Domestic Homicide Review (DHR)

North Worcestershire Community Safety Partnership

Overview Report into the deaths of

Ashley [July 2021]

and

Ryan [August 2021]

Julia Greig

Overview Report Author

Date: 26th February 2023

Version: 4

Contents

Preface

This is a Domestic Homicide Review Report referring to the life and death of Ashley and Ryan. These are the pseudonyms chosen by the panel and will be used throughout this report.

I would like to begin by expressing my sincere sympathies, and that of the panel, to the family and friends of Ashely and Ryan. This review has been undertaken in order that lessons can be identified to inform future responses to domestic abuse.

I would like to thank the panel and those that provided chronologies and individual management reviews for their time and co-operation.

1. Introduction

1.1 This joint report of a domestic homicide review (DHR) examines agency responses and support given to Ashely and Ryan, residents of North Worcestershire prior to their deaths in July and August 2021. The decision to review both deaths was taken, following an initial DHR Panel meeting on 16th September 2021 in order to optimize input from partner agencies who were likely to have dealt with both parties, and was a decision finalised after consultation with the Home Office and reiterated with them on 4th November 2021.

1.2 In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before their deaths, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.3 The review considers agencies contact and involvement with both Ashely and Ryan from 1st December 2019 to date of Ryan's death on the 3rd August 2021. This represents the period of time that Ashley and Ryan were in an intimate relationship and the period following Ashley's death.

1.4 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed (or has died) as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each case, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.5 Every effort has been made to conduct this review process with an open mindset and to avoid hindsight bias. Those leading the review have sought the views of family members and made every attempt to manage the process with compassion and sensitivity.

2. Timescales

2.1 This review began in May 2022, the panel met on four occasions and was concluded in February 2023. Reviews, including the overview report, should be completed, where possible, within six months of the commencement of the review. There was a delay in commencing the review as the chair originally appointed to undertake the review was unable to continue and another chair had to be recruited. In addition, the decision was taken to stagger the timetable for this review, due to other DHRs being completed in the area at the time and so as not to overwhelm agencies completing IMRs.

2.2 There was a delay incurred in the sign-off of the final report by the Community Safety Partnership due to the volume of work in early 2023. The report was approved by the Community Safety Partnership at an extraordinary meeting in ???. There was a further

delay in submitting the final report to the Home Office due to an oversight within the Community Safety Team at Worcestershire County Council

2.3 The panel was reconvened in December 2024 to review amendments to the report following feedback from the Home Office Quality Assurance Group.

3. Confidentiality

3.1 The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers.

3.2 The pseudonyms agreed for use on this review are Ashley and Ryan which have been used to protect the identity of the individuals involved. In the absence of involvement from family and friends, these pseudonyms were chosen by the panel.

4. Terms of Reference

4.1 Statutory Guidance (Section 2.7) states the purpose of the DHR 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 on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- Contribute to a better understanding of the nature of domestic violence and abuse;
- Highlight good practice.

Specific terms of reference set for this review

- Identify examples of good practice, both single and multi-agency.
- Analyse the quality of risk assessments undertaken. Were links between Mental Health (including risk of suicide), Domestic Abuse (including historical domestic abuse) and Substance Misuse identified at any risk assessment?
- Whether risk was or was not identified, where can practitioners within your agency receive advice or support if they suspect domestic abuse? Was this taken up in this

case? If this is available would the advice extend to consultation or referral across agencies?

- Is there evidence of whether any identified risk had been assessed as reaching the threshold for inter-agency information sharing?

- What evidence is there of communication and information sharing between agencies? How could information sharing and communication have been improved during the scoping period both within and between agencies?

- Was consideration given to issues of culture, race, religion or belief? What role if any, did these issues play for Ashley and Ryan in accessing services and support?

- To what extent did Covid-19 Lockdown and potential isolation impact on the Ashely and Ryan accessing support, e.g., for domestic abuse or mental health services?

- To consider recommendations and actions from previous Domestic Homicide Reviews and assess if they are recurring/reappearing in this review.

5. Methodology

5.1 The method for conducting DHR's are prescribed by the Home Office Guidelines. These guidelines state: "Reviews should illuminate the past to make the future safer and it follows therefore that reviews should be professionally curious, find the trail of abuse and identify which agencies had contact with the victim, perpetrator or family and which agencies were in contact with each other. From this position, appropriate solutions can be recommended to help recognise abuse and either signpost victims to suitable support or design safer interventions".

5.2 The review was undertaken using the Significant Incident Learning Process (SILP), a learning model which engages frontline staff and their managers in reviewing cases, focussing on why those involved acted in a certain way at the time.

5.3 The SILP model of review adheres to the principles of:

- Proportionality
- Learning from good practice
- The active engagement of practitioners involved at the time
- Engaging with families
- Systems methodology
- Avoidance of hindsight bias

5.4 Following the decision to undertake the review, all agencies were asked to check their records about any interaction with Ashley or Ryan.

5.5 Where it was established that there had been contact all agencies promptly secured all relevant documents, and those who could make an appropriate contribution were invited to become panel members. Agencies that were deemed to have relevant contact were then asked to provide an Agency Report detailing the specific nature of that contact and responding to the specific terms of reference.

5.6 The aim of the Agency Report is to look openly and critically at individual and organisational practice to see whether the case indicates that changes could or should be made to agency policies and practice. Where changes were required then each Agency Report also identified how those changes would be implemented.

5.7 Each agency's Agency Report covered details of their interactions with Ashley and Ryan, and whether they had followed internal procedures. Where appropriate the report writers made recommendations relevant to their own agencies and prepared action plans to address them. Participating agencies were advised to ensure their actions were taken to address lessons learnt as early as possible. As part of this process Agency Report authors, where appropriate, interviewed the relevant staff from their agencies.

5.8 The findings from the Agency Reports were endorsed and quality assured by senior officers within the respective organisations who commissioned the report and who are responsible for ensuring that the recommendations within the Agency Reports are implemented.

5.9 Following receipt of the Agency Reports a learning event was held involving practitioners and managers who worked directly with Ashley and/or Ryan and their families. A recall day took place to review the first draft of the overview report.

5.10 Those agencies who provided Agency Reports are detailed within section 7 of this report.

6. Involvement of Family, Friends, Work Colleagues, Neighbours and Wider Community

6.1 The CSP wrote to Ashley's sister and Ryan's mother in June 2022 to inform them of the review. The independent reviewer wrote to Ashley's sister, child and ex-husband and to Ryan's mother in October 2022 inviting them to participate in the review, and included the Home Office leaflets with each letter and details of advocacy support. Unfortunately, no response was received from any of the family members that were contacted.

6.2 The review also attempted to identify Ashley's employer as an additional source of information but were unsuccessful.

6.3 Further letters were sent to Ashley's sister, child and ex-husband and to Ryan's mother in February 2023 to inform them that the review had concluded and would be submitted to the Home Office for quality assurance; they were advised that there was still opportunity to contribute to the review and were invited to contact the independent reviewer. At the time of writing, no contact has been received from the family members.

7. Contributors to the Review

7.1 The agencies that have contributed to this review are as follows:

- West Mercia Police

- Worcestershire Children First
- Worcestershire Acute Hospitals NHS Trust
- Herefordshire and Worcestershire Integrated Care Board (ICB) (formally the Clinical Commissioning Group)
- Redditch Borough Council

7.2 Agency report authors were independent with no direct involvement in the case, or line management responsibility for any of those involved.

8. The Review Panel Members

8.1 The DHR panel members were as follows:

Name	Role	Agency
Julia Greig	Independent Chair	Review Consulting
Paul Kinsella	Advanced Public Health Practitioner	Worcestershire County Council
Steve Cook Lesley Fisher	Detective Inspector	West Mercia Police
Bev Houghton	Community Safety Manager	Bromsgrove District Council & Redditch Borough Council
Heather Manning Amanda Williams Sarah Dempsey	Head of Safeguarding & Designated Nurse Named Nurse Safeguarding Deputy Designated Nurse for Safeguarding	Herefordshire and Worcestershire Integrated Care Board
Jon Elgar	Tenancy Manager	Redditch Brough Council
Deborah Narburgh	Head of Safeguarding	Worcestershire Acute NHS Trust
David Cookson	Deputy Head of Probation	HM Prison & Probation Service
Claire King	Safeguarding Services Manager	Herefordshire and Worcestershire Health and Care NHS Trust
Gillian Adams	Senior Independent Domestic Violence Advisor	West Mercia Women's Aid
Suzanne Simms Daniel Gray	Practice Manager	Worcestershire Children First

	Head of Quality Assurance & Principal Social Worker	
Matt Burke	County Manager	Cranstoun

8.2 Independence and impartiality are fundamental principles of delivering DHR and the impartiality of the independent chair and report author and panel members is essential in delivering a process and report that is legitimate and credible. None of the panel members, had direct involvement in the case, or had line management responsibility for any of those involved.

8.3 In addition, suicide prevention team were invited to review and comment upon this report.

9. Author of the Overview Report

9.1 North Worcestershire Community Safety Partnership appointed Julia Greig to chair the review and author the Overview Report. Julia works both independently and for a local authority in the southeast as a registered social worker, with extensive social work experience in the statutory sector working with adults. She has completed the Home Office approved course for Domestic Homicide Review Authors provided by Advocacy After Fatal Domestic Abuse (AAFDA) and is an accredited reviewer using the Serious Incident Learning Process. She maintains her CPD through Review Consulting and the AAFDA Network. She is currently undertaking Safeguarding Adult Reviews and Domestic Homicide Reviews in other local authority areas. Julia Greig is independent of all agencies involved in this case and has never worked in Worcestershire or for any of its agencies.

10. Parallel Reviews

10.1 Police arrested Ryan on suspicion of murder following concerns that Ashley would not have been able to reach the loft hatch to secure the ligature used and Ryan's disclosure of assault. However, following further research and the post-mortem, whilst Ryan was in police custody, it was ascertained that it was possible that Ashley could have accessed the loft hatch and that this was the most probable theory. Ryan was therefore released under police investigation until 1st October 2021.

10.2 His Majesty's Coroner recorded suicide as the cause of death for both Ashley and Ryan

11. Equality And Diversity

11.1 The nine protected characteristics in the Equality Act 2010 were assessed for relevance to the Review.

11.2 Ashley was a black British woman, described by agencies as mixed heritage, black/white British. Ryan was a white British man. Both were 35 years old at the time of their deaths. A Home Office report published in 2021 analysed 124 DHRs[1]. The analysis

[1] DHRs_Review_2019-2020_Report_Final_Draft.pdf

found that with regards to sex, 80% of the victims were female and 20% male. The Crime Survey for England and Wales has also estimated that 1.6 million women and 712,000 men aged 16 years and over experienced domestic abuse in year ending March 2024, and so women were around twice as likely to have experienced domestic abuse than men.[2] For perpetrators, 83% were male and 17% female. Eighty-six percent of victims were British and 85% of perpetrators were British. Five percent of DHR victims, and fourteen percent of all homicide victims were Black/African/Caribbean/Black British. The ethnicity of perpetrators is around 70% white British. However, ONS data found no significant difference between any domestic abuse estimates across different ethnic groups. ONS data shows that approximately half of violence against the person offences were identified as domestic abuse related for women aged between 20 and 44 years and that just over 5% of people aged 35-44 have experienced domestic abuse. The age group with the highest proportion of domestic homicide victims were aged 30 to 39, representing 26%. The age group with the highest proportion of perpetrators was also 30-39 (33%).

11.3 Across all the reviews analysed there were 127 victims, of which 14 were, or appeared to be, victims of domestic abuse who died by suicide. Eleven were female and three were male. Their average age was 36yrs. In the reviews analysed there are 109 perpetrators, of these 11 died by suicide after the homicide.

11.4 Both Ashley and Ryan were parents. Ashley had a child who was an adult at the time of Ashley's death; Ryan had a child who was of primary school age. Ashley's child lived with her until they moved to live with their step-father in around March 2020. Ryan's child lived with their mother, although it is believed they spent approximately one week living Ryan and Ashley in February 2020 before police returned the child to the care of their mother. In the Home Office analysis, there were dependent children in 52% of the households where the victim was aged under 60.

11.5 It is thought that Ashley and Ryan commenced their relationship from December 2019. Analysing the relationships between the victims and perpetrators shows that for 73% of the victims the perpetrator was a partner or ex-partner. Ashley had experienced domestic abuse in previous relationships, analysis shows that 46% of victims had been the target of a perpetrator previously, almost always their previous partner. Ryan had perpetrated domestic abuse in a previous relationship and had an offending history. Approximately 60% of perpetrators were indicated to have a previous offending history. Of these three quarters had abused previous partners.

11.6 With regards to vulnerabilities, Ashley used alcohol and drugs, she had a diagnosis of borderline personality disorder and experienced mild depression. Ryan also experienced poor mental health and used drugs and alcohol. The Home Office analysis showed that 61% of victims had a vulnerability, with 34% having one vulnerability and 27% having more than one. Of the vulnerabilities, 34% were mental ill-health, 28% were problem alcohol use and 22% were illicit drug use. For 26% of those with a mental health vulnerability this was depression and 16% had suicidal thoughts. Fourteen percent had attempted to take their life by suicide and, with 14% also, the vulnerability was low mood or anxiety. Seventy-one percent of the perpetrators in the DHR analysis were considered to have a vulnerability and the most common were illicit drug use, mental ill-health, and problematic alcohol use. Thirty one percent of

[2] Domestic abuse victim characteristics, England and Wales - Office for National Statistics

perpetrators were affected by mental health issues and for 23% this was depression and 21% were suicidal thoughts.

11.7 Ashley had also been a looked after child. Research shows that care leavers are 4-5 times more likely to commit suicide than their peers in adult life[3]. These vulnerabilities are explored further in the analysis.

12 Dissemination

12.1 In accordance with Home Office guidance all agencies and the families of Ashley and Ryan are aware that the final Overview Report will be published. Agency reports will not be made publicly available. Although key issues if identified will be shared with specific organisations the Overview Report will not be disseminated until clearance has been received from the Home Office Quality Assurance Group.

12.2 The content of the Overview Report has been suitably anonymised to protect the identity of the those who died and relevant family members. The Overview Report will be produced in a format that is suitable for publication with any suggested redactions before publication.

12.3 The Overview Report will be shared with the panel member agencies and the CSP, and will be published on the Worcester City website.

13 Background Information (The Facts)

13.1 On the 13th July 2021 police were contacted by ambulance control who were in attendance at Ashley's address following contact from Ryan, who stated he had found Ashley hanging from the loft outside the spare bedroom. He told police that he had slept the night in the spare room after the pair had argued whilst both drunk. He also disclosed to that during the argument he had thrown his mobile telephone at her which had caused a cut above her eye.

13.2 Due to the circumstances presenting to police, Ryan was arrested on suspicion of murder. During his police interview Ryan said that he and Ashley often argued, and it had been getting worse more recently. He said that Ashley had been physically abusive to him in the past causing him black eyes and he had grabbed her during arguments. He also said that Ashley would regularly go through his phone and would not allow him to go on Instagram. Other information provided during interview by Ryan indicated alcohol and drug use featured as part of unreported domestic abuse incidents and that both parties were prescribed anti-depressant medication.

13.3 Following the results of the Home Office post-mortem Ryan was released under police investigation until 1st October 2021.

[3] Report of the Children and Young People's Health Outcomes Forum - Mental Health Sub-Group (publishing.service.gov.uk)

13.4 On the 3rd August Ryan's mother contacted both police and ambulance to report that her son had locked himself in her bathroom and she could not get in. Police attended, forced the bathroom door and found that Ryan had hanged himself. Officers conducted CPR and first aid until the arrival of paramedics. Ryan was conveyed to hospital but died a short time later.

14 Chronology

Background History

14.1 Ashley had been a looked after child and continued to be looked after when her child was born in 2003, as a result her child was also 'looked after'. Ashley's looked after status ended when she turned 18 years of age, after which she was supported by Aftercare Services, this ceased when she turned 21.

14.1 Ashley had a history of overdose and self-harm. She had previously been a victim of domestic abuse and had suffered assaults by ex-partners. Ashley had been a victim of rape by an ex-partner which had dramatically impacted on her mental health and ability to feel safe and secure. This had led to drug use, although it appears use of drugs predated this incident, which was a contributing factor toward her child being taken into care in around 2014 for a period of 11 months.

14.2 The perpetrator was convicted in 2017 and sentenced to twelve years in prison, sex offenders register and a protection from harassment restraining order. Ashley subsequently received threats from the perpetrator's family. This led to a Home Security Assessment being completed by Redditch Borough Council (RBC) in 2018.

14.3 When Ashely met her ex-husband she seemed to have turned her life around. She had managed to secure and sustain employment, care for her child and appeared to feel happy in life. Following her separation from him, Ashley's mental health and presentation appeared to decline. At the beginning of the period subject to review Ashley was living with her child.

14.4 Ryan received two sentences for possession of an imitation firearm with intent to cause fear in 2010 and 2018. For the latter offence Ryan received an 18-month prison sentence from which he was released on licence on the 2nd September 2019 with the licence expiring on the 1st June 2020. His release was also subject to the condition not to contact or approach his child without prior approval of his supervising officer. Ryan was classed as high risk to known adults and children due to the nature of the offence he committed.

14.5 Ryan was also recorded as an involved person with regards to one domestic abuse investigation relating to an ex-partner in 2017, who was the mother of his child. This took place in Essex however, his ex-partner moved to Redditch to get away from him. She was seen by West Mercia police (WMP) following a request by Essex police. The incident related to a verbal argument and threats to kill. His ex-partner also stated that Ryan had placed his hands around her neck causing reddening. WMP completed a DASH risk assessment and made referrals to the Independent Domestic Violence Advocate (IDVA) service and children's services. Ryan had also returned to the Redditch area and therefore a Risk Management Plan was raised. It was recorded

that Ryan's ex-partner engaged with agencies and there were no further issues reported.

14.6 Ryan also had a history of attendances at hospital as a result of physical assaults, details of the assailant(s) were not recorded.

Combined Narrative Chronology

14.7 In January 2020 Ashley's husband contacted RBC and completed a Notice to Vacate in order to terminate the joint tenancy with Ashley. He stated he had separated from Ashley as she had an affair, and he said she was now living 'a party lifestyle.' RBC contacted Ashley to advise that the joint tenancy would be coming to an end and arrangements would be made to see if a sole tenancy could be granted.

14.8 On the 23rd January 2020 Ashley was seen in person by a GP. She told the GP that she had separated from her husband about two months prior. She said that she felt okay but was worried she might get anxiety and depression. She confirmed that she used alcohol but had decreased her intake, her sleep was disturbed, appetite was okay and had no suicidal thoughts or self-harm. Ashley was prescribed Propranolol[4] for anxiety and advised to attend again for review or if symptoms worsened.

14.9 On the 31st January 2020 Ashley contacted RBC to discuss her account and seek advice on Universal Credit. Ashley reported she had been off sick from work and, now her ex-husband was not living at the property, her financial situation had changed.

14.10 On the 2nd February 2020 Ryan's child's school reported to police that the child had not attended school for a week. Staff from the school had visited his home address twice and were informed he did not live there anymore. They subsequently contacted police for a safe and well check to be carried out. Police carried out research and found him safe and well at the home address of Ashley and Ryan. He was returned to his mother's address due to his licence conditions and because it could not be confirmed at that time that permission had been sought.

14.11 On the 11th February 2020 Children's services received a referral from Probation stating that Ryan's ex-partner had left their child in Ryan's care. A Social Work Assessment was undertaken, care and support put in place, and a risk assessment also incorporated into the Social Work Assessment on how Ryan's contact with his child could be safely managed, supported and supervised by the paternal Grandmother. The referral was completed and step-down to Early Help Services to support the mother with behaviour management.

14.12 On the 17th February 2020 RBC visited Ashley to place her on a license agreement, a permanent tenancy could not be awarded due to the rent arrears. Ashley would remain on the license whilst she resolved the rent issue, once resolved she could be signed onto a sole, secure tenancy.

[4] Propranolol belongs to a group of medicines called beta blockers. It is used to treat heart problems, help with anxiety and prevent migraines.

14.13 On the 11th March 2020 children's services received a referral from Ashley's child's school. The child did not wish to return home to their mother as she was drinking alcohol again. A Social Work Assessment was recommended by the Family Front Door. The child went to stay with their step-father, Ashley's ex-husband, a previously completed Parenting Assessment had determined him as an appropriate carer.

14.14 On the 20th March 2020 RBC had telephone contact with Ashley as the Covid-19 lockdown period had just commenced and she was feeling isolated and confused about her benefits. Ashley was advised to contact the Jobcentre to seek advice as there was an issue with her Universal Credit claim. Ashley agreed to do so and rang back later that day to advise it was all sorted.

14.15 Ashley was taken to Alexandra Hospital on the 17th April 2020 by ambulance. Ambulance crew had witnessed Ashley having a seizure. She said she had used cocaine three days previously. She said she was a regular user and had not slept in three days. Ashley referred to her recent separation. It was determined that she could be experiencing alcohol/drugs withdrawal. Replacement fluids were given, Ashley's condition improved, and she was discharged home. Ashley's GP and children's services were notified. As her child was now in her step-father's care there was no further action for Children's social care.

14.16 On the 6th June 2020 Ryan had a telephone consultation with his GP reporting feeling very angry all the time. Ryan said he had stopped taking Fluoxetine[5] in October and since then had been feeling angrier. He reported sometimes feeling anxious, low in mood but denied any specific stressors or feeling suicidal. He said he lived with his partner who was supportive. Ryan said problems started with cocaine use but that he had not used for more than a year. He declined psychological therapies and agreed to start Sertraline[6] and was counselled regarding side effects. Ryan was advised how to seek urgent help if needed. One month's prescription of Sertraline 50mg was issued as per NICE guidance for depressive disorder with follow up review in 2 weeks.

14.17 On the 9th June 2020 Ashley called RBC to say that she had started a new job and had cancelled the Universal Credit claim. She stated she would make a payment on Friday to clear her account.

14.18 On the 3rd July 2020 Ashley phoned RBC and spoke to a duty Rent Officer. She said that she had started work 6th June and as a result her Universal Credit was stopping. In addition, her partner, Ryan, had moved in. Advice was provided on council tax and benefit changes.

[5] Fluoxetine is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI). It's often used to treat depression, and sometimes obsessive compulsive disorder and bulimia. It works by increasing the levels of serotonin in the brain. Serotonin is thought to have a good influence on mood, emotion and sleep.

[6] Sertraline is a type of antidepressant known as a SSRI. It's often used to treat depression, and also sometimes panic attacks, obsessive compulsive disorder (OCD) and post-traumatic stress disorder (PTSD).

14.19 On the 10th July 2020 RBC had a telephone call with Ashley. She had a new job and her benefits were now in payment. Her account was back up to date and she could now sign on a secure tenancy.

14.20 On the 13th July 2020 RBC made a home visit to Ashley to sign the Secure Tenancy Agreement. Ashley stated she had been struggling with her finances and with her mental health during the Covid-19 pandemic. She stated she was starting to feel better and contacting the GP for further support regarding her mental health was discussed. The property was in good order and Ashley did not require any support with tenancy sustainment.

14.21 Ashley had a telephone consultation with a GP on the 30th July 2020 reporting a decline in her mental health and brief suicidal thoughts. She said it had been a bad year, she had separated from her husband, and her child had gone to live with him. She reported not really having any friends and her sister, with whom she was close, lived far away. She said she had left her job as care assistant as she felt too much stress. She said she wanted to get better then to look for something else. One month's supply of Sertraline 50mg tablets was prescribed. Ashley was made aware of the side effects and that she should not expect a good effect until 2-3 weeks after starting. Ashley was given the contact details for Healthy Minds and a 'Not fit to work' note for one month. Ashley was advised to have a follow up appointment in two weeks.

14.22 On the 21st August the GP surgery sent Ashley a text message to advise a medication review was required as a new prescription had been requested. The prescription was renewed to prevent medication stopping but with a request to make appointment for review.

14.23 On the 28th September a new 'not fit for work' note was issued for one month. A text was sent to Ashley to advise her to make appointment for a medication review as request had been made by Ashley for a new prescription. The prescription was not issued.

14.24 Ashley spoke with a Rent Officer (RBC) on the 5th October and stated she was struggling financially since her separation. RBC referred Ashley to the Financial Inclusion team for advice.

14.25 Ashley had a telephone consultation with a GP on the 9th October 2020. She reported feeling much better and was back at work. A repeat prescription was issued, and safety netting advice was given for any worsening symptoms.

14.26 On the 26th October 2020 Ryan had a telephone review with a GP. He had been prescribed Sertraline in July 2020 but had stopped using them because they stopped him maintaining an erection and ejaculating. Ryan said he had tried Fluoxetine and Citalopram; Sertraline was the only one that worked. Ryan reported his mood was not good and agreed he needed to be on Sertraline. A review in 3-4 weeks was advised.

14.27 On the 18th December 2020 Ryan had a telephone review with a GP. He reported that the Sertraline had not been working as well, he had tried 100mg for two days and felt

a lot better again, so he was happy to step up to 100mg and review progress in four weeks. Prescription for one month's supply of Sertraline 100mg issued.

14.28 On the 15th January 2021 Ryan's GP surgery received an A&E notification from University Hospital Birmingham (UHB) reporting that he had attended after being hit over the head with a baseball bat. This was followed on the 20th January 2021 by a letter from the UHB Oral and Maxillo-Facial Surgery department with regards to a closed fracture to his cheek bone.

14.29 Ryan presented at Alexandra Hospital on the 16th February 2021 with palpitations for the last three days following excessive usage of alcohol/drugs and no food. He advised he had taken four grams of cocaine that night. Ryan was treated and discharged home. His GP was notified.

14.30 On the 12th March Ryan had a telephone consultation with a GP. His recent admission to hospital, use of alcohol and recreational drugs were discussed, and he stated that all was fine now. Ryan reported recently noticing an inflamed spot on his face and scabby inflamed spots inside his nose, but no perforated septum. The GP prescribed a trial of antibiotics and requested photographs by text which Ryan subsequently submitted.

14.31 Ashley had a telephone consultation with a GP on the 15th March 2021. She reported feeling fine on Sertraline 50mg and that she wanted to stay on it. A six month review was agreed.

14.32 On the 26th March 2021 Ashley phoned the Rent Team (RBC), to discuss some missing payments. She emailed over proof of payment to the Rent Officer.

14.33 On the 19th April 2021 RBC received contact from West Mercia Police, who had received a call from a neighbour, regarding Ashley being verbally abusive to the neighbour. The neighbour also reported the smell of cannabis coming from the property. On the 29th April RBC visited Ashley's home with a police officer, there was no answer, and a card was left.

14.34 Ryan had a telephone review with the GP on the 25th May 2021. He reported he had not taken Sertraline for last three weeks. Since stopping the medication he had felt like his mood was all over the place, feeling angry all the time and wanted to go back on the Sertraline 100mg. Sertraline 100mg prescribed with review in two weeks. Ryan discussed a 'shaking' episode he had 2 days previous whilst intoxicated. He had told his employer and they had asked for a fit note from his GP. Ryan was advised that a fit note could not be issued as he had not lost consciousness and was advised that if his employer wished to investigate then they should do so through Occupational Health.

14.35 RBC visited Ashley on the 26th May 2021 to discuss the neighbour report. Ashley seemed well, she was missing her child but had met a new partner and felt things had improved. Ashley admitted she had been smoking a small amount of cannabis, and she was told this should not be done in the property, she agreed. With regard to the

neighbour complaint, she advised she only had a few friends round now and then and they were not loud. Ashley felt the neighbours were targeting reports as they were friends with her ex-husband, and they weren't happy she had met someone new. It was agreed that Ashley would ensure she is respectful of her neighbours.

14.36 On the 27th June 2021 Ashley contacted the police to report Ryan as a missing person. She stated he had been missing since the previous night following a verbal argument between the two when Ashley thought he had been talking to another woman on a night out. Ashley said Ryan suffered with his mental health and had not been taking his medication. Police missing persons enquiries were commenced, and an investigation log was recorded for domestic abuse in relation to the argument that Ashley disclosed. A DASH risk assessment was completed with the outcome of medium risk, however Ashley declined to answer the risk assessment questions. Ryan returned to the address safe and well the following day. The investigation log was assessed by the Harm Assessment Unit and a referral was made to children's social care due to the presence of both children. However, children's social care state they received no such reports for either child around this date.

14.37 On the 29th June 2021 a neighbour contacted police and stated that Ashley had recently told them that Ryan had hit her when she had said something he did not like. The neighbour stated that it had taken place in the past few months. No further action was taken as it was assumed this related to the report made by Ashley on the 27th June.

14.38 On a day in mid-July 2021 Ashley was found deceased at her home and Ryan was arrested on suspicion of murder. Whilst in custody Ryan was seen by a health care practitioner and deemed fit to be detained and interviewed. On his release Ryan was provided with details of support agencies which included amongst others NHS, Samaritans and Respect should he wish to contact any of them to seek help in relation to the loss of his girlfriend.

14.39 A few days later Ryan's sister contacted police concerned for her brother following the death of his girlfriend. The police incident log recorded that he had cut his wrist, taken his mother's car and that his sister believed he was drunk therefore a risk to himself. Ryan returned to his mother's address whilst his sister was still on the phone to the police. Officers attended and awaited the arrival of the paramedics who assessed Ryan. He informed both paramedics and police that he was depressed in relation to the loss of his girlfriend but was no longer feeling suicidal. He was assessed by paramedics and deemed fit, officers then conveyed him to a friend's address and provided him with contact details of support agencies should he require them. A notification was sent to Ryan's GP by the ambulance service.

14.40 Ryan had a telephone consultation with a GP. He reported initially feeling responsible for Ashley's death, not sleeping and experiencing flashbacks. The GP prescribed

Sertraline 100mg and Diazepam[7] 2mg, and provided contact details for CRUSE bereavement and the Crisis team by text.

14.41 Towards the end of July 2021 police received a report from a member of the public stating that Ryan was drunk and was trying to climb the fence at the rear of their property. They approached Ryan and asked him to leave. Ryan became abusive towards them. He had left the area prior to police arrival. Ryan was spoken to by officers, he apologised for his behaviour and could not recall exactly what had happened as he was drunk at time. He was struggling to come to terms with the death of his girlfriend. He had been living with his mother but was looking for somewhere else to live. He informed the officer that he was receiving support from his GP in relation to his girlfriend's death.

14.42 Around a week later Ryan was found hanging in the bathroom of his mother's home and died a short while later in hospital.

15 Overview

15.1. The overview summarises what information was known to the agencies and professionals involved about the victim and the perpetrator.

15.2. The agencies involved in this review knew Ryan and Ashley well. However, little was known about them as a couple. The police first became aware of their relationship in February 2020 when responding to concerns of the welfare of Ryan's child.

15.3. RBC had worked with Ashley for a number of years and had built a rapport with her with, one officer having known her for five years. RBC commented that Ashley was always very open and honest about any difficulties she was experiencing, and appropriate advice and support was provided in response. Ashley made RBC aware of a new partner in July 2020 but this was the one and only time she mentioned him, otherwise RBC had no knowledge of Ryan.

15.4. Children's services were also aware of Ashley and Ryan, in respect of their children, and had been involved with Ashley and her child for a number of years, however, they were not aware of the connection between Ashley and Ryan.

15.5. Ashley had been registered at her GP surgery since 2014 and Ryan had been registered at his surgery since birth, save for a period of eight years (2010-2018) when he moved out of the area. However, Ashley and Ryan were registered at different surgeries. Ryan made one reference to a partner to his GP in June 2020, otherwise neither practice was aware of the relationship between the two.

15.6. The GP practice records demonstrated an awareness of Ashley's previous experience of domestic abuse through self-disclosure and MARAC minutes.

[7] Diazepam belongs to a group of medicines called benzodiazepines. It is used to treat anxiety, muscle spasms and seizures or fits. It's also used in hospital to reduce alcohol withdrawal symptoms, such as sweating or difficulty sleeping.

15.7. The police, children's services and RBC were all aware of the domestic abuse history for Ashley and police and children's services were aware of Ryan's offending history including domestic abuse of an ex-partner. The suspected domestic abuse incident in June 2021 was only known to police. Primary care were not aware of Ryan's previous offending history.

16 Analysis

16.1 The analysis will address the terms of reference and the key lines of enquiry within them. In doing so it will examine how and why events occurred, information that was shared, the decisions that were made, and the actions that were taken or not taken. It will consider whether different decisions or actions may have led to a different course of events. It will also highlight examples of good practice.

Assessment of risk

16.2 Risk was assessed in relation to domestic abuse using the Domestic Abuse Stalking and Harassment Indicator Checklist (DASH) on one occasion following the report made by Ashley to police on the 27th June 2021. This was the only disclosure of domestic abuse during the period. Despite Ashley declining to contribute to the DASH, the officer responding recorded that Ryan suffered with his mental health and had had issues in the previous year with drugs and alcohol. The risk assessment was recorded as medium risk although no rationale for this level was recorded. There was no previous history recorded on police systems suggesting either was a suicide risk, nor was there any previous domestic abuse recorded between the two.

16.3 However, Ashley had been known to WMP since 1997 and had been recorded as a victim of 23 offences ranging from assault, indecent assault, rape, criminal damage, burglary and racially aggravated assault, and nine domestic abuse investigations pre-dating her relationship with Ryan. Ryan had been known to WMP since 2004. He was recorded as a victim of assault on one occasion and the defendant for seven offences and as suspect for nine offences ranging from theft, burglary, sexual assault, assault and threats to kill. He was also recorded as a perpetrator of domestic abuse on one occasion in relation to his ex-partner including threats to kill and non-fatal strangulation. Ryan was described, upon his release from prison, as a risk to known adults and children. Despite this links were not made to the historical domestic abuse and Ryan's offending history, and did not contribute to the overall assessment of risk.

16.4 Research of the police incident log highlighted two children were present at the address at time of argument on the 27th June, Ryan's child and Ashley's child. However, only Ashley's child was recorded on the investigation log as being present at the time. There is no record to suggest police spoke to or visited Ryan following this incident to conduct a "return interview" with regards the missing episode or to further investigate the domestic abuse incident which may have been beneficial to the filing of the investigation and any relevant information sharing. The investigation log was assessed by the HAU department and a referral was made to children's early help, although this was not received by children's social care.

16.5 The third-party disclosure, two days later, regarding possible domestic abuse appears to have been considered by officers to relate to the incident reported on the 27th June 2021, despite the report including reference to physical abuse. Police recall

speaking to Ashley on the telephone in relation to the neighbour report but, could not recall clarifying or confirming with her if any further domestic abuse incident had taken place since the 27th June. Appropriate action, in line with force policy, would have been to clarify with Ashley, then record a domestic abuse investigation and complete with a DASH risk assessment. If the information could not have been clarified police could have completed a police intelligence report recording the details for future reference.

16.6 With regards to the children, risk was considered upon received referrals by children's service. This was in relation to the referrals received in respect of Ashley's child in March and April 2020 from the school and A&E respectively. Children's services were able to establish that Ashley's child was safe and that her ex-husband was an appropriate carer.

16.7 In respect of the incident relating to Ryan's child on the 11th February 2020 a completed a child risk assessment determined a medium risk. Based on information police held regarding Ryan's previous offence and licence conditions they made the appropriate decision to remove the son from his care. Upon receipt of the referral Children's services completed an assessment, incorporating a risk assessment, confirmed arrangements for safe contact between Ryan and his child and provided support to the mother with behaviour management via Early Help Services.

16.8 The GP did not receive any domestic abuse notifications during the time Ashley was in a relationship with Ryan. The GP, therefore, did not consider this as part of any risk assessment. They did, however, consider self-harm, alcohol intake and suicide risk when making clinical judgements for Ashely.

16.9 Ryan had a history of drug and alcohol abuse and a long-standing history of depression for which he was prescribed antidepressant medications intermittently since 2018. There is a correlation between substance misuse and mental illness, and they are known as being bi-directional which means that patients who abuse substances will often suffer with mental health issues and vice versa[8]. There was evidence of the GP specifically asking Ryan about substance misuse during the consultations. Locally there are drug and alcohol agencies to support patients, and the GP was aware of this support. The GPs that consulted with Ryan were able to recognise the risks attached to poor mental health and substance misuse. When patients present to a GP with complex mental health concerns that have the potential to escalate resulting in significant harm occurring to the patient the GP will assess the risk and discuss signs and symptoms for the patient to be aware of and how and when to either seek further support from the GP or another appropriate clinician/specialist.

16.10 When Ryan attended GP appointments he described himself as feeling angry, it was during a later appointment that Ryan stated that he had a supportive partner. There was no exploration as to the impact that his mood might have upon the relationship. However, the GP was not aware of Ryan's offending history and the opportunities to do so are further compromised by the lack of time available during an appointment, what the person wishes to disclose and remote consultations.

[8] www.pysch.net/depression-and-substance-abuse

16.11 Following Ashley's death and Ryan's arrest, a custody pre-release risk assessment was carried out for Ryan. It was recorded that he was not suffering any mental health issues, nor was there a heightened risk of suicide due to the offence under investigation. It was noted that he was to reside with his mother therefore would not be alone. He was provided with support agency documentation which included contact details for a number of agencies including NHS and Samaritans.

16.12 Although, following his release under investigation, it was evident that Ryan was experiencing suicidal ideation, he was assessed by paramedics, who deemed him fit, and he was again provided details by police of support services that could assist him if he wished to contact them.

16.13 Overall, risk assessments focussed on Ashley and Ryan as individuals in isolation, save for the first reported incident on the 27th June. There was no consideration of their histories, the contributing factors and risks which they bought to their relationship, this was partly because agencies were not aware that Ashley and Ryan were in a relationship, and in some instances agencies were not aware of Ryan's history of offending and perpetration of domestic abuse.

Suicide risk and links between mental health, drug misuse, domestic abuse

16.14 In Worcestershire approximately fifty-five people a year die by suicide.[9] Suicide is often the end point of a complex history of risk factors and distressing events, and the prevention of suicide has to address this complexity. As there is no single risk factor for suicide, the prevention of suicide does not sit with any single organisation. In many cases, suicide can be reduced through identification of risk, public health interventions and high quality evidence-based care. This section examines the impact of protected characteristics, adverse life events and trauma experienced by Ashley, as detailed in the background history and chronology.

16.15 Ashley was at risk of suicide, with a history of overdose and self-harm. There is a wealth of research that shows that emotional and psychological distress is significantly higher in domestic abuse survivors than in the general population[10], individuals with depression were seven times more likely to experience suicidal ideation, as those without depression.[11]

16.16 People known to be in contact with mental health services represent around 27% of all deaths by suicide in England. Of all people that had been in contact with mental health services who died by suicide in England, nearly half (48%) had been in contact with mental health services within seven days before their death. A large proportion (82%) of patients that died by suicide in England were assessed to be at 'low' or 'no risk' of suicide in short-term risk assessments before their death.[12]

16.17 Research has also found that post-traumatic stress disorder is higher for domestic abuse survivors than any other mental health condition, yet health services often fail to identify the symptoms of PTSD in the context of domestic violence, and the need

[9] Suicides in England and Wales by local authority - Office for National Statistics
[10] Forbes et al (2014)
[11] Pilowsky et al. (2006)
[12] Suicide prevention strategy for England: 2023 to 2028 - GOV.UK (www.gov.uk)

for specific domestic abuse trauma interventions for survivors.[13] Ashley likely experienced post-traumatic stress disorder as a result of previous domestic abuse relationships which included a sexual assault. A study of 4,008 women over a two-year period and found that women with histories of sexual assault were three times more likely to have PTSD and twice as likely to have depression than those without; and that survivors who had been subjected to multiple and/or repeated abuses were most likely to experience PTSD, depression; and also, substance use problems.[14] Furthermore, the severity of these co-morbidities increased incrementally with the increase in concurrent abuses and/or repetition of abuses over time. The strongest and most consistent risk factors for PTSD and depression was experiencing both physical and sexual assault. Any abuse combined with sexual assault, is associated with the poorest health outcomes, including memory loss, suicide ideation and attempted suicide. The second most common category, with the next poorest outcomes is a combination of physical and emotional and psychological abuse.[15] In addition, survivors who had been abused by more than one person were more likely than those who had been abused by a single perpetrator to express suicidality.[16]In an analysis of DHRs 64% of victims had been the target of an abuser before and for 46% of these victims the abuser was the previous partner.[17]

16.18 Research dating back to 1981 found that those who had previously felt suicidal reported feelings of hopelessness, and that hopelessness was strongly associated with the individuals' perception of themselves as lacking social desirability.[18] Domestic abuse survivors who experience feelings of despair or hopelessness, experience panic, terror or past trauma are most highly correlated with suicidality, with 96% of the survivors researched, who reported suicidal thoughts or acts, saying they felt despairing or hopeless.[19] Such feelings can be interpreted as having a negative relationship with self and attachment anxiety, with a link between individuals having less self-compassion, feeling less belonging, and experiencing a higher level of burdensomeness and are associated with increased depressive symptoms.[20] Feeling alone and feeling like a burden have also been identified as key predictors of suicidal behaviour along with a desire and capacity for suicide.[21]

16.19 Research has found that suicide risk for individuals using substances is five to ten times higher than the 3 to 5% risk in the general population, for those using opiates it is fourteen times higher. Those misusing substances also made multiple suicide attempts.[22] The risk of suicidality also increases for domestic abuse survivors who self-medicate through drug and alcohol use.[23]

16.20 Self-harm has also been identified as a key risk factor for suicide. Research has found that the risk of suicide in the first year following self-harm to be forty-nine times greater

[13] Trevillion et al (2012)
[14] Hedtke et al. (2008)
[15] Potter et al. (2021)
[16] Whitlock et al., 2015
[17] Annex_A_DHRs_Review_Report_2020-2021.pdf (publishing.service.gov.uk)
[18] Linehan and Nielsen (1981)
[19] Aitken and Munro (2018)
[20] Øverup et al. (2017)
[21] Joiner (2007)
[22] Espinet et al. (2019)
[23] Bolton et al. (2006)

than the general population. Self-harm and suicidality have common risk factors, such as, experience of trauma, abuse, or chronic stress, few effective mechanisms for dealing with emotional stress, poor relationships or isolation, depression or anxiety and feelings of worthlessness.[24]

16.21 NICE have reiterated the importance of risk-assessment tools and scales not being used to predict future suicide or repetition of self-harm. NHS England have asked that all services develop highly personalised assessment and management of needs, risks and contexts, often referred to as safety planning.[25] The governments five year suicide prevention strategy has proposed issuing guidance on safety planning, and training and quality improvement programmes.[26]

16.22 A 2021 ONS report found that in females the suicide rate for the mixed ethnic group was higher than other groups. Locally and nationally, there is anecdotal evidence that mixed heritage could be a risk factor.

16.23 Ashley had been a looked after child. Research shows that care leavers are 4-5 times more likely to die by suicide than their peers in adult life.[27] Research also suggests that when children in care are compared with children who have not been in care, they tend to have poorer outcomes in a number of areas such as educational attainment and mental and physical health.[28] A literature review found evidence to suggest that looked after children are more likely to experience emotional, behavioural and attachment problems across their development, which is likely to impact personal and intimate relationships. Furthermore, people who have been looked after may be at an increased risk of using harmful behaviours or experiencing harm in their intimate relationships.[29] It is important to recognise that just because a looked after child stops being 'looked after' when they turn 18, this doesn't mean that they stop being a looked after child, with its associated impacts and adverse experiences; they are and remain care experienced people.

16.24 The research outlined above illustrates the complexities in Ashley's life, some of which stemmed back to her childhood and prevailed throughout adulthood. It demonstrates the interface between a number of factors and shows that no one issue can be addressed in isolation without regard to the others. The Government's five year suicide prevention strategy highlights the risk factors associated with suicide. The Government's ambition is to ensure access to training and support in suicide prevention for every individual, and to ensure there is 'no wrong door' for anyone experiencing suicidal thoughts or feelings, with systems and services that are connected around individual's needs.[30]

The Suicide Timeline

[24] Hawton et al., 2014; Whitlock et al., 2015; Chan et al., 2016

[25] Overview | Self-harm: assessment, management and preventing recurrence | Guidance | NICE

[26] Suicide prevention strategy for England: 2023 to 2028 - GOV.UK (www.gov.uk)

[27] Report of the Children and Young People's Health Outcomes Forum - Mental Health Sub-Group (publishing.service.gov.uk)

[28] Rahilly, T. and Hendry, E. (eds) (2014) Promoting the wellbeing of children in care: messages from research. London: NSPCC.

[29] Constructions and experiences of intimate relationships for care experienced people: A rapid review of literature

[30] Suicide prevention strategy for England: 2023 to 2028 - GOV.UK (www.gov.uk)

16.25 The Suicide Timeline[31] is as a practical tool, for use by practitioners, developed through research and analysis of case studies to understand the interactions between perpetrators of coercive control and their victims, and how these interactions may be linked to escalating and de-escalating risk of serious harm or homicide. The behavioural data gathered through this research is organised into a sequence of stages that represent potential escalating risk. The further along the stages, the higher the risk of serious harm, with opportunities at every stage to cease the progression. Each stage provides indicators of perpetrator and victim characteristics. Although the stages are arranged sequentially they are not necessarily mutually exclusive, they can and do overlap and may not occur in order with 'circling' through the stages occurring in some cases.

Stage	Alleged perpetrator characteristics	Victim characteristics
1. History	History of domestic abuse, coercive control, stalking, routine jealousy, violence, history of criminal behaviour	History of vulnerability. Previous domestic abuse, coercive control or sexual assault, away from home (student), previous local authority care
2. Early Relationship	Speed and intensity	Speed and intensity
3. Relationships	Dominated by controlling patterns, violence in many cases	Subject to violence, drugs and alcohol, sexual violence
4. Disclosure	Control escalating, violence may escalate, persistent harassment	Starts to tell other about the abuse
5. Help-Seeking	Alleged perpetrator may use victim's mental health against them, may make threats to family/friends, counter allegations	Mental health services, GP for mental health, A&E, child services, social services, police
6. Suicidal Ideation	Alleged perpetrator may encourage suicide, persistent contact, threats	Suicide attempts, self-harm, may so they 'can't go on', may be convinced they will be killed, may have lost custody of the children
7. Complete Entrapment	Stalking, threats, persistent contact, threats to others, violence	May say 'I will never be free' or similar,
8. Suicide	Common for alleged perpetrators to find body, in some cases abuse transferred to victim's family	Most common to be at home with ligature, other methods also noted

16.26 Stage one draws on previous research which identified that perpetrators are both repeat and serial offenders and that those who employ coercive control are likely to do so in all their intimate relationships. Criminal behaviour does not just relate to a criminal record and previous convictions, but may also be identified through testimony from professionals, the victim, family or the perpetrator themselves. History may also be identified through behavioural characteristics. In relation to the victim, vulnerabilities from past domestic abuse, sexual abuse, child neglect, bereavement, or eating disorder may exist, as well as vulnerabilities including drug and alcohol misuse which preceded the relationship.

[31] Building a temporal sequence for developing prevention strategies, risk assessment, and perpetrator interventions in domestic abuse related suicide, honour killing, and intimate partner homicide - Research Repository (glos.ac.uk)

16.27 The early relationship represents stage two. It is marked by relationships that develop quickly with early cohabitation, early pregnancy, or early declarations of love. Families report the strong influence exerted by the perpetrator at an early stage and often express concerns about the speed of which the relationship developed.

16.28 Relationships are dominated by intimate partner abuse with many experiencing serious repeated violence. Control and violence starts at an early stage within the relationship.

16.29 During stage four the victim identifies the behaviour of the perpetrator as abusive and may start to disclose, usually to friends and family first. Disclosure may be incremental and may come before explicit help-seeking. Disclosure in health settings is common as the environment may feel more confidential and supportive, although research suggests that victims are more likely to disclose to their GPs than in an A&E setting, with victims returning to surgeries 30 or 40 times before managing to disclose domestic abuse. Perceived escalation of the seriousness of the abuse is a key factor in the victim deciding to disclose. Equally shame, perpetrator threats, child custody issues, fear over increased violence, and how disclosure will affect social interactions, were reasons for hesitating to reveal abuse. Early disclosure appears to be more common in cases of domestic abuse suicide, than the homicide cases. It is important for practitioners to recognise that a disclosure will not represent the beginning of the risk but will likely be indicating an escalation. Disclosure is distinct from help-seeking as it is more likely to be linked to exploration and validation for the victim.

16.30 Help-seeking can occur in stage five usually after disclosure, and often in response to the victim's perception that the abuse has escalated and things have become more serious, it may also be as a result of fear for the safety of children. Active help-seeking can be seen as a threat to the control exerted by perpetrators, as a result there may be consequences, and the perpetrator may also increase their control in response. Perpetrators are seldom deterred as a result of help-seeking, even if the help sought includes police involvement and results in arrest, prosecutions, civil orders and so on, with perpetrators continuing to exert control despite any sanctions. In the cases reviewed, help was most commonly sought from mental health services and the police.

16.31 When help is sough from mental health services the help sought is for mental health linked to the domestic abuse being experienced. However, services do not always make those links explicitly, prescription medication was a more common response than specific help with the abuse. The victim's mental health help-seeking appeared to dominate assessments of them and the victim assessments of themselves leading to self-blame. The victim being perceived as 'mentally unstable' created perceptions that they were culpable in the abuse. This can become worse, and attention further diverted when the victim self-harms, talks about suicide, or makes attempts to kill themselves. In some cases, it was felt by victims that if they received mental health support they would become 'strong enough' to leave the abuser.

16.32 Although suicidal ideation is placed at stage six, this is considered the latest, but most common stage that suicidal ideation is noted. Self-harm, suicidal ideation and suicide attempts are sometimes seen as confirmation of mental instability, re-focusing attention on the victim's mental health rather than the abuse. Suicidal ideation can

occur in parallel with homicidal ideation in perpetrators of high-risk abuse, and all suicidality should be taken seriously.

16.33 At stage seven the victim feels and sometimes vocalises that they feel trapped in a situation from which there is no escape and feel that nothing will get better. The perpetrators persistence means that the victim feels that they will never be out of their life. In many cases the relationship has ended, but the contact and control or stalking behaviours persist. The threat of sanction does not appear to deter on its own.

16.34 The most common method of suicide is ligature and in many cases the perpetrator is the last person to see the victim and, in many cases, discovered the victim's body. In some cases it seems clear that the victim had taken their own life and intended to do so, in some cases there was evidence that the perpetrator had encouraged suicide, and some families expressed concerns that suicide had been staged. It is common for the suicide to be accepted based on the mental health history of the victim, especially if there was a history of suicidal ideation.

16.35 It is known that Ashley had a history of vulnerability including being a Looked After Child, substance misuse which preceded her relationship with Ryan, previous domestic abuse and sexual assault. Ryan's history included a history of perpetrating domestic abuse and a history of criminal behaviour including convictions. Their relationship appeared to commence with speed, shortly after Ashley's separation from her ex-husband, and they appeared to be living together from an early stage in the relationship. It is however unclear what the relationship between Ashely and Ryan looked like. The first disclosure took place in June 2021 to police where Ashley shared there had been an argument, and this was followed by a disclosure to a neighbour by Ashley that Ryan had hit her. Ashely had contact with her GP throughout the scoping period in relation to her mental health but did not disclose domestic abuse and did not show any signs of suicidal ideation. It is not known if Ashley felt entrapped, she did not vocalise this to anyone but the research outlined above suggests this as a possibility. Ashley died at home with the use of a ligature, Ryan was the last person to see her and discovered her body.

16.36 Application of the suicide timeline goes some way to understand Ashley's experiences and a possible escalation of risk which ultimately culminated in her suicide. However, too little is known to directly apply each stage of the Suicide Timeline. Nevertheless, it demonstrates how information can be gathered as an aid to assess risk, identify escalations in risk, and consider prevention strategies and interventions. The application of the timeline also highlights the importance of greater professional curiosity to minimise the risk of misinterpretation of presentations of mental and physical ill health, which may in fact be attempts of disclosure and help-seeking.

Domestic abuse advice and support

16.37 For police, when dealing with suspected domestic abuse incidents, staff can seek advice from their supervisors, from the Harm Assessment Unit and from staff within vulnerability and safeguarding departments. Staff also receive relevant training and information from the police learning and development department in relation to identifying potential domestic abuse and risk.

16.38 Officers reported that they did not require advice in relation to domestic abuse in this case. There was only one incident identified during the scoping period. This was initially reported as a missing person episode. However, when the reason for Ryan being missing was disclosed by Ashley as a result of a verbal argument between them, officers correctly identified the potential for domestic abuse, recorded it and completed a risk assessment.

16.39 Both GP practices were asked for copies of their Domestic Abuse Policies as part of this review. The practice for Ashley did not have a standalone policy but had Women's Aid guidance available for staff. The Integrated Care Board (ICB) carried out a support and self-assurance visit in March 2022 and were assured that all staff were aware of safeguarding processes and who to discuss concerns with both within the surgery and external agencies, for example the ICB Safeguarding Deputy Designated Nurse (Primary Care), the ICB Named Professional for Safeguarding (General Practice), Worcester Children First Family Front Door, and adult social care where relevant.

16.40 In acute healthcare services the hospital IDVA (HIDVA) service was launched in August 2018 and was implemented within a context where levels of awareness, skills and confidence amongst Trust staff, relating to (undisclosed) domestic violence and abuse, was low. Considerable time and effort were invested in raising awareness of the HIDVA service and building relationships throughout the Trust. There is a consensus that this work has been worthwhile and that good working relationships have been built evaluation of the service has been positive to date.

16.41 Worcestershire Acute Hospitals NHS Trust (WAHT) safeguarding training is available to staff and the WAHT Safeguarding team provide guidance and support to frontline professionals, including signposting to further resources.

16.42 Safeguarding and domestic abuse training is available to Redditch Brough Council staff, and they are aware the DASH for use with people experiencing or reporting domestic abuse.

Access to services

Equality and Diversity

16.43 The protected characteristics relating to Ashley and Ryan are detailed in section 11. Agencies reported that there was no information to suggest that their culture or beliefs impacted on the sequence of events that lead to either of their deaths. There was no information or inference in police records to indicate that the incidents were motivated or aggravated by culture, race, religion or belief. Where there was contact with police or in any of the joint working that took place there is nothing to infer that any of these factors were relevant in decision making. It was not believed that they played any role for Ashley and Ryan in accessing services and support.

16.44 However, it was noted that there was no explicit consideration of equality and diversity issues by the agencies working with Ashley and Ryan and as such it is not

possible to say with confidence that this did not affect their ability to seek or access support and services.

Impact of the covid-19 lockdown

16.45 In March 2020 the UK Prime Minister introduced a nationwide lockdown. All non-essential contact and travel was prohibited, and many services moved to remote working. Restrictions began to ease in July 2020 and people were able to meet up in limited numbers outside. There was further easing of restrictions in August 2020.

16.46 There was a further national lockdown introduced for four weeks on the 2nd November 2020 and from the 21st December 2020 London and the Southeast entered its third lockdown, this was extended nationwide on the 6th January 2021. The 'stay at home' order was finally lifted on the 29th March 2021 with most legal limits on social contact being removed on 19th July 2021 . Therefore, throughout most of the period in the scope for this review the country was in lockdown.

16.47 In some cases, victims' access to ongoing support or help with mental or physical health conditions was reduced during the lockdown, anecdotally people chose not to access services so as not to burden the reportedly overwhelmed services.

16.48 However, both Ashely and Ryan had contact with their GP surgeries during the pandemic and they were both able to get appointments with the GP to discuss their health issues, albeit these consultations were predominantly undertaken remotely. It cannot be ignored however that the effects of the pandemic and the lock down periods did impact negatively on the mental health of the wider population[32].

16.49 During the Covid 19 lockdown, it was noticeable that Ashley's mental health declined, with financial concerns being a contributing factor. Ashley also alluded to the fact that her separation from her child was affecting her mental health, and this would likely have been exacerbated due to the covid restrictions which would have prevented Ashley from visiting her child and vice versa. The covid-19 lockdown may have made Ashley feel more isolated and may have been a contributing factor to an apparent increased use of alcohol and drugs.

Communication and Information Sharing

16.50 There is limited evidence of information sharing between agencies during the review period although there is evidence of information being shared prior to the scoping period, for example, probation and police had shared information with children's services regarding Ryan's offending history, prison release date and incidents relating to Ryan's child and ex-partner.

16.51 During the scoping period information was shared with children's services by Ashley's child's school, acute health services and probation in relation to potential risks to the children.

[32] Covid 19 Mentla Health and Wellbing Surveilance Report - Important findings - GOV.UK (www.gov.uk)

16.52 Following the reported incident of domestic abuse in June 2021 police referred to Children's Social Care, Early Years as there were children present at the time, although this was not received by children's social care. No other referrals were made by police at that time or subsequently.

16.53 Regardless, the effectiveness of sharing this information would likely be compromised as Ashley provided an alternative surname to police on the 27th June. This was a recurring theme with agencies referring to Ashley by various different surnames which might have affected their ability to join the dots.

16.54 There were further opportunities to share information with health services when police responded to concerns for Ryan's welfare. However, as it was deemed he had capacity to seek assistance for himself and did not consent to information being shared, it was not. What is not conclusive is if police actually sought Ryan's consent to refer.

17 Conclusions

17.1 This DHR considers the death of two individuals who died as a result of domestic abuse. The historical factors in this case indicate a likelihood of Ashley being the victim of domestic abuse and Ryan being the perpetrator. Ryan admitted to police that he had argued with Ashley and thrown a mobile phone at her face causing an injury, Ashley also disclosed a verbal argument between the two. However, whilst in custody Ryan disclosed controlling behaviour and physical abuse perpetrated by Ashley. Nonetheless, the purpose of a DHR is not to attribute blame, although it has been challenging to apply analysis in this case where questions remain unanswered about what happened.

17.2 Information known to agencies was variable, although most knew Ashley and Ryan well and were familiar with their personal histories. Children's services were aware of Ashley's previous experiences with domestic abuse and substance misuse and of Ryan's offending history including domestic abuse. Police were also aware of Ashely's past experiences of domestic abuse and Ryan's previous offences. Ashley's GP and Redditch Borough Council knew about her previous experiences of domestic abuse, substance misuse and mental health issues, however Ryan's GP had no knowledge of his offending history and Redditch Borough Council did not know Ryan at all. Acute health services had contact with both Ashely and Ryan following misuse of substances but were not aware of any domestic abuse issues. Only the police knew that Ashley and Ryan were a couple.

17.3 During the period there were two reports of domestic abuse, the first being when Ashley reported Ryan as a missing person and disclosed a verbal argument and the second report from a third party. Both reports presented missed opportunities to investigate further, by following up with Ryan in relation to the first incident, and confirmation and clarity with Ashley in relation to the second. However, it is recognised that these were the first and only reports of domestic abuse in relation to Ashley and Ryan as a couple.

17.4 Whilst risk was assessed in relation to domestic abuse, other assessments of risk focused on the individual without consideration of the other person. Risk assessments did not take into account previous history and risk.

18 Lessons Identified

18.1 This section will summarise what lessons are to be drawn from the case, including early learning identified during the review process and whether this has already been acted upon.

18.2 Risk assessment focused on the current relationship and did not consider the personal history and associated risk factors. WMP confirmed that the expectation is to consider previous convictions and any risk management plans relating to previous partners and whilst this usually does happen the volume of reported domestic abuse incidents makes this difficult to always fulfil. Officers need to be reminded of the importance of considering historical factors that might contribute to the assessment of risk.

18.3 Equality and diversity issues were not explicitly considered by agencies in this case. Practitioners and professionals should be aware of the protected equality and diversity issues experienced by the people they work with, how this may indicate an increase in risk, how this may affect their ability to seek help and to access services.

18.4 There were missed opportunities to share information with other agencies which may have enabled sharing of pieces of the puzzle. Agencies need to ensure consent is obtained in order to share information and where there is risk of harm that information is shared with all relevant agencies.

18.5 All practitioners and professionals should employ a Think Family approach to ensure consideration is given to the effects and impacts upon other family members when people present with poor mental health and substance misuse.

19 Recommendations

- Improve the quality of risk assessment by ensuring historical factors are considered
- Increase practitioner understanding and competence in applying a Think Family approach
- Improve information sharing with relevant agencies when risk is identified
- Improve practitioners' recognition, consideration and response to individuals' protected characteristics and lived experience
- Worcestershire Community Safety Partnerships to seek the specialist advice from the suicide prevention team in future domestic abuse suicide reviews, including the team in scoping meetings, and keeping the team updated on the DHRs being undertaken, as part of a mortality review.

The following organisations made specific recommendations for their agencies:

West Mercia Police

- Reinforce with staff necessity to obtain consent from persons who have mental capacity to refer/share information with relevant partner agencies if so required

Herefordshire and Worcestershire Integrated Care Board

- Patients with complex needs which include Mental health concerns often benefit from continuity of seeing one named GP, and a flag on the healthcare record system to alert all staff to the named GP

- To raise awareness of learning from DHR's with all clinical staff

Redditch Borough Council

- It is recommended that detailed recording of all tenant contacts and regular case management continues to be promoted.

- To ensure that all existing and new housing staff receive regular domestic abuse and safeguarding training.