RESTRICTED

A Domestic Homicide Review of the death of GRACE

March 2022

EXECUTIVE SUMMARY

Report Author: Mike Cane

Dated: 26TH March 2024

Contents:

1. The Review Process

1.1 This summary outlines the process undertaken by the Darlington Community Safety Partnership Domestic Homicide Review Panel in reviewing the tragic death of Grace, who was resident in their area. This is a Domestic Homicide Review conducted under the mandatory requirements of the Domestic Violence, Crime and Victims Act 2004.

1.2 To protect the identity of those involved, pseudonyms were used for both adult subjects in the review. The victim will be referred to throughout as Grace. There is no perpetrator directly involved in the death in this case. However, Grace did have an ex-partner who will be referred to throughout the review as Ryan. Grace's family were consulted and agreed to the use of these pseudonyms.

Subjects of the Review:

- The victim; Grace, a female aged 19 years old at the time of her death. She was white British.

- Her ex-partner, Ryan, was also 19 years old at that time. He is white British.

1.3 There were no criminal proceedings in this case, however, an inquest into Grace's death was opened in March 2022. The inquest hearing was conducted at Crook Coroner's Court, Civic Centre, Crook, Co. Durham in January 2023. The family were represented by a barrister instructed by Hogan Lovell Solicitors of Holborn, London.

HM Coroner concluded that Grace died as a result of suicide noting her specific motivation to act as she did is not clear on the evidence available, '*but on balance derived from her low mood, due to the ending of a relationship and the pressure of balancing work & studying for examinations'.*

1.4 The family of the deceased challenged the Coroner's ruling through the High Court. The case was listed on 20th February 2024 and was uncontested. The family of the deceased challenged the Coroner's ruling through the High Court. Whilst the court maintained Grace's death was recorded as 'Suicide' it was agreed to amend the wording of Section 3 of the Record of Inquest to:-

'Her specific motivation to act as she did is not clear on the evidence available, but on balance derived from her low mood due to an emotionally abusive relationship'.

1.5 There were delays in the launch of a Domestic Homicide Review. There was no formal notification from Durham Police to the Community Safety Partnership. The first contact with the Darlington Community Safety Partnership (DCSP) was a letter received from a national charity; 'Advocacy After Fatal Domestic Abuse' (AAFDA) dated 3rd May 2022. The letter outlined the circumstances of the case and confirmed that AAFDA had been approached by Grace's parents who were dissatisfied with the response of agencies regarding their daughter's tragic death.

1.6 Following receipt of the AAFDA letter, the DCSP convened a meeting on 5th July 2022. The meeting comprised of ten professionals representing agencies across the public and voluntary sector. Information was shared on the level of agency involvement. A summary of statements provided by the deceased's friends and colleagues to the police were also shared at the meeting. Following deliberations each representative was asked if they believed the criteria was met to commission a Domestic Homicide Review (DHR). The unanimous view was that the criteria was not met. The family were informed of the outcome.

1.7 In August 2022, the Chair of the DCSP notified the Home Office of the decision that they did not believe the criteria was met to commission a DHR. The Home Office responded in March 2023 that a Quality Assurance panel had met and believed that this case would benefit from a Domestic Homicide Review.

1.8 The following month, the new Chair of the DCSP informed members of the partnership that a DHR would be commissioned and an Independent Chair & Author appointed to coordinate the process. The Independent Chair met with Grace's parents before the first DHR panel convened.

1.9 The first DHR panel meeting was held on 10th July 2023. A briefing was delivered to IMR authors in September 2023. A second DHR panel meeting was convened on 23rd October 2023. The final panel meeting was held on 6th December 2023. Grace's parents attended this final panel meeting.

1.10 A Community Safety Partnership (CSP) has a statutory duty to enquire about the death of a person where domestic abuse forms the background to the homicide and to determine whether a review is required. In accordance with the provisions of section 9 of the Domestic Violence, Crime and Victims Act 2004 (amended 2013), a Domestic Homicide Review should be:

"*A review of the circumstances in which the death of a person aged 16 years or over has, or appears to have, resulted from violence, abuse or neglect by-*

(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) A member of the same household as himself."

Although the victim took her own life, the Partnership were concerned there may have been domestic abuse and elements of coercive control within her relationship with her ex-partner.

1.11 The statutory guidance states the purpose of the review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted upon and what is expected to change as a result.
- Apply those lessons to service responses including changes to policies and procedures as appropriate.
- Articulate life through the eyes of the victim, to understand the victim's reality; to identify any barriers the victim faced to reporting abuse and learning why interventions did not work for them.
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

2. Contributors to the review

2.1 Eleven agencies have contributed to the Domestic Homicide Review by the provision of summary reports or chronologies. Three agencies then provided Individual Management Reviews (IMRs) to outline and analyse their own single agency actions, contacts and decision-making. The review chair and panel agreed that reports, chronologies, IMRs and other supplementary details would form the basis of the information provided for the overview author.

2.2 The following organisations were required to produce an Individual Management Review:

- Integrated Care Board (on behalf of GP practices for the victim and the ex-partner).
- Tees Valley YMCA.
- Harbour Domestic Abuse Services.

Every effort was made to achieve the independence of the IMR authors. However, the structure of the YMCA meant that this simply was not possible. This was outlined openly and transparently at the first DHR panel and accepted by the Independent Chair as the only way to progress the review. The Independent Chair is satisfied that the YMCA IMR is a balanced account of that agency's interaction with the victim.

2.3 Other agencies provided scoping, summaries and chronologies:

- Tees, Esk & Wear Valleys NHS Foundation Trust.
- Primary Care (Darlington) Contraception Services.
- County Durham and Darlington NHS Foundation Trust (CDDFT).
- 'We Are With You' (WAWY) – substance misuse treatment.
- Durham Police.
- The victim's employer.
- Humankind (mental health support)
- 'SHOUT' (mental health charity)

2.4 The Independent Chair would also like to acknowledge the efforts and commitments of the victim's family and colleagues for help in pulling together significant amounts of background information to assist the Domestic Homicide Review.

3. The Review Panel members

3.1 The Chair of the Review Panel is Mr Mike Cane. He is also the appointed Independent Author for the review.

Name	Agency & Job Title
Darren Ellis	Community Safety Programme Manager - Darlington Borough Council
June McStravick	Project Lead – Tees Valley YMCA
Carley Ogden	Named Nurse for Safeguarding Adults - County Durham & Darlington NHS Trust
Jen Moore	Designated Nurse Safeguarding Adults - North East & North Cumbria Integrated Care Board (representing GP practices)
Nicki Smith	Associate Director of Nursing (Safeguarding), Tees Esk & Wear Valleys NHS Foundation Trust
Julie Wheatley	Team Manager Social Workers Mental Health and AMHP Service, Darlington Borough Council West Park Hospital
Francesca Smith Trish Watson (from 2nd panel)	Team Manager Safeguarding Adults Team - Darlington Borough Council Senior Practitioner, Safeguarding Adults Team- Darlington Borough Council
Lee Blakelock Liane Green (from 2nd panel)	Detective Chief Inspector - Durham Constabulary T/Detective Chief Inspector Durham Constabulary
Joanne Pattison	Scrutiny and Improvement lead, Safeguarding, Durham Constabulary
Rachael Williamson	Service Manager for Durham & Darlington – Harbour Domestic Abuse Services
Emily Thornley	Team Leader Harbour Domestic Abuse Services
Simone McGill	Harbour (specialist in young people and domestic abuse)

Ken Ross	Public Health Principal – Public Health lead for Mental Health and Suicide, Darlington Borough Council
Ben Thompson	Probation Service (withdrew after 1st panel as no involvement with either subject of the review)

With the exception of Tees Valley YMCA (as already outlined), the panel members were completely independent and had no direct dealings with the subjects of the review nor management responsibilities to any front line worker involved with any of the subjects of the review.

4. Author of the overview report

4.1 The appointed Independent Author is Mike Cane. He is completely independent of the Darlington Community Safety Partnership and has no connection to any of the organisations involved in the review. He is a former senior police officer where his responsibilities included homicide investigation, safeguarding and investigation of child abuse, rape and other serious sexual offences. He has extensive experience as a panel member for Domestic Homicide Reviews and is a former member of a Safeguarding Vulnerable Adult Board, several Domestic Abuse Strategic Partnerships and a number of Local Safeguarding Children Boards. During his police career he was Force lead for domestic abuse, child protection and vulnerable adults. He chaired the MARAC meetings across four Local Authority areas for several years and was also Chair of the Sexual Assault Referral Centre (SARC) management board. He has previous experience of conducting Domestic Homicide Reviews, Safeguarding Adult Reviews and Child Safeguarding Practice Reviews as an Independent Chair/Author. Mike completed accredited DHR training for Chairs in 2010 and refresher training in 2017. He attended AAFDA (Advocacy After Fatal Domestic Abuse) conferences in 2018 and 2019 as well as taking part in AAFDA training on ‘involving children in Domestic Homicide Reviews’ in 2021 and ‘best practice in managing DHRs’ in 2022.

He has designed and delivered domestic abuse training (identification, risk assessment & risk management) to staff across the public/voluntary sector.

5. Terms of Reference for the review

5.1 The terms of reference were agreed at the convening of the first DHR panel:

Terms of Reference
Were practitioners sensitive to the needs and vulnerabilities of the victim? When, and in what way, were the victim's wishes and feelings ascertained and considered? Was the agency response person-centred and tailored to the needs of this victim? Was she clearly informed of options/choices available to help in her decision making? Were there any barriers to the victim accessing support?
Were practitioners knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator?
Did the agency have policies and procedures in place relating to domestic abuse? Were these complied with in relation to identification of abuse, taking positive action, safeguarding and signposting / referrals?
Were risk assessments carried out? Were they effective and robust? Was the identified level of risk appropriate to the presenting circumstances? Did the agency use a recognised domestic abuse risk assessment tool? Were risk assessments reviewed and updated in response to changing circumstances or information?
How effective was information sharing in this case? Did professionals have confidence to discuss concerns with multi-agency colleagues?
What were the key points or opportunities for assessment and decision making? Do assessments and decisions appear to have been reached in an informed and professional way?
How did the use of social media affect this case?
Did the Covid-19 restrictions in 2020 and 2021 have any direct impact on the victim?
What information was known about the victim's ex-partner? Was he subject to MAPPA, MATAC or any other perpetrator intervention programme? Were there any injunctions or protection orders in place?

MAPPA is the Multi-Agency Public Protection Arrangements. These are statutory processes to manage sexual and violent offenders. The 'Responsible Authorities' (police, Probation Service and HM Prison Service) all have statutory responsibilities to protect the public under national MAPPA guidelines). *MATAC is Multi-Agency Tasking and Coordination. It is a scheme currently being rolled out in many areas across the UK to specifically manage serial and repeat perpetrators of domestic abuse.*
Were mental health services accessed by the victim or ex-partner in this case?
Was alcohol or substance misuse a factor in this case?
Were family, friends or colleagues aware of any abusive behaviour towards the victim prior to her death? If so, how was this information communicated? Were there any barriers to communication?
Did the victim's employer have domestic abuse policies in place? Do staff have the knowledge on how to seek help if they are experiencing domestic abuse or they are concerned about a colleague suffering such abuse?
Did any restructuring during the period under review have any impact on the quality of service delivered?
Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim and ex-partner? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

6. Summary chronology

6.1 Contact with agencies or professionals was minimal. Grace and Ryan were young people, in employment and living with their parents. A large amount of information was considered by the DHR panel which emanated from private messages between the victim and her partner, the victim and her mum, or between the victim and her friends. The content of these messages was not known to professionals at that time.

The DHR panel considered any agency contact during the two years of Grace and Ryan's relationship:

6.2 On 28th January 2020, Ryan self-referred to the North East Council on Addictions (NECA). This is a substance misuse service. He reported he was 'sniffing' one gramme of ketamine daily. He was placed on a waiting list. There are no further entries on the NECA records until the substance misuse service contract was taken over by 'We Are With You' (WAWY). In September 2020 WAWY took steps to contact Ryan. There was no reply to their telephone call and the referral was closed the same day.

He had further initial contacts with services in July and August the same year but did not seek further treatment or support.

6.3 On 1st April 2020, Grace texted the 'SHOUT' helpline. SHOUT is a mental health charity. She gave her name as 'Sophie'. The call was noted as 'general unhappiness'. She informed the call-taker that her partner had trust issues and went on to disclose that he would get annoyed at 'little things' and she was having to adjust her behaviour to try to appease him. This was not categorised by 'SHOUT' as a call linked to domestic abuse. Grace again texted the 'SHOUT' mental health helpline on 22nd May 2020. This is recorded as a short (ten minute) interaction. She reported anxiety related to her sex life. Grace was worried about getting pregnant. SHOUT staff advised her to write down her thoughts as a reference point and to speak to her GP.

6.4 On 12th January 2021, Grace had a telephone appointment with her GP regarding her mental health. She described feeling depressed for 12 months. She reported crying for no reason, not wanting to go out. However, she denied any suicidal ideation. The GP advised Grace she could self-refer to 'Talking Changes'. The practitioner also referred Grace to the GP Aligned Mental Health Team. The following day, the GP Aligned Mental Health Team (a service provided by TEWV staff) records show they made

three attempts to contact Grace by telephone. There was no reply. The next day (14th January) they again tried to telephone Grace. Again, there was no reply. The notes state that they therefore sent a 'opt-in' letter to Grace with advice that if she did not contact the team, she would be discharged from the service. On 25th January, the Aligned Mental Health Team records note there had been no response to the opt-in letter and Grace was subsequently discharged from their service.

6.5 On 30th March 2021, Grace attended a face to face session with the YMCA. This was a group session and the content was related to mental health and well-being. She attended further face to face youth sessions at the YMCA on 15th May, 18th May and 25th May. Further sessions continued throughout 2021.

6.6 On 1st July 2021, according to Harbour Domestic Abuse Services records, Grace made a self-referral to their service. However, Grace's mum states it was she who actually made the contact and made no secret of this. She was open with Harbour that she was ringing on behalf of her daughter.

Following her mum's call a few days earlier, on 5th July Grace had an appointment with Harbour. It was a telephone call back. A risk assessment was conducted during the call. Grace agreed to be placed on a waiting list for group support sessions (the 'Inspire' programme).

6.7 Grace continued with regular appointments to see her GP. There were nine further contacts during 2021, the majority of these were face to face. These were for unrelated medical issues.

6.8 Grace attended three further group youth sessions with the YMCA during February 2022. The last of these was on 15th February.

6.9 Also in February 2022 Grace ended the relationship with Ryan.

6.10 In March 2022 Grace spent a full day at work. She had started a new relationship and her new boyfriend walked her home from work. Her family describe her mood as happy at that time. Grace had dinner with her parents. During dinner she exchanged a number of messages with her new boyfriend. She then went upstairs to shower. Grace researched 'how many paracetamol would cause a fatal overdose'. She then tied a dressing gown cord around her neck which she used to hang herself from a wardrobe in her bedroom. There was no alcohol or controlled drugs in her body and no note was left.

7. Key issues arising from the review

7.1 The emerging themes identified during this review:

- This was a close, intimate relationship between two young people which lasted for two years.
- Grace and her ex-partner suffered from low mood.
- There was minimal contact with services.
- Misuse of drugs by her ex-partner affected several aspects of their relationship.
- Both subjects of the review were in employment.
- Grace and Ryan each lived with their parents.
- Neither Grace nor Ryan have any criminal convictions.

8. Conclusions and Lessons Learned

8.1 This tragic case involved an intelligent, professional, young woman taking her own life. She had a good career and had secured a place at university to be fully accredited in her chosen profession. The post mortem examination confirmed she had no alcohol or illegal drugs in her body.

8.2 Grace was popular and had a wide circle of friends from her school days and from colleagues at work. She enjoyed socialising and many social events have been referred to during this review.

8.3 Grace had been in a relationship with Ryan for two years from January 2020 to February 2022. They were close and friends describe them as loving each other. They spent a lot of time in each other's company during Covid-19 'lockdowns' when access to their wider social network was limited.

8.4 Her ex-partner, Ryan, was a regular user of drugs. He declared he was addicted to ketamine. He introduced Grace to illegal drugs and she took them on occasion at social gatherings. Grace encouraged Ryan to get help with his addiction. He did make initial contact with services but never carried on to treatment stage.

8.5 Grace had experienced low mood in the past. She had a consultation with her GP about this and was signposted to specialist services but she did not contact them. Other direct 'messaging' between Grace and Ryan suggest she had previously taken an overdose of paracetamol.

8.6 It is not the function of the Domestic Homicide Review to determine the reason(s) a person took their own life. That is a matter for HM Coroner. However, the DHR should consider all aspects and pressures of a victim's life if they are to try to understand their experiences, decision-making and thought processes. In addition to any domestic abuse, Grace did feel under pressure from her workload and her studies. She regularly went into work on her day off (indeed in March 2022 she gave up both of her rest days). Her private messaging between family or friends also suggest she felt under pressure. Eventually she asked to reduce her paid role to four days per week to alleviate pressure.

8.7 There is no doubt that the nature of the relationship between Grace and Ryan was abusive. He would regularly send her insulting messages. He would call her nasty names and send derogatory messages. Much of his behaviour was selfish. When reviewing the private messages between them, it is clear that Grace demonstrated maturity and common sense. Ryan appears chaotic, inconsistent and almost childish.

8.8 There is evidence of controlling behaviour within the relationship. This was not a case of Ryan controlling Grace's finances, restricting her movements or being physically violent. The control was much more subtle:

- Driving his car too fast and on the wrong side of the road. This made Grace feel unsafe. When she asked him to stop he just laughed which confirmed Grace was not in control of the situation.

- Attacking her self-worth. He sent many demeaning and insulting messages at all times of the day and night.

- Boasting of his 'drug' lifestyle to Grace's friends when he knew this may create a wedge between Grace and her friendship group.

- Leaving her alone on nights out. He would 'block' her on social media so she couldn't contact him and make her worry for his welfare.

- Messaging her when she was out with her friends to check where she was and who she was with (jealousy).

- Regularly turning up when she was out with her friends so he could take Grace home with him.

- Sending messages and voicemails to Grace's friends when he would describe intimate details.

- Making threats to kill himself (a theme of exercising control which is sadly common in many DHRs).

8.9 In the early stages of the relationship it is apparent that Grace did not recognise this as an abusive relationship. However, her own messages do indicate that she did eventually realise this was abusive and controlling. In February 2022, she found the strength to end the relationship.

8.10 There was very little agency involvement. Hence, the level of information held by agencies is limited and there were few opportunities for professionals to intervene. There was never any disclosure of domestic abuse. Police were never called. At one GP appointment (on the telephone) there was a disclosure of low mood but the reasons were explained by Grace as due to isolation from Covid-19 lockdowns. However, the Domestic Homicide Review found no evidence of 'routine enquiry' by professionals (i.e. proactively asking if domestic abuse was an issue).

8.11 Grace did not seek help from any agency relating to domestic abuse. Her mother contacted both Tees Valley YMCA and Harbour Support Services without Grace's knowledge (the former as she was concerned about Grace's isolation from friends, the latter as she was worried that the relationship with Ryan was abusive). Grace did agree to attend the YMCA and subsequently enjoyed their group sessions. She did agree to speak on the telephone with Harbour but made it clear to her mum she wasn't happy about this.

8.12 In July 2021, Harbour carried out a recognised (domestic abuse) risk assessment. The assessed level of risk was a standard case ('current evidence does not indicate likelihood of serious harm'). The assessed level of risk was correct in relation to the disclosures made and associated context. There was a missed opportunity when there was no further proactive contact or updates provided by Harbour to Grace about the length of time for the waiting list on their group programme. She remained on the list eight months later when she died.

8.13 Grace's family were not satisfied with the initial police response. In the days following Grace's death, they describe that they attended the police station to enquire about a Domestic Homicide Review. The parents report that a Duty Inspector did not appear to understand the DHR process and simply replied 'it was a suicide'. The police did not notify the Community Safety Partnership of the nature of the death. This meant further delays and further distress for the family.

8.14 This was a tragic taking of a young life. Grace's demeanour on the night of the incident is described as 'happy'. Yet within two hours of returning home

she had researched how many paracetamol it would take for a fatal dose. She then hanged herself in her bedroom.

The DHR panel and Darlington Community Safety Partnership express their condolences to Grace's family at this difficult time.

9. Recommendations

9.1 The Darlington Community Safety Partnership (CSP) reviews the educational programmes being delivered in colleges and secondary schools regarding healthy relationships and domestic abuse. The CSP should be satisfied that the content of such programmes includes being respectful to partners and being able to describe what a healthy relationship looks like. Young people should be empowered to recognise domestic abuse in all its forms. In particular young people should be confident how to seek help or support if they are being abused or if they believe a friend is suffering abuse.

9.2 Durham Police reviews the training delivered to their middle and senior managers in relation to Domestic Homicide Reviews. The training should include an awareness of the Domestic Homicide Review process and in particular those cases where a person has taken their own life, but concerns have been expressed that the deceased may have been subjected to domestic abuse or coercive control prior to their death.

9.3 The Local Authority and the Office of the Police & Crime Commissioner (as commissioners of services) ensure Harbour Domestic Abuse Service put systems in place which automatically trigger contact to clients who are on a waiting list for group support work. This is to enable continued support and maintain engagement.

9.4 The SHOUT mental health charity updates its training programme to give staff confidence in recognising all forms of domestic abuse and in particular, emotional abuse.

9.5 The Integrated Care Board will reiterate to primary care providers the importance of ensuring that they have domestic abuse policies in place to support and guide staff in decision making when supporting individuals who have been subjected to domestic abuse or it is suspected that they may be a victim. In the absence of a specific domestic abuse policy, the issue of domestic abuse will be comprehensively covered within the safeguarding polices. The domestic abuse information will make reference to the Domestic Abuse Act 2021 and include specifically the support required to victims of suspected coercion and control.

9.6 The Community Safety Partnership receives reassurances from health agencies operating in and around Darlington that 'routine enquiry' (still at a

pilot stage in many localities) is being considered within those agencies' domestic abuse policies and procedures.

9.7 All services, agencies and partners in Darlington to commit to reducing the number of lives lost to suicide, through engagement with the local implementation of the cross-government suicide prevention strategy which seeks to achieve a reduction in suicides in England over the next five years.

9.8 The Community Safety Partnership should encourage all relevant organisations to widen their use of alternative communication methods, in particular those that are most frequently used by young adults. This review has highlighted the preferred mediums for communication for young people are via a variety of social media and other platforms. Agencies should consider adapting ways of engaging to encompass modern means of communication (subject to statutory requirements) as traditional telephone calls and letters may not always be the most appropriate method.

9.9 The Community Safety Partnership encourages local organisations to consider implementing the 'Ask Me' scheme. This is an initiative to develop an appreciation of domestic abuse in all its forms, within the wider community and helps survivors of domestic abuse, or their friendship network, to access help.