North Yorkshire
Community Safety Partnership

A Domestic Abuse Related Death Review of Jayne

April 2024

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Pen Portrait – Family Memories of Jayne

A few words from Jayne's mother and sister:

"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."

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Section 1: Introduction

1.1 This Domestic Abuse Related Death Review (DARDR) examines agency responses and support given to Jayne, a resident of North Yorkshire, prior to her tragic death in April 2024.

1.2 In addition to agency involvement, the review will also examine the past, to identify any relevant background or indicators of harm or of potential abuse before her death. It will consider if support was accessed and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify lessons that can be learned from this incident.

1.3 The circumstances of the death were initially provided by North Yorkshire Police via email to the Chair of the North Yorkshire Community Safety Partnership on 30th April 2024.

1.4 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 Jayne. The perpetrator will be referred to throughout as Clive. Jayne's ex-husband, who was also violent to Jayne, will be referred to as Peter. Initial scoping indicated an abusive relationship which resulted in the launch of a Domestic Abuse Related Death Review (DARDR). Jayne's family were consulted and agreed to the use of these pseudonyms.

1.5 The review will consider all agencies' contact and involvement with Jayne and Clive from April 2019 through to the date of Jayne's death. This five year period was agreed as appropriate in order to give a full picture of Jayne's life and vulnerabilities. However, to fully understand Jayne's experiences and see life through her eyes, the panel agreed to consider any significant event or pattern of events spanning her lifetime. These are also documented within the review.

1. 6 The key purpose for undertaking DARDRs is to enable lessons to be learned where a person is killed as a result of domestic violence and abuse or takes their own life and suffering domestic abuse or experiencing coercive control may have been a significant factor. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand what happened and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.7 The DARDR Panel and North Yorkshire Community Safety Partnership extend their condolences to Jayne's family at this difficult time.

Section 2: Timescales

2.1 The review began in November 2024 with the appointment of an Independent Chair and a separate Independent Author. The first DARDR panel meeting was held on 22nd January 2025. On 11th March 2025 there was a briefing for authors on how to complete Individual Management Reviews (IMRs) where it was also noted to agree standards and ensure compliance with national guidance. The second DARDR panel was held on 30th April 2025. The panel met for a third time on 14th July 2025 and finally on 22nd September 2025.

The victim's family were invited to the final panel meeting and Jayne's sister attended. She met the panel members and had an opportunity to ask questions.

2.2 The DARDR was concluded in December 2025 following presentation to the North Yorkshire Community Safety Partnership, who agreed with the conclusions, learning and recommendations.

Section 3: Confidentiality

3.1 The content and findings of this review will be 'confidential', with information available only to those participating officers and professionals and where appropriate their organisational management. It will remain confidential until the review has been approved for publication by the Home Office Quality Assurance Board.

3.2 The victim, Jayne, was 49 years old at the time of her death. Her partner, Clive, was 50 years old at that time. They had no children together, however Jayne has a child from a previous relationship with Peter. When the child was nearly three years old, they were removed from Jayne's care due to safeguarding concerns. All subjects of this review are British citizens who reside or did reside permanently in the UK. Their ethnicity is white / British.

Section 4: Terms of Reference

4.1 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	How effective was the MARAC? 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).
11	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? 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). 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
12	How did agencies recognise and respond to issues of equality and diversity? 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?
13	Were there any barriers to reporting abuse or violence? Did professionals consider trauma informed practice?
14	How were issues relating to Child Protection identified and managed?
15	Was there evidence of economic abuse taking place?
16	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?

4.2 As the review gathered further information and the Chair & Author met with the victim's family, one additional terms of reference was added in response to this updated information:

- How were reports of sexual violence investigated and supported?

4.3 The sexual abuse was not perpetrated by Clive and Jayne declined to report all incidents. There was potential economic abuse carried out by both Clive and Jayne towards vulnerable adults. In addition, Jayne had her own house which had been built by her father. At one point Clive moved in without Jayne and refused to leave. Was Clive controlling Jayne with regards to economic abuse?

4.4 These terms of reference were discussed and agreed with Jayne's family.

Section 5: Methodology

5.1 The North Yorkshire Community Safety Partnership (NYCSP) was formally notified of the circumstances of the death by the police on 30th April 2024. All agencies likely to be involved in the review were notified in writing to secure records. On 7th May 2024 an initial scoping exercise was commenced to determine the level of agency involvement. On 21st August 2024, the NYCSP Chair made a decision that a DARDR would be conducted. The inquest into the victim's death opened on 10th 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.

5.2 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."

5.3 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.

5.4 For this review, the term domestic abuse is in accordance with the statutory definition of domestic abuse contained within the Domestic Abuse Act 2021:

‘Definition of “domestic abuse”

(1) This section defines “domestic abuse” for the purposes of this Act.

(2) Behaviour of a person (“A”) towards another person (“B”) is “domestic abuse” if—

(a) A and B are each aged 16 or over and are personally connected to each other, and

(b) the behaviour is abusive.

(3) Behaviour is “abusive” if it consists of any of the following—

(a) physical or sexual abuse;

(b) violent or threatening behaviour;

(c) controlling or coercive behaviour;

(d) economic abuse (see subsection (4));

(e) psychological, emotional or other abuse;

and it does not matter whether the behaviour consists of a single incident or a course of conduct.

(4) “Economic abuse” means any behaviour that has a substantial adverse effect on B’s ability to—

(a) acquire, use or maintain money or other property, or

(b) obtain goods or services.

(5) For the purposes of this Act A’s behaviour may be behaviour “towards” B despite the fact that it consists of conduct directed at another person (for example, B’s child).

(6) References in this Act to being abusive towards another person are to be read in accordance with this section.

(7) For the meaning of “personally connected”, see section 2.

2 Definition of “personally connected”

(1) For the purposes of this Act, two people are “personally connected” to each other if any of the following applies—

(a) they are, or have been, married to each other;

(b) they are, or have been, civil partners of each other;

(c) they have agreed to marry one another (whether or not the agreement has been terminated);

(d) they have entered into a civil partnership agreement (whether or not the agreement has been terminated);

(e) they are, or have been, in an intimate personal relationship with each other;

(f) they each have, or there has been a time when they each have had, a parental relationship in relation to the same child (see subsection (2));

(g) they are relatives.

(2) For the purposes of subsection (1)(f) a person has a parental relationship in relation to a child if—

(a) the person is a parent of the child, or

(b) the person has parental responsibility for the child.

(3) In this section—

"child" means a person under the age of 18 years;

"civil partnership agreement" has the meaning given by section 73 of the Civil Partnership Act 2004;

"parental responsibility" has the same meaning as in the Children Act 1989 (see section 3 of that Act);

"relative" has the meaning given by section 63(1) of the Family Law Act 1996.'

5.5 The overarching reason for the commission of this review is to identify what lessons can be learned regarding the way local professionals and organisations work individually and collectively to safeguard victims.

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.

5.6 Initial scoping suggested that several agencies in North Yorkshire and elsewhere had involvement with the subjects of the review. Chronologies were requested and nine organisations were required to submit an Individual Management Review (IMR) of their agency's involvement. Other agencies submitted summary reports of their limited involvement. The DARDR Chair made enquiries to confirm the independence of the IMR authors.

Section 6: Involvement of family, friends, neighbours and wider community

6.1 Jayne's family were approached at the start of the DARDR. They were supported by an advocate from the Homicide Service from Victim Support. Telephone contact was made by the Chair to the victim's mother and sister. This contact (including via their advocate) was maintained on a monthly basis throughout the review.

6.2 Jayne and her sister were adopted and grew up on a farm with their mother and father. Their father died just before Jayne was 30 years old.

6.3 Jayne had always wanted to find her biological mum and did, continuing a relationship with her and an additional brother and sister from her biological mother's side.

6.4 Jayne's biological mum was also contacted by the DARDR Chair. She was pleased that a review was taking place but did not feel emotionally well enough to contribute. She had re-connected with Jayne a few years ago but did not know a great deal about Jayne's earlier life. However, the Chair did maintain contact throughout the process and she fully supports the report.

6.5 On 12th June 2025, the Independent Chair, Independent Author and the advocate from the Homicide Service visited Jayne's mother and sister to discuss the review and find out more about Jayne's life.

6.6 Jayne's mother started by saying Jayne *"was the sweetest thing."*

6.7 In the late 1990s and early 2000's, Jayne and her sister were very much into the rave scene. They would *"work hard all week and then party hard all weekend,"* using MDMA – the drug known as ecstasy.

6.8 Jayne's sister described how ecstasy had a bad effect on Jayne and as a way of "coming down" from a "high" both sisters started using heroin.

6.9 It was around this time that Jayne started suffering with agoraphobia. She would have panic attacks if she went out during the day and only ever went out if it was to a nightclub or rave party.

6.10 Jayne's sister stated that Jayne believed heroin helped Jayne with her mental health.

6.11 Jayne's sister explained that in the early 2000s, Jayne funded her habit with fraud – using stolen credit cards and cheques. When Jayne was with Clive she got involved with dealing drugs and exploitation of a vulnerable man. But it is the opinion of Jayne's sister, this was on her own volition and was not something she was forced to do.

6.12 Jayne's sister explained that Jayne first started in a relationship with Clive around 2001. They remained in an "*on-off*" relationship from then on until he killed her. It continued secretly, even when Jayne got married and Clive had other relationships.

6.13 Jayne married Peter and after many years of trying for a baby, Jayne finally fell pregnant and gave birth in 2016. At this time both her and Peter were drinking heavily, as well as taking Valium and temazepam. Jayne's sister said that despite this, they were both good parents.

6.14 In 2018, Jayne's baby was removed by Children's Social Care, due to Jayne being a victim of domestic abuse and still living with Peter, despite her efforts to leave him. Jayne's mother described of the child how *"Jayne bravely went out to the car to wave them off"*.

6.15 Jayne's mother explained that the removal of Jayne's child had a big impact on Jayne and, *"it destroyed her"*. Jayne had waited so long for her baby, and the child was removed from her care.

6.16 In 2019 Peter went to prison for assaulting Jayne and Clive immediately moved in with Jayne. Until then, Peter was not aware of their relationship.

6.17 Jayne would never acknowledge to professionals that she was in a relationship with Clive, as she thought it would affect the decision by Children's Social Care for the return of her child. Janye's sister said of them, *"Clive was toxic. They loved each other but their whole relationship was toxic"*.

6.18 Jayne's sister did not like Clive and would never go to Jayne's house if she knew he was there. This meant she spent less time with her sister.

6.19 Jayne's sister said that when Clive went to prison (for fraud), Jayne reduced her alcohol consumption and stopped drinking vodka and just drank lager and wine. She always used heroin.

6.20 The family reported that both Jayne and Clive managed to deceive DWP into giving them large payments for fixing or buying "white goods" which were never purchased. The money was used to buy drugs.

6.21 Jayne's sister explained that Jayne only became frightened of Clive in the last few years. In addition to her declining mental health, Jayne's physical health was deteriorating. She had an abscess in her groin which made her legs painful and she found it really difficult to walk.

6.22 Jayne's sister describes Jayne as being amicable and rational but as soon as she had a drink, she was a different person and hard to manage. *"She chose Clive over everybody. She stuck up for him"*.

6.23 Jayne declined to work with Horizons, North Yorkshire's adult drug and alcohol service. Although Horizons offered support numerous times over the review period, she blamed them, amongst other partner agencies, for the removal of her child.

6.24 Jayne's sister described one particular incident where she arrived at Jayne's house shortly after it had occurred. Jayne was at the top of the stairs, arguing with a male friend about Clive. Both the male and Jayne fell. The arguing continued and Jayne took herself to the top of the stairs and deliberately threw herself down, to stop the arguing. Jayne's sister said that whilst Clive had not physically caused the injuries, the argument was as a result of him and his behaviour.

6.25 Jayne sister described another incident that Jayne had told her about where Clive was trying to get Jayne to stand up, but she couldn't due to the pain in her leg. So Clive stamped on her and pulled her ponytail so hard to pull her up, that her hair came out.

6.26 On New Year's Day in 2023, Clive slapped Jayne in front of Jayne's mother, sister and her sister's partner. On another occasion, Clive grabbed Jayne's mother. This resulted in the family physically beating Clive.

6.27 Jayne's mother suspected domestic abuse and whilst she was not frightened of Clive she didn't want to 'push' him too much as he said he had family in Ireland and he had asked Jayne to move there with him. Therefore, Jayne's mother held back with involving herself with their relationship as she feared Clive may convince Jayne to move to Ireland and be at further risk.

6.28 When their relationship broke down and Clive refused to move from Jayne's house in November 2023, Jayne's mother told Jayne that she would go to the house herself, as a woman in her eighties, and physically get him out. Jayne pleaded with her not to: *"Mum don't. I'll suffer the*

consequences". This was the first time that Jayne had ever admitted to her mum that there was domestic abuse.

6.29 Jayne's family were invited to the final panel meeting which occurred on 22nd September 2025. Jayne's sister attended and 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*."

6.30 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.

Section 7: Contributors to the Review

7.1 Twelve agencies have contributed to the DARDR by the provision of summary reports or chronologies. Nine agencies then provided Individual Management Reviews (IMRs) to outline and analyse their own single agency actions, contacts and decision-making. The DARDR Chair and panel agreed that reports, chronologies, IMRs and other supplementary details would form the basis of the information provided for the overview author.

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

- 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)

7.3 Other agencies provided scoping, summaries and chronologies:

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

Section 8: The Review Panel Members

8.1 The DARDR panel 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

8.2 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.

Section 9: Chair and Author of the Overview Report

9.1 **Chair**

9.1.1 The appointed Independent Chair is Mike Cane. He is completely independent of the North Yorkshire 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 is a former member of a Safeguarding Adult Board, several Domestic Abuse Strategic Partnerships and a number of Safeguarding Children Partnerships. 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 Chair of the Sexual Assault

Referral Centre (SARC) management board. He has previous experience of conducting DARDRs, Safeguarding Adult Reviews and Child Safeguarding Practice Reviews as an Independent Chair/Author.

9.1.2 Mike completed accredited DARDR 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 'best practice in managing DARDRs' in 2022. In 2024 Mike completed the Level 3 accredited training from Advocacy After Fatal Domestic Abuse (AAFDA) for DARDR Chairs.

9.2 Author

9.2.1 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.

9.2.2 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.

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

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

Section 10: Parallel Reviews

10.1 The inquest into Jayne's death was opened in September 2024. The inquest is yet to be concluded.

10.2 At the time of writing the Independent Office for Police Conduct (IOPC), are still investigating matters.

10.3 TEWV conducted an "After Action Review (AAR)".

10.3.1 The AAR review was held in April 2024 and staff from the Whitby and Ryedale Integrated Community Team were in attendance at the review. This included a member of the patient safety team, the initial assessor, and the Advanced Nurse Practitioner. Also in attendance was the Consultant Psychiatrist, Medical Secretary and the Team Manager.

10.3.2 Areas of good practice / examples of good quality care: were highlighted as:

- TEWV safeguarding team attended MARAC meetings and these MARAC meeting minutes were reviewed by the initial assessor as part of the assessment process.
- Safeguarding was raised and a PAMIC (**Potentiality** for the **Adult's Mental** Health to **Impact** on the **Child)** tool was completed.
- Contact with other agencies involved with Jayne was noted and staff asked about her carers and Next of Kin as part of the assessment process.
- Staff had also reviewed Jayne's care after a referral to supporting victims for her had been rejected.

10.3.3 There were no actions for wider learning identified.

Section 11: Equality and Diversity

11.1 The protected characteristics named under the Equality Act 2010 are age, sex, gender reassignment, marital status, race, religion/belief, pregnancy, sexual orientation and disability.

11.2 The victim and the perpetrator were not married at the time of her death. Jayne was still married to her first husband. Although they had permanently separated, they did not seek a divorce.

Jayne and Clive's marital status did not affect any of the services provided. However, due to neither of them acknowledging the nature of their relationship (i.e. intimate partners) there was a gap in services being offered as the referral pathway was not progressed in terms of domestic abuse.

11.3 No issues were identified during this review applicable to gender reassignment, sexual orientation, race or religion.

11.4 The victim was a vulnerable woman but was not registered as disabled, nor in receipt of statutory services. Jayne suffered from both physical and mental ill-health linked to use of alcohol and drugs, domestic abuse and emotional harm as a result of the removal of her child from her care.

11.5 The perpetrator was not registered with any disability but had mental health concerns linked to his alcohol dependency.

11.6 The Domestic Homicide Project[1] recently released their fourth annual report which states:

'A total of 242 domestic abuse related deaths were recorded between April 2022 to March 2023, including 80 intimate partner homicides (IPH).

Victim and suspect demographics remained consistent with previous years, with the majority of victims being female aged 25-54 years old, and majority of perpetrators being male and of the same age bracket.

Four in five perpetrators were known to police before the homicide occurred, three in five for domestic abuse, and over a third were known to other agencies, demonstrating the need for a multi-agency approach to effectively safeguard victims.

Across the three years of data recorded by the project, around 10% of suspects were recorded as either currently or previously having been managed by police or probation.'

These statistics reflect the subjects of this DARDR. Jayne was the female victim and her male ex-partner/partner was the perpetrator. This data also confirms that Jayne was in the age group statistically most likely to be a victim and Clive was in the age range most frequently identified for perpetrators.

Clive was known to police and other agencies and had previously perpetrated domestic abuse. He was being managed under MATAC.

11.7 Women are much more likely to be the victim of domestic abuse.

The Crime Survey for England and Wales (CSEW)[2] estimated 7.4% women and 3.3% men experienced domestic abuse in the last year. This equates to an estimated 1.6 million women and 712,000 men.

As in previous years, women were disproportionately represented among victims of domestic abuse-related crimes, with 72.5% of all victims being female in the last year. For domestic abuse-related sexual offences, the proportion of female victims was 92.1%

65.4% of victims of domestic homicide were female compared with 12.3% of victims of non-domestic homicide between the years ending March 2021 to March 2023.

Women are also likely to be killed by a partner or ex-partner, as is the case with Jayne.

[1] The Domestic Homicide Project is a **Home Office funded research project** led by the National Police Chiefs' Council (NPCC) and delivered by the Vulnerability Knowledge and Practice Programme (VKPP) in collaboration with the College of Policing.
[2] Crime Survey for England and Wales (2024)

In the year ending March 2022[3], female victims were more commonly killed by a partner or ex-partner (33%) or a family member (13%). For males the suspected killer was more commonly a friend or acquaintance (18%), stranger (15%) or other known person (9%).

11.8 Mental health is a factor affecting many victims of domestic homicide.[4]

Mental health issues were recorded for 48% of the victims. The mental health issues do not differentiate between those which existed prior to their experiences of domestic abuse and those which are directly related to the experience of being abused.

Of the mental health issues noted, depression is most often found (26% of the issues recorded). 16% of victims had suicidal thoughts and 14% had attempted to take their own life. Low mood / anxiety was also a mental health issue impacting on 14% of victims. The other mental health issues noted include anxiety, dementia or Alzheimer's, panic attacks, psychosis, PTSD, and self-harm.

It is noted Jayne had mental ill-health which supports this data. As does the CSEW which notes a higher percentage of domestic abuse victims had a long-term or temporary illness.

Research into mental health and domestic abuse, carried out for Women's Aid[5] states:

"*Survivors of domestic abuse who are experiencing mental ill health (because of or exacerbated by the abuse) often feel stigmatised, marginalised or ignored*."

When considering the vulnerabilities of perpetrators, 71% had been recorded with at least one vulnerability (which is a larger proportion than the 61% of victims).

In examining the type of vulnerability, illicit drug use, problematic alcohol use and mental ill-health were the largest proportions (30% to 33%).

The Domestic Homicide Project also noted:

'Key indicators of risk present in the perpetrator's history consistently include: controlling and coercive behaviour, mental ill health, alcohol use, drug use and separation/ending of the relationship.'[6]

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[3] Office for National Statistics (ONS), released 9 February 2023, ONS website, article, [Homicide in England and Wales: year ending March 2022]

[4] Key findings from analysis of domestic homicide reviews: October 2019 to September 2020 (Updated 12 April 2023)

[5] Women's Aid. (2021) Mental health and domestic abuse: A review of the literature. Bristol: Women's Aid

Clive was known for his controlling and coercive behaviour. His excessive use of alcohol and drugs was linked to his mental ill-health.

11.9 As we can conclude from the data, Jayne's intersectionality[7] brought together several of the factors / protected characteristics which exacerbated her vulnerability and disadvantage.

Section 12: Dissemination

12.1 The following organisations/people will receive a copy of this report after any amendment following the Home Office's quality assurance process:

- Jayne's family
- All organisations within the North Yorkshire Community Safety Partnership
- North Yorkshire Safeguarding Adults Board
- North Yorkshire DARDR Panel
- Office of the Mayor for North Yorkshire and York
- Home Office DARDR team
- The Domestic Abuse Commissioner for England & Wales
- HM Coroner
- Independent Office for Police Conduct (IOPC)

[7] The value of intersectionality in understanding violence against women and girls | UN Women – Europe and Central Asia Intersectionality is the interconnected nature of social categorisations such as race, class, gender, disability etc as they apply to a given individual, regarded as creating overlapping and interdependent systems of discrimination or disadvantage.

Section 13: Background information

Case specific background

13.1 The victim, Jayne, was born in the UK. She was married to Peter, and they had one child together. The relationship ended due to the Peter's violence and abuse towards Jayne. Police were involved and eventually Peter was arrested, charged and convicted. This resulted in him receiving a custodial sentence in 2019.

13.2 Jayne's child was removed from her care in 2018 and stayed with a family member. Jayne had supervised visits. This was due to the domestic abuse in the household and substance use by both Jayne and Peter.

13.3 Almost immediately after Jayne's estranged husband, Peter, went to prison, Clive moved in with Jayne. In almost all cases, throughout the five year timeframe of this review, both denied they were in an intimate relationship.

13.4 At this time, in 2019, both Clive and Jayne were dependent on controlled drugs (heroin).

13.5 Clive was a perpetrator of domestic abuse in North Yorkshire with two previous partners. Further research on the Police National Database (PND) indicated that Clive had perpetrated domestic abuse against other victims elsewhere in the UK. He was a known drug user and had a history of violence towards police.

13.6 It appears it was not until 8th March 2021, when the police received information, indicating there was the first detail of an intimate relationship between Clive and Jayne.

13.7 In 2022 Jayne stopped taking drugs but started drinking and at one point told agencies that she was drinking 2-3 bottles of vodka daily.

13.8 Clive has a background of chronic substance use, initially documented in 1999, including alcohol, heroin, street and prescribed benzodiazepines and sleeping tablets. He was issued with medications to treat dyspepsia (indigestion) in April 2022. Later in the scoping period amitriptyline was added to his regular prescriptions of codiene for pain, alongside a referral to the pain clinic. Clive was also prescribed clopidogrel, to prevent further strokes and thiamine, calcium and vitamin D (dietary supplements).

13.9 Clive was known to local alcohol and drug services. There were periods of engagement and plans for community detoxification from alcohol in August 2019, though this was cancelled by the provider. He was treated with medical management of alcohol detoxification while an inpatient but would relapse once discharged. His behaviour is documented by

secondary care as being challenging. He would present to out of hours GP or the Emergency Department (ED) with various injuries exhibiting erratic and aggressive behaviour, sometimes leaving before assessment. During one admission in August 2019 the ward doctor documented (that Clive was) *"volatile and required security presence, this persisted throughout the day and he was removed from the ward and discharged"*.

13.10 Clive was also commiting numerous aquisitive crimes involving fraud, burglary, robbery and theft.

13.11 Clive was also regularly exploiting vulnerable people by moving in with them and using their properties to commit other crimes such as drug dealing and stealing money from them. This activity is known as "cuckooing."[i] He referred to one such victim as "his grandad". Information suggests Jayne may also have been involved in exploiting others.

13.12 Jayne suffered with her mental health. In addition to trauma from losing custody of her child, possibly evoking emotions of her own adoption and various dependencies, Jayne suffered with agoraphobia, anxiety and depression.

13.13 Jayne also had periods of self-harm and suicidial thoughts.

13.14 In the last six months of her life, there was an escalation in injuries Jayne reported to services, Clive being the perpetrator. Clive was on police bail at the time of Jayne's death and had a Domestic Violence Protection Order (DVPO), restricting any contact with her.

13.15 Late one evening in April 2024, a member of the public called the ambulance to say that Jayne was in the river and Clive had hold of her. The member of the public knew them both.

13.16 Jayne was taken to York hospital, where a few hours later, she died. The cause of death was:

- Hypoxic-Ischaemic brain injury, due to:
- 1b: Cardiac Arrest, due to:
- 1c: drowning
- 2: fracture of the right femur and alcohol intoxication

13.17 Clive was arrested at the scene, and later charged with the murder of Jayne.

13.18 The inquest into Jayne's death was opened on 10th September 2024 and at the time of writing has still not been concluded.

13.19 Clive was found guilty by unanimous verdict at Leeds Crown Court after a 2 week week trial. He was sentenced to life imprisonment with a minimum term of 21 years.

Section 14: Chronology

14.1 The domestic abuse DARDR Panel agreed to review agency records going back five years before Jayne's death. In some instances, earlier records were also checked as they could provide an insight into the life experience of both Jayne and Clive. This is a chronology of those agency contacts.

14.2 In January 2016, Jayne was pregnant and expecting a baby with her then husband, Peter. At that time she was being supported for maternity by Harrogate and District Foundation Trust (HDFT).

14.3 The baby was born in Spring 2016 at 38 weeks and was monitored by HDFT for signs of Neonatal Abstinence Syndrome, as both parents were on a methadone programme and using heroin.

14.4 In August 2018 there was a Strategy Meeting as a result of domestic abuse in the family home, where the conditions were described as "poor." Jayne stated the abuse had started in 2016. A decision was made for the child to stay with a family member.

14.5 Later that month the child was removed from Jayne's care, and she had twice weekly supervised family time.

14.6 On 7th May 2019 Jayne attended the Police Station to report that her ex-husband, Peter, had held a knife to her ribs and was in breach of a non-molestation order. A risk assessment was conducted by officers which was graded as high risk, and a referral was made for the Multi Agency Risk Assessment Conference (MARAC). Safeguarding measures were put in place for Jayne.

14.7 Later that month, Peter was arrested for breach of non-molestation order, assault and affray. He was remanded into custody and on the 2nd July 2019, sentenced to 2 years imprisonment and issued with a 5 year restraining order.

14.8 On 15th May 2019, North Yorkshire Police received intelligence stating that Peter was in prison, and Clive had moved in with Jayne.

14.9 On 20th May 2019, North Yorkshire Police received intelligence that there was a male victim of "cuckooing" by Clive and had been ongoing for a year. This was the first of numerous intelligence reports over the next five

years that demonstrate a concerning modus operandi (MO) by Clive, exploiting several vulnerable people.

14.10 On 7th June 2019, Jayne did not attend a mental health appointment. Once spoken with, Jayne stated that she had never received a letter with the appointment date. This is a pattern of behaviour of not attending appointments.

14.11 On 14th June 2019 a neighbour, who was part of the cocoon watch[ii] for Jayne, reported to North Yorkshire Police :

“in the last few minutes a male who they believed was P at the address and was advised to call if he attended. The male had wrote “I heart you” outside the door and left on foot in drink.”

Peter was in prison at the time so the male was probably Clive.

14.12 On 19th June 2019 Tees, Esk & Wear Valleys NHS Foundation Trust (TEWV), who provide mental health services in North Yorkshire, attempted to contact Jayne by telephone to offer an appointment for a review as she had missed two appointments. The phone was ringing but there was no answer and no voicemail facility. A ‘Text and Opt in’ letter was sent and requested contact within the next 14 days.

14.13 On 4th July 2019 Jayne contacted TEWV service and left a message requesting a home visit and that she wanted to engage with services. Considering her diagnosis and severity of her agoraphobia Jayne was offered an appointment as a home visit.

14.14 On 15th July 2019 Jayne attended a face to face Work Capability Assessment (WCA) accompanied by her mother who was present during the assessment. The healthcare professional recorded:

“She had two recent suicide attempts, takes medication, is under the community mental health team and has specialist input. She had a recent hospital admission and recent previous drug and alcohol use, and she successfully completed a detox program.”

14.15 On 17th July TEWV carried out a home visit with Jayne to assess needs following MARAC who reported, in summary:

“Mood variable struggles more when mood low. Poor sleep but appetite stable. Childhood trauma (see paragraph 15.2.1). Denies alcohol use, reports no illicit substance use since Nov 2018 and smokes cigarettes. Friend and teenage relative present. Jayne reported staying with her teenage relative who is there to assist her and give her mother ‘a break’. Friend lives opposite her house and keeps in contact. Friend stayed in the appointment with her...Child reported to be a protective factor. Struggles to go out and avoids crowded and busy places which leads to isolation.

Reported recent assault and robbery at cash point which has increased her fears of being out in public. Jayne shared due to her anxieties she did not report this crime to the police as did not want to go through process of reporting a crime. Jayne states she wants support to help her go out and help with her mood."

14.16 On 1st August 2019, Clive was discharged from Scarborough General Hospital after a collapse attributed to alcohol excess. It was recorded that he was:

"Volatile and required security presence, this persisted throughout the day, and he was removed from the ward and discharged".

14.17 On 7th August 2019 North Yorkshire Police were made aware that a male known to them had been robbed several times by another male and needed financial help due to this or food vouchers. The offender was identified as Clive. Officers spoke with the victim who explained that Clive had been doing this for a year. An adult Public Protection Notice (PPN) was submitted.

14.18 On 28th August 2019 there was a report from a member of the public:

"Jayne had run off down the street as the male who lives there has assaulted her and he is still in the property. Caller states that about an hour ago, she witnessed the male banging about trying to get into the property and then saw him go around the back of the house. She witnessed Jayne looking "angry" and Clive slapping Jayne. She then saw Jayne try push Clive away towards the door as if trying to get him out. Jayne then broke free and fled the address, being chased by the male down the street. He then returned to the property alone and turned off all the lights. The caller did not know the name of the male but believes he is intoxicated. The Force Control Room (FCR) operator recognised that this could be Clive. Officers attended and described the house as "clearly a male living in one room and a female in another". Clive was arrested for assault and criminal damage and whilst in custody stated, "JAYNE IS GONNA GET FINISHED OFF". Jayne was located and returned home with officers. Jayne told officers she and Clive are not in a relationship, they are extremely close friends. She told officers, "Clive would now blame her". Jayne did not wish to pursue a complaint and told officers she does not support police involvement, Clive had not assaulted her, and they were 'messing around.'"

14.19 All throughout this incident it was not classified as domestic abuse. However, a task was sent through to the Officer In the Case (OIC) to complete a PPN (which was not completed) with the following response:

"Further to last task Jayne has confirmed that Clive does not live at her address, and they are not in a relationship. They are old friends, and the incident happened at her home address where he occasionally stays in a spare bedroom."

It was documented that Jayne was fearful about reprisals from Clive if he believed it was her who called police. Clive was charged with criminal damage but released with no further action regarding the assault. He pleaded guilty to criminal damage and was ordered to pay compensation (£45).

14.20 Jayne's declining health was evidenced in a report from TEWV on 17th December 2019:

"Jayne explained that since she saw a colleague for her initial assessment she had not seen other workers: The Care Coordinator was under the impression Jayne had been seeing a psychologist, so acknowledged that Jayne had not been seen for some time. Jayne presented as anxious about the visit but gradually settled into the session. Jayne explained that her nephew moved in 6 months ago and is doing his 'A' levels. The Care Coordinator was able to meet her nephew a little later and introduce herself...Jayne explained she did not feel safe in her own home, and this is an ongoing theme for her...However, it is a real struggle for Jayne to feel safe in her home, so she asked her friend's partner to move in which has helped. Jayne explained that she has felt low and scared to go out. Struggling to leave her house is her main problem and if she goes out someone needs to go with her. Her friend visits daily to see if she needs any shopping. Jayne managed to go to 'Lidl' a few weeks ago with a friend but experienced a panic attack and had to wait outside. Jayne explained that it is 'the people' she is avoiding and shared that she has been experiencing these difficulties since Feb 2019. Jayne explained that she ended her work in Jan 2016 when she had her child."

14.21 On 1st January 2020, Jayne reported to the police that Clive (who she described as a friend) kept coming to her house at all hours, banging on her door. If she did not let him in he shouted in the street and threatened to smash her door in. Jayne let him in, so it did not disturb the neighbours. Clive also left voicemails if she did not open the door, she had these on her phone. Clive did not like it when she asked him to leave and got very angry. Jayne disclosed to the Force Control Room operator that Clive had dragged her across the street before, threatened to stab her and her family and she was worried he may carry through with his threats. Jayne disclosed this has been on-going for around six months. On 2nd of January 2020, Jayne told officers she did not want to see an officer and would like it to be logged, and she would call back if anything else happened.

14.22 The Neighbourhood Policing Team (NPT) were tasked to attend to see if they could encourage Jayne to report. Jayne was not at the address. Repeated attempts were made and a note left at the address. Jayne agreed to come into the police station on the 10th of January 2020. She denied what she had said on the call and said she had had issues with a friend but stated this was not Clive. Jayne was asked about Clive, and she said he lived elsewhere and had not caused her any problems, she has known him for 22 years and under drink/drugs he is a "nightmare" but did not disclose any offences. No reports/arrests were made. No PPN was submitted as she was still referring to him as "friend".

14.23 On 3rd January 2020, after being arrested and in custody for burglary, Clive was sent to Scarborough General Hospital with a head and facial injury. He had been hit with a metal bar two days previously. Due to his historical contact with mental health services and drug / alcohol issues he was referred to the Liaison and Diversion Team for contact with mental health services, drug and alcohol dependency. Clive had alcohol dependency and prescribed drug use (reported he was being prescribed pain relief by his GP but admitted to purchasing more of the same medication due to tablets not helping). A safety summary was completed and letter sent to Clive's GP. There was also a referral to Humankind (Part of Horizons) for support with alcohol dependency. It was recommended that Clive contact his GP to arrange a review of his medication.

14.24 Both Clive and Jayne did not engage with DWP for assessments for Universal Credit and both received additional payments for clothes, bills and occasional large sums of money (over £700) for large purchases such as "a new boiler". This was despite no face to face contact. This occurred several times including April and October 2022 and February 2024.

Face-to-face appointments were limited in 2020 due to coming out of the covid restrictions and when someone is determined to have Limited Capability for Work and Work-Related Activity (LCWRA). This means they are not required to seek work or engage with Universal Credit to continue receiving payments. An advance can be applied for by phone or online, there is no requirement to attend a Jobcentre, although they can access support on a voluntary basis.

14.25 In March 2020, intelligence was received by North Yorkshire Police that Jayne was exploiting the same vulnerable male being exploited by Clive. Jayne was apparently paid £15.00 per week to clean the male's flat, but the flat was a complete mess.

14.26 At the end of March 2020, and the start of the pandemic, Jayne asked TEWV for a letter to evidence she was a "vulnerable person" to allow her to visit supermarkets at a quieter time. Jayne explained to TEWV that the

Covid restrictions had significantly reduced her anxiety. The letter enabled access to the 'Vulnerable Persons' time in supermarkets during Covid 19. This was due to significant social anxiety difficulties. There was a consideration to use the delivery service but Jayne needed to build her confidence being outside and not lose this skill altogether.

14.27 On 6th April 2020 TEWV requested advice regarding medication from a Consultant Psychiatrist as Jayne was significantly struggling with sleep and self-care. This was discussed in a team meeting and the psychiatrist telephoned Jayne on 21st April 2020 to inform her that he had increased her medication. Jayne's GP was informed. On 5th June 2020 Jayne contacted the duty worker to explain that she had stopped taking the medication due to side effects.

14.28 On 22nd June 2020 Jayne telephoned TEWV to state that she was really struggling with her mental health. She could not remember the last time she had spoken to her Care Coordinator, and she was advised because the Care Coordinator was busy that gaps between appointments may be longer than usual. Jayne sounded upset and did not want to get anyone into trouble but was struggling. No suicidal ideation or harm to others was expressed. The last contact with the Care Coordinator was two months prior, on 21st April 2020. (This was due to the TEWV Care Coordinator being absent from work and her appointments were not reallocated).

14.29 On 26th June 2020, a nurse from TEWV had planned telephone contact with Jayne which evidenced that her speech was at a normal rate however quiet. She reported that anxiety was getting in the way of her recovery. Her mood was 'objectively and subjectively euthymic', and she denied any active planning to take her own life. However, she did express thoughts (when prompted) of 'slitting her throat'. Jayne explained this usually happened when her anxiety was 'sky high' and it was more about wanting the feelings to disappear. She felt Mirtazapine was much more effective than Fluoxetine and said she had noticed a reduction in suicidal thoughts (reported feeling very angry on Fluoxetine).

14.30 On 18th July 2020, Clive had been brought into York Teaching Hospital (YTH) by ambulance after he was found collapsed in the street with a suspected overdose:

"Diazepam found on person. Referred for drug and alcohol difficulties. acute hospital nursing staff contacted TEWV Liaison Psychiatry for advice and support. Undertook assessment. Unable to gain full history due to level of confusion. At that time was not engaged with community drug and alcohol services. Reported using heroin daily via smoking but denied IV usage. Reported daily high alcohol consumption. Requested money for

drugs and alcohol. No drug screen was available since admission. Appeared to lack capacity. 1-1 observations were in place as he had been trying to leave and had commenced on unplanned medically assisted alcohol withdrawal. Diagnosis was likely to be accidental overdose of illicit Benzodiazepines."

14.31 Clive continued on his current treatment plan. An urgent application for a DoLS (Deprivation of Liberty Safeguards)[iii] was requested and reviewed by TEWV as Clive lacked capacity and was an absconding risk. He was kept on 1-1 observations and observed for opiate withdrawal. Clive denied being on methadone. This was to be reviewed again on 23rd July 2020

14.32 It was reported Clive was in hospital after being found unconscious in the street. It was reported that he had been drinking 1.5 bottles vodka and using 2-3 'bags' of heroin prior to admission. The referrer also reported Clive had disclosed that he had purchased 150 illicit benzodiazepine tablets and had taken 70 of those on the day he was found unconscious however stated that this was not an intentional overdose. Clive was expected to be discharged the following week.

14.33 On 23rd July 2022 a follow up review by TEWV showed that Clive appeared better. He was less confused, orientated and understood the reason for his admission. He denied an intentional overdose. He stated that he had purchased illicit 'Benzo's' from the internet and had taken a mixed concoction of substances and alcohol. He had been agitated overnight so had been moved to a side room with 1-1 nursing. A DoLS was still in place. Overdose risk and harm reduction were discussed with Clive and treatment options for opiate and alcohol dependency explored. He was not displaying any significant alcohol or opiate withdrawal therefore symptomatic treatment concluded. He was advised about medically assisted alcohol withdrawal and continued with IV Pabrinex whilst an inpatient. He was to go home when medically fit. Clive reported that he lived with his grandfather. The acute hospital nursing team were advised by the doctor to consider an adult safeguarding referral for the grandfather. Clive was referred to the North Yorkshire Horizons (drug and alcohol service) for dependencies. On 25th July 2020 Clive left hospital.

14.34 On 17th August 2020, Jayne phoned the GP with suicidal thoughts. On checking up the following day, she stated she was having private counselling and was given numbers for the Crisis Team. The dose of antidepressants was increased.

There are numerous dates of Jayne expressing suicidal ideation with various services including: February, August and September 2021; January and May 2022; April, May and September 2023 and lastly on 3rd February 2024.

14.35 On 11th January 2021, Jayne had a telephone consultation with the GP. Jayne stated she was not suicidal but did have a headache following walking into a door with an injury to the right eyebrow.

14.36 On 21st February 2021, Jayne and her partner were dropped at the GP Out of Hours surgery, by Jayne's mother. Jayne had a self-harm wound to her right forearm that she reported she had cut the previous night with a knife. Jayne smelt of alcohol. She denied falling. Jayne became upset during the examination where there was a large 'v' shaped flap which needed hospital assessment, but Jayne didn't want to go.

14.37 The following day the GP called Jayne on her mobile. They discussed the incident on 21st February 2021. Jayne said she was not in a good place but denied suicidal thoughts but had them when she harmed herself. Jayne stated that her mother was paying for private therapy. There was a person in the background during the consultation saying, "tell them you had alcohol." Another referral was made to TEWV in March 2021 but Jayne was discharged due to non-engagement.

14.38 On 8th March 2021, North Yorkshire Police received information that, *"a vulnerable male was providing Clive's girlfriend, J, with money to top up his electric meter, however there were concerns J was not using the victim's money with the right intentions."*

14.39 In April 2021, there is a record from TEWV stating that Jayne did not attend that day and had not attended an appointment three weeks prior. It was noted that she had been discharged due to non-attendance before Christmas. There was a discussion with the Multi-Disciplinary Team (MDT) and a further letter was sent highlighting that the service had tried to contact Jayne via telephone without success and also that unfortunately Jayne had missed two planned appointments. The letter requested Jayne contact the service to discuss if there were any concerns with attending appointments. It explained that the service could then look at ways to help Jayne to meet with service representatives. It also recommended that Jayne contact her GP to discuss other support that might be available. The letter stated that if they did not hear from Jayne within seven days they would assume she did not want to meet and the service would inform her GP. Subsequently, there was no response to the letter and Jayne was discharged from the service on 4th May 2021.

14.40 On 12th April 2021 both Jayne and Clive rang Universal Credit by telephone requesting a "Budgeting Advance." Jayne asked for money to fix a broken boiler and Clive asked for money for clothes and footwear as he stated that he had put on weight in covid. Jayne rang at 1pm and Clive at 3.30pm. Jayne was given £350 to be paid into her account on 14th April

2021. Clive was given £250 to be paid the same day. At this point they were not using the same bank account (but did later that year).

14.41 On 28th June 2021 Clive was admitted to a medical detox centre for detox from alcohol, heroin and illicit methadone. However, Clive self-discharged against medical advice before treatment was complete on 6th July 2021.

14.42 On 7th July 2021 Clive contacted Universal Credit and gave new bank account details in the name of Jayne.

(Claimants must confirm they have the account holder's permission to use their bank account, and the account holder is asked to confirm their details. Claimants must ensure they can access their money. DWP has measures in place to ensure that payments of benefit are made to the correct bank account relating to that particular customer. Where alternative measures are requested by the customer which involve a third party, then well-established processes are in place to ensure that those payments are made securely and appropriately).

14.43 At 3.39am on 9th August 2021 Jayne called the police via 101 and stated she wanted picking up and taking away because she had suicide ideation. The call-taker asked why she felt like that, she said because of abusive men. Jayne was asked if she was alone at that time, and she responded to say she was, and nothing had happened that evening. Jayne was advised of the Crisis team. Jayne said she had tried this in the past but "they are rubbish". Jayne then terminated the call but before she ended it, the Force Control Room operator heard a male in the background saying, *"YOU NEED TO STOP THIS NOW".* Police attended, the lights were on at Jayne's address but there was no answer to knocking. There were no sounds of a disturbance and they could see through the curtains. Officers attempted to call and text Jayne. No further action was taken.

14.44 At 4.14 am there was a further call where Jayne called to say she was feeling suicidal. She talked about slitting her throat, that her child had died and there was no point in living, her life was 'shit' and her divorce was causing stress. Officers related this to the previous call and asked the call taker to try to find out who the male was in the background. Jayne was advised to call the crisis team, she confirmed she was with her friend Clive. Jayne told the call taker that she had the resources to go through the night and would ring the crisis team in the morning. She was described as much calmer by the end of the call. Clive told officers he had come to Jayne's address to support her.

14.45 Jayne made a further 999 call at 8.28am on 9th August 2021 saying she wanted sectioning as she was going to kill herself. She would not ring the Crisis team as they would just tell her to ring the following day. Jayne

stated she has lost her child, her sister did not talk to her, and her mum was not nice. She was sick to death of being alive, she just wanted to go, she wanted to die. Jayne was crying on the call. Clive came on the phone, he stated he didn't know what to do as she was distraught. Clive told the Force Control Room he would ring an ambulance.

14.46 Later that day on 9th August 2021, Jayne attended Scarborough Emergency Department following suicidal ideation - threatening to slit her throat. She denied intent to kill herself but 'didn't know' if she would do it in future.

"Protective factors included mum and child. History gathered: Extensive mental health - suicide attempts since age of 11. Jayne was adopted. Mother said this had been very difficult for her. Domestic abuse by husband of 10 years. Jayne used to use heroin, had been clean for 2 and a half years. Denied marijuana use or other illicit drugs. Multiple panic attacks affected functionality and could not work. Lived alone. Jayne voiced fear that if she engaged with mental health services it would be used against her in court and by social services in getting her child back."

14.47 Jayne was re-referred to TEWV Liaison Psychiatry following presentation at hospital following an incident the previous evening. Jayne explained that,

"she lived alone in her own home and that she had a child primary school age. His father was abusive towards her, and she stabbed herself as a result of this 2 years previously. Sadly, she lost custody and saw them once a month for 3 hours. Jayne had not worked since she had her child (used to work for a computer company) and avoided going out alone due to anxiety/agoraphobia. Jayne shared that she had tried to harm herself on previous occasions in the last 2 years. The first was when she stabbed herself and the second when she took an overdose 6 months after this. More recently she had made cuts to her wrists, this was 7 months ago, and scarring was visible. Jayne reported she did not trust social workers, and this was related to her losing custody of her child. It was reported that Jayne had grabbed a knife the previous evening when her friend Clive was over, this was impulsive and her intention had been to cut her throat, he stopped her, and no harm was caused. The police were called and advised to seek mental health support."

14.48 An assessment was completed and Jayne reported childhood trauma and had felt depressed for a long while. She stated that she was no longer taking Sertraline but was open to taking medication. The completed assessment identified low mood and anxiety affecting activities of daily living. It was noted that there was a history of drug and alcohol use but that Jayne had completed a detox in November 2018 and there was no

apparent relapse. Jayne shared that her previous relationship was domestically abusive - physical, psychological and emotional abuse from ex-husband. She reported that she had previous contact with the Independent Domestic Abuse Service (IDAS) but did not find it helpful. Jayne reported that there were some issues related to housing conditions and finances.

14.49 Jayne was discharged from hospital the following day on 10th August 2021. A safety summary was completed and the case was re-referred for the GP to re commence anti-depressants and transfer for graded exposure intervention. (This is a therapeutic technique commonly used to treat social anxiety disorder.) The crisis number was given and Jayne was signposted to other support networks e.g. TEWV Crisis, Anxiety UK, debt advice number and charity numbers to help with furniture etc. There was a request for the Community Crisis Mental Health Team (CMHT) to inform the Advanced Nurse Practitioner if a referral was not accepted. An assessment letter was sent to the GP

14.50 On 11th August a trainee psychologist attempted to contact Jayne following a conversation with the GP, who reported Jayne was experiencing suicidal thoughts. It was noted that an appointment was scheduled for 17th August 2021 for an initial assessment. On telephone contact Jayne did not pick up and her voicemail was full. It was reported that Jayne had previously had a long supportive conversation with her GP and there were concerns regarding thoughts to cut her throat.

14.51 Jayne was called three times but there was no response. The GP receptionist agreed to try and call Jayne to inform her about the appointment with the Integrated Care Team (ICT) on 17th August 2021. ICT had also sent a text to clarify Jayne's appointment time. The GP receptionist reported that the telephone calls had not been successful regarding contacting Jayne but they had sent two text messages informing her of the appointment with ICT and encouraged her to contact her GP if she needed additional support.

14.52 On 17th August 2021, Jayne attended the appointment with Clive. In the assessment Jayne reported historical trauma. She reported struggling with significant loss in her life. She struggled to attend appointments but wanted support with coping with anxiety and to feel more settled on medication. She also voiced hopes of returning to work as an electrician. She stated that she did not have suicidal ideation but her mood reported as variable. Jayne explained that she would access support from health services. The safety summary was reviewed and a safety plan was completed.

14.53 A further internal meeting about Jayne agreed an outcome. She was accepted onto a waiting list for anxiety management and social support. A trainee psychologist was booked to meet with Jayne to discuss plan. Jayne was referred for support from an Individual Placement and Support Worker (IPS).

14.54 On 11th September 2021 Jayne called the police to state she was going to kill herself. It is reported that she sounded drunk and the call taker could hear others in the background. The police attended, she was noted to be drunk and was with her partner. They stated that they were going out for breakfast.

14.55 On 30th September 2021 there was an abandoned 999 call. On playback the call taker could hear *"let me out"* over and over. The call taker phoned back, and Jayne said that nothing had been going on but that she is *"sick to death of it"* and *"please just ignore the call"*. Jayne then swore a lot and thanked the call taker for ringing and Jayne hung up. The number came back to Jayne, but she did not confirm her name. She sounded under the influence of something at the time of the call.

14.56 Officers were dispatched and attended Jayne's address. There were no signs of a disturbance and there was no answer to knocking. Officers called back and a male answered the phone who told Jayne it was the police, but she would not come on the phone, and the line was cleared. Officers eventually managed to speak to Jayne on the phone and advised her they would need to see her in person due to the nature of the call. They attended Jayne's address. Clive answered the door, drunk, and told officers Jayne was upstairs in bed, and she was fine, but he was advised officers needed to see her. Jayne came down, she said she was ok and had a bad day but did not want to say why. Clive told officers it was because she cannot see her child. There were no disclosures of any crimes and no further action was taken.

14.57 On 15th October 2021 North Yorkshire Police received information that described Jayne as Clive's girlfriend. *"Clive is likely to keep any stolen property at his girlfriend Jayne's address."*

14.58 On 12th January 2022 North Yorkshire Police received a call that Jayne was trying to cut her own throat. Officers attended but Jayne was at the Out of Hours Service with Clive who had a cut to his hand stating it had been cut by a mug whilst trying to take the knife from Jayne but later said he had fallen down the stairs. Both were drunk. Clive was advised to attend the Emergency department but refused.

14.59 A PPN was submitted with Jayne as victim, graded medium by officers. Jayne did not consent to referrals and she did not answer the risk assessment questions. An 'Adult at Risk' form was also submitted. The

PPN was triaged on the 13th January 2022 by the Domestic Abuse Coordinator (DAC) and reviewed by the Domestic Abuse Officer (DAO) on 9th February 2022. The grading was left as medium. The review by the DAO stated,

"This does not seem to be a domestic incident. It looks more to be a mental health incident - more than likely what was described to and then by ambulance regarding the female putting a knife to her throat. Injuries to the male from with the knife whilst taking it off the female - as described, or the broken mug. Attending officer states they have an extensive DV history together - this is incorrect. There are no previous incidents reported. They both have extensive history with previous partners. I will instigate a Domestic Violence Disclosure Scheme (DVDS)[iv] - unfortunately, the likelihood Jayne will engage to receive the disclosure is slim but that is not a reason not to try. There is a child linked to Jayne - it looks like the child is cared for out of area so is safeguarded and no referral needed. No referrals. No flags. DVDS instigated".

No arrests were made.

(North Yorkshire Police employ specialist domestic abuse support staff in the Domestic Abuse Team. A DAO is a Domestic Abuse Officer and a DAC is a Domestic Abuse Coordinator. Both are carried out by Police staff (not warranted officers). The DAC is a supervisor role for the DAO.)

14.60 Between 23rd February and 23rd March 2022 there were numerous attempts by staff in North Yorkshire Police to disclose a DVDS with Jayne. On 23rd March 2022 Jayne declined for the DVDS to be served.

14.61 On 7th April 2022, North Yorkshire Police received information that Jayne was drinking two bottles of vodka per day, taking heroin, and still driving under the influence of substances in order to supply controlled drugs.

14.62 On 5th May 2022, Clive attended Crown Court for an offence of fraud by false representation, stealing and handling goods. He was remanded into custody and later sentenced to 15 months. Jayne blamed a neighbour and was arrested on 10th May 2022 for intimidation of a witness and received a caution.

14.63 Whilst in custody, Jayne threatened to slit her own throat and the following day, on 11th May 2022, was detained under S136 Mental Health Act. Upon assessment, Jayne disclosed daily use of alcohol and heroin.

"Mental Health Act (1983) Assessment undertaken following Section 136. During the assessment Jayne presented as calm, polite and amiable and engaged well with the assessment. Jayne disclosed that she had someone staying with her, she was somewhat evasive around the circumstances leading to her taking in this person. Stating he wasn't

paying rent, but she was looking after him. Jayne reported being drunk this morning which led to an altercation with her neighbour who she reports 'got my friend sent to jail'. Denied any thoughts to end her life and denied any such thoughts in the recent past. Reporting drinking and using 2 bags of heroin a day. Not clear around how this was being funded. Expressed a desire to stop but did not want to work with Horizons. Presenting with possible withdrawal symptoms e.g. shivering and sweating. Mental state examination completed and no bizarre or unusual thoughts consistent with delusional beliefs noted. No evidence of acute mental illness, no mood or psychosis symptoms evident and denied any thoughts to harm self or others. Did not meet the criteria for detention under the mental health act therefore discharged from section 136 as not felt to be suffering from severe and enduring mental Illness requiring hospital admission."

14.64 On 13th May 2022, post examination, there was an MDT meeting. The MDT decision was not to offer managing emotions work due to current substance use, but Jayne had already stated in the 136 mental health assessment that she would not engage with Horizons.

14.65 On 6th June 2022, Clive was admitted to hospital with a stroke, renal failure secondary to rhabdomyolysis (condition caused when muscle is damaged and breaks down releasing electrolytes, toxins and proteins into the blood). He was discharged on 23rd June 2022 with a referral to the stroke clinic.

14.66 On 25th July 2022, Jayne was arrested for driving over the prescribed limit, charged and dealt with at Magistrates Court on 8th August 2022.

14.67 On 2nd September 2022, Jayne had a telephone consultation with her GP. It was a difficult conversation as Jayne was intoxicated. She stated that she was drinking 1.5 bottles of vodka per day and that she is sick if she does not drink and has blood in her vomit. She stated that it was her brother-in-law who was in the background of the call shouting. He came on the phone and was rude /obstructive and asking questions. The GP asked to speak with Jayne and offered a face to face appointment. Jayne initially agreed then declined saying she would make contact the following week. She stated that she did not want Horizons.

14.68 On 10th September 2022 the police carried out a welfare check on Jayne at her home address due to concerns regarding her alcohol use. Jayne did not answer her door when police knocked, however entry was granted through a friend who walked straight into the house as it was insecure and got permission from Jayne to allow them in. It was approximately 2.00pm at the time of the welfare check Jayne was sat in her bed in her underwear drinking a glass of orange juice with vodka, showing signs of

self-neglect to her personal care. Her bed was dirty, the duvets had no covers on and there was minimal furniture in her room, she smoked in the room with a variety of lighters and lighter fluid around and no fire alarm. Jayne stated herself she was struggling with alcohol and she said that she consumed two 70cl bottles of vodka a day. Due to this she was struggling financially and on average had one meal every four days, where she was borrowing money from a friend due to not having money for food. Jayne explained that she had no motivation to do anything. Her living room had little furniture and appeared to be in the process of being decorated. The kitchen was very disorganised and cluttered. The back door which she used was insecure as she was wanting to put a cat flap into it. Potentially Jayne would have benefited from an input from 'Living Well'[v] – a service which helps adults to improve health. This information was shared with Health and Adult Services.

14.69 In September 2022, a Social Worker made several attempts to speak with Jayne and when finally made contact, Jayne would not agree to support but did agree to a referral to 'Living Well'. This support was then declined.

14.70 Jayne did engage with Horizons and completed a triage assessment on 12th October 2022 where she reported she was drinking 2-3 x 70cl bottles of vodka per day.

14.71 On 17th October 2022, Jayne received a further payment for £812 for a new boiler. In this case the customer requested a budgeting advance.

The advance is a discretionary payment, therefore the Universal Credit (UC) agent must decide, based on the information provided by the customer, by asking further questions, if necessary, to determine whether the advance should be paid. A budgeting advance can be refused if the UC agent concludes based on the information provided by the customer or any previous historical data held on the UC digital record that the payment will not be used for the requested purpose.

14.72 In October 2022 there were numerous intelligence reports on Jayne concerned in the supply of drugs.

14.73 On 26th October 2022 Jayne declined further support from Horizons as she stated as she had been alcohol free for 17 days and was attending Alcoholics Anonymous (AA). The case was then closed.

14.74 On 16th December 2022, Clive was released from custody on licence until 3rd August 2023.

14.75 Jayne was at the Out Of Hours Surgery on 17th January 2023 for a head injury stating she had fallen down the stairs. The head wound was glued, and she advised she lived on her own.

14.76 On 23rd January 2023, Clive had a triage assessment with Horizons stating he had been alcohol free for 8.5 months.

14.77 In the first few months of 2023 there was lots of intelligence recorded by North Yorkshire Police that Jayne and Clive together (or separately) were dealing drugs.

14.78 On 31st March 2023 Jayne rang the police to make a complaint about her neighbour. In that call she stated she lived with her partner, Clive. The record was incorrectly linked to the wrong Clive. This prevented the pathway for support for domestic abuse.

14.79 On 21st April 2023 Jayne saw a GP face to face. Jayne was seen with mum, looking very unkempt. She stated that she wanted to kill herself and slit her throat but everyone kept stopping her. She described an altercation with someone in the street, from which she received a bruised eye and broken wrist. Jayne stated that she had drank alcohol that morning . The GP called the Crisis Team, but Jayne did not attend and when chased, Clive said she was asleep and then would be travelling elsewhere.

14.80 On 22nd April 2023 Jayne had a further face to face appointment with a nurse from TEWV for an assessment of her mental state and risk. Jayne reported a history of trying to end her life and episodes of self-harm since aged 11 years. She had a cast on her left forearm and reported that her partner Clive was having an altercation with a man, and she put herself between them and 'he' pushed her over which led to breaking two bones in her arm and a black eye. Jayne stated that she wanted to get to the point where she did not want to end her life. Jayne explained she would not go to Horizons so she was advised she could access Alcoholics Anonymous (AA). She reported she had stopped heroin two months previously but continued to drink daily. It was identified that she had drunk half a bottle of vodka prior to the assessment.

14.81 Jayne agreed for the Registered Mental Health Nurse (RMN) speaking to her mother for any further information. It was noted that Jayne had poor self-care. Jayne stated that she was still married to her first husband due to concerns over the property and that if divorced, Jayne would be forced to sell the house to give half of the money to Peter. She said that that she had been married to him for 11 years and he became abusive when her child was born. She also stated that prior to her marriage she had been in other relationships which were domestically abusive. She explained that at that time she lived with Clive and they had been together for a few years. She reported that there was no domestic violence, that he was supportive and he worried about her as he had had to stop her harming herself. There was no evidence of any psychotic symptoms. There was also no evidence which would suggest clinical depression however

extensive use of alcohol would impact on mood so would be difficult to fully assess unless abstinence was for a long period. Capacity was intact and Jayne was able to understand and retain information in relation to her care and make informed decisions. Jayne was informed that she would benefit from trauma therapy to address past issues but it would be difficult to engage with this whilst so reliant on alcohol. She was advised to access AA.

14.82 It was assessed that there was no further role for the Crisis team. Jayne did not want to engage at that point and had capacity to make that decision. Jayne had supportive people around her and was aware of how to seek help. She was advised to consider AA to support with alcohol reduction. She was provided with the number for the mental health response line and advised to speak to her GP. A letter was sent to her GP.

14.83 On 24th April 2023 Jayne made a self-referral via telephone to the Crisis team. Jayne requested to be sectioned to a psychiatric hospital. However, when she had been assessed by the Crisis team a couple of days earlier and there had been no indication of an acute mental illness. There were long standing issues with alcohol, but on a positive note Jayne had abstained from heroin. Jayne stated that she needed to be away from home for a few weeks, but no reason was given. She reported drinking high levels of alcohol on a daily basis. She declined support from Horizons stating Horizons called social care and took her child away. The RMN highly suspected Jayne was under the influence of alcohol and making 'vague threats' to end her life. On one occasion she asked the RMN*, 'Do I need to commit a crime to get sectioned?'* then ended the call.

14.84 The outcome documented, *"Jayne could be impulsive especially when under the influence of alcohol including self-harm and overdose, this can lead to significant harm and even accidental death by misadventure, chronic history of suicidal thoughts."* The RMN stressed Jayne may increase her risks in the community to gain psychiatric hospital admission.

14.85 On 11th May 2023 Jayne had a further visit to A&E stating she had a cut on her arm from a fall the previous day. It was recorded that Jayne was under the influence of alcohol at this attendance. She reported she had fallen downstairs between five and twelve steps on two occasions in the previous 24hrs - claiming paranormal activity pushed her from behind resulting in rolling downstairs. (Jayne's sister gives an explanation for this at paragraph 6.25).

14.86 On 17th May 2023 Jayne had a telephone consultation with her GP and stated she was suicidal but lived with a partner who was a protective factor. The GP marked a visit to her home address, which was done later

where Jayne and Clive were present. They disclosed they were drinking two bottles of vodka each per day. Jayne had a bruised, swollen eye. Clive stated she had fallen and hit her face on the hearth. Clive at this point had disengaged with NY Horizons.

14.87 On 26th May 2023 at 11am and as a result of unrelated enquiries, North Yorkshire Police attended Jayne's home address. Jayne was present, she had serious bruising to her face and she said she had fallen over.

14.88 Later that day at 5.44pm Jayne arrived at hospital and she was admitted in the Intensive Care Unit (ICU) with shortness of breath and right leg pain. She was later stepped down to the ward once her 'sats' had stabilised. She had a history of trauma two weeks prior to admission. She also had a history of multiple falls due to alcohol access. An Xray showed pneumonia , and she was treated with antibiotics. A CT scan was done which revealed acute left facial bone and left rib fractures. There was swelling to the left hand where an Xray showed distal ulna fracture. A trauma and orthopaedics (T&O) review was done, and plaster cast was applied. She had a fall as an inpatient and a repeat Xray of the left wrist showed new displaced distal ulna fracture. Following a further T&O review, a new cast was applied, which was to be removed after six weeks. Jayne was advised of a follow up appointment in the fracture clinic in six weeks. A Tissue Viability Nurse review was done for cavity in the left axilla (armpit). She was transfused with three units of blood while in hospital for low haemoglobin count.

14.89 On 28th May 2023 an urgent DoLS was authorised for seven days to prevent her from leaving hospital. Jayne was discharged from hospital on 7th June 2023 after having had pneumonia and sepsis.

14.90 On 11th July 2023 an injunction was served on Clive and others to stay away from a named person and location where the vulnerable person had been exploited.

14.91 On 26th July 2023 Clive called North Yorkshire Police, saying he was going to smash all the polices faces in, he was going to kill himself. He asked the call taker for their name. It sounded like he was having an argument with a female, saying he would shoot anyone that came to the house. He was overheard saying to a woman *"let's f*****g have it then, silly ****"*.

14.92 Police attended and spoke to Clive and Jayne. Clive stated he had been in York District Hospital after a stroke the previous night and had discharged himself (records indicate that Clive discharged himself before he was seen by a doctor). Jayne said Clive had been in hospital, come home and drunk a bottle of vodka. He was intoxicated, and he said Jayne was self-harming due to struggling with her mental health, as she is only allowed to see her child once a month for three hours supervised, under orders of

Social Services. Clive also said he had removed a knife from Jayne to stop her from self-harming. Checks stated there have been no domestic abuse incidents between either party. Both were left at the property. A PPN adult at risk form was completed for support to Jayne for mental health. A domestic abuse PPN was not submitted and the information was not shared with the domestic abuse team.

14.93 On 30th July 2023 Jayne reported to North Yorkshire Police feeling suicidal and that no one helps her. The call then ended. The Force Control Room tried calling back and she ended the call. The call was triaged by mental health and the Force Incident Manager (FIM). They managed to call Jayne back and she sounded intoxicated. She was sat at a cemetery saying she just wanted to breathe and not feel like death each morning. She said her head was *"f****ed",* the crisis team were no good, they don't help and she had spoken to the doctors.

14.94 Police attended and spoke to Jayne for an hour. She was described as being *"in a much better frame of mind"* and provided with appropriate contacts for support. A PPN adult at risk form was submitted.

14.95 On 1st and 2nd August 2023 both Jayne and Clive respectively were referred to Health and Adult Services for support from a Social Worker due to their vulnerabilities.

14.96 In Health and Adult Services a safeguarding concern for Jayne from Clive's probation officer was received. The concerns were linked to Jayne and Clive being in a relationship and living together. Both individuals were known to have alcohol use issues. Both had been in York Hospital within the previous two months. Jayne had Sepsis. There was concern for Jayne's general wellbeing and current living conditions. It appeared that she struggled to cope. A Customer Service Advisor screened the referral out of Safeguarding and changed to a request for support.

14.97 A Social Worker did try to ring Jayne on 3rd, 8th and 9th August 2023. There was no reply to call with no option for voicemail.

14.98 On 9th August 2023 staff from Health and Adult Services had a phone conversation with Clive to ascertain his views and wishes in regard to the reported safeguarding. At the time of the call Clive was on his way to the GP to hand in a form which his probation officer had given him to request some rehabilitation support. Clive confirmed that it was him that raised the concern to his probation officer and understood the risks, having had a stroke two months earlier, which really scared him as it had caused him to be paralysed on his right-hand side. Clive was fully aware that as long he remained living with his partner the cycle of alcohol use was likely to continue which would have serious consequences of further life-threatening health issues. Clive would have liked to be back in

employment to provide him with a routine and focus but was aware that he needed to get better first. Clive said that he did not like to live in a home that is untidy, waking up to unwashed pots and pans and wanted to have his own place again eventually, if possible, and accommodation with support.

14.99 To support Clive to identify his care and support needs he consented to a face-to-face Social Care Needs Assessment with no further action needed as the result of this safeguarding. Clive recognised that he could not remain living with Jayne and that he needed support. When he got anxious with feelings of paranoia at times it could trigger him to use alcohol as a coping mechanism and most likely to happen whilst he remained living with Jayne, who also had alcohol issues.

14.100 A safeguarding information gathering form for Clive was completed. The outcome decision was onward referral/signposting only. The referral was closed to safeguarding and Clive consented to a Social Care Needs Assessment. Clive had capacity to make his own choices and recognised that he needed support. The risk of further harm due to wrong lifestyle choices and neglect remained.

14.101 On 9th August 2023 a coordinator from the service, "Living Well" carried out a welfare visit to Jayne. They knocked on the front and back door but there was no reply. They spoke to a neighbour who said she had seen both Jayne and Clive that morning and thought that they were going out. A few moments later Clive appeared at the rear of the property. The coordinator showed their ID and Clive invited the coordinator inside and immediately offered his TV license. A female was sitting on the floor and the coordinator asked if she was Jayne. The coordinator asked how she was, and she replied that she was fine really. She stated that she had been in hospital for three days over the weekend (returned home on Monday 7th). She said that she had not felt all that well for some weeks having previously been treated in hospital with sepsis. She had been admitted again on Friday with dehydration and malnutrition both of which she believe were related to the sepsis. She stated that she did not have an appetite. Neither she nor Clive appeared to have been drinking alcohol and there was no evidence of any in the lounge or kitchen. The coordinator asked about her mental health, and she said that it was a bit up and down but not bad really. The coordinator asked how she was managing financially, and she said that it was as tough for them as it is for anyone else, but they get by. The coordinator asked if she was willing to accept any help and she immediately replied she would like a new cooker *"and I haven't had any white goods for years".* Jayne and Clive thanked the coordinator for checking up on her and for calling round.

14.102 On 23rd August 2023 Jayne attended the Out Of Hours Surgery having been assaulted with an injury to her left wrist/arm from twisting and a punch to left side of her head. There was no history or information on who assaulted Jayne in the notification.

14.103 Later that day at A&E, Jayne attended and appeared to be under the influence of alcohol. Her dress was torn and her left forearm was in an elbow cast. She had a swollen left part of the face. It was known that she was a previous victim of domestic violence with her husband who she stated they were no longer together but were not divorced. Jayne stated she was assaulted by her lodger following some argument. Jayne had declined to divulge the name of the lodger. She was punched on the left part of her face and her left hand was twisted two days previous. Jayne said that she was not interested in involving the police or social workers. No children had been present during that incident.

14.104 Jayne was reviewed clinically for the injuries and advice was given. After an X-ray her arm was to be placed in a cast. Jayne absconded after the X-ray. All attempts to reach her proved negative. A report was made for a secondary safeguarding review – but it was felt that the case did not meet the criteria for a MARAC referral as the assault was not by an intimate partner. Jayne refused to give the name of her attacker and insisted it was the ex-lodger who no longer lived at the address. It was passed to the Safeguarding Children Team to review for risks to a child, as records indicated that Jayne had contact with her child. Was Jayne hiding domestic abuse as she was concerned her child would not be returned to her?

14.105 On 4th September 2023 the Independent Coordinator (IC) and Reablement Manager from Health and Adult Services made a visit to Jayne's house for an assessment. The IC knocked on the door. There was no answer but the door was visibly unlocked. Ther IC called through a broken panel in the door. An unknown male answered the door and they were informed that Jayne was out. The male said Jayne had just popped out and invited them in. IC said there was no need to come in if Jayne was not there. They agreed to return fifteen minutes later.

14.106 Jayne then came to the door and invited them out into the courtyard to talk. Jayne said that she had forgotten they were coming, so they discussed the original referral. Jayne said she was fine and didn't need any help. She had her arm in a sling and pot. She said she had fallen up the curb outside and had fractured her jaw, arm and wrist five days earlier. She was due back at the fracture clinic for another x-ray the following day. Jayne said she was managing at home and that she didn't need any support. Jayne said she would like her referral to be closed down to Health and Adult Services. The IC said she would post her a

closure letter in the post and there would be the Customer Service Centre number on so she could refer herself in the future should her circumstances change, she said she would.

14.107 At 1.32pm on 13th September 2023 following two pieces of information received a few days earlier, the police requested a welfare check. A police officer attended and noted:

"I have been to see Jayne tonight and I can confirm she has injuries, but she is refusing to tell me what has happened. She said she had fallen. I have created an incident due to me seeing the injuries and that she is happy for some support from the DV unit and Clive not being present. Clive wasn't present she said she didn't know where he was and that she hadn't seen him for a few days. This intel was shared with DVDS team (DAC) – DAC wrote, 'DVDS previously prepared and declined by Jayne. Please re-offer if any further contact.'"

14.108 Later that day at 10.22pm police attended for a welfare check for Jayne. Jayne was seen with a black eye, scratches on her neck, broken arm in two places, she said her ex-boyfriend was *"gone for good"*. A PPN and risk assessment were completed. Jayne did not disclose the injuries were caused by Clive but there was reasonable belief to suspect this. Clive came round to pick up his belongings from Jayne's house whilst she was on the phone to the DAO. There was a verbal altercation whilst the DAO was on the phone so 999 was called.

14.109 Clive was arrested for an assault. Jayne stated that Clive had not caused any of the injuries and told police she had fallen and hit her head, and the arm was due to the previous assault. Jayne did not wish to pursue a police complaint. The case was closed. A Domestic Violence Protection Order (DVPO) was prepared and granted on the 19th September 2023 for 28 days (until 17th October 2023). Police served the DVPO (issued by the court) to Clive at a hotel in Scarborough.

14.110 Welfare checks and calls with Jayne were attempted. Jayne was spoken to and said she was fine and was staying at a friend's but would not disclose who. The DAO reviewed Jayne as a high risk case and referred it to MARAC. The DAO spoke to Jayne who declined North Yorkshire Horizons and they discussed IDAS and Clare's Law (DVDS).

14.111 Jayne was referred to the Crisis Team on 13th September but despite at least four unanswered calls, Jayne did not engage with them.

14.112 On 14th September Jayne was referred to IDAS as a High risk case.

14.113 On 15th September 2023 a safeguarding concern was raised for Jayne by the police. The concern stated;

“carried out a welfare check with Jayne due to information received that she had been beaten up by Clive. As they were attending she was outside her house painting her front door. They went inside and noticed that the house was clean compared to their last visit she said, "ITS BECAUSE HE'S NOT HERE". They sat and chatted, Jayne would not say what had happen and who had done it, she said she had just fallen. She had her left arm in pot, and she said it was broken in 2 places her left eye was bruised and on her neck she had 3 deep cuts / scratches. She had attended hospital to get the pot on. They tried to get more information out of her, but she just kept saying "IT DOESN’T MATTER". They believed that Clive had caused the injuries and that's why he wasn't at the address. Jayne did say that she is fed up of being beaten up by her partners and said she really didn't want to go down these lines again. Jayne is not strong enough to be on her own and will need support to stop her from going back. She has a child that is in the care of a family member due to DV in that relationship too, but Jayne stated that she would like to try to get him back full time, so this could be a way forward in supporting her. Jayne has her mum that lives nearby and she is very supportive. They have just cleaned her house up and Jayne feels a lot better about it. Jayne asked for support. She could do with some financial support around the house with her day to day living. She has no cooker and cannot afford a new one, her backdoor is not very secure and if someone wanted to be in it would be easily done.”

14.114 On 17th September 2023 the police received a dropped 999 call. Clive and Jayne were at the address and started arguing between them when the Force Control Room called back. Clive demanded to know why the police were looking for him.

Clive was arrested for an assault on Jayne.

14.115 On 20th September Jayne spoke with Health and Adult Services but advised that Clive was now her ex-partner, and she did not feel she needed support other than financial. The safeguarding referral was then closed.

14.116 On 22nd September 2023 North Yorkshire Police received information that Jayne was threatening to take her own life if Clive didn’t return to her. The information was shared with the Domestic Abuse Team, but there was a missed opportunity for the DVDS to be re-offered. The officers update on the police record clearly stated the mother of Jayne was willing to receive calls about Jayne if police were concerned or wanted to know where she was. This could have been explored as a potential means to deliver the DVDS with mum’s support.

14.117 On 25th September 2023 Jayne had a face to face consultation with her GP. They discussed the history of the assault. The lodger had moved out

and had been to court about it. Jayne stated that she now lived alone in her own home, trying to reduce her alcohol intake. Her diet was poor and she did have some suicidal thoughts and had attempted to cut her throat the previous week. Nutrition advice was given. The GP reported 'Racoon eyes noted – black eyes bilateral – no exploration.'

14.118 Jayne consented for a referral to mental health and the Social Prescriber. A referral was sent to CMHT. Medications were issued for sleep and increase in antidepressants. A Social Prescriber contacted Jayne who wanted the support and agreed for them to make contact the following week. The Social Prescribing Team made three attempts to call up until 5th October 2023 but were unable to make contact.

14.119 On 26th September 2023 IDAS telephoned Jayne and Jayne confirmed she was safe to talk. They discussed IDAS and the support they could offer. Jayne said things were fine and there were no ongoing issues with Clive. She did not confirm if she was in a relationship with Clive or had contact with him. Jayne stated she was struggling with a wrist injury, and it was caused by another random male. He had kicked off with her friend, she intervened, he grabbed her by the wrist and threw her into the road. Jayne said she had no current contact with this person, does not know who he is or where they live. The police had told her he had mental health problems and couldn't do anything. Jayne said her main issue was feeling that her front door was not secure. She said people had broken in previously and when asked "who", she said associates, friends. She feels afraid when she goes out but also scared to stay in. Jayne confirmed she could lock the door but felt like it wouldn't take much to put it through. Jayne was offered items such as door brace, or howzar lock so she could create a safe room but she declined saying she just wanted a new door. Jayne said she had support from her GP, the Crisis Team, local Police Community Support Officer (PCSO) and has a support worker who had helped her access the food bank. She had asked people she knew if they could change the door. Jayne was on long term sickness and unable to work due to her mental health. Jayne was asked if she felt she needed support in relation to Clive. She declined saying she just wanted her door sorting, but it had been nice to talk, and she appreciated the call. Jayne was not seen by IDAS until November as she did not attend appointments that were then rearranged.

14.120 Jayne was referred to TEWV mental health services again on 27th September 2023. An appointment was offered for 18th October 2023 that she didn't attend and a further one arranged, which she did attend on 14th November 2023.

14.121 On 28th September 2023 Universal Credit notes record that Clive was working with the Local Authority and that his payment would need to be

recalled as Clive was not allowed to be in contact with the third party bank account holder (Jayne) ex-partner due to police involvement.

14.122 On 30th September 2023 Health and Adult Services received a safeguarding concern for Jayne from hospital. The concern stated Jayne disclosed that she had been physically assaulted by her partner or ex-partner when attending NHS outpatient's clinic. She had visible bruising and swelling to both eyes.

14.123 The hospital submitted a safeguarding concern that was added on to the system appropriately and forwarded to the relevant care & support locality team.

14.124 On 10th October 2023 Clive was moved into Teen Challenge UK, which is an alcohol rehabilitation centre in Melton Mowbray, Leicestershire. He was there on an 11 month placement. He left ten days later on 20th October 2023, information suggesting he was evicted.

14.125 On 24th October 2023 Jayne reported that she had been sexually assaulted by a male, whom the previous day had been assaulted with a knife by Clive. Information suggested that Jayne was present when Clive and the male were fighting. This meant that Clive will have been in breach of conditions. Clive was eventually arrested and charged with drunk and disorderly behaviour. The male was arrested for the sexual offence on Jayne, but the case was concluded with no further action due to insufficient evidence (see analysis at paragraph 16.18.2).

14.126 Clive was arrested on 25th October 2023 for threats to kill a man. Whilst in custody, he was screened for a mental health assessment.

14.127 On 1st November 2023 Jayne saw her GP and disclosed the sexual assault. No adult safeguarding risk or assault risk were recorded.

14.128 The following day, Jayne was reviewed in the Rapid Diagnostic Clinic accompanied by her partner and one of the outpatient nurses was concerned about domestic abuse. Jayne confessed to previously being heroin dependent but had been clean for many years. However, she was now dependent on alcohol, consuming more than two bottles a day. She was referred to hepatology for their advice as she did appear jaundiced. Tests for A, B and C hepatitis and an HIV screen were requested. Her partner had suffered with hepatitis B and C in the past.

14.129 Clinicians felt that Jayne's partner was controlling as he kept trying to change the conversation. A referral for advice was made to the safeguarding team. A MARAC referral was made and the case was heard on 21st November 2023.

14.130 On 14th November 2023 Jayne attended a mental health initial appointment where a comprehensive initial assessment and a risk assessment were completed. No carer was present. Personal and mental health history were taken. Jayne demonstrated capacity at the time of the assessment although she was not formally assessed. She was able to articulate herself well, weigh up options and retain and communicate back information about her care Jayne advised her alcohol and drug intake had significantly reduced therefore no referral was warranted for North Yorkshire Horizons. However, she reflected that she was still surrounded by people who engaged in these activities. She described a chaotic lifestyle and she was vulnerable in terms of her relationship with her on/off partner. She had also been assaulted by a male friend recently. Jayne wanted support with anxiety and trauma. She declined adding any next of kin details onto the patient system.

14.131 MARAC Outcomes from 21st November 2023:

- IDAS - Encourage Jayne to receive the DVDS re: Clive
- North Yorkshire Police - Make the local Safer Neighbourhood Team (SNT) aware that Clive may be living at Jayne's property, leading to an increased likelihood of incidents

14.132 On 21st November 2023 Jayne's case was presented at a TEWV formulation meeting.

The outcome was that a Community Nurse was to liaise with the Independent Sexual Violence Advisor (ISVA) to determine what work was being undertaken to avoid duplication. There was consideration of a possible referral to Supporting Victims.

14.133 On 27th November 2023 North Yorkshire Police recorded that Clive and Jayne had been in a volatile relationship for a number of years where he had assaulted Jayne. She had not made any complaints which professionals believed was due to fear of Clive. On Monday 27th November 2023, Jayne was found with a black eye but refused to confirm how this was caused.

14.134 On 27th November 2023, the ambulance service reported a possible assault on a female. They had received a call from a passerby who had found Jayne "black and blue". Jayne told the ambulance service she had been assaulted.

14.135 Officers attended, Jayne had injuries to her face, she said she had fallen over but did allude to men being *"shit"*. Jayne appeared drunk at the time. Officers suspected her injuries were due to an assault based on previous domestic abuse history, which could not be substantiated as Jayne said she had fallen, and no assault had happened. The DAO spoke to Jayne

and Jayne again said she had fallen over. Jayne told officers Clive was with her at home. A member of the public had come forward to say Jayne had told them Clive had caused the injuries. Clive was arrested for assault occasioning actual bodily harm.

14.136 A Domestic Violence Protection Order was granted in court until the 28th of December. Officers engaged with Jayne's mum, who confirmed Clive had assaulted Jayne and taken money (approx. £50). Clive had breached his Domestic Violence Protection Order by being with Jayne at her address. He was arrested for the breach and issued a fine. Regular welfare checks were completed throughout the duration of the Domestic Violence Protection Order. Clive's case was closed on 21st December 2023 due to evidential difficulties. A PPN was reviewed by the DAO and graded high and referred to MARAC. Markers were put in place on police systems.

The police recorded:

"It is clear that Jayne is fearful of the detained person. Her demeanour on his arrest was one of desperation for him to know that she hadn't said anything. This is a clear concern as she doesn't appear to understand the risk to herself. She would not allow officers to photograph injuries and had to be restrained during his arrest to prevent an obstruction."

14.137 North Yorkshire Health and Adult Services safeguarding decision was made to progress to a formal planning meeting for Jayne. There had been twelve incidents since October and multiple incidents recorded in the previous five days. The most recent had been 29th November 2023 where Jayne had contacted the police stating she would slit her throat as she wanted Clive home and he was not allowed there for the next 28 days.

14.138 On 30th November Clive made a report to Health and Adult Services of domestic abuse for years by his partner. Clive knew it was being reported to the police and was happy to make a statement and he was worried officers wouldn't believe him or would make fun of him for making the report as he felt that male domestic abuse victims were seen as weak. The disclosures were: Jayne waking him up by putting a hot screwdriver in between his toes, holding a knife over his head when he woke up threatening to stab him. The reporting person had seen some of the scars where Clive said Jayne had stabbed him. Clive also disclosed Jayne threatened to kill herself if he left, burnt herself with a cigarette and threatened to tell police he had done it. Clive said Jayne often carried knives. Clive also disclosed he had previously broken Jayne's wrist as she had been trying to stab herself in the neck with a bottle and he was trying to stop her doing it. Clive was subject to bail conditions not to contact Jayne.

14.139 An appointment was made to take a statement from Clive, which officers were going to be late for. They said Clive was out and was *"steaming"* drunk. Clive was eventually visited and declined to make a complaint. The Domestic Abuse Team triaged the case as high risk but did not contact Clive due to him being a perpetrator of domestic abuse. The case was due to be listed at MARAC on the 12th December. The case was closed.

14.140 On 1st December 2023 Clive was arrested for attempt rape on another female known to him. After an investigation, this case was finalised with no further action taken due to insufficient evidence.

14.141 On 8th December 2023 Health and Adult Services and police did a joint visit to see Jayne and offer support after receiving a safeguarding referral after she had disclosed that injuries had been caused by her partner. Jayne denied this disclosure and when informed of a referral to IDAS stated she didn't want it as she had worked with them before, and she didn't feel it helped. The police officer informed Jayne of the Domestic Violence Protection Order and explained now was the time to look at how they could keep her safe.

14.142 On 11th December 2023 the referral to IDAS was received and later, as Jayne had recently been referred to an Independent Sexual Violence Advocate (ISVA), the service planned to join the two so that Jayne only had one advocate. The experienced ISVA had a good working knowledge of domestic abuse. However, by 22nd January 2024, IDAS closed the case as Jayne confirmed that she did not want support from them.

14.143 Also on 11th December 2023, Jayne called the police to say that she wanted Clive back in the next hour or she would kill herself. This was treated as a hoax call.

14.144 On 11th December 2023, Jayne attended an appointment with TEWV. The outcome was a referral to both IDAS and KYRA[8] (a local women's support group) which were made that same day. There was also a request to the GP for Jayne to be referred to the Social Prescriber for support with accessing vouchers for food/energy/clothing etc.

14.145 MARAC Outcomes from 12th December 2024:

- All agencies - Confirm where the couple are living
- North Yorkshire Police – i) Offer DVDS disclosure
  ii) Promote IDAS support

[8] https://www.kyra.org.uk/

14.146 On 14th December 2023 Horizons were informed via MARAC that Clive was a domestic abuse perpetrator with Jayne being the victim. This was the first time they were made aware of any domestic abuse between this couple.

14.147 Clive was adopted into the Multi-Agency Tasking and Coordination[vi] (MATAC) on the 20th December 2023. Adoption had been proposed by North Yorkshire Police. There were further MATAC meetings in February, March and April 2024.

14.148 On 19th December 2023 the residential setting where Clive was living reported Jayne had attended thirty minutes previously and asked staff to give a note to Clive. The reporting person had given it to Clive, who had then informed him that there were conditions in place to stop her contacting him. Clive then went to the shop and Jayne was sat on a bench outside the residential home waiting for him. Staff reported to North Yorkshire Police that he told her to *"f*** off"*.

14.149 The following day during a Domestic Violence Protection Order welfare check, Clive was found at Jayne's address. Jayne became obstructive with officers by brandishing a bottle and threatening to harm herself. Clive was arrested for breach of Domestic Violence Protection Order and issued a £100 fine.

14.150 By 4th January 2024 North Yorkshire Police received information that Clive was back living with Jayne (the Domestic Violence Protection Order had expired on 28th December 2023).

14.151 On 26th January 2024, a Social Care Needs Assessment was commenced for Jayne. This was a 'living' document that was added to throughout the support HAS gave to Jayne. On that date Jayne described herself as very mentally strong and felt she was able to deal with anything. However, in recent months her physical health had not been brilliant. Jayne had a confirmed health diagnosis of: emphysema, pneumonia, chronic liver disease, historic rib and spine fracture. Jayne had experienced 'blackouts' recently, she explained that she had been told this was epilepsy. She explained she had seen the physiotherapist but didn't think there would be much more involvement. Jayne had previously had involvement from the community mental health team, but she did not feel they offer any valuable support, as they always end their involvement. Jayne had a history of mental health problems, and at times had struggled with suicidal thoughts. Jayne had struggled with drug dependency. Jayne no longer used drugs, however, did struggle with alcoholism. Jayne resided with her partner Clive, who said their relationship was purely platonic. Jayne stated that Clive was her carer and supported her around the home. Both of them had struggled with alcohol and there had been

concerns around domestic violence between the two, however both stated this was not the case. Jayne however stated her mum would always pick her up if she needed support. When asked what support she needed Jayne stated both her and Clive looked after each other. Jayne wanted her door repaired, it was missing a pane of glass and did not lock. Stairs were a big issue for Jayne and she explained she had to crawl up the stairs at times.

14.152 On 31st January 2024 Jayne attended Scarborough Emergency Department presenting with collapse. She reported having these episodes for the previous six weeks and had been unsteady since April 2023 (when she had sepsis). Historically Jayne had presented with many falls and denied other injuries. Jayne reported that she drank one bottle of vodka per day . She was coded for a secondary safeguarding review and was reported to be at risk of self-neglect. Treatment included a CT scan (which showed left mandibular fracture probably aged). Probably aged fracture of the zygomatic arch on the left. Aged fracture of the orbital floor on the right. There were no skull vault or skull base fractures identified. Jayne then absconded following scans. The clinician tried to call Jayne on the only number she had but it was found to block unknown numbers, so it was not possible to leave a message. The Emergency Department contacted Yorkshire Ambulance Service requesting they call at Jayne's house and bring her back in light of the above where she was to be prioritised on arrival.

14.153 On 3rd February 2024 Clive reported to the police that Jayne was going to kill herself and that she was threatening to stab herself. Both were intoxicated. Clive kept telling Jayne to calm down. The police did not attend but sent an ambulance due to the mental health aspect. Jayne was taken to the Emergency Department and referred to the mental health liaison team.

14.154 A budgeting advance was approved for £812 and was paid into Jayne's bank account on 8th February 2024.

14.155 On 6th March 2024, Clive was referred to the Psychiatric Liaison Team (PLT) following admission into acute hospital on the 2nd of March for suspected seizure from prescribed appropriate medication. Clive was discharged from the Psychiatric Liaison Team on the 7th March 2024 with a documented plan for Psychiatric Liaison Team to contact North Yorkshire Horizons and to request they see Clive the following week. He was discharged from the acute ward on 11th March 2024. The Psychiatric Liaison Team assessment, whilst primarily for alcohol use in this instance, also included a brief mental state examination and risk assessment. There is some evidence that the safety plan was co-created but there is no documented record that Clive was given a copy of the

plan. Clive spoke about partner Jayne stating she was still drinking, suggesting she had a dependence. He believed she had gone to stay with family since he had been in hospital. He shared the outcome of health investigations explaining that Jayne had been diagnosed with Irritable Bowel Syndrome.

14.156 On 4th April 2024 Jayne stated Clive had kicked her out of her house, when asked by Force Control Room if he was being violent Jayne said, *"you're joking aren't you, he's always violent"*.

14.157 Jayne then went to her mum's address. She wanted Clive removing from her address. Jayne disclosed she had been beaten up by Clive and her collarbone had been broken again. She was too scared to go back because Clive had taken over her property and she was worried about repercussions. Jayne stated to officers that she wanted Clive out, and that she had been trying for the last week. Jayne mentioned that she had a broken shoulder but skimmed passed that saying she blacked out. She wanted to talk to officers without Body Worn Video on. When the Body Worn Video was turned off, she explained that she had been camping at Orchard Field with Clive in March and had been walking up the hill in the field with Clive about six feet behind her. She said he had slipped and grabbed her leg, pulling her to the ground and landing on top of her - breaking her shoulder and ribs. She kept saying it doesn't matter, and tried to divert the conservation, saying it was an accident but then said it must have been deliberate as she couldn't understand why he grabbed her and not just put his hands out to save himself. Jayne then showed officers, a bald patch on the top of her head, explaining Clive did this to her about six weeks previously, by pulling her ponytail and pulling it out. When asked more about the circumstances, she said police didn't need to know the circumstances as he had previously blacked her eyes, broken limbs and pulled her hair. Jayne then mentioned that she had also lost a tooth and showed officers a missing tooth. When asked if Clive had done this, she replied, *"yes about five weeks ago"*. Jayne said that all she wanted was him out of her house and didn't want to provide any statement to police as she was scared of the repercussions, mentioning that he would go to jail and come back and blame her. It was explained that police would safeguard her, but she still did not want to make any statements. She did agree to medical consent.

14.158 On 4th April 2024 Clive was arrested for assault on Jayne. It was graded high risk and reviewed by the DAO. A MARAC referral was submitted. The DVDS was mentioned again as being declined previously, and there were no clear attempts to re-offer this during conversation between the DAO and Jayne. A Victim Personal Statement was completed. Whilst in

custody on 5th April 2024, Clive was assessed by TEWV mental health service.

14.159 Clive was placed on police bail until 5th July 2024 and a Domestic Violence Protection Order was in place until 4th of May 2024. Domestic Violence Protection Order checks were requested and completed throughout the order. Jayne confirmed she still did not want to pursue a complaint. She wanted to move on with her life with no hassle. On the 23rd of April, Jayne attended the front counter asking to speak to the DAO. Jayne was offered the DVDS by another DAO in person and she declined. She said she loved Clive and always would and would take him back. She said they had not spoken for a couple of weeks. Jayne was present with an older male - no details of who this male was. Jayne was intoxicated.

14.160 On 9th April 2024 Jayne had been at her friend's address and when she left, met with Clive and engaged in conversation with him which was witnessed. Clive was arrested for breach of Domestic Violence Protection Order and received £50 fine on 11th of April 2024. A PPN was completed and graded high risk and reviewed as high risk. A MARAC was pending for the couple so the incident would be picked up in research. The DAO rang Jayne who was rushing on the phone and did not have time to speak as she was meeting her mum.

14.161 On 18th April 2024 the Health and Adult Services safeguarding referral was closed at the request of Jayne. She did not feel that any further work was required around the safeguarding and felt that the relationship was over therefore no further risk. Jayne declined support to look at a safe place to move from the area and did not wish to work with IDAS.

14.162 On 23rd April 2024, Clive was arrested for rape. The victim was a person known to him. At the time of writing this case is still being investigated.

14.163 On 23rd April 2024 a review of Clive by 'Liaison & Diversion' was undertaken whilst he was in custody for the rape investigation. Clive had no thoughts to harm himself or others. He denied any drug use. He reported trying to reduce his alcohol intake however was still drinking daily and suffered seizures and withdrawals. The Care Navigator explained to Clive that following his last contact, North Yorkshire Horizons had been called, and they told 'Liaison & Diversion' that due to disengagement with them he would have to attend in person or request a referral from his GP. Clive confirmed that he was staying with a friend and had a 28-day Domestic Violence Prevention Order against him preventing contact with his ex-partner. Clive explained he was in contact with the local authority to explore options for accommodation in the long term. During the entirety of the 'Liaison & Diversion' contacts Clive was not

assessed as or reported to be suffering from a mental illness requiring admission into hospital and the team's assessment did not indicate any need for an onward referral into secondary mental health care.

14.164 The Ambulance Service were called just before midnight in late April 2024. Jayne was in the river trapped under a tree. Clive and others were in the water apparently trying to help drag Jayne out. Jayne was removed from the water and CPR was commenced. Clive was shouting, *"Jayne has killed herself".* Clive was initially arrested for breach of Domestic Violence Protection Order.

14.165 Jayne's injuries confirmed at hospital as traumatic brain injury, bleed on the brain, right fractured shoulder, right severe femur fracture and fracture of ribs. Clive was arrested for attempt murder. The breach of the Domestic Violence Protection Order was not pursued as the attempt murder investigation took precedence. Jayne was on life support and was not expected to survive.

14.166 The following morning Jayne died.

14.167 Clive was further arrested for murder and subsequently charged and remanded into custody.

14.168 After a two week trial, Clive was found guilty of the murder of Jayne.

Section 15: Overview

15.1 There were several emerging themes identified that affected Jayne, Clive and their relationship.

15.2 **Mental Health**

15.2.1 Jayne has a history of trauma leading to poor mental health and started from a very young age. Jayne was adopted and records indicate that she was being supported by mental health services from the age of 11. Mental health is then a dominant factor throughout her life, with a spiralling cycle of substance use and dependencies, undoubtedly contributing to declining mental health.

15.3 **Alcohol and Substance Use**

15.3.1 Jayne and Clive were both known to North Yorkshire Horizons in a limited capacity. Horizons is a drugs and alcohol service. During the scoping period there were two referrals into service for Jayne and a total of six referrals in for Clive.

15.3.2 It is clear Clive used alcohol and numerous substances including Class A and B drugs and prescription drugs. He spent at least two periods at rehabilitation centres.

15.4 **Criminality**

15.4.1 Clive was involved in various types of criminality, and it can be assumed that this was to fund his dependencies. He exploited vulnerable people to use their properties for supplying controlled drugs as well as stealing their money from them. He was convicted for some of these crimes and sentenced to fifteen months in prison in 2022.

15.4.2 There is also lots of information supporting that Clive was involved in the supply of controlled drugs. Some of this intelligence implicates Jayne but it is not known if this was part of domestic abuse and controlling and coercive behaviours to force her to do this.

15.5 **Lack of professional curiosity.**

15.6 **Missed opportunities for agency intervention.**

15.6.1 There were numerous missed opportunities where police officers did not recognise a relationship between Jayne and Clive or did not suspect domestic abuse. This means referrals to specialists were not done resulting in absence of intervention from safeguarding and partners.

15.6.2 Clive breached his Domestic Violence Protection Order a number of times and there were missed opportunities and lack of robust court

intervention to be able to better manage a serial perpetrator of domestic abuse.

15.7 **Record keeping errors with regards to personal details.**

15.8 **Lack of understanding or practice of trauma informed care.**

15.9 Jayne had been in a previous relationship where she was a victim of domestic abuse. Jayne rarely confirmed a relationship with Clive, and it is still not clear why. Clive also rarely stated that he was in an intimate relationship with Jayne and would describe himself as the lodger, a friend etc. This will be discussed later in the analysis (section 16).

15.10 **Disengagement**

15.10.1 Establishing initial contact and subsequently maintaining engagement with Jayne was a challenge for many agencies. The reasons behind this are complex and considered fully in Section 16.

Section 16: Analysis

16.1 The DARDR panel reviewed a five year time frame to analyse the life experiences of Jayne and Clive. For most of that time frame, the two were not open about being in a relationship, although it would appear they were. The individual Terms of Reference highlighted specific questions that could illuminate experiences, interactions, missed opportunities or good practice carried out by professionals across a variety of agencies. Each Term of Reference is now addressed in detail.

The panel has debated the questions at length. Any gaps reflect the panel's inability to determine what happened, or where the reasons behind the issues remain unclear.

16.2 **Were practitioners sensitive to the needs or vulnerabilities of the victim?**

16.2.1 On the 14th Sept 2022 when a request for support was made by the police to Health and Adult Services regards Jayne self-neglecting, the Prevention and Access Team responded quickly and contacted Jayne in a timely manner trying both calling her and using text messages. Jayne seemed comfortable communicating via text message with the social worker and agreed to a Living Well[vii] referral.

16.2.2 Within a week of receiving Jayne's referral, the Living Well Coordinator made contact with Jayne and spoke to her on the phone. It was identified that Jayne was low on utilities, so the Living Well Coordinator looked into whether she would be entitled to a utility voucher and sent her a food voucher. Jayne didn't want the Living Well coordinator coming to the house as she said she was getting ready to have it decorated and the house was a mess. The Living Well coordinator recommended they met in a supermarket cafe in October 2022, which was a good idea and gave Jayne an alternative option. Jayne was agreeable to this suggestion although did not attend on the day. The Living Well coordinator then tried to contact Jayne by phone every couple of weeks until mid-November 2022 to rearrange a visit but had no response. A closing letter was sent to Jayne and with no response the case was closed. This was reviewed by the team's manager and was felt appropriate to close their involvement.

16.2.3 On 2nd August 2023 a safeguarding concern for Jayne was received by Clive's probation officer as both were using alcohol which was causing issues. The Probation Service had concerns for Jayne's wellbeing and current living conditions as she had sepsis and appeared to be struggling to cope. A Customer Service Advisor triaged this out as a safeguarding concern and changed to a request for support, as Jayne had stated that she would like some support. This was the correct decision; there was no abuse identified, except for potential self-neglect, but because Jayne was

saying she would like support, offering a Social Care Needs Assessment was more proportionate and appropriate than undertaking a safeguarding enquiry.

16.2.4 The information gathering form was completed appropriately and proportionally. Within the information gathering Jayne's health diagnosis of emphysema, pneumonia, chronic liver disease, historic rib and spine fracture and sacroiliitis are recorded, and the enquiry officer has documented these are relevant to the safeguarding as they are factors that increase Jayne's vulnerabilities. This information was gathered from the Yorkshire and Humber care portal, and the fact that Health and Adult Services have access to this information directly is of great value. It means certain health information can be gathered quickly and action taken.

16.2.5 Health and Adult Services practitioners clearly acknowledged and were sensitive to Jayne's health conditions, her care and support needs and her vulnerabilities. This was evidenced within safeguarding information gatherings, safeguarding meetings and within Jayne's Social Care Needs Assessment.

16.2.6 Every time Health and Adult Services received a safeguarding concern they considered Jayne's mental capacity and it was documented that there were no apparent issues in Jayne's mental capacity at the time, in relation to the safeguarding enquiry.

16.2.7 In all interactions practitioners from IDAS demonstrated sensitivity to Jayne's needs and vulnerabilities. Efforts were consistently made to respect her wishes and feelings whilst providing opportunities for support and engagement.

16.2.8 Yorkshire and Scarborough NHS Trust acknowledged there was not a consistent sensitivity to the vulnerability or whole picture of Jayne's needs. Her falls were attributed to mental ill-health and or substance use indicating a lack of routine and selective enquiry.

16.2.9 The Probation Service was managing Clive and therefore had limited contact with Jayne. There was acknowledgement of some of the vulnerabilities, however there were at times a lack of professional curiosity, such as an over-reliance on the explanations provided by Clive.

16.2.10 In relation to Jayne's broken arm being caused by another person, reported by Clive on 4th April 2023, the practitioner partially verified this with the police, but could have followed this up with a referral to Adult Social Care.

16.2.11 Primary care made reasonable adjustments to support Jayne's engagement, particularly when she requested telephone appointments

due to struggling to attend the surgery because of agoraphobia. In July 2019 Jayne was offered an appointment as a home visit. This demonstrates good practice as presentation was considered and the appointment venue was adjusted by offering a home visit.

16.2.12 When Jayne disclosed a decline in her mental health along with suicidal ideation, the team demonstrated effective safety planning by referring her to secondary mental health services with her consent, while ensuring she had the necessary details for crisis services. Additionally, the GP maintained regular contact with Jayne, which included conversations with her mother for added support and direct engagement with Jayne following her visits to the Emergency Department.

16.2.13 TEWV evidenced in the records from each assessment and contact with Jayne that her needs and vulnerabilities were understood, documented and clearly took into account a number of Jayne's vulnerabilities and previous trauma. These included those in relation to her as a victim of domestic abuse and violence and previous mental health involvement. This included a significant history of substance use and agoraphobia symptoms that Jayne clarified was the catalyst to her heroin dependency to help manage her agoraphobic symptoms. A home visit was offered to accommodate this, reflecting sensitivity to her needs.

16.2.14 North Yorkshire Police submitted multiple referrals via PPNs for Jayne, including to IDAS and Health and Adult Services. It appears Jayne was struggling on several incidents through lack of contact with her child after they were taken into the care of the local authority. North Yorkshire Police recognised too that Jayne was minimising the abuse and giving alternative explanations for her injuries (falling over), they had reasonable belief that Clive had caused the injuries and took positive action with arrest and imposing a Domestic Violence Protection Order.

16.2.15 During every interaction with the police, Jayne was clearly very worried about repercussions of engaging with North Yorkshire Police, through fear of what Clive would do or how he would respond. Jayne was well known to domestic abuse teams and her vulnerabilities and needs were explored in MARAC on several occasions.

16.2.16 Jayne was regularly signposted to the crisis team following deterioration in her mental health, and on some occasions a welfare check was completed due to officers' concerns.

16.3 Were professionals knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim?

16.3.1 There were missed opportunities for early identification of Jayne and Clive being in an intimate relationship. The first incident reported between Jayne and Clive was by a member of the public on 28th August 2019. Jayne defined her relationship with Clive at this stage as "*extremely close friends*". In order to classify it as an intimate relationship, some professional curiosity or further exploration into what "*extremely*" means, would have assisted. In hindsight, it is clear Jayne and Clive were in a relationship from the beginning. If Jayne had been offered support in the early stages of their relationship, would she have been able to leave?

16.3.2 The 'Domestic Abuse Matters' training for police officers and staff began roll out around 2021. This has seen a positive impact on the understanding of domestic abuse, specifically controlling and coercive behaviour, across all frontline professionals.

16.3.3 On the 30th of November 2023 a safeguarding concern for Jayne was raised by a physiotherapist from Malton and Norton District Hospital. The concern stated Jayne disclosed that she had been physically assaulted by her partner or ex-partner when attending an NHS outpatients clinic. Jayne had visible bruising and swelling to both eyes. The safeguarding concern was added appropriately and forwarded to the relevant care & support locality team.

16.3.4 An enquiry suspected that Jayne was with Clive when she said she was Christmas shopping in Scarborough. A Domestic Violence Protection Order was in place. Health and Adult Services reported it to the police.

16.3.5 York and Scarborough NHS Trust have embedded domestic abuse training and have clear processes to follow where domestic abuse is suspected/disclosed. However, Jayne's perceived lifestyle was a barrier to professionals considering domestic abuse. In August 2023 when Jayne attended the hospital following an assault she named a lodger as responsible and declined to provide their name. This illustrates a lack of professional curiosity as systems already contained information that she was a victim of domestic violence, with her husband, to whom she was now estranged, but not divorced.

16.3.6 The GP Practice does not have any 'history of domestic abuse' or 'MARAC' codes in the Electronic Medical Record (EMR) to alert professionals to this risk as would have been expected following the MARAC information requests regarding Jayne in 2019 and 2023.

16.3.7 Recording information about domestic abuse in the patient electronic record is vitally important to provide holistic care and holistic safeguarding. The GP practice acknowledges that Primary Care domestic abuse codes were not applied to the records for Jayne. There is an adult

safeguarding code, but minimal information in relation to why Jayne has this code added to her records.

16.3.8 Practitioners have a responsibility to know and recognise the signs, presenting problems and conditions associated with domestic abuse and to use selective/clinical enquiry to question what is heard and to decide if the patient's presentation warrants concern.

16.3.9 Indicators in this situation included Jayne suffering multiple injuries requiring treatment which were attributed to alcohol use. In addition Jayne was experiencing emotional symptoms of depression, self-harm/suicidal tendencies. Also, there was evidence of an intrusive and aggressive male audible on telephone consultations with Jayne.

16.3.10 Professional curiosity regarding the emotional and psychological symptoms displayed by Jayne is important and in this case it would be expected that a clinical enquiry was raised regarding domestic abuse with Jayne to have been completed within Primary Care appointments when safe to do so.

16.3.11 TEWV records reflect the clinicians involved in her care were aware that domestic abuse was a factor in Jayne's vulnerabilities. It was good practice that at one point where Jayne was not supported in an official capacity by TEWV services, trust staff had still liaised with Supporting Victims (Helping people living in North Yorkshire to cope after crime and get their lives back to normal as soon as possible) in November 2023. They also shared an update that there had been a recent and apparent ongoing domestic violence / sexual assault where there was a belief that the Supporting Victims service could meet Jayne's needs given the domestic abuse she was experiencing.

16.3.12 Jayne herself was aware that there were ongoing concerns being discussed at MARAC and the records reflect she had declined and later supported a referral to the local domestic abuse support service and women's support group by staff.

16.3.13 TEWV staff are a key partner in the MARAC processes and are present in the MARAC meetings where cases are discussed. Information shared is recorded and available on the Electronic Care Records (ECR) in order that clinicians have the relevant information to support patients whose cases have been heard.

16.3.14 The Trust's safeguarding team also provide advice in relation to domestic abuse and safeguarding matters and support clinicians if they have concerns for a victim and this is supported by the wealth of information regarding domestic abuse on the TEWV intranet Domestic Abuse page.

16.4 **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?**

16.4.1 Out of the nine agencies who submitted Individual Management Review reports, all of them had a policy with regards to safeguarding.

16.4.2 However, not all agencies had a stand-alone domestic abuse policy. TEWV had a domestic abuse procedure at the time of this review but is now a policy.

16.4.3 The TEWV Trust has a wealth of information regarding domestic abuse for staff on its staff intranet pages and there was guidance for domestic abuse and safeguarding regarding women's safety during the Covid 19 period that linked to the governments 'spotting the signs'. There were several other supporting organisations' links available that included the NHS Website links / public information on domestic abuse and included promoting the helpline numbers and advice regarding recognising the potential signs of abuse.

16.4.4 North Yorkshire Housing, formally managed domestic abuse via local authority safeguarding policies. However, since April 2024, they now have a separate policy for domestic abuse.

16.4.5 Health and Adult Services have domestic abuse covered within their Safeguarding Adults Operational Guidance. At the time the safeguarding concerns for Jayne it was the October 2019 version in place. This has since been updated in August 2024.

16.4.6 For the Probation Service, policies and procedures were in place relating to the management of domestic abuse perpetrators. Police checks were requested at appropriate times, though not at all critical points in the sentence. The Spousal Assault Risk Assessment (SARA) was completed in accordance with policy and procedure. Whilst this should have been reviewed at key points in the sentence, the assessment remained relevant and in line with existing Risk of Harm assessments.

16.4.7 MARAC updates were provided and the Probation Service was represented at meetings however there is no evidence that the information shared was acted upon and used to inform the risk assessment or risk management plan.

16.4.8 All staff within North Yorkshire Horizons receive both internal and external training on domestic abuse. There is a safeguarding lead who can also offer support to staff if needed and a organisational domestic abuse policy. All staff have both safeguarding and managerial supervisions where they are provided the opportunity to discuss any concerns.

16.4.9 North Yorkshire Horizons have a policy relating to domestic abuse which clearly states what steps practitioners need to take. All staff are trained in the completion of domestic abuse DASH risk assessments and refer into MARAC/MATAC if deemed necessary.

16.4.10 The Social Care Act Assessment from Health and Adult Services was proportionate and acknowledged the domestic abuse, but it did have limited information regarding Jayne's needs. This was because Jayne did not want to discuss in detail and stated she did not require any support within the home as she felt she got enough support from Clive who she described as her main carer.

16.4.11 A carers assessment was not offered to Clive, but with the information that had been gathered regards the domestic abuse within the safeguarding meetings and MARAC meetings this would not have felt appropriate.

16.4.12 A safeguarding adult referral should also have been considered for a number of attendances/admissions at York and Scarborough NHS Trust.

16.4.13 There was no professional curiosity around Jayne's fall. This could have been due to previous notes which may not have been available/acknowledged to reference history of domestic abuse but also that it was recorded that she stated she "keeps falling."

16.4.14 The falls were attributed to alcohol use. No substance use support services were involved at this time but an alcohol withdrawal pathway was in place. Jayne was not referred to mental health services in the department as the records note she was keen to go home.

16.4.15 There are policies in place for York and Scarborough NHS Trust, and staff are guided to consider capacity where a patient's capacity is in doubt. It is likely Jayne was deemed to have capacity and there was a view that her lifestyle was her potentially an unwise decision to make. Her declining a referral to support services was also accepted without consideration of her vulnerabilities.

16.4.16 At the time of the scoping the GP practice did have a practice policy for domestic abuse. A template policy had been developed by the ICB Safeguarding Team and has been available for practices to implement since November 2021. The Domestic Abuse Policy for the practice recommends that all staff are trained as part of the induction and mandatory training process to identify the signs and indicators of domestic violence and abuse. Practices are responsible for ensuring their staff are competent and confident in carrying out their responsibilities for safeguarding, and the GP Practice Manager has confirmed that all their staff have completed their safeguarding training, are fully compliant, and

have been for the last three years. At the time of the scoping period all front-line clinicians should have completed each 3-year cycle; 8 hours (Adult Level 3 safeguarding) and 12 hours (Children's Level 3 safeguarding training), (Royal College of General Practitioners (RCGP), 2019).

16.4.17 The domestic abuse policy for the GP Practice states that an inconsistent relationship with health providers, including frequently missed appointments and non-compliance, may be indicators of domestic abuse that require further exploration. However, the policy does not specifically outline actions for professionals to take if a client is not engaging (see recommendations).

16.4.18 North Yorkshire Police domestic abuse policy is in alignment with the College of Policing Authorised Professional Practice (APP) and is available for all to see on the internal source and is easily accessible by all. There are procedures linked to all areas of domestic abuse, including stalking and harassment, DVDS, police perpetrated domestic abuse, honour-based abuse and female genital mutilation. It is in date and to be reviewed March 2028.

16.4.19 It should be noted that North Yorkshire Police have improved processes so that all DAOs should approach supervisors to downgrade or not flag, prior to considering downgrading an incident.

16.4.20 There were missed opportunities for delivery of the DVDS. Jayne declined the DVDS in March 2022. There are at least three occasions where this could have been re-offered, for example, Jayne being in custody for an unrelated incident, Clive being in prison for a long period or attending a welfare check following information that Jayne had been violently assaulted by Clive and Clive was not present when officers arrived. Clive was sentenced to fifteen months in prison. This was an opportunity for services such as the police and IDAS to work with Jayne.

16.4.21 Throughout the incidents involving Jayne and Clive, it is not always clear that the DVDS was reoffered to Jayne on each review. Perhaps there were opportunities where other agencies could have explored DVDS with Jayne during their engagement following attendance at multiagency meetings and/or direct work with Jayne.

16.4.22 The Safeguarding Inspector introduced a DAO template on Niche (computer record-keeping system for the police) in January 2023, that is used for all medium and high-risk cases of domestic abuse. This template ensures a thorough review through THRIVE[viii] of each case, explicitly captures the need to consider DVDS each time and ensures all safeguarding actions completed are clearly listed.

16.4.23 There has also been the implementation of dip-sampling DAO reviews, which began shortly after this template was embedded. The dip-sampling is carried out by DACs monthly, which allows DACs to provide feedback and guidance as necessary in their Individual Performance Meetings (IPMs). In October 2023, a new work return form was completed, which requests all DAOs complete a form following any review they do. This looks at time spent mainly to capture the demand in the team but is also a useful tool in making dip-sampling for DACs much easier to manage and conduct.

16.4.24 There are policies and guidance around the need to take positive action in cases of domestic abuse, particularly in those of high risk. In the case of Jayne and Clive, an evidence- led prosecution (ELP) was initially considered on the 4th of April 2024. This is where the investigation will be continued, in the absence of a victim supporting such an investigation, relying on evidence only. Jayne initially consented to officers gaining access to her medical records. When the officer explained about ELP, the officer stated Jayne '*begged*' them not to as it would cause further distress. It was felt by the officer that it would not be beneficial to access Jayne's medical records without an account from her of the domestic abuse.

16.4.25 There was an opportunity to take this case to the Crown Prosecution Service (CPS) to seek a charge and remand at this point as an ELP. This incident was awaiting a review by the Detective Sergeant when Clive murdered Jayne. The case was then transferred to the Major Investigation Team. A review of the case summary in relation to the investigation following Jayne's murder show offences from the 4th of April were amongst the offences Clive was arrested for after Jayne death (a wounding and two assaults occasioning actual bodily harm).

16.4.26 The PPNs submitted to the domestic abuse team were all submitted correctly to the domestic abuse team in a timely manner.

16.5 Were risk assessment and risk management processes for domestic abuse victims or perpetrators correctly used in this case?

16.5.1 The police were called by either Jayne or Clive on at least twenty occasions in the five year period where there was a disturbance or call for help. Many of these are documented as at least one of them, if not both, being intoxicated.

16.5.2 The police did not attend all of the calls, and sometimes, Jayne's call to say she was at risk of taking her own life, meant that the ambulance service was called as a more suitable agency to attend. However, when

the police did attend, often responding to a disturbance or abandoned 999 call, it was not until September 2023, when a such call was identified as domestic abuse and managed accordingly.

16.5.3 Often Jayne would have injuries, or there would be blood on the floor, but before September 2023 Jayne would describe Clive as a 'lodger" or 'friend'. There were certainly missed opportunities for professional curiosity and further exploration of the relationship between the two, especially considering the amount of calls to the address involving the same two people, where visible injuries were often seen.

16.5.4 There are just two calls which are specifically graded as domestic abuse calls and therefore supported by the through the DASH (Domestic Abuse, Stalking, and Harassment) risk assessments. This is a risk matrix used by all police forces to help assess the severity of a domestic abuse incident. Both were graded as high (the most serious), the second one being on 4th April 2024 when Clive had 'kicked out' Jayne.

16.5.5 On the 26th of January 2024 a Safeguarding Outcomes Review meeting was held within Health and Adult Services. The Safeguarding Coordinator, Enquiry Officer, GP and Police Vulnerability Assessment Team attended; the Housing Needs Specialist, IDAS and the local police gave apologies. Appropriate information was shared and the actions were agreed before closing the case to safeguarding.

16.5.6 The safeguarding was closed at that stage, not because the risk had been reduced, but because Jayne did not want any further support via safeguarding or involvement from Health and Adult Services or IDAS. All actions that could have safeguarded Jayne had been taken or offered and there were no further benefits to remaining open to safeguarding procedures and it was made clear to all attendees that if further incidents happened or Jayne changed her mind then a further safeguarding concern could be raised and risk reassessed.

16.5.7 On the 17th of April 2024 the enquiry officer from Health and Adults Services visited Jayne with the police. They discussed safeguarding and Jayne explained Clive hadn't hurt her, but he did have another woman in the house and she said that she was 'done with him' and they were over now. Jayne stated she hadn't seen him and neither had her mum. She said her mum would 'wring his neck' if she did see him. Jayne said that Clive had destroyed her house and left it in a right state. She described how he had used plates and not washed them. Jayne again went on to say she was really done with him and didn't want him back.

16.5.8 The Domestic Abuse Stalking and Harrassment (DASH) Risk Assessment had not been completed by the enquiry officer, but it was documented in

the information gathering that the police had completed and this was shared by the police and they stated they had made a referral to MARAC.

16.5.9 Health and Adult Services Risk Assessments were completed within the information gathering stage and at each safeguarding meeting, although there was limited information recorded in the risk assessment sections.

16.5.10 Prior to the writing of this report Health and Adult Services had already recognised that recording in risk assessments needed to be improved. They are currently making changes to the electronic recording forms and include prompts of what things to consider, aiding better recording. The latest August 2024 Health and Adult Services Safeguarding Operational Guidance has advice on what impact should be considered within the risk assessment to ensure an appropriate and proportionate response such as:

- Nature of the risk of harm (physical, emotional, or otherwise).
- Likelihood (and frequency) of the harm occurring.
- Severity of harm should it occur.
- Effectiveness of any current risk reduction measures; and impact on individual wellbeing domains.

16.5.11 Although DASH assessments were not always completed by staff at IDAS, practitioners clearly identified Jayne as a high-risk victim and provided individualised safety planning when possible.

16.5.12 At this time Community Rehabilitation Companies (CRC's) had been abolished and Clive was managed by the Probation Service. Community Rehabilitation Company was the term given to a private-sector supplier of the Probation Service and Prison-based rehabilitative services for offenders in England and Wales. It was replaced in 2020 by the National Probation Service.

16.5.13 Appropriate work was undertaken pre-release, including a handover meeting with the prison and Clive, at which time Clive stated that he intended to return to his partner, Jayne's, address on release. Police intelligence checks were carried out by the Community Rehabilitation Service practitioner and logged on the system. These checks indicated that there was intelligence that drug dealing was occurring from the property. There were also reports of police attending and finding Clive injured and another where Jayne stated she had been pushed down the stairs but did not indicate who had pushed her. There was discussion with Clive about this and a referral was made to 'Shelter' to explore alternative accommodation. However, Clive declined this support and ultimately, he was allowed to return to his partner's address on release, 16th December 2022. Given the risks indicated by the police intelligence reports, a decision could have been made to assess Jayne's address as

unsuitable; although appropriate referrals were made to identify alternative accommodation.

16.5.14 GPs and primary care staff are not required to be experts in domestic abuse or in conducting risk assessments. Formal DASH risk assessments are not completed by GP practices in North Yorkshire. However, they should be able to identify and respond to varying levels of risk associated with domestic abuse situations. This capability is supported by the RCGP Safeguarding toolkit: Domestic abuse (covers child and adult) | RCGP Learning

The SafeLives DASH (domestic abuse, stalking and honour-based violence) risk checklist is widely used by specialist domestic abuse workers to identify high risk cases of domestic abuse, stalking and 'honour' -based abuse. It is not expected or recommended for use in general practice as dedicated training, sufficient time and domestic abuse expertise are necessary to complete this with a victim/survivor.

These clinical toolkits have been developed in partnership between the RCGP and funding and delivery partners. The resources have been created for primary healthcare professionals and patients.

16.5.15 There is no documented evidence in Jayne's electronic medical record (EMR) indicating that targeted clinical inquiries about domestic abuse took place, which is what would have been expected.

16.5.16 With regards to TEWV - Jayne was supported to an appointment by Clive in August 2021 where Jayne had described the trauma she had experienced with her son's father who had stabbed her and subsequently received a custodial sentence. Along with the outcome of this meeting the safety summary was reviewed, and the safety plan was completed.

16.5.17 Jayne had already been heard in MARAC with a previous partner (but not at this point with Clive) though there were still two alerts highlighting she had been subject to domestic abuse on record.

16.5.18 When Jayne was at hospital there was an opportunity for the clinician to ask Clive to leave the assessment to raise the subject of domestic abuse given Jayne's history as part of professional curiosity during the safety review. Her dress was torn and her left forearm was in an elbow cast and she had a swollen left part of the face. Jayne stated she had been assaulted by her lodger following some argument and declined to divulge the name of the lodger. She had stated that she did not want the police involved. These are all indicators of potential domestic abuse and could have been explored more by the clinician. Jayne did however eventually share with York and Scarborough Teaching Hospital during an

appointment that she had been subject to domestic violence from Clive and a subsequent MARAC meeting was heard regarding this disclosure.

16.5.19 Risk assessment and risk processes are integral to the assessment process carried out by clinical staff within clinical services and this case was no exception. Jayne had several safety summary reviews and risks reviewed during her care and treatment within TEWV.

16.5.20 The After-Action Review completed by TEWV following her death highlighted that at Jayne's last appointment prior to her death a comprehensive assessment and risk assessment had been completed. Also, at assessment Jayne had advised her alcohol and drug intake had significantly reduced therefore no referral was warranted for drug and alcohol services.

16.5.21 The outcome of her last referral reflected that it had been closed with no planned interventions from the community team. There was a clear plan for Jayne's care to be referred and signposted to other services.

16.5.22 The records reflect that whilst Clive's primary diagnosis was for alcohol abuse his mental health and risk was also assessed in March 2024 whilst an inpatient in the acute hospital. Furthermore, a safety plan had been co-created and a risk assessment acknowledged his risk history and recent agitation whilst on the ward in context to alcohol withdrawal and reflected there were no safeguarding concerns at that point. This was noted as good practice however there was no evidence recorded that he had received a copy.

16.5.23 There was one PPN which North Yorkshire Police incorrectly did not classify as domestic abuse despite a PPN being submitted. The further submitted PPNs were all appropriately graded as high risk by officers and DAO. MARAC referrals were submitted, with the exception of one as a MARAC update and PPNs shared appropriately with IDAS.

16.5.24 There are, however, gaps in the judicial system, with the sentencing of one breach of Domestic Violence Protection Order resulting in a fine of just £50. Such a lenient sentence does not help deter criminals from further offending and more importantly, does not provide reassurance for victims. Jayne would not see any consequences for Clive and may prevent her from reporting in the future.

16.6 Did the agency adhere to information sharing protocols agreed with partners?

16.6.1 The independent review has found a firm multi-agency approach in regard to Clive, which has included a coordinated response between the

Housing Needs Service and the Probation Service with ongoing communication and information sharing to reduce risk. There was also a wider response with attendance at MAPS meetings within the Community Safety Hub which assists with intelligence sharing.

16.6.2 The review has highlighted attendance at Multi-agency Risk Assessment Conference (MARAC) by The Housing Needs Service who attended as part of the commitment to responding to domestic abuse. However, it is not clear if actions were given to the Housing Needs Service from the MARAC to evidence the effectiveness from a Housing Needs perspective.

16.6.3 An area of good practice has shown that intelligence was promptly shared when known and all options were explored from the Housing Needs Service to provide accommodation for Clive to reduce the risk of harm.

16.6.4 On the 30th Nov the safeguarding concern was received into Health and Adult Services Prevention and Access Team who undertake initial information gathering for safeguarding's, but because they knew multiple incidents had been reported and indicated that the Domestic Abuse was ongoing they felt a Multi-agency meeting was required to establish the level of risk and they appropriately forwarded it directly to the locality team to undertake the safeguarding enquiries. On the 1st of December 2023 the safeguarding was assigned to the same enquiry officer within the locality team who undertook the previous safeguarding enquiry. This was important, so Jayne had consistency with the people she was liaising with and could build up trust and rapport with them.

16.6.5 There were some agencies that sent apologies to the safeguarding meetings and this could have potentially been a missed opportunity for information to be shared in a timely manner and to assist with the joint risk assessment and creation of a keeping safe plan.

16.6.6 For the Probation Service, domestic abuse police checks were made at different points of sentence, and information was used by practitioners to contribute to risk assesments. When a request was submitted on 5th January 2023, however, there was no evidence that a response was received, or whether this was followed up by the practitioner. The practitioner was therefore reliant on checks completed on 19th October 2022. This is in line with policy guidance, although good practice guidance would suggest that a lack of response from partner agencies should be followed up within a reasonable time. This occurred again on 20th September 2023, although the Probation Service subsequently attended a MARAC meeting on 3rd October 2023. The lack of information received from North Yorkshire Police did not materially affect risk assessments or decisions at the time.

16.6.7 There is evidence of timely information flow into primary care from other health agencies. Information sharing from primary care to the MARAC could have been more informative. The information shared did not give a full picture of Jayne's mental health and substance use risks at that time.

16.6.8 On 20th May 2019 a letter was sent to MARAC from a GP stating due to lack of information provided by MARAC and no direct child protection concern the GP would not provide further information without explicit consent from the patient involved (see recommendations).

16.6.9 TEWV is a key member of the Multi Agency Safeguarding and Domestic Abuse Boards and Subgroups that serve York and North Yorkshire and is a core member of the MARAC and MAPPA arrangements. Local services work together in an integrated way to support individuals who require mental health support and by nature of the liaison services they are providing specialist mental health assessments for patient's attending general hospitals, dealing with a range of problems including self-harm, adjustment to illness and physical and psychological co-morbidities and work with medical / surgical and other colleagues as part of their everyday practice. The record in this case evidences such practice.

16.6.10 There was also evidence of good communication between the Psychiatric Liaison Team and the GPs through documented correspondence which detailed the assessments and recommendations made from those assessments including rationales.

16.6.11 Referrals to IDAS from North Yorkshire Police are automatically made for high risk cases with or without consent. On all incidents graded high risk between Jayne and Clive, the PPN was shared with IDAS. There were multiple Health and Adult Services referrals submitted for Jayne.

16.7 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?

16.7.1 For the Health and Adult Service, each time there was a safeguarding concern raised, for Jayne it was an opportunity to offer her a Social Care Needs Assessment and support as well as a keeping safe plan. When a safeguarding concern was raised risk was reassessed with the new information gathered and Jayne's views and wishes were revisited with her. After each information gathering was completed there was a decision made whether the adult safeguarding enquiry should continue or end. All assessments and decisions made were informed in a professional way and no opportunities were missed.

16.7.2 There were a number of occasions where there were opportunities for assessment of risk for York and Scarborough NHS Trust, particularly in light of fractures being identified and a parity of attendance with Clive at a different Emergency Department.

16.7.3 There were missed opportunities to explore potential domestic abuse risks with Jayne following the presentation at health services concerning physical injuries. While the GP reviewed and acted on the information received from attendances at the Emergency Department, contacting Jayne, the clinical enquiry did not address domestic abuse despite there being significant indicators of such abuse.

16.7.4 Key points and opportunities for assessment by nature are identified at every contact made with the patient for TEWV as part of the assessment and review process. These can be facilitated in several ways through observation and engagement with the patient face to face, through case discussions, including daily 'huddles' and team meetings, care planning and multi-agency forums such as MARAC.

16.7.5 Co-creation is at the core of decision making in TEWV creating an equal partnership with people who use the services, and the care records reflect this throughout. During the review of the records there was clear evidence that both Jayne and Clive were involved in the decision making of their care, where this was not possible in Clive's case the records reflect that a Deprivation of Liberty Dols (DoLS) application was made whilst he was under the care of the Acute Trust.

16.7.6 The risk gradings by North Yorkshire Police and the DAO's in response to the incidents were correct. However, one incident was not classified as domestic abuse. This meant no review by a specialist within their Domestic Abuse Team and the incident was not flagged appropriately. Since then guidance and processes have been implemented in approximately mid-2022 that any decision made not to flag an incident or reduce the risk grading must be agreed by a DAC with a full rationale as to why.

16.7.7 There were missed opportunities for an Evidence-Led Prosecution (ELP). This is where the police can prosecute in the absence of victim engagement. There is now guidance on North Yorkshire Police systems around ELP with drop-in sessions provided in August 2023 around ELP (introduction, common issues encountered and Q&A).

16.7.8 There were issues with the serving of the DVDS. It is not clear through every interaction with Jayne whether the DVDS was offered each time. Jayne was aware there was a DVDS in relation to Clive for her to receive and it is not uncommon for a victim of domestic abuse to not want to hear a DVDS (e.g. fear of change/consequences, denial, manipulation,

shame/stigma, trauma response, hope for change). However, could this offer have been made in a different way or by a different agency?

16.7.9 Clive was in prison from May 2022 to December 2022, the DVDS was prepared for Jayne in February 2022 and first declined by Jayne in March 2022. It had been offered again to Jayne through use of MARAC and DAO interactions, however it is not always clear a direct conversation was had with Jayne regarding the DVDS. The gap in which Clive was in prison was a prime opportunity to further pursue the DVDS. It would appear that the Domestic Abuse Team were unaware of this and therefore did not use this opportunity to engage with Jayne, share the DVDS and support her to end the relationship.

16.7.10 In November 2022, the MATAC Coordinator built further links with the prisons and North Yorkshire Police were given access to the Prisoner Intelligence Notification System (PINS). A domestic abuse spreadsheet was developed for all nominals who had been involved in MATAC and PINS would inform North Yorkshire Police of their current prison and release date. The release dates of MATAC nominals are shared with partners one month prior to release. This is also accessible for ad hoc enquiries. Of note, Clive was adopted into MATAC in December 2023.

16.7.11 On 7th July 2021 Clive contacted Universal Credit and gave new bank account details in the name of Jayne. This was another opportunity to identify a relationship albeit DWP do not attend MARAC meetings.

16.7.12 The first incident reported between Jayne and Clive was by a member of the public on 28th August 2019. Jayne defined her relationship with Clive at this stage as "*extremely close friends*". In hindsight, it is clear Jayne and Clive were in a relationship from the beginning. If Jayne had been offered support in the early stages of their relationship, would she have been able to leave? Sharing intelligence with the domestic abuse team could have prompted early involvement. Clive has an extensive history of domestic abuse. This would have been an opportunity for a DVDS.

16.7.13 It is clear throughout the chronology in the case of Jayne and Clive, there were several missed opportunities for PPNs. PPNs are the first step to allow a thorough risk assessment by the DAOs. Officers are advised that they are to use and complete a PPN in relation to every domestic abuse related incident to a satisfactory standard, and if this is not the case, the safeguarding team will go back to the officer to rectify. In the case of Jayne and Clive, it is clear for a significant period, police believed their relationship to be that of friendship, which in meant professionals had a gap of any risk assessments between them. Where a domestic abuse related case does not have a PPN linked, the DACs are able to highlight these in their triaging and request the officer completes a PPN.

16.7.14 Some of the cases where PPNs were missed include, Clive and Jayne '*shouting at each other'*, Jayne calling regarding an elderly male she was caring for and telling Clive to '*shut the f**k up'* whilst on the call. On the latter call, it was received by Force Control Room who stated, '*this is how they speak'*. There was one occasion where a PPN was submitted and the DAO had reviewed as non-domestic abuse, subsequently not flagging Jayne and Clive or contacting Jayne.

16.7.15 On 27th November 2023, the ambulance service reported an assault on Jayne. When officers attended, Jayne had visible injuries to her face and reported falling over. The officers in attendance suspected Jayne injuries were as a result of an assault, based on Jayne and Clive's recorded history. A member of the public had come forward in this case, confirming Clive had caused the injuries, and he was subsequently arrested for assault occasioning actual bodily harm and made subject to a Domestic Violence Protection Order. One officer wrote the following:

"It is clear that Jayne is fearful of the DP. Her demeanour on his arrest was one of desperation for him to know that she hadn't said anything. This is a clear concern as she doesn't appear to understand the risk to herself. She would not allow officers to photograph injuries and had to be restrained during his arrest to prevent an obstruction."

16.7.16 This highlights good recognition by the officer in terms of recognising the potential mannerisms and presentation of domestic abuse victims. It is very common to see victims of domestic abuse to minimise the abuse and deny any incident had occurred, through total fear and worry of consequences. In this case, the perpetrator, Clive, would become aware and Jayne would be seen as 'colluding' with the police and therefore going against Clive. This is often because the repercussions of this are detrimental to the victim.

16.8 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?

16.8.1 Every time a new safeguarding concern was received into Health and Adult Services, Jayne was asked what her views and wishes were and her voice was clearly captured within her adult social care record. There were times where Jayne was offered different places to meet and could communicate with Health and Adult Practitioners via phone calls, text or in person visits. Joint visits with police were utilised, so Jayne did not have to repeat her views and wishes and cause her to become overwhelmed.

16.8.2 Jayne was informed about what home support and equipment could be offered by a range of Health and Adult Services, including Living Well and the Reablement Team and how IDAS could also support her with regards to the domestic abuse along with the enquiry officer.

16.8.3 On absconding from the Emergency Department after fractures and head injuries had been detected, there was good practice by the Emergency Department practitioners involving requesting the ambulance to bring Jayne back in light of the results. However, there were no safeguarding concerns raised for this incident. Professional curiosity was lacking regarding the injury.

16.8.4 Jayne was brought back and re-admitted but she self-discharged from hospital and was viewed to have capacity to make this decision. Care was transferred to her GP to follow up, and it was assumed she had capacity. However, given Jayne's vulnerabilities a referral to the Trust Safeguarding Team may have led to a safeguarding referral. Such a referral may have been appropriate in these circumstances.

16.8.5 Jayne was signposted to other agencies but appeared to not want to engage. It is understood that there was a fear of other agencies following her experience with Children's Social Care over her child. Staff at York and Scarborough NHS Trust could have supported Jayne more to explore and allay those fears.

16.8.6 There were a number of key points when it would have been expected that domestic abuse checks would have been made by the Probation Service. These were not done and instead, in some cases, police intelligence inquiries were requested. There is no evidence that new information received was utilised in assessing and managing the risks posed.

Domestic abuse checks were at the time, made through the NYP Vulnerable Adults Team. Police intelligence checks are broader and focus on criminality and intelligence. There is significant crossover between the two, but the former is more specific and should have been used instead of the generic request for police intelligence. The Probation Service has recently reinforced the importance on the expectation for domestic abuse checks to be made and for the information to be included in risk assessments.

16.8.7 There is strong evidence that the GP ascertained Jayne's wishes and, with Jayne's consent, spoke directly with her mother to offer support. The GP provided Jayne with options to be referred to mental health, drug, and alcohol services. Jayne's wishes were taken into account both when she agreed to the referrals and when she stated that she did not wish to pursue them.

16.8.8 The chronology indicates the ongoing efforts to engage Jayne, not only regarding her health but also to acknowledge her challenging social circumstances at times. This was demonstrated by referring her to the practice's Social Prescriber for assistance with food vouchers, clothing, and energy supply.

16.8.9 There is a long history of involvement with TEWV services that has documented Jayne's relationships with substance use / street drugs especially heroin and her symptoms of agoraphobia. She had also reported self-harming behaviour where she stabbed herself in response to arguments with her then husband. Jayne also described feelings of depression. She was signposted to other specialist services such as IDAS and Horizons for her substance use and domestic abuse and was awaiting trauma informed care.

16.8.10 Jayne did not aways engage with these specialist services, but it wasn't aways clear that this was explored thoroughly with Jayne in order to really understand the barriers for her.

16.8.11 Jayne was very clear in her wishes against police action, which was mainly focussed on fear of repercussions. It is clear Jayne was in complete fear of any repercussions or reprisals from Clive should she be seen to engage with police.

16.8.12 Jayne was offered support through the DAOs, IDAS and other agencies on several occasions, as well as through multi-agency meetings. Jayne's thoughts and views on the Domestic Violence Protection Orders which had been imposed on Clive were clearly documented, despite Jayne not appearing to want the orders, her welfare was still checked throughout the duration and called with updates following any breaches. Despite Jayne making it clear throughout many of North Yorkshire Police's interactions that she would not like to engage, for reasons already outlined, North Yorkshire Police did take positive action through use of arrest and Domestic Violence Protection Orders to try and protect Jayne.

16.9 How did use of alcohol or other substances impact on this case?

16.9.1 Both Jayne and Clive used alcohol and the Health and Adult Services received referrals for them both with regard to self-neglect. Jayne said in the past she had used drugs, but during the periods that Health and Adult Services were involved it appeared to be alcohol that she used. In February 2024 Clive explained he was working with Horizons, but stated Jayne wasn't.

16.9.2 In April 2024 Jayne was looking really well when she was not in a relationship with Clive and was staying with her mum as she was eating

well and had reduced her alcohol intake significantly. Jayne acknowledged it had been difficult but was hoping to continue to limit the amount she drank.

16.9.3 Health and Adult Services did not have any information to evidence that the domestic abuse increased when Jayne or Clive had been drinking alcohol, but it is likely that it will have had an impact.

16.9.4 Both Jayne and Clive had a long history of alcohol and substance use, though the extent of their use at the time of the murder remains unclear. Historical information indicates that Jayne had previously had an opiate dependency, but this later shifted to alcohol. Similarly, whilst Clive had a known history of substance use, his drug of choice at the time was unclear. However, it is reasonable to conclude that substance and alcohol use likely influenced their behaviour and decision making throughout their relationship. Jayne reported to be drinking approximately two bottles of vodka per day and the last referral in March 2024 for Clive stated he was drinking two to three bottles vodka per day although had received an alcohol detox on admission to hospital. It is not known whether Clive resumed drinking alcohol upon discharge.

16.9.5 The impact of Jayne's drug and alcohol use significantly affected this case. Over time, Jayne's health declined markedly, and she exhibited symptoms of alcohol use. These symptoms included vomiting blood, persistent diarrhoea, blackouts, and seizures, along with a deterioration in her liver function and signs of self-neglect. This behaviour was noticeable during visits to her GP, where she appeared unkempt and intoxicated. Falls caused by her intoxication were frequently reported as the reason for her physical injuries. However, there was a lack of professional curiosity regarding other possible explanations for her injuries, even after the risks of domestic abuse were identified in 2023 via the MARAC.

16.9.6 Jayne’s use of alcohol and other substances delayed engagement with mental health services to deliver trauma informed care. This has raised the issue as has been in seen in previous cases about the difficulty in addressing mental health and substance use issues and which should come first or together.

16.9.7 Clive was assessed as having an unhealthy relationship with alcohol and the records reflect that he had been referred into alcohol reduction services but had not subsequently engaged. He was offered a Liaison & Diversion (L&D) contact and review of his care each time he was arrested and there was evidence of discussions at a team huddle to determine the level of assessment he required and who was best placed to offer an

assessment / review. These huddle discussions and rationale for level of assessment is clear within the records.

16.9.8 There was evidence of follow up support by the Liaison and Diversion team who were proactive to support Horizons with accommodation when his bail conditions prevented him to return home. However, he refused on numerous occasions attempts to offer him assessments in custody despite the new risks of harm identified. This was notable good practice.

16.9.9 An After-Action Review (AAR) was carried out by TEWV following the incident and during this review of his care it was noted that the safety plan in place was reflective of the current risk and had been updated by Psychiatric Liaison Team (documented 6th March 2024) when Clive was discharged from hospital. Furthermore, Clive was then referred to L&D on the 5th April 2024 where his safety summary was updated but his safety plan was not in order to reflect changes relating to bail conditions.

16.9.10 There was also some evidence that the plan had been co-created though it was not clear whether he had received a copy. The summary of risks identified that he had denied any risk to himself and there was no history recorded. Whilst there were historical risks noted he denied being bullied or exploited by others and he also denied all the allegations being put to him of experiencing bullying threating behaviour or been exploited by others toward himself. There were known historical assaults.

16.9.11 His most recent assessment regarding risk to others acknowledges the current alleged offence of assault (whilst being held in custody for the alleged offence). Numerous attempts were offered for an assessment whilst he was in custody and court following his arrest for murder, because of the new risks of harm he posed.

16.9.12 The lead agencies IDAS and Drug and Alcohol Services from North Yorkshire Horizons were identified as having a key role to support Jayne with interventions around her substance and alcohol use in order that therapy could be impactful and effective.

16.9.13 It is evident throughout North Yorkshire Police information that both Jayne and Clive struggled with alcohol and substance use.

16.9.14 For Clive, Jayne described him as a ‘nightmare’ to officers when under the influence of drugs or alcohol, this would infer that Clive was even more unpredictable and/or aggressive whilst intoxicated. Clive was said to have attended detox centres in 2020, 2021 and 2023.

16.9.15 Jayne was known for use of alcohol and illicit substances prior to her involvement with Clive. However, it appears Jayne’s alcohol intake increased when in a relationship with Clive. Was this a coping mechanism for the abuse? Jayne was offered North Yorkshire Horizon’s

referrals during engagements with DAOs. North Yorkshire Police had received multiple calls from Jayne who was suspected to be intoxicated at the time of the call. Following a welfare check on Jayne in September 2022, she disclosed to officers she was drinking two 70cl bottles of vodka a day.

16.9.16 There is a suggestion on police systems that Jayne and Clive were involved together in purchasing and dealing of drugs, which may increase the difficulties for Jayne in leaving the relationship with Clive given the dependency.

16.9.17 Discussions were held at MARAC and MATAC for Clive and Jayne to agree ways in which agencies could encourage and support both Clive and Jayne accessing support from North Yorkshire Horizons.

16.9.18 On one occasion where it was alleged Clive assaulted Jayne and he was subsequently arrested, Jayne told officers she had fallen over. The officer recorded:

"Jayne is known to be alcohol dependent and so her claim of having sustained the facial injuries by falling are not unrealistic".

Perhaps alcohol use may have formed some of the decision making in this particular investigation.

16.9.19 On another investigation,

"Although the entry was read to the victim a number of times by the officer, she is distracted and appears intoxicated so may not be aware of what she is signing" and *"The victim has signed a negative pocket note book entry which names Clive, this is the only time she has made any reference to him being responsible."*

16.9.20 As part of this Domestic Abuse Related Death Review, the Body Worn Video footage was reviewed. This showed that the OIC did read the entry more than once to Jayne but she was not entirely lucid. Due to levels of intoxication was Jayne able to retain any support or advice that she had been given by police/DAOs?

16.9.21 In summary, Jayne's use of alcohol made it difficult for professionals to assess whether her injuries were caused by domestic violence or by falling when intoxicated. This view is supported by Jayne's sister. During a meeting with the Independent DARDR Chair and Author her sister recalled several incidents when Jayne had accidentally fallen. Together with Jayne's reluctance to inform professionals that Clive assaulted her this had a dual effect of both masking his violence and creating a challenging set of circumstances for front-line staff to navigate.

16.10 **Was mental health a factor in this case?**

16.10.1 Clive struggled with feelings of anxiety and paranoia at times and his Probation Officer thought that he used alcohol as a coping mechanism and they were concerned that the ongoing cycle was likely to have serious consequences to which Clive may have further life-threatening health issues.

16.10.2 Jayne explained she was really struggling with her mental health because of not having custody of her child and Clive stated that Jayne regularly said she would kill herself, and he had to 'disarm' her which resulted in her being 'hurt'. Sometimes in domestic abuse situations perpetrators can claim that the victim has mental health issues and at risk of hurting themselves.

16.10.3 Jayne told professionals that she had previously had involvement from the Community Mental Health Team, but she did not feel they offered any valuable support, as they always ended their involvement.

16.10.4 The Probation Service was aware that both victim and perpetrator suffered from poor mental health. A referral to Adult Social Care was made in respect of Clive.

16.10.5 Throughout the review timeline, Jayne suffered from poor mental health, experiencing episodes of emotional dysregulation, and presenting to health services in crisis. She disclosed suicidal ideation and displayed severe self-harming behaviour often using a knife and threatening to slit her throat. Jayne engaged sporadically with mental health services, agreeing to a referral to secondary mental health services, but was unable to manage consistent engagement. She often cited barriers such as the trauma of her child being removed, viewing this as a direct result of her previous engagement with mental health services. This followed a traumatic ten-year history of domestic abuse with her ex-husband.

16.10.6 Jayne's use of drugs and alcohol may have been a way to self-medicate the symptoms stemming from her mental health issues and past trauma. For future learning, it may be beneficial to consider these behaviours more thoroughly as potential indicators of domestic abuse. This approach could foster a deeper understanding of the underlying issues and improve support for individuals in similar circumstances.

16.10.7 The term mental health describes mental health as encompassing emotional, psychological, and social wellbeing, which influences how a person thinks feels and behaves. It is a crucial aspect of overall health impacting daily life, relationships and even physical wellbeing. Good mental health allows individuals to cope with life challenges, maintain healthy relationships and contribute to their communities the key

aspects are described as emotional, psychological and social well-being that impacts on daily life.

16.10.8 This definition resonates with Jayne's life experiences as highlighted in the review and it is recognised that trauma can significantly impact a person's mental health that can potentially lead to conditions such as anxiety, depression and post-traumatic stress disorder.

16.10.9 Jayne was first referred into secondary mental health services as a child aged 12 years and there was some contact in the 1990's due to drug induced problems and anxiety. However more recently there had been issues relating to interventions around substance use.

16.10.10 Jayne had been identified as requiring trauma informed care. This is not a recognised mental health illness itself but is a framework / approach to care that recognises the impact of trauma on a person.

16.10.11 Clive had been known to TEWV secondary mental health services since 2011 albeit they were brief contacts in relation to him struggling with anxiety. Eleven of these contacts were associated with alcohol and drug use and seven fell within the time frame of the scope of the review. These contacts were with front line mental health services in the six months leading up to his arrest for the murder and there was no identifiable mental health issues reported in any of the assessments.

16.10.12 During the review dates, North Yorkshire Police received nine direct calls from Jayne, struggling with her mental health and/or making threats to harm herself/take her own life.

16.10.13 On one occasion, in August 2021, Jayne called three times in one evening, asking to be picked up and taken away as she was going to kill herself, feeling suicidal, wanting to slit her throat and wanting "sectioning". Officers attempted to complete a welfare check on the first call, however Jayne was not present and did not respond to texts or calls. Each time Jayne called on this night, she was advised to contact the crisis team. Clive was present for each and was said to be 'supporting' Jayne. On the last call, Clive described Jayne as 'distraught' and he was advised to phone an ambulance.

16.10.14 There was also another incident of concern whereby it is alleged Jayne was trying to slit her throat, Clive was trying to retrieve the knife from Jayne and in the process received an injury. The officers completed a PPN graded medium risk for Jayne and Clive, however the DAO deemed this not to be a domestic abuse related incident and did not flag or contact Jayne. An adult at risk PPN was submitted in relation to Jayne's mental health and need for support. If the DAO had made contact with Jayne, it may have led to further discussion about her personal situation and

relationship with Clive, possibly prompting further intervention at this stage.

16.10.15 One call from Jayne reporting feeling suicidal resulted in officers attending to speak to her in person. It is recorded the officers spent an hour with Jayne and she was described as in a 'much better frame of mind' by the end of the conversation. An adult at risk PPN was also completed on this occasion.

16.10.16 Jayne was advised to contact the crisis team on many occasions and subsequent adult at risk PPN's followed many of the encounters around Jayne mental health. The safeguarding meeting for Jayne scheduled late 2023, which was mentioned at the MARAC on the 12th of December, was where one of the actions was for Health and Adult Services to invite TEWV, IDAS and DAO to the meeting.

16.10.17 In relation to Clive, there have been two calls to the police relating to his mental health concerns. These calls are Clive behaving erratically. On one occasion, Clive called in a panicked state to say someone was trying to kidnap, torture and kill him. It transpired he was subject to a DOLs at the hospital and had managed to flee the premises, he was becoming violent and aggressive.

16.10.18 On another occasion, Clive called and threatened to *'smash the police's face in'*. It transpired Clive had discharged himself from hospital following a stroke and had been drinking alcohol. Clive told the Force Control Room Jayne had been self-harming with a knife. An adult at risk PPN was submitted on this occasion for Jayne.

16.11 How effective was the MARAC?

16.11.1 Jayne and Clive were heard at MARAC on four separate occasions but on two out of four referrals, Jayne had not given consent for MARAC. This is in line with policy and procedure that DAOs and other professionals do not need consent for MARAC where there is a risk of significant harm or death. Actions were delegated for professionals as per policy and multi-agency agreement to try encouraging Jayne to engage and safeguard her.

MARAC 1 – DAO - with consent (Oct 23)

MARAC 2 - YTH - unaware, no consent. (Nov 23)

MARAC 3 – DAO - unaware, no consent (Dec 23)

MARAC 4 – DAO - with consent (April 24)

16.11.2 A MARAC referral is considered for every high-risk incident. DAOs are able to send MARAC updates, within reason, such as in cases where a further

incident has occurred within close timescales of the last MARAC being heard and there is no change/escalation in risk.

16.11.3 There was one MARAC update sent relating to Jayne and Clive, following a Domestic Violence Protection Order breach on the 20th of December 2023 where Clive was found at Jayne address. This was agreed with the DAC.

16.11.4 The last MARAC was the 12th of December 2023, Clive was adopted and discussed at MATAC on the 20th of December and there was also a strategy meeting held for Jayne on the 18th of December – all these meetings included attendance from multi-agencies and sharing of information and risk. A MARAC referral following the breach would not have been productive. The MARAC update was circulated to partners in attendance at the MARAC.

16.11.5 The actions set at the meeting were all relevant, encouraged multi-agency working and were risk focussed. The MARAC was also used as another means to encourage Jayne to receive the DVDS through partners. The focus was on Jayne, as is the aim and purpose of a MARAC, including trying to encourage Jayne to engage with partners, securing her premises, and a request for increased awareness due to Jayne and Clive residing together. There was also clear consideration for Clive in terms of ensuring he was flagged appropriately as a serial perpetrator, offering North Yorkshire Housing and '+Choices' upon arrest and requesting that MATAC did not archive him at the next scheduled meeting.

16.11.6 On one MARAC (December 2023), North Yorkshire Police were tasked to attend to visit Jayne to offer DVDS and promote IDAS. It cannot be confirmed if that DVDS was re-visited on that occasion. There was a plan for IDAS to visit Jayne with North Yorkshire Police and Health and Adult Services on the 28th of December 2023 but the IDAS worker was unable to attend due to leave. There is no record to confirm if the visit from IDAS took place or not. This represents a gap in the MARAC procedures. The MARAC delegates need to be satisfied that the actions have been carried out.

16.11.7 There was however a successful visit to Jayne on the 8th December 2023 between Health and Adult Services and North Yorkshire Police where Jayne agreed to engage with Health and Adult Services. It is not always documented by domestic abuse agencies after each MARAC if the actions were completed or not.

16.11.8 Police, IDAS, Health and Adult Services, CSC, NYC Housing, Foundation were present for 100% of the MARACs involving Jayne and Clive.

16.11.9 The Health and Adult Service felt MARAC was very effective and an excellent opportunity to share information and identify any outstanding actions that could safeguard Jayne.

16.11.10 York and Scarborough NHS Trust Safeguarding Team were contacted directly about an outpatient appointment attended by Jayne and her (unnamed) partner. A non-consent MARAC referral was made which was heard on 21st November 2023 with contributions from multiple agencies. The referral was made for a professional judgement regarding this referral, as Jayne was previously known for being a victim of domestic violence and having reviewed all the hospital attendances for falls and her partner's behaviour which caused concern. There were no MARAC actions set for the NHS Trust, and it was noted in the MARAC meeting that Jayne was to be encouraged to accept a DVDS regarding her partner's history.

16.11.11 The Probation Service reported that information was shared at MARAC however the Probation practitioner failed to take this information into account when assessing and managing the risk.

16.11.12 Some level of information sharing from the GP to MARAC would be warranted, particularly considering the individual's mental health and history of substance use. This sharing would enable agencies to better understand the current risks and to develop appropriate safety planning for the individual. Furthermore, if there were any uncertainties regarding information sharing, it would have been advisable for the GP to reach out directly to the MARAC coordinator to discuss their concerns, thereby preventing potential barriers to protection.

16.11.13 The records reflect that Jayne had been discussed at MARAC on four separate occasions with two separate perpetrators. The more recent MARACs in 2023 referred in by York Teaching Hospital cited Clive as the perpetrator, referred in following Jayne's attendance at their Accident and Emergency services. TEWV's Safeguarding Team are the mental health trust's Single Point of Contact (SPOC) for MARAC.

16.11.14 Jayne's ECR records reflected the details shared and risks highlighted within MARAC for staff supporting Jayne. There was evidence that the MARAC Adviser who attended the meetings shared risk information and guided the clinician currently involved in Jayne's care to the MARAC information on Jayne's ECR. This contributed to the review of her care in the process by requesting if trauma work could be considered despite Jayne's alcohol usage. This was notable good practice in terms of presenting Jayne's case in the multi-disciplinary formulation meeting where her safety summary was updated to reflect current risk that was

posed from others. This also highlights good practice elements of co-production.

16.11.15 The MARAC held in December 2023 following a referral due to three high risk incidents and Clive's antisocial behaviour, highlighted that Jayne had been offered a referral to IDAS but had declined. At this point Jayne was living in 'supported living' and staff there had contacted the police due to Clive reporting abuse from Jayne. An action from the MARAC was to revisit the offer of an IDAS worker for Jayne which was carried out and resulted in Jayne consenting to a referral to IDAS and KYRA (a woman's support group). The community nurse also requested her GP to refer Jayne to the Social Prescriber for support with accessing food/ clothing etc.

16.11.16 An assessment of Jayne's care needs including risk, took place prior to the MARAC meeting however as a result of the MARAC the outcome was shared with the clinician and a request made to consider trauma work despite Jayne's consumption of alcohol.

16.11.17 On 11th April 2024, a case note entry was added to Clive's ECR to highlight risk information had been shared within a MARAC meeting and his records were updated to reflect the risks associated with Clive. This was less than two weeks before Jayne was murdered.

16.12 What information was known about the ex-partner? Was the ex-partner subject to MAPPA, MATAC[ix] or any other perpetrator intervention programme? Were there any injunctions or protection orders in place?

16.12.1 MATAC

MATAC (Multi-agency Tasking and Coordination) is a multi-agency approach aimed at identifiying, managing and disrupting serial high harm domestic abuse perpetrators, with the aim to reduce reoffending and protect victims. Unlike MARAC, which focuses on high risk victims, MATAC focuses on perpetrators.

16.12.2 MATAC has been embedded in North Yorkshire Police since November 2018. MATAC adoptions are considered via three routes; the RFGV (recency, frequency, gravity and victims) algorithm, run monthly, professional judgement of the MATAC team who review custody and MARAC and via referrals both internally and from external partner agencies.

16.12.3 Clive was a perpertrator of domestic abuse in North Yorkshire with two previous ex-partners. Further research on an additional police system

called the Police National Database, indicates that Clive was a perpetrator of domestic abuse out of area in Cleveland, with a further ex-partner. He was a known drug user and had a history of violence towards police.

16.12.4 Clive was adopted into MATAC on the 20th December 2023, following proposal of adoption by North Yorkshire Police. In total, there were five meetings during the course of Clive being subject to MATAC. Throughout each MATAC meeting, every new incident that occurred within those dates between Jayne and Clive or other relevant criminal activity was shared and discussed at the meeting.

16.12.5 Clive was served the MATAC letter on the 9th January 2024 at Jayne's address and this was recorded on Body Worn Video. He appeared unsteady on his feet when officers arrived and was dressed down to boxers. A female could be heard in the property saying "*get out of my house*". It was assumed this was Jayne. It is unclear if she was asking Clive or the officer to get out of the house. It appeared when the female said, "*get out of my house*", Clive responded with, "*p**s off with you*". The officer attempted to read out the letter to Clive, who was unhappy with the content, specifically when the officer was trying to read out the definition of domestic abuse as Clive accused him of calling him "*gay*". The officer did not manage to get through the entire letter to Clive before Clive told him to "*go away*".

16.12.6 Clive was well known to the local police. He did not engage in any part of the MATAC process in order to address any of this behaviour.

16.12.7 Prior to archiving a MATAC nominal, agencies have a multi-agency discussion about whether it is appropriate to archive. On North Yorkshire Police systems, it appears Clive was archived on the meeting of the 17th of April 2024. The chair advised they proposed Clive was not archived from the meeting and in fact, should be brought back the following month, with a request for increased policing of the Domestic Violence Protection Order which was in place at the time and consideration for other ways to disrupt Clive. The Neighbourhood Policing Team Inspector who attended, recalls the following:

"The suggestion was raised that Clive should be archived as a perpetrator from the meeting. I do not recall who raised this suggestion. I was, as always, asked for my opinion in support or opposition to this and I asked for Clive not to be archived. I believed his behaviour was, if anything, escalating. There were still outstanding criminal enquiries and investigations. It is my understanding that the consensus in the meeting was that Clive should be retained as a perpetrator for discussion at the next meeting."

16.12.8 There appears to be a discrepancy between the minutes of the meeting and the recollection of the MATAC chair and Inspector in attendance. However, Jayne was murdered before the next MATAC meeting was scheduled. Despite the minutes saying that Clive had been archived, this did not actually happen, so the mistake in the record of the meeting would have been recognised at the time of the next meeting taking place

16.12.9 MATAC is a consent-based process and relies heavily upon perpetrator engagement, which in the case of Clive was none. MATAC has a 'red route' process, which looks at ways of disruption, deterrence and pursuing however it is limited in its capabilities which North Yorkshire Police are continuously working to address. It is not just North Yorkshire Police's duty to explore disruption tactics, there are other means in which agencies can support the 'red route'. During a MATAC meeting, for example, tenancy breaches, probation engagement and increased protection of the victim are all explored.

16.12.10 **Domestic Violence Protection Order**

Three Domestic Violence Protection Orders were imposed against Clive following three of the incidents involving Jayne. Clive was identified as a 'person of interest' within MATAC in November 2023, due to the increase of Domestic Violence Protection Orders, MARACs and reports of domestic abuse. This led to Clive being adopted into MATAC in December 2023.

Clive was subject to three separate Domestic Violence Protection Orders from September 2023 to April 2024 in relation to Jayne.

- 19/09/2023 - 17/10/2023 - no breaches reported

- 30/11/2023 - 28/12/2023 - 2 breaches reported, dealt with at court 21/12/2023 - Clive was issued with £100 fine

- 6/4/2024 - 4/5/2024 1 breach reported. Dealt with at court 11/04/2024, £50 fine issued

16.12.11 There appears to be leniency with the punishment for the breaches. The first breach of a Domestic Violence Protection Order is usually dealt with by a £50 fine, any additional breaches beyond that would ordinarily result in a prison sentence. The maximum sentence that can be issued in relation to a Domestic Violence Protection Order is two months imprisonment. Clive was found to have breached the second order on two occasions. However, he was dealt with at court for both at the same time, therefore the fine was increased to £100. The third order had one breach, as it was a new order, and perhaps the court had only taken the

order itself into account, rather than the full picture and Clive's history of breaches, however this is unconfirmed.

16.12.12 Clive received a fine on this occasion too. At the time of Jayne's murder, Clive was in breach of the Domestic Violence Protection Order again. However, given the nature of the report on the in April 2024, the breach was not deemed a priority to pursue.

16.12.13 There is an on-going pilot into Domestic Abuse Protection Orders (DAPO) in areas of the UK which started in April 2024, including Greater Manchester Police, the Metropolitan Police and more recently Cleveland Police. DAPOs can be applied for across all courts (family, civil and criminal) and can add much more stringent restrictions on perpetrators, e.g. enforcing exclusion zones, requiring attendance at behavioural change programmes, substance use programmes and even mandating electronic tagging. A review will be completed in 2026 to look at the effectiveness and outcomes prior to deciding on a full roll-out across England and Wales. North Yorkshire Police has already started to link in with other forces who are participating in the pilot. DAPOs, if rolled out, will add much more control and management of high risk perpetrators of domestic abuse.

16.12.14 As part of an operational uplift in 2024, North Yorkshire Police appointed a Domestic Violence Protection Order Coordinator. This role oversees the Domestic Abuse Court Presentation Officers (DACPOs), provides day-to-day supervision of Domestic Violence Protection Orders, and ensures consistency in training across the force and supports the wider domestic abuse team. On April 1, 2024, the DACPO team launched a case management pilot in York and Selby to enhance the support provided to domestic abuse victims during and after the Domestic Violence Protection Order period. This initiative ensures proactive enforcement of orders, effective handling of breaches, and reduced risk of repeat offending. It also strengthens victim support through signposting, referrals, and safety planning. The pilot has been well received and will be reviewed later in the year for potential expansion across the force. This was not embedded in the in the area where Jayne and Clive resided at the time of this incident.

16.12.15 Recently, North Yorkshire Police identified challenges in accurately tracking Domestic Violence Protection Order welfare checks. To address this, in February 2025, the force introduced Domestic Violence Protection Order welfare check templates to streamline data collection. These templates record when a check is requested, origin of request, the date and outcome of the check, and the attending officers. The DACPO team monitors these checks and follows up as necessary. This is to ensure the

Domestic Violence Protection Orders are being actively monitored throughout their duration.

16.12.16 Health and Adult Services believe there was effective information sharing regards previous reported domestic abuse incidents that involved Clive and what involvement agencies had with him. This enabled multi-agencies to jointly risk assess and consider what actions agencies could take to reduce the risks Clive posed in MATAC and in adult safeguarding meetings. Details and updates with regards to the Domestic Violence Protection Order were shared; this was important, so all agencies could report any known breaches to the police.

16.12.17 None of the agencies were aware that Clive was ever heard at MAPPA. There was mention of a potential MAPPA referral and a police representative said that escalating to MAPPA could be tried but felt that it would not meet the MAPPA referral threshold.

16.12.18 The Probation Service and the General Practice were not aware that Clive had been under MATAC processes please.

16.13 How did agencies recognise and respond to issues of equality and diversity?

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?

16.13.1 There is no evidence that suggests Health and Adult Services delivered or offered any negative support or took or didn't take any actions that had an adverse effect on safeguarding Clive because of any of the nine protected characteristics. There was no evidence of unconscious bias or discrimination in any assessments or in any decision making.

16.13.2 All individuals entering treatment in Horizon are asked the same standard questions, ensuring a consistent approach regardless of any protected characteristics. There is no evidence to suggest the victim or perpetrator were treated any differently based on factors such as age, race, gender or any other characteristic. Additionally, there is no indication of unconscious bias influencing assessments, decisions or actions taken in this case. North Yorkshire Horizons staff regularly explore unconscious bias in safeguarding supervisions as well as receiving specific training around this.

16.13.3 York and Scarborough NHS Trust believe that Jayne's mental health and dependence on substances masked what life was like for her. She had a

history of trauma and trauma informed care was not applied leading to the risks not acknowledged.

16.13.4 Throughout contact with TEWV services there is evidence that staff were responsive and considerate in general to the needs of Jayne and Clive. Jayne's assessments appeared to be focused on seeking her views and concerns on how services can support appropriately.

16.13.5 During covid for example, the records reflect that a supportive letter was sent on behalf of Jayne in order that the difficulties she was experiencing with shopping could be reduced in order that Jayne could be supported to shop in the vulnerable persons hour. Jayne also described missing her mother who was self-isolating and that her ability to self-care had been significantly reduced. There was a lack of routine, and her concentration was felt to be problematic on occasions.

16.13.6 Whilst Jayne was clear in describing these care and support needs it was not clear if the clinician had discussed a potential referral to adult social care for support. However, what was evident was that the concerns had been discussed in the team huddle with regards to her self-care and therefore, she was placed on the 'Persons of Interest board' in order to keep her case a priority.

16.13.7 Clive was subject to a Deprivation of Liberty Safeguards (DoLS) enquiry having been found with reduced consciousness whilst in the acute general hospital in July 2020 thought to be as a response to an accidental overdose of illicit Benzodiazepines. Overdose and risks and harm reduction including treatment options were discussed (including a referral to Horizons).

16.13.8 Whilst agreeing to be discharged back home to his grandfather's it was also acknowledged the potential impact on the grandfather and the records reflect the acute hospital was to consider a potential referral to safeguarding for the grandfather. Whilst this is seen as good practice it is unclear in the mental health trust ECR if this took place or the outcome of the safeguarding referral if it had. It should be noted that it is now believed that the "grandfather" was actually the vulnerable male Clive was exploiting. This was information shared with the police in May 2023.

16.13.9 In August 2021 Jayne was seen by the Liaison and Diversion team whist in the acute hospital following an incident where she had grabbed a knife with the intention of harming herself when her friend Clive was at home with her. On this occasion it was reported to have been impulsive, and Clive had been reported to have stopped her. Police colleagues were contacted.

16.13.10 On assessment, Jayne described experiencing childhood trauma. Trauma informed care had been identified as a need throughout contacts with Jayne however following discussions with the care team as part of this review Jayne's primary need at that point was her substance use. Given this assessment the options to keep a referral open for services was not tenable and therefore her referrals following assessments were then closed.

16.13.11 During an assessment with Jayne the records reflect she had completed a detoxification without a relapse following in November 2018 however Jayne did imply she had some financial issues at that time and had some debt but declined providing any details. There could have been an opportunity for professional curiosity to explore further financial concerns at this point.

16.14 Were there any barriers to reporting abuse or violence? Did professionals consider trauma informed practice?

16.14.1 Health and Adult Services has not identified any barrier to reporting abuse or violence and from the information explored. They have used their knowledge about Jayne in tailoring their approaches to her.

16.14.2 North Yorkshire Horizons approach is rooted in trauma-informed practice. All staff receive both initial and ongoing training to ensure sensitivity to those affected by trauma.

16.14.3 Trauma informed practice is also considered during safeguarding supervision to ensure this is embedded and to ensure practitioners know how to respond appropriately to potential vulnerabilities.

16.14.4 Communication with other services and use of trauma informed practice were evident throughout including the strategic decision to limit IDAS contacts to avoid confusion.

16.14.5 There was one occasion (December 2023) where Clive was brought in to York and Scarborough NHS Trust with chest pain after an "alleged violent incident". There were no linked attendances for Jayne but on 31st January 2024 a number of fractures were detected, some of which were aged. Could these have been caused around this time? Due to not referring Jayne to Safeguarding there was the lack of opportunity to review parity of victim/perpetrator attendances for a full picture at MARAC.

16.14.6 Jayne had attendances around the same time as Clive (February 2024) but did not engage with treatment. She was brought back to hospital and admitted with a number of fractures but she self-discharged and re-presented on 31st January 2024 and 1st February 2024. Had a referral to

safeguarding been made they may have been able to link “partner attendance” to both activities and considered a MARAC referral. Each attended different Emergency Departments in the trust – Jayne to York and Clive to Scarborough. Was this a conscious decision? Did this affect Jayne’s willingness to engage in treatment at York?

16.14.7 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” albeit a fairly vague one. Acknowledgment of the MARAC alert (the trust flags all cases heard at MARAC) was not apparent and there were multiple opportunities to refer to the Safeguarding team for advice and onward escalation.

16.14.8 The Probation Service accept there was an error of not following up a request for information to the police and a general lack of professional curiosity.

16.14.9 There may have been missed opportunities for the GP to explore Clive's relationships and possible domestic abuse. Whilst professional curiosity is advised, opportunities and clinician's confidence to explore this area is likely to have been influenced by Clive's presentation, behaviours and criminality. It would not be expected that a formal risk assessment of domestic abuse be made by a front line primary care clinician. Had Clive disclosed behaviours consistent with any form of domestic abuse it would be expected that the GP consider any actions needed to manage the risk to the victim and any children, to signpost and support the perpetrator to address their behaviour and to consider other unmet health needs. The approach to managing a person who perpetrates domestic abuse may depend on whether the person directly acknowledges their behaviour as a problem.

16.14.10 Considering a trauma informed approach was crucial, given the significant impact of Jayne's past experiences on her mental health and coping mechanisms. Jayne experienced trauma before the scoping period, regarding domestic abuse and the removal of her child. Jayne and her mother informed the GP about the trauma and its negative effects on Jayne's motivation to engage with mental health and social care. Recognising her past trauma may have helped professionals understand her reluctance to seek services and adopt a more trauma informed approach. Gopal et al. (2023) emphasize the importance of general practice adopting such an approach to better understand barriers to service engagement.

16.14.11 Jayne was initially known to secondary mental health services in 1987 aged twelve regarding a query concerning psychosomatic abdominal pain and possible drug induced concerns along with anxiety during the 1990’s.

16.14.12 Several of her referrals into secondary care related to substance use issues and she was open to the Integrated Care Team in 2019 following a referral for a psychiatric assessment which highlighted heroin use and history of agoraphobia, self-harm, including attempts to take her own life.

16.14.13 Domestic abuse was also a feature in secondary mental health services and Jayne had self-harmed by stabbing herself in the groin because of experiencing domestic abuse with her ex-husband. The records reflect the incident subsequently resulted in social care becoming involved to protect her child. This was a potential barrier for Jayne as a result.

16.14.14 During the period of involvement for the scope of this review there is evidence to support that trauma informed practice was considered however it was the opinion of professionals that Jayne's primary need was to address her drug and alcohol issues in order that trauma informed work could be facilitated.

16.14.15 Throughout some of the engagements with Jayne, it is apparent she was fearful of repercussions if Clive was aware she had engaged with North Yorkshire Police. One of these encounters is where officers noted Jayne's physical demeanour was one of fear. In the 101 call made by Jayne following the incident reported in January 2022, she was repeatedly asking the Force Control Room if it would '*come back*´ on her and whether Clive would know she has reported. Jayne also said Clive calls her a '*grass*' for phoning the police, contacting the police would '*make him worse*' and she '*keeps the peace*' by letting him in.

16.14.16 On another occasion, Jayne told officers she was fearful of reprisals from Clive if he believed it was her that contacted police and that Clive would now '*blame her*'. Jayne minimised the abuse or gave an alternative explanation for her injuries (such as falling over) and would only talk to officers without their Body Worn Video activated. However it is believed that some of Jayne's disclosures were captured on Body Worn Video in April 2024.

16.14.17 There was another occasion where Jayne was upset at officers for arresting Clive following a breach of Domestic Violence Protection Order, and as such brandished a bottle and threatened to harm herself. This is recognised as a barrier, through Jayne fearing retaliation from Clive and trying to manage his behaviour. Clive has also reportedly made threats to her family members, which may be another barrier, through emotional manipulation or coercion. There is consideration for other barriers such as financial dependence, societal pressures or lack of access to support. There is no suggestion from North Yorkshire Police information that Jayne was dependent upon Clive financially, however it is apparent they were actively consuming alcohol and taking/obtaining illicit substances. Their

joint use of alcohol and other substances glued them together and this in itself may have been a further barrier, i.e. it affected their demeanour when professionals offered to help. In addition, Jayne's increase in her alcohol use could have been a coping mechanism due to the abuse and violence she faced from Clive.

16.14.18 North Yorkshire Police attended welfare checks on Jayne on two occasions. Clive was not present. Officers noted visible injuries to Jayne and Jayne explained that she had fallen. Officers did try to explore any domestic abuse concerns at the time in a safe environment. On one of these occasions, officers had reasonable belief that Clive had caused the injuries and as such arrested Clive which is where one of the Domestic Violence Protection Orders was imposed. Although this was not what Jayne expressed she wanted, officers were acting with Jayne's safety and wellbeing in mind given the concerns of abuse. Jayne was updated following breach of Domestic Violence Protection Order hearings and offered support during encounters, mainly from IDAS.

16.14.19 On one occasion officers attended Jayne's address to arrest Clive following an alleged assault. Officers were arresting Clive for an assault on Jayne whilst Jayne stated repeatedly *'he has not done owt to me'*. Jayne was trying to get past the officer to be in the same room as Clive but the officer did not allow this. Clive was asked to finish his cigarette. Clive asked for a glass of water, the officer replied, "*you can have a glass of water mate*" and handed the cup to Jayne to fill. As the officer was arresting Clive, Jayne sat beside Clive, saying *"why can't people stay out of my life, nothing has happened"*. One officer asked Jayne in front of Clive, *"are you alright?"*. The officer handing Jayne the glass and calling Clive *'mate'* may seem insignificant, however this actually speaks volumes in domestic abuse. The officer may have unintentionally added or colluded with the tremendous control Clive had on Jayne and again unintentionally appeared to 'side' with Clive by referring to him as mate. Although not done deliberately, this was not a good example of using trauma informed practice. The officer asking Jayne if she was okay was done with absolute good intentions, however again it is not a safe environment for Jayne to be able to discuss anything with the officer in relation to any domestic abuse. Jayne repeatedly saying he had not done anything, trying to be in the room with Clive and sitting beside him, is her way of desperately trying to show Clive that she did not call the police, she does not want the police and she is loyal to him.

16.14.20 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. Jayne has already made it abundantly clear during most of her engagements she is fearful of repercussions from Clive so it is reasonable to assume that Jayne would seem to 'disengage' with police at this point.

16.15 How were issues relating to Child Protection identified and managed?

Jayne's child was under a care order from November 2018 before they were three years old, meaning they were under the care of the Local Authority but lived with their paternal grandmother. The care order granted that Jayne would have monthly supervised visits.

Family time was reviewed through the looked after child process along the way over the years, but remained supervised by a support worker, and remained monthly due to the concerns over Jayne's presentation.

When the decline in family time was becoming more consistent and apparent, conversations were had with Jayne about how this could be improved to ensure she could spend quality time with the child.

Jayne was supported with an 'inspiration for change' worker from around 2021. Jayne was also encouraged to engage with Horizons and IDAS, but sadly this did not happen.

By November 2023 Jayne was not consistent with the visits or if she did visit she was often unwell and at times had visible injuries including bruising to the face and was perceived to be under the influence of alcohol or substances. This effected the child emotionally and in December 2023 when the child was just 8 years old, they decided that they no longer wanted contact with Jayne.

Undoubtedly the removal of Jayne's child will have had a profound effect on her mental health and ability to engage with services to support a recovery from substance use.

16.16 Was there evidence of economic abuse taking place?

16.16.1 There were missed opportunities to investigate Clive as an offender for fraud. A more robust approach may have seen Clive sentenced to custody earlier than 2022 and prevented further abuse to Jayne.

16.16.2 In March 2020, information was received by North Yorkshire Police that Jayne was exploiting the same vulnerable male being exploited by Clive and she cleaned once per week for £15, but the flat was a complete mess, and she did not clean. It is not known if Clive forced Jayne to do

this, although Jayne's sister was satisfied that Jayne did this on her volition.

16.16.3 This could be another missed opportunity for services to engage with Jayne and identify any possible controlling and coercive behaviour or provide support through rehabilitation.

16.16.4 There are numerous examples of both Jayne and Clive successfully asking DWP for large sums of money in order to help fund the purchase of "white goods." Jayne's sister explained that these goods were never purchased and the money was used to purchase drugs and alcohol.

16.16.5 Clive did use Jayne's bank account for DWP to pay Universal Credit. DWP received information and upon understanding the relationship between Jayne and Clive, immediately stopped Clive from using Jayne's bank account. This was good practice.

16.6.6 At the beginning of April 2024, Jayne reported to the police that Clive had kicked her out of her own house, which she owned. He was living there rent free and not contributing towards the bills. Jayne's mother knew about this and explained that she wanted to go to the house herself to evict him. This is when Jayne pleaded with her to not get involved and for the first time admitted that Clive was abusing her and if her mother got involved, there would be 'consequences'.

16.17 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?

16.17.1 None of the agencies reported a restructuring of service during the period under review other than North Yorkshire Police who, at the beginning of 2024, introduced a new role of a Domestic Violence Protection Order Coordinator.

16.17.2 Covid-19 restrictions meant that telephone consultations were in place instead of face to face for York and Scarborough NHS Trust and ICB, but there is no evidence that this had any impact on care.

16.17.3 Clive was reluctant to attend hospital during the restrictions.

16.17.4 TEWV records reflect that Jayne was engaged with services during the Covid-19 pandemic and the records reflect that she was supported as a vulnerable person during this period. Home visits and telephone contacts were available to her to provide a continuity of care throughout her involvement. Her mother was also self-isolating due to her age.

16.17.5 Communication was maintained by speaking daily and texting however there were concerns around Jayne's concentration and her self-care had significantly reduced. Whilst this would meet the criteria for care and support needs there was nothing to indicate in the records that there had been a discussion around a potential referral to Health and Adult Services.

16.17.6 Support with Jayne's mental health needs continued and advice around helpful activities was provided however there was a gap in service provision due to communication issues. Jayne was unsupported for a 5-month period which is a significant length of time in service provision over this period.

Additional Term of Reference

16.18 How were allegations of sexual violence progressed? Was the victim supported in compliance with national best practice?

16.18.1 From what is known, there are two occasions when Jayne was a victim of sexual violence. Jayne's sister describes an occasion when the vulnerable man Jayne was exploiting, sexually assaulted her when she was in the shower. This was never reported to the police or any other agency, and in her sister's opinion, this is because Jayne was taking the man's money. As professionals were never involved in that case, we cannot assess the full facts of what took place or how the incident impacted upon Jayne's vulnerability or trauma.

16.18.2 However Jayne did make a report in October 2023 stating that she had been sexually assaulted by a male, whom the previous day had been assaulted with a knife by Clive. Did Clive injure the male as a result of the sexual violence on Jayne? Jayne's sister was aware of this incident and explained that the male had grabbed Jayne's buttocks. Jayne also disclosed this sexual assault to her GP, who reports that Jayne had explained that's he had reported the matter to the police. However, there is no record of a safeguarding referral.

16.18.3 Jayne also disclosed two historic rapes to clinicians at hospital when she was being treated for fractures in November 2023. The correct referrals were made and police recorded a further crime report, albeit with minimum details. The police did not investigate the matters as Jayne had asked for the matters not to be progressed.

16.18.4 The IDVA service has been an integral part of the panel and explained that as soon as they were aware of the sexual assault, ensured support to Jayne. Jayne had already been allocated an IDVA for the domestic abuse from Clive and instead of overwhelming Jayne with an additional sexual

violence advocate, offered one advocate who was experienced in both areas and could support Jayne accordingly. In January 2024 Jayne stated she did not want support from the IDVA service.

Section 17: Conclusions and Lessons Learned:

17.1 Jayne was a victim of domestic abuse perpetrated by several intimate partners. This included significant physical violence, controlling behaviour and breach of restraining orders.

17.2 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.

17.3 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.

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.

17.4 There is evidence that professionals adapted and tailored their response to support Jayne with her complex needs. For example, in October 2022 a 'Living Well Coordinator' was providing Jayne with utility and food vouchers. Jayne did not want the professional at her home and so the coordinator arranged to meet her in a nearby supermarket café.

An earlier example was when Jayne's GP noted she was struggling to attend the surgery because of agoraphobia. The GP then offered a 'home visit' appointment. Home visits were also offered by TEWV mental health practitioners during their contact with Jayne.

17.5 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.

17.6 In 2019, health professionals had contact with Jayne during a home visit. The circumstances suggested she was vulnerable (two recent suicide

attempts). A 16 year old relative was staying with Jayne, but there were no interventions in relation to the teenager's welfare. Professionals may not have fully recognised that this was a child living in vulnerable conditions. No referrals were made to Children's Services. Jayne was admitted to hospital two weeks later following a collapse at home due to excess use of alcohol.

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.

17.7 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.

17.8 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.

17.9 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.

17.10 The GP practice did not have any codes on their records to alert practitioners that Jayne was a victim of domestic abuse.

17.11 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.

17.12 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.

17.13 This DARDR had identified that GPs and primary care staff in North Yorkshire do not undertake formal DASH risk assessments. Current guidance from the Royal College of GPs is that DASH is not to be used in General Practice and Primary Care and there are alternative risk assessments in place.

17.14 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.

17.15 The Probation Service requested police intelligence checks as part of their work managing Clive. However, despite this, the level of domestic abuse between Jayne and Clive was not correctly identified.

In addition, the Probation Service shared information at MARAC meetings. However information from the MARAC was not included within existing risk assessments by the probation practitioner.

17.16 Alcohol and substance use were clear factors affecting Jayne and Clive's behaviour and their interaction with services. Clive was alcohol dependent and spent time at detoxification centres in 2020, 2021 and 2023. Both parties being intoxicated were common observations at police attendances and during some of the contacts with other agencies.

Jayne's family have confirmed that she began using controlled drugs before she met Clive. This began as part of the 'rave scene' in the 1990s. As with many people, recreational drug use morphed into heroin use.

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.

Alcohol and drug use were also significant factors as Jayne's physical health and living conditions deteriorated.

Alcohol and substance use were a major factor in child protection concerns and ultimately led to the removal of Jayne's child from her care in 2018.

17.17 Jayne and Clive had extensive contact with mental health professionals – this included both of them accessing secondary mental health services.

Clive's contacts were overwhelmingly linked to alcohol abuse.

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.

17.18 Jayne and Clive's case was listed at Multi-Agency Risk Assessment Conferences (MARACs) - for the highest risk victims of domestic abuse - on four occasions between October 2023 and April 2024. The last MARAC meeting was only one week before Jayne was murdered by Clive.

Although the MARAC was well attended and actions set were proportionate, records are not clear on whether all the actions were in fact carried out. This represents a gap in the effectiveness of the MARAC process.

Changes to MARAC agendas have now been changed and actions are checked at the start of each meeting.

17.19 Multi-Agency Tasking and Coordination (MATAC) is a multi-agency process to manage serial perpetrators of domestic abuse. There has been a national roll-out of MATAC and the process has been embedded in North Yorkshire since November 2018. Due to the level of resources required, only the highest risk or most prolific offenders can be included in the MATAC process.

Clive was identified as a serial perpetrator of domestic abuse. There were at least three of his previous victims listed on police databases. He was accepted into MATAC in North Yorkshire in December 2023. Although not essential, MATAC options are more effective if the perpetrator engages with agencies. Clive chose not to engage in any aspect of the MATAC process.

As no court orders were in place, options for professionals to disrupt or deter Clive were limited. Clive was still being managed under MATAC when he murdered Jayne.

17.20 All agencies involved in this review recognise the importance of trauma-informed practice. However, some professionals noted that to engage in

such practice was difficult when Jayne was intoxicated either through alcohol or controlled drugs. It was challenging to engage with Jayne and then maintain that engagement.

The main gap in applications of trauma-informed practice was from the police attending emergency calls. Clearly the police priority during such urgent calls is the preservation of life, protection of individuals and securing or preserving evidence. Due to this, on occasion officers did make clumsy remarks such as “Are you alright?” or by calling Clive ‘mate’. Both such remarks are likely to influence Jayne’s responses when speaking to the officers. It is acknowledged that police responding to such volatile situations including violence, aggression and use of alcohol or drugs may be facing rapidly changing circumstances requiring dynamic interventions. However to ask a victim of domestic violence if they are ‘alright’ in front of the perpetrator is unlikely to achieve a reliable response. (see recommendations)

17.21 There is some suggestion of economic abuse involved in this relationship. Jayne owned her own house – her family described that Clive had moved in and ‘took over the house’. They think it highly unlikely he paid rent or contributed to any household bills.

After one MARAC meeting the Department for Work and Pensions (DWP) were notified and a representative completed an action to prevent Clive having direct access to Jayne’s bank account.

17.22 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.

17.23 When a murder takes place following such significant agency involvement, missed opportunities can be assessed by comparing the signs or indications from this particular case against the ‘eight steps to homicide’ model developed by Professor Jane Monckton-Smith[9]:

1. *A pre-relationship **history** of stalking or abuse by the perpetrator*

2. *The romance **developing quickly** into a serious relationship*

[9] Monckton Smith, J (2020). Intimate partner femicide: Using Foucauldian Analysis to Track an Eight Stage Progression to Homicide

3. *The relationship becoming dominated by **coercive control***

4. *A **trigger** to threaten the perpetrator's control - for example, the relationship ends or the perpetrator gets into financial difficulty*

5. ***Escalation** - an increase in the intensity or frequency of the partner's control tactics, such as by stalking or threatening suicide*

6. *The perpetrator has a **change in thinking** - choosing to move on, either through revenge or by homicide*

7. ***Planning** - the perpetrator might buy weapons or seek opportunities to get the victim alone*

8. ***Homicide** - the perpetrator kills his or her partner and possibly hurts others such as the victim's children*

The relationship between Jayne and Clive can be seen to follow steps one to five; in particular with the increase in level and frequency of violence being perpetrated against Jayne.

Section 18: Recommendations:

18.1 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.

18.2 Single Agency Recommendations

18.2.1 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.

18.2.2 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.

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18.2.3 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

18.2.4 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.

18.2.5 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.

Appendix

North Yorkshire Police - Domestic Violence Disclosure Scheme

North Yorkshire Police has developed a detailed data dashboard that outlines the reasons why disclosures under Clare's Law may not be provided. While the dashboard cannot capture every specific reason, each decision is fully documented within Occurrence Enquiry Logs (OELs), which offer tailored reasoning for each case.

In 2023-2024, out of 1,242 cases, 65.62% did not meet the threshold for disclosure, 29.15% were not disclosed due to non-engagement (numerous attempts and methods of delivery would be attempted prior to closure), 3.06% were not disclosed due to the absence of a safe method, 2.17% were deemed disproportionate to disclose following multi-agency panel review.

Of 598 cases that did meet the threshold, when you remove external factors beyond Police control such as the person at risk delaying appointments or partner agencies / panel consultation being required for more complex cases, approximately 80% were disclosed in time.

North Yorkshire Police continue to develop and refine data tools, drawing on best practices from other forces, His Majesty's Inspectorate of Constabulary (HMIC), and the College of Policing (CoP). Recently, they have integrated a RAG (Red-Amber-Green) rating system into the Tactical Performance Meeting (TPM), allowing them to pre-emptively address potential delays and allocate resources across the Domestic Abuse (DA) team more effectively. The focus is on reducing police-related delays.

Where there is relevant information to disclose, they do so. The ethos is centred on transparency and community safety, while balancing and managing risk through considered and often nuanced communication.

The Domestic Abuse Team at North Yorkshire Police is fully trained on the eight-stage Domestic Homicide Review (DHR) timeline. The force contributed to the 2015 consultation to extend Clare's Law to include disclosures involving ex-partners. It is recognised that risk often increases after a relationship ends—particularly where coercive and controlling behaviour (CCB) was previously present—so disclosure and safety planning are prioritised accordingly.

In instances where there is no information to disclose, applicants are still contacted and advised of the potential escalation of risk post-separation. These individuals are signposted or referred to specialist support services as appropriate.

Partners in North Yorkshire Police play an active role in DVDS (Domestic Violence Disclosure Scheme) processes, including panels such as MARAC, MATAC, MAPPA, and child/adult safeguarding mechanisms. They also prioritise high-risk DVDS cases and have systems in place to respond promptly.

North Yorkshire Police has recently updated their DVDS policy to ensure a Public Protection Notification (PPN) is submitted in cases where children are residing with the person at risk, a disclosure follows a Right to Know (RTK) after an incident, or there are high-risk markers associated with the alleged perpetrator.

North Yorkshire Police is committed to sharing proportionate information wherever possible to keep people safe. In some cases, they may hold no relevant data, or the information may not meet the legal criteria for disclosure under Clare's Law. Nevertheless, applicants are provided with contextual information and statistics to encourage continued vigilance and engagement with support services, even in the absence of a disclosure.

When a disclosure is not authorised, this is based on a clear rationale, including any potential risk escalation to current or former partners or suspects. The DVDS panel may recommend against disclosure where it could increase danger. These decisions are thoroughly recorded on Police systems and remain open to review.

North Yorkshire Police are always striving to improve performance in this area. They are committed to transparency and accountability, with every non-disclosure now recorded on a revised audit-tool template that clearly outlines the reason for non-disclosure and any associated risks.

The current focus is on reducing police-related delays (22.91%) and person-at-risk delays (20.74%). Police delays have, in part, been due to staffing challenges in line with significant increases in both RTA and RTK numbers (between 2021 and 2024, there was a percentage increase of over 125% for DVDS applications) which are now being addressed through the RAG-rated DA tactical plan and additional temporary resourcing. Delays involving the person at risk are often linked to lack of contact details, incorrect information, or unresponsiveness.

A broader improvement plan is underway to address delays across all stages of the domestic abuse Right to Know (RTK) and Right to Ask (RTA) processes. This includes links with the Force Control Room (FCR), the Single Online Home platform, domestic abuse review processes, and actions for MARAC chairs.

Glossary - Acronyms and Processes

AA	Alcoholics Anonymous
ABH	Actual Bodily Harm
HAS	Health and Adult Services
BWV	Body Worn Video
CPS	Crown Prosecution Service
CRC	Community Rehabilitation Company
DA	Domestic Abuse
DAC	Domestic Abuse Coordinator
DVDS	Domestic Violence Disclosure Scheme (Clare's Law)
DVPN	Domestic Violence Protection Notice
DVPO	Domestic Violence Protection Order
ED	Emergency Department
EDT	Emergency Duty Team
EMR	Electronic Medical Record
FCR	Force Control Room
ICT	Integrated Care Team
IDAS	Independent Domestic Abuse Service
ISVA	Independent Sexual Violence Advocate
IMR	Individual Management Review
MAPPA	Multi-Agency Public Protection Arrangements This is a statutory process used to manage Registered Sex Offenders (RSOs) or the most violent offenders. The police, HM Prisons and the Probation Service are the three 'Responsible Authorities' within the MAPPA process. MAPPA has different categories of offender and different 'levels' which determine the level of resources required to manage that dangerous individual. In addition to the three 'Responsible Authorities', other agencies (for example GPs, hospitals, local authorities or registered social landlords) may also be invited to participate within MAPPA
MARAC	Multi-Agency Risk Assessment Conference These are meetings attended by several agencies who share information and formulate a plan to protect those victims of domestic abuse assessed at the highest risk of harm.
MAST	Multi-Agency Screening Team
MATAC	Multi-Agency Tasking and Coordination
MDT	Multi-Disciplinary Team

MO	Modus Operandi
NFA	No Further Action
NPS	National Probation Service
OIC	Officer In Case
PPN	Public Protection Notice
PND	Police National Database
RMN	Registered Mental Health Nurse
SARA	Spousal Assault Risk Assessment
SNT	Safer Neighbourhood Team
YDH	York District Hospital

References

Multi-agency statutory guidance for the conduct of DHRs (Home office 2016)

DHRs 'Key findings from analysis of DHRs' (Home Office 2016)

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[i] **Cuckooing**

"cuckooing (also known as "forced home invasion") – a tactic used by criminals, typically drug dealers, to take over the homes of vulnerable individuals, such as care leavers or those with addiction, physical or mental health issues, and use the property as a base for criminal activity. This is a common characteristic of the county lines business model and can occur in a range of settings such as rental and private properties, student accommodation, prisons, and commercial properties;

https://www.gov.uk/government/publications/criminal-exploitation-of-children-and-vulnerable-adults-county-lines/criminal-exploitation-of-children-and-vulnerable-adults-county-lines

[ii] **Cocoon Watch**
Neighbourhood and police safety schemes
Cocoon watch schemes request the help and support of neighbours, family and relevant agencies in protecting the victim by contacting the police immediately if further incidents occur. A cocoon watch identifying the victim is only implemented with the informed consent of the victim.
College of Policing https://www.college.police.uk/app/major-investigation-and-public-protection/domestic-abuse/victim-safety-and-support#neighbourhood-and-police-safety-schemes

[iii] **DoLS – Deprivation of Liberty Safeguard**
The Mental Capacity Act allows restrictions and restraint in some cases to be used in a person's support, but only if they are in the best interests of a person who lacks capacity to make the decision themselves and only if it is necessary and proportionate to do so. The urgency of the situation would be part of the consideration of whether to apply a short term restraint or restriction, to provide care or treatment, for example.
https://www.scie.org.uk/mca/dols/at-a-glance/

[iv] DVDS Domestic Violence Disclosure Scheme
Clare's Law was introduced across England and Wales in March 2014. It followed the case of the murder of Clare Wood. Clare was a 36 year old woman with a 10 year old daughter. She had met a male named George Appleton on 'Facebook' and they had formed a relationship. Unknown to Clare, Appleton had a long history of violence towards women which included harassment and kidnapping a former partner and holding her at knifepoint for several hours. When Clare had ended the relationship with Appleton, he had threatened to kill her. These threats were not taken seriously by the police and no officer warned Clare about Appleton's background. In February 2009, Clare was murdered by Appleton. He had raped and strangled her, then set her body on fire. A subsequent campaign by Clare's family and friends resulted in

the introduction of 'Clare's Law'. The Domestic Violence Disclosure Scheme is an option for professionals to consider, to protect victims of domestic abuse.

[v] **The Living Well Service**

The Living Well Service helps adults improve their health, wellbeing and independence, they work with people who are experiencing a range of different situations including those who are isolated, bereaved, lacking confidence or who are close to needing health and social care services. Living Well Coordinators;

- identify what is important to the person, and what their priorities are
- identify what potential networks of support the person has and can access
- help the person identify what changes they would like to make to improve their lifestyle and home environment
- identify barriers and challenges to improve the person's wellbeing and independence, and help to adapt to those barriers for example, finding ways for the person to attend a local community group
- help the person to achieve their goals

[vi] **MATAC**

MATAC is a multi-agency approach that focuses on identifying serial perpetrators of domestic abuse and challenging their offending behaviour to prevent future incidents of domestic abuse. This project was rolled out in North Yorkshire in 2019 through the Domestic Abuse: Whole Systems Approach project, involving six other regional police forces in the Northeast. The aim is to develop and strengthen partnership working and innovatively tackle domestic abuse. The intended overall outcome of MATAC is to reduce reoffending of the most harmful and serial domestic abuse perpetrators and to safeguard victims and their families.

A range of interventions can be delivered via MATAC, including support, prevention, diversion, disruption and enforcement.

The key aims are as follows:

- Prevent further domestic abuse related offending
- Improve victim safety
- Change offender behaviour
- Improve partnership engagement

The MATAC team identify nominals to be engaged with and challenged about their behaviours in several ways:

- Recency, Frequency, Gravity & Victims (RFGV) analytical spreadsheet - The RFGV algorithm is a tool used by police and other agencies to identify and prioritize domestic abuse perpetrators for intervention. It uses a scoring system based on the Recency, Frequency, Gravity, and Victim vulnerability of reported incidents. This helps determine which offenders pose the greatest risk and need more intensive management.

Recency: How recently an incident occurred.

Frequency: How often an offender has been involved in domestic abuse incidents.

Gravity: The severity of the incidents (e.g., the seriousness of the harm caused).

Victim: The vulnerability of the victim(s) involved.

The RFGV algorithm is used in conjunction with other tools and processes, such as DOMESTIC ABUSESH risk assessment tools and MATAC (Multi-Agency Tasking and Coordination), to identify and manage high-risk perpetrators.

By analysing these factors, the algorithm helps identify perpetrators who may require more targeted intervention, such as offender management plans, mental health support, or social support, to reduce the risk of future harm.

- Referrals into MATAC from partner agencies
- Professional judgement via researching Multi-Agency Risk Assessment Conferences lists, detained persons and the Domestic abuse Daily Management Meetings (DMM).

[viii] THRIVE – this is a mnemonic used by Police to risk assess incidents:
Threat
Harm
Risk
Intelligence
Vulnerabilities
Engagement

https://www.college.police.uk/guidance/vulnerability-related-risks/introduction-vulnerability-related-risk

[ix]

***** End of Report *****