



North Yorkshire  
Community Safety Partnership

**A Domestic Abuse Related Death Review of Jayne  
April 2024**

**Executive Summary**

**Report Author: Vanessa Rolfe**

**8 December 2025**

## Contents

<b>1</b>	<b>The Review Process</b>
<b>2</b>	<b>Contributors to the Review</b>
<b>3</b>	<b>The Review Panel members</b>
<b>4</b>	<b>Author of the Overview Report</b>
<b>5</b>	<b>Terms of Reference for the Review</b>
<b>6</b>	<b>Summary Chronology</b>
<b>7</b>	<b>Key Issues arising from the Review</b>
<b>8</b>	<b>Conclusions and Lessons Learned</b>
<b>9</b>	<b>Recommendations from the Review</b>

## 1. The Review Process

- 1.1 This summary outlines the process undertaken by the North Yorkshire Community Safety Partnership’s panel for Domestic Abuse Related Death Reviews (DARDRs) in reviewing the homicide of Jayne who was resident in their area.
- 1.2 ‘Jayne’ is a pseudonym. It will be used throughout the review in order to protect the victim’s identity. This pseudonym has been agreed with her family. The perpetrator in this case is referred to by the pseudonym, ‘Clive’.
- 1.3 Clive was found guilty of murder by a jury in late 2024 and was sentenced to life with a minimum of 21 years in prison.
- 1.4 The North Yorkshire Community Safety Partnership (NYCSP) was formally notified of the circumstances of the death by the police on 30<sup>th</sup> April 2024. All agencies likely to be involved in the review were notified in writing to secure records. On 7<sup>th</sup> May 2024 an initial scoping exercise was commenced to determine the level of agency involvement. On 21<sup>st</sup> August 2024, the NYCSP Chair made a decision that a DARDR would be conducted. The inquest into the victim’s death opened on 10<sup>th</sup> September 2024. At the time of writing, the inquest has still not concluded, and a date of a hearing is yet to be set once the IOPC investigation has concluded. This is likely to be in 2026.
- 1.5 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 or death 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 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.”*
- 1.6 The North Yorkshire Community Safety Partnership identified that in this case the death met the criteria of the Domestic Violence, Crime and Victims Act 2004 and commissioned a DARDR.
- 1.7 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.
- To establish whether the events leading up to the homicide could have been predicted or prevented.

## 2. Contributors to the Review

2.1 The following agencies contributed to the review by provision of chronologies and Individual Management Reviews or summary reports:

- North Yorkshire Police
- NHS Humber and North Yorkshire Integrated Care Board (representing GP services )
- Tees, Esk & Wear Valleys NHS Foundation Trust (TEWV)
- York and Scarborough Hospitals NHS Foundation Trust
- North Yorkshire Horizons (substance use services)
- Health and Adult Service - North Yorkshire Council
- The Probation Service
- Housing Needs Service – North Yorkshire Council
- Independent Domestic Abuse Service (IDAS)

2.2 Other agencies provided scoping, summaries and chronologies:

- Community Safety Ryedale
- Harrogate and District NHS Foundation Trust (HDFT)
- Department for Work and Pensions

The IMR authors were completely independent and had no role in any of the decisions made or actions undertaken by their respective agencies prior to Jayne’s death.

### 3. The Review Panel members

3.1 The Domestic Homicide Review panel was comprised of the following people:

Name	Position & Organisation
Mike Cane	Independent Chair
Vanessa Rolfe	Independent Author
Odette Robson	Head of Community Safety & CCTV North Yorkshire Council
Allan Westcott	Community Safety Officer (Domestic Abuse) North Yorkshire Council
Clare Crossan	Detective Chief Inspector North Yorkshire Police
Nicola Hields	Deputy Designated Nurse for Safeguarding Adults, Children and Children Looked After (HNYICB)
Nicki Smith	Associate Director for Nursing (Safeguarding), Tees, Esk & Wear Valleys NHS Foundation Trust
Nicola Cowley	Head of Safeguarding and Complex Needs, York & Scarborough Teaching Hospitals NHS Foundation Trust
Rebecca Kendall	North Yorkshire Horizons (substance use services)
Dan Atkinson	Public Health

Karen Gullon	Health and Adult Service - North Yorkshire Council
Joseph Howard	The Probation Service
Victoria Stoker	Housing Service – North Yorkshire Council
Rhonda Hackett	Department for Work and Pensions
Izzy Birley (also providing advice on reported incidents of sexual abuse)	Independent Domestic Abuse Service (IDAS)
Bridget Skaife	Partnerships Manager, Community Safety, North Yorkshire Council

#### 4. Author of the Overview Report

4.1 The appointed Independent Author is Vanessa Rolfe. Vanessa is completely independent of North Yorkshire Community Safety Partnership and has no connection to any of the organisations involved in the review.

Vanessa is a former senior police officer as a career detective mainly in safeguarding roles, both adults and children, as a practitioner, manager and senior manager. Vanessa was also a Senior Investigating Officer (SIO) leading numerous investigations into homicides and other unexplained deaths.

Vanessa is now freelance as a safeguarding consultant subject matter expert.

In July 2024, Vanessa completed the Level 3 accredited training from Advocacy After Fatal Domestic Abuse (AAFDA) for DARDR Chair. This accreditation gives her the foundations and skills to manage and author reviews of deaths where safeguarding is a concern.

## 5. Terms of Reference for the Review

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

1	Were practitioners sensitive to the needs or vulnerabilities of the victim?
2	Were professionals knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim?
3	Did the agency have policies and procedures in place relating to domestic abuse? Did these include actions for professionals if a client did not engage? Were these policies complied with?
4	Were risk assessment and risk management processes for domestic abuse victims or perpetrators correctly used in this case?
5	Did the agency adhere to information sharing protocols agreed with partners?
6	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?
7	How were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?
8	How did use of alcohol or other substances impact on this case?
9	Was mental health a factor in this case?

10	<p>How effective was the MARAC?</p> <p>MARAC is a Multi-Agency Risk Assessment Conference. It is a meeting of professionals to share information and formulate plans to protect the victim and their children in the highest risk domestic abuse cases (those cases where the victim is assessed as at risk of significant harm).</p>
11	<p>What information was known about the ex-partner? Was the ex-partner subject to MAPPA, MATAC or any other perpetrator intervention programme? Were there any injunctions or protection orders in place?</p> <p>MAPPA is the Multi-Agency Public Protection Arrangements. These are statutory processes to manage sexual and violent offenders. The 'Responsible Authorities' (police, National Probation Service and HM Prison Service) all have statutory responsibilities to protect the public under national MAPPA guidelines).</p> <p>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</p>
12	<p>How did agencies recognise and respond to issues of equality and diversity?</p> <p>Please consider the nine protected characteristics and how these may have impacted on services or impacted on the perception of the individual(s). Was there any evidence of unconscious bias in assessments, decisions or actions taken?</p>
13	<p>Were there any barriers to reporting abuse or violence? Did professionals consider trauma informed practice?</p>
14	<p>How were issues relating to Child Protection identified and managed?</p>
15	<p>Was there evidence of economic abuse taking place?</p>
16	<p>Did any restructuring during the period under review have any impact on the quality of service delivered? Did the Covid-19 pandemic affect service delivery?</p>

## 6. Summary Chronology

- 6.1 The victim, Jayne, was 39 years old at the time of her death.
- 6.2 The perpetrator, Clive, was 40 years old at the time of the murder.
- 6.3 Jayne and her sister were adopted by their parents and they grew up on a farm. Jayne's father gifted both daughters a house each and Jayne lived in this throughout her adult life.
- 6.4 Jayne had always wanted to find her biological mother and did in her late teens maintaining a relationship with her and an additional brother and sister
- 6.5 Jayne's sister explained how her and Jayne were both into the rave scene in the 90s and used a lot of MDMA (ecstasy) – working hard all week and partying hard all weekend. They both started using heroin as a way of coming down from a high to be able to work. And so started a life of addiction for Jayne, firstly with controlled drugs and latterly with alcohol.
- 6.6 Jayne started suffering with agoraphobia which continued throughout her life and really impacted her greatly during the pandemic
- 6.7 Jayne's sister explained how Jayne started getting involved with crime – fraud – in order to fund her addictions. This also continued throughout her life, with Police intelligence suggesting her and Clive were both involved in the supply of drugs in addition to the exploitation of a vulnerable elderly man – for which Clive eventually was convicted and served months in prison.
- 6.8 Jayne married a man called Peter, who was physically abusive towards Jayne. They had a child together in 2016.
- 6.9 Jayne first started in an on/off relationship with Clive around 2001. Their relationship continued often in secret, even when Jayne married Peter, and continued until he killed her in April 2024. Peter was also a perpetrator of DA on Jayne.
- 6.10 One of the most traumatic events in Jayne's life was when her almost 3 year old child was removed from her by Social Services in 2018 due to the domestic abuse and substance use.
- 6.11 In 2019 Peter was convicted of a serious assault on Jayne and went to prison. This provided an opportunity for Clive to move into Jayne's house and was described to services by them both as "the lodger."
- 6.12 Clive went to prison in 2022 serving part of a 15 month sentence for fraud.

- 6.13 In November 2023 the relationship between Jayne and Clive broke down but Clive refused to move out of Jayne’s house.
- 6.14 In April 2024 a person who knew both Clive and Jayne was walking home from work and saw Jayne in the river with Clive next to her. The witness called the ambulance and Police. Jayne was taken to hospital but later died. Clive was arrested at the scene.
- 6.15 Clive was subsequently charged with murder and was found guilty by the jury and was sentenced to life with a minimum of 21 years in prison.

## **7. Key Issues arising from the Review**

### **7.1 Cross-cutting themes**

- Mental Health
- Alcohol & Substance Use
- Criminality
- Lack of professional curiosity
- Missed opportunities for agency intervention
- Record keeping errors
- Lack of understanding of trauma informed practice
- Disengagement

### **7.2 Risk assessment and information sharing**

- There was good information between the Police and IDAS
- There could have been better information sharing from probation and the GPs – especially into MARAC
- Once the MARAC process had started, information sharing improved

### **7.3 Professional curiosity and decision-making**

- There was certainly a lack of professional curiosity from health professionals regarding Jayne’s injuries and an assumption they had been as a result of intoxication

- The Police could have asked more questions about the relationship between Jayne and Clive to better understand their living arrangements

#### 7.4 **Multi-agency working**

- For the vast majority of interactions involving multi-agency professionals, there was effective information exchange. This included multi-agency discussions and referrals to a variety of services. However, there were gaps when some organisations' records indicated their staff were aware that Clive and Jayne were intimate partners but the nature of their relationship was not shared with other agencies including with the police.
- Once the MARAC process had been initiated (Oct 2023) there is good evidence of information sharing. There were 4 MARAC meetings before Jayne's death (Oct, Nov and Dec 2023 and in April 2024)

#### 7.5 **Systemic barriers**

- The removal of Jayne's child was a barrier to her trusting agencies to support her
- The barriers were that Jayne did not disclose but she was not supported to do this by professional curiosity and staff being confident to address the "elephant in the room"
- Each agency needed to ensure a trauma-informed approach in supporting Jayne. This did not happen for all services. On another occasion, Jayne was asked about her injuries in front of Clive – which is not trauma informed practice. It is very unlikely, that a victim of domestic abuse who is in complete fear for her life will confirm the perpetrator has committed anything against them whilst they are physically present in the room.
- Other barriers such as financial dependence, societal pressures or lack of access to support

## 8. Conclusions and Lessons Learned

- 8.1 Jayne was a victim of domestic abuse perpetrated by several intimate partners. This included significant physical violence, controlling behaviour and breach of restraining orders.
- 8.2 The perpetrator, Clive, was a violent individual. He had used violence against his intimate partner Jayne, against former partners, against professionals and against other vulnerable people in the community.
- 8.3 Jayne was not an 'invisible' victim. During the five year period this review has considered, police were called more than 20 times. There was also significant involvement from health professionals including her GP practice, mental health practitioners from Tees, Esk & Wear Valleys NHS Trust (TEWV), hospital clinicians from York & Scarborough NHS Trust and social care staff from Health and Adult Services. A major gap in provision of services was due to the lack of identification that Jayne and Clive were in an intimate relationship. Jayne and Clive repeatedly told professionals that they were just 'close friends'. This meant services were not routed via a domestic abuse pathway for several years.
- 8.4 Professionals focused their efforts on the presenting issues such as alcohol and substance use, mental health, physical injuries and self-neglect, but did not consider the wider impact of potential domestic abuse or controlling and coercive behaviour.
- 8.5 During Jayne's attendances at hospital, clinical staff dealt professionally with her injuries. However, these injuries were attributed to falls relating to her mental health or alcohol/substance use. There was a lack of professional curiosity and domestic abuse does not appear to have been considered. This includes attendances where Clive accompanied Jayne to the hospital and staff did not ask him to leave the treatment room which would have presented an opportunity for possible disclosures.
- 8.6 The panel accepts that this was five years before Jayne's death and today's activities with regards to safeguarding ensures that professionals are reminded of the 'think family' approach.
- 8.7 There is no doubt that a significant factor in Jayne declining involvement with North Yorkshire Police on many occasions was due to fear of Clive. This includes her denying to officers that she and Clive were in an intimate relationship.

- 8.8 Engagement by other agencies was also challenging. Professionals discussed this in detail at the DARDR panel meetings. Agencies agreed that Jayne was an intelligent woman. Her use of alcohol and other substances created practical difficulties in engagement, but the consensus of professionals was that a major reason behind their inability to meaningfully engage with Jayne was her due to her fear of Clive and not wanting him to be aware that she had been contacted with those agencies.
- 8.9 In addition, professionals and Jayne's own family noted the deep love she had for her child. The child had been removed while still pre-school age. Jayne's mum described to the DARDR Chair how the day they were taken away by Children's Services, Jayne went out to the car to wave them off. Jayne's mum said tears were running down Jayne's face. She thought the removal would only be temporary. However, the child remained under the care of Children's Services (residing with paternal grandparents). Professionals believe that Jayne may have tried to mask domestic abuse in an effort to ultimately regain custody of her child.
- 8.10 There were missed opportunities in relation to delivering proactive disclosures to Jayne about Clive's violent background. Although Jayne had declined a Domestic Violence Disclosure Scheme (DVDS) delivery in March 2022, there were further opportunities when this could have been reviewed and professionals to have offered a disclosure to Jayne.
- 8.11 Once police recognised that this was an intimate relationship, there was good proactive work by North Yorkshire Police who secured three separate Domestic Violence Protection Orders (DVPOs) to protect Jayne from Clive. In addition, when these orders were breached, enforcement action was taken. However, when he appeared at court for the breaches, Clive received only a minimal fine. Such a sentence is likely to have indicated to Jayne that there were no significant consequences to Clive for his actions.
- 8.12 Jayne's use of alcohol and other substances may have been a factor in masking domestic abuse. She was reluctant to make allegations against Clive through her fear of him. Therefore when describing how her injuries had been caused through falling whilst drunk, this gave credibility to her account. Professionals did not always demonstrate sufficient professional curiosity to challenge this.
- 8.13 Jayne had some involvement with mental health services from the age of eleven years and later due to her drug use connected to the 'rave scene'. In later years Jayne's mental health manifested itself in her making

several '999' calls relating to taking her own life. It is also clear that the removal of her child from her care resulted in mental health symptoms such as low mood, trauma and depression.

8.14 Opportunities were missed for a timely review of a potential Evidence-Led Prosecution. In April 2024 Jayne suffered significant injuries following an attack by Clive. He had been arrested but Jayne felt unable to assist the investigation, almost certainly due to her fear of him. There was no application for a charge and remand in custody on the lower evidential threshold. Clive murdered Jayne less than three weeks later.

8.15 **Reflections from family**

Jayne's sister told the panel that Clive was '*insidious*' and that Jayne and he hid his behaviour so well. Jayne's sister accepted that it was very difficult for professionals to see and make any difference. She said, "*The victim becomes a mouthpiece for what he wants to say.*" Jayne's sister also said, "*You can love someone with all your heart but you don't necessarily like what they do.*"

Jayne's sister thanked those professionals who had tried to help her sister and stated that she hoped this review process might help someone else.

*"Jayne was the most loveable, caring woman who was always there for her friends and family. She was a wonderful daughter, sister and mother. She had her own unique place in this world, enriching the lives of all her friends and family. Her individuality of character is tremendously missed, never to be forgotten."*

## **9. Recommendations from the Review**

### **9.1 Multi-Agency Recommendations**

#### **Recommendation 1**

The North Yorkshire Community Safety Partnership (NYCSP) should be reassured of multi-agency training programmes scheduled to improve:

- (a) Front line practitioner's confidence in challenging accounts from victims or perpetrators regarding the nature of their relationship.
- (b) Professional's ability to use professional curiosity relating to unexplained injuries or inconsistent accounts about how injuries may have occurred.
- (c) Recognition that use of alcohol or other substances may be masking domestic abuse.

#### **Recommendation 2**

The NYCSP should be notified of updated multi-agency training programmes in place to improve professional's understanding of trauma and trauma informed practice. This is already a strategic priority for the Safeguarding Adults Board.

#### **Recommendation 3**

The MARAC Steering Group carries out dip sampling of MARAC minutes to ensure actions are updated and that records reflect the completion of actions within the agreed timescales.

#### **Recommendation 4**

The North Yorkshire Safeguarding Adults Board (NYSAB) should complete a multi-agency audit to ensure:

- Adult safeguarding concerns raised by agencies include all relevant information and are of a good quality.
- regular attendance from all appropriate agencies at adult safeguarding planning and outcome review meetings (including sending an appropriately qualified deputy if the regular attendee is unavailable).
- all relevant information is shared appropriately by all agencies.

## **Recommendation 5**

The NYCSP reviews recommendations from previous DHRs / DARDRs within North Yorkshire, to ensure consistency and progress towards improvements to services for victims of domestic abuse.

## **9.2 Single Agency Recommendations**

### **9.2.1 Independent Domestic Abuse Service (IDAS)**

#### **Recommendation 6**

**IDAS should introduce an ‘Early Case Review’ Protocol to implement a process for early review and coordinated action planning in high-risk cases where engagement is difficult. This plan would need to be easily accessible within the case file and inform all future practitioner contact.**

#### **Recommendation 7**

IDAS should facilitate guidance sessions for practitioners so that all practitioners receive guidance and training around support planning and receive case management supervision which covers case note recording.

Staff would benefit from refresher training to ensure that all significant information is contained within case notes to ensure that relevant information is accessible in one consistent place ensuring that all relevant information is accessible to the different practitioners that may have contact with the victim.

#### **Recommendation 8**

IDAS should work with local courts to give training and awareness in domestic abuse where staff would benefit from refresher training to ensure improved understanding when making determinations on sentencing for breach of Domestic Violence Protection Orders (DVPOs) and consequences for victims and perpetrators.

\* The quality of sentences for DVPOs is a common issue nationally, and this subject area should be considered as part of national learning by the Home Office and the Domestic Abuse Commissioner’s office.

## 9.2.2 Integrated Care Board (ICB) – Primary Care - General Practice

### Recommendation 9

The GP Practice should ensure that all General Practice staff have access to, and are familiar with, an approved Domestic Abuse Policy and knowledge of the RCGP Safeguarding Standards, in particular the knowledge and capabilities around domestic abuse so that they are able to recognise signs and indicators of domestic abuse which should prompt professional curiosity. [RCGP safeguarding standards for general practice](#). (A template Domestic Abuse Policy is available from HNYICB for adoption by practices.)

### Recommendation 10

GP Practice staff should be confident to enquire sensitively about domestic abuse when indicators may be present that an individual may be a victim or perpetrator, and it is safe to do so. GP Practice staff should be able to recognise and respond appropriately to the different levels of risk in domestic abuse which can include: referral/signposting to domestic abuse agencies, safeguarding considerations (child and adult) and making MARAC referrals when there are signs of high risk domestic abuse and also be conversant with local escalation procedures and support pathways for both victims and perpetrators.

### Recommendation 11

GP Practice staff should be able to document information about domestic abuse accurately and safely in the patient record, taking into consideration the risks associated with patient online access as set out in the RCGP guidance: [RCGP Safeguarding toolkit: Part 4: Documenting safeguarding concerns and information | RCGP Learning](#) and [GP online services toolkit: Clinical safety | RCGP Learning](#). This will be supported by raising awareness of the new safeguarding RCGP (2024) standards and toolkit – highlighting the sections on domestic abuse and the coding of this on the EMR.

\* Safeguarding level 3 training is delivered annually by the ICB Safeguarding Team and Named GPs for General Practice primary care staff across North Yorkshire and York and includes updates on Domestic abuse and safe documentation.

### **9.2.3 North Yorkshire Police**

#### **Recommendation 12**

North Yorkshire Police should ensure regular audit of records for domestic abuse victims to evaluate the impact of domestic abuse training and assessing improvements and quality regarding the coding of MARACs.

#### **Recommendation 13**

North Yorkshire Police should ensure Evidence-led Prosecutions (ELP) are considered in all domestic abuse cases. This should be supported by a written document to record that ELP has been considered, with a rationale if not fulfilled.

#### **Recommendation 14**

North Yorkshire Police should ensure communication and guidance to officers around the value and importance of Public Protection Notices (PPNs) to help ensure consistent practice and early identification of risk.

#### **Recommendation 15**

North Yorkshire Police should deliver training to Force Control Room staff on domestic abuse to ensure staff working within the call centre guide, and not dictate, whether a call despatch is domestic abuse related. Assessment of domestic abuse should be done by the attending officers with support from research from the Force Control Room staff

### **9.2.4 North Yorkshire Probation Service**

#### **Recommendation 16**

North Yorkshire Probation Service should ensure that all practitioners complete the mandatory domestic abuse training.

#### **Recommendation 17**

North Yorkshire Probation Service should work to improve the management of MARAC information by using planned staff development events to ensure that all practitioners are aware of the need to complete SARA assessments and

incorporate these into overall risk assessments. This will highlight the importance of MARAC information and the need to complete actions identified within MARAC meetings, and, the need to follow up on police checks where information is not received in a timely manner.

#### **Recommendation 18**

North Yorkshire Probation Service should improve the management of Domestic Abuse cases in order to embed learning by using the manager/practitioner reflective supervision process to explore the management of domestic abuse cases.

### **9.2.5 Tees, Esk and Wear Valley NHS Foundation Trust (TEWV)**

#### **Recommendation 19**

TEWV should strengthen routine domestic abuse enquires and the recording of this in the Electronic Customer Record.

#### **Recommendation 20**

TEWV should have further consideration of patients accessing services with dual diagnosis, especially where this can lead to difficulties in the service engaging the patient.

**These recommendations will be incorporated into a 'SMART' action plan with leadership and scrutiny provided by the North Yorkshire Community Safety Partnership.**