Domestic Homicide Review C11

Arising from the death of

“Louise” - September 2016

Safer Devon Partnership

on behalf of Exeter Community Safety Partnership

Executive Summary

Version FINAL (following QA)

June 2019

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Introduction

Review process

1. This is a summary of the Safer Devon Partnership domestic homicide review into the death of Louise (a pseudonym agreed with her family), undertaken on behalf of Exeter Community Safety Partnership in whose area she had lived for just over a year.

2. Louise, a White British woman aged 23, with no children, was found dead in September 2016 by housing support staff in the central Exeter flat where she lived on her own. An inquest in November 2017 reached a verdict of suicide, identifying the means as equipment Louise had ordered from the internet. Earlier in the year Louise had reported to Devon & Cornwall Police domestic violence from QQ, her former partner, during their relationship in 2010 and 2011, when both were aged around 18 and living within the Bedfordshire Police area. This was under investigation by Bedfordshire Police at the time of her death.

3. Safer Devon Partnership, taking account of updated Home Office guidance on domestic homicide reviews which requires certain cases where victims of domestic abuse take their own lives to be considered, set up a Domestic Homicide Review into Louise's death. They decided this because, although any domestic abuse suffered by Louise was historic, it may have contributed to her significant mental health problems, and she reported it for the first time, and feared further contact from the alleged abuser, while in Devon.

4. Eleven public and voluntary sector agencies gave a chronology or other detailed information for the Review, with a brief outline of their role in providing services for Louise. Eight of these agencies were also asked to prepare an Internal Management Review (an internal report whose author was not involved in the events). With the permission of HM Coroner, the Panel saw the note Louise had left addressed to those who would discover her death. Other sources included a report from Louise's General Practitioner (GP), attendance at the inquest, and relevant regulators' reports.

Table 1: Agencies contributing evidence

Agency	Services provided	IMR?
Devon & Cornwall Police	Emergency response to suicide attempts. Response to reported historic domestic abuse and liaison with Bedfordshire Police who took on investigation of this.	Y
Devon County Council	Mental Health Act assessment through Emergency Duty Team	N
Devon Doctors	Out of hours primary care	N
Devon Partnership Trust	Mental health care, including psychiatric liaison team, inpatient treatment and various forms of community treatment.	Y
Devon Rape Crisis and Sexual Assault Services (Rape Crisis)	Assessment following report of historic rape.	Y
Exeter City Council	Housing advice and commissioning of temporary supported accommodation at Trailways Hostel, then floating support at a flat (Flat Z).	Y
Mount Pleasant Health Centre	Primary care	N
Royal Devon & Exeter NHS Foundation Trust	Assessment & treatment in Emergency Department, sometimes followed by inpatient treatment.	Y
Sanctuary Supported Living (Sanctuary)	Floating support in Flat Z	Y
Splitz Support Services (Splitz)	Domestic abuse support services	Y
South Western Ambulance Services Trust	Advice or referral via NHS 111 Emergency response to 999 calls.	Y

5. The Review built on the contact already established by Devon Partnership Trust with Louise's parents, who were consulted on the Root Cause Analysis which the Trust prepared following her death. With their assistance the Review contacted several of her friends. Seven people contributed their views in some way. The Panel is grateful for the insights and information shared. Where references are made to the views of family and friends in this report they draw from these sources, but do not claim to be the views of all members of the family or friends. The Review Panel offers condolences to Louise's parents, siblings and all her friends and family.

Review Panel

6. The Domestic Homicide Review Panel met five times and also conferred by electronic means and through working groups. Panel members were from Devon and Cornwall Police (Serious Case Review Team), Devon County Council (Adult Social Care), Exeter City Council (Community Safety Manager), NEW Devon Clinical Commissioning Group (Designated Nurse, Safeguarding Adults), Royal Devon and Exeter NHS Trust (Senior Safeguarding Nurse) and Splitz Support Service (Safeguarding Team). The Panel was supported by the Safer Devon Partnership Co-ordinator for Domestic Homicide Reviews, who is contactable at Devon County Council.

7. The Panel's Independent Chair and report author has knowledge of community safety, partnerships and domestic abuse and experience of previous domestic homicide reviews. She has a past career in public sector regulation and has never been employed by any of the agencies concerned with this Review. None of the Panel had any direct connection with the people, events or decisions covered by the review.

8. The Review Panel operated collaboratively to reach agreed conclusions. These have been discussed with Louise's parents whose views have been taken into account. The report and recommendations are agreed by the whole Panel and signed off by Safer Devon Partnership's Executive Group and Exeter Community Safety Partnership. The report has been approved by the Home Office appointed national Quality Assurance Panel for domestic homicide reviews.

Terms of reference

9. The Review covers the period during which Louise was in contact with agencies in Devon, i.e. October 2015 to September 2016. It does not attempt to assess what happened while Louise was with QQ, or what help from agencies in their home area would have been available had she sought it at the time, as the relationship ended five years before her death.

10. The terms of reference reflect Home Office guidance and the particular context for this death. In summary they were to invite the involvement of family and friends, review agency contacts with Louise for opportunities to identify or prevent domestic abuse, and report on lessons for improving services. The Panel agreed, in the light of initial information available, that questions should cover her disclosure of past domestic abuse to agencies in Devon; the support she received in addressing her concerns about past and potential abuse; how agencies co-operated to meet her needs. It looked for lessons about how to respond to people who disclose domestic abuse in past relationships (or other trauma) in another part of the country.

11. The Review takes account of Louise's disability through mental ill health, and comments on the actions of Devon Partnership Trust as relevant to these terms of reference. It does not review her diagnosis or medication, which were considered at the inquest and the Trust's internal Root Cause Analysis.

Findings

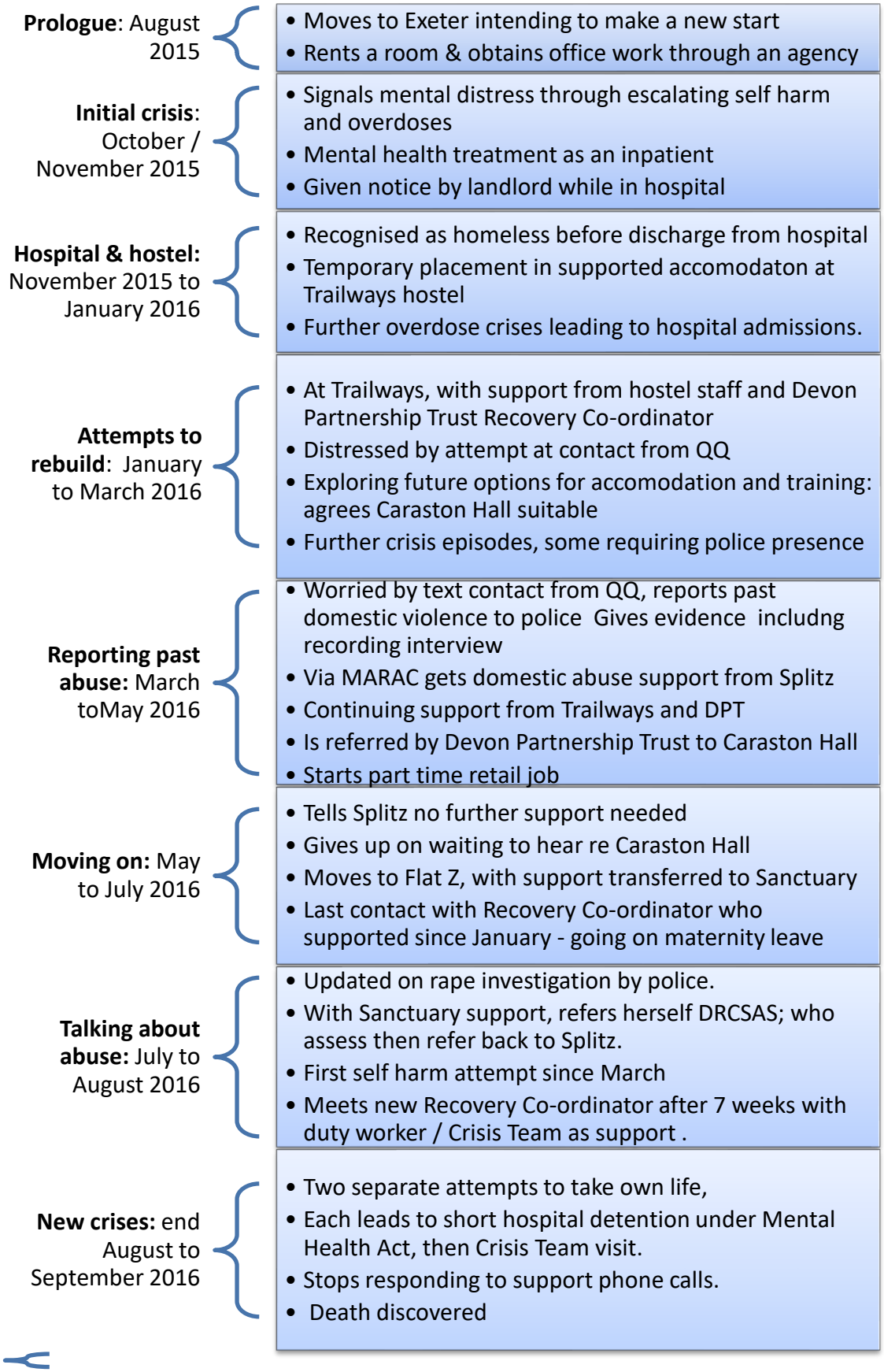
Summary chronology

12. Louise first came to the attention of public services in Devon in October 2015, when she attended Royal Devon & Exeter hospital's Emergency Department with cuts to her arm which she explained as deliberate self-harm. She had not at that point registered with a GP but did so a few days later. Over the following 11 months, Louise:

    - made a dozen attempts to harm herself or take her own life until March 2016, and again from mid August 2016; with emergency responses from ambulances, the Emergency Department, Devon Partnership Trust and on some occasions police;
    - was diagnosed as suffering from Emotionally Unstable Personality Disorder (EUPD) and treated by Devon Partnership Trust throughout the year;
    - attended or phoned Mount Pleasant Health Centre 26 times, and Devon Doctors (out of hours service) 4 times, to discuss both mental health medication and physical health problems,
    - was placed in supported housing by Exeter City Council: initially at Trailways, a staffed hostel and from June 2016 in Flat Z, managed by the Council, with floating support from Sanctuary;
    - made new friends, started a part time retail job and was offered a place on a college course;
    - disclosed past domestic abuse to Devon & Cornwall Police, and provided evidence through them to Bedfordshire Police who initiated investigation of a reported rape by QQ in 2011;
    - received support from Splitz in dealing with unwanted social media contact from QQ; and
    - contacted Devon Rape Crisis and Sexual Abuse Service seeking counselling for her memories of rape, which they were unable to provide while she remained afraid of the (alleged) perpetrator.

13. In Figure 1 a simplified storyline outlines the complex and interrelated chronology of Louise's life in Exeter.

Figure 1: Outline stages of Louise's life in Exeter



Key issues arising

14. Agencies in Exeter responded promptly to Louise at repeated moments of crisis over the year. She was taken to the Emergency Department by ambulance a dozen times following self harm, normally after calling for help herself via NHS111. This resulted in physical treatment essential to her health, and mental health assessment by the Psychiatric Liaison Service. Police were involved on about half these occasions, either to locate her or to enter property, when she put herself at risk.

15. These emergency responses were in general well co-ordinated between agencies and appropriate to the situation. The Review saw evidence of thoughtful and conscientious care as staff tried to engage with her at times of distress. However, she found some crisis interventions used to protect her and others distressing, for example when she had to be restrained on a motorway bridge. In her final note, explaining that she felt unable to bear the continuing mental suffering, she wrote: "I don't want to keep trying to somehow deal with and cope with my own mind. It's tortuous and to be so aware of it makes it worse".

16. Exeter City Council responded well in meeting Louise's housing need, which started in November 2015 when her landlord evicted her while she was on a mental health ward. They placed her in Trailways, a staffed hostel which provided structured and appropriate support, and she regularly confided concerns or sought advice from staff. Trailways staff do not have specialist skills, but were aware of the support Louise received from other agencies on mental and physical health, and, later, on domestic abuse, and aimed to collaborate with this. These interventions enabled Louise to survive a difficult winter and start planning a future, so that by mid 2016 she had taken positive steps including finding work, reporting past abuse to police, and choosing her own home.

17. However, she was in a more vulnerable situation than she or agencies realised. There had been delays and confusion in arranging accommodation and support for her to move on from Trailways, where she spent seven months rather than the usual two. She thought Devon Partnership Trust was arranging a placement for her at Caraston Hall, a local not for profit service which has staffed houses in Exeter supporting people with mental health needs. All concerned agreed this would be suitable, and funding was available, but the referral process was delayed by misunderstanding of process within Devon Partnership Trust. The impact of this delay is hard to judge. In June Louise arranged, through Exeter City Council, to move to single occupancy Flat Z. By then, she wanted more independence and might not have found sharing accommodation with other people with complex problems helpful.

18. Louise received floating support in Flat Z from Sanctuary, commissioned by Devon County Council and referred by Exeter City Council. However, Sanctuary did not record or make effective use of handover information from Trailways passed on by the Council. The support worker from Sanctuary, SW1, built a good relationship with Louise and tried to help her get support from other agencies, but lacked information on how risks might escalate and what other agencies were doing. Louise still had a mental health condition which included rapid mood swings, and a police investigation was under way which might raise new fears of contact by her former partner.

19. Sanctuary were aware that Louise was receiving support from Devon Partnership Trust's Community Mental Health Team. This had been in place since January 2016, through a Recovery Co-ordinator, RCO1, who went on maternity leave in July, seeing Louise for the last time just 10 days after SW1 started working with her. Again, there was no contact between the agencies at the point of transition, and no named contact for Louise (or SW1) in Devon Partnership Trust until a locum Recovery Co-ordinator, RCO2 was assigned at the end of August. Despite the signs of hope and apparently favourable circumstances, Louise remained at risk from her mental illness. While support from a duty Community Team worker, or in crisis the Crisis Team, was available to Louise if she called for it, this gap in familiar, trusted support - known to be important to people with her mental health diagnosis and to trauma victims – was significant.

20. The response to the domestic abuse reported by Louise was generally effective and appropriate. However, it could have started sooner, and been better integrated with her mental health treatment. Historic domestic abuse was noted by Devon Partnership Trust early in their treatment of Louise, but not explicitly addressed in her care plan. Once Louise shared concerns about contact from her ex-partner, she received safety advice and encouragement to report, and at the point when she did contact police she got good multi-agency support to tell her story. It was only then that she disclosed the severity of the violence she recalled.

21. The correct response to the reported abuse was initiated, through criminal investigation of the past and support for Louise from a Splitz Independent Domestic Violence Advisor for safety planning between March, on referral from police, and May, when she decided she no longer needed it. However, Devon Partnership Trust did not fully assess how talking about memories of abuse might affect Louise's mental stability. When, in July, she felt a need for psychological help in dealing with her memories of rape she self-referred to Rape Crisis, who advised that they were unable to help as her fear of QQ had returned. (Louise knew he was interviewed by Bedfordshire Police around this time.) Rape Crisis referred her back to Splitz, who provided telephone support

from then on. While both agencies correctly applied their guidelines, the episode added to Louise's sense that services were unable to help her.

22. In the month from mid-August until her death Louise had repeated crises, finding new ways to attempt to end her life. The five agencies (Devon Partnership Trust, her GP, Sanctuary, Splitz and police) working with her on an ongoing basis had no shared assessment of the suicide risk, or of plans to mitigate it. Staff vacancies and holidays added to the fragmentation of community support. While she had some telephone contact with her parents, they were unaware of her renewed suicide attempts. Devon Partnership Trust made inadequate efforts to contact her father[1], as they should have done during two Mental Health Act assessments in this period. Around a week before her death, Louise told her GP she felt low, unsupported and unsure what happens next. As one of her friends asked "Who was in charge of making sure all these agencies were coordinating? Who was looking out for Louise?"

23. Individual staff were indeed looking out for Louise but some lacked relevant information and sometimes misunderstood each other's roles. Someone able to see the whole picture might still not have been able to prevent Louise's death. However, better co-ordination could have helped her feel supported in finding a way forward, despite her mental distress. It would have enabled staff working with her to fulfil their specialist roles with a fuller understanding of the context, and to escalate concerns about her risk level, or about gaps in provision by other agencies.

Conclusions

24. Louise's tragic death was not a direct result of domestic abuse: she did not cite this as a reason for her action, and had not been prompted to it by anyone. It is likely, however that domestic violence which she reported suffering while still in her teens was a contributory factor to the mental illness from which she sought escape by taking her own life. While it is not possible to distinguish the effects of her underlying illness, past trauma and present fear of her former partner, her symptoms included flashbacks of violence and fear that others might turn out to be abusers. These are common long term effects of trauma, so responses to them should take this into account.

25. The Review has thrown light on support offered to victims of domestic and sexual violence and abuse, and on multi-agency collaboration to prevent suicide. In identifying factors that helped or hindered Louise, and systems that worked well or were ineffective, it draws lessons which can benefit others who seek help in dealing with past trauma. It is important that services, while

[1] Her father was the Nearest Relative under Section 26 of the Mental Health Act.

managing risk, are trauma sensitive, recognising the impact that past events may have on current interactions.

Lessons to be learned

26. Despite its tragic ending, Louise's story reveals examples of good practice by agencies, individually and together, which should be encouraged. This includes thoughtful and caring action by some staff both in crisis and community support; well co-ordinated emergency responses to self harm; housing support which built trust and encouraged positive steps; multi-agency support for the police "achieving best evidence" video interview, and liaison between two police services to investigate past sexual offences.

27. Overall there was insufficient co-ordination between agencies. Staff who tried to link up sometimes struggled to find out what other agencies were doing, and systems for sharing information were not always effective. As a result, Louise, a vulnerable victim of a suspected serious sexual offence, moved to the new home she had chosen in Flat Z without clear arrangements as to how agencies would work together to support her. By a coincidence of timing, RCO1, who could have played a key role in this, started maternity leave after only seeing Louise once in her new setting.

28. When Louise's situation deteriorated and she resumed attempts to take her own life, Devon Partnership's Trust contact with her family was, with no good reason, below the level required by the Mental Health Act and encouraged by the 2014 "Information and Suicide Prevention Consensus Statement". Louise's family have, in their contribution to the Review, stressed the message she left in her final note, that mental health services need to improve, and that health professionals should learn through listening to service users and bereaved families. They pointed out that if families are unaware of suicide attempts they are unable to help. It is welcome that the 2018 Independent Review of the Mental Health Act advocates changes to national policy to facilitate involvement of family and friends.

29. Gaps in mental health staffing have a real impact on people who use services. Pressures from finances and availability of staff may explain why even predictable vacancies, such as maternity leave, are not filled immediately. However, this makes it more important to anticipate the impacts and enable other agencies to help mitigate them and ensure some continuity of support. The resulting instability may have a financial as well as a human cost, as crisis intervention uses more resources than planned support.

30. The response to the domestic abuse reported by Louise was generally effective and appropriate. However, it could have started sooner, when she first disclosed past abuse to Devon Partnership Trust in November 2015, and

have been better integrated with her mental health treatment. It was not until March that, prompted by Trailways, she reported concerns about contact from her ex-partner to police, who responded correctly in addressing both potential past crimes and current risk. All agencies should be prepared to respond to disclosure of historic domestic abuse including consideration of any current risk from the perpetrator. Louise's experience also illustrates a potential gap in provision of help for effects of past trauma where there is any related current risk, or (possibly unfounded) fear of it.

31. Since Louise's death, there have been a number of positive developments in Devon which address some of the lessons.

- Agencies across Devon and Torbay are collaborating on a suicide prevention plan in line with national strategy. This includes training for some front line staff, which Splitz staff have undertaken.
- Devon Partnership Trust, in 2017, introduced mandatory training on domestic abuse for all clinical staff in the roles Louise would have encountered.
- Devon Partnership Trust now has an overnight telephone single point of contact service. This might have helped Louise, as many of her self harm episodes were at times when the only way of accessing mental health services was through the Psychiatric Liaison Service in the Emergency Department.
- Royal Devon & Exeter NHS Foundation Trust has doubled the proportion of clinical staff trained in domestic abuse and continues to roll this out.
- Sanctuary Supported Living have improved their process for handling referrals and assessing risk.
- The LEESAR Partnership (led by Splitz and including Rape Crisis), which has been commissioned to deliver domestic and sexual violence and abuse services across Devon from April 2018, has clarified pathways for victims reporting historic abuse.

Recommendations

32. These recommendations are developed in more detail in the separate action plan.

R1 Ensure that support staff from a range of statutory and community settings have the skills to identify when someone is considering suicide, have the confidence to ask, the knowledge to effectively signpost and ability to share concerns with other agencies involved in the person's care.

R2 Routinely share mental health risk assessments with providers of housing support, subject to client consent.

R3 Build capability in the workforces of Devon agencies, including Devon Partnership Trust, to respond in a timely and appropriate way to victims of domestic and sexual violence and abuse.

R4 Review how well Devon Partnership Trust policies and procedures on contact with families fit with the national consensus statement on information sharing and suicide prevention.