



# Safer Somerset Partnership and Safer Communities Torbay

## Domestic Abuse Multi Agency Death Review

### Executive Summary

Into the death of Eleanor (pseudonym) in  
August 2015

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## **1. Preface**

1.1 Domestic Homicide Reviews (DHRs) came into force on the 13<sup>th</sup> April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

- a) A person to whom she was related or with whom she was or had been in an intimate personal relationship or
- b) A member of the same household as herself; held with a view to identifying the lessons to be learnt from the death.

1.2 This death was not caused by a homicide but a suicide. It was not mandatory at the time of the incident for a DHR to be undertaken in these circumstances however a decision was made jointly by both the Safer Somerset Partnership and Safer Communities Torbay to undertake a Domestic Abuse Multi Agency Death Review. This review examines the circumstances surrounding the death of Eleanor (pseudonym) in the Torbay area on 5<sup>th</sup> August 2015 as well as her previous residence in Somerset. An additional specific purpose of this review was to establish what lessons could be learnt from inter-agency working across a larger footprint. The principles underpinning the review process have been followed in accordance with the Home Office Multi-Agency Statutory Guidance on the Conduct of Domestic Homicide Reviews- Original published April 2011 and Revised version- 1<sup>st</sup> August 2013, in addition to the more recent guidance published in December 2016.

## **2 Introduction**

2.1 This review examines the circumstances surrounding the death of Eleanor (pseudonym) who was 53 years of age and had lived in Somerset for many years. Eleanor's accommodation at the time of her death was a safe house provided by Torbay Domestic Abuse Service in Devon.

2.2 Eleanor was a single lady. She had been known to Mental Health services in the Somerset area since 1993 and the Somerset Drug and Alcohol Support Service for a number of years also. She had two children; a son and a daughter although both were no longer in her care at the time of her death.

2.3 Eleanor had been in a relationship with Harry (pseudonym) for 8 months and the relationship ended in September 2014. Eleanor expressed to her support workers at the Somerset Drug and Alcohol Service that she felt she was being stalked. Paladin, a national stalking support service became involved because Eleanor was signposted to this agency by her support workers. She told these two services that Harry was

leaving her notes, knocking on the door pressurising her to answer the door, breaking into her property and tampering with her personal items.

- 2.4 Through the support of Paladin and the Somerset Integrated Domestic Abuse Service Eleanor was found temporary accommodation in Torbay. At the beginning of June 2015 Eleanor moved into a safe house in Torbay provided by Sanctuary Housing/Torbay Domestic Abuse Service. Before moving to Torbay Eleanor completed a course with the Somerset Drug and Alcohol Support Service and had abstained from taking any substances.

3 Incident summary:

- 3.1 Following Eleanor's move to Torbay, a number of transfers/referrals were made to the Torbay area from Somerset to ensure that the support she had received could be continued. Eleanor had difficulty in registering with a GP in the Torbay area because she did not have any identification. As a result of this the Mental Health service; Devon Partnership could also not offer her support immediately until a referral had been made by a GP in Torbay. This was done on 24<sup>th</sup> June 2015 as a result of Eleanor attending a GP surgery in Torbay on two occasions feeling paranoia and anxious. On the 24<sup>th</sup> July 2015, the GP is reported to have advised her that he considered her to be "over-using" her medication". This caused her to be very upset and she drove off erratically on 24<sup>th</sup> July.
- 3.2 On the evening of 26<sup>th</sup> July 2015, Eleanor was taken to hospital in an ambulance after calling NHS 111 reporting to have taken an overdose of tablets. When paramedics arrived she was abusive and aggressive and was holding a Stanley knife. It is not known whether it was an intentional overdose and if it was what triggered Eleanor to take an overdose.
- 3.3 The following day, Torbay Domestic Abuse Service received a text from Eleanor which did not make complete sense. It is reported that the messages were garbled and she made reference to getting drunk as her only way of getting help, she also advised in the text that she was not able to eat or sleep. It is unknown when this was message was sent by Eleanor to the service. Eleanor rang Torbay Domestic Abuse Service advising the staff that she had left the hospital and was advised to return home. On 29<sup>th</sup> July 2015 Torbay Domestic Abuse Service received another text from Eleanor which appeared to be calmer stating that she had received an appointment to see the Mental Health Team at Devon Partnership on 26<sup>th</sup> August 2015.
- 3.4 Between 27<sup>th</sup> and 30<sup>th</sup> July 2015 Eleanor drove to Somerset to visit some family members. Whilst in the area on the 30<sup>th</sup> July 2015 she attended a Somerset Drug and Alcohol Service office. Professionals from this service alerted Devon Partnership with concerns over Eleanor's wellbeing because she seemed 'dishevelled and acting out of character'. They had concerns over her drug and alcohol misuse. On the same day Harry attended the court assessment and advice service where he was re-bailed for an offence where Eleanor was not the victim however it is understood by agencies supporting Eleanor that she knew about this offence.

- 3.5 On 31<sup>st</sup> July 2015, Eleanor alerted the Torbay Domestic Abuse Service that she was sat in her car in a supermarket car park feeling scared, frightened and could not move. Emergency services including police and ambulance were made aware and attended. Eleanor voluntarily agreed to go to hospital where a mental health assessment was undertaken. The outcome of this assessment was that she did not meet the criteria for admission, however would be kept in overnight to be re-assessed in the morning because she was still experiencing the effects of a psychoactive substance. Numerous assessments were undertaken whilst Eleanor was in hospital on 1<sup>st</sup> August 2015. Eleanor was discharged on 1<sup>st</sup> August and advised that the Crisis Resolution Home Treatment Team would be supporting her from now on. It is reported by Devon Partnership that this information together with the latest position on Eleanor's discharge was shared with the Torbay Domestic Abuse Service. However to the contrary, it is reported by Torbay Domestic Abuse Support Service that they were not made aware that Eleanor had been discharged from hospital. This was a Saturday where staff work on-call hours only.
- 3.6 On 2<sup>nd</sup> and 3<sup>rd</sup> August 2015, Eleanor was visited at the safe house by the Crisis Resolution Home Treatment Team who offered her support and prescribed her with some medication. Eleanor also gave assurances to this service that she had no suicidal thoughts. The Torbay Domestic Abuse Service also attempted to make contact numerous times on the 3<sup>rd</sup> August but to no avail. This service also contacted the hospital to find out whether Eleanor was still in hospital, it was at this point that Torbay Domestic Abuse Service were made aware that Eleanor was discharged on 1<sup>st</sup> August 2015.
- 3.7 On 4<sup>th</sup> August 2015, the Crisis Resolution Home Treatment Team attempted to make contact with Eleanor via phone on two occasions. The same team also attempted to visit Eleanor also but to no avail. Torbay Domestic Abuse Service also attempted to make contact several times on this day.
- 3.8 On 5<sup>th</sup> August 2015, due to no successful contact being made by either service, the Torbay Domestic Abuse Service gained entry to undertake a welfare check and found Eleanor deceased.
- 3.9 Eleanor took her own life by lacerations to her arm and throat. Although Eleanor had made suicide attempts before these were by overdoses.
- 3.10 The key purpose of this review was to enable lessons to be learned from Eleanor's death. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened, and most importantly, what needs to change in order to reduce the risk of such a tragedy happening in the future.
- 3.11 The Review considered all contacts/involvement agencies had with Eleanor and Harry during the period January 2014- August 2015, as well as any events, prior to January 2014, which are relevant to mental health, violence and abuse.

3.12 The agencies participating in this Domestic Abuse Multi Agency Death Review are:

Somerset County Council  
Somerset Partnership NHS Foundation Trust  
Somerset Clinical Commissioning Group  
Avon and Somerset Constabulary  
Knightstone Housing (SIDAS- Somerset Integrated Domestic Abuse Service)  
Turning Point (SDAS- Somerset Drug and Alcohol Service)  
Torbay County Council  
Sanctuary Housing (TDAS- Torbay Domestic Abuse Support Service)  
Devon and Cornwall Constabulary  
Devon Partnership

3.13 The commissioners of this report did not wish for family members of friends of Eleanor to be contacted about this review. The rationale for this decision was because it is not a full review, and instead has a limited focus

#### **4 Analysis**

4.1 The Panel met and discussed the following areas to ascertain whether agencies had acted in accordance with their procedures and guidelines and whether any improvements could be made.

Eleanor's disclosures of stalking and abusive behaviour from Harry  
MARAC to MARAC transfer  
Transfer of care between domestic abuse support service providers  
Transfer of care between mental health providers  
Cross- authority working

4.2 Eleanor's disclosure of stalking and abusive behaviour

4.2.1 The Panel discussed and found that Somerset Drug and Alcohol Service provided Eleanor with the correct advice; namely the contact details of a specialist agency that could help her. Paladin followed best practice policies and procedures by undertaking a risk assessment at the earliest opportunity and identified a number of key risk factors including stalking. It was reported by Eleanor that she found petrol in her shed which she believed Harry had put there, also that the furniture in her house had been tampered with which she also believed to be Harry, that her house keys had gone missing after she left the window open and that she believed Harry had taken these keys in order to have access to her home. Following this they referred the case to MARAC for a multi agency discussion and to ensure Eleanor was supported locally by the specialist domestic abuse provider.

4.2.2 Reports were made to the police and the Panel did not feel fully assured that the necessary actions had been taken to address Eleanor's complaint and Harry's behaviour. This was because the level of disclosures by Eleanor known to Paladin in

their view clearly equated to greater and more proactive investigative actions of stalking/harassment under the Protection from Harassment Act 1997. Avon and Somerset Constabulary did speak with Harry about his behaviour and provided him with a warning. It is unclear whether this was a verbal warning or a PIN (Police Information Notice) notice. A PIN is a written warning which can be issued to an individual advising them that if their behaviour continues it would warrant harassment and would be treated as such by way of a formal investigation. However it was felt by the Panel that the stalking behaviour was not correctly identified and dealt with robustly by using the relevant legislation.

- 4.2.3 Another conclusion resulted from Panel discussions was that of professional's confidence and knowledge levels in being able to identify and assess the impact of stalking on victims particularly where there are other variables present; mental health, substance misuse and /or domestic abuse.
- 4.2.4 There were a number of agencies involved in supporting Eleanor with her range of needs, however it became clear during our Panel discussion that there wasn't a clear lead agency. There is some work under development in Somerset to ensure that individuals with multiple needs are supported appropriately with agencies collaboratively working stronger together.
- 4.2.5 The Panel also considered the use of MARAC within this case and whether it was the correct forum. The Panel agreed that a multi-agency forum was essential to bring together the information about Eleanor's support needs however it was felt that the elements of stalking brought to the meeting by Paladin were not fully explored or understood. Following the Panel meeting, the Independent Chair sought further information on a new model being implemented in Hampshire; a Stalking Clinic. This is a multi-agency forum similar to that of a MARAC however is specifically for high risk cases of stalking and will also include a clinical psychologist as part of the discussions in order that the risks associated with the behaviour are thoroughly understood and mitigated against in terms of actions agreed by agencies present. Within this discussion it also became known that in October 2014 the Somerset Drug and Alcohol Service tried to make a referral into MARAC, which was a case involving two parties not in an intimate relationship where stalking was the abusive behaviour, and it was declined.
- 4.3.1 The Panel discussed the actions that were agreed at the MARAC meeting in Somerset and established that one action, which was given to an agency that was not physically represented at the MARAC, was not completed. It was agreed that it would have been unlikely this one action would have changed the result of this case however it enabled the Panel to discuss actions from MARAC meetings and whether it is appropriate to give an agency an action when they are not present at the meeting. The Panel concluded having sought advice from 'Safe Lives' (a national charity supporting the development of MARACs) and Devon and Cornwall colleagues, that best practice would be the MARAC coordinator to link with the agency not present at the meeting to check understanding and accuracy of the action in order that it could be undertaken within the timeframe.

- 4.3.2 In addition to the above, the Panel also discussed whether actions arising from a MARAC meeting should be considered at the next MARAC meeting to ensure they have been completed. The Panel concluded that the MARAC was a process for sharing information and not an agency in which the role would be to hold agencies to account. This is due to time and resources. Agencies sign up to a MARAC protocol with the expectation that actions given to them by the Chair should be undertaken unless for good reason which should be considered by the MARAC Chair and Coordinator. Also, agencies are asked to confirm to the MARAC Coordinator when actions are complete. It was noted by the Panel that non-attendance by agencies and/or lack of engagement does have an impact on the outcomes generated by the MARAC.
- 4.3.3. The Panel sought confirmation that the correct paperwork and information had been received by Devon and Cornwall Constabulary as a result of the MARAC to MARAC transfer. However in relation to the above action, confirmation should also be sought by the receiving MARAC that all actions have been completed. 'Safe Lives' were consulted in relation to the MARAC to MARAC transfer process and the Panel was advised that there is no formal protocol/policy and instead this is reliant on each MARAC coordinator or domestic abuse provider sharing the most relevant and current information with the receiving MARAC.
- 4.4 Transfer of care between Domestic Abuse Support Service Providers**
- 4.4.1 The Panel discussed how the two domestic abuse support service providers coordinated Eleanor's case and support during her transition move from Somerset and Torbay. The Panel felt that there had been good communication between these two agencies during the course of the move, however the severity of Eleanor's mental health was not known or fully understood by either specialist domestic abuse service provider. It is believed that this was because the true extent of Eleanor's mental health had not been fully appreciated by Somerset Integrated Domestic Abuse Support Service in order that it could be shared with Torbay Domestic Abuse Service as part of the referral. Somerset Partnership NHS Foundation Trust were not in attendance at the MARAC meeting in Somerset, however information was shared via a written update into this information sharing forum. Nevertheless efforts were made to establish further information and it is also noted that there was a telephone conversation between Torbay Domestic Abuse Support Service and Somerset Partnership NHS Foundation Trust on 3<sup>rd</sup> June 2015.
- 4.4.2 Research was undertaken by the Independent Chair to try and identify what a 'good' referral to another domestic abuse provider might include. It would appear that this does not exist and is therefore based on professional judgement, nevertheless 'Safe Lives' have a 'Leading Lights' programme. This is an accreditation programme for domestic abuse service providers. Within this framework it recognises the importance of multi-agency working; assessing the suitability of agencies whom clients are referred onto and service provision standards; the importance of

specialist proactive risk-led approaches to identifying an individual's risks and needs correctly in order that they can be met and addressed.

- 4.4.3 Views were also sought from the Panel in relation to how victims move from one area to another and how the process of registering with a GP in the new area is undertaken. Sometimes victims, including Eleanor in this instance, move without any personal identification cards and therefore find it difficult to register with a GP in their new area to seek their medication and support from these services. In some areas it was found that there are GP champions for Domestic Abuse whose role involves raising the awareness amongst their fellow clinical colleagues and acknowledging that failing to provide personal identification should not be a barrier to care for these individuals who have been identified as high risk victims of abuse. Although Eleanor was able to gain an emergency prescription on 11<sup>th</sup> June 2015 whilst living in Torbay without being registered at the GP practice, we also know that there were difficulties between 3<sup>rd</sup> June and 11<sup>th</sup> June 2015 when she first arrived in Torbay in being able to register with the GP due to lack of personal identification.
- 4.4.4 The Panel also discussed the suitability of a safe house versus a refuge where there would be peer support from other victims. Due to the complexity of Eleanor's mental health the Panel concluded that the safe house was most probably the best type of accommodation for her. This was because her mental health issues could have caused disruption to other residents in the same building. However the Panel did acknowledge that Eleanor had moved to a new area and there was no evidence of Eleanor being supported and encouraged to access peer support or join group work programmes facilitated by the Torbay Domestic Abuse Service despite these courses being offered to all clients. Torbay Domestic Abuse Service reported to the Panel that they focussed on supporting Eleanor on the crisis situation.
- 4.4.5 The last point which was raised in relation to this transfer of support between the providers relates to the tenancy condition in which Eleanor agreed to upon arrival in Torbay. The Panel were advised that Eleanor accepted the offer, support and temporary accommodation from Torbay Domestic Abuse Service based on an 8 week stay. It is unclear from the Panel discussions whether this agency had discussed this with Eleanor at the end of July. The beginning of August would have been the end of this 8 week stay. Torbay Domestic Abuse Service advised that the request to extend the agreement had not been made and neither had a notice been served on Eleanor for her to be evicted. The Panel did not feel assured that this had been dealt with robustly given Eleanor's mental health issues however Torbay Domestic Abuse Service confirmed following the Panel meeting that there was a clear process in place to agree extensions with clients and that this was being routinely used.

#### 4.5 **Transfer of care between Mental Health Providers**

- 4.5.1 The Panel felt that there had been some very proactive communication between Somerset Partnership NHS Foundation Trust and Devon Partnership. The Panel felt that Somerset Partnership had acknowledged the importance of Eleanor's transfer

of care and therefore took the necessary steps to ensure a smooth transition to another service/area. However the Panel were advised that Eleanor's care could not be transferred from one crisis team to another crisis team without being registered with the local GP in the new area. This is a national policy and only a small selection of cohorts are exempt from this process; veterans, pregnant women etc.. The Panel discussed the impact of this on Eleanor and the delay it caused to her accessing appropriate services. The conclusion was that accessing mental health crisis teams when an individual is already known to a crisis team in another area should be improved in order to support the patient's transition.

4.5.2 The Panel found that Devon Partnership felt satisfied by the information provided by Somerset Partnership NHS Foundation Trust and had a number of encounters with Eleanor when she moved to Torbay in June 2015.

#### 4.6 **Cross Authority working**

4.6.1 The Panel found as a result of their discussions that the communication between Devon Partnership and Torbay Domestic Abuse Service was not always timely and clear. This most probably was the result of numerous workers within both agencies being involved as there was not one single point of contact holding this case/patient in each agency. An example discussed at length during the Panel meeting was that of the removal of knives from Eleanor's safe house in Torbay, which was undertaken by Torbay Domestic Abuse Support Service due to concerns of self-harm. It is unclear from the review whether the rationale for removing the knives was adequately shared with Devon Partnership until the collation of the chronology which supports this review.

### 5 **Effective Practice/Lessons to be learnt**

5.1 There was a number of examples agreed as a Panel that illustrated effective practice. For example; Paladin referring Eleanor to MARAC in order to link her to local support available through Somerset Integrated Domestic Abuse Service. See the Overview Report for more information on effective practice.

### 6 **Conclusions**

6.1 In reaching their conclusions the Review Panel have focussed on the following questions;

- Has the Panel fulfilled the Terms of Reference for this review by undertaking a variety of lines of enquiry, including discussing the draft chronology and entering broader more strategic discussions about cross authority working?
- Will the actions and suggestions for improvement improve the response domestic abuse and stalking victims have in the future?
- Was Eleanor's death predictable?
- Could Eleanor's death have been preventable?

- 6.2 The Review Panel are satisfied that the Terms of Reference have been fulfilled and that discussion did take place at the Panel meeting to consider what was known prior to the tragic incidents in August 2015.
- 6.3 The Panel is of the opinion that the agreed recommendations appropriately address the points raised throughout the review, particularly in relation to the lessons learnt.
- 6.4 Was Eleanor's death predictable?
- 6.4.1 Eleanor had a history of self harming, misusing alcohol and taking overdoses, which could be regarded as suicide attempts, and this was known by the numerous agencies; GP practice in Somerset (Somerset Clinical Commissioning Group), the Somerset Drug and Alcohol Service and Somerset Partnership NHS Foundation Trust.

Eleanor's mental health diagnosis was that of bipolar disorder and that she experienced paranoid delusions when depressed. Between June 2015 and August 2015 when she moved from Somerset to Torbay there was no evidence to suggest that Harry was still in touch with Eleanor, however Eleanor's behaviour on 31<sup>st</sup> July 2015 following a visit to Somerset on 30th July 2015 was described as 'out of character' and therefore one might argue that some contact may have taken place either directly or indirectly during this time.

There was a deterioration of Eleanor's mental health at the end of July 2015 and this was acknowledged by the Panel. A number of mental health assessments were undertaken by Devon Partnership Trust, however these concluded that there was no acute mental health illness.

- 6.4.2 The Review Panel therefore concludes that given the information above and her history it was predictable Eleanor would attempt to take her own life again quite soon, however it was not foreseen that she would do this in this way.
- 6.5 Could Eleanor's death have been prevented?
- 6.5.1 The Review Panel conclude that following the robust mental health assessments undertaken Eleanor was not deemed to have such mental ill-health that she required in-patient services therefore her death could not have been prevented. Had Eleanor been deemed suitable for inpatient mental health services this may have reduced the likelihood of it happening of her taking her own life but the Panel believe it would not have eliminated the risk completely. Communication could have been improved between the two main service providers supporting Eleanor during this difficult time; Torbay Domestic Abuse Support Service and Devon Partnership Trust however the Panel did not feel that this communication could have prevented Eleanor taking her own life.

## **7 Recommendations**

- 7.1 Torbay Domestic Abuse Service

- 7.1.1 This agency should link with the local GP practices in close proximity to their safe houses/refuge and build a rapport with the practice in order that the domestic abuse service can become more familiar with the practice. The aim is also so that the GP practices can assist new arrivals with GP registration at the earliest opportunity, recognizing that the individuals may not always have personal identification with them and that this should not impact on their access to healthcare. This recommendation is also applicable to Somerset Integrated Domestic Abuse Support Service also.
- 7.1.2 This agency and the Devon Partnership should develop a joint working protocol outlining how they will work together when they are supporting the same individuals.
- 7.1.3 All referrals into their service for temporary accommodation should be advised to bring identification with them and at least one month's supply of medication (If medically safe) or a record of the medication in order that support can be ascertained from the new local GP practice for assistance to prevent a deterioration in their health.
- 7.2 Somerset Integrated Domestic Abuse Service
  - 7.2.1 When making a referral, which involves a victim with multiple needs, the referring agency must ensure that as much detail is shared with the new agency in order to support the transition including consideration for travelling to the new service with medication, identification etc... In addition this would include details of any drug and alcohol related misuse and mental health issues and the contact details of these services, in order that the new agency can directly link with the support worker from the old service for information. Within Somerset, this is part of a Joint Working 'Multiple Needs' Protocol which needs revising in order to reflect the importance of key information, contact details and to enable a seamless transition between services.
- 7.3 MARAC (Somerset)
  - 7.3.1 MARAC Protocol to be refreshed and circulated to all partners reminding them that their agreement to this process stipulates that actions should be completed in a timely fashion. Where actions are not completed; the MARAC Chair and Coordinator should be informed of the rationale at the earliest opportunity.
  - 7.3.2 An action should only be given to those agencies physically present at the MARAC meeting who understand the context and ask of the action. Where this is not possible, actions can be suggested and then followed up outside of the MARAC meeting by the MARAC Coordinator to the proposed action owner.
- 7.4 MARAC (Somerset and Torbay)

- 7.4.1 Both forums to consider what processes are in place to discuss high risk victims of stalking when they are not familial or partner/ex-partner cases e.g. consideration of the Hampshire model.
- 7.5 Avon and Somerset Constabulary
  - 7.5.1 To consider developing and implementing a training scheme relating to stalking and harassment in order to ensure that officers and staff feel confident in dealing with complaints of this nature, and understand the separate offences of stalking and harassment.
  - 7.5.2 To raise awareness of these issues by identifying champions for these issues across the police force similarly to that already undertaken by Devon and Cornwall Constabulary.
- 7.6 NHS England
  - 7.6.1 To consider nationally whether MARAC victims can be added to the exemptions for immediate referrals to and acceptance by mental health crisis teams instead of insisting upon a GP referral.