family member would require additional sensitivity, and given his previous decline, the report was not sent to him. As the child remains under 5 it was also decided that contact with them would not have been appropriate.

1.11 Involvement of her partner and their Family, Friends, Work Colleagues, Neighbours and Wider Community

Partner

1.11.1 This was a death by suicide and there was no perpetrator in relation to the death. However, Adam was the perpetrator of domestic abuse within the relationship and was contacted as per section 1.10.2 in relation to his involvement.

1.12 Parallel Reviews

[12] AAFDA provide emotional, practical and specialist peer support to those left behind after domestic homicide. For or more information, go to: https://aafda.org.uk.

1.12.1 There was no criminal trial or other parallel reviews such as safeguarding reviews in relation to Jenny's death by suicide.

1.12.2 *The Coroner's Inquest*: The death of Jenny was referred to the HM Coroner, and an inquest was opened and adjourned at South London Coroner's Court in September 2020 with the inquest hearing taking place in January 2021.

1.12.3 *Children:* There are no parallel reviews in relation to Child A. At the first Review Panel meeting, it was noted that the ongoing care of Child A was with her father, Adam.

1.13 Chair of the Review and Author of Overview Report

1.13.1 The Chair and author of this DHR is Danielle Davis, an Associate of Standing Together Against Domestic Abuse (Standing Together). Danielle has received Domestic Homicide Review Chair's training from Standing Together. This is the first DHR that Danielle has Chaired, and therefore she has received mentor support via Standing Together from Althea Cribb, an experienced DHR Chair having authored over 20 reviews. Danielle has over ten years' experience working in the domestic abuse sector including through frontline and strategic roles. She has previously worked as the Head of the Knowledge Hub at SafeLives, a national domestic abuse charity which included managing programmes such as the Home Office funded One Front Door pilot, the MARAC quality assurance programme and the Leading Lights service accreditation programme. Danielle has also worked extensively within Local Government in strategy, policy and commissioning in the field of domestic abuse.

1.13.2 Standing Together is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response (CCR).[13] The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides. Standing Together has been involved in the Domestic Homicide Review process from its inception, chairing over 90 reviews across England and Wales from 2013 until present day.

1.13.3 *Independence:* Danielle has no connection with the Bexley area, Bexley Community Safety Partnership, or any of the agencies involved in this case.

1.14 Dissemination

1.14.1 Once finalised by the Review Panel, the Executive Summary and Overview Report will be presented to the Bexley CSP Board for approval and thereafter will be sent to the Home Office for quality assurance.

[13] For more information, go to: https://www.standingtogether.org.uk/ccr-network.

1.14.2 Once agreed by the Home Office, the Executive Summary and Overview Report will be shared with local partners, and the Executive Summary published. There will be a range of dissemination events to share learning.

1.14.3 The Executive Summary will also be shared with the Police and Crime Commissioner and the Mayor's Office for Policing and Crime (MOPAC).

1.14.4 The recommendations will be owned by the Bexley CSP, with the Domestic Abuse and Sexual Violence Manager being responsible for monitoring the recommendations and reporting on progress.

1.15 Previous Case Review Learning Locally

1.15.1 This is the eighth DHR commissioned locally.[14]

1.15.2 The Review Panel considered the learning and recommendations from other reviews in the analysis and the development of recommendations for this DHR. These have identified the following learning and/or recommendations as relevant to this DHR:

- **Domestic abuse enquiry within health**: in another suicide DHR in 2019 the victim of domestic abuse had accessed a number of healthcare settings including mental health services. That review found no evidence that she had been asked about domestic abuse. There are similarities in this case, although there were some occasions where routine enquiry did happen, there were more opportunities where enquiry could have taken place.

1.15.3 These issues are discussed in the analysis.

[14] To access published DHRs, go to: https://www.bexley.gov.uk/services/community-safety-and-environment/bexley-community-safety-partnership/about-bcsp.

2. Background Information (The Facts)

The Principal People Referred to in this report						
Referred to in report as	**Relationship to the victim**	**Age at time of victim's death**	**Ethnic Origin**	**Faith**	**Nationality & Immigration Status**	**Disability**
Jenny	Victim	49	White British	Not disclosed	British	Not disclosed
Adam	Husband	49	White British	Not disclosed	British	Not disclosed
Child A	Biological child	Under 5	White British	Not disclosed	British	None identified

2.1 The Death

2.1.1 Jenny lived in the London Borough of Bexley until her death when she was found dead by her husband, Adam, in August 2020. The day before her death the couple had argued which resulted in him leaving the home with their child to stay in a hotel for the night. During this time Jenny had sent text messages to her husband including one message which stated, *"I have loved and lived. I've done a shit job at loads of stuff although always wanted to be perfect. I have missed out on so much. I have made people more important than myself and slowed my own progress. I am so unhappy and I don't want to live like this. I just always wanted to find my legs. I always thought that's when I married my husband but he lied and defrauded me and my family*". He stated that she later called him and said she intended to kill herself, specifying she would do so with a scarf that he had bought her. Adam did not take Jenny seriously as he stated to the police after her death that this is something she had threatened to do on previous occasions. The next day Adam came home and found Jenny hanged by the scarf to the kitchen door. There were several photographs of her child set out on the floor in front of her.

2.1.2 A police investigation at the time of death was conducted by Police who concluded that the death, whilst unexpected, had no suspicion of third-party involvement.

2.2 Background Information

2.2.1 At the start of the review period in 2010 Jenny and Adam were married and living in Bexley, Jenny would have been 40 and Adam 39 and they had no children. We know from the GP that prior to the review period, between 2008 to 2013, Jenny had attended a number of private clinics for IVF and fertility treatment.

2.2.2 Before Jenny and Adam were married, Adam had been previously married and had two children. We have limited information regarding this but do know during the review period that his children from this marriage were of university age and Adam had very little contact with them, although at some points was sending money to them.

2.2.3 At the time of the death Jenny was a stay at home parent, but there is no information regarding her career prior to this. Adam worked in London as an investment banker.

2.2.4 The first contact in the review period was through London Ambulance Service in 2011 when Jenny had taken an overdose and had to go to Accident and Emergency. She stated this was down to 'family issues' but there was limited enquiry as to what this meant and with whom. She was referred to the Adult Mental Health service at the time which was delivered by Oxleas but declined any additional support.

2.2.5 In 2013 Jenny attended her GP and subsequently Lewisham and Greenwich Hospital for a wrist fracture which she described as having done when she fell over.

2.2.6 A year later in 2014 she attended the GP again to register her pregnancy. In 2015 Jenny gave birth to her first child at age 45. Over the next few years she had contact with Oxleas Health Visiting Service (which later changed to Bromley Healthcare Health Visiting Service due to a commissioning change) and her GP in relation to antenatal care.

2.2.7 We know from various accounts that at some point in 2016 Jenny's mother was killed in a 'hit and run' incident which when speaking to agencies Jenny referred to having to attend a court case for.

2.2.8 In early 2018 Jenny attended her GP as she felt depressed, she was prescribed medication and over the next few years and attended a number of reviews with the GP regarding her depression and medication.

2.2.9 Later in 2018 the first and only reported domestic abuse incident occurred, and thus the only recorded and known incident agencies knew about. Jenny had called the police from a bathroom where she had fled a physical assault by Adam. Police attended and Adam was arrested but later released with No Further Action (NFA) being taken. A Merlin[15] notification was sent to Children's Services regarding the incident and a Child and Family Assessment undertaken which closed in June 2019, again with no further action required.

2.2.10 In 2019 Jenny attended the urgent care centre run by The Hurley Group on two separate occasions for fractures. The first was in March which was a fracture to her wrist, the second was in May and was for a fracture to her foot. On both occasions she was referred to a

[15] The MERLIN/PAC is the MPS electronic system for notifying the local authority Children's Service about a child or young person who has come to notice and replaced the paper 'Form 78' which prior to this was faxed to Children's Services on a daily basis. This system is also used for missing person reports (MERLIN/MIS) and to notify vulnerable adults who come to notice (MERLIN/ACN)

fracture clinic. At the end of 2019 she attended Accident and Emergency and was later admitted to a ward relating to a lung abscess and infection which she was treated for and returned home the next day.

2.2.11 In August 2020, Jenny was found dead in her home by Adam.

3. Chronology

3.1 Time Period Under Review

3.1.1 The period reviewed was from September 2010, a year before the first known significant incident, up until the date of her death. The below section provides a year by year chronology of events which gives an overview of what was known to whom over the eleven year review period.

2011

3.1.2 At around 9pm on the 14th September an ambulance was called as Jenny had reported to have taken an overdose of Valium. She was assessed by the London Ambulance Service (LAS) staff and taken to the Accident and Emergency department at Queen Elizabeth Hospital. The ambulance staff documented that Jenny had taken an overdose due to 'having various domestic issues'.

3.1.3 In the early hours of the next morning (around 3am on the 15th) Oxleas confirmed with Jenny that she had taken a significant amount of medication commonly used for sleep problems, anxiety and depression[16] with half a bottle of red wine. In terms of the medication she took, she told staff she had purchased them online on the 'black market' rather than them having been prescribed. There was an attempt to complete a mental health assessment, but Jenny was reported to have 'refused'. Jenny had however continued to discuss that her overdose was related to 'family issues' although was also reported to not want to discuss the circumstances leading to her overdose, answering a number of questions as 'no comment'. As such, no mental health or psychiatrist assessment was completed, however, the Liaison Team did complete a referral to the community mental health team that day. Jenny was reported to have left with her husband, Adam.

3.1.4 On the 15th and 16th September Oxleas Adult Mental Health team attempted to telephone Jenny but did not get a response. On the 20th September Jenny called them back and stated she did not require any ongoing support. She reiterated that the circumstances leading to her overdose was feeling upset following ongoing 'family problems with her partner's family' and that she had no intent of killing herself.

2013

3.1.5 On the 13th November Jenny attended her GP Surgery. She had pain to her left wrist following a fall five days prior. The surgery referred her for an x-ray which confirmed she had a fracture.

[16] Diazepam and Zopiclone.

3.1.6 Following the confirmation of the fracture Jenny attended Lewisham and Greenwich Emergency Department at around 9am on the 14th November. She was given a slab and referred to the fracture clinic for a follow up in two weeks time.

3.1.7 On the 27th November Jenny attended the fracture clinic at Lewisham and Greenwich Hospital where she received an x-ray to review her wrist injury. She was referred to physio-therapy and a follow up was arranged for six weeks time.

2014

3.1.8 Jenny was due to attend her fracture follow up appointment at Lewisham and Greenwich Hospital on 29th January but did not attend. There is no evidence that this was followed up.

3.1.9 Jenny attended The GP Surgery on 9th October 2014 to book antenatal care for her pregnancy. She was referred to Darent Valley Hospital which is part of Dartford and Gravesham NHS Trust.

3.1.10 Oxleas Health Visiting Service received the antenatal notification on the 21st November.

3.1.11 The pregnancy booking form received by the midwife from the GP recorded 'overdose of drug' on 14/09/2011. However, it gave no further details regarding the type of drug or how much was taken, whether it was significant, intentional or unintentional or if it was a suicide attempt.

3.1.12 At the appointment full medical and obstetric history was taken. Jenny confirmed this was an unplanned, first pregnancy but stated that she was very happy to be pregnant. Although information prior to the review period from the GP suggested Jenny had been attending private clinics for fertility treatment between 2008-2013. Additionally subsequent midwifery booking documentation states this to be a planned pregnancy but one that occurred after stopping hormone replacement therapy given for presumed menopause. This might suggest that the pregnancy was unexpected, rather than unplanned.

2015

3.1.1 Jenny and Adam attended the ward in early June 2015 for a planned induction of labour due to maternal age. Poor progress of labour resulted in the delivery of a full term infant, born in good condition, by emergency Caesarean Section. Both Jenny and Child A were discharged after 'an uneventful immediate post-natal period' when care was transferred and appropriate documents sent to the Community Midwifery Team. Jenny was given all relevant post-natal care information. There was no information recorded regarding Adam other than the fact he attended.

3.1.2 The community midwife visited Jenny the next day and noted that there were no concerns with both Jenny and Child A. It was not noted whether Adam was present or that domestic abuse was discussed.

3.1.3 On 18th June Oxleas Health Visiting Service attended Jenny's home to complete the New Birth Visit. At this appointment the Family Health Needs Assessment was also completed. During the assessment Jenny reported that there were no concerns about her health including no history of depression. Adam was not at the appointment but Jenny reported that he was supportive of her and she has support locally from her extended family. She was given details of the local children's centre and the health visitor planned to see her at the Well Child Health Clinic for a follow up.

3.1.4 The midwife visited Jenny at home again on 19th June. Jenny was generally well but advised to rest more and reduce activity. There was no information recorded regarding Adam other than the fact he was in attendance.

3.1.5 A final visit on 22nd June by a midwifery support worker was undertaken and found good progress with Jenny and Child A so they were discharged from the Community Midwifery Service.

3.1.6 Jenny and Child A were seen by the health visitor at the Well Child Health Clinic on 2nd July. A couple of weeks later Jenny was seen by her GP at The GP Surgery for her six week postnatal check up, where no concerns were noted. There is no evidence that Jenny was asked about domestic abuse.

3.1.7 During August to November there was some communication with Jenny and Adam regarding routine vaccinations for Child A.

2016

3.1.8 On 18th February Jenny attended the Child Health Clinic for advice on weaning. She attended again on 28th April.

3.1.9 In June 2016 the one year developmental letter was sent to Jenny from Oxleas Health Visiting Service with the Age and Stages Questionnaire[17]. Jenny returned the questionnaire which was received on the 6th July and indicated Child A was developing age appropriately.

3.1.10 On 17th July the Metropolitan Police Service (MPS) were called to Jenny and Adam's address following three men assaulting them. The report to the police stated that at around 1am the doorbell rang. Both Jenny and Adam went downstairs to open the door where they were confronted by three people with one male shouting at them. They proceeded to punch Adam several times, and Jenny when she attempted to intervene before they all left in a vehicle. The conclusion was that the individuals had attended the wrong address. There

[17] Ages & Stages Questionnaires® (ASQ®) provides reliable, accurate developmental and social-emotional screening for children between birth and age 6.

was no further action. Both Jenny and Adam were offered support through Victim Support in relation to this incident but were recorded as having 'declined'.

3.1.11 On the 12th October the Metropolitan Police Service (MPS) were called to a function in East London by the venue's security as Jenny was reportedly intoxicated and being abusive. The security staff noted that Jenny had left the venue with an unknown male and the pair had been arguing. During the argument Jenny fell over and had bumped her head. When the police arrived the male described himself as her husband, but shortly left in a taxi. The MPS called the London Ambulance Service (LAS) to check Jenny as she had bumped her head and vomited. The LAS took Jenny to the Royal London Hospital (RLH) accompanied by MPS. An adult safeguarding Merlin was created however following consultation with Adult Social Care, was not shared as there were no safeguarding needs identified.

3.1.12 On 24th December the Metropolitan Police Service (MPS) attended the address from a central station following an alert of an intruder alarm. They were told it was set off in error but the records did not state whether it was Jenny or Adam spoken to.

3.1.13 On 14th July Jenny called the Metropolitan Police Service (MPS) to report that her neighbours were smoking drugs in their back garden which was getting into her house and she was concerned about her child. The police did not attend but did refer the incident to the Safer Neighbourhood Team (SNT) to follow up.

3.1.14 Before SNT had followed up, two days later on the 16th July, Adam called the Metropolitan Police Service (MPS) with the same concerns Jenny raised regarding their neighbours drug use. The MPS spoke to the neighbours about the issue.

3.1.15 In August 2017 Jenny as referred to Darent Valley Hospital surgical service, by the GP, for a possible abdominal hernia via the Choose and Book Service. In December she was seen in the Out-patient Department by a general surgeon for assessment of the presence of a hernia. An abdominal examination was normal, she was noted to be fit and well with a well healed Caesarean scar. She was discharged from the service back into the care of the GP and a discharge letter sent.

3.1.16 On 7th September Jenny attended the Child Health Clinic with Bromley Healthcare Health Visiting Service[18] for Child A's two year review. The Family Health Needs Assessment was completed and documented no changes and no concerns were raised during the assessment. Child A was accepted on to the caseload for universal services.

[18] The Health Visiting Service was transferred from Oxleas to Bromley Healthcare on 1st June 2016 so Child A's care was passed to the new service provider.

3.1.17 On 27th February Jenny attended The GP Surgery where she discussed feeling depressed. She was prescribed Sertraline, an antidepressant. She was offered a referral to counselling but was reported to have declined.

3.1.18 Around one month later on 28th March Jenny returned to The GP Surgery for a follow up appointment regarding her depression. She reported side-effects from the Sertraline and was switched to Citralopram, a different anti-depressant.

3.1.19 On the 15th April, just after midnight, the Metropolitan Police Service (MPS) were called to Jenny and Adam's home address by Jenny who had fled to the bathroom with her phone to call them after Adam had punched her in the face multiple times.

3.1.20 Information from the MPS describe the preceding events as explained by Jenny. She stated that her and Adam had been out at a bar in London and Adam had left her there and was not answering his phone. This meant Jenny had to make her own way home in a taxi. When she arrived home Adam and the babysitter were there, who left upon Jenny's arrival. An argument ensued which resulted in Adam shouting at Jenny and punching her in the face causing her to fall over. She managed to break free and get to the bathroom where she locked herself in to call the police.

3.1.21 Police noted she had a bloody and swollen nose, plus scratches to her arms and back of the neck. Jenny described to police that her mother had died in a car accident 18 months ago and that the case relating to her death had only finished two weeks ago. She also said that Adam's behaviour has 'become very unpredictable recently and they were arguing more and more'. The police record also stated that she had said he was very abusive and that she did not want him back at the address.

3.1.22 The Domestic Abuse, Stalking and Harassment and 'Honour'-based violence Risk Indicator Checklist (DASH RIC) was completed and rated as 'standard' risk. Jenny was offered medical aid which she was described as 'declining' and the National Centre for Domestic Violence (NCDV) card but was recorded to have 'declined' to be referred to support.

3.1.23 Adam was arrested and taken to the Police Station. Police noted he had scratches to his face and split and swollen lips. Adam was interviewed about the incident and described Jenny as 'very volatile and had tried to commit suicide around six years ago' he said that she had attacked him in November 2017 which he had not reported, but that he had temporarily moved out of their address.

3.1.24 Adam's explanation for the assault was that he had wanted to leave the bar and she wanted to stay. As such he left and got a train home, leaving her there. When she arrived home shortly after he said he apologised for leaving her there. Adam stated that she 'attacked him, grabbing and scratching his face and gouging at his eyes'. He stated that he tried pushing her away but eventually punched her 'a couple of times as she wouldn't stop'. He

believed the force he used was proportionate under the circumstances, although he said in hindsight he could have dealt with the situation better.

3.1.25 The police spoke to Jenny later in the morning and she said she did not want Adam to be prosecuted 'as this was a one-off incident following them having drunk too much'.

3.1.26 The Crown Prosecution Service (CPS) were consulted and recommended the matter be No Further Actioned (NFA'd) so Adam was released without charge and returned to the family home.

3.1.27 On the 16th of April Children's Services received the Metropolitan Police Service (MPS) generated Merlin notifying them of the incident and a contact record was opened to allow initial checks.

3.1.28 On the 17th of April Children's Services began their Child and Family Assessment. They telephoned Jenny to discuss the incident. Jenny informed them that the police were not taking any further action. The Children's Services records state that Jenny 'denied the nosebleed' which was noted in the record as potentially minimising the severity of the incident. Jenny reiterated what she had told the police which was that her mother had died in a 'hit and run' incident and that she had been attending court in relation to that. She also noted that they had been coordinating a 'major renovation to the kitchen' which led to the argument. Children's Services records note that Jenny stated her relationship with Adam was good and that it was the first time an argument had led to physical violence.

3.1.29 Children's Services suggested a referral to Bexley Women's Aid which Jenny is noted as 'rejecting'. Adam was also offered a referral to Caring Dads which he declined.

3.1.30 On the 19th April both Adam and Jenny signed and returned a consent form to Children's services allowing them to share information with other agencies in relation to the assessment. The next day Children's Services gathered information from; The GP Surgery and Child A's nursery.

3.1.31 On the 24th April Jenny attended The GP Surgery for a follow up appointment in relation to her depression.

3.1.32 On the 1st May Jenny attended the Drop In Clinic at Erith Health Centre provided by Bromley Healthcare. Child A was weighed which was all in line with age expectations and no concerns were raised.

3.1.33 Children's Services closed the Child and Family Assessment on 13th June deciding that 'No Further Action' was required. They concluded that Adam was 'remorseful' and that Jenny recognised that her child was her priority and would leave Adam if the behaviour continued. Children's Services records report that Adam 'was remorseful of his actions and both parents informed it had been an isolated incident which had taken place after they had been drinking which could have been a contributory factor'.

3.1.34 Within the closure outcome it was noted that 'the capacity for change in this family is possible particularly as parents are able to understand the worries and concerns and impact for children in these circumstances'. Children's Services sent the closure letter to the family, The GP Surgery and Child A's nursery.

2019

3.1.35 On 19th March Jenny attended a clinic run by The Hurley Group with a hand injury which she stated was from falling down the stairs. An x-ray showed a fracture of the 5th metacarpal[19] and she was referred to the fracture clinic at Queen Elizabeth Hospital under Lewisham and Greenwich NHS Trust.

3.1.36 Jenny attended the fracture clinic on 27th March where her injury was reviewed. Jenny told the consultant she had a neighbour who had been assisting her to strap her wrist and that she had been performing gentle exercises. Jenny told staff she had fallen down the stairs whilst carrying a shoe box and had put her hand through the banister to save her fall. On examination, the hand was bruised and swollen. She had bony tenderness over the little finger knuckle and base of the little finger. She was noted to have a reduced range of movement to the little finger. She was sent for an x-ray which showed an undisplaced spiral fracture of the little finger metacarpal bone. Jenny did not wish for a cast and therefore the finger was strapped and a wrist splint was applied. She was referred to the fracture clinic at Queen Elizabeth Hospital for follow-up. There is no evidence to suggest that she attended this or that it was followed up.

3.1.37 Jenny attended the urgent care centre again two months later in May 2019 where she booked in with a 'foot and rib injury'. On this occasion Jenny did not wait to be seen by a nurse and left the centre.

3.1.38 The next day Jenny returned to the urgent care centre and booked in with a 'foot problem'. She was assessed by a nurse practitioner who recorded in the notes that she sustained the injury by falling over four days prior. There was no recorded information regarding how Jenny had fallen over or the mechanism of the injury.

3.1.39 She was found to have tenderness to the forefoot on the fifth metatarsal bone[20] which was swollen and bruised. She was sent for an x-ray which showed a spiral fracture of the fifth metatarsal. She was fitted with a walking boot and referred to the Queen Elizabeth Fracture Clinic.

[19] The fifth metacarpal bone (metacarpal bone of the little finger or pinky finger) is the most medial and second-shortest of the metacarpal bones.

[20] The fifth metatarsal is the long bone on the outside of the foot that connects to the little toe.

3.1.40 On the 28th August Jenny attended The GP Surgery as requested by them to review her anti-depressant medication. She remained happy on Citalopram, reporting no side effects and therefore remained prescribed it.

3.1.41 In October 2019 Jenny attended the emergency department at the Queen Elizabeth Hospital where she expressed that she thought she might have sepsis. She had started to feel unwell ten days ago and been to the GP who prescribed her Amoxicillin. She reported symptoms of lethargy, shortness of breath sweating (including night sweats), dry cough, pain in her chest and back and high fevers (41). She also reported feeling confused and auditory hallucinations for the last few days - hearing dogs barking and earlier in A+E was hearing music playing that wasn't there. She further reported she was having headaches, cold peripheries and diarrhoea. Jenny also noted a rash development on her legs but advised she normally get these when she is stressed or reacting to certain medication.

3.1.42 Jenny's patient history was obtained, she advised that she had not travelled but informed that her husband had recently returned from a business trip from Tokyo and Singapore on 12/10/2019 and he had became unwell with similar symptoms including respiratory/flu like symptoms. Their 4-year-old child was also reported to be unwell with a dry cough and a temperature.

3.1.43 Jenny was sent home however in the early hours of that morning around 4am she was called and advised to come back in as her test results showed concerns including shadowing on her chest x-ray. She came back in and after investigations she was diagnosed with lung contusion and pneumonia. During the investigation a body map was completed which recorded there were no noted marks or bruising on her body and all pressure areas were intact. The emergency department record marked 'Safeguarding and Mental Health issues' but noted there were no concerns. It was also recorded that Jenny consumed minimal alcohol.

3.1.44 Jenny was admitted to a ward and returned home the next day.

2020

3.1.45 On 31st January Adam attended The GP Surgery for a routine not related health appointment.

3.1.46 On 2nd July Jenny had a telephone consultation with The GP Surgery as they had requested a review of her anti-depressant medication. Jenny reported to be happy on Citalopram and with the dosage.

3.1.47 On a day in August, the day before Jenny was found to have died, Jenny, Adam and Child A planned to go crabbing in Kent. The information in this part reflects the information Adam had told the police about this day. Adam recounted that Jenny had a toothache and booked an emergency dentist appointment, but insisted Adam take Child A without her. Whilst on their way Adam stated that he received a text message from Jenny which said she was upset they

had gone without her and that she would have come if they had waited. He said he turned around and went home, however Jenny had locked herself in their bedroom and would not come out. Several hours later Child A informed Adam that Jenny was no longer in the house. He did not contact her as he did not want to make the situation worst.

3.1.48 Adam stated that later that day Jenny had returned and continued not to speak to him, returning to the bedroom. At around 4pm after Adam had started a BBQ, Jenny came downstairs and Adam states she was 'verbally aggressive' towards him regarding changing their PayPal account. Adam said she was angry and stated, 'she couldn't do this anymore' and asked him to leave. He stated that this upset Child A and they agreed that he would take their child with him. They booked into a local hotel for the evening.

3.1.49 Just after 6:30pm Adam received a text message from Jenny stating "*I have loved and lived. I've done a shit job at loads of stuff although always wanted to be perfect. I have missed out on so much. I have made people more important than myself and slowed my own progress. I am so unhappy and I don't want to live like this. I just always wanted to find my legs. I always thought that's when I married my husband but he lied and defrauded me and my family*". Shortly after this she called him, and Adam stated that she had told him she had drunk two bottles of wine and 'was going to kill herself with a scarf he had bought her'. He stated that he did not take the threat seriously and that he did not call her back as he 'did not want to make the situation worst'. Child A and Adam stayed in the hotel that evening.

3.1.50 Adam returned home with Child A at around 8am the following day. He found Jenny hanging by the kitchen door with a scarf. At 8.21am the London Ambulance Service recorded 'Recognition of Life Extinct'.

4. Overview

4.1 Summary of Information Known to the Agencies and Professionals Involved

Jenny

4.1.1 Jenny was not known to many agencies, those that she had accessed were primarily health services. There was little known by agencies in relation to Jenny's relationship or domestic abuse, although there were occasions where her family life and relationship was discussed. This section will provide an overview of what was known by each agency in relation to Jenny.

The GP surgery

4.1.2 The GP Surgery is the registered GP surgery for all family members. Jenny had been registered at the surgery since 1987 and registered her child there after their birth in 2015. Since the birth of her child in 2015 she had 32 appointments at the surgery including 8 contacts of note, seven of which were in person and one over the telephone. The remaining appointments were for a range of conditions including minor illnesses and routine health checks.

4.1.3 Five out of the eight contacts of note with the surgery related to Jenny seeking support for depression. She originally attended in February 2018 where she discussed her low mood which had been persistent for about a year which she told the GP she attributed to her mother's death in a car accident and the ongoing court case. Jenny was offered counselling but stated she had a lot of support from her friends and family, which the GP notes as a strong protective factor, and only wanted medication. She was prescribed sertraline. During this attendance the practice IMR highlighted that the GP conducted a thorough assessment of her symptoms which included a review of the situation at home and the support available to her. She was not explicitly asked about domestic abuse.

4.1.4 In March and April 2018, she attended the surgery for reviews of her depression and medication. She discussed in March having side effects from the sertraline and was changed to citalopram. She had two more reviews at the surgery relating to her depression, one in May 2019 and one in July 2020. The latter was over the telephone.

4.1.5 Of the remaining three contacts Jenny had with the surgery one related to a fractured wrist in 2013. Jenny presented with pain to her left wrist which she told the GP was due to a fall five days earlier. An x-ray confirmed she had fractured her wrist.

4.1.6 Jenny attended twice in relation to her pregnancy and related care. In 2014 she registered her pregnancy at the surgery, and attended in July 2015 for her six week post-natal check.

4.1.7 On three further occasions the surgery received health related updates from other agencies. This included information in 2011 from the Queen Elizabeth Hospital regarding Jenny's

overdose and twice in 2019 regarding the fractures she had to her wrist in March (when she attended the Queen Elizabeth Hospital) and her foot in May (when she attended an urgent care centre run by The Hurley Group). From the surgery records there were no follow up discussions with Jenny regarding the overdose or injuries.

Lewisham and Greenwich NHS Trust

4.1.8 Lewisham and Greenwich NHS Trust provides acute services to the people living in Greenwich and Bexley and acute and community services to people mainly living in Lewisham. The trust has two hospital locations; Queen Elizabeth Hospital (QEH) in Woolwich and University Hospital Lewisham (UHL) in Lewisham.

4.1.9 Jenny attended the Erith MIU for an x-ray on the 14th November 2013 following a referral from her GP due to wrist pain, they referred her to the Emergency Department at QEH. Jenny told staff that she had injured her wrist five days prior after falling over at home. At the time it was noted that she was a 'dominant housewife' but there was no record of domestic abuse enquiry or disclosure.

4.1.10 She was seen at the fracture clinic two weeks later on the 27th where she was referred to physiotherapy for a splint and a follow up appointment was arranged for six weeks time. In January, Jenny did not attend the follow up appointment, and there was no follow up to this by the clinic. There were no further records seen for follow up until the next recorded date below, it may be that these records were lost due to the time period and transition to electronic records.

4.1.11 Jenny attended the walk-in centre again six years later in March 2019 where she had a wrist fracture again. She was reviewed by a consultant who said there was no rotational malalignment and so treatment would be conservative. Jenny told the consultant that she had a neighbour who was helping her to strap her wrist. There was no record of domestic abuse enquiry or disclosure.

The Hurley Group

4.1.12 The Hurley Group provides Unscheduled Care Services in Bexley through two Urgent Care Centres based at Erith District Hospital and Queen Mary's Hospital, Sidcup. The GP Out of Hours service also runs out of the Queen Mary's Urgent Care Centre site. During the review period Jenny attended the Erith Urgent Treatment Centre three times.

4.1.13 Jenny's first attendance was in March 2019 where she attended with an injury to her right wrist.

4.1.14 The notes state that Jenny attended the urgent care centre alone. Although there is a specific question on the clinical system Adastra relating to 'adult safeguarding and domestic abuse concerns' before closing down the clinical notes, there were no concerns flagged and there was no record of Jenny being asked about domestic abuse during this contact.

4.1.15 Jenny attended the urgent care centre again two months later in May 2019 where she booked in with a 'foot and rib injury'. On this occasion Jenny did not wait to be seen by a nurse and left the centre.

4.1.16 Jenny attended again the next day but only booked in with a foot injury, not mentioning the rib pain she had mentioned in the booking the day before. As such the rib injury does not appear to have been discussed. There was no flag on the system regarding concerns around adult safeguarding and domestic abuse, but also no record of the question being asked.

Dartford and Gravesham NHS Trust

4.1.17 Darent Valley Hospital (DVH) is an acute NHS hospital run by Dartford & Gravesham NHS Trust.

4.1.18 Jenny's first contact with Dartford and Gravesham NHS Trust was in November 2014 where she was seen for her pregnancy booking by a community midwife at a local Children's Centre. It is the Trust's policy that women are informed, by letter that a period of time during the appointment will be with a midwife, alone. This allows an opportunity for unhindered, confidential discussion. Jenny received written information regarding domestic abuse and support available for victims/survivors, as well as the national domestic abuse helpline number at this time.

4.1.19 Antenatal routine enquiry regarding domestic abuse was undertaken at this appointment. This is something the Trust asks of every woman who books a pregnancy. They discuss children living at a different address, previous involvement by children's services, any adults with learning difficulties, any history of substance or alcohol misuse, any involvement with probation or youth offending services and domestic abuse. This assessment also addresses mental health issues, language and literacy, social issues, additional health needs, smoking, antenatal wellbeing and screening and vaccination. Jenny did not disclose any areas of concern when asked and confirmed that she was in a supportive relationship with her husband and had never felt frightened or been harmed by anyone at home.

4.1.20 There was no evidence within the Trust's documentation to suggest that the information from the GP regarding Jenny's overdose was noted or explored further at this appointment. As Jenny stated there was no history of mental health related concerns for either herself or her husband the midwife would not have generated a Concern & Vulnerability form (a form of communication between midwives and the safeguarding midwife in maternity services) for referral to the Maternity Safeguarding Hub.

4.1.21 This culminated in a maternity health and obstetric risk assessment which highlighted maternal age as the only identified potential risk factor and a review appointment, for this reason, was given at sixteen weeks' gestation. Blood was taken for routine testing.

4.1.22 The outcome of this contact resulted in advice being given regarding the schedule of care, wellbeing in pregnancy, breastfeeding and antenatal classes. A pregnancy care plan, a

schedule of antenatal appointments and information about the maternity unit, including useful telephone contact numbers, was given. No concerns were disclosed by Jenny or identified by staff during the assessment.

4.1.23 Jenny attended ten further antenatal appointments between December 2014 up to the birth in June 2015.

4.1.24 Maternal mental wellbeing was considered at each postnatal contact and an outcome was documented on each occasion as 'good'. This would have been an assessment made through conversation and observation of Jenny as a new mother. The assessment format is a tick box chart which doesn't always lend itself to more probing questions and conversation.

Oxleas NHS Trust

4.1.25 Oxleas NHS Foundation Trust provide a wide range of health and Social Care services in South East London, specialising in community health, mental health and learning disability services. The Children's Health Services in Bexley at the time Jenny was known to Oxleas comprised of the universal services from 0-19 years which included the health visiting, school nursing, the specialist children's services and CAMHS. In May 2017 the Health Visiting Service was transferred to Bromley Healthcare and Jenny and Child A's care was transferred there.

4.1.26 On the 15th September 2011 following Jenny attending the Queen Elizabeth Hospital Emergency Department, she was referred to Oxleas Adult Mental Health service.

4.1.27 Jenny reportedly did not want to have blood taken due to a needle phobia and did not want to discuss her medical history during a discussion with the A&E doctor, insisting that she wanted to leave the department. Jenny did however have an ECG taken and accepted Bexley Urgent Advice line card with number.

4.1.28 Jenny was reported to have left the department with her husband and a further referral was made to the Liaison Intake Team.

4.1.29 The Adult Mental Health Team telephoned Jenny twice to follow up; on the 15th and 16th September. On both occasions Jenny did not answer.

4.1.30 Jenny called the Adult Mental Health team on 20th September to respond to their calls. She expressed she had been upset when taken to the hospital, reporting on-going family problems with her partner's family. She stated that she had drunk a bottle of wine as she was 'so fed up'. She reported feeling okay at the time of call and had no intent of killing herself. She expressed that she did not want any further involvement with the Community Adult Mental Health Team. A letter closing the case was sent to Jenny and her GP.

4.1.31 The Oxleas Health Visiting Service received an antenatal notification on 21st November 2014. The New Birth Visit was completed on 18th June 2015 where the Family Health Needs Assessment was completed.

4.1.32 The Health Visitor described the home environment as spacious and documented that the family seemed happy there. The anecdotal evidence from agencies was that the family presented as affluent. No reported concerns with her health and no history of depression mentioned. Adam is recorded as not being seen at home during the appointment, but Jenny reported he was supportive of her and she also received support from her extended family that lived local. All necessary information was given, and Jenny was advised to access the local children's centre for socialising/networking with other families from the local area.

4.1.33 Between 2nd July 2015 to 13th January 2017 Jenny attended a number of routine appointments at the Child Health Clinic for post natal appointments and health checks.

4.1.34 On 1st June 2017 the Health Visiting Service was demobilised to Bromley Health Care.

London Ambulance Service

4.1.35 The London Ambulance Service (LAS) respond to emergency 999 calls, providing medical care to patients across the capital, 24-hours a day, 365 days a year. Other services they offer includes providing pre-arranged patient transport, finding hospital beds and working with the police and the fire service to deal with large-scale or major incidents in London.

4.1.36 The LAS only had contact with Jenny on two occasions. The first was on 14th September when they were called to her home address where she had reportedly taken an overdose of Valium, Zopiclon and alcohol. The LAS records highlight that she had taken the overdose due to 'various domestic issues'. There is no evidence that LAS staff enquired about this or whether it was related to domestic abuse.

4.1.37 The ambulance staff took Jenny to the Queen Elizabeth Hospital Emergency Department where a handover of care was provided to hospital staff.

4.1.38 LAS have a domestic abuse policy, which at the time of this DHR is was being reviewed. At the time of the initial incident in 2011 there was no domestic abuse policy in place. The first policy was developed in 2018 alongside a training offer.

4.1.39 All LAS clinical staff attend a Safeguarding Adult and Children Level 3 mandatory training day. This training covers the core competencies, knowledge, skills, attitudes and values in relation to domestic abuse as set out in the Intercollegiate Document for both Adult and Children Safeguarding (2018) This training would equip staff with the necessary skills to be able to recognise and understand the impact of domestic abuse and know how to make the appropriate safeguarding referrals. This was not in place in 2011.

4.1.40 The second time the LAS had contact with Jenny was on 20th October 2019 where the Queen Elizabeth Hospital had attempted to make contact with her over the telephone to

inform her that she needed to come back to the hospital following an investigation of her condition which highlighted she had a lung abscess and sepsis.

4.1.41 The ambulance staff reported that Jenny was at home with her husband, and they brought her back to the hospital where a handover of care was provided to the hospital staff.

Bromley Healthcare

4.1.42 Bromley Healthcare (BHC) was established in 2011 as a social enterprise, providing a wide range of community health care services to people of all ages in Bromley and Bexley. It offers services in clinics, community settings, nursing homes and many other places. Bromley Healthcare provides the Universal 0-19 Children's Public Health Service in the London Borough of Bexley. Bromley Healthcare started delivering this service in The London Borough of Bexley on 1/06/2017 (previously delivered by Oxleas NHS Foundation Trust).

4.1.43 Jenny was only seen on two occasions by Bromley Healthcare staff on 07/09/2017 and 01/05/2018 at the Child Health Clinic with Child A for routine heath review and weighing. There had been no previous reports of domestic abuse when the case was transferred to Bromley Healthcare and the Health Visiting service only saw her at the Child Health Clinic.

4.1.44 At the appointment on 7th September 2017 the Family Health Needs Assessment was completed. It would appear the routine enquiry question was not asked which may have been due to the clinic setting and lack of privacy at the time within the Clinic setting. The Health Visiting Service were also unaware of any history of depression or mental health. Their involvement concluded with the family remaining in the universal services.

MET Police

4.1.45 Since 1st January 2014 there were eleven contacts with Jenny and Adam. These included house alarm activations, disputes with neighbours, finding a knife in the street and a trespass into their back garden.

4.1.46 On 12 October 2016 police were called to an address in E1 where a social function had been taking place. On arrival security at the venue were trying to control Jenny who was intoxicated and being abusive. It appears that Jenny had left the venue with a man and they had begun to argue outside. Jenny had fallen over and reportedly banged her head. The man said he was her husband and this was not disputed by Jenny. The London Ambulance Service[21] were called because of Jenny's head injury and she had vomited.

[21] This was not recorded in the LAS IMR

4.1.47 By the time of the arrival of the LAS the man had left in a taxi and Jenny was reported to have asked the LAS to ring Adam, who was at home.

4.1.48 Police accompanied Jenny and the LAS to the Royal London Hospital and when spoken to, Adam said that he had no idea who the man was being under the impression that she had gone out with friends.

4.1.49 On 15 April 2018 the next and only other contact of significance was when police were called to the home by Jenny who alleged that Adam had punched her in the face after they had been out at a club in London and that she had locked herself in the bathroom.

4.1.50 Jenny had not wanted medical assistance at the time and was given a National Centre for Domestic Violence (NCDV) card, but stated that she did not wish to be referred by police.

4.1.51 Jenny told police she had lost her mother in a car accident 18 months ago and the court case had finished only two weeks ago. She said that Adam had been becoming more unpredictable recently and they were arguing more and more. She did not want him to return to the home. There was no evidence that a Domestic Violence Protection Notice/Order[22] was explored by the police.

4.1.52 Later that morning Jenny was seen again, she said that she did not want Adam to be prosecuted as this was a one off incident following them both having had too much to drink. She was asked and responded to the DASH questions and this was risk assessed as Standard.

4.1.53 Police consulted with the Crown Prosecution Service whose advice was to take No Further Action (NFA). A MERLIN was created for the child and shared with the Bexley Multi Agency Safeguarding Hub (MASH).

Children's Services

4.1.54 The first contact Children's Service had with Jenny and the family was on 16th April 2018 following a MERLIN being sent in to the Multi Agency Safeguarding Hub (MASH) following the domestic abuse report the day before.

4.1.55 A telephone call was made to Jenny and one home visit was conducted where both Jenny and Adam were present. Jenny was offered a referral to Bexley Women's Aid for additional support which she was reported to have 'declined'.

[22] A DVPN is an emergency non-molestation and eviction notice which can be issued by the police, when attending to a domestic abuse incident, to a perpetrator. Because the DVPN is a police-issued notice, it is effective from the time of issue, thereby giving the victim the immediate support they require in such a situation. Within 48 hours of the DVPN being served on the perpetrator, an application by police to a magistrates' court for a DVPO must be heard. A DVPO can prevent the perpetrator from returning to a residence and from having contact with the victim for up to 28 days.

4.1.56 Following the home visit and agency checks with the GP and child's nursery, the decision was made to take no further action he rational for this decision was that the family were not known prior to the incident, police were taking NFA as well, the information back from multi-agency checks was positive and that Jenny had called the police and would separate from Adam should it happen again. The latter included the comment that the social worker 'felt that she had minimised the incident'.

4.1.57 This decision was made through the Children's Services procedure with management and supervision with a senior social worker. However the decision was made with limited information and although it was discussed that Child A was not allocated to a Health Visitor, we know that Bromley Healthcare were involved so it is unclear why this was missed or not followed up. It was also noted that Jenny and Adam had requested that they did not want extended family involved in the assessment which could have limited the assessment in understanding the dynamics of their relationship.

Adam

4.1.58 There was very little known to agencies about Adam. He only attended the GP once during the review period for an unrelated reason and all other contact was through the police, mainly, with the exception of the domestic abuse report, for unrelated reasons such as home intrusion alarm responses or when he found a knife in a public place. This section, rather than duplicating contacts that have been discussed in the above section, will add further detail and information about Adam through these contacts.

The GP surgery

4.1.1 The GP surgery was the registered GP surgery for all family members. Adam had been registered at the surgery since 2008.

4.1.2 From the point Adam registered with the surgery he only attended once, in January 2020 for an ear infection. He had no further contact with them until after Jenny's death when the GP spoke to him on 4 occasions to offer support to him and Child A.

MET Police

4.1.3 Aside from the one incident of domestic abuse Adam was only known as a victim when reporting various crimes to the police including home intrusions and a knife that he found in a public place.

Children's services

4.1.4 Following the decision on 16th April 2018 to progress with a Child and Family Assessment a home visit was completed on 19th April where Adam was seen, as well as Jenny and Child A. At the home he was noted to have been seen and spoken to separately.

4.1.5 The Child and Family Assessment concluded on 13th June 2018. Children's Services records report that Adam 'was remorseful of his actions and both parents informed it had

been an isolated incident which had taken place after they had been drinking which could have been a contributory factor'.

4.1.6 Children's Services had offered Adam a referral to Caring Dads[23] which he was reported to have declined.

[23] Caring Dads intervention program has been firmly situated within the realm of gender-based violence. It is not an accredited domestic abuse perpetrator programme, but more a programme to help fathers understand the impact of domestic abuse on their children.

5. Analysis

This section will provide an analysis of what was known to whom and where there may have been areas of good practice, or lessons that could be learned. Within this section we will respond to the key lines of enquiry within the terms of reference which were;

- Analyse the communication, procedures and discussions, which took place within and between agencies.
- Analyse the co-operation between different agencies involved with Jenny or Adam [and wider family].
- Analyse the opportunity for agencies to identify and assess domestic abuse risk. In particular the role of enquiry.
- Analyse agency responses to any identification of domestic abuse issues. In particular incidents of first time reporting and how this impacts assessment of risk.
- Analyse organisations' access to specialist domestic abuse agencies.
- Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.
- Analyse the intersectionality of Jenny's experience of mental health (depression), bereavement, alcohol use and domestic abuse. In particular how this may have impacted Jenny's ability to be identified by agencies, or seek support in relation to domestic abuse.

5.1 Domestic Abuse

5.1.1 Taking into account the government definition above, information gathered by the police as part of the death investigation it is clear that Adam had exerted abusive behaviour towards Jenny, although the extent and severity is not clear as there was only one incident reported to the police and minimal enquiry from other agencies.

5.1.2 Tragically, it will never be possible to know the full extent of Jenny's experiences. However, as a minimum it appears she may experienced the following:

5.1.3 ***Physical abuse:*** Jenny reported a physical assault from Adam which resulted in her being injured. Adam admitted that he had committed the assault and caused the injuries. This was initially an arrest for Actual Bodily Harm[24] (ABH) which was no further actioned, but highlights the level of injury. Aside from the one incident reported it is difficult to establish the frequency or severity of physical abuse Jenny experienced. Both her and Adam noted that it was the only incident of abuse within their relationship, however we know that there can be barriers for victims to disclose. In fact, SafeLives found that on average high-risk victims live with domestic abuse for 2.3 years and medium risk victims for 3 years before getting help which

[24] The offence is committed when a person intentionally or recklessly assaults another, thereby causing Actual Bodily Harm. It must be proved that the assault (which includes "battery") "occasioned" or caused the bodily harm. Bodily harm has its ordinary meaning and includes any hurt calculated to interfere with the health or comfort of the victim: such hurt need not be permanent, but must be more than transient and trifling: (R v Donovan [1934] 2 KB 498).

indicated the length of time it can take for victims to disclose their experiences. It is also notable that Jenny had a young child and there may have been fear around the involvement of statutory agencies in relation to that. Jenny did attend heath settings on three occasions over the review period for fractures. There is no evidence that these were related to domestic abuse, however it is notable that SafeLives research found that 23% of high-risk victims attend A&E as a result of their injuries in the year before getting effective help, many multiple times. In this case Jenny attended urgent care two times in the year before her death. It is also notable that on the second occasion in 2019 she initially presented with a rib and foot injury, the rib injury was never explored with her when she returned the next day. We can therefore conclude that Jenny undoubtably experienced physical abuse on at least one occasion, and although it is possible, she may have experienced it on more occasions, there is no evidence known to agencies to confirm she did.

5.1.4 ***Children and pregnancy:*** We know that prior to the review period until 2013 Jenny had attended private clinics for infertility treatment which indicates she wanted to start a family. At the time she had her child she was considered an older mum with that factory being the only noted 'risk' to the pregnancy on her health records. The birth was via a planned caesarean which indicated there were some complications. We can infer from these points that Jenny may have perceived the likelihood of having another child difficult in those circumstances and may have expected Child A to be her only child. At the time of her conception Jenny had stopped taking medication for suspected menopause, which also may have meant the pregnancy may have been unexpected, albeit agency information confirms she was happy about it. The fact that Jenny had sought support to conceive and likely anticipated that it would be her only child, may have made her particularly protective. We can reflect on how this is may have had an impact of Jenny's ability to seek help due to a fear of statutory involvement, particularly from Children Social Care. Aside from Jenny perhaps feeling protective of Child A, and the potential that domestic abuse might have, in Jenny's mind, risked having her child removed, we also know that pregnancy itself is a risk factor for abuse escalating. Research highlights that domestic abuse can often start in pregnancy, and some indicates that it can increase as the pregnancy develops and postpartum[25]. If Jenny was experiencing ongoing domestic abuse within her marriage it may have escalated around the time of her pregnancy in 2014 and birth in 2015. Indeed, the only reported incident of domestic abuse was in 2018 following the birth of Child A, however there were references to 'family issues' and 'domestic issues' to health agencies before this. It is therefore possible, but to no conclusive extent, that the pregnancy and postpartum period may have had an impact on Jenny's experiences of domestic abuse. We can assume that if she was

[25] https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-016-1122-6

experiencing ongoing domestic abuse that having a young child that she had tried so hard to have, may have impacted her ability to seek help due to fear of her child being removed.

5.1.5 ***Economic abuse:*** We do not know if economic abuse was a factor within the relationship, but we do know finances were mentioned on two occasions. Firstly, in Adam's account of the argument on the day before Jenny's death he described her being angry about him changing their PayPal details. Secondly, in the text message from Jenny on the evening of her death she made reference to Adam 'defrauding' her and her family. As such it is possible that economic abuse was a factor within the relationship.

5.1.6 Police information highlighted that there were some references relating to Jenny and Adam's economic status. As a family unit we can assume that there were no signs of deprivation as the health visitor notes commented on the spacious nature of the home, and Children's Services also conducted home visits. Based on the information we know, the household income would have been from Adam's salary as an investment banker. As Jenny was described as a stay at home parent her access to finances is unknown but would have relied on Adam's income. We can reflect on how this would have impacted Jenny's ability to seek help which can often be dependant on having access to a telephone, internet, transport and other means all of which would depend on her access to money, which was reliant on Adam. This would be particularly problematic if she needed to seek help discreetly. How much access Jenny had to economic resources is not clear, however Adam's account of the argument the day before her death, Jenny was noted to be angry at him for changing the PayPal account. This could be a sign that Adam was limiting Jenny's access to finances, although there is no evidence to suggest that is the case definitively. Another indication that Adam may have had more control over the finances could be inferred through Jenny's text message to Adam the day before her death in which she mentioned him 'defrauding her and her family'. Of course, Adam's account was that this related to him sending money to his children from a previous relationship rather than it being fraud related. Jenny's lack of an independent income would also have impacted her choices in terms of leaving the relationship which we know on at least two occasions (after the domestic abuse incident and the day before her death) she had wanted to do.

5.1.7 ***Mental health, trauma and domestic abuse:*** We know that Jenny had mental health related needs throughout the review period. In 2011 she took an overdose, which based on agency information we cannot determine was unintentional, or whether it was an attempt of suicide. We can however assume based on the information Adam told the police that it was a suicide attempt. He also discussed that she had threatened suicide often, which is why he did not take her threats seriously. We do know conclusively that the episode was linked to her family relationships, although due to a lack of enquiry, exploration or follow up by the agencies that directly saw Jenny or received the information, we do not know the nature of these dynamics.

5.1.8 It is clear that adverse experiences within her intimate and family relationships had caused Jenny enough distress to seek medication to help her sleep which she ordered online on the

'black market', which was also not explored by agencies. The fact that sleep disturbance is prevalent for women who experience domestic abuse and Jenny had indeed stated her distress was due to 'family issues' should have prompted domestic abuse enquiry. In fact, the presence of both sleep disturbance and domestic abuse is a predictor for depression, which Jenny subsequently sought support for.

> ***"Sleep disturbances were prevalent among women experiencing intimate partner violence, with both insomnia and nightmares predicting the presence of depression"***
>
> Pigeon, Wilfred R et al. "Sleep disturbances and their association with mental health among women exposed to intimate partner violence." Journal of women's health (2002) vol. 20,12 (2011): 1923-9. doi:10.1089/jwh.2011.2781

5.1.9 In 2018 Jenny sought help through her GP for depression due to her low mood. Domestic abuse was not explored during her initial appointment or any of her reviews so it is not clear whether it was a contributory factor or not. Based on the information Jenny told her GP, it was a result of bereavement following the sudden death of her mother in a car accident.

5.1.10 In fact, we know that there were two episodes of potential trauma[26] within the review period, both the incident reported to the police when three men assaulted her and Adam, and her mother being killed in a hit and run car accident. If she was experiencing ongoing domestic abuse this would have only compounded her experience of trauma. Jenny was never assessed psychologically, and trauma was not explored. She also did not receive support in relation to these incidents (although she was offered victim related support following the assault at her home) and although the GP did offer her counselling in relation to the bereavement, Jenny did not want it. However, if Jenny was experiencing trauma this will have affected her engagement with services which could explain some of the perceptions professionals had of her. For example, she was described by Oxleas NHS Trust Community Mental Health Team as 'uncooperative' and other agencies such as Children's Services described her as 'refusing' services. These can be common presentations in clients impacted by complex trauma[27]. From Jenny's last text message, she also highlighted some indication of 'foreshortened future'[28] such as a loss of hope *("I have loved and lived"),* limited

[26] Trauma is an emotional response to a terrible event like an accident, rape or natural disaster. Immediately after the event, shock and denial are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea. While these feelings are normal, some people have difficulty moving on with their lives (American Psychological Society)

[27] https://www.ncbi.nlm.nih.gov/books/NBK207191/

[28] Trauma can affect one's beliefs about the future via loss of hope, limited expectations about life, fear that life will end abruptly or early, or anticipation that normal life events won't occur (e.g., access to education, ability to have a significant and committed relationship, good opportunities for work). (Trauma Informed Care, Treatment Improvement Protocol (TIP) Series, No. 57. Substance Abuse and Mental Health Services Administration (US); 2014)

expectations about life ("*I am so unhappy and I don't want to live like this"*) and that normal life events won't occur *("I just always wanted to find my legs"*).

5.1.11 Given the prevalence of domestic abuse amongst women with mental health needs, it is vital that domestic abuse enquiry take place. Research highlights that there is a correlation between mental health and domestic abuse. For example between 30-60% of women with a mental health problem report having experienced domestic violence[29]. In this case Jenny was never asked about domestic abuse by the GP, the Urgent Care Centre, or the Emergency Department when she took an overdose or presented with depression. It is positive now however that the GP practice has an updated policy where patients who overdose will be followed up, and routine enquiry takes place where depression is discussed. SafeLives also found that victims of domestic abuse with mental health needs were more likely than victims who did not have mental health needs to visit their GP or Accident and Emergency (A&E) before they get help for the abuse. We know in Jenny's case she had attended the GP, A&E and urgent care centre's prior to her death. Although no one agency has the full picture, improved enquiry within the settings Jenny was known for mental health related could have helped all agencies understand her experiences more fully.

5.1.12 ***Suicide and domestic abuse:*** A significant number of victims of domestic abuse commit suicide[30]. The issue of suicidal ideation should be a key issue for those responding to and managing domestic abuse, although the only known incident of abuse was through the police in 2018, there were more opportunities to identify suicide risk in relation to Jenny's mental health presentations. Had there have been more enquiry during these presentations around domestic abuse, the risk could have been more readily explored. Studies have shown that almost 30 women attempt suicide every day as a result of experiencing domestic abuse. It is also estimated that that every week three women take their own lives[31]. The DASH risk assessment considers suicide and self-harm for victims. The link between mental ill-health and domestic abuse is also clearly recognised in guidance for healthcare professionals. Routine enquiry into domestic abuse is required in adult mental health services and will form a recommendation from this review.

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[29] Howard, L.M., Trevillion, K., Khalifeh, H., Woodall, A., AgnewDavies, R., & Feder, G. (2009). Domestic violence and severe psychiatric disorders: Prevalence and interventions. Psychological Medicine, 40(6), 881–893.

[30] Of women who have experienced domestic abuse in the last six months, 500 commit suicide every year. Almost 200 of those had attended hospital for domestic abuse on the day they died, (p.32) Department of Health Responding to Domestic Abuse – A Resource for Healthcare professionals
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/597435/DometicAbuseGuidance.pdf

[31] In 2014/15 there were 50 male and 107 female domestic homicide victims (which includes intimate partner homicides and familial homicides) aged 16 and over". Home Office, "Key Findings from Analysis of Domestic Homicide Reviews" (December 2016), p.3.

"Analysis of the whole Standing Together DHR sample (n=32) reveals gendered victimisation across both types of homicide with women representing 85 per cent (n=27) of victims and men ninety-seven per cent of perpetrators (n=31)". Sharp-Jeffs, N and Kelly, L. "Domestic Homicide Review (DHR) Case Analysis Report for Standing Together "(June 2016), p.69.

5.1.13 ***Alcohol use and domestic abuse:*** We do not know the extent to which alcohol features in Jenny's life. We have information about Jenny drinking wine on the night of her overdose in 2011 and it was also a feature on the day of her death. We know that the police assisted Jenny following an incident at a club in which she had been drinking alcohol, and that her and Adam had been drinking alcohol on the day of the domestic abuse police report in 2018. However drinking alcohol alone is not problematic, so the extent to which this had an impact on her life is not known. It is clear that agencies had little information of cause for concern, with some indications that there was not an issue around problematic alcohol use. The GP had no record of Jenny experiencing problematic alcohol use. Her medical notes from 2016 highlight that she stated her alcohol intake was two units per week. Similarly, the midwifery records stated in 2014 that prior to her pregnancy Jenny would consume no more than two units per week. During the Child and Family Assessment in April 2018 the use of alcohol, although described as a contributory factor in the escalation during the police reported incident, was not discussed with Jenny or Adam. Alcohol use by victims of domestic abuse is a complicated issue. At times it can be misinterpreted and used against the victim, yet it could also be seen as victims are likely to turn to alcohol as a means of coping with their experiences of abuse. In a global study of intimate partner violence, the odds were higher worldwide in relationships where one or both partners had problems with alcohol, compared to relationships where neither of them did[32].

Learning Points:

- Calling the police to an incident of domestic abuse shows the level of severity of a victim's experience. However, first time calls in relation to domestic abuse can cause professionals to see the incident through an isolated lens as a 'one off incident' particularly where victims and the perpetrator of the offence affirm that. Professionals need the training and awareness to understand that domestic abuse is rarely a one off incident, and to support victims to feel safer in discussing their experiences.

- Domestic abuse is not always directly disclosed by victims to professionals, however there can be patterns and trends such as mental health needs or unexplained injuries. It is important that all professionals are able to recognise some of the more subtle signs of domestic abuse, and confident in enquiring specifically about domestic abuse where there may be causes for concern or indicators.

- Domestic abuse can happen over a period of years, with no disclosure to agencies. It is vital that patterns can be picked up through information sharing to ensure professionals have the information they need to prompt enquiry.

[32] Alcohol, Drugs and Crime (ncadd.org)

- Economic abuse is now included in the Domestic Abuse Act (2021) statutory definition yet it is often not explored, and was not discussed by agencies throughout Jenny's contact with services.

Recommendation 1:

Multi-agency training across Bexley should be reviewed to ensure it includes i) the dynamics of domestic abuse being a pattern of behaviour and ii) economic abuse and the impact it may have on victims' ability to seek support.

Recommendation 2

Bexley Domestic Abuse Strategic Partnership Board should receive quarterly updates with i) a breakdown of attendance at multi-agency training by agency and ii) breakdown of the number of DA champions trained from each agency in order for improved strategic oversight to ensure that all agencies are trained and have access to a champion.

Recommendation 3:

All GP practices across Bexley should have a domestic abuse trained champion.

Recommendation 4:

All agencies domestic abuse policies should include routine enquiry as standard practice where mental health needs are identified, even where a diagnosis is not present (e.g. sleep disturbance).

Recommendation 5:

The Domestic Abuse Health Sub Group should conduct an audit of routine enquiry practice across all health settings to understand current practice, and make recommendations for improvements.

5.2 Information sharing and health

5.2.1 Jenny had contact with seven health organisations during the review period which apart from her depression were primarily routine contacts. There was some good information sharing between these organisations and Jenny's GP as can be seen in Diagram A with the purple dotted lines. This included the Queen Elizabeth Hospital updating the GP after the overdose in 2011 and The Hurley Group sharing information regarding Jenny's wrist fracture in 2019. However, there were some gaps and opportunities for better information, some of which may have helped create opportunities for follow up.

5.2.2 These are explored under two main themes around sharing information regarding i) the overdose and Jenny's mental health and ii) Jenny's fracture injuries.

Key:

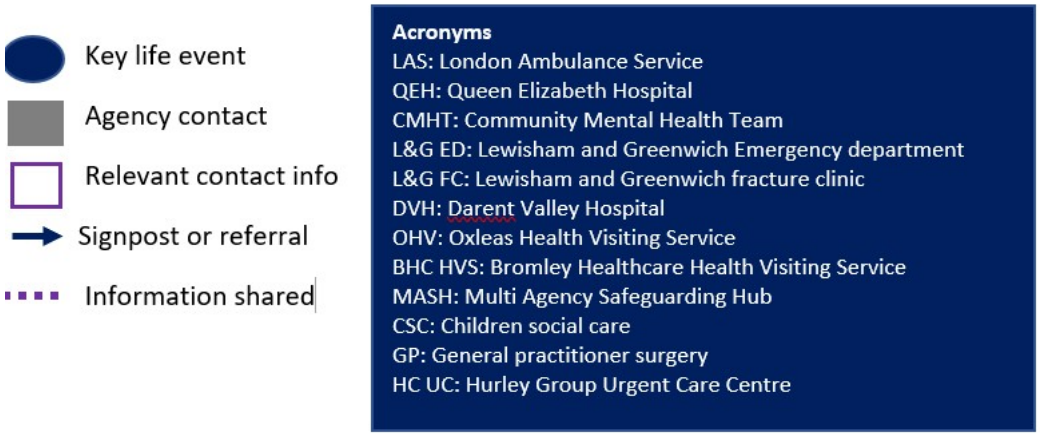
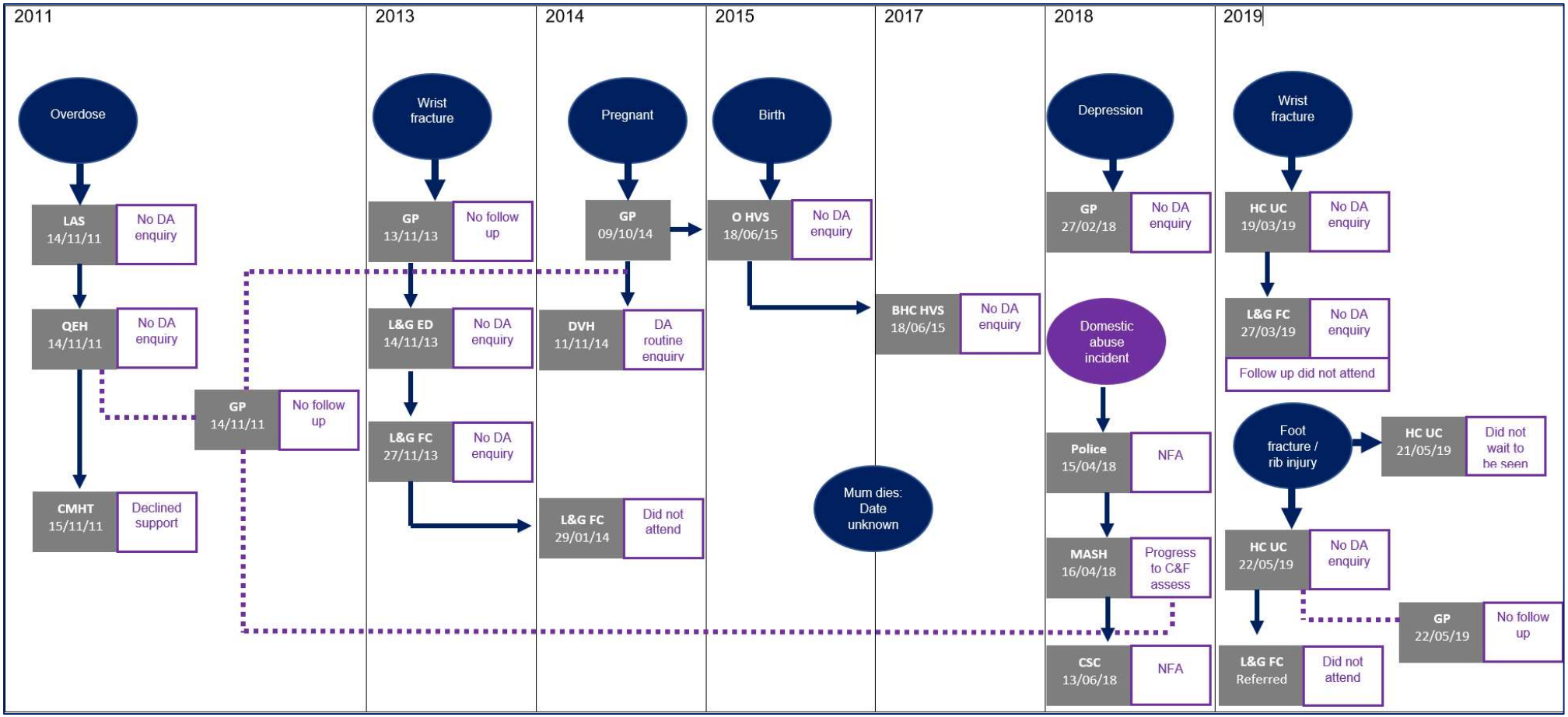


Diagram A: overview of key contacts



i) The Overdose and Jenny's mental health

5.2.3 The Queen Elizabeth Hospital Emergency Department updated The GP Surgery when Jenny had attended due to an overdose including that she had been referred to the Community Adult Mental Health Team (CMHT) provided by Oxleas NHS Trust for follow up support. This is evidence of good practice as it provides the GP with the opportunity to follow up.

5.2.4 Although information regarding the overdose was shared with The GP Surgery, they did not follow up with Jenny either by telephone or at a future appointment. This was standard practice at the time and The GP Surgery had no policy in place to encourage GPs to follow up with patients that had taken an overdose. Positively this has now changed, and it would be standard practice for GPs at The GP Surgery to follow up with any patient where an overdose has been taken.

5.2.5 At the time, when Oxleas NHST Trust CMHT offered support to Jenny, she stated that she did not require it. This was shared by Oxleas NHS Trust with the GP however it was not standard practice at the time to follow up on patients that had taken an overdose, the fact that Jenny did not want support from the CMHT might have caused the GP to ask more questions at another appointment had they have known.

5.2.6 When Jenny attended the Queen Elizabeth Hospital, she told staff there, as well as staff during follow up discussions with Oxleas NHS Trust CMHT, that she did not require support as she had a good support network and knew where to get support.

5.2.7 However, there were signs that Jenny did require additional support as she had discussed not being able to sleep which is why she had purchased the medication she had used in the overdose via the 'black market' online. As discussed in the previous section, sleep disturbance can be an indication of domestic abuse and could have prompted further enquiry.

5.2.8 This could have been an indication that there were ongoing difficulties that were potentially related to Jenny's mental health and there could have been an opportunity to offer support for some of the symptoms that Jenny was experiencing such as the sleeplessness, which may have created positive relationships and engagement with the CMHT and created more opportunities for disclosure in the future.

5.2.9 In 2014 there was another opportunity for improved information sharing regarding Jenny's mental health amongst health organisations. When Jenny attended the GP to register her pregnancy, they completed a referral to Dartford and Gravesham NHS Trust. On the referral the GP had noted that there was a 'overdose of drug' but the information on the referral was limited and did not provide further details regarding this. At the booking appointment with the midwife there was no evidence that this was discussed as part of the assessment, despite mental health being one of the areas of the assessment.

5.2.10 Maternity practice now would triage a previous suicide attempt, if already known or disclosed, as 'red' in the traffic light triage system, in line with Darent Valley Hospital maternity mental

health guidelines. This would then be reviewed at the Maternity Safeguarding Hub by the maternity mental health and safeguarding midwives. Any woman with current or enduring mental health issues would be given an appointment to be assessed by the consultant obstetrician who leads on mental health. An incident that had taken place more than a year before pregnancy booking, however, would be seen potentially as historical information and not necessarily deemed significant.

5.2.11 In April 2018 following the police reported domestic abuse incident, Children's Services conducted a Child and Family Assessment. Part of this assessment included multi-agency checks and the GP was asked to provide information regarding the family. Children's Services records highlight that The GP Surgery had not included the overdose in 2011 so the social worker was not aware.

Narrative / Learning Point:

- Discussions around mental health often focus on the symptoms that are being experienced rather than the cause. Where individuals disclose mental health needs, either indirectly (e.g. sleep disturbance) or directly by seeking support for depression there is limited enquiry from professionals. Domestic abuse was never discussed through Jenny's presentations with mental health needs.
- Where there are mental health related needs and victims do not engage with support services, there is a tendency to see them as uncooperative or unwilling to 'help themselves'. Mental health, including trauma, can be a reason for their inability to engage with services and so understanding their needs as a barrier could enable better opportunities for engagement.

Multi Agency Recommendation 2:

See recommendation 2.

Multi Agency Recommendation 6:

All agencies working with victims and survivors of domestic abuse should work in a trauma informed way. The Bexley Domestic Abuse Strategic Partnership Board should consider an audit of trauma informed practice across services.

ii) Jenny's Fracture injuries

5.2.12 The second theme in terms of information sharing amongst health agencies was around Jenny's fracture injuries, of which there were 3 incidents over the review period.

5.2.13 The GP Surgery was aware of the 2013 fracture as Jenny had presented to them in the first instance and they referred her for an x-ray. They were not made aware of the fracture in March 2019, but were informed by a letter from The Hurley Group about the foot fracture in May 2019.

5.2.14 Had all of these instances been shared with The GP Surgery, it may have prompted professional curiosity with the GP. Particularly as the two incidents in 2019 were relatively close in time, and they would have been aware of the domestic abuse incident in 2018 at that point based on the information sharing request sent by the MASH.

5.2.15 The May 2019 update to the GP from The Hurley Group regarding the fracture did not trigger a follow up from the GP with Jenny, which at the time was in line with standard practice for the surgery as fractures were followed up by the fracture clinic at the hospital. The practice now would be for the GP to follow up where there is note around a fracture if domestic abuse was known. However, this would not have been the case for Jenny as there was no domestic abuse recorded on her notes. This is learning discussed below, as there was an opportunity for it to have been recorded from 2018 when Children's Services requested GP information following the domestic abuse incident. The request for information did not include information relating to the cause for concern, which was the domestic abuse, and the GP did not follow up to enquire further. Had this information have been shared, the GP surgery could have noted domestic abuse on Jenny's record and the fracture in 2019 would have been followed up by the GP as standard practice.

5.2.16 As discussed, in 2019 at the point of the two fractures, there was a known history of domestic abuse following the police reported incident in April 2018. The GP surgery should have known about this from the Children's Service's Child and Family Assessment in 2018 which included multi agency checks with The GP Surgery on 20th April 2018. However, the information request checks sent from Children's Services did not include specific information regarding the trigger incident for their involvement. So, although The GP Surgery would have had a record of the request for information, they would not have known it was related to domestic abuse.

5.2.17 If The GP Surgery had information highlighting the Children's Services referral was in relation to domestic abuse this would have triggered a follow up with Jenny in May 2019 when the surgery was made aware of her fracture from The Hurley Group.

Narrative / Learning Point:

- Health is a vast system made up of numerous organisations that cross geographical boundaries. This makes information sharing difficult and in some cases different Trust's, and the GP are not aware of the full picture which can limit opportunities to follow up, or enquire about domestic abuse. As the GP is often the health agency with the most information, if they were aware of presentations within wider health settings they would be in a better position to understand patterns and possibly enquire about domestic abuse.
- Children's Services information requests as part of the Child and Family Assessment do not always include information on the safeguarding concern which limits agencies ability to record potential issues.

Recommendation 7:

London Ambulance Service and NHS Trust's who may see patients for injuries (such as Emergency Departments or Walk-in Centres) should receive training around domestic abuse identification, assessment and response.

Recommendation 8:

London Ambulance Service and NHS Trust's who may see patients for injuries (such as Emergency Departments or Walk-in Centres) should update the relevant GP surgery where injuries are treated within their setting so that GP's have the full picture

Recommendation 9:

Children's Services information requests from multi-agency partners should include detail relating to the specific safeguarding concern as domestic abuse to ensure all agencies can flag on their respective systems

Recommendation 10:

The Children's Safeguarding Board should conduct an audit on the information sharing requests sent to partner agencies where the concern is due to domestic abuse, to assure that all requests for information contain details about the concern

Recommendation 11:

Children's Social Care should consider including a prompt, on their requests from partner agencies as part of enquiries, about recording the domestic abuse concern on their respective system

5.3 Domestic abuse enquiry

5.3.1 As highlighted in diagram A, there were a number of opportunities where Jenny could have been asked specifically about domestic abuse. In total we identified 12 contacts across 8 organisations where domestic abuse enquiry could have been considered.

Within health settings

5.3.2 In considering this analysis from Healthcare Agencies, reference should be made to the Department of Health – Responding to Domestic Abuse Guidelines, "All health practitioners, whether working in emergency, acute, primary care or community health, have a professional responsibility, if you identify signs of domestic abuse or if things are not adding up, to ask patients alone and in private, whether old or young about their experience of domestic or other abuse, sensitively. Routine enquiry into domestic violence and abuse is Department of Health policy in maternity and adult mental health services". These were in 2011 after the overdose, in 2013 regarding the fracture, in 2015 by the health visiting service at the new birth visit, in 2018 when Jenny presented to the GP with depression, in 2019 regarding the two separate fracture incidents.

Signposting and referral

5.3.3 There were two specific opportunities where Jenny could have been referred to domestic abuse support, namely; the domestic abuse police reported incident and through ongoing contact through Children's Services. Jenny was offered a referral to Bexley Women's Aid through children's services which she did not want at the time, and the police gave her the details of the National Domestic Violence Centre.

5.3.4 The police response to the domestic abuse incident did not record the use of any local specialist agencies. Jenny was offered a referral to the National Centre for Domestic Violence and given one of their cards, but she did not want to be referred. It would have been good practice to see in the record that a local specialist agency had also been offered.

5.3.5 During the Child and Family Assessment home visit on 20th April Jenny was offered support from Bexley Women's Aid, and Adam was offered support through Caring Dads.

5.3.6 The multi-agency checks in April 2018 did not include the Health Visiting Service which could have limited the ability for agencies to follow up with Jenny and ensure that she had ongoing support and opportunity to seek help. This was a case of human error as the social worker had not identified a health visitor, and their supervision with a manager had not followed it up.

Risk assessment

5.3.7 There were two opportunities for a domestic abuse risk assessment within the review period, both relating to the only incident of domestic abuse known to agencies. The two opportunities were through the police and Children's Services.

5.3.8 The police conducted a DASH risk assessment with Jenny the morning of the incident (around 2am) which was recorded as standard. On the evening of the assault Jenny discussed Adam being increasingly 'unpredictable' which there is no evidence was explored further in terms of whether this was a sign of escalation.

5.3.9 The Children and Family Assessment did not appear to include a separate DASH risk assessment with Jenny.

5.3.10 Jenny was seen alone at the home visit on 20th April, however it was in the family home and Adam and her child were still present for the appointment, albeit in a different room.

5.3.11 Considering this was the only face to face contact Children's Services had with Jenny before making the decision to close the case, it would have been good practice to have organised another meeting with Jenny to provide an opportunity to explore domestic abuse in a safer environment. This was not recorded to have been discussed in the supervision and management notes before the case was closed.

5.3.12 As part of the risk assessment conducted in the Child and Family Assessment, multi agency checks formed part of the decision making to close the case. During these checks the social worker noted that there was not a health visitor allocated however there was contact with Bromley Healthcare at that time and had had contact on two occasions including September 2017 before the incident and in May 2018 whilst the assessment was still ongoing.

5.3.13 This information sharing gap was not picked up during the management and oversight meetings in May or June for an area to check and follow up. By ensuring the Health Visiting Service were aware of the incident there would have been a better opportunity for the social worker to conduct a more robust risk assessment.

Narrative / Learning Point:

- Not all agencies enquire about domestic abuse specifically, even where there are opportunities.
- Victims may sometimes use phrases such as family issues, or similar when discussing their experiences. This could be unrelated to domestic abuse, but we cannot assume it to be the case. Where individuals are open with professionals about issues within their personal relationships, enquiry should always progress to explore whether the issues could constitute domestic abuse, and enquire specifically where this may be the case.

Recommendation 12:

- All health agencies should sign up to the Bexley Community Safety Partnership's lanyard scheme which includes a 45 minute training session on domestic abuse and a visible lanyard to promote disclosures

Recommendation 13:

- The training provided as part of the lanyard scheme should be reviewed to ensure it includes information about the language victims may use when disclosing (i.e. they may not always use the term domestic abuse

5.3.14 Through the IMR process all agencies were encouraged to reflect on improvements they could make within their own agency based on the learning from the review. The below highlights the recommendations each single agency have identified.

Single Agency Recommendations

Children's Services:

1. All Children's Services assessments should include a specific domestic abuse risk assessment with the non-abusive parent as standard, at an appointment on their own

The Hurley Group

1. Implement a system prompt if a patient has attended with a previous injury
2. Update on DA/DV at next educational event for all staff June 21 (including learning from DHR's)
3. An agreement re consistent questioning/approach for exploration of those patients presenting with injuries and how this is documented. We are aiming for a written statement relating to DA/DV in all patients attending following an injury. This is currently being asked and a tick box filled in if there is a concern but we would like to extend this as above.
4. Review of our Adult safeguarding policy/DA policy as part of this review.

GP Surgery

1. Establishing a culture of routine enquiry regarding domestic abuse so that this becomes standard practice
2. Increasing awareness and knowledge of all staff regarding domestic abuse, particularly in relation to the practice now being a domestic abuse champions
3. Establishing an adult safeguarding register and monthly meetings to review this
4. Safeguarding leads to share learning points at monthly clinical meetings
5. Ensuring patients are aware of support available to them at the surgery eg. through posters in waiting room, practice website
6. Develop a standalone Domestic Abuse policy

Dartford and Gravesham NHS Trust

1. Additional routine enquiry in antenatal practice
2. Encouragement of professional curiosity
3. Development and implementation of a joint Adult and Children Safeguarding Hub

5.4 The role of informal networks

5.4.1 Agencies knew very little about Jenny and Adam's wider networks including extended family, however they were mentioned as a cause for concern and a sense of support for Jenny on multiple occasions.

5.4.2 In September 2011 when Jenny initially attended the Queen Elizabeth hospital due to the overdose, she noted that the reason had been due to domestic and family related stresses.

5.4.3 In April 2018 during the Child and Family Assessment conducted by Children's Services the family had stated they did not want to include extended family.

5.4.4 During the assessment the social worker was made aware that Adam had two children of university age from a previous relationship. This was noted as a cause of contention in their relationship as Adam had been sending them money without Jenny's knowledge, which had led to arguments. However it was noted that Adam's previous relationships were not explored as part of the assessment.

Good Practice Identified

5.4.5 The GP Surgery: In the last few months the surgery has become a domestic abuse champion. This was done prior to them knowing that Jenny had a history of domestic abuse and was to be the subject of a DHR. As part of the work on domestic abuse they have implemented the following:

- routine enquiry - ensuring that all clinicians are aware to ask about possible domestic abuse (in regards to Jenny's case this pertains particularly to patients presenting with depression)
- ensuring clinicians know how to risk assess patients disclosing domestic abuse, how to safely record this in their notes and how to access support services
- an adult safeguarding register (which includes those experiencing domestic abuse)
- regular monthly practice safeguarding meetings to discuss any adult safeguarding concerns and to share learning

5.4.6 The following recommendations were made in the surgery IMR:

- Establishing a culture of routine enquiry regarding domestic abuse so that this becomes standard practice
- Increasing awareness and knowledge of all staff regarding domestic abuse, particularly in relation to the practice now being a domestic abuse champions

- Establishing an adult safeguarding register and monthly meetings to review this
- Safeguarding leads to share learning points at monthly clinical meetings
- Ensuring patients are aware of support available to them at the surgery eg. through posters in waiting room, practice website

5.4.7 Dartford and Gravesham NHS Trust: There is evidence that routine enquiry was carried out in accordance with the Trust's policy at Jenny's pregnancy booking and that maternal mental wellbeing was considered at each postnatal contact and an outcome was documented on each occasion as 'good'. The Trust now has the Hospital Independent Domestic Abuse Advisor Service available, a new addition since Jenny received maternity care. The HIDVA's work closely with staff in all areas of the hospital and contribute to the level 3 safeguarding training which is a new 'family focused' programme. The HIDVA speaks about identification of concern, assessment of risk, support and referrals. The IMR made the following single agency recommendation:

Develop a standalone Domestic Abuse policy

5.4.8 The Community Safety Partnership has begun a scheme for health professionals where they can be given lanyards to wear which highlight they are trained and able to deal with disclosures of domestic abuse. This includes a 45 minute training session around domestic abuse.

6. Conclusions and Lessons to be Learnt

6.1 Conclusions

6.1.1 The Review Panel extends its sympathy to the family and friends of Jenny. Due to the nature of this case which meant Adam did not want to be involved, and that agencies had no information known to them about wider family, friends or networks, it was not possible to gain any input in to the review from Jenny's family and friends. As such the Chair and Panel have tried to find examples of Jenny's voice and wishes where possible to hold her at the centre of this review.

6.1.2 Jenny only ever sought help from professionals regarding domestic abuse specifically on one occasion. Throughout her contact with agencies we know that there were times in her life where she faced challenges including her mental health and bereavement following her mothers death.

6.1.3 Throughout her experiences with services Jenny was only asked directly about domestic abuse once through routine enquiry, despite there being opportunities for her to have been asked in other settings and contexts.

6.1.4 The only time she did proactively disclose domestic abuse was when she called the police, and she noted that Adam was becoming increasingly unpredictable. She did not want to access specialist services at the time and was recorded as being at standard risk of harm.

6.1.5 There were opportunities identified within the review to strengthen the response to enable victims more opportunities to disclose and seek support in the future.

6.2 Key Themes and Learning Identified

6.2.1 **Information sharing:** It is vital that agencies share information where there are issues relating to safeguarding including mental health and domestic abuse. There were occasions picked up in the review where information sharing did not happen. We have highlighted this throughout the analysis; multi agency recommendation 4 and single agency recommendation 1 relates to this.

6.2.2 **Enquiry:** Agencies that include routine enquiry within their policies such as midwifery conducted enquiry where stipulated. However where there is not a policy and incidents that could have been considered a possible indicator were realised by other agencies enquiry often did not take place. We have discussed this throughout the analysis and recommendations relate to improved policies and training in spotting the signs and proactive enquiry.

7. Recommendations

7.1 Single Agency Recommendations (Identified by Individual Agencies)

7.1.1 The following single agency recommendations were made by the agencies in their IMRs. They are described in section 5 following the analysis of contact by each agency.

7.1.2 These recommendations are also presented by agency in the single agency recommendation action plan template. These recommendations should be acted on through the development of an action plan, with each agency reporting on progress to the Bexley Community Safety Partnership.

7.1.3 These recommendations are highlighted in the analysis section.

7.2 Multi Agency Recommendations (Developed by the Review Panel)

7.2.1 The Review Panel has made the following recommendations during this review in response to learning identified. These are described in section 5 as part of the analysis.

7.2.2 These recommendations are also presented in the multi-agency recommendation action plan template. The Bexley Community Safety Partnership is responsible for overseeing then development and monitoring of an action plan. Recommendations are:

7.2.3 **Recommendation 1:**

Multi-agency training across Bexley should be reviewed to ensure it includes i) the dynamics of domestic abuse being a pattern of behaviour and ii) economic abuse and the impact it may have on victims ability to seek support.

7.2.4 **Recommendation 2**

Bexley Domestic Abuse Strategic Partnership Board should receive quarterly updates with i) a breakdown of attendance at multi-agency training by agency and ii) breakdown of the number of DA champions trained from each agency in order for improved strategic oversight to ensure that all agencies are trained and have access to a champion

7.2.5 **Recommendation 3:**

All GP practices across Bexley should have a domestic abuse trained champion

7.2.6 **Recommendation 4:**

All agencies domestic abuse policies should include routine enquiry as standard practice where mental health needs are identified, even where a diagnosis is not present (e.g. sleep disturbance).

7.2.7 **Recommendation 5:**

The Domestic Abuse Health Sub Group should conduct an audit of routine enquiry practice across all health settings to understand current practice, and make recommendations for improvement.

7.2.8 Recmmendation 6:

All agencies working with victims and survivors of domestic abuse should work in a trauma informed way. The Bexley Domestic Abuse Strategic Partnership Board should consider an audit of trauma informed practice across services.

7.2.9 **Recommendation 7:**

London Ambulance Service and NHS Trust's who may see patients for injuries (such as Emergency Departments or Walk-in Centres) should receive training around domestic abuse identification, assessment and response.

7.2.10 **Recommendation 8:**

London Ambulance Service and NHS Trust's who may see patients for injuries (such as Emergency Departments or Walk-in Centres) should update the relevant GP surgery where injuries are treated within their setting so that GP's have the full picture.

7.2.11 **Recommendation 9:**

Children's services information requests from multi-agency partners should include detail relating to the specific safeguarding concern as domestic abuse to ensure all agencies can flag on their respective systems.

7.2.12 **Recommendation 10:**

The Children's Safeguarding Board should conduct an audit on the information sharing requests sent to partner agencies where the concern is due to domestic abuse, to assure that all requests for information contain details about the concern.

7.2.13 **Recommendation 11:**

Children's Social Care should consider including a prompt, on their requests from partner agencies as part of enquiries, about recording the domestic abuse concern on their respective system.

7.2.14 **Recommendation 12:**

All health agencies should sign up to the Bexley Community Safety Partnership's lanyard scheme which includes a 45 minute training session on domestic abuse and a visible lanyard to promote disclosures.

7.2.15 **Recommendation 13:**

The training provided as part of the lanyard scheme should be reviewed to ensure it includes information about the language victims may use when disclosing (i.e. they may not always use the term domestic abuse.

Appendix 1: Glossary

A&E	Accident and Emergency
AAFDA	Advocacy After Fatal Domestic Abuse
CCG	Clinical Commissioning Group
CCR	Coordinated Community Response
CPS	Crown Prosecution Service
CRIS	Crime Recording and Information System
CSP	Community Safety Partnership
CSU	Community Safety Unit
DASH RIC	Domestic Abuse Stalking and Harassment Risk Indicator Checklist
DHR	Domestic Homicide Review
FSW	Family Support Worker
FLO	Family Liaison Officer
GP	General Practitioner / Practice
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review
LAS	London Ambulance Service
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
MERLIN PAC	(MPS) report completed by police officer when they encounter a child in circumstances that cause a concern
MOPAC	Mayor's Office for Policing and Crime
MPS	Metropolitan Police Service
OIC	Officer in the Case
SIO	Senior Investigating Officer
SLT	Senior Leadership Team

SPOC	Single Point of Contact
VAWG	Violence against Women and Girls

Appendix 2: Terms of Reference

Domestic Homicide Review Terms of Reference:

Case of Jenny

This Domestic Homicide Review is being completed to consider agency involvement with Jenny and Adam following the death of Jenny in August 2020. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose of DHR

1. To review the involvement of each individual agency, statutory and non-statutory, with Jenny and Adam during the relevant period of time 01/09/2010 to August 2020 (inclusive). To summarise agency involvement prior to 01/09/2010.
2. To establish what lessons are to be learned from the domestic abuse related death regarding the way in which local professionals and organisations work individually and together to safeguard victims.
3. To 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.
4. To apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
5. To prevent domestic abuse and domestic abuse related deaths and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.
6. To contribute to a better understanding of the nature of domestic violence and abuse.
7. To highlight good practice.

Definitions: Domestic Violence and Coercive Control

8. The Overview Report will make reference to the terms domestic violence and coercive control. The Review Panel understands and agrees to the use of the cross government definition (amended March 2013) as a framework for understanding the domestic violence experienced by

the victim in this DHR. The cross government definition states that domestic violence and abuse is:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.

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

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group."

Equality and Diversity

9. The Review Panel will consider all protected characteristics (as defined by the Equality Act 2010) of both Jenny and Adam (age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation) and will also identify any additional vulnerabilities to consider (e.g. armed forces, carer status and looked after child). The following are local area protected characteristics to consider.
10. The Review Panel identified the following protected characteristics of Jenny and Adam as requiring specific consideration for this case;
    - **Age:** Jenny was due to turn 50 twelve days prior to her death, which although there is no indication of this being significant, may have some relevance. She was also a first time mother after an unplanned pregnancy at 44 years old. The review will consider how these factors may have been experienced by Jenny, particularly in the context of domestic abuse.
    - **Disability:** A mental health condition is considered a disability if it has a long-term effect on your normal day-to-day activity. This is defined under the Equality Act 2010. As Jenny had experienced mental health at varying periods within the review scope, we will consider the extent to which it impacted her experiences.

- **Marriage:** Jenny and Adam were married at the time of Jenny's death.
- **Pregnancy and maternity:** Jenny's child was born in 2015 so there was a period of pregnancy and agency contact relating to this. We know from evidence and research that pregnancy is often a point of escalation in terms of domestic abuse.
- **Sex:** Jenny was female and we know that domestic abuse is experienced disproportionately by women.

11. The following issues have also been identified as particularly pertinent to this domestic abuse related death;
    - **Depression and suicidal ideation:** Jenny experienced depression and had attempted suicide prior to her death. There is also note of Adam experiencing depression.
    - **Substance use:** There is some agency contact which suggested Jenny may have experienced problematic alcohol use.
12. Consideration has been given by the Review Panel as to whether either the victim or the perpetrator was an 'Adult at Risk' Definition in Section 42 the Care Act 2014: "An adult who may be vulnerable to abuse or maltreatment is deemed to be someone aged 18 or over, who is in an area and has needs for care and support (whether or not the authority is meeting any of those needs); Is experiencing, or is at risk of, abuse or neglect; and As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it."
    Abuse is defined widely and includes domestic and financial abuse. These duties apply regardless of whether the adult lacks mental capacity.

    If it is the case that any party is an adult at risk, the review panel may require the assistance or advice of additional agencies, such as adult social care, and/or specialists such as a Learning Disability Psychiatrist, an independent advocate or someone with a good understanding of the Mental Capacity Act 2005.

    The conclusion by the panel is that Jenny was not considered an Adult at Risk. There was one liaison with Adult Safeguarding which will be explored as part of the review.

13. *Expertise:* The Review Panel will therefore invite Mind in Bexley to the panel as an expert/advisory panel member to the chair to ensure they are providing appropriate consideration to the identified characteristics and to help understand crucial aspects of the suicide.
14. The Chair of Review will make the link with relevant interested parties outside the main statutory agencies.

15. The Review Panel agrees it is important to have an intersectional framework to review Jenny's and Adam's life experiences. This means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand one's journey and one's experience with local services/agencies and within their community.

Parallel Reviews

16. There are no ongoing parallel reviews taking place. The Coroner's Inquest has been completed. It states that investigations where section 5(2) of the Coroners and Justice Act 2009 applies, in what circumstances the deceased came by his or her death; "The deceased hanged herself from a door handle at her home being found dead by her husband in the morning of XX August 2020. She had a considerable amount of alcohol in her blood when she did this act and this may have coloured her thinking. Her intent to die is not found provide in the circumstances". The conclusion of the Coroner as to the death is recorded as "Died having hanged herself".

Membership

17. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.
18. The following agencies are to be on the Review Panel amend as appropriate:
    a) Solace Women's Aid
    b) Community Safety Partnership
    c) Metropolitan Police Service
    d) Children Social Care
    e) The Hurley Group
    f) London Ambulance Service
    g) Oxleas NHS foundation trust
    h) Lewisham and Greenwich NHS
    i) The GP Surgery
    j) Dartford and Gravesham NHS trust
    k) Mind in Bexley

Role of Standing Together Against Domestic Violence (Standing Together) and the Panel

19. Standing Together have been commissioned by Bexley CSP to independently chair this DHR. Standing Together have in turn appointed their DHR Associate (Danielle Davis) to chair the DHR.

The DHR team consists of two Support Officers and a DHR Manager. The DHR Support Officer (Helene Berhane) will be the main point of contact and will coordinate the DHR and the DHR Team Manager (Hannah Candee) will have oversight of the DHR. The manager will quality assure the DHR process and Overview Report. This may involve their attendance at some panel meetings. The contact details for the Standing Together DHR team will be provided to the panel and you can contact them for advice and support during this review.

Collating evidence

20. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted, and secure all relevant records.
21. Chronologies and Individual Management Review (IMRs) will be completed by the following organisations known to have had contact with TO and SO during the relevant time period:
    a. Metropolitan Police Service
    b. Children social care
    c. The Hurley Group
    d. London Ambulance Service
    e. Oxleas NHS foundation trust
    f. Lewisham and Greenwich NHS trust
    g. The GP Surgery (via the Clinical Commissioning Group)
    h. Dartford and Gravesham NHS trust

We will ask for Summary of Engagement's and potentially short reports from Bromley Healthcare and Jenny's dentist if possible.

22. Further agencies may be asked to completed chronologies and IMRs if their involvement with Jenny and Adam becomes apparent through the information received as part of the review.
23. Each IMR will:
    - Set out the facts of their involvement with Jenny and/or Adam;
    - Critically analyse the service they provided in line with the specific terms of reference;
    - Identify any recommendations for practice or policy in relation to their agency;
    - Consider issues of agency activity in other areas and review the impact in this specific case.
24. Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought Jenny and Adam in contact with their agency. These agencies are:
    a) Solace Women's Aid

b) Mind in Bexley

Key Lines of Inquiry

25. In order to critically analyse the incident and the agencies' responses to Jenny and/or Adam, this review should specifically consider the following points:
    a) Analyse the communication, procedures and discussions, which took place within and between agencies.
    b) Analyse the co-operation between different agencies involved with Jenny or Adam [and wider family].
    c) Analyse the opportunity for agencies to identify and assess domestic abuse risk. In particular the role of enquiry.
    d) Analyse agency responses to any identification of domestic abuse issues. In particular incidents of first time reporting and how this impacts assessment of risk.
    e) Analyse organisations' access to specialist domestic abuse agencies.
    f) Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.
    g) Analyse the intersectionality of Jenny's experience of mental health (depression), bereavement, alcohol use and domestic abuse. In particular how this may have impacted Jenny's ability to be identified by agencies, or seek support in relation to domestic abuse.

As a result of this analysis, agencies should identify good practice and lessons to be learned. The Review Panel expects that agencies will take action on any learning identified immediately following the internal quality assurance of their IMR.

Development of an action plan

26. Individual agencies to take responsibility for establishing clear action plans for the implementation of any recommendations in their IMRs. The Overview Report will make clear that agencies should report to Bexley Community Safety Partnership on their action plans within six months of the Review being completed.
27. Bexley Community Safety Partnership to establish a multi-agency action plan for the implementation of recommendations arising out of the Overview Report, for submission to the Home Office along with the Overview Report and Executive Summary

Liaison with the victim's family and [alleged] perpetrator and other informal networks

28. The review will sensitively attempt to involve the family of TO in the review, once it is appropriate to do so in the context of on-going criminal proceedings. The chair will lead on family engagement with the support of the Community Safety Partnership, and where appropriate specialist services.
29. The Review Panel discussed the involvement of children in the DHR at the 1st Panel Meeting and have decided it is inappropriate for this review. The panel has considered the following factors; the age of Jenny and Child A.
30. Adam will be invited to participate in the review.
31. Family liaison will be coordinated in such a way as to aim to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.
32. The Review Panel discussed involvement of other informal networks of Jenny or Adam and agreed it was proportionate to the DHR to invite the following persons (family members of Jenny (to be identified) and Jenny's friend to be involved in the DHR.

Media handling

33. Any enquiries from the media and family should be forwarded to Bexley Community Safety Partnership who will liaise with the chair. Panel members are asked not to comment if requested. Bexley Community Safety Partnership will make no comment apart from stating that a review is underway and will report in due course.
34. Bexley Community Safety Partnership is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

35. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.
36. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

Appendix 3: Single Agency Recommendations – Action Plan Template

Recommendation	Scope of recommendation i.e., local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome

OR CAN USE

Recommendation 1: *(Insert Recommendation and desired outcome)*					
REF	**Action (SMART)**	**Lead Officer**	**Monitoring Arrangements and Key Milestones**	**Target date for completion**	**Completion Date and Outcome**
1.1					
1.2					
1.3					

Appendix 4: Multi Agency Recommendations – Action Plan Template

Recommendation	Scope of recommendation i.e., local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome

OR CAN USE

Recommendation 1: *(Insert Recommendation and desired outcome)*					
REF	**Action (SMART)**	**Lead Officer**	**Monitoring Arrangements and Key Milestones**	**Target date for completion**	**Completion Date and Outcome**
1.1					
1.2					
1.3					