Safer Cornwall

Community Safety Partnership

Domestic Homicide Review

Into the death of Jayne (pseudonym)

in June 2021

Executive Summary

Independent Review Chair: David Warren QPM, LLB, BA, Dip. NEBSS

Report Authors: David Warren and Michelle Baird BA, MBA

Review Completed: 2.9.2022

Family Tribute to Jayne

If we could define an angel, it would be you.

Bright, beautiful and immensely caring.

Always thinking of others before yourself.

We will cherish all of the happy memories and laughter we shared with you.

Your sparkle will never be forgotten.

Your memory will continue to shine on through all who feel so blessed and privileged to have known such an incredibly precious soul as you.

Love you to the moon and back.

The Review Panel thanks Jayne's family for their moving tribute and assures them that the actions resulting from this review, to improve the quality of services for the benefit of others, will stand as a testimony to Jayne's life.

Section One - The Review Process

1.1. This summary outlines the process undertaken by Safer Cornwall Domestic Homicide Review Panel during the Review into the death of Jayne (pseudonym) who was a Cornwall resident at the time of her death.

1.2. The following pseudonyms have been used for the deceased, her child and ex-partner, to protect their identities and those of their family members: Jayne (the deceased), May (her child) and Martin (her ex-partner).

1.3. Jayne died from multiple injuries which would have been immediately fatal and were consistent with the accident. At the Coroner's Inquest, it was highlighted that there was no eyewitness evidence that explains Jayne's death; nor was there evidence of her intent from a note, email, text or otherwise. The Coroner therefore reached an Open Conclusion.

Jayne had previously made a number of attempts to self-harm prior to her death. One such attempt caused serious injuries that required hospital treatment. She indicated to passers-by who had gone to her aid, that she had tried to take her own life as she was not safe at home.

1.6. A decision to undertake a Safeguarding Adults Review (SAR) and a Domestic Homicide Review (DHR) was taken by the Chairs of the Cornwall and Isles of Scilly Safeguarding Adult Board and the Safer Cornwall, Cornwall's Community Safety Partnership in July 2021. The Home Office and the Care Quality Commission (CQC) were informed of this decision in August 2021. The Independent DHR Chair was appointed in September 2021 and the first meeting of the DHR Panel was held at the earliest opportunity in November 2021.

1.7. Eleven of the organisations involved with the Review have completed Individual Management Reviews (IMRs) as they had relevant previous contacts with Jayne and/or May or Martin.

Section Two - Contributors to the Review

2.1. The 19 agencies contacted are:

• Advocacy After Fatal Domestic Abuse (AAFDA): This specialist Charity is providing an Advocacy Service for Jayne's family. It had no previous involvement with either Jayne, Martin or May.

• Cornwall Council Adult Social Care: This department had relevant contacts with Jayne and has provided an Individual Management Review (IMR). A senior member of this agency is a DHR Panel Member.

• Cornwall Council Safeguarding Adults Board: This service had no direct contacts with Jayne, May or Martin. The Chair of the Cornwall Safeguarding Adults Review is a Member of the Panel, he had no previous contact.

• Cornwall Council Children and Family Services, Together for Families: Following Jayne's attempt to take her own life in March 2021, May was appointed a children's social worker and an IMR has therefore been provided. A member of this organisation who is independent of any contact with Jayne or May is a Review Panel Member.

• Cornwall NHS Provider Trusts: [includes Cornwall Partnership NHS Foundation Trust (CFT) and Royal Cornwall Hospital Trust (RCHT)]. These Trusts had relevant contacts with Jayne, Martin and May and a combined IMR was completed. A member of the RCHT who is independent of any contact with Jayne, Martin or May is a Review Panel Member.

• Cornwall Housing Ltd: This service had no relevant contact with Jayne, Martin or May. A senior member of this agency is a Panel Member.

• Cornwall Multi Agency Risk Assessment Conference (MARAC): The Cornwall MARAC Chair confirmed that Jayne and May had been referred to a MARAC meeting and has provided a report under a Memorandum of Agreement.

• Devon and Cornwall Police: This Police Force had relevant contacts with Jayne and Martin and an IMR was completed. A member of this organisation who is independent of any contact with Jayne, Martin or May is a Review Panel Member.

• First Light: This domestic abuse support service has provided an IMR in relation to Jayne. A senior member of this charity is a Review Panel Member.

• NHS Kernow was the clinical commissioning group for Cornwall and the Isles of Scilly and is now known as NHS Cornwall and Isles of Scilly Integrated Care Board (ICB). A senior member of this organisation who is independent of any contact with Jayne, Martin or May is a Review Panel Member.

• Surgery A: This Cornwall GP Practice (through an independent GP from NHS Kernow CCG) provided an IMR in relation to contacts with Jayne. The IMR author had no previous contact with Jayne or her child.

• Surgery B: This Devon GP Practice where Martin is a patient, provided an IMR which confirmed that there had been no relevant contacts.

• National Probation Service: This service had no relevant contacts with Jayne or Martin. A senior member of this agency is a Review Panel Member.

• Pentreath Ltd: This service provided an IMR in relation to contacts with Jayne primarily in relation to vocational support.

• South Western Ambulance Service NHS Trust: This service provided an IMR in relation to contacts with Jayne. The IMR author had no previous contacts with Jayne, Martin or May.

• Suicide Liaison Service: This service has confirmed that whilst providing support to Jayne's family after Jane's death, there had been no prior contact with Jayne.

• University Hospitals Plymouth NHS Trust: This Trust had relevant contact with Jayne only and has provided an IMR. A member of the Trust who is independent of any contact with Jayne is a Review Panel Member.

• Victim Support: This service notified the Review that it had no relevant contacts to report.

• We Are With You: (Drug and Alcohol Service re Positive People employability programme). This organisation notified the Review that they had no previous contact with Jayne, Martin or May. A member of this organisation is a Review Panel member.

2.2. The following also contributed to this Review:

• Jayne's family provided relevant information which has been included in the Overview Report of this Review.

• Jayne's ex-partner Martin provided information to the Review and has given a response to the allegations of controlling behaviour.

• HM Coroner provided the DHR Review with papers submitted for the purpose of the Inquest.

Section Three - The Review Panel Members

3.1. The DHR Panel consists of senior officers, from statutory and non-statutory agencies who are able to identify lessons learnt and to commit their organisations to setting and implementing action plans to address those lessons. With the exception of the First Light Panel member, none of the members of the Panel have had any contact direct or indirect with Jayne, Martin or May.

The Panel Members are:

• Alexandra Morgan-Thompson: Quality and Information Manager, Cornwall Housing Ltd

• James Sawford: Adult Safeguarding Service Manager, Cornwall Council Adult Social Care

• Martin Bassett: Safeguarding Adult Reviews and Development Manager, Cornwall Council

• Laura Ball: Domestic Abuse and Sexual Violence Strategy Lead; Cornwall Council

• Anna MacGregor: Domestic Abuse Co-Ordinator and Multi Agency Risk Assessment Conference (MARAC) Chair; Cornwall Council

• Sid Willett: Drug Related Death Prevention Coordinator, Cornwall Council Drug and Alcohol Team

• Rebecca Sargent: Head of Children and Families Services East Cornwall, Cornwall Council Together For Families

• Michelle Cole: Service Manager for Safeguarding, Quality and Governance, Children's Health & Wellbeing, Cornwall Council Together for Families

• Stephen Reid: Detective Chief Inspector, Devon and Cornwall Police

• Detective Sergeant Rob Gordon: Criminal Case Review Team, Devon and Cornwall Police

• Mel Francis: Service Manager, First Light

• Wayne Derbyshire: Senior Probation Officer, National Probation Service

• Mark McCartney: Named GP for Adult and Child Safeguarding, NHS Kernow Clinical Commissioning Group (CCG)

• Chris Rogers: Named Safeguarding Professional, South Western Ambulance Service Trust

• Paula Chappell: Intermediate Public Health Practitioner, Intermediate Public Health Practitioner, Suicide Prevention

• Zoe Cooper: Consultant Nurse for Integrated Safeguarding Services for CFT and RCHT, Freedom to Speak Out Champion, RCHT Prevent Lead, Royal Cornwall Hospital Trust & Cornwall Partnership NHS Foundation Trust.

• Angela Hill: Named Nurse for Safeguarding Adults, University Hospitals Plymouth NHS Trust

• Sam Dixon: Team Leader, We Are With You (Drug and Alcohol Service re Positive People Employability Programme)

• David Warren: Home Office Accredited Independent Chair

• Review Administrator: Joanna Braybon Cornwall Council

3.2. Expert advice regarding domestic abuse service delivery in Cornwall has been provided to the Panel by Mel Francis of First Light which provides the commissioned Independent Domestic Violence Adviser (IDVA) Service in Cornwall. Specialist advice regarding self-harming and suicide has been provided to the Panel by Paula Chappell Suicide Prevention Lead, Public Health, Cornwall Council. Specialist advice regarding Safeguarding Adults has been provided by Martin Bassett, the manager of the Cornwall Safeguarding Adults Reviews.

3.3. The DHR Panel met formally five times. (Due to COVID restrictions, all meetings were held on 'Teams'). The schedule of the meetings was rearranged after the first meeting to facility Devon and Cornwall Police investigations.

• 12 November 2021, (10.00 to 13.00hours)

• 1 April 2022, (10.00 to 13.00hours)

• 10 June 2022, (10.00 to 13.00hours)

• 5 July 2022, (1100 to 1300hours)

• 26 July 2022 (1100 to 1300)

Section Four - Chair of the Review and Report Author

4.1. The Chair and Joint Author

4.1.1. The Chair of this joint Safeguarding Adults Review and Domestic Homicide Review is legally qualified and is an accredited Independent Chair of Statutory Reviews.

4.1.2. He has no connection with the Cornwall and Isles of Scilly Safeguarding Adults Board or Safer Cornwall, the Community Partnership and is independent of all the agencies involved in the Review. He has had no previous dealings with Jayne, Martin or May.

4.1.3. He has an extensive knowledge and experience working in the field of domestic abuse and sexual violence at local, regional and national level.

Between 2004 and 2011 he was the Home Office Criminal Justice System Manager for the Government Office Southwest. Amongst his responsibilities were the funding and monitoring of the delivery of local services to address domestic violence and sexual crime. He was a founder member of both the Southwest Regional Safeguarding Children's Board and the Safeguarding Adults Board. He was also a member of a number of Central Government committees, including those relating to the development of Violence Against Women and Children policies, the national development and implementation of DHRs and the national funding of local domestic and sexual abuse services.

4.1.4. Since 2011 he has chaired numerous statutory reviews including Serious Case Reviews, Mental Health Reviews, Drug Related Death Reviews and DHRs across the country. He has been a keynote speaker at several National Conferences on domestic and sexual abuse, most recently in 2020 on the particular issues facing Domestic Homicide Reviews in cases relating to Suicides.

4.1.5. For a number of years, he carried out voluntary work as the chair of a substance abuse support charity and has provided pro-bono legal work for a refuge and its residents.

4.2 The Joint Author

4.2.1The Joint Author of this Review has no connection with the Cornwall and Isles of Scilly Safeguarding Adults Board or the Community Safety Partnership, Safer Cornwall and is independent of all the agencies involved in the Review. She has had no previous dealings with Jayne, Martin or May.

4.2.2. She is a qualified accredited Independent Chair of Statutory Reviews with indepth knowledge of domestic abuse, coercive control, suicide risk and mental health.

4.2.3. Her qualifications include 3 Degrees – Business Management, Labour Law and Mental Health and Wellness. She has held positions of Directorship within companies in the Recruitment and Corporate Wellness industry and trained numerous employees within charitable and corporate environments on domestic abuse, coercive control, self-harm, suicide risk, mental health, and bereavement. She has a diploma in Criminology, Cognitive Behavioural Therapy and Effective Freedom Therapy (EFT).

Section Five - Terms of Reference

The Terms of Reference were agreed at the outset of the review as follows:

5.1 This joint Domestic Homicide Review and Safeguarding Adult Review, which is committed within the spirit of the Equality Act 2010, to an ethos of fairness, equality, openness, and transparency will be conducted in a thorough, accurate and meticulous manner in accordance with the relevant statutory guidance for the conduct of Safeguarding Adult Reviews (SARs) and for Domestic Homicide Reviews.

5.2 The Review will identify agencies that had or should have had contact with Jayne and/or her partner Martin and/or Jayne's child May between 1 January 2015 and the date of Jayne's death in June 2021 or any relevant contact prior to that period.

5.3 Agencies that have had contact with the deceased, Jayne and/or her partner Martin and/or her child May should:

- Secure all relevant documentation relating to those contacts.
- Produce detailed chronologies of all referrals and contacts.

• Commission an Individual Management Review (IMR) in accordance with respective Statutory Guidance for the Conduct of Domestic Homicide Reviews and Safeguarding Adults Review[1].

5.4 The Review Panel will consider:

Each agency's involvement with Jayne, Martin and May from 1 January 2015 until June 2021, as well as all contact prior to that period which may be relevant to domestic abuse, violence, controlling behaviour, self-harm or other mental health issues.

5.4.1. Whether the agencies or inter-agency responses were appropriate leading up to and at the time of Jayne's death?

5.4.2. Whether there was any history of mental health problems or self-harm and if so, whether they were known to any agency or multi-agency forum?

5.4.3. Whether there were any other known safeguarding issues relating to Jayne or her child May?

5.4.4. Whether there was any history of abusive behaviour towards the deceased and whether this was known to any agencies?

5.4.5. Whether there are any lessons to be learned from the case about the way in which professionals and agencies worked individually or together to safeguard Jayne and/or her child May?

5.4.6. Whether agencies have appropriate policy and procedures to respond to needs of a vulnerable adult and to recommend changes as a result of the review process?

5.4.7. Whether agencies have appropriate policy and procedures to respond to domestic abuse and to recommend any changes as a result of the review process?

5.4.8. Whether practices by agencies were sensitive to the ethnic, cultural, religious identity, gender and ages of the respective individuals and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded?

5.4.9. Whether family or friends want to participate in the Review. If so, ascertain whether they were aware of any safeguarding concerns or abusive behaviour to Jayne prior to her death?

5.4.10. Whether, in relation to the family members, were there any barriers experienced in reporting the vulnerabilities of Jayne or the abuse she was subjected to?

5.5. The Review must be satisfied that all relevant lessons have been identified within and between agencies and will set out action plans to apply those lessons to service responses including changes to inform national and local policies and procedures as appropriate.

5.6. The Review will consider any other information that is found to be relevant, and which may contribute to a better understanding of the nature of domestic abuse and adult safeguarding.

5.7. The Review will also highlight good practice.

Section Six - Summary Chronology

6.1. Jayne's family and friends have recounted that Jayne suffered from anxieties as a result of difficult familial childhood experiences and received help initially from the school and later was referred by her GP to the Cornwall Partnership NHS Foundation Trust, Cornwall Child & Family Services. She received support for 'anxiety, depression, school avoidance, sleep issues'.

6.2. According to her sister, it was at this time, when she was still feeling vulnerable that she met Stuart (pseudonym), an older man (approximately 30 years older than Jayne). Her sister suspected from conversations with Jayne, that Stuart had groomed her after providing her with summer work. While the sister could not recall if Jayne was over the statutory age of consent (16 years of age) at the time she started to have sexual relations with this man, she did know that

[1] The Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Section 7) and The Care Act (2014) Guidance (14.162 and 14.63)

later Jayne eventually moved in with him. Her relationship with Stuart appears to have lasted for about 10 years during which time she had no further contact with medical services and did not come to the attention of any other agency until June 2015. It was at about this time that she confided in her sister that she was worried about her relationship with Stuart. He had started to be critical of her putting on weight. He bought her an exercise bike and insisting on her exercising. Jayne told her sister and a close friend that this sapped her confidence and that she felt low. They could see she was visibly distressed and anxious.

6.3 In June 2015 Jayne attended her GP Practice and it was recorded: "…she has felt more moody than normal in the past few months. She alluded to problems within family but did not elaborate on them. She was given information about the National IAPT (Improved Access to Psychological Therapies) programme as she could self-refer and felt she may like someone to talk to about issues".

6.4. In January 2016 Jayne was taken to her GP Practice by Stuart, who described himself as her ex-partner with whom she had remained friends. Jayne informed the GP that she had been feeling really low for the previous few weeks since breaking up from her partner. The consultation notes recorded "Poor sleep/ motivation/ self-harming - cuts on abdominal, feels mental. Drove up to the cliffs this morning with the intention of jumping off, but came home and called her sister, feels she may do it again".

6.5. An urgent referral was made to Cornwall Partnership NHS Foundation Trust, Community Mental Health Team (CFT CMHT) by her GP highlighting her disturbed sleep, reduced appetite, negative view of self and low self-esteem. She had no previous history of suicidal ideations/intent and previously had counselling with Child and Adolescent Mental Health Team (CAMHs) approximately 10 years earlier, whilst in school due to bullying, anxiety and depression, which was also attributed to her parents separating.

6.6. In January 2016 Jayne again attended her GP Practice and the consultation notes record "Feeling improved today, some mild agitation and numbness and apathy feelings. Feels thoughts on Monday were 'stupid' and no further suicidal ideation. Poor sleep. Discussed life stressors: Low suicidal risk. Good eye contact, Low self-esteem and anxiety and depression episode. Discussed options including SSRIs3 *(antidepressants)* , self-refer OSW *(Outlook South West*) Review 1/52, seek help if worsening thoughts".

6.7. Later the same day, Paramedics attended Jayne's home following a call from Stuart, who again described himself as her ex-partner. He had witnessed Jayne tying the string from the blinds around her neck, with alleged suicidal intent. She was reported as calm but not forthcoming with any information, nevertheless the paramedics assessed there was no immediate risk.

6.8. The next day Jayne was seen by a Consultant who arranged for immediate HTT (Home Treatment Team) input and asked Jayne's GP to prescribe Jayne with Mirtazapine 15mg from that day.

6.9. Over the following days and weeks Jayne was in regular contact with the Home Treatment Team (HTT) over her suicidal ideation. In February 2016 Jayne told the team that she felt better, due to the support she was receiving from Stuart, her family and friends, although it was noted that Jayne did not fully engage with HTT during the period, declining visits and not answering calls. A month later during a joint visit with Home Treatment Team (HTT) and Community Mental Health Team (CMHT), Jayne reported feeling better but disclosed continuing relationship difficulties. She was assessed as low risk for self-harm at the time but agreed to an appointment at a named unit.

6.10. In March 2016 Jayne was seen by her GP for low self-esteem and occasional suicidal thoughts, although she had said she had made no plans to do anything about them. It was noted that the computer coding for safeguarding purposes – "cause for concern" was in place and she was prescribed an increase of mirtazapine to 30mg. The GP also ensured that she had all relevant emergency numbers readily available.

6.11. In April 2016, Jayne attended a planned appointment at a named hospital unit, she reported feeling better after taking medication for 6-8 weeks. Jayne agreed to be discharged from Community Mental Health Team (CMHT) and referred to a programme for mood management and

relationship counselling. It was noted that Jayne did not appear to be suffering from a severe and enduring mental health need and did not require input from secondary care mental health services.

6.12 Not long after this, Jayne commenced a relationship with Leo (pseudonym) who was about 25 years older than her. Jayne described him to her sister, as 'the love of her life'. Her sister stated the two of them were very happy. After May was born, Jayne worried about who the father might be, as she told her sister that just prior to meeting Leo, she had intercourse with another man, Zak (pseudonym). Zak was a friend of the family who was about 20 years older than her.

6.13. During her pregnancy, Jayne was seen in the antenatal clinic 5 times. Mental health concerns were noted in the maternity notes. In November 2016, Jayne was seen on the day assessment ward for abdominal pain, but it is not documented whether she was asked the routine enquiry for domestic abuse on any of the previous visits.

6.14. In December 2016, Jayne attended the hospital Emergency Department after a road traffic accident in which her car rolled over. She could not recall the event and a Specialist Perinatal Mental Health Team (SPMHT) referral was made with Jayne's consent. A doctor asked about alcohol and drug use which Jayne denied. In the assessment it was documented that Jayne appeared very dazed, unable to recall any details from the accident, she reported having 'extremely low mood' and she had not slept for three days prior to the accident. The following day she was discharged to the care of a Community Midwife. While the Community Mental Health Team (CMHT) made attempts to contact her, they were unsuccessful. However, in January 2017, Jayne attended a CMHT meeting with her father. She was reported as, 'difficult to engage, with her father answering most of the questions'. Jayne disclosed some fleeting suicidal thoughts. The plan was to refer her to the Perinatal Team to follow up. They reported 'commence anti-depressants' (although Jayne was very reluctant to start any medication) and a further assessment was required by the Perinatal Team.

6.15. In January 2017 Jayne's Midwife called the Specialist Perinatal Team (SPMHT) due to concern about Jayne's presentation. The Midwife wanted to know what was happening with Jayne following her recent visit to Hospital. No records were found on RIO (Information records system) regarding the assessment until later in January 2017. However, in January 2017 Jayne was seen in the Consultant Obstetric Clinic. She was prescribed Sertraline for anxiety and depression. The Obstetrician documented that they would contact the GP, CMHT and SPNMHT regarding follow-up plan for mental health.

6.16. Between late January 2017 and early February 2017, the Lead Nurse for SPMHT attempted to contact Jayne on a number of occasions but without success and in February Jayne's Midwife raised her concerns about Jayne with SPMHT. From a safeguarding perspective the following actions were agreed with the Lead Nurse continuing to try to contact Jayne. An urgent assessment would be required following the birth of the baby. Social Care would be alerted either via the Lead Nurse and/or Midwife. The Lead Nurse also spoke to Jayne's GP who agreed to contact Jayne. If the contact was unsuccessful, they would request a Police welfare check. The Lead Nurse contacted Children's Social Care and made a Multi-Agency Referral Unit (MARU) referral in respect of the unborn baby. The next day there were discussions between the Lead Nurse and a Social Worker in the MARU regarding the concerns for the unborn baby. It was noted in the records that Jayne had never mentioned whether she had a partner and if so, what involvement he might have with the baby. A pre-birth social work assessment commenced, and a multi-plan was put in place.

6.17. Mid-February 2017, CMHT were able to contact Jayne and carry out a telephone assessment although it was noted that Jayne was again difficult to engage. Jayne was induced the following day and she explained she had struggled to engage with the Midwife or attend ante-natal classes because she had been involved in a car accident. Jayne added she was planning to live with her sister when she first leaves hospital. She said this was her first baby and that the father was in contact, but she was not clear about his level of involvement although she did not feel she would be able to rely on him for support. Jayne expressed her concern that Social Care would take her baby away. The CMHT Nurse's impression was of someone who was ill prepared, confused and frightened and she thought Jayne would benefit from a face-to-face assessment, clarification of

concerns and opportunities for support. There followed an email trail between the Consultant Obstetrician and Lead Nurse relating to concerns about non-engagement and Jayne voicing suicidal ideation.

6.18. In late February 2017 as a result of concerns on the ward about Jayne, the SPMHT was contacted regarding Jayne's deteriorating mental health following the birth. It was explained that Jayne would not sleep and was hearing voices. She displayed paranoid tendencies but denied any thoughts of suicidal ideation. The nurse requested that the Consultant Psychiatrist for SPMHT assess Jayne later that day. His initial thoughts were that Jayne 'may have a primary psychotic illness or depression with psychotic symptoms'. Jayne was prescribed anti-depressant medication and her sister agreed for her to be discharged into her care with the baby the next day. The Lead Nurse called the Social Worker to inform them of the situation and a DNA test was repeated.

6.19. Two days later, the Lead Nurse and a Nurse from the HTT conducted a joint home visit at Jayne's sister's home. Jayne denied any difficulties with her mental health but reluctantly accepted input from the HTT as an alternative to possible admission to hospital. The following day Jayne was put on medication and referrals to Early Intervention Team were made.

There were continued visits with Jayne by SPMHT, an assessment was made that her illness was 'more attributed to familial and early life event vulnerabilities and recent stressors'. It was agreed that visits would continue until July 2017. During one of those visits in late February 2017, Jayne confided that she had been contacted by another male, 'who may be the father' who said he did not want to know the child. Jayne's sister reported she had observed Jayne was finding it harder to bond with May but did not think she would harm the baby. She said Jayne had not washed for 2 days. She seemed disengaged and although she asked when they would be visiting again, she was described as 'seemed quite childlike'. A joint agency plan was made; that the HTT would continue daily visits for as long as necessary; the Early Intervention and Psychosis Team to visit weekly and plan care; Health Visitor to contact Jayne and a joint visit by the SPMHT Leader and HTT was planned.

6.20. In March 2017, Jayne's sister rang the HTT after finding Jayne putting a plastic bag over her head on two occasions. This was in response to her friend Leo, who Jayne had described as the love of her life, realising, on seeing that baby May was of dual heritage, that he could not be the baby's father. A DNA test confirmed this. Ten days later Jayne's sister disclosed Jayne had met with the likely biological father the day before and he had brought a female along. He allegedly told Jayne, he wanted to have custody of baby May, that he wanted to adopt her with his partner. He had apparently given Jayne 'until Friday to decide'. Jayne was documented as being understandably worried and anxious. This resulted in having thoughts of 'suicide' again, she got a black bag and took it to her room. She denied putting it over her head, but she did have it with her. She was persuaded by the nurse that it was not good to decide about the baby when she was not well and to wait until after a possible MBU (Mother and Baby Unit) placement.

6.21 A few days later, Jayne disclosed some detail about May's father. Jayne gave his name and ethnicity. He was much older than her by approximately 20 years. She claimed she knew no more information about him. Jayne reported feeling better and did not want to go to MBU.

6.22 In late April 2017, Jayne contacted HTT to say she had taken an overdose. She was admitted to a hospital Emergency Unit in relation to a Paracetamol overdose. An assessment indicated she was not psychotic but stressed by her social and housing situation. However, a few days later on she was again admitted to Hospital after an overdose on Anadin extra. She was referred to PLS (Psychiatric Liaison Service) and a Mental Health Act Assessment was recommended. A plan was made to admit her informally to a named Hospital pending further assessment for specialist care. In May 2017 Jayne was assessed by a Consultant Psychiatrist as she was 'desperate to leave the Hospital'. The assessment deemed that Jayne was willing to accept treatment, work with the Home Treatment Team and was safe to be discharged. The following day she moved to her sister's home.

6.23. In June 2017, Jayne and May moved into their own private rented accommodation. It was not long prior to this, that she had started seeing Martin, an older man whom she had known for some time through her father. Soon after moving into her new home, Jayne invited Martin to live with her and May.

6.24. In November 2017, the reports from EIT (Early Intervention Team) documented Jayne's improved mental health, and May was discharged from the ChIN (Child in Need) process. It was recorded that Jayne had engaged well with EIT.

6.25. In December 2017, a Family Group Conference was held, and a family and friends support plan put in place. The case was closed after a period of multi-agency child planning with Jayne's family provided ongoing support.

6.26. In September 2019, Jayne started a hairdressing course which she described as a 'dream she had wanted to follow since teenage years. Subsequently she was discharged from EIT services as she was described as stable and symptom free.

6.27. Jayne and Martin were together for approximately 3 ½ to 4 years and May called him "Daddy". For the majority of their relationship, they had no contact with agencies, including the Police. In February 2021, this changed when Jayne, called the Police after an argument, during which Martin threatened to hit her. Jayne told the Officers she was not frightened that he would carry out this threat, but said she wanted Police help in removing Martin from her property as she wished to end the relationship. Martin left the house and as Jayne did not want to pursue the matter criminally, the crime was filed and closed. The Officers did however make a referral to the domestic abuse support service, 'First Light, 'which over the following few days made unsuccessful attempts to contact Jayne by text messages. Later Jayne allowed Martin back to the house.

6.28. In March 2021 Jayne made an attempt to take her own life which resulted in her suffering serious spinal injuries. She was transferred to a specialist Hospital unit in Devon. Consequently, First Light transferred the helpline contact to the Health IDVA (Independent Domestic Violence Advisor). Due to the seriousness of her injuries (to her spine and right arm) she was not initially interviewed regarding safeguarding to both her and May, although concerns had been noted that domestic abuse may have precipitated her actions as she had told 'passers-by 'that she was not safe at home. She later told a worker from the Hospital Discharge Team that: 'I did what I did because I was in an abusive relationship'. She stated that the relationship had lasted approximately three years but was now over, however Jayne added that Martin was still trying to contact her, but she was ignoring him. Subsequently Jayne was also asked whether she was safe at home. It was recorded that she broke eye contact, hesitated before saying, "I didn't, but I think now I'm here, maybe I was". She added that she thought it was just threats, and that her partner would not actually hurt her.

6.29. After Jayne had undergone surgery, Police Officers were able to speak to her. They completed a standard DASH[2] for her. She informed them that she suffered from depression and was on medication for this. She said that no particular incident led her to jump off the bridge, but that she tried to end her life as she was feeling very low. She stated that this was, in part, due to her allowing her ex-partner back into her life and house. She did not disclose any criminal offences but did ask for officers once again to remove him from her property.

6.30. The Health IDVA made a follow-up call to the Hospital Safeguarding Lead, who confirmed that they had gathered initial information from ward staff and would submit a Safeguarding Referral. The IDVA requested that Jayne be offered support services, including Psychiatric Liaison and she also contacted MARU (Multi Agency Referral Unit) regarding her concerns relating to May.

6.31. In March 2021, a MARU referral was raised by May's nursery to Children's Services and a safeguarding referral was completed. It documented concerns that May's behaviour had deteriorated since Martin returned to the family home. May had been heard to say; "Daddy punched Mummy". Jayne however only disclosed that Martin had made threats and was controlling. Jayne is reported as saying that she did not know the correct spelling of his surname, but he was older than her, and they met in a pub and were in a relationship. The Safeguarding Referral was made the same day by the hospital Safeguarding Team detailing concerns of potential domestic abuse towards Jayne from her partner Martin.

6.32. In March 2021 Jayne confirmed to the Hospital Discharge Team that her relationship with Martin was over and that she would be receiving support from her family, however there were

[2] DASH is a domestic abuse risk identification, assessment and management model.

concerns that Martin was 'constantly' contacting her. The case was discussed at a Safeguarding Triage Meeting and the decision was taken that Jayne was at risk of continued domestic abuse. An action plan was agreed and over the following weeks, this plan was implemented through a multi-agency approach, agencies including Hospital staff, Adult and Children's Safeguarding, Social Workers, Mental Health, Police and the IDVA. There was continuing concern about Martin's behaviour towards Jayne, who while expressing the desire for him to leave, nevertheless did not want the Police to remove him from her home.

6.33. Late March 2021 Hospital staff again asked Jayne to accept contact from the IDVA but she declined, and the case was closed. Later an Adult Social Worker confirmed to the IDVA that a DASH and MARAC referral would be made if Jayne consented, however after she repeatedly declined contact, she was given helpline contact details and the case was again closed. Jayne stated that Martin was no longer at her home and she wanted to be discharged from hospital. Her sister confirmed that Martin had given back keys to the premises which were then secure, however he continued to send unwanted text messages to Jayne. As Jayne did not make a formal complaint there was no further action taken.

6.34. In April 2021, Jayne was taken to the Emergency Department after taking an overdose of Ibuprofen and for an infected wound. She stated that these were not suicide attempts.

6.35. Later in April 2021 Adult Social Care received an email from CMHT that Jayne reported that Martin had been in contact and had stayed at her house for 2 nights. She felt unable to say no when he turned up, but denied they were in a relationship. Martin was described in the record, as manipulative and controlling. However, Jayne strongly denied that Martin was the reason she had jumped from the bridge. Martin had kept hold of her car following the incident on the bridge, but she felt unable to report to the Police that he had her car as she was unable to deal with the stress of repercussions.[3] (It is noted that in June 2021 Jayne had told the Children's Social Worker, it was due to Martin that she tried to kill herself. She added that she had a Mental Health appointment, and her sister was supposed to go with her, but Martin went instead. It is alleged that he later told Jayne's sister, 'Mental Health' had said that Jayne was fine, and that Social Services were just exaggerating everything.)

6.36. In June 2021 Martin moved back in with Jayne and May. May had been due to go and stay with her aunt to allow Jayne to recover, but Martin insisted he would look after May. Jayne was described by the Children's Social Worker as being in a very fragile state due to Martin's return. Martin was said to feed Jayne's fears and anxiety by telling her that May would be taken from her. (Martin denied he said this).

6.37. In June 2021, as a result of concerns from May's Social Worker that Martin was controlling Jayne, it was noted that Jayne did not have access to her finances or car and was not able to see her friends. Jayne wanted to end the relationship but was not sure how to do so. It was hoped that with Social Care support and the Community Psychiatric Nurse (CPN) support she may feel strong enough to be without him. The enquiry concluded that Jayne was clear she did not want Martin involved in her life, however he was now living with her. Martin had a history of violent/threatening behaviour to a previous partner (2009) and setting their clothing alight[4]. In June 2021 Jayne's CPN emailed Children's Social Services that Jayne had asked Martin to leave, but he asked her to give him more time. Jayne had stopped taking her medication since Martin returned home. It was agreed that a multi-agency conference should be arranged.

6.38. Jayne reiterated to May's Social Worker in June that while she did not think Martin would hurt her or May, she wanted the Social Worker to ask him to leave as she did not want Police involvement. She said she did not know how she would cope having Martin there for the whole weekend. However, she did not want to speak to the IDVA Service, nor for Social Care to talk to her Landlord. She also confirmed she did not want the Police to go to her house. In June 2021 a MARAC referral was made, and Jayne was regularly checked. She stated she was OK, that Martin had said that he would leave, but Jayne did not seem convinced that this was what she wanted.

---

[3] Martin has told the Review he bought the car for Jayne but felt she was 'in no physical or mental state to drive it safely. She would have been a danger to herself and to the public as her arm was still in plaster.'

[4] Martin has admitted to the review that he burned some of his then partner's clothes during a row,
after discovering she was having an affair with a friend of his. She refused to support any prosecution against him.

Jayne was told that a conference had been requested and she was to think about what she wants and how she could be helped. A Domestic Violence Disclosure Scheme disclosure (Clare's Law) was not considered as Jayne was aware of the incident when he burned some of his wife's clothing after she had been having an affair with his friend. His wife had declined to prosecute him for criminal damage.

6.39. In June 2021, there was good practice with the Children's Social Worker sharing her concerns for May. Jayne had not been engaging with support and she was worried over Jayne's capacity to keep herself safe and her capacity regarding the relationship, although due to her inconsistencies this was hard to judge, (sometimes she would want him to stay and on others she wanted him out.) The Social Worker decided she needed to listen to May to assess the risks and whether to exercise powers in relation to the Children Act. She recorded that she spoke to May who told her, that she was happy that 'Daddy was back' ….and 'Mummy is happy too'…. 'Daddy shouted at Mummy when he was living with us before – it made me feel sad'…'Daddy hasn't shouted since he has moved back in.' Due to illness Jayne was not seen for several days but a meeting was arranged for July 2021.

6.40. On the day of Jayne's death, after she attended hospital for a pre-arranged appointment with a psychiatric nurse and being told the nurse was off work ill, Martin has stated that Jayne was upset and asked him to take her and May out for the day. Jayne suffered fatal injuries from an accident whilst on the day out. The Police attended and interviewed witnesses who confirmed that Martin and May were some distance away when the incident happened. Martin was arrested on suspicion of engaging in coercive and controlling behaviour. The investigation concluded that there was insufficient evidence to indicate an offence had been committed.

6.41. The postmortem revealed multiple injuries which would have been immediately fatal and were consistent with the accident. Toxicology identified therapeutic levels of Sertraline and Olanzapine. There were no significant findings.

Section Seven - Key Issues and Conclusions

7.1. The Review Panel considered all of the evidence presented in the reports from those agencies that had contacts with Jayne, Martin and/or May as well as information gathered from Jayne's family and from Martin and his family. The Panel also took account of relevant learned research.

7.2. The Review Panel acknowledged the views of Jayne's sister that Jayne's episodes of anxiety appeared to be stress related, from difficult familial experiences, she had been worried after the birth of May and when her relationships were in difficulties.

7.3. It was a result of information provided by Jayne's family, that the Review Panel learnt that Jayne's main partners had been significantly older than her, Stuart was approximately 30 years older than Jayne, Leo, was approximately 25 years her senior, Zak was about 20 years older and Martin 45 years older. Whilst there is no available evidence to indicate that any of the agencies involved with Jayne and May had any knowledge of the first three of the afore mentioned during their relationships with Jayne, family members have expressed a view that the age difference between Jayne and Martin should have been explored by professionals as she was vulnerable to grooming from older males. Devon and Cornwall Police did investigate the allegations of controlling and coercive behaviour by Martin but found insufficient evidence to support any criminal proceedings. The Review Panel has, nevertheless, concluded that routine or appropriate enquiries about domestic abuse should have taken place when she presented to services in mental distress. This routine enquiry may then have prompted a conversation to enquire if there was any grooming, exploitation and abuse within the relationship.

7.4. Whilst a family member has stated that Jayne had said she preferred older men because they made her feel special, she added that Jayne felt other parents talked about her when she took May to school due to the wide age difference between her and Martin. This affected her already low confidence and increased her anxieties. The Panel draws attention to the known links between mental health issues and domestic abuse.

7.5. There is significant independent research that indicates that intimate partner violence is a common health care issue[5]. The Crime Survey for England and Wales (2017) highlights that women with a long-term illness or disability were more likely to be victims of recent domestic abuse (within the last year) than those without one; to a ratio of 15.9% compared with 5.9%.) One in four women who have died by suicide had been the victim of physical violence, one in five had suffered psychological violence and one in six had been sexually assaulted.

7.6. A further research document stated: "These (anxiety) issues can make the abusive situation even worse, as the partner or ex-partner may make use of a diagnosis" (for example, telling them they are useless and talking for or over them in the presence of others.) It was stated in the above research that; "It can also be difficult for professionals to see beyond mental health issues and to recognise that an abusive relationship may be at the heart of the problems"[6].

It is alleged by members of the family that Jayne's relationship with Stuart ended with her confidence destroyed after he told her, she needed to lose weight and bought her an exercise bike and that Martin's propensity to answer medical questions directed to her also sapped her confidence by making her feel inadequate[7].

7.7. Many examples of individual good practice by professionals working with Jayne were identified during the Review, these include:

• The GP's prompt referral to appropriate mental health services.

• The consistent high standard of timely care and appropriate referrals by Ambulance Personnel on the occasions they were called to attend to Jayne.

• The Lead Nurse for SPMHT (Specialist Perinatal Mental Health Team) was particularly tenacious in contact with both Jayne and partner agencies, postpartum to ensure Jayne received the necessary care from the health team for both her and May.

• Jayne's CMHT (Community Mental Health Team) care coordinator also provided excellent care in the last few months of her life. She built up a trusting relationship with Jayne and was the fulcrum for informing external agencies about Jayne's wellbeing and voicing her concerns.

7.8. On the other hand, the Review Panel highlights concerns regarding:

• The failure to make an early referral to the MARAC.

• The breaches in not following Devon and Cornwall Police Policy relating to recording incidents of domestic abuse. Completing only a standard DASH risk assessment in spite of Jayne having told members of the public that she had tried to take her own life because she had been experiencing domestic abuse at home.

• The failure of agencies to refer May back to the Health Visitor Service, after Jayne's hospital discharge whilst still suffering with physical and mental health issues after jumping from the 30ft bridge.

• The failure to notify Jayne that the CPN she had an appointment to meet at hospital was off work ill. This caused her distress on the day of her death.

Section Eight - Lessons Learnt

8.1. The following summarises the lessons agencies have drawn from this Review. The recommendations made to address these lessons are set out in the Action Plan template in Section 9 of this Report.

8.2. **Cornwall Council Adult Social Care**

8.2.1. Record keeping and case notes were insufficiently detailed to clarify what communication, intervention or meetings may have taken place which may have influenced further actions.

---

[5] Health consequences of intimate partner violence (Prof. J. C. Campbell published in Lancet 13 April 2002)

[6] https://healthtalk.org

[7] Martin has asked that it is emphasised that whilst some medical practitioners found his answering their questions on behalf of Jayne to be controlling behaviour, he did so because she found it difficult to speak to professionals when she was feeling stressed. Her father also answered questions on her behalf.

8.2.2. The delay in coordinating a safeguarding conference in order to assess risks and to decide on a course of actions to counter those risks was not in keeping with the level of risk identified over the course of visits and communication with other agencies.

8.3. **Cornwall Council Children and Family Services, Together for Families**

8.3.1. Communication between agencies is key to ensure that a DASH risk assessment is completed and shared leading to the earlier involvement of domestic abuse services at the earliest stage.

8.4. **Cornwall NHS Provider Trusts (CFT & RCHT)**

8.4.1. More curiosity could have been exercised regarding the men/partners in Jayne's life. This includes previous partners, the father of May, as well as Martin. In cases where there is domestic abuse alleged/present the needs of the child/children in the home needs to be considered.

8.4.2. Staff could have explored the claim that Martin was a mental health nurse, who he worked for or in what capacity. A Person in Position of Trust (PIPOT) referral process is part of the Children's and Maternity level 3 children's safeguarding training and incorporated in the Adult Safeguarding training level 2.

8.4.3. There were several opportunities to ask about Routine Enquiry (RE) into domestic abuse which were not pursued due to Martin being present. Creative ways of seeing Jayne on her own and asking about domestic abuse will consequently be explored through training.

8.4.4. An earlier Adult Safeguarding Conference (ASC), strategy meeting, or multi-agency meeting may have been beneficial in bringing all involved agencies together for a cohesive response to support Jayne to separate from Martin. The care coordinator did raise general concerns with a member of the CFT Safeguarding Team to ascertain if there was anything more, she could do, but it was recorded the Adult Safeguarding Officer concluded the safeguarding was being handled by the Local Authority. An escalation to the Council may have provided an earlier opportunity to bring all agencies together.

8.4.5. There is evidence of good practice, particularly in the last few months leading up to Jayne's death. Some members of staff went out of their way to provide Jayne with the best care. The Lead Nurse for the SPMHT was particularly tenacious in contact with both Jayne and partner agencies, post-partum to ensure Jayne received the necessary care from the health team for both her and May. Jayne's CMHT Care Coordinator also provided excellent care in the last few months of her life. She built up a trusting relationship with Jayne and was the fulcrum for informing external agencies about Jayne's wellbeing and voicing her concerns.

8.4.6. Jayne was seen by health staff, predominantly Acute Care at Home (ACAH), practically every day from her return home in April to the date of her death. On the few occasions she was not seen face to face, she was contacted by phone. There was evidence of good information sharing and multi-agency working.

8.5. **Cornwall Multi Agency Risk Assessment Conference (MARAC)**

8.5.1. The MARAC meeting could have been more effective if the referral had been more comprehensive at the point of identifying the risk. There had been a lack of information relating to the risks to Jayne and there had been no discussion relating to the impact on May.

8.6**. Devon & Cornwall Police**

8.6.1. It was acknowledged that Devon and Cornwall Police's Domestic Abuse Policy is robust and withstands scrutiny well. It is regularly reviewed by a Domestic Abuse Steering Group and changes are made when identifiable opportunities to provide a better service are presented.

8.6.2. The review highlighted occasions when Officers could have shown greater professional curiosity during their contact with Jayne and Martin.

8.6.3. Devon and Cornwall Police are currently undertaking a new PEEL14 review and in addition have internal processes carried out by their Crime Standards Team to ensure the continued attention to crime data integrity is maintained. It is thought that individual deviations from expected practice are inevitable but minimised through these checks and measures.

8.6.4. There was an occasion on 5 March 2021 when DASH risk assessments were unavailable to view, this is being addressed by the Force installing a new computer system - NICHE.

8.7**. First Light**

8.7.1. The IMR Author highlighted the difficulties in being able to offer face to face contact with Jayne and that this inhibited a safety and support plan being agreed with Jayne around her discharge from hospital. This was due to both COVID restrictions and long travel distances as Jayne was in Hospital in Devon.

8.7.2. There is ongoing learning with regards to how to safely contact those who are referred to First Light. The instigation of 'safe' contact relies heavily on the information provided by referrers, however persistent issues have been raised with regards to the accuracy of information provided. A new system is being implemented within Devon and Cornwall Police which, together with the input from other referring agencies, is expected to address this issue of information shared to the point of inter-agency referral to First Light.

8.7.3. There was limited input in relation to Hospital discharge planning from First Light in terms of what needed to be considered to ensure Jayne's safety and protection from Martin following her return home.

8.7.4. Processes within the Helpline Service have changed to ensure that referrals made within 3 months of the previous closure, will automatically be allocated to the previous IDVA. If this had been the case at this time, it would have provided a better opportunity for First Light to work jointly with Jayne's Social Worker to gain a thorough assessment of and response to risk posed at that time.

8.8. **Surgery A (Cornwall)**

8.8.1. The IMR Author highlighted that whilst the practice has ongoing safeguarding meetings, the detail within the consultation (chronology) notes did not include who was present at these meetings and what was discussed. He considered that it may be helpful for the Practice to reflect on this and consider if this should be changed.

8.8.2. There was some social history included in the consultation notes, however, it may be useful for Practitioners to consider expanding this to demonstrate that it has been discussed in the consultation and to include the details of any adults that are present during consultations with children.

8.8.3. It is generally recommended that if a patient presents with indicators for domestic abuse, then questions regarding their experience should be in a private discussion. There was no record of any disclosure of domestic abuse, or of this being explored during adult presentations with mental health needs, injuries, or unexplained symptoms. It may be helpful for the practice to reflect on this and consider the way that possible domestic abuse is explored and then recorded in the notes.

8.9. **Surgery B (Devon)**

8.9.1. This GP practice had no contact with either Jayne or May and no relevant contacts with Martin, therefore has no lessons to learn or good practice to highlight.

8.10. **Pentreath Ltd**

8.10.1. Whilst Pentreath was providing Jayne with vocational support, there were times when additional financial issues and the need for food through the provision of food bank vouchers were identified. Jayne never had any concerns raised regarding her involvement with Martin or May[8].

8.11. **South West Ambulance Service NHS Trust**

8.11.1. Other than highlighting the proactive work of a Paramedic in submitting a Datix (information sharing system entry) to enable a warning flag to be placed on Jayne's address, there were no lessons to learn from the Ambulance Service contacts with the family.

[8] Jayne's family has asked that it be added that Jayne kept Martin private due to embarrassment of what people might think of her, so did not disclose the relationship to Pentreath Ltd

8.12. **University Hospitals Plymouth NHS Trust**

8.12.1. The hospital did not have its own in-house IDVA, but the Cornwall Health IDVA was in a position to offer Jayne support and was present at the discharge meeting.

8.12.2. The safeguarding expertise from the Hospital Safeguarding Practitioner, who followed the principle of MSP (Making Safeguarding Personal), including the management of May at home, the IDVA being expedited, facilitation and good partner-agency communication was highlighted as good practice.

Section Nine - Recommendations and Action Plans for the Review

9.1. The DHR Panel's recommendations and up to date action plan (at the time of publication) is detailed in the adjoining document. After publication of this report, Cornwall and Isles of Scilly Safeguarding Adult Board and Safer Cornwall Community Safety Partnership will discuss with partner agencies how other existing cross agency strategies can build on these recommendations.