A Domestic Homicide Review of the death of Grace

March 2022

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Pen Portrait of Grace

Grace, 19 years old, was a beautiful and much loved only child. Her name was chosen when we first set eyes on her bright red hair and lily white Irish skin. Grace was named after her mum's grandma and her dad's Irish grandparents.

From day one Grace was such a character, and hence an only one, a feisty red head, a fun, cheeky child with a beaming smile and a loving nature. There was never an ounce of malice in Grace, she was such a kind soul. With her upward or downward turned mouth, what you saw was what you got with Grace. Wherever she went, whatever she turned her hand to she was noticed and remembered and mostly for all the right reasons.

Her school life was happy and successful. Grace excelled at sports. Playing netball and cross country running for County Durham and cycling with her school from Darlington to Paris. Grace also enjoyed drama, dancing and singing, she sang like an angel and had a phenomenal memory for song lyrics.

After leaving school Grace worked in an opticians for three and a half years where she seemed very popular and well-liked, and despite her young age she was chosen as their staff representative. Grace was the youngest student to study for her dispensing optician exams, her goal being to go to university to finish off her studies and qualify as an optician.

As her Lancashire grandma used to repeatedly say, "she's just a joy to be around". Grace was our world and we both miss her with every breath we take, our hearts are broken. It was the honour of our lives to watch our daughter grow.

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Section 1: Introduction

1.1 This report of a Domestic Homicide Review examines agency responses and support given to Grace, a resident of Darlington, prior to her tragic death in March 2022.

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

1.3 The circumstances of the death were not initially considered within the remit of a Domestic Homicide Review and there was no formal notification from the police who attended the incident to the Community Safety Partnership. The full details of the considerations, discussions and decisions are contained at section 5 of this overview report.

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

1.5 The review will consider all agencies' contact and involvement with Grace and Ryan from March 2019 through to the date of Grace's death. This three year period was agreed as appropriate in order to give a full picture of Grace's life. However, to fully understand Grace's experiences and see life through her eyes, the panel agreed to consider any significant event or pattern of events spanning her lifetime.

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

Section 2: Timescales

2.1 The review began in May 2023 with the appointment of an Independent Chair and Author. The first DHR panel meeting was held on 10th July 2023. A briefing was delivered to IMR authors in September 2023. A second DHR panel meeting was convened on 23rd October 2023. The final panel meeting was held on 6th December 2023. Grace's parents attended this final panel meeting.

2.2 A confidential copy of the report was shared with the family prior to the approval of the DHR report by the Home Office Quality Assurance panel. This was to enable the family to make any comments or give feedback. Their feedback was detailed and necessitated a further convening of the DHR panel so that all agencies could respond. The family were then provided with the panel responses to their queries or requests. This included some alterations or clarifications to the overview report.

2.3 The DHR was concluded in March 2024 following presentation to the Darlington Community Safety Partnership, who agreed with the conclusions, learning and recommendations.

Section 3: Confidentiality

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

3.2 The victim, Grace, was 19 years old at the time of her death. Her ex-partner, Ryan, was also 19 years old at that time. Both subjects of this review are British citizens who reside or did reside permanently in the UK. Their ethnicity is white / British.

Section 4: Terms of Reference

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

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

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

Section 5: Methodology

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

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

5.3 In August 2022, the Chair of the DCSP notified the Home Office of the decision that they did not believe the criteria was met to commission a DHR.

5.4 The Home Office responded in March 2023 that a Quality Assurance panel had met and believed that this case would benefit from a Domestic Homicide Review.

5.5 The following month, the new Chair of the DCSP informed members of the partnership that a DHR would be commissioned and an Independent Chair appointed to coordinate the process.

5.6 Once the Independent DHR Chair was in place, further scoping took place and the review began its work. The Chair met with the victim's family and their appointed advocate at an early stage of the review. A DHR panel was formed. The aim of the DHR panel was to deliver the review as soon as practicable. The DHR Panel Chair is confident the review maintained focus and the final report was completed in good time.

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

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

a) A person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship, or
b) A member of the same household as himself / herself."

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

'Definition of "domestic abuse"

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

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

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

(b) the behaviour is abusive.

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

(a) physical or sexual abuse;

(b) violent or threatening behaviour;

(c) controlling or coercive behaviour;

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

(e) psychological, emotional or other abuse; and it does not matter whether the behaviour consists of a single incident or a course of conduct.

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

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

(b) obtain goods or services.

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

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

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

2 Definition of "personally connected"

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

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

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

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

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

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

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

(g) they are relatives.

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

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

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

(3) In this section—

- *"child" means a person under the age of 18 years;*
- *"civil partnership agreement" has the meaning given by section 73 of the Civil Partnership Act 2004;*
- *"parental responsibility" has the same meaning as in the Children Act 1989 (see section 3 of that Act);*
- *"relative" has the meaning given by section 63(1) of the Family Law Act 1996.*

5.9 The overarching reason for the commission of the review is to identify what lessons can be learned from this tragedy.

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

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted upon and what is expected to change as a result.

- Apply those lessons to service responses including changes to policies and procedures as appropriate.

- Articulate life through the eyes of the victim, to understand the victim's reality; to identify any barriers the victim faced to reporting abuse and learning why interventions did not work for them.

- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter- agency working.

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

6.1 Grace's family were integral to the Domestic Homicide Review process. Their firm belief was that their daughter had suffered domestic abuse and they felt strongly that a review should be launched to examine the background and nature of the relationship between Grace and Ryan. This belief has never wavered. After the Community Safety Partnership met and decided the circumstances did not meet the criteria to hold a review, the family appealed to the Home Office, supported by their advocate.

6.2 Although there was very little contact between Grace or Ryan and professionals before her death, there were a number of statements obtained by the police during the course of their investigation. These included long term friends and colleagues of Grace. In addition to the police witness statements, there were also a large number of email exchanges between Grace's friends and her mother. All of this documentation was reviewed and considered by the DHR Chair.

6.3 The DHR panel met to discuss any approaches to friends and colleagues. The panel debated the merits and risks associated with such approaches. The police statements gave quite a lot of information but the panel acknowledged that sometimes people are not as comfortable when speaking with the police as they may be with others. However, the same friends and colleagues had also supplied email information directly to Grace's mother. This reflected their personal memories of Grace but also gave candid accounts of various events that had taken place. The panel accepted that these were young adults (aged in their early 20s) who had suffered the trauma of losing their friend in such tragic circumstances. The panel did not believe that any added value would outweigh the additional emotional harm of approaching the friends for a third time.

6.4 The exception was an approach to the victim's employer. The DHR Chair travelled to Grace's place of work. It was important that the views of the employer were discussed as there had been reference by Grace to pressures she faced at work and in her studies. The Chair spoke with the manager. This was a new manager, as the previous manager was on long term absence and could not be approached. The Chair was able to examine the employer's various policies and procedures that were in place. These related to well-being and domestic abuse. The Chair also gave an open invitation that any of the staff that worked with Grace could feel free to discuss their memories of her with him. However, in addition to the manager being on long term absence (with no expected return date), one member of staff had left the company altogether, one had moved to another regional office and one was off on maternity leave. There was only one member of staff remaining. The Chair asked the new manger to let the

employee know that if he wished to do so, then the Chair could speak with him in person or on the telephone. A few days later, the manager rang the DHR Chair. After careful consideration, the young employee had told the manager he had said all he could really say. He had nothing to add. The employee (through their manager) did say they were not being obstructive but that they really did not think there was anything that would provide additional information or context.

6.5 There were also hundreds of private telephone / text / social media messages reviewed by the DHR panel. These were mainly between Grace and Ryan. Some were between Grace and her mum. These provided a great deal of information to the review. The messages are private and sensitive. They are summarised at section 17 of this report. The actual messages are contained in a confidential appendix and will not be made available to the public.

6.6 The DHR Chair wrote to Ryan. As Grace's ex-partner, he may have been able to add further information or give clarification to certain events. He was invited to take part in the review. He did not respond to the letter.

6.7 Grace's parents were kept updated throughout the review process via their AAFDA advocate. The parents also accepted an invitation to attend the third DHR panel meeting where they were able to meet the panel members.

6.8 A copy of the DHR overview report was shared with the victim's family prior to presenting the findings to the Community Safety Partnership. The family gave feedback which resulted in some minor amendments to the report.

6.9 Grace was an only child. Her parents continue to grieve the tragic loss of their daughter. A pen portrait is provided at the start of this report. The Domestic Homicide Review panel express their sincere condolences to the family at this very difficult time.

Section 7: Contributors to the Review

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

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

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

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

7.3 Other agencies provided scoping, summaries and chronologies:

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

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

Section 8: The Review Panel Members

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

8.2 The Domestic Homicide Review panel comprised of the following people:

Name	**Agency & Job Title**
Darren Ellis	Community Safety Programme Manager - Darlington Borough Council
June McStravick	Project Lead – Tees Valley YMCA
Carley Ogden	Named Nurse for Safeguarding Adults - County Durham & Darlington NHS Trust
Jen Moore	Designated Nurse Safeguarding Adults - North East & North Cumbria Integrated Care Board (representing GP practices)
Nicki Smith	Associate Director of Nursing (Safeguarding), Tees Esk & Wear Valleys NHS Foundation Trust
Julie Wheatley	Team Manager Social Workers Mental Health and AMHP Service, Darlington Borough Council West Park Hospital
Francesca Smith Trish Watson (from 2nd panel)	Team Manager Safeguarding Adults Team - Darlington Borough Council Senior Practitioner, Safeguarding Adults Team- Darlington Borough Council
Lee Blakelock Liane Green (from 2nd panel)	Detective Chief Inspector - Durham Constabulary T/Detective Chief Inspector Durham Constabulary
Joanne Pattison	Scrutiny and Improvement lead, Safeguarding, Durham Constabulary
Rachael Williamson	Service Manager for Durham & Darlington – Harbour Domestic Abuse Services
Emily Thornley	Team Leader Harbour Domestic Abuse Services
Simone McGill	Harbour (specialist in young people and domestic abuse)
Ken Ross	Public Health Principal – Public Health lead for Mental Health and Suicide, Darlington Borough Council
Ben Thompson	Probation Service (withdrew after 1st panel as no involvement with either subject of the review)

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

Section 9: Author of the overview report

9.1 The appointed Independent Chair and Author is Mike Cane. He is completely independent of the Darlington Community Safety Partnership and has no connection to any of the organisations involved in the review. He is a former senior police officer where his responsibilities included homicide investigation, safeguarding and investigation of child abuse, rape and other serious sexual offences. He has extensive experience as a panel member for Domestic Homicide Reviews and is a former member of a Safeguarding Vulnerable Adult Board, several Domestic Abuse Strategic Partnerships and a number of Local Safeguarding Children Boards. During his police career he was Force lead for domestic abuse, child protection and vulnerable adults. He chaired the MARAC meetings across four Local Authority areas for several years and was also Chair of the Sexual Assault Referral Centre (SARC) management board. He has previous experience of conducting Domestic Homicide Reviews, Safeguarding Adult Reviews and Child Safeguarding Practice Reviews as an Independent Chair/Author.

Mike completed accredited DHR training for Chairs in 2010 and refresher training in 2017. He attended AAFDA (Advocacy After Fatal Domestic Abuse) conferences in 2018 and 2019 as well as taking part in AAFDA training on ‘involving children in Domestic Homicide Reviews’ in 2021 and ‘best practice in managing DHRs’ in 2022.

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

Section 10: Parallel Reviews

10.1 The inquest into Grace's death was opened in March 2022. The inquest hearing was conducted at Crook Coroner's Court, Civic Centre, Crook, Co. Durham in January 2023. The family were represented by a barrister instructed by Hogan Lovell Solicitors of Holborn, London.

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

10.2 The family of the deceased challenged the Coroner's ruling through the High Court. The case was listed on 20th February 2024 and was uncontested. The court agreed to amend the wording to reflect that this was an abusive relationship;

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

10.3 Neither subject of the Domestic Homicide Review were accessing services under the Care Act 2014. There was no requirement for a Safeguarding Adult Review. However, a copy of the Domestic Homicide Review will be shared with the Darlington Safeguarding Adults Partnership.

10.4 The victim and her ex-partner did not have any children. No children were affected by any of the issues in this case. Therefore there was no requirement for a Child Safeguarding Practice Review.

10.5 Following Grace's tragic death, Durham Police carried out an investigation. This included downloads and examinations of Grace's telephone and her ex-partner's telephone. Witness statements were taken from several friends and colleagues of Grace. The ex-partner, Ryan, was interviewed under caution at the police station regarding the nature of his relationship with Grace.

After reviewing the case, the police made a determination that the evidence did not meet the threshold for a criminal prosecution. The bar for such a prosecution is high, i.e. the police would need to believe there was a realistic prospect of a conviction with the burden of guilt being 'beyond all reasonable doubt'.

Section 11: Equality and Diversity

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

11.2 The victim and her ex-partner were not married at the time of her death. Their marital status did not affect any of the services provided.

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

11.4 The victim was a young woman who lived at home with her parents. She was not registered as disabled, nor in receipt of statutory services.

Females aged 24 years or under have seen the largest increase in the suicide rate since detailed recordings began in 1981.

ONS data for the period ending March 2023 shows that a high proportion of women aged 16–19 years were the victims of any domestic abuse (9% of that age group) compared with those aged 20-24 (6.3%), 25-34 (6.8%), 35-44 (7%), 45 to 54 (4.2%), 55-59 (6.6%) and those aged 60 years and over (3.2%).[1]

11.5 The ex-partner was a young man who had little contact with any services.

11.6 With regard to sex, around three-quarters of suicides in England are males (4,129 deaths; 74.0%), consistent with long-term trends, and equivalent to 16.0 deaths per 100,000. The rate for females taking their own life is 5.5 deaths per 100,000.

HM Coroner ruled a verdict of suicide at the inquest in January 2023. The Judicial Review was appealed for a change in the wording regarding the reasons for the action Grace took. The verdict of suicide remains unchallenged.

The North East region has the highest suicide rate in England.

Data also shows that females were the victim in 73% of domestic-abuse related crimes in England in the year ending March 2021.[2]

The Domestic Homicide Project states:

'*Across the two-year period 1 April 2020 to 31 March 2022 there were 470 deaths in total which took place in a domestic setting or following domestic abuse, including 43% intimate partner homicide, 24% suspected victim suicide, 22% adult family homicide, 8% child death, and 3% 'other'. Police*

[1] The Crime Survey for England and Wales (CSEW) 2023
[2] Office for National Statistics 2021

are identifying more suspected victim suicides with a history of domestic abuse – up 28% to 64 cases in year two.'[3]

11.7 Recent research notes 'the perpetrators of abuse in suicide cases were three times more likely to have engaged in coercive and controlling behaviour than those in intimate partner homicides.'[4]

Section 12: Dissemination

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

- HM Coroner
- All organisations within the Darlington Community Safety Partnership
- Darlington DHR Panel
- Office of Police and Crime Commissioner for Durham
- Darlington Safeguarding Adults Partnership
- Home Office DHR team
- The Domestic Abuse Commissioner for England & Wales
- Grace's family

[3] The Domestic Homicide Project is a Home Office funded research project led by the National Police Chiefs' Council (NPCC) and delivered by the Vulnerability Knowledge and Practice Programme (VKPP) in collaboration with the College of Policing.

[4] Learning Legacies: An Analysis of Domestic Homicide Reviews in Cases of Domestic Abuse Suicide – Sarah Dangar(July 2022)

Section 13: Background information

Case specific background

13.1 The victim, Grace, was born in the UK in 2002. She was 19 years old at the time of her death. Her ex-partner, Ryan, was also born in the UK and was also 19 years old at the time of the tragedy. They began a relationship in January 2020. They became very close and spent a lot of time together.

13.2 During the Covid-19 lockdowns the couple spent even more time in each other's company. The rules relating to mixing in groups and 'bubbles' of contact meant that meeting in person with their wider friendship group was prohibited.

13.3 There were incidents of abusive behaviour. None of these were reported to professionals as abuse. Though Grace did state to a domestic abuse support worker that her boyfriend could be 'slightly jealous' and be quite nasty to her over these thoughts. The support worker explained to Grace this was domestic abuse.

13.4 Grace did occasionally use illicit drugs. Her ex-partner, Ryan was a habitual drug user.

13.5 Grace ended their relationship in February 2022.

13.6 On Saturday 5th March 2022, Grace went on a 'work's night out'. She became close with a colleague and they were seen in a club by her ex-partner Ryan and his friends. Grace left the premises and spent the night with her colleague. She later received abusive texts and messages from her ex-partner.

13.7 On Monday 7th March 2022, Grace was on a day off from work but still went in to the office to study, complete course work from college and prepare for some forthcoming examinations. Her new partner, who had spent the night with her on Saturday walked her home after work.

13.8 After arriving home, Grace had dinner with her parents. She then went upstairs to shower. She researched how many paracetamol would be a fatal dose, before tying a dressing gown cord around her neck, which she used to hang herself from a wardrobe in her bedroom. Her father found her body and began CPR. An ambulance was called and the crew also carried out CPR. Grace was taken to hospital where she sadly died the following week.

Section 14: Chronology

14.1 The Domestic Homicide Review panel agreed to review agency records going back three years before Grace's death. It was apparent from the outset, that the level of contact with agencies was minimal and therefore the opportunity for learning was limited. This chronology summarises all relevant contact with organisations from the public and voluntary sector from the victim and from her ex-partner.

14.2 To widen the scope, the Independent DHR Chair met with the victim's family at a very early stage of the review. They were able to signpost to other records or documents that may be of use. The Chair also made contact with the victim's employer. This gave a more detailed picture of the victim's life.

14.3 The DHR Chair also accessed a significant amount of information from the victim's telephone data; including calls, texts and a variety of social media messaging. Although not contained within the chronology section, the findings of these retrievals are contained within the analysis section of this review. Information was also provided from HM Coroner with a significant bundle of documents being forwarded to the DHR Chair.

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

14.5 On 1st April 2020, Grace texted the 'SHOUT' helpline. SHOUT is a mental health charity. She gave her name as 'Sophie.' The call was noted as 'general unhappiness.' She informed the call-taker that her partner had trust issues and went on to disclose that he would get annoyed at 'little things' and she was having to adjust her behaviour to try to appease him. This was not categorised by 'SHOUT' as a call linked to domestic abuse.

14.6 Grace again texted the 'SHOUT' mental health helpline on 22nd May 2020. This is recorded as a short (ten minute) interaction. She reported anxiety related to her sex life. Grace was worried about getting pregnant. SHOUT staff advised her to write down her thoughts as a reference point and to speak to her GP.

14.7 On 29th July 2020, Ryan had an appointment with his GP. This was a telephone contact due to the Covid-19 restrictions in place at that time. He expressed concerns regarding his use of ketamine and the effects on his mental health. He wanted help to stop using the drug. Ryan was signposted to the 'Talking Changes' and 'NECA' services.

14.8 On 11th August 2020, Ryan had a telephone assessment with Tees, Esk & Wear Valleys NHS Foundation Trust (TEWV). This was as a result of a self-referral to their 'Talking Therapies' service. The key issues raised within the assessment were Ryan's misuse of substances and self-reported increase of this during lockdown which impacted his mood and paranoia. This information was then shared with the GP.

14.9 On 12th January 2021, Grace had a telephone appointment with her GP regarding her mental health. She described feeling depressed for 12 months. She reported crying for no reason, not wanting to go out. However, she denied any suicidal ideation. The GP advised Grace she could self-refer to 'Talking Changes'. The practitioner also referred Grace to the GP Aligned Mental Health Team.

14. 10 The following day, 13th January, the GP Aligned Mental Health Team (a service provided by TEWV staff) records show they made three attempts to contact Grace by telephone. There was no reply. The next day (14th January) they again tried to telephone Grace. Again, there was no reply. The notes state that they therefore sent a 'opt-in' letter to Grace with advice that if she did not contact the team, she would be discharged from the service.

14.11 On 25th January, the Aligned Mental Health Team records note there had been no response to the opt-in letter and Grace was subsequently discharged from their service.

14.12 On 26th February 2021, Grace had her first (online due to covid restrictions) youth session with the Tees Valley YMCA. This followed on from an initial enquiry by Grace's mother. She engaged in another online session with the YMCA on 11th March.

14.13 On 30th March 2021, Grace attended a face to face session with the YMCA. This was a group session and the content was related to mental health and well-being.

14.14 Grace attended further face to face youth sessions at the YMCA on 15th May, 18th May and 25th May. Further sessions continued throughout 2021.

14.15 Grace had two appointments with County Durham and Darlington NHS Foundation Trust (the Urgent Care Centre at Darlington) in May 2021. Neither of these attendances were relevant to this review.

14.16 On 1st July 2021, according to Harbour Domestic Abuse Services records, Grace made a self-referral to their service. However, Grace's mum states it

was she who actually made the contact and made no secret of this. She was open with Harbour that she was ringing on behalf of her daughter.

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

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

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

Section 15: Overview

15.1 The emerging themes identified during this review:

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

Section 16: Analysis

16.1 This case involved very little contact with professionals or agencies. The chronologies collated as part of the review, showed there was only infrequent contact between practitioners and either the victim or her ex-partner.

16.2 Each of the 'Terms of Reference' agreed at the first DHR panel (and endorsed by the victim's parents) will use information gathered from chronologies and Individual Management Reviews. However, a lot of information originated from messages directly between the victim and her ex-partner or from statements and emails from friends and colleagues provided to the police and Grace's mum after Grace's tragic death. None of this information was known to professionals before Grace's death.

16.3 Were practitioners sensitive to the needs and vulnerabilities of the victim? When, and in what way, were the victim's wishes and feelings ascertained and considered? Was the agency response person-centred and tailored to the needs of this victim? Was she clearly informed of options/choices available to help in her decision making? Were there any barriers to the victim accessing support?

16.3.1 There was no indication to the GP from Grace that she was experiencing relationship problems or was the victim of domestic abuse. There is limited information documented from an appointment in early 2021. Grace reported in a consultation on 12th January 2021 that she was experiencing low mood and frequent crying episodes. It is important to note this consultation was on the telephone as during that time there were national restrictions in place related to Covid-19. Face to face consultations were prohibited unless essential. During the 12th January discussions, Grace was provided with advice regarding a service called 'Talking Changes' and advised she was able to self-refer to them. The practitioner referred Grace directly to the GP 'Aligned Mental Health Team'.

The Aligned Mental Health Team tried to contact Grace four times by telephone and twice by letter. She did not respond. As part of the DHR, enquiries were made with the 'Talking Changes' service. They confirmed that Grace did not self-refer.

This was the only consultation with the GP during the timeframe of this review that Grace mentioned mental health or low mood.

The next appointment Grace attended was four months later and was for an unrelated medical ailment. It appears that the practitioner did not refer

back to the appointment in January as there is no entry in the notes that suggests any discussion around her low mood on this occasion.

16.3.2 The YMCA confirm that all attendees at their youth sessions including Grace are asked at the start of the session:

'How are you?'

'Do you have any issues to discuss?'

'How is your wellbeing?'

YMCA staff ask these questions as their youth sessions are a space for young people to discuss issues they are facing either in a group or one to one.

All attendees are informed that the YMCA staff can help to support them and refer on to other agencies if needed.

16.3.3 Harbour carried out an initial assessment with Grace on the telephone in July 2021; an independent safety and support plan was created through a one to one assessment. This provided clarity to the support that could be offered. Grace did not want to engage with any further one to one support but did agree to be placed on the waiting list for group work. A barrier at this time was the sheer length of the waiting list due to the Covid-19 restrictions in place. Group work did not commence until after national restrictions were lifted. As part of this review, Harbour have confirmed that Grace was still on the waiting list at the time of her death.

16.3.4 Harbour have confirmed to the DHR panel that an outreach support worker is available if individual support is required. However due to Grace expressing her wish for group work only, (which was identified during the assessment), no outreach support was put in place.

16.4 Were practitioners knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator?

16.4.1 The youth workers at the YMCA are aware to look for signs of vulnerability with all their attendees. If they have a concern about a young person they work through the 'Continuum of Need Framework' and speak to the safeguarding lead. If a need to inform the local authority had arisen then they would follow the appropriate actions within their policy and procedures.

16.4.2 Although CDDFT had no reason to be concerned of any domestic abuse taking place (all of Grace's attendances were for unrelated medical reasons) their frontline practitioners are trained at Level 1 to 3 (depending on role) in safeguarding. The Trust also employs 'Domestic Abuse

Champions' and a hospital based IDVA to provide advice and guidance to practitioners if they had concerns about possible domestic abuse.

16.4.3 Harbour are a specialist domestic abuse support service. The DHR process has verified that the staff who spoke to Grace had completed their mandatory safeguarding training and knew what action to take if they had concerns for the safety of a client.

Harbour did not have any contact with the ex-partner.

16.4.4 The GP had no reason to believe Grace was experiencing domestic abuse. During their (telephone) appointment in January 2021 relating to Grace's low mood, Grace disclosed the reason behind her low mood was due to Covid-19 isolation from her friends.

16.4.4 The DHR panel observed that although there were no apparent indicators of domestic abuse, neither was there any specific evidence of 'routine enquiry'[5] taking place i.e. staff being proactive in asking about any domestic abuse in all cases. The DHR panel felt this to be important, when considering the high number of young people that are known to be experiencing domestic abuse or controlling behaviour.

16.5 Did the agency have policies and procedures in place relating to domestic abuse? Were these complied with in relation to identification of abuse, taking positive action, safeguarding and signposting / referrals?

16.5.1 Harbour are a dedicated domestic abuse service. Their policy on safeguarding and domestic abuse forms the core of their business. The DHR panel has confirmed all policies were up to date and complied with in this case.

16.5.2 Tees Valley YMCA has a safeguarding adults and children policy and procedure. There were no disclosures of domestic abuse nor any information which suggested domestic abuse was taking place.

16.5.3 The GP practice does not have a policy relating specifically to domestic abuse. The safeguarding adults policy refers throughout to 'abuse' but does not specifically include domestic abuse as a category.

16.5.4 CDDFT has a domestic abuse policy readily accessible for all staff. The Trust has recently developed a flow chart that will be included in the new

[5] Routine enquiry is a term used to describe asking all service users in a healthcare environment about their experience of domestic and sexual violence. No signs of abuse or suspicions of abuse are needed as routine enquiry involves asking everyone. Source – House of Commons Library 'The role of healthcare services in addressing domestic abuse' (briefing paper May 2021).

(revised) version of the policy to provide an easy reference to front line practitioners.

16.6 Were risk assessments carried out? Were they effective and robust? Was the identified level of risk appropriate to the presenting circumstances? Did the agency use a recognised domestic abuse risk assessment tool? Were risk assessments reviewed and updated in response to changing circumstances or information?

16.6.1 During the consultation with the GP in January 2021 there was no formal risk assessment carried out. However the GP notes identify that Grace had no suicidal ideation. This demonstrated that the risk of self-harm was considered albeit not through the use of a formal risk assessment.

16.6.2 As there were no disclosures from Grace nor any suspicion that she may be experiencing domestic abuse, then no risk assessments were conducted by the YMCA or by CDDFT.

16.6.3 Harbour Domestic Abuse Services records indicate they received an initial contact from Grace through their 'live chat' facility on 1st July 2021 (Grace's mum states it was she who actually made the call and was open about this with Harbour).

A call back was arranged for 5th July. On that date, the Harbour support worker spoke to Grace for over half an hour. During that time the support worker completed the nationally recognised 'DASH' (Domestic Abuse Stalking & Harassment) risk assessment. This is a series of questions designed to establish the level of risk involved in that particular case. There are twenty seven questions in total. Each positive answer to a question is added which creates a 'score'. A high risk case is a score of 14 or above. A medium risk is 10-13. A standard risk incident is a score of 1-9. Grace's score on the DASH model was 3. She answered 'no' to twenty four of the twenty seven questions. These included questions on whether Grace was frightened, whether she felt isolated from family and friends, if the abuse was happening more often and if the abuse was getting worse. She answered 'yes' to three of the twenty seven questions. These were:

a) *'Are you feeling depressed or having suicidal thoughts?'*

   Grace stated she had depressive thoughts in the past and never got any support around this.

b) *'Does Ryan try to control everything you do or is he excessively jealous?'*

Grace said her partner is 'slightly jealous'. She said he worried that she would get with someone else when she is out without him and that he can be quite nasty to her over these thoughts.

c) *' Has Ryan had problems in the past year with drugs, alcohol or mental health?'*

Grace said her partner suffered with a ketamine addiction in the past but had support around this and was no longer a user. She stated that when he used ketamine his abuse towards her was worse and he would be verbally abusive.

The 'score' on this domestic abuse risk assessment clearly showed this to be a standard risk case. However, the DASH format also encourages staff to use 'professional judgement'. The support worker (whose full time role is to support victims of domestic abuse) made notes that she believed Grace was minimising the abuse and that 'Grace did not believe that what she was suffering was emotional abuse'. She went on to tell the support worker that her mother 'made' her refer to Harbour as her mum believed she was being emotionally abused. Grace also said that her partner calls her a 'slag' and a 'slut' during arguments and that he starts these arguments, but it is not 'abusive'. The support worker tried to explain that this verbal abuse is not normal and would be classed as domestic violence.

Grace said she was willing to engage with Harbour services and take part in the 'Inspire' programme to increase her knowledge of domestic abuse.

The support worker noted Grace's responses to the questions on the DASH risk assessment and applied their professional judgement but the case remained assessed as 'standard' risk.

The DHR panel have reviewed this grading. The 'standard' risk assessment was appropriate i.e. 'The current evidence does not indicate likelihood of serious harm'.[6]

16.7 How effective was information sharing in this case? Did professionals have confidence to discuss concerns with multi-agency colleagues?

16.7.1 No agency considered multi-agency information sharing relating to domestic abuse was required in this case.

16.7.2 The GP made appropriate referrals or ensured signposting to other health services based on Grace's disclosure of 'low mood.'

[6] Source: Safe Lives Guidance 2014

16.7.3 There were no disclosures made to YMCA staff and so there was no information to share.

16.7.4 The only agency which conducted a domestic abuse risk assessment was Harbour. They concluded this was a standard risk case. Local protocols are for high risk cases (a very small proportion of all domestic abuse incidents) to be shared between relevant agencies in order to agree a safety plan to protect the victim. There was no requirement, nor indeed any processes in place to share the details of a standard risk case with other organisations. To do so could be a breach of UK General Data Protection Regulations (i.e. the proportionality and necessity of sharing personal sensitive information). Even if information had been shared, there was no further information held by Durham Police, the Probation Service, registered social landlords or health services that would have altered the assessed level of risk.

16.8 What were the key points or opportunities for assessment and decision making? Do assessments and decisions appear to have been reached in an informed and professional way?

16.8.1 The Harbour waiting list for attendance on their group based 'Inspire' sessions was fully booked and had a significant backlog for places. However, Grace did not receive any further contact from Harbour in the eight months up to her death. There are only limited resources available but this could be regarded as a missed opportunity to maintain contact (even if it was a simple monthly text or call to say that she was still allocated a place on the waiting list). This was especially important as Grace was reluctant to engage (indeed it was not Grace but her mother who had initiated the contact with Harbour).

16.8.2 The domestic abuse risk assessment conducted in July 2021 was correct. Actions were in line with agency policies.

16.8.3 The GP Aligned Mental Health Service made four telephone calls and wrote two letters to Grace to check if she wished to engage with their service. Grace did not respond to the calls or letters.

16.9 How did the use of social media affect this case?

16.9.1 In common with many young people, this young couple spent many hours each day and night accessing various forms of social media. The scale of messaging between them was enormous (thousands of messages). However, a young person's representative (from Harbour Support Services) was invited on to the DHR panel. They advised that such numbers and frequency are not uncommon, indeed they are in line with the expected

level of contact between an intimate couple in that age group. The issue to consider is how a young person can view what a healthy relationship 'looks like' from their perception of society. This is reinforced by the young person's exposure to social media and how relationships they see 'on line' can be viewed as the 'norm' when this is not the case. Even if Grace saw her relationship with Ryan as normal, the view of the Harbour professional is that this is not what a healthy relationship looks like.

16.9.2 The issue of social media meant that the victim and her partner were in almost constant contact. The ex-partner used access to devices and various social media platforms to exercise control over Grace. He sent insulting or degrading messages, he checked where she was or who she was with. This meant that Grace had no respite, as even when she blocked him, he found another means to contact her. This may have made Grace feel trapped.

Ryan also sent messages to Grace's friends. Several examples of these messages are contained in section 17 of this report.

16.10 Did the Covid-19 restrictions in 2020 and 2021 have any direct impact on the victim?

16.10.1 The GP (telephone) appointment in January 2021 was due to low mood. The comments and the timing suggest a lot of this was due to isolation because of the Covid-19 lockdown restrictions. Conversely, as they were in the same Covid 'bubble', Grace was spending a lot of time alone with Ryan.

16.10.2 Due to loneliness, Grace's mum encouraged her to attend the YMCA sessions. Initially these were online but very soon after her first session the meetings became face to face group sessions and staff recorded Grace was enjoying the interactions.

16.10.3 The Covid-19 restrictions meant that there was a long waiting list for the Inspire Programme (Harbour group support sessions).

16.11 What information was known about the victim's ex-partner? Was he subject to MAPPA, MATAC or any other perpetrator intervention programme? Were there any injunctions or protection orders in place?

MAPPA is the Multi-Agency Public Protection Arrangements. These are statutory processes to manage sexual and violent offenders. The 'Responsible Authorities' (police, Probation Service and HM Prison Service)

all have statutory responsibilities to protect the public under national MAPPA guidelines).

MATAC is Multi-Agency Tasking and Coordination. It is a scheme currently being rolled out in many areas across the UK to specifically manage serial and repeat perpetrators of domestic abuse.

16.11.1 The victim's ex-partner is the same age (several months younger) than Grace.

16.11.2 Ryan has no previous convictions, nor has he ever been charged with any criminal offences. He has been arrested twice for 'football crowd' related disorder but was not charged.

16.11.3 His contact with mental health services and his use of controlled drugs are documented elsewhere in this report.

16.11.4 Ryan has never been recorded at any incident of domestic violence or abuse reported to the police. This applies to both his relationship with Grace and also to any relationships with previous intimate partners. He has never been listed at any multi-agency discussion forum related to domestic abuse and has never been subject to a restraining order or a non-molestation order. He is not known within the MAPPA or MATAC systems.

16.11.5 The Independent Chair of the DHR wrote to Ryan at the start of the Domestic Homicide Review process inviting him to take part. He did not respond to the letter.

16.12 Were mental health services accessed by the victim or ex-partner in this case?

16.12.1 The victim's contact with her GP in January 2021 for low mood resulted in signposting to 'Talking Therapies' and a direct referral to the GP Aligned Mental Health Service. Grace did not contact 'Talking Therapies'. The Aligned Mental Health Service rang her four times and wrote two letters. She did not respond and her case was then closed.

16.12.2 Grace also contacted the 'SHOUT' mental health charity in April and May 2020. These contacts were via text message. The messages were not recognised by SHOUT staff as linked to domestic abuse (this forms part of the learning for this review).

16.12.3 Ryan had a telephone appointment with his GP in July 2020. He reported concerns regarding his use of ketamine and the effects on his mental health. He wanted to stop using the drug (of note, it appears from messages between the two that Grace had encouraged Ryan to seek help).

The GP signposted him to ‘Talking Changes’ and NECA (North East Council on Addictions). He did not make contact with either agency.

16.12.4 Ryan made a direct self-referral to Tees, Esk & Wear Valleys NHS Trust (TEWV) in August 2020. During their telephone assessment, they discussed his triggers, thought processes, physical feelings and emotions. The identified issue was his substance misuse.

As part of the assessment he was asked about his social situation, motivation to change, harm to others, safeguarding considerations and protective factors. He reported that he was encouraged to seek help from his family, friends and his girlfriend. During assessment, safeguarding was explored to which he reported he had never been in an abusive relationship.

At the conclusion of the assessment he was signposted to ‘Humankind’ for support with his substance misuse (this is a charity who provide support to meet people’s complex health and social needs). As part of the DHR process, checks were made with Humankind. They confirmed Ryan did not make contact with them.

16.13 Was alcohol or substance misuse a factor in this case?

16.13.1 Ryan is described by friends as an ‘habitual’ drug user. Grace did use drugs occasionally. One friend has stated that they believe Ryan used his drug taking lifestyle as a way of putting distance between her and Grace (see full details at paragraph 16.14).

16.13.2 Several of Grace’s friends have disclosed that they knew Ryan was a regular user of ketamine. The friends also saw Grace taking drugs on two occasions:

- In April 2021, Grace was on a social day out with four friends in York. One of her friends described in detail how Grace and another friend went to the toilet in a well-known pub chain. They were gone for a long time. Even though they had all been drinking alcohol, the friend states that Grace’s behaviour had changed. She could barely walk. Grace fell down a set of stairs at the train station (a group of police officers came over to see if Grace was okay). On the train, her friend could see Grace’s eyes were rolling back into her head. Her friend took her back to her house and explained to her own parents that Grace had taken drugs. She commented ‘Grace didn’t seem to know where she was’. Of note, Ryan was not present during that day out and did not travel to York. It was a ‘girls only’ day. However, Ryan did text Grace’s friend the following day. He said, “Thanks for

letting Grace stay with you last night and looking after her". The friend believes this was subtle messaging to remind her that Grace was now part of his drug taking lifestyle.

- In August 2021 at Leeds Music Festival. Friends have given accounts that Ryan bought ketamine at the event. He apparently declared that he 'would rather get it for her as its safer'. Another friend stated that Ryan 'sorted her a bag of ketamine' and confirms Grace took the drug during one of the music acts. This friend is clear that in their opinion 'Ryan didn't force the drug on Grace', just that he obtained it for her. They only know of this one instance at the festival where Grace took a controlled drug.

16.13.3 The DHR panel has viewed messages that show Ryan's use of controlled drugs was a source that increased tension within the relationship and also increased his level of abusive and insulting messages towards his partner, Grace.

16.13.4 When Ryan sought help with his mental health issues (see paragraph 16.12) he cited his addiction to drugs as a reason for his mental health problems. He confirmed he had never had any treatment in relation to his addiction.

16.13.5 There is also evidence within messages between Ryan and Grace that Grace researched drug addiction advice sites online. It appears that Grace was actively trying to get help and information for Ryan to stop his drug addiction.

16.14 Were family, friends or colleagues aware of any abusive behaviour towards the victim prior to her death? If so, how was this information communicated? Were there any barriers to communication?

16.14.1 As part of the DHR process, the Independent Chair reviewed various documents. These included statements made to the police and email exchanges between Grace's mum and Grace's friends and colleagues.

The Chair viewed twelve documents with information from nine different friends of Grace. They describe a variety of events or incidents that they witnessed or heard about regarding the relationship between Grace and Ryan. The events are predominantly friend's observations of social nights out or of day trips to other cities when they were drinking or to events such as music festivals. Some examples are given here:

16.14.2 Accounts from friends:

Friend A

Friend A noted an incident when Grace described Ryan driving his car way too fast and on the wrong side of the road. When Grace told him to slow down, apparently Ryan just laughed at her. The friend herself did not witness the driving.

Friend B

Friend B described how Grace had told her that at some point in their relationship Ryan had told her to kill herself. This comment (which another friend also described; though her knowledge of the remark was given 4th hand – by 'friends of friends') was allegedly made during the 'first lockdown' (so probably spring or early summer of 2020). Although her friend said Grace did not seem fazed by the comment, Friend B told Grace that it was a disgusting thing to say and told her to ignore him and not speak to him again.

Friend B also outlined an incident in Leeds during a social night out. This account is verified by several other friends who were all present on the night out. They confirm it was on 5th February 2022. There were a mixed group of young men and women (aged 19-21 years). There was some trouble in a queue while waiting to get into a nightclub. The girls were allowed by the doormen to go to the front of the queue and so were temporarily separated from the men. Ryan did not like this and apparently 'blocked' Grace on his phone so she couldn't get in touch with him (several friends state Grace told them this was a common occurrence; that Ryan would go 'missing' on nights out, knowing this would upset Grace as she would be worried for his safety).

Friend C

Friend C gave a similar recollection of the night out in Leeds in February 2022. Friend C was also present at a social evening on 5th March 2022. She saw Grace kissing a young man she worked with. Friend C is aware that they subsequently spent the night together in a hotel. This kiss was seen by some of Ryan's friends who apparently reported this to him. Grace told Friend C that Ryan was angry. The following day, Grace showed Friend C screenshots of messages from Ryan. These were extremely insulting and graphic remarks.

Friend C also recorded a conversation with Ryan in March 2022. This was after the relationship with Grace had ended but he had rang Friend C to express his annoyance at Grace spending the night with her new boyfriend. The Independent DHR Chair has listened to this voice recording. Although Ryan's tone is calm and his voice is not raised, the conversation could still be interpreted as a form of control. He is sharing Grace's intimate details with one of her friends and making remarks about the new liaison.

Friend D

Friend D also confirmed the events in Leeds on 5th February 2022. Friend D adds that Grace ended the relationship with Ryan the following day. Friend D is certain it was Grace that ended the relationship and that Grace knew it was the right thing to do.

Friend D is also aware that after the incident on a night out (described by Friend C) in March 2022, Grace 'blocked' Ryan from all social media messaging except text messages.

Friend E

Friend E described an incident that happened during a night out in Darlington in March 2022. Ryan had apparently seen Grace dancing with a male friend who is gay. The next day, Friend E recalled that Grace told her Ryan had shouted at her when he saw her dancing with the other man. Grace said to Friend E that she told Ryan they were no longer together and she can dance with who she wants. Friend E's observations from her conversation with Grace (both from Ryan shouting and also the nasty messages) were that Grace was laughing and joking about the situation. Friend E states that Grace did not appear upset or distressed by the messages.

Friend F

Friend F did not like Ryan and she made no secret of this. She recalled Ryan sent her videos of him 'doing lines' of drugs in his bedroom. Friend F states Ryan knew she did not agree with taking drugs and she believes this was a way of Ryan putting 'distance' between her and Grace.

Friend F described an incident early on in Ryan's and Grace's relationship when Friend F had invited Grace to a night out for Friend F's birthday. Grace had not gone on the night out but did 'message' Friend F to wish her a happy birthday. Friend F was annoyed when Ryan came on the line, interrupting Grace and Friend F's conversation when he said, "We'll do some bags for you tomorrow". Friend F is sure that again this meant taking illegal drugs. Ryan sent a similar message at a later date referencing drug use and using vulgar terminology.

Friend F also described that when Grace learned that Ryan had been unfaithful, she wanted to tell Grace to end the relationship but she knew that would be hard 'because she loved him' and that it was a serious relationship.

Friend F states that even on a 'girls night out', Ryan would turn up at the same venue at the end of the evening. Grace would leave to go back to Ryan's house.

16.14.3 With many different accounts from friends and colleagues, it is clear that all thought this to be an unhealthy relationship. They thought Ryan disrespectful and that Grace could do much better.

16.14.4 None of Grace's friends are aware of any incident of physical abuse or the threat of physical abuse from Ryan towards Grace (indeed when reviewing hundreds of messages between Grace and Ryan there is never any suggestion of the threat of physical violence towards her). Grace did confide in many friends and described nasty text messages or 'Snapchat' messages. She gave her friends details of the messages and showed them screenshots. She never disclosed to any friend any physical violence.

16.14.5 This was a difficult topic for friends and colleagues to navigate. They knew Ryan's behaviour was wrong. They knew it was abusive and insulting. Some recognised it as controlling. One friend said, "when someone really likes somebody there is not much you can say that will change their minds". Several friends advised Grace to end the relationship and they were happy when she found the strength to do so.

16.14.6 Grace lived at home with her parents. They were a close family and spent time together every day. When Grace's parents met with the Independent DHR Chair, it was apparent that her father was not aware of any particular issue relating to an abusive relationship prior to Grace's death. However, Grace's mother had a number of concerns. Since her daughter's death, she had outlined these to the police and at the Coroner's inquest. Grace's mum then shared her thoughts with the Independent DHR Chair.

16.14.7 Her mum stated that Grace was in a relationship with Ryan for just over two years from January 2020 to February 2022. She said, "Over the two years, Grace would often return home from seeing Ryan, very distressed and unhappy." She confirmed the friend's accounts that Grace had told her about Ryan driving his car way too fast and that when she told him to stop he just laughed and carried on the same manner of driving. She reported this made Grace feel unsafe and frightened. Her mum believes this was exacerbated by the fact that a friend of Grace had been seriously injured in a road traffic collision involving excessive speed.

16.14.8 Grace's mum also has the same recollection as Grace's friends regarding Ryan constantly 'blocking' her on social media. Her mum believes this was a source of control.

16.14.9 Following the first Covid-19 'lockdown', Grace's mum was concerned about her daughter's low mood. She is aware Grace spoke to her GP about this. In January 2021 her mum also arranged for Grace to become involved with the YMCA so she could make new friends. A few months later, Grace's mum rang the YMCA without Grace's knowledge and requested they deliver a group session on 'healthy relationships'. This was subsequently delivered by staff at the YMCA.

16.14.10 Grace's mum still had concerns about the nature of Grace's relationship with Ryan. In June 2021 she contacted 'Harbour' (a specialist domestic abuse support service). Her mum states that Grace was not keen to engage with Harbour, but her mum contacted them anyway and arranged for a Harbour support worker to ring Grace. This took place on 5th July 2021 while mum and daughter were away for the weekend shopping in Manchester. Her mum recalls Grace answered the call and spoke with the Harbour support worker for over half an hour. Her mum stated, "After the telephone call, Grace made it apparent to me she would not be engaging further with Harbour. I was upset by Grace's choice as I remained concerned about the nature of her relationship with Ryan." Grace's mum made further contact with Harbour later that same month and subsequently attended two Harbour group sessions herself. She says, "I was looking for any suggestions that they could make for me to gently support Grace going forward."

Grace's mum consented to sharing some of her own history to add some context around her concerns:

> *"I was in an abusive relationship for several years until I ended that relationship. At that time I did not seek any professional advice or support. However, years later, as part of my job, it came to my knowledge that the local domestic abuse charity Harbour offered the Freedom Programme for people who experience domestic abuse. I felt this could be helpful in order to come to terms with what I had experienced. Although by then, the abuse was 15 years earlier, Harbour told me that anyone can attend their Freedom Programme regardless of when the domestic abuse had occurred. I therefore attended the Harbour Freedom Programme around 2006. One of the aims of the programme is to recognise abusive and controlling behaviour. I firmly believe that, as a result of attending the Freedom Programme, I could see the coercive and controlling nature of the relationship that Grace was in. This knowledge of Harbour and their Freedom programme is why I wanted Harbour to provide support to Grace."*

16.14.11 At the end of February 2022, Grace's parents went away to Edinburgh where they stayed for two nights. When they returned home, Grace told them Ryan had been round and they had agreed to hand each other's 'stuff' back as the relationship had ended. The parents were not aware that Ryan had stayed the night at their house while they were away. He and Grace had been intimate (Grace later told her friends she had 'messed up'). Her mum was not aware that Ryan had stayed the night until after Grace's death.

16.14.12 In late February and early March 2022, Grace's mum heard several amicable telephone calls between Grace and Ryan. When her mother

asked if the relationship was back on, Grace replied that it wasn't but that Ryan was finding the break-up difficult.

16.14.13 The last call Grace's mum heard was on 2nd or 3rd March. She states that Grace's voice was raised and assertive. Grace told her mum "He won't be ringing me again, he's got the message now".

16.14.14 On Saturday 5th March, Grace went on a night out with friends from work. She did not return home until the Sunday morning. Grace's mum described that Grace went into work on the Sunday. It was her day off but she wanted to get some coursework completed. Her mother gave her a lift because she had a lot of books and a lap top computer to carry. Her mum picked her up from work that evening. Grace was upset as she had received a lot of abusive messages from Ryan. Grace said he had called her 'fat' and a 'whale'. Her mum reports that Grace was very self-conscious of her weight. Ryan had also called Grace 'desperate' and a 'slapper'. Grace told her mum she had now 'blocked' Ryan on all social media. This included 'Snap Chat'. However she did still receive text messages from him.

16.14.15 The following day, Monday 7th March, Grace again went in to work on her day off. She was trying to keep on top of her course work for her studies. Her mum walked with her that morning as she was worried for her welfare. Later that afternoon, Grace sent a message to her mum that she did not need help carrying her bags home as the young man she had kissed on the night out that weekend would be walking her home. Grace arrived home about 7.00pm and both parents describe she was in good spirits; even dancing in the garden while she was looking for her keys to get in the house.

16.14.16 The family sat down for dinner almost straight away. Grace's mum states that "Grace began receiving lots of messages. Upon picking her phone up to look at the messages, her face immediately fell. " Grace's mum believes these messages were from Ryan. (Note: this is unlikely. See section 18).

16.14.17 Grace and her mum were very close. She was also close to her father who helped her with her course work and studies. The two of them would regularly go for a walk on an evening to clear their heads. But there was a special bond between mum and daughter. They spent a lot of time together and her mother clearly had significant concerns about the nature of Grace's relationship with Ryan. She tried to support her by offering advice and by seeking help from outside agencies.

16.15 Did the victim's employer have domestic abuse policies in place? Do staff have the knowledge on how to seek help if they are experiencing domestic abuse or they are concerned about a colleague suffering such abuse?

16.15.1 The Independent DHR Chair visited the victim's workplace during the course of the Domestic Homicide Review. He was able to view the organisation's policies and procedures.

16.15.2 The company has a comprehensive policy on mental well-being of staff. This is accessed via the internal I.T. systems. There are copies of sections of the policy prominently displayed in the private staff areas of the business. The policy contains a section with a link to domestic abuse. This includes advice on what to do if you are suffering domestic abuse or if you believe a colleague is experiencing domestic abuse (including links to 'how to get help').

16.15.3 All employees at the company are required to complete an 'I-Learning' package as part of their induction process. The I-Learning includes modules on safeguarding and domestic abuse. The content explains different types of abuse, signs to look out for (with several examples) and a section with the title 'Get help if you think you might be an abuser'. The National Domestic Abuse Helpline number is also provided.

16.16 Did any restructuring during the period under review have any impact on the quality of service delivered?

16.16.1 There was no restructuring within any of the agencies that had contact with the victim or her ex-partner during the timeframe of this review.

16.17 Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim and ex-partner? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

16.17.1 No issues were identified in relation to ethnicity, language, or religious identity of the victim or her ex-partner. Both were white British, born in the UK.

16.17.2 Grace attended many sessions with Tees Valley YMCA. They note that their youth workers at YMCA are sensitive to all areas of a young person's identity. Staff encourage open discussions, as well as providing private space if needed. They report that Grace did not express the need for 1:1 support and was very happy to discuss all topics in the group sessions.

Section 17: Summary of Messages

17.1 As already stated earlier in this report, there was very little contact between Grace or her ex-partner and statutory/voluntary agencies. Therefore it was vitally important to consider other sources of information that would help the DHR panel to understand Grace's life over the two years of her relationship with Ryan.

17.2 There were thousands of messages contained on Grace and Ryan's mobile telephones. Many of these are affectionate. The police used 'keyword' searches during their investigation to triage the messages as the volume was so high. Further key word search requests followed by the family solicitors and by the Independent Chair for the DHR. These were shared with HM Coroner as part of the inquest into Grace's death.

17.3 The DHR panel developed a table of private messages between Grace and Ryan, Grace and her mum and Grace relating to her employer. These remain private and are contained within a confidential appendix, not available for public reading.

17.4 The content of the messages reflect Grace's life and pressures. They include:

- Many references to Ryan's jealousy.
- Ryan being abusive, insulting and using degrading terminology towards Grace. Followed by apologies and telling her that he loves her.
- Grace mentioning her anxiety, low self-esteem and her struggles with her mental health.
- Grace telling Ryan his behaviour is manipulative and controlling.
- Messages between Grace and her parents indicating she felt under significant pressure with her work, studies and course work.
- Several references from Ryan that he is thinking about killing himself (with responses from Grace begging him 'not to do anything stupid').
- Messages from Grace (note to self) expressing her frustrations and disappointment at her perceived lack of support from her employer and that she is struggling with her course work.

- Confirmation from Grace (note to self) that she wants to reduce her contracted employment hours to 4 days per week as she is not getting a day off.

- A message from Grace to Ryan that she had previously took an overdose of paracetamol as she ‘thought I had lost you’.

- Grace expressing to Ryan she is ‘mentally drained’.

- References from Grace to Ryan that she was stressed and that the deadline of her exams looming was ‘overwhelming’.

- Confirmation from Grace to Ryan that she has ‘blocked’ him on all social media as she has never been spoken to in such a degrading way.

Section 18: Timeline of events from Grace arriving home on the evening of the tragedy.

18.1 Grace's parents expressed concerns to the DHR Chair that when Grace came home on the evening of the tragedy she was happy, but that something changed. Her mum described how Grace's 'face immediately fell' during dinner. It is important to consider the events that evening in some detail:

18.2 That day was a Monday and was Grace's day off. However she went into work to do some coursework for college and prepare for examinations. There had been some incidents over the weekend. Grace had received abusive messages from Ryan following a night out when she had spent the night with her new boyfriend. Grace's mum was worried about her and so 'walked' her in to work and helped carry her books.

18.3 At 2.53pm that afternoon, Grace sent a message to her mum that her new partner (a colleague) would walk home with her (the new partner has confirmed this account and that they walked a long route, walking slowly and chatting).

18.4 Grace arrived home at about 7.00pm. She was laughing and smiling. Her parents describe her dancing in the back garden while waiting for the back door to be unlocked. The timing should be accurate as Grace's mum had sent her a text asking if she was coming home for tea. Grace replied at 6.48pm that she would be home in five minutes. Once Grace came in to the house, they sat down almost immediately for dinner. Grace's mum observed, "She began receiving lots of messages. Upon picking her phone up to receive the messages, her face immediately fell."

18.5 Grace's parents are worried that Ryan may have been sending her abusive messages and that this affected her mood. This is highly unlikely. We know that Grace had blocked Ryan from all social media messaging except text messages. This is confirmed by her own account to her mum and to her friends.

18.6 The last text message from Ryan was at 8.30am that Monday morning, not on the evening. There are a number of 'Snapchat' messages to Grace's telephone starting at 7.00pm (just as the family were sitting down to dinner). These messages were not from Ryan but were from her new boyfriend who had just walked her home. The first message is from Grace to the new boyfriend at 7.00pm. She sent two more messages to him at 7.01pm and 7.03pm. He replied at 7.06pm. The flow of messages continued for the next half an hour with a total of 26 messages in the two-way conversation. The DHR Independent Chair has viewed the content of these messages and confirms there is nothing in them that is threatening, abusive or even controversial. It is an online conversation between two young people that can best be described as expressing their feelings and

tentatively seeing how the other felt about the relationship. It includes confirmation that Grace was intending to go away to university. The last message between the two was at 7.32pm.

18.7 After dinner, Grace went upstairs to her room. Her mother states this was at about 7.30pm. Around twenty minutes later Grace shouted down to her parents to let them know she was going to have a shower. Between 8.00pm and 8.45pm her mum could hear loud music being played and the shower was being used. Her parents state this was her usual behaviour to play music while showering and drying her hair.

18.8 At 7.44pm, Grace altered or deleted a ‘file’ in her mobile phone. The contents are no longer retrievable but the title includes her ex-partner’s first name. This was not an exchange of messages but was a repository for items (most likely previous messages or mementoes).

18.9 Also at this time, Grace was exchanging messages with one of her best friends. The friend cannot be certain on the exact time but she believes the online chat took place between 8.00pm and 9.10pm. The two friends had known each other most of their lives. Grace sent her friend some photos as it was the friend’s birthday. They said how proud they were of each other and that they hadn’t gone the typical route going to university but had found really good careers. They chatted about work and Grace said the exams were hard but the friend told her how it would all be worth it in the end. The friend finished by saying she was always there if Grace needed anything and that she missed her and loved her.

18.10 Between 8.41pm and 8.50pm, Grace conducted a web search on her mobile telephone ‘How many paracetamol would cause a fatal overdose?’

18.11 Grace’s father found her hanging in her room at 9.15pm.

Section 19: Conclusion and Lessons Learned

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19.11 Grace did not seek help from any agency relating to domestic abuse. Her mother contacted both Tees Valley YMCA and Harbour Support Services without Grace's knowledge (the former as she was concerned about Grace's isolation from friends, the latter as she was worried that the relationship with Ryan was abusive). Grace did agree to attend the YMCA

and subsequently enjoyed their group sessions. She did agree to speak on the telephone with Harbour but made it clear to her mum she wasn't happy about this.

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

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

19.14 This was a tragic taking of a young life. Grace's demeanour on the night of the incident is described as 'happy'. Yet within two hours of returning home she had researched how many paracetamol it would take for a fatal dose. She then hanged herself in her bedroom.

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

Recommendations

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

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

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

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

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

6. The Community Safety Partnership receives reassurances from health agencies operating in and around Darlington that ‘routine enquiry’ (still at a pilot stage in many localities) is being considered within those agencies’ domestic abuse policies and procedures.

7. All services, agencies and partners in Darlington to commit to reducing the number of lives lost to suicide, through engagement with the local implementation of the cross-government suicide prevention strategy which

seeks to achieve a reduction in suicides in England over the next five years.

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

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

10. The Community Safety Partnership considers ways to highlight the ‘Find a way’ project (wefindaway.org.uk). This scheme in the North East of England gives advice and information to third parties who may be concerned about a loved one or friend.

References

Multi-agency statutory guidance for the conduct of domestic homicide reviews (Home office 2016)

Domestic Homicide Reviews 'Key findings from analysis of domestic homicide reviews' (Home Office 2016)

'The Social Worker's Guide to The Care Act 2014.' (Pete Feldon 2017)

'A Practical Guide to the Mental Capacity Act 2005.' (Matthew Graham and Jakki Cowley 2015).

PEEL Inspections into domestic abuse (HMICFRS November 2017)

Vulnerability, Knowledge and Practice programme (Home Office, National Police Chief's Council, College of Policing 2020-2021)

Untangling the concept of coercive control (Sylvia Walby & Jude Towers 2018)

Crown Prosecution Service policy on domestic abuse cases and the VAWG strategy (2017)

Office for National Statistics (2021)

Learning Legacies: An Analysis of Domestic Homicide Reviews in Cases of Domestic Abuse Suicide – Sarah Dangar

House of Commons Library 'The role of healthcare services in addressing domestic abuse' (briefing paper May 2021)

Safe Lives Guidance 2014

wefindaway.org.uk