Wiltshire Domestic Review

EXECUTIVE SUMMARYOF THE OVERVIEW REPORT

Into the death of Adult P

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1 Introduction

1 This Review examines agency responses and support given to the deceased Adult P in Wiltshire and their contacts with Adult P's partner Adult Q, prior to Adult P's death

1.1 The circumstances of Adult P's death are:

1.1.1 Adult P, aged 20 at the time of her death, had been in a relationship with Adult Q, who was 27 years of age, for approximately four years. At the time of her death they were living together in a tent in the garden of Adult P's family home.

1.1.2 Adult P was reported missing by her brother at 9.25pm on 29th September 2015. She had last been seen by Adult Q outside his mother's home during the evening of the 28th September 2015. They had earlier been arguing in the Town Centre and she had told him she would wait for him outside his mother's house whilst he had a shower. When he came out about twenty minutes later at approximately 7.10pm, she was gone but he found an earring, a necklace and his tobacco on a wall with the words "I love you forever" written on the wall. Concern grew as she was not contactable on her mobile and she had not returned home as she normally would.

1.1.3 On 1st October 2015 Wiltshire Police teams commenced a search and at 13.06 she was found hanging from a tree close to a small bridge not far from Adult Q's mother's home.

1.1.4 A Coroner's Inquest concluded that Adult P had taken her own life and the cause of death was hanging. There were no criminal proceedings initiated in relation to Adult P's death.

1.2 On 1st December 2015 Wiltshire Community Safety Partnership considered the circumstances of Adult P's death i.e. that she was believed to have taken her own life but had previously been known to have been a victim of domestic abuse from Adult Q and had been referred to the Wiltshire Multi Agency Risk Assessment (MARAC). The Wiltshire Community Safety Partnership Chair took the decision to undertake a Domestic Homicide Review and on 1st December 2015 the Home Office was informed.

2 The Review Process

2.1 This summary outlines the process undertaken by the Wiltshire Domestic Homicide Review Panel in reviewing the death of Adult P.

2.2 On 1st December 2015 a decision to undertake a Domestic Homicide Review was taken by the Wiltshire Community Safety Partnership and the Home Office notified of this decision.

2.3 The process began on 21st January 2016 with an initial meeting of agencies that potentially had contact with Adult P and Adult Q prior to her death. The Review concluded on 27th May 2015.

2.4 Adult P's father, mother and Adult Q were contacted at the commencement of the Review. Adult Q signed a consent form for the Review to access his medical records and both he and Adult P's mother stated they wanted no further involvement with the Review. Adult P's father chose the pseudonym for his daughter and signed the consent form for the Review to access her medical records. He asked to be kept informed of the progress of the Review but said he did not want any other engagement. At the conclusion of the Review Adult P's father did not respond to invitations to read or discuss the Review Reports. Adult P's mother was told the outcomes of the Review but declined the offer to read the Reports.

2.5 The agencies participating in this Domestic Homicide Review are:

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)

Bristol Gloucester Swindon and Wiltshire Community Rehabilitation Company (BGSW CRC)

Child and Adolescent Mental Health Services (CAMHS)

Curo Housing

Great Western Hospital

Kingdown School

National Probation Service

Royal United Hospital (RUH)

South Western Ambulance Service NHS Trust

Splitz Support Service

Victim Support

Wiltshire Anti-Social Behaviour Risk Assessment Conference (ASBRAC)

Wiltshire Citizens Advice Bureau

Wiltshire Clinical Commissioning Group

Wiltshire Council Adult Services

Wiltshire Council Children's Social Care (CSC)

Wiltshire Council Early Help

Wiltshire Council Education Welfare Service

Wiltshire Council Revenue and Benefits

Wiltshire Domestic Abuse Conference Call (DACC)

Wiltshire Housing Options

Wiltshire Multi Agency Risk Assessment Conference (MARAC)

Wiltshire Police

Wiltshire Substance Misuse Service.

2.6 The agencies were asked to secure all relevant documentation and to give chronological accounts of their contacts with Adult P and Adult Q prior to her death. Where organisations had no involvement, or insignificant involvement, they informed the Review accordingly.

2.7 Of the twenty-four agencies contacted about this Review, six responded that they had no relevant contact with either Adult P or Adult Q. Eighteen organisations completed Independent Management Review (IMR) with information indicating some level of involvement.

3 The Facts

3.1 The following facts are representative of the numerous contacts that Adult P and Adult Q had with agencies.

3.1.1 Adult P and her two elder brothers were first known to Children's Social Care (outside Wiltshire) in September 1997. Medical records indicate a documented history of domestic abuse between Adult P's parents. Adult P's mother has confirmed the abuse and said that Adult P often witnessed the violence from an early age. In 1998 Adult P and her two brothers were placed in foster care as their parents were not able to look after them at that time. Her father later obtained a Residence Order that gave him parental rights in 1999.

3.1.2 From the age of eight, Adult P and her brothers lived mostly with her father and step-mother. The step-mother had four children of her own living with them. Adult P spent short periods during 2002 living with her mother, whilst her full siblings remained in their father's care. There were a number of recorded incidents of domestic abuse between Adult P's father and her step-mother and for a period in 2002, they separated, resulting in Adult P spent some time in foster care as her father was struggling as a single parent working full time.

3.1.3 During this period, Social Care received a number of notifications regarding the domestic violence between Adult P's father and stepmother and about concerns about neglect and physical abuse on Adult P. There was no record of a strategy discussion being held and the physical harm to Adult P was classified as chastisement by the social worker. The effect on Adult P of witnessing domestic abuse apparently was not considered.

3.1.4 On 3rd July 2003 Adult Q first came to the attention of the Youth Offending Team as a result of two offences involving the theft of alcohol. It was noted during a core profile assessment that there were indication of recent solvents and alcohol use. Adult Q claimed he had first used alcohol when he was 12 and solvents from the age of 13 years of age. His mother confirmed that Adult Q had refused family therapy and medication for attention deficit hyperactivity disorder (ADHD).

3.1.5 On 11th November 2005 Adult P's stepmother admitted to a social worker that she was struggling as a single parent as she and Adult P's father had separated a couple of years earlier but she was still caring for his three children as well as the children they have together. By March 2006 it appeared that Adult P's father had moved back with her step-mother, as the police attended an incident of domestic abuse between them in which Adult P's father was the perpetrator.

3.1.6 In August 2006 Adult P's step-mother gave birth to another baby of which Adult P's father was the father. There were several further incident of domestic abuse the worst being on 23rd August 2006 when he assaulted his partner with a shoe whilst she was holding their two week old baby. The baby was hit and was taken to hospital with a bump on his head. A child protection medical examination was undertaken and there were no signs of injury to the baby.

3.1.7 There were repeated incidents of Adult P's poor behaviour at school. In May 2007 she began a six-week course of social skills intervention to address her anger and emotional issues. By the start of 2009 she was reported to have an anger problem. Her parents did not attend meetings either arranged by the School or the Education Welfare Service (EWS). They were issued with penalty notices, which were not paid and they were then invited to a Court Assessment Interview which they did not attend. The case was referred for prosecution.

3.1.8 Adult P was no longer of statutory school age from the last Friday in June 2011 but continued to have support from her NEET worker. In November 2011 during a meeting with the NEET worker, she explains she needed either a job or an apprenticeship because she was living with her boyfriend, Adult Q, and needed money. Adult P was supported to register on an apprenticeship website and complete an application.

3.1.9 The first reported incident of domestic abuse between the couple was on 14th May 2012, Adult Q telephoned the Police, to report that he was having a dispute with Adult P and she was smashing the flat up and he wanted her removed. Officers attended and Adult P disclosed that Adult Q had pushed her to the floor and bitten her back. Adult Q was arrested for common assault. A domestic abuse report was completed with a DASH standard risk assessment. The Child Protection Referral Unit (CPRU), Social Services Department (SSD) and the Safeguarding Nurse were notified. Adult Q was released without charge having stated in interview, that he had been assaulted first and he denied assaulting Adult P. Adult P moved out of Adult Q's flat, contacted Wiltshire Housing explaining her situation and that she had been in local authority care when she was young. Options were explained to her and actions agreed but on 9th July 2012 her social worker stated he had no knowledge of her previously being in care. The referral was subsequently closed, with no further action being undertaken, although Adult P's NEET worker continued try to sort out Adult P's housing problems.

3.1.10 On 2nd August 2012 Adult P saw her GP and said that she had been in a controlling relationship but that it had ended. Adult P explained, she stabbed herself in April 2012 as a cry for help. The GP prescribed antidepressants and referred her to a counsellor and the mental health team. However, in the early hours of the following day Adult P was admitted to hospital after taking an overdose of the anti-depressants. A mental health assessment was carried out by the CAMHS team and Adult P described having drunk alcohol and taken MDMA and cannabis at a friend's house and had a verbal and physical fight with Adult Q, following which she impulsively took the tablets, partly as a result of being challenged to do so by Adult Q. Adult P did not describe this as a suicide attempt. She did however go on to disclose that she had taken an overdose of paracetamol in 2011 also following an argument with Adult Q, but that she did not seek help. She also reported stabbing herself in the leg three months previously and attended the Minor Injuries Unit. The assessment highlighted suicidal ideation and self-harming which Adult P related to her relationship with Adult Q and lack of a stable home.

3.1.11 Adult P and Adult Q continued their on-off relationship, with the police being called several times as a result of reports of domestic abuse involving them with each on occasions being considered to be the perpetrator. on most occasions they would refuse to make statements of complain against each other.

3.1.12 Throughout August and September 2012 Adult P received significant help from her NEET worker with housing, benefits and finding her way around other services. On 31st August 2012 Housing confirmed that they had referred Adult P to Social Services for a joint initial assessment but as she had temporarily stayed with her step-mother, she was no longer considered to be homeless. On 7th September 2012 Adult P reported to CAMHS she had received several missed calls and nasty texts from Adult Q. Adult P stated she was keeping the texts to show the police. Adult P advised by CAMHS not to have any further contact with Adult Q. She later told CAMHS that although she was aware the relationship would not go anywhere when she felt lonely she considered getting back with him. On 5th October 2012, Adult P told CAMHS that Adult Q was still constantly phoning her, calling her a “whore” and “thick”. She was advised to change phone and not to respond to any calls or texts. Adult P added that she had no contact from her social worker and felt let down by him as he stated he would help and she felt he had not done anything.

3.1.13 On 26th October 2012, Adult P reported to CAMHS that she had taken all of her benefits out of her account as Adult Q knew her bank details. She said she felt suicidal the previous night following contact with Adult Q. Three days later she disclosed to CAMHS that she had self-harmed by cutting her abdomen with scissors. Adult P reported that self-harming started when things started to go wrong with Adult Q.

3.1.14 On 29th November 2012 Adult P’s social worker contacted a Housing Options advisor and stated that he was aware Adult P had been ‘sofa surfing’ for a few weeks. He advised that assistance and support was being offered under Section 17 of the Children Act 1989 and that the three areas of need were being addressed through CAMHS, NEET and Housing. Housing informed the social worker that Children's Services were the lead agency for finding Adult P accommodation as she was in foster care and therefore, a “section 20 child”. The social worker said he could not find any reference in Adult P's case notes that she was in foster care and he would make further enquiries and ring back. (She had been in care at an early age in another local authority area.)

3.1.15 On 12th December 2012, a Child in Need meeting was held. Adult P, her Social Worker, Housing, NEET and CAMHS attended. Adult P was then living with her father and stepmother. In the absence of host families, private rented accommodation was explored. CAMHS did not believe that Adult P has a mental health condition and that her difficulties were due to social concerns and difficulties. CAMHS would support Adult P until she was 18 years old and refer to Adult Services if necessary. Two days later a foster carer confirmed that Adult P had been in her care from January 1998 to November 1998 and from December 1998 she had shared custody of Adult P for eight weeks followed by one weekend a month until Adult P was seven years of age.

3.1.16 On 18th December 2012, the Outreach Service for Children and Adolescents (OSCA) Clinical Team Manager contacted Adult P's social worker to share concerns about Adult P's situation. The social worker stated he believed her needs were mainly mental health due to overdose and housing issues and that his role was peripheral. Two days later the social worker was contacted again as Adult P was staying with a friend and had not received her benefit payment and they had no food and very little electricity. It was requested her social worker urgently address this as it was stressed that Adult P was at risk.

3.1.17 Over the Christmas and /New Year period the police were called twice to deal with assaults on Adult P by Adult Q. On 14th January 2013 Adult P told CAMHS that she was seeing Adult Q but that they were not back together. She added that she felt the relationship with Adult Q had been the cause of her low mood and stated that he was physically and emotionally abusive towards her and she knew she should not see him. Two weeks later she reported getting abusive texts from Adult Q's family via Facebook and on her phone.

3.1.18 On 25th January 2013 the police received several calls that Adult Q was assaulting Adult P outside Warminster Railway station. Despite Adult Q's bail conditions not to contact Adult P they had met to have a drink together. After an argument, Adult Q grabbed her by the hair and smashed her head into a fence. She fell to the floor where he kicked her in the side.

3.1.19 On 2nd March 2013 Adult P was drunk and disorderly on the communal landing of the block of flats where she was living. Adult P was arrested and headbutted the police officer and was found in possession of a small amount of cocaine. Consequently, she was issued with a first written warning and the next day she was given a verbal warning after complaints about the loud music coming from her property. This was followed on 6th March 2013 after further reports of noise nuisance, when another verbal warning was issued. On 7th March 2013 drug paraphernalia was found in her room and a verbal warning was given but after Adult P was arrested on 31st March 2013 for an assault on another resident, a second written warning was given, subsequently, following more damage a final warning was given that a Notice of Seeking Possession could be served. An Antisocial Behaviour Contract (ABC) was signed by Adult P on 22 May 2013 and a case conference took place.

3.1.20 On 10th June 2013, Adult Q attended a GP appointment. He said that he had been in prison for breach of bail conditions and he was prescribed antidepressants.

3.1.21 On 26th June 2013 Adult P was sentenced to 12 month community order, 12 months supervision and 60 hours of unpaid work for an assault on Adult Q. She was praised by her Offender Manager and key worker for completing 'Getting To Know You' programme. She set a personal goal to obtain employment and advised the Offender Manager she has got the restraining order in relation to Adult Q removed the previous week. She did not want to be reconciled with him however she did disclose she had made contact with him and wanted to stay in touch.

3.1.22 On 13th August 2013, Adult Q met with his Offender Manager as although the Court order to attend a Positive Relationships course had started 1st February he still had not started the course. Adult Q explained to his Offender Manager that he had had no contact with Adult P. Although this was later proven to be untrue as they were seen together no action was taken. On 22nd September 2013 Adult P reported to the police that Adult Q had breached his Restraining Order by contacting her. Officers spoke to Adult P, however she refused to make a statement or to answer any questions. A PPD1 was completed and assessed as HIGH risk as Adult P refused to engage and answer questions for the risk assessment. The circumstances were referred to a MARAC meeting on 5th November 2013.

3.1.23 The following day, 23rd September 2013, Adult P admitted to her Offender Manager that she had been seeing Adult Q for several weeks and they had resumed their relationship. She also said that there had been constant arguments and physical violence (on both sides) during that time. She disclosed that Adult Q has physically assaulted her by grabbing her around her throat to strangle her on a few occasions, pushing her, as well as emotional abuse by flirted with others in front of her, pressurised her to pawn her mobile phone for money and putting pressure on her to lift the Restraining Order. Adult P who had a good awareness of the impact this destructive relationship was having on her emotionally and physically felt that she required professional help and presented as frustrated and angry with herself for letting Adult Q back into her life. The Offender Manager contacted an IDVA requesting support for Adult P, however he received a response that at that time they could only accept referrals once they have been identified as high risk because of limited capacity. The Offender manager therefore completed a DASH risk assessment with a High risk harm assessment. He highlighted that Adult P would welcome intervention from an IDVA and considered that the Freedom Project would help keep her motivated to remain away from Adult Q.

3.1.24 On 6th November the police received a report that Adult P was being assaulted by Adult Q in the street. Independent witnesses provided a statement and Adult Q was arrested and charged with common assault and a breach of his restraining order. The next day Adult Q attended the first session of the Positive Relationships course. The day after he reported that Adult P was sending him threatening text messages. Adult P was arrested and charged and bailed with harassment.

3.1.25 On 22nd November 2013 Adult Q's Offender Manager contacted him following concerns raised by the Positive Relationships facilitator. He admitted he was drunk at the session and he was reminded that he had signed to say he was not to turn up drunk, which he acknowledged.

3.1.26 On 3rd December 2013 a MARAC meeting considered Adult P and Adult Q as there had been four incidents of reported domestic abuse in a twelve-month period. Agencies shared information and an action plan was set to try to address theorists identified; alcohol; breach of injunction; physical harm; non engagement; suicidal mental health issues; escalating violence; (strangle).

3.1.27 On 24th December 2013 the Police received a call reporting that Adult P and Adult Q were fighting in the street. When officers arrived at the scene Adult P was unset but would not speak to them. As Adult P and Adult Q had marks on their faces both arrested for assaulting one another. No further action was taken about the assaults as neither would make a complaint but Adult Q was charged with breaching bail conditions and charged to court.

3.1.28 On 20th February 2014 Adult P reported to her Offender Manager that she had moved and was renting a room through a friend of family and that she had obtained employment as a waitress. A week later her father told the Offender Manager she was living with Adult Q. On 15th March 2014 the police received a call that Adult P and Adult Q were arguing in the street. Adult P told the police that Adult Q was drunk and they had taken a taxi. He had grabbed her by the throat because she would not kiss him. She ran from the taxi with Adult Q chasing her, and she jumped into a lake, (telling the police, that she would rather kill herself than have Adult Q assault her again). Adult Q was arrested for common assault, a PPD1 submitted with a medium risk assessment. The MARAC was informed and the IDVA updated. Adult P refused to make a statement and as there were no independent witnesses the CPS directed that no further action should be taken.

3.1.29 On 16th April 2014 Adult P visited her GP and reported that she had been subjected to more recent domestic violence, consequently she felt low and was not able to concentrate. She was prescribed an increased dose of medication and referred for counselling.

3.1.30 On 3rd May 2014, the police were called to a train station, after reports that Adult Q had assaulted Adult P. He was arrested for common assault and possession of drugs. Both were extremely drunk and Adult P was treated by paramedics and taken to hospital. Adult P disclosed to the emergency room doctor that she had taken an overdose one week previously. Neither Adult P nor Adult Q would cooperate with police. Nevertheless, a PPD 1 was completed with a DASH High risk assessment. On 24th September 2014 Adult P was again taken to hospital having taking an overdose after an argument with Adult Q. It was noted that Adult P became very aggressive and abusive towards staff and she was asked to leave the ward.

3.1.31 On 7th October 2014, Adult Q attended Probation offices where Adult P had an appointment. After he left with her in breach of his conditions, he was arrested and placed before the court the same day.

3.1.32 On 16th November 2014, Adult P's father reported to Police that she was arguing with Adult Q in a field. Adult Q was in breach of bail conditions by being there. Police officers attended but Adult P refused to make a complaint statement. She did have injuries but would not say how they occurred nor would she cooperate with the DASH risk assessment process. Adult Q was arrested and released without charge after a CPS charging decision.

3.1.33 On 27th January 2015, Adult Q attended an assessment with Wiltshire Substance Misuse Service (WSMS). He disclosed difficulties in his relationship with Adult P and that he had been arrested for domestic violence over 20 times in four years. He said he drank daily and wanted to learn how to control his use of alcohol. His risk assessment highlighted that he had been both a victim and perpetrator of domestic abuse. Other risks identified were around Adult Q being homeless and having a poor diet, along with outstanding debts. On 2nd April 2015 when Adult Q attended an appointment at WSMS he was under the influence of cannabis and was therefore advised that no drugs were to be brought onto premises. He stated he would stop use when he started work. On 2nd July 2015 due to multiple missed appointments and lack of contact, Adult Q was discharged from WSMS and the file closed. Probation and his GP were notified of the discharge. Five days later Adult Q went to prison and whilst he was in prison Adult P wrote to him, re-igniting their relationship.

3.1.34 Adult Q was released from prison on the 24th August 2015 and was met by Adult P. They spent the next three or four nights in hotels locally, but when they ran out of money they lived in a tent in the back garden of Adult P's family home. Adult Q described this period of their relationship as fine. He said that Adult P was optimistic about the future; she had a job as a cleaner and would get up early to go to work. He said that she was looking forward to having a home of her own and children with Adult Q.

3.1.35 On the evening of Monday 28th September 2015, Adult P and Adult Q were seen arguing in Warminster town centre. They continued arguing as they walked to Adult Q's parent's home. Adult P waited outside while Adult Q went in for a shower. When Adult Q came out Adult P had gone. She had left an earring, a necklace and Adult Q's tobacco on the wall, with the words 'I LOVE YOU FOREVER' written on a wall. Adult Q phoned Adult P and she answered, stating she had decided not to wait for him and was on her way home, a journey of about 1km. Adult Q told her he would phone her in half an hour to check she was safely home but when he did phone she did not answer. After trying to contact her several more times, Adult Q called Adult P's brother and asked him to report her missing, which he did at 9.25pm the next day. Police missing person enquiries were carried out and at 13.06pm on 1st October 2015 Adult P's body was found hanging from a tree.

4 Key issues arising from the review

4.1 The Review Panel, having had the opportunity to analyse the information obtained from agencies, one of Adult P's friends and from the Coroner's Inquest, and considered the key issues in this Review to be:

4.2 Significant family history of domestic abuse being the norm, where Adult P was not only witnessing domestic abuse but was the victim of domestic abuse.

4.2.1 This review has revealed evidence that Adult P had been exposed to domestic abuse throughout her childhood, with her father being the perpetrator of significant violence towards her step-mother and prior to this, to her mother. There is at least one report of Adult P also suffering childhood physical abuse at the hands of her father. (Her father told the Review that he had grown up in a household where domestic abuse regularly occurred.)

4.2.2 From records, Adult P's step-mother suffered visible symptoms of abuse on more than one occasion. Although the couple lived separately for long periods, the abuse continued with the police being called on many occasions however the step-mother repeatedly declined to press charges for the violence she suffered.

4.2.3 Individual Management Review (IMR) authors noted that in her childhood, Adult P did not have anyone who was a role model on how to be in a relationship and that this impacted on how Adult P was able to have a relationship with others. There were no records of her parents or step-mother attending any of the many school meetings or subsequent court proceedings in respect of Adult P's poor attendance and behaviour. The school had no contact details for her father for a number of years.

4.2.4 In February 2015, the Police were called to Adult P's step-mother's address after she attacked Adult P. The Police arrested the step-mother due to the injuries Adult P sustained to her face, but Adult P refused to press charges. In May 2015 Adult P reported physical abuse from her brother and father that resulted in bruising and her being offered a Refuge space, which she declined.

4.2.5 There is a wealth of evidence about the negative effects of children witnessing domestic abuse. The effects are significant with children displaying symptoms similar to abused children. They tend to be fearful and show more anxiety and depression than other children, which affects their behaviour at school. (See for example, Meta-analysis by Evans S et al 2008).

4.2.6 McFarlane et al. (2003) found that girls, 12–18 years, of abused mothers showed behaviour problems such as aggression and delinquency. Cummings et al. (1994) reported that female adolescents tend to feel anger. This may help to explain Adult P's behaviour and admitted short fuse.

4.2.7 Adult P talked about the domestic violence, abuse and control that Adult Q exerted over her to agencies. Often she said that the relationship had ended and that she did not want to be with him. She loved him but recognised that the relationship was abusive and not good for her physical or mental health and emotional wellbeing. In spite of this she also maintained that he understood her and that he was the only person to whom she could talk.

4.2.8 Like her step-mother before her, Adult P was unwilling to make a complaint or talk to police about any of the incidents of domestic abuse that she experienced. This made it difficult for the police to take any action against Adult Q except in the limited number of times when independent witnesses were present and provided statements. Crown Prosecution Service (CPS) on occasions declined to prosecute due to lack of victim statements.

4.2.9 Adult P was also identified as being a perpetrator of violence against Adult Q. However, as some of the IMR authors noted, this needs to be taken in the context of the aggression and control that Adult Q exerted over her, what some academics have referred to as violent resistance. (See for example, Johnson M (2008) and Hester M (2012).) Adult P recounted how Adult Q wound her up and she would explode and take action, break his windows or fight back. According to the Police Adult P was recorded as the perpetrator on more occasions than Adult Q.

4.2.10 Adult P often witnessed violence in the family home. Her father was reported to take a door off its hinges in anger. When this is normal behaviour it is not so surprising that Adult P retaliated against Adult Q by breaking his windows.

4.2.11 Her father suggested that she had an anger problem similar to the one that he had when he was younger and got involved in the criminal justice system. Her friend said that any violence that she saw was instigated by Adult P in response to Adult Q "winding her up". It is evident that this happened on many occasions as demonstrated by the chronology of events and may explain why in the reporting period, the Police recorded twenty-three incidents of domestic violence between them; on eleven occasions Adult Q was the perpetrator and on twelve occasions it was Adult P. Agencies recorded that: 'They were as bad as one another'.

4.2.12 The findings in this review would suggest because Adult P was seen as a perpetrator as well as a victim this may have masked her vulnerability.

4.3 Adult P's vulnerability and fragile mental state feeling belittled and unloved

4.3.1 The review has found many examples where Adult P felt let down by the people around her. She talked about her biological mother, "My mother has never been there for me … I used to miss her but now I don't care".

4.3.2 She felt let down by her father, who she said did not want her living with him. Adult P reported that she had been raped/abused by one of her brother's friends and that her father had done nothing about this. She wanted her father to acknowledge that he should not have ignored it and that he should have done something about it.

4.3.3 Adult P disclosed many instances of domestic abuse with Adult Q, reporting feelings of being controlled, isolated from others and becoming introverted, losing what she described as her "lively sociable personality". However, when she discussed her relationship with Adult Q in a psychiatric assessment, she said that she felt that she had no one else in the world apart from Adult Q and when they quarrelled she felt that she might as well end it.

4.4 History of self-harm

4.4.1 There were many instances of Adult P taking overdoses and harming herself, including superficial cuts to her stomach and stabbing herself with scissors. Adult P reported taking an overdose of paracetamol in 2011 but did not seek help, she reports that this followed an argument with Adult Q; she also attended Minor Injuries Unit (MIU) with Adult Q, with lacerations where she had stabbed herself in the leg in April 2012.

4.4.2 In September 2013 she took an overdose and self-harmed. In May 2014, when she attended the Emergency Department following injuries she sustained from Adult Q, she disclosed that she had taken an overdose the previous week. She also disclosed this to her GP.

4.4.3 All of the self-harming and suicide attempts followed 'arguments' with Adult Q.

4.5 Alcohol and drugs

4.5.1 Both Adult P and Adult Q regularly used drugs and alcohol.

4.5.2 At other times, notably to her Offender Manager, GP and mental health worker, she said that she rarely used alcohol and was trying to cut down on her cannabis use. In early 2015 she reported sleeping problems when she was trying to go without cannabis. She did however have traces of both in her body when she died.

4.5.3 Adult Q drank heavily and when attending Offender Manager appointments he often turned up drunk. This was challenged, but he did not see his alcohol or drug use as problematic. He reported that he drank sociably three or four nights per week at home or with girlfriends at their accommodation. He said it was usual "to drink 8-12 cans of Stella or a bottle of vodka or brandy and get drunk".

4.5.4 Adult P's Offender Manager offered her an assessment with the local drug and alcohol agency to assess her suitability for a Drug Rehabilitation Requirement as part of her sentencing proposal. Unfortunately, she failed to attend two appointments so this was not taken forward.

4.5.5 The police recounted that either drugs or alcohol or both, fuelled most of the incidents of reported domestic abuse between Adult P and Adult Q.

4.6 Lack of any agency taking ownership/lead role

4.6.1 When Adult P was first in a relationship with Adult Q and suffered domestic abuse, she was still a juvenile.

4.6.2 The Children's Social Care IMR author noted that a number of the professionals who were involved with Adult P during 2012/2013, including CAMHS, NEET, Housing and the Police, did not raise the on-going risks of domestic abuse to Adult P or challenge that Children's Social Care, as the responsible lead agency, were not considering this risk sufficiently.

4.7 Transition between child and adult services

4.7.1 In the absence of support from her social worker, Adult P received a great deal of support for the eight months prior to her eighteenth birthday from the CAMHS team. The worker went beyond her normal role to support Adult P with her housing, education and training. She accompanied her to the doctor and helped with her benefit claims and secured emergency payments and food parcels. At this time she was also receiving support from the Youth Offending Team, now part of Early Help, which also contains the NEET Service. There was demonstrated good joint working between these services and the Housing Key Worker from the supported accommodation where Adult P lived.

4.7.2 CAMHS made no referral to adult mental health services as it was always considered that Adult P did not have any real mental health needs and that her problems were as a result of her difficult social circumstances. It was not believed that she would meet the criteria for adult mental health services. There were however handover meetings between CAMHS, YOT and Probation who took over her offender management once Adult P was sentenced as an adult.

4.7.3 In the months following Adult P's eighteenth birthday and the withdrawal of services that she trusted, her Housing Key Worker reported difficulties in engaging with Adult P. She was non-communicable, not answering phone or text messages. She did not attend meetings. It was only with the threat of losing her tenancy that Adult P started to re-engage.

4.8 Risk of age gap

4.8.1 Adult P started a relationship with Adult Q about the time she left school aged sixteen. He was twenty four years old. The first police report of domestic abuse came seven months later when she was still a child and he was an adult. The police did refer to Children's Social Care, but no further action was taken by them on the basis Adult P and Adult Q were reported to have separated. This should not have been taken at face value and a full risk assessment should have been undertaken.

4.8.2 Recent child sexual exploitation case reviews have highlighted the difficulties inherent in adolescent sexual relationships and in services responses to them. One important message of relevance to this review is to always call anyone under the age of eighteen a child so that their status is never overlooked (Brooke 2016).

4.8.3 The significant age gap was not picked up on by any of the agencies. Today such an age difference would have rung alarm bells, and is a risk factor for child sexual exploitation. Child safeguarding procedures would be implemented by Children's Social Care. The police, following the first report of domestic abuse would have referred Adult P to the Police Child Sexual Exploitation Team (CSE). Significant work would be carried out with her in order to try and support her to leave the inappropriate relationship. There also would have been a large focus from the CSE team to deter the older male from seeking out the younger female.

4.9 Lack of Stable Housing

4.9.1 After leaving school, Adult P moved in with Adult Q, as her father disapproved of the relationship and told her to leave the family home. When she ended this relationship following the first reported incident of domestic abuse she became homeless.

4.9.2 Adult P went to stay with friends, her aunt or her step-mother on a temporary basis. Throughout the IMRs there is evidence to suggest that Adult P felt unwanted by her father and step-mother and even though her step-mother's house was her family home, she had no room of her own, had to sleep on her brother's bedroom floor and was never allowed to stay for long.

4.9.3 During 2012 there was confusion about who was responsible for Adult P's housing and whether or not Children's Social Care had a responsibility to house her. Whilst there was some involvement by Social Care to find alternative accommodation for Adult P there was minimal link up with the Wiltshire Housing Options and no joint assessment of her needs. Adult P's CAMHS and NEET workers spent a lot of time helping her to find housing and to access benefits. There is evidence of good joint working between them and Wiltshire Housing Options. For CAMHS this was outside of their normal role but was justified because of the belief that Adult P's lack of a stable place to live had a significant impact on her mood throughout their involvement with her.

4.9.4 Adult P did not have any secure accommodation until she moved into a supported flat in February 2013. However, due to poor behaviour this did not last. She received her first written warning on the 4th March and the second on the 4th April.

4.9.5 Adult P failed to engage with support workers and had serious breaches of her tenancy agreement including for non–engagement with support, noise, damage to her flat, letting visitors use her flat when she was not present, assault towards another resident and possessing drug paraphernalia. She had a total of fourteen warnings whilst the agency struggled to help her sustain her tenancy.

4.9.6 The non-engagement with her tenancy key worker meant that she did not get the support she would have with, for example, budgeting, benefit issues and registering with a GP. Despite signing an acceptable behaviour contract agreement on 22nd May, Adult P continued to miss appointments and breached her agreement. She finally left the scheme voluntarily on 29th October 2013, so that she did not have to pay for damage to her flat. This meant that she was termed intentionally homeless which impacted on her ability to secure future accommodation. She started to look for privately rented accommodation.

4.9.7 Wiltshire Housing Options made a number of appropriate referrals at the right times in attempting to house Adult P. Sometimes she would engage and placements were offered and other times she would not turn up and decide to stay with friends or family ("sofa surfing"). There is evidence to suggest that at times Adult P went back to live with Adult Q even when this was not what she wanted because of the abuse.

4.9.8 The lack of somewhere to live impacted on Adult P in a number of ways. She reported to CAMHS that she would like for example, to address her issues relating to anger but felt unsure about how she could make changes, as she was not staying anywhere regularly. She also wanted to engage with other activities, for example, on 21st September 2012 Adult P talked to CAMHS about needing more structure to her day and that having too much time to think was impacting on her mood and gave her too much time to think about Adult Q. She wanted to go to college and get qualifications, do some voluntary work, but could not commit to any of this due to issues relating to her accommodation and her mood.

4.9.9 Housing remained a problem for Adult P. At the time of her death she was living with Adult Q in a tent in the garden of the family home.

5 Lessons to be learned

5.1 Avon and Wiltshire Mental Health Partnership NHS Trust

5.1.1 The IMR author noted that Adult P was charged and convicted of assault on her partner and housemates so may have been viewed as less vulnerable than perhaps she was.

5.1.2 AWP communicated the idea of "referrals" to other services (LIFT, WSMS) to the GP. This was potentially misleading language implying an action delivered, whereas these contacts could only be actioned by Adult P herself. Communication around the idea of "referral" to services that require the service user to be pro-active in making contact, should be clearer.

5.1.3 Adult P did not have clear advice about how to re-access mental health service in the event of her mental health deteriorating.

5.1.4 Domestic abuse risk management and Safeguarding needs to be specifically and explicitly addressed whenever a vulnerability to abuse is identified during risk assessment.

5.1.5 Need to update Standard Operating Procedures and remind staff of the resources available to support them.

5.1.6 Service users who have had contact with any part of AWP services should be copied in to letters to their GP and these letters should contain advice about clear, realistic and deliverable actions to be taken in the event of deterioration in, or recurrence of, mental health needs.

5.2 Bristol Gloucester Swindon and Wiltshire Community Rehabilitation Company (BGSW CRC)

5.2.1 Adult P may have benefited from targeted alcohol work, which could have been delivered internally or a referral to a specialist agency.

5.2.2 It's not clear how consistently issues were being followed up with the relevant agencies, which may be a recording issue.

5.2.3 In terms of specialist support for Adult P, there was a referral to a specialist support service for women, but at the time provision was not consistently being provided in Trowbridge. Had this support been available, Adult P could have engaged with this service whilst subject to an Order and this support could have continued even when the Order had terminated. Furthermore, Adult P may have benefited from a volunteer mentor, who could have provided additional support.

5.2.4 It's evident from the Delius records that Adult Q did not consistently comply with the requirements of the Court Orders, enforcement action should have been taken sooner to clearly demonstrate that this was not acceptable and would not be tolerated.

5.2.5 The IMR author noted that reflective supervision should be prioritised, so Offender Managers are encouraged to explore how these cases are being managed and to ensure that key risk issues are not being missed. It's also imperative that the CRC continues to work in close liaison with other agencies to improve outcomes for victims, perpetrators and communities.

5.3 Child and Adolescent Mental Health Services (CAMHS)

5.3.1 CAMHS should have raised concerns, along with other agencies about the lack of effective multi-agency working to support Adult P. They should not have relied on another agencies raising these concerns, but should have escalated their concerns. The voice of Adult P was very clear in the clinical notes and should have been escalated through the agency managers.

5.3.2 Domestic abuse risk management and Safeguarding needs to be addressed whenever a vulnerability to abuse is identified. Opportunities were missed to address the domestic abuse because workers concentrated on Adult P's immediate housing and financial situation. Safeguarding needs should have been discussed with the safeguarding lead when Adult P's needs were unmet and she was at continued risk of harm.

5.4 Curo Housing Association

5.4.1 Adult P left her Curo Housing accommodation very soon after the disclosure of domestic abuse was made, but it would have been beneficial if there was one lead agency in such cases to ensure all agencies were aware of the situation and the possible effects of decisions made by individual agencies.

5.5 Kingdown School

5.5.1 Since 2010 in particular, the Head and senior pastoral leaders reviewed, amended and implemented policies and procedures to support the most challenging students and their families. Attendance issues are monitored and support offered.

5.5.2 The IMR author was confident that child protection and welfare practices have improved considerably since 2010. Child protection is very high profile, staff are not afraid to report incidents and do so quickly. There is better alternative provision and more resources available to help deal with the most vulnerable and challenging students.

5.5.3 Awareness of domestic abuse requires improvement and will be included as part of future child protection training.

5.6 National Probation Service

5.6.1 Adult P

5.6.1.1 There was a lack of focus on Adult P's own offending and limited work to address her behaviour in terms of her propensity to utilise violence towards others. A referral to Keeping Calm and Conflict Resolution was considered in the original order but not proceeded with. This would have targeted the offending behaviour.

5.6.1.2 There is no evidence to suggest, through the contact entries, that the line manager of the Offender Managers was active in the management of this case.

5.6.1.3 As identified in the Pre-Sentence Report, Adult P had a history of misusing both alcohol and cannabis and whilst this was monitored throughout the period of supervision, with disclosures of minimal use, no work appears to have been completed to address this.

5.6.1.4 Contact with Adult P's GP would have ensured a better understanding of her emotional well-being and closer monitoring of the risk of harm that she posed to herself.

5.6.1.5 Following disclosure of a self-harm incident, a risk review was not completed. This would have allowed appropriate exploration of the incident to be contained in the assessment.

5.6.1.6 Following the revocation of Adult P's original order and subsequent re-sentencing, there is no evidence, from the contact logs, that a referral to Positive Relationships was prioritised in order for the intervention to start promptly.

5.6.1.7 Initial Sentence Plan should have been completed in a timely manner.

5.6.2 Adult Q

5.6.2.1 An Initial Sentence Plan was started and logged as completed, however the document in OASys was locked incomplete, with no completed sentence plan objectives.

5.6.2.2 Home visits should have been undertaken in order for the Offender Manager to assess the suitability of the accommodation and for an investigative approach to be taken.

5.6.2.3 All interventions should have started promptly after the commencement of the Community Order to avoid a delay in offence focused work being undertaken.

5.6.2.4 There appears to have been a lack of focus to undertake offence focused work with Adult Q whilst waiting for the start of the Positive Relationships group work programme. This was a missed opportunity for Adult Q to start reducing his risk of serious harm and managing his own behaviour in relationships.

5.6.2.5 Work to address alcohol misuse was not undertaken, despite evidence to suggest that Adult Q was utilising alcohol on a frequent basis and to excessive quantities.

5.6.2.6 Initial Sentence Plan to evidence the objectives to be achieved during the course of supervision.

5.6.2.7 Reviews should have been prioritised following significant events.

5.6.2.8 The level of contact with Adult Q was reduced without defensible rationales. The initial reduction of contact took place before any offence focused work had been undertaken.

5.6.2.9 There was no evidence through the contact entries that the line manager of OM1 had any active involvement in the management of this case.

5.6.2.10 A MARAC referral was prioritised by the Offender Manager of Adult P, there is no evidence to document that OM1 had considered such a referral and if OM1 had discussed with Adult P's OM the referral that they made.

5.7 Royal United Hospital (RUH)

5.7.1 There are no clinical practice issues that have been identified when reviewing the details of the contacts documented in the medical records, however improvement was needed in the assessment of the risks to Adult P associated with Domestic abuse and her chaotic lifestyle.

5.7.2 There would be an expectation by the safeguarding team that any staff would be able to question further when a patient discloses that they have been a victim of domestic abuse. The Trust now delivers a domestic abuse awareness training programme.

5.8 Wiltshire Clinical Commissioning Group

5.8.1 The Primary care practice requires improved policies and procedures to manage patients following disclosure of domestic abuse.

5.8.2 Better recording of information about where vulnerable patients are actually living and who is living with them is required.

5.8.3 Whilst the main District General Hospitals have easy access to Mental Health services, Community hospitals do not. Adult P was not offered direct support during her attendance at Trowbridge Minor Injuries Unit and the Practice should have made a documented effort to contact her after they received this letter in May 2015. In future it has been agreed that a new policy will be developed to ensure some contact is made with patients who are subject to domestic violence. This could be attempts at direct telephone contact or letters suggesting GP review. However, being mindful of the situation, this could alternatively be in terms of medication review or general health check so that perpetrators are not alerted. Outside support with this will be sought from Splitz and other specialist organisations.

5.8.4 Better recording of other agencies involved with patients need to be developed. Records of specific named social workers or other external agencies should be recorded under the administration tab in the patient record. Communication with these agencies need to be improved and GPs encouraged to make direct contact with other agencies, if relevant, after direct patient contact or letters are received.

5.8.5 The Practice has developed a standing item at the weekly business meeting to discuss child and adult safeguarding issues so that all GPs and managers are aware of current issues with patients and their families. The practice has always run a personal list system so that a named GP has responsibility for a patient and usually their family but this ensures other team members are also aware in case of contact through other systems such as the Duty Doctor.

5.8.6 Wiltshire Clinical Commissioning Group recognises that the learning from this domestic homicide review needs to be disseminated to other practices at local GP events to improve practice around domestic abuse throughout the area.

5.9 Wiltshire Council Children's Social Care (CSC)

5.9.1 The history and chronology of involvement should always be considered within assessments as a predictor of capacity to change and parenting capacity in general

5.9.2 Joint assessments with housing should be undertaken whenever a child/young person is at risk of homelessness. During such assessments, the wider needs of the child/young person should be considered and the homeless issue should not overshadow any other concerns highlighted. The single assessment that is completed covers all aspects of a child's needs, providing a holistic picture of them, which ensures all of the assessment framework domains are considered.

5.9.3 Young people who are in domestically abusive relationships and are subject to physical harm should be considered under our child protection procedures. This should include the use of the Child Sexual Exploitation Screening Tool and liaison with the Emerald Team (Wiltshire Council and Police Child Sexual Exploitation Team).

5.10 Wiltshire Council Early Help

5.10.1 Case recordings needed to be analytical and not just descriptive. If there are gaps in recording these should be explained.

5.10.2 There should always be management oversight and this should be recorded.

5.10.3 An evidence based assessment of what is contributing to being NEET should be undertaken.

5.10.4 A clear chronology of events between Adult P and Adult Q would have been beneficial to understanding the issues in their relationship and also Adult P's mental health.5.10.5. Specific actions regarding safeguarding issues should be present in NEET recordings. There was liaison with Social Care following Adult P being assaulted, having moved in with her boyfriend and a joint approach to dealing with Adult P's housing issues was attempted but no follow up was documented.

5.11 Wiltshire Education Welfare

5.11.1 In instances of poor engagement a home visit prior to making decisions of significance could provide additional information.

5.11.2 At the time of this case EWS practice was not supported by a wider interagency approach the same way that it would be now, through the Common Assessment Framework.

5.11.3 A sanction-based approach must be carefully assessed alongside the supportive working. Where there are also siblings of concern a family/sibling involvement could be considered with one lead professional.

5.11.4 It does not appear that historic concerns and concerns regarding Adult P's siblings were taken into consideration, regarding the longevity of concern or the complexity of the family dynamic. If this had been evident it could be considered that a parenting assessment could have been undertaken to highlight needs within the family home.

5.11.5 There was no individual record of a discussion with Adult P which may have informed of her wishes and feelings. From current practice this would be obtained through the Common Assessment Framework document.

5.12 Wiltshire Council Housing Options

5.12.1 Staff should follow up advice provided to clients on support agencies with appropriate referrals to those specialist services and escalate concerns appropriately.

5.12.2 Housing staff need to better understand safeguarding triggers and how issues / concerns should be reported.

5.12.3 A requirement for housing staff to better understand the importance of safeguarding and domestic abuse issues and attend regular annual training.

5.12.4 Improved understanding of what agencies are available to assist those fleeing domestic abuse.

5.12.5 To improve working relations between Housing and social care to ensure that young people are not pushed between services leading to no service/officer taking real ownership of the case.

5.12.6 Review and consider the support being offered to young people in supported accommodation who exhibit poor behaviour and how it is effectively managed.

5.13 Wiltshire Domestic Abuse Conference Call (DACC)

5.13.1 Participation in the DACC has been limited and sporadic. A common area of feedback from agencies is that they find it hard to find time for staff in their respective agencies to research cases listed and then take part in a conference call.

5.13.2 Participation of agencies who call in/or, in the MARAC case who turn up, to share relevant information and take on actions to reduce risk, support victims and children and look at ways to tackle offenders.

5.14 Wiltshire Multi Agency Risk Assessment Conference (MARAC)

5.14.1 One of the risks identified from the minutes from the MARAC dated 3rd December 2013 is alcohol. The minutes indicate Adult Q was intoxicated during the domestic incident. It is important that Alcohol/Drug agencies attend MARAC.

5.14.2 One of the risks identified was mental health. Mental Health attendance is crucial for MARAC as mental health issues are frequently identified. A real difficulty MARACs face is that they are not on a statutory footing like MAPPA and therefore securing attendance of key agencies can be difficult. Making it statutory and identifying key statutory agencies who should take part in MARAC would be beneficial.

5.14.3 The IDVA had difficulty in contacting Adult P. It is important for the Chair to consider who/what agency has engagement with victim and look to signpost IDVA through that agency to try and see a victim who may have engagement issues.

5.15 Wiltshire Police

5.15.1 Wiltshire Police have carried out extensive training of all front line officers around domestic abuse and to take positive action. Officers have also received training on the new coercive and controlling behaviour law that came into effect on the 31st December 2015.

5.15.2 Where there is a large age gap such as the one that presented at the start of the relationship in this case, there will be a referral to the Child Sexual Exploitation (CSE) team where significant work would be carried out in order to try and support her to leave the potentially inappropriate relationship. There also would have been a large focus from the CSE team to deter the older male from seeking out the younger female. This ensures a strong focus is kept upon the subject and that victims are protected whilst suspects are deterred or prosecuted. It also allows a much stronger link between Social Services and police when presented with challenging young females in potentially harmful relationships.

5.15.3 A system of informing officers of the number of domestic incidents involving both victims and perpetrators has been developed, which will soon be available on the NICHE crime recording system. This will allow officers to easily identify serial abusers and victims rather than having to refer to each individual incident.

5.16 Wiltshire Substance Misuse Services

5.16.1 In viewing the notes surrounding Adult Q's treatment order with us the IMR author suggests that the order should have been taken back to Court sooner as an unworkable order due to the ambivalence to the Court order and lack of commitment shown to treatment by Adult Q

5.16.2 Clarity of Adult Q's relationship status should have been discussed with Adult Q's Offender Manager following the Police report, that he gave permission for his ex-partner to enter his accommodation demonstrated a relationship of sort was evident, however the WSMS priority and focus is around substance mis-use treatment.

6 Conclusion

6.1 In reaching their conclusions the Review Panel has focused on the questions:

6.1.1 Have the agencies involved in the Review used the opportunity to review their contacts with Adult P and Adult Q in line with the Terms of Reference (ToR) of the Review and to openly identify and address lessons learnt?

6.1.2 Will the actions they take improve the safety of vulnerable domestic abuse victims in Wiltshire in the future?

6.1.3 Was Adult P's death predictable?

6.1.4 Could Adult P's death have been prevented?

6.2 Have the agencies involved in the Review used the opportunity to review their contacts with Adult P and Adult Q in line with the Terms of Reference (ToR) of the Review and to openly identify and address lessons learnt?

6.2.1 The Review Panel acknowledges that the Individual Management Reviews and other reports have been thorough, open and questioning from the view point of Adult P. The Panel is satisfied with the evidence provided by those organisations that have shown that their contacts with Adult P and Adult Q were in accordance with their established policies and practice have no lessons to learn. Other organisations have used their participation in the Review to properly identify and address lessons learnt from their contacts with Adult P and Adult Q in line with the Terms of Reference.

6.3 Will the actions they take improve the safety of vulnerable domestic abuse victims in Wiltshire in the future?

6.3.1 The Panel, while satisfied that the implementation of the recommendations made within the Review will address the needs identified from the lessons learnt and make life safer for young people who are victims of domestic abuse, emphasises the need for all agencies to make referrals to specialist domestic abuse services and when the abuse is with a child, to remember that it is a safeguarding concern and to take appropriate action to protect the child from further abuse.

6.4 Was Adult P's death predictable?

6.4.1 The Panel discussed Adult P's history of self-harm and attempts to take her own life, at length. She was recorded as deliberately having taken four overdoses between 2011 and 2014 and an 'accidental' one in August 2012 when Adult P reported that Adult Q had challenged her to take the tablets. Some of these attempts were accompanied with self-harm. In March 2014 following an assault by Adult Q she ran away from him and jumped into a lake which she later said was because she would rather kill herself than have Adult Q assault her. It is not known if this was a serious attempt or not but she did take another overdose in May of that year. In September 2014, after another failed attempt, Adult P was recorded as ambivalent about the overdose, felt stupid as it had not worked and that she might do it again if pushed. All of the suicide attempts were following 'arguments' with Adult Q.

6.4.2 The Review Panel nevertheless noted that there were many other reported incidents of arguing and abuse between them when she did not take an overdose. Her life was described as difficult and complex and there was no way that any individual or organisation could have anticipated what particular set of circumstances would 'push' Adult P into making such an attempt. Furthermore, when Adult P did successfully take her own life she did not take an overdose but killed herself by hanging.

6.4.3 There was a divergence of opinion in the Panel as to whether or not it was predictable, given her upbringing, repeated attempts at suicide and the trajectory she was on, that Adult P would end her life at some time. However the Panel was in agreement that there was no indication that it was inevitable.

6.4.4 The Review Panel finally came to the conclusion that they were satisfied that there was no single reason that could be identified to predict her death at that time.

6.5 Could Adult P's death have been prevented?

6.5.1 The Review Panel discussed this in detail. Adult P was brought up in a family environment that lacked positive role models on forming good relationships. Domestic abuse and non-engagement with the police was the norm in both her childhood and adult life. She was never given any specialist help when she witnessed abuse as a child that would make her more resilient and able to walk away and stay away from Adult Q when he was abusive to her.

6.5.2 At the time of her death, Adult P and Adult Q had resumed their relationship after his release from prison and they were living together in a tent in her father's garden. Adult Q described this period of their relationship as fine; he said that Adult P was optimistic about the future; she had a job as a cleaner and would get up early to go to work. There was no pattern of escalating risk and no single factor that could be identified as the trigger. There was no one agency that she was involved with that could have intervened and prevented her taking her own life on that day.

6.5.3 The Panel has therefore concluded that whilst there are many lessons to be learnt there was nothing any agency could have done that would have prevented Adult P's death at that time.