For Publication

Safer Barnsley Partnership

Domestic Homicide Review

Overview Report: Lucy

Died: May 2022

Chair and Author: Ged McManus
Assisted by: Carol Ellwood-Clarke QPM

Date finalised: November 2023

For Publication

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Family Tribute

From being a small child, Lucy was a people person, she was fun to be around and always very social. She would help anyone, especially her family, and she was always very generous and would share anything she had with others.

Lucy loved swimming, and when Lucy was 14, she got her life saving badge and later went on to work as a relief lifeguard at the local council swimming baths. She also enjoyed windsurfing and used to play volleyball, as she loved being part of a team.

When Lucy was in her teens, she would take her maternal gran out for the day, and even though her gran had dementia, they both used to enjoy spending the day together and getting out and about.

At the age of 25 years, she gave birth to her only child.
She adored her child and loved being a mum, and between both parents, they made sure they had a good childhood and wanted for very little.

Later in life, Lucy used to buy, prepare, cook, and serve food out of the back of her car, to the homeless people in Barnsley on a Tuesday evening.
This stopped due to the pandemic, but she then went on to donate to the local food bank.

This is just one example of how generous she was, as she would always go above and beyond to help people through work, alongside family and friends.

We miss company, daily calls, and the help and support she gave all her family.
We just miss her.

1 INTRODUCTION

1.1 This report of a Domestic Homicide Review (DHR) examines how agencies responded to, and supported, Lucy, a resident of Barnsley, prior to her death in May 2022. The panel would like to express its condolences to Lucy's family on their tragic loss. All names used in the report are pseudonyms agreed with Lucy's family.

1.2 Lucy and her partner, Dennis, had been together for approximately 11 years and lived with each other in Lucy's house in the Barnsley area, which she owned outright. During early 2022, the couple split up, and Dennis moved out of the house. It seems that this split was temporary, and that Dennis later moved back into the house.

1.3 On a day in May 2022, Lucy did not arrive at work for a planned meeting. This caused concerned colleagues to contact the police. The police forced entry to the property and found both Lucy and Dennis dead. A note, apparently written by Dennis, indicated that he had killed Lucy and then killed himself.

1.4 A forensic post-mortem was carried out which concluded that the cause of Lucy's death was;

1. Upper airway obstruction and hypoglycaemia [associated with insulin toxicity].
2. Codeine toxicity, alcoholic liver disease and acute alcohol intoxication.

The pathologists report commented that insulin was detected in blood samples, this is injectable and there were needle marks in the lower abdomen through which it may have been injected. The police concluded that there was no third party involvement in Lucy's death.

1.5 The intention of the review process is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources, and interventions, with the aim of avoiding future incidents of domestic homicide, violence, and abuse. Reviews should assess whether agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.

1.6 **Note:**
It is not the purpose of this DHR to enquire into how Lucy died.

2 TIMESCALES

2.1 The first meeting of the DHR panel took place on 5 January 2023. The final panel meeting took place on 5 July 2023. After this, further work took place to complete a final draft of the overview report, which was shared with the panel and Lucy's family.

2.2 After an extensive period of consultation, both Lucy's mum and her adult child provided feedback and had a number of questions, which resulted in revisions to the report. Further information was sought from the police to clarify some matters. They were supported in this by their Victim Support Homicide Worker. The report was concluded in November 2023.

3 CONFIDENTIALITY

3.1 The findings of each review are confidential until publication. Information is available only to participating officers, professionals, their line managers and the family, including their support worker, during the review process.

3.2 The report uses pseudonyms in order to protect the identity of the victim and perpetrator.

4 TERMS OF REFERENCE

4.1 The purpose of a DHR is to:

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

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

Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

Contribute to a better understanding of the nature of domestic violence and

abuse; and

Highlight good practice.

(Multi-Agency Statutory guidance for the conduct of Domestic Homicide Reviews [2016] section 2 paragraph 7)

Subjects of the DHR

Victim: Lucy, aged 55 years

Perpetrator: Dennis, aged 67 years

Specific Terms

1. What indicators of domestic abuse did your agency have that could have identified Lucy as a victim of domestic abuse, and what was the response?

2. What knowledge did your agency have that indicated Dennis might be a perpetrator of domestic abuse against Lucy, and what was the response? Did that knowledge identify any controlling or coercive behaviour by Dennis?

3. How did your agency assess the level of risk faced by Lucy? In determining the risk, which risk assessment model did you use, and what was your agency's response to the identified risk?

4. How did your agency respond to any mental health issues, substance misuse, and/or self-neglect, when engaging with Lucy and Dennis?

5. What services did your agency provide for Lucy and/or Dennis; were they timely, proportionate, and 'fit for purpose' in relation to the identified levels of risk?

6. When, and in what way, were the subjects' wishes and feelings ascertained and considered? Were the subjects advised of options/choices to make informed decisions? Were they signposted to other agencies, and how accessible were these services to the subjects?

7. Were single and multi-agency policies and procedures, including the MARAC, followed? Are the procedures embedded in practice, and were any gaps identified?

8. Were there issues in relation to capacity or resources in your agency that affected its ability to provide services to Lucy and/or Dennis, or on your agency's ability to work effectively with other agencies? This should consider any impact of amended working arrangements due to Covid-19.

9. What knowledge did family, friends, and employers have that Lucy was in an abusive relationship, and did they know what to do with that knowledge?

10. Were there any examples of outstanding or innovative practice arising from this review?

11. What learning has emerged for your agency?

12. Does this learning appear in other Domestic Homicide Reviews commissioned by Safer Barnsley Partnership Board Partnership?

4.2 **Timeframe Under Review**

The review covers the period from 11 November 2018 to Lucy and Dennis's deaths in May 2022.

This time period was chosen because even though the couple had been together for over 10 years, there had never been any report of domestic abuse in their relationship. The panel therefore looked for significant events that may reasonably indicate a start point for the review. In November 2018, Lucy sought help from alcohol services. The panel thought that this was a significant event and chose to start the timeline of the review from that point.

5 METHODOLOGY

5.1 Following the discovery of the death of Lucy and Dennis, a police investigation began to establish the facts. The police made a referral to the Safer Barnsley Partnership for consideration of whether a Domestic Homicide Review should be conducted.

5.2 At a meeting on 16 June 2022, the Safer Barnsley Partnership agreed that the circumstances of the case met the criteria for a DHR and agreed to conduct a Domestic Homicide Review. The Home Office was informed on 11 January 2023, following the first DHR panel meeting. The delay in notifying the Home Office was an administrative oversight and did not affect the commissioning of the review. The delay between the decision to conduct a review and the first

DHR panel meeting was a result of difficulties in sourcing an appropriately qualified DHR chair and their availability to start the work.

5.3 The first DHR panel meeting took place on 5 January 2023. Terms of Reference were agreed, and agencies agreed to provide information to the review by way of Individual Management Reviews (IMRs). Lucy's employer agreed to provide a narrative report.

5.4 At the point of the first meeting of the DHR panel, some elements of the police investigation were not concluded. The coroner had not set a date for an inquest. The Chair of the DHR notified the coroner of the review; subsequently, the coroner indicated for the DHR to be concluded prior to the inquest taking place. In order to facilitate this, the coroner gave permission for the police to disclose witness statements – taken for the purposes of the coroners' enquiry – to the DHR. These are referenced appropriately in the report.

5.6 The panel met four times: responses and additional queries outside of these meetings were addressed via telephone and email. The DHR panel carefully considered the material provided by agencies and the contributions made by the family. Following the DHR panel's deliberations, a draft overview report was produced: this was discussed and refined at further panel meetings.

5.7 The medical cause of Lucy's death was not known until October 2023 due to extensive forensic work required. The report was concluded in November 2023 following final consultation with Lucy's family.

6 INVOLVEMENT OF FAMILY, FRIENDS, WORK FRIENDS, NEIGHBOURS, AND WIDER COMMUNITY

6.1 Family

6.1.1 Lucy's mum and her adult child, Alex, were both assisted by a Victim Support Homicide Worker. The Chair of the review wrote to both Lucy's mum and Alex, enclosing the relevant Home Office leaflet. The letters inviting Lucy's family to contribute to the review, were given to them (personally) by their Victim Support Homicide Worker, and they agreed to contribute to the review.

6.1.2 The Chair of the review met Lucy's mum and Alex, who were assisted in the meeting by their Victim Support Homicide Worker. Their contribution to the review is appropriately referenced throughout the report.

6.2 **Employer**

6.2.1 Lucy's employer agreed to contribute to the review, and a senior manager sat on the DHR panel. The employer provided a narrative report about Lucy's employment.

6.2.2 Lucy had worked for her employer since 2005 and her role involved carrying out visits in the community on a regular basis.

6.2.3 Over the years prior to Lucy's murder, Lucy's employer became aware of Lucy's heath concerns, which sometimes resulted in periods of sickness absence. She was absent from work through illness from August 2021 to April 2022.

6.3 **Work Friends and Colleagues**

6.3.1 The Chair of the review wrote to Lucy's work friends and colleagues, inviting them to contribute to the review. The letter included the appropriate Home Office leaflet and was distributed (personally) to Lucy's colleagues by her employer.

6.3.2 As a result of the invitation to contribute to the review, two of Lucy's work friends met with the Chair of the review.

6.3.3 **Contribution from Friend 1**

Friend 1 described Lucy as a kind, generous, and genuine person who would do anything for everyone. Lucy was open and said things as they were. Lucy had the reputation of being a strong character in the work environment, but this was only a front and was because she was passionate.

6.3.4 Friend 1 had known of Lucy for over 20 years, through working for the same employer. However, it was only after they began working together, around 2018/2019, that they became close friends: speaking at work and daily outside of work via telephone calls. Friend 1 described that when Lucy first started working in her team, she was vulnerable due to her alcohol use, and there was a lot of support provided. After a period of time, it was known that Lucy had started to drink alcohol again.

6.3.5 Lucy was sociable in the office, for example, often preparing and sharing food for everyone, feeding everyone, and bringing in items such as colouring books for colleagues' children. Lucy and Friend 1 did not socialise outside of the

office, which was linked to Covid-19 and Lucy's health conditions, but often spoke on the telephone outside working hours.

6.3.6 **Knowledge of Dennis**

Friend 1 described Dennis as 'solitary', and that he did not appear to have friends outside his relationship with Lucy. It was known that he had money and owned properties, but these properties were thought to be lived in by his family members. Lucy told Friend 1 that Dennis was receiving about £3000 per month from a pension.

6.3.7 **Knowledge of Lucy and Dennis's Relationship**

Friend 1 said that, as a couple, Lucy and Dennis appeared happy and solid together in their relationship. Lucy loved cats and dogs. They owned a caravan in France and went to France for around three weeks every year. Lucy told Friend 1 that there was no intimacy in her relationship with Dennis, which Lucy was happy about. They were more like companions.

6.3.8 Friend 1 described how she was aware that arguments had started in the relationship prior to Lucy's death, and that Lucy and Dennis had split up in January 2022. The arguments were over financial matters and an issue over an expensive watch, which Dennis had promised to someone. Lucy said that Dennis did not pay towards the house or bills. Lucy had funded a new kitchen.

6.3.9 Lucy told Friend 1 that Dennis had turned off Lucy's landline and mobile phone, and that this had caused Lucy distress because the landline was the number that had belonged to her grandmother and had sentimental value (Lucy lived in and owned her grandmother's former home). Friend 1 had spoken to Lucy about making a will, to ensure that financial matters were in order for Lucy's adult child, Alex[1].

6.3.10 Friend 1 stated that after Lucy and Dennis split up in January 2022, Dennis started to watch the house and watch Lucy. This made Lucy nervous, and as a result, Lucy had CCTV and a new lock installed on the gate outside the property. Lucy told Friend 1 that Dennis had stated that he was going to report Lucy to the police for driving whilst under the influence of alcohol. Friend 1 described how Lucy and Dennis got back together after their dog had fallen ill and they had to take the dog to the vet for treatment. After this, they started spending time together.

[1] A pseudonym agreed with Lucy's family.

6.3.11 **Work**

Friend 1 provided some examples of Lucy's work ethic, which included –

- Working in a soup kitchen and providing food: she would usually be joined by Dennis.
- Lucy and Dennis taking food and other items to a tenant who had recently given birth and was short of money.
- Lucy would often source items for tenants who were struggling financially.
- Dennis would often drive Lucy to work appointments. On the face of it, this was thought to be in order to ensure that Lucy did not have to worry about being over the alcohol limit to drive herself (Lucy's employer was not aware of this).
- Lucy was worried about the alcohol testing that was to be introduced at work and had purchased her own breathalyser (over £300) to test her alcohol levels.

6.3.12 **Domestic Abuse**

On occasions, Friend 1 had seen Lucy at work with bruises (mainly on her arms), which was thought to be linked to Lucy's vulnerability and falling over. At no stage did Friend 1 think that this was due to domestic abuse, and nothing about Lucy's presentation and explanations led her to believe otherwise. Friend 1 stated that if Lucy was being physically abused by Dennis, then she strongly felt that Lucy would have spoken out about this, told her, and left the relationship, such were her strong values.

6.3.13 Within the workspace, there are Well-being Champions that are freely advertised for staff to contact. There is information on the company Intranet*. Friend 1 stated that one of the things that may have prevented Lucy seeking support, was going to a venue or agency and the risk of meeting a client, etc.

6.3.14 Two other colleagues alerted the police when they became concerned that Lucy did not attend an important work meeting. Information in their statements to the police, included that a third colleague had spoken to Lucy the evening before her death, and everything had appeared fine. Lucy had arranged work appointments for the day that she was found deceased.

6.3.15 * Lucy's employer provided the following information:
There has been a Domestic Abuse Policy in place since 2018, and this is available on our intranet for all employees to access. The information details steps to look out for should an individual be suffering domestic abuse, and includes support available and signposts people to a number of agencies,

including IDAS. We also have a number of Wellbeing Champions across the organisation from numerous different service areas. Staff are able to access this confidential support, should they wish.

6.4.1 **Contribution from Friend 2**

Friend 2 described Lucy as a 'force to be reckoned with'. A physically small but an emotionally strong person who would stand up for what she believed in. At the same time, Friend 2 was aware of Lucy's vulnerabilities, and especially in 2022, saw that Lucy was struggling physically, for example, with pain in her limbs.

6.4.2 Friend 2 first met Lucy when (aged 18) Friend 2 worked for a different agency. Later, after a move of agency, Friend 2 and Lucy worked together. Friend 2 described how Lucy sometimes tried to shield her from bad news and did not always share difficult health news. Friend 2 thought that this was because she was younger than Lucy and had known Lucy from being a teenager.

6.4.3 Lucy was a kind and generous person who would often give friends and colleagues small gifts. Lucy bought small gifts for Friend 2's children when they were doing exams at school.

6.4.4 **Knowledge of Dennis**

Friend 2 previously thought that Dennis was a good man and had been comfortable in his company. Dennis was generous with his time and had helped Friend 2 and her family on a number of occasions. Friend 2 was aware that Dennis owned properties and that Lucy expressed discontent that Dennis's sibling lived in one of the properties.

6.4.5 **Knowledge of Lucy and Dennis's Relationship**

Friend 2 had no sense of any domestic abuse in Lucy and Dennis's relationship. They appeared content with each other until their relationship breakdown in January 2022. Friend 2 knew that Dennis had spent a lot of time on an extension at Lucy's house. When this was finished, Lucy was pleased and proud about it. Lucy told Friend 2 that Dennis would often have food ready for her when she got home from work.

6.4.6 After the relationship breakdown, Lucy told Friend 2 that Dennis had cut off the utilities at her house and cancelled her mobile phone contract. Friend 2 was concerned about this due to Lucy's poor health and was glad when she quickly obtained another mobile phone. At this time, Lucy became concerned

and didn't want to leave the house because she thought Dennis would be watching her. Friend 2 arranged for the CCTV at the house to be modified in order to make Lucy feel better.

6.4.7 In general, Lucy had her own money and was able to buy the things that she wanted, for example, nice clothes or a pair of expensive boots. Lucy told Friend 2 that she was estranged from Dennis's family, and that Lucy and Dennis would sometimes argue about this. Lucy had fallen out with one of Dennis's siblings and would not agree to be in the same room as them.

6.4.8 **Work**

Friend 2 described a very close working relationship with Lucy, and especially during Covid-19 lockdown, they were in touch all the time. Friend 2 admired Lucy's work ethic and her willingness to help people. On a number of occasions, Friend 2 had seen Lucy spend her own money to help clients with food and small household items.

6.4.9 After Lucy's hospital admission in August 2021, colleagues were aware of Lucy's poor health and how she was physically impacted by this. For example, she struggled to walk up steps or for long distances. Colleagues who knew Lucy was struggling, rallied around to make sure that she was organised at work and that her work did not suffer.

6.4.10 Friend 2 commented that Lucy was not very IT literate. Colleagues would joke that Lucy was jinxed, as things would often go wrong for her. In this context, Friend 2 was not surprised that Dennis would have access to utility accounts, etc., as Friend 2 thought that Lucy may struggle to manage them herself online.

6.5 **Nail Technician**

Following Lucy's death, the police obtained a statement from a nail technician who visited Lucy at home, regularly, from October 2021 until Lucy's death. Appointments would normally be every three or four weeks and would take place in the dining room of Lucy's home. Dennis was always present and would take part in the conversation. Specific incidents are referenced in section 13.3 of the report.

7 CONTRIBUTORS TO THE REVIEW / AGENCIES SUBMITTING IMRs

7.1	**Agency**	**Contribution**

South Yorkshire Police	IMR
Barnsley Hospital NHS Foundation Trust	IMR
South West Yorkshire Partnership NHS Foundation Trust	IMR
Yorkshire Ambulance Service	IMR
NHS South Yorkshire ICB – Barnsley	IMR
Barnsley Recovery Steps (Humankind)	IMR
Lucy's employer	Narrative report

7.2 As well as the IMRs, each agency provided a chronology of interaction with Lucy and the perpetrator, including what decisions were made and what actions were taken. The IMRs considered the Terms of Reference (TOR) and whether internal procedures had been followed and whether, on reflection, they had been adequate. The IMR authors were asked to arrive at a conclusion about what had happened from their own agency's perspective, and to make recommendations where appropriate. Each IMR author had no previous knowledge of Lucy or the perpetrator, nor had any involvement in the provision of services to them.

7.3 The following agencies were written to as part of the scoping process for the review; however, they held no information on the victim or perpetrator prior to the incident:

- Barnsley Adult Social Care
- Barnsley Children's Social Care
- Probation Service

7.4 Information about agencies contributing to the review.

South Yorkshire Police
South Yorkshire Police is the territorial police force responsible for policing South Yorkshire in England.

Barnsley Hospital NHS Foundation Trust
Barnsley Hospital is managed by a Board of Directors. The Board is responsible for the operational management of the hospital and, with input from the Council of Governors, sets the direction for the future of the hospital.

South West Yorkshire Partnership NHS Foundation Trust
The Trust exists to help people reach their potential and live well in their communities. The Trust does this through its mental health, community, learning disability, and wellbeing services across Barnsley, Calderdale, Kirklees, and Wakefield. The Trust also provides specialist secure mental health (forensic) services for the whole of Yorkshire and Humber.

Yorkshire Ambulance Service (YAS)
YAS covers nearly 6,000 square miles of varied terrain, from isolated moors and dales to urban areas, coastline, and inner cities. YAS serves a population of over five million people across Yorkshire and the Humber and strives to ensure that patients receive the right response to their care needs as quickly as possible, wherever they live. YAS employs more than 5,800 staff, who together with over 1,100 volunteers, provides a vital 24-hour, seven-days-a-week, emergency and healthcare service.

NHS South Yorkshire ICB – Barnsley
NHS South Yorkshire Integrated Care Board – Barnsley (sometimes shortened to ICB), represents 32 GP practices and over 245,000 patients and is based in South Yorkshire. It has responsibility for commissioning healthcare for the population of Barnsley. Commissioning is a process of planning and buying services to ensure that the people who live in the borough have the right healthcare.

Barnsley Recovery Steps (Human Kind)
Barnsley Recovery Steps is a drug and alcohol service that offers a range of free, confidential, and non-judgemental services for adults aged 18+ and their families whose lives are affected by drugs and/or alcohol.

The aim of the service is to support people to stay safe and live happier, healthy lives, free from drugs and alcohol. They have experienced and professional teams who will work with individuals on their journey to recovery from drugs and/or alcohol.

Independent Domestic Abuse Service (IDAS)

IDAS is the largest specialist charity in Yorkshire, supporting anyone experiencing or affected by domestic abuse or sexual violence. Their services include refuge accommodation, community-based support, peer mentoring, group work, and access to a free and confidential 'out of hours' helpline. A team of accredited specialist workers (IDVAs and ISVAs) support people through the criminal justice system, in addition to providing emotional support and safety planning advice.

8 THE REVIEW PANEL MEMBERS

Ged McManus	Independent Chair and Author
Carol Ellwood-Clarke	Support to Chair and Author
Rosemary Clewer	Senior Commissioning Manager, Stronger, Safer & Healthier Communities Business Unit, Barnsley Metropolitan Borough Council
Calise Martin	Case Review and Policy Officer, South Yorkshire Police
Abigail Akers	Intelligence Researcher, South Yorkshire Police
Rebecca Slaytor	Named Nurse, Adult Safeguarding, Barnsley Hospital NHS Foundation Trust
Emma Cox	Associate Director of Nursing, Quality and Professions, South West Yorkshire Partnership NHS Foundation
Catherine Holiday	Named Professional for Safeguarding Yorkshire Ambulance Service
Gillian Pepper	Adult Safeguarding Nurse Specialist, NHS South Yorkshire ICB – Barnsley
Claire McEvoy	Area Manager, Barnsley Recovery Steps (Humankind)
Katherine Allott-Stevens	Head of Estate Services, Berneslai Homes
Donna Clark	Area Manager IDAS (Domestic Abuse Service)
Alice Barker Milner	Policy Officer for Domestic Abuse, Barnsley Metropolitan Borough Council, Healthier Communities

Al Heppenstall	Housing and Case Management Team Lead, Barnsley Metropolitan Borough Council
Amy Hoyle	Contracts and Relationships officer, Domestic Abuse, Barnsley Metropolitan Borough Council

Each panel member was independent, having no previous knowledge of the subjects nor any involvement in the provision of services to them. The exception was the representative of Lucy's employer.

9 AUTHOR AND CHAIR OF THE OVERVIEW REPORT

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 set out the requirements for review Chairs and Authors. In this case, the Chair and Author was the same person.

9.2 Ged McManus was chosen as the DHR Independent Chair and Author. He was judged to have the skills and experience for the role. He has experience as an Independent Chair of a Safeguarding Adult Board (not in Barnsley or an adjoining authority). Ged served for over thirty years in different police services in England. Between 1986 and 2005, he worked for South Yorkshire Police – a contributor to this review – before moving to another police service. The commissioners of the review were satisfied of his independence, given the length of time since he had any involvement with South Yorkshire Police.

9.3 Carol Ellwood-Clarke supported the Chair. She retired from public service (British policing – not South Yorkshire) in 2017, after thirty years, during which she gained experience of writing Independent Management Reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews and Safeguarding Adults Reviews. In January 2017, she was awarded the Queens Police Medal (QPM) for her policing services to Safeguarding and Family Liaison. In addition, she is an Associate Trainer for SafeLives.

9.4 Between them, they have undertaken the following types of reviews: Child Serious Case Reviews; Safeguarding Adults Reviews; multi-agency public protection arrangements (MAPPA) serious case reviews; Domestic Homicide Reviews; and have completed the Home Office online training for undertaking DHRs. They have both completed accredited training for DHR Chairs, provided

by AAFDA. Both have completed previous DHRs in Barnsley.

10 PARALLEL REVIEWS

10.1 An inquest was opened and adjourned immediately following Lucy's murder. It had not been concluded at the time of completion of the DHR.

10.2 No other agency contributing to the review, has carried out any form of internal enquiry regarding the circumstances of the case.

10.3 A DHR should not form part of any disciplinary inquiry or process. Where information emerges during the course of a DHR that indicates disciplinary action may be initiated by a partnership agency, the agency's own disciplinary procedures will be utilised: they should remain separate to the DHR process.

11 EQUALITY AND DIVERSITY

11.1 Section 4 of the Equality Act 2010 defines protected characteristics as:

Age (for example an age group would include "over fifties" or twenty-one-year olds. A person aged twenty-one does not share the same characteristic of age with "people in their forties". However, a person aged twenty-one and people in their forties can share the characteristic of being in the "under fifty" age range).

Disability (for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act).

Gender reassignment (for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully 'passes' as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act).

Marriage and civil partnership (for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic).

Pregnancy and maternity

Race (for example colour includes being black or white. Nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be "black Britons" which would encompass those people who are both black and who are British citizens).

Religion or belief (for example the Baha'i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be).

Sex

Sexual orientation (for example a man who experiences sexual attraction towards both men and women is "bisexual" in terms of sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So, a gay man and a lesbian share a sexual orientation).

Section 6 of the Act defines 'disability' as:

(1) A person (P) has a disability if:
(a) P has a physical or mental impairment, and
(b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.

11.2 Lucy was a 55-year-old, heterosexual, white British woman. She had been separated from her husband for many years and divorced only approximately a year before Lucy's death. Lucy had an adult child. Lucy suffered from diabetes, which was controlled by her diet. She suffered from alcoholic liver disease and

the complications of that condition. Lucy regularly attended medical appointments and was engaged in her treatment.

11.3 Dennis was a 67-year-old, heterosexual white British man. He was divorced and had no children. Dennis also suffered from diabetes. His condition was controlled by insulin. Dennis had hearing problems and had regular treatment for his condition. In February 2022, Dennis was prescribed medication to treat depression.

11.4 The panel considered whether Lucy could be classed as having a disability as defined by Section 6 of the Equality Act 2010. There was evidence presented to the review, that she had presented with problems with alcohol. Although her use of alcohol was undoubtedly significant in her life, the Equality Act 2010 (Disability) Regulations 2010 (SI 2010/2128) specifically provide that addiction to alcohol, nicotine or any other substance (except where the addiction originally resulted from the administration of medically prescribed drugs) is to be treated as not amounting to an impairment for the purposes of the Equality Act 2010. Alcohol addiction is not, therefore, covered by the Act.

11.5 Both Lucy and Dennis attended or rearranged all medical appointments. They both appeared to be engaged in their treatment and were able to discuss and make decisions on appropriate treatment options. There are no records held by agencies that indicated Lucy or Dennis were disabled within the meaning of the Act.

11.6 The panel discussed whether the 12-year age difference between Lucy (55) and Dennis (67) could have created an imbalance of power between the couple. The panel was unable to come to a conclusion on this, as there was no information in agency records to indicate that the age difference was the source of any issues that the couple may have had.

11.7 Domestic abuse, and domestic homicide in particular, is predominantly a gendered crime: with women by far making up the majority of victims, and by far the vast majority of perpetrators being male. A detailed breakdown of homicides reveals substantial gendered differences.

According to the Office for National Statistics homicide report[2]:

[2] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/yearendingmarch2021

There were 114 domestic homicides in the year ending March 2021. This is a similar number to the average over the last five years (121). These numbers reflect the low level of domestic homicides seen since year ending March 2017 and the general downward trend in the number of domestic homicides over the last 10 years. While the coronavirus (COVID-19) pandemic restrictions did not lead to an increase in domestic homicides in the latest year, as may have been expected, non-domestic homicides decreased by 17% (from 508 to 420).

Of the 114 domestic homicides, 67 victims were killed by a partner or ex-partner (down from 74), 27 were killed by a parent, son or daughter (down from 32), and 20 were killed by another family member (up from 15).

Almost half (49%) of adult female homicide victims were killed in a domestic homicide (75). During COVID-19 lockdown periods covering 23 March to 3 July 2020, 5 November to 2 December 2020, and 5 January to 31 March 2021, this was 56%, highlighting the change in composition of homicides during the restrictions. Of the 75 female victims, 72 were killed by a male suspect (Appendix table 31).

Males were much less likely to be the victim of a domestic homicide, with only 10% (39) of male homicides being domestic related in the latest year, a similar proportion to the previous year.

In over a third of female adult victims, the suspect was their partner or ex-partner (37%, 57 homicides).

11.8 There is no evidence arising from the review of any negative or positive bias on the delivery of services to Lucy or Dennis based on the protected characteristics.

12 DISSEMINATION

Lucy's family
Home Office
Safer Barnsley Partnership
H M Coroner
All agencies that contributed to the review
South Yorkshire Police and Crime Commissioner
Domestic Abuse Commissioner

13 BACKGROUND, OVERVIEW AND CHRONOLOGY

13.1 Introduction

13.1.1 This part of the report combines the Background, Overview and Chronology sections of the Home Office DHR Guidance overview report template. This was done to avoid duplication of information and to recognise that the review was looking at events over an extended period of time. The narrative is told chronologically. It is built on the lives of Lucy and Dennis and punctuated by subheadings to aid understanding. The information is from documents provided by agencies and material gathered by the police during the homicide investigation. Quotes are taken from police statements that were disclosed for the purposes of the DHR. Analysis appears at section 14 of the report.

13.2 Lucy

13.2.1 Lucy's mum says that Lucy was a genuine, caring, and thoughtful person who would do anything to help anyone. Lucy spent a lot of time with her mum, and they got on well.

13.2.2 Lucy had a child, Alex, with her then husband. Lucy split from her husband when the child was around two years old.

13.2.3 Lucy and Alex would often visit Lucy's mum, and Sunday lunch was an event they all looked forward to. Lucy and Alex had a close relationship and enjoyed many activities together, such as kickboxing. Alex says that Lucy was outgoing and had many friends.

13.2.4 Both Lucy's mum and Alex were aware of Lucy's long-standing health issues related to alcohol, which they thought may have been present before she met Dennis.

13.3 Dennis

13.3.1 Dennis was the youngest of five siblings. One of his siblings provided a statement to the police, and some of the information from that statement is used here.

13.3.2 Dennis was a healthy and happy young man who gained a qualification in welding when he left school. He became a plant manager for British Coal in his early thirties and went on to undertake similar roles in Africa and America.

13.3.3 Dennis was married and divorced twice. During his second marriage, Dennis and his wife had a substantial lottery win. At the time of his death, Dennis still owned properties that had been bought with the money. His second marriage ended in around 2010. Dennis moved into Lucy's house in 2011.

13.4 Lucy and Dennis's Relationship

13.4.1 Lucy's mum and Alex told the Chair of the review how soon after Lucy's relationship with Dennis started, it was difficult to see Lucy without Dennis, as they would always be together.

13.4.2 Lucy's mum stopped hosting Sunday lunch because it became unpleasant. She did not enjoy Dennis's company and thought that he had a superior attitude towards her and the rest of the family.

13.4.3 Dennis began building an extension at the rear of Lucy's house. This went on for seven years and caused the house to be very dark at the rear, as the existing walls could not be opened up until the extension was watertight. Previously, Lucy had enjoyed cooking and often entertained friends, but this gradually stopped because she became a little embarrassed at the state of her house. Lucy tried to go out for meals with Alex whenever possible so that Alex didn't have to visit the house: Dennis was usually included. Alex tried to buy tickets for the theatre and other events for Christmas and birthdays so that Alex and Lucy could spend some time together. This eventually stopped, as Lucy would cancel or make an excuse not to attend. It seemed that Lucy's world became much smaller during her relationship with Dennis.

13.4.4 When Alex graduated from university, they only requested two tickets to the ceremony so that Lucy and Alex's grandmother could attend. This was deliberate act, so that they could spend some time together without Dennis.

13.4.5 Lucy's family described Dennis as a hoarder, and as a result, Lucy's house gradually became more untidy and filled with his possessions. Alex's former bedroom was used as storage for Dennis's tools and other things.

13.4.6 Dennis's sibling said that there would often be arguments in the relationship, and Lucy would ask Dennis to leave.

13.5 Events During the Timescale of the Review

Note: Both Lucy and Dennis had many routine medical appointments for a number of issues. Most appointments are not listed here. Both suffered from diabetes.

13.5.1 On 31 October 2018, Lucy was admitted to Barnsley Hospital for treatment for deranged liver function. She was diagnosed with chronic liver disease due to alcohol. Lucy stayed in hospital until 5 November 2018. A referral was made by the hospital to Barnsley Recovery Steps.

13.5.2 On 6 November 2018, Lucy completed a structured assessment with Barnsley Recovery Steps for entry into their substance misuse service, following referral from Barnsley Hospital. The assessment was completed at Lucy's home.

Lucy reported that her recent hospital admission scared her and made her realise her drinking needed to be addressed. Lucy gave consent to all forms of contact, should she disengage. She also consented for information to be shared with Dennis, her employer, pharmacy, and GP.

Dennis was present during the assessment.

13.5.3 Lucy remained in treatment with Barnsley Recovery Steps until 17 January 2019, when she reported being abstinent from alcohol for 10 weeks. She was discharged from the service and understood that she could refer herself back into the service at any time. In total, there were six face-to-face appointments in this episode of treatment. Lucy was accompanied by Dennis for all of them.

13.5.4 On 27 August 2021, Lucy was admitted to Barnsley Hospital and treated for E. coli in urine, hospital acquired pneumonia, and alcoholic liver disease. Lucy's treatment included an alcohol detox programme. She was discharged home on 28 September 2021. During this hospital admission, Lucy was supported by the hospital alcohol care team. Lucy did not want a referral to Barnsley Recovery Steps, as she thought that she may come across some of her own work clients. As a result, the hospital alcohol care team kept in touch with Lucy regularly (by telephone) until 28 October, when Lucy reported

being abstinent from alcohol since being in hospital and did not require further support.

13.5.5 On 31 August 2021, Lucy became absent from work due to illness.

13.5.6 Lucy's family told the Chair that following her discharge from hospital, Lucy joined an online Alcoholics Anonymous group and attended a number of meetings, which she did not find easy.

Note: Alcoholics Anonymous do not maintain a record of meeting attendance, and no information on this is available.

13.5.7 On 15 January 2022, Dennis contacted the police. Dennis said that he had recently split up from Lucy after an 11-year relationship. Dennis said that someone he believed to be Lucy, had sent messages from his Facebook account to a friend, alleging that he was having an affair with the friend's wife.

Officers attended, and Dennis was advised that this was a civil matter. He confirmed that he only wanted words of advice giving to Lucy, which the officer did over the phone. The officer reiterated to Dennis that there would be no criminal investigation. Dennis indicated that there were previous incidents of domestic issues with Lucy, but he would not provide any further detail when pressed and said that there was nothing in the last six months that would be within a window for prosecution. Due to this, no further action was taken. A DASH risk assessment was completed, with Dennis as the victim. The assessment showed a standard risk.

Lucy's child, Alex, told the Chair of the review that Dennis and Lucy shared a Facebook account in Dennis's name. This had started because some years previously, Lucy had been locked out of her own account for some reason.

13.5.8 At around this time, Lucy's family say that Dennis had the house telephone cut off and cancelled Lucy's mobile phone contract. Lucy had Covid-19 and was very isolated. Alex obtained a spare mobile phone so that Lucy could have contact with family members.

13.5.9 On 18 January 2022, Lucy sent a text message to Friend 2, stating that Lucy and Dennis had split up and that Dennis had cut off the utilities and her mobile phone. The text message was from a new number.

13.5.10 On 20 January 2022, Dennis had a routine appointment with a nurse at his GP surgery to discuss his diabetes. He said that: "he had been having a lot of stress recently with family life".

13.5.11 On 21 January 2022, Lucy telephoned the Barnsley Hospital alcohol care team and said that she had been drinking for eight or nine days following the breakdown of her relationship with Dennis. She was given advice. A member of the team rang Lucy the following day, but the telephone was not answered. A message was left, asking Lucy to make contact if she needed anything further. Nothing further was heard from Lucy.

13.5.12 On 6 February 2022, Lucy sent a text message to Friend 2, stating that Dennis had taken Lucy's car.

13.5.13 On 7 February 2022, during a telephone call between Lucy and a work colleague, the colleague formed the impression that Lucy was intending to take her own life. As a result, the colleague called the ambulance service, who attended at Lucy's home. When an ambulance crew attended at Lucy's home, Lucy was certain that she did not want to harm herself. Lucy said that she had drunk three bottles of wine and did have tablets in the house but was not going to take them. The ambulance crew asked Lucy to travel to hospital, which she declined. A mental capacity test was conducted, and Lucy was deemed to have capacity to make the decision not to travel to hospital. Written information was left with Lucy for an alcohol support service and details regarding a mental health support group. Lucy signed paperwork to confirm that she was remaining at home against medical advice.

13.5.14 On 14 February 2022, Dennis had an appointment with a GP. Dennis discussed with the GP, issues with family, Lucy, and physical and mental abuse. Dennis said that he had moved out of Lucy's house and was living with family. He had thoughts of self-harm but no direct plans to harm himself. Dennis was prescribed sertraline[3]. At this time, Dennis's sibling was helping him to look for a property to rent, but the search was unsuccessful. In March 2022, Dennis sought a repeat prescription and disclosed some minor side effects of the medication. As a result, the prescription was changed to fluoxetine.

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

13.5.15 In February 2022, Lucy's nail technician visited her at home for a prearranged appointment. During this appointment, Lucy told the nail technician that the relationship with Dennis had ended. Lucy said that Dennis had taken her car, cut off the internet, and blocked her from accounts, for example, Netflix. The technician formed the impression that Dennis dealt with financial matters, as Lucy didn't seem to know what to do.

Lucy's mum and adult child thought that Dennis had probably helped set up Lucy's online accounts, which may account for the impression that Lucy didn't know what to do. Alex dealt with Lucy's estate after Lucy's murder, and she told the Chair of the review that Lucy dealt with her own financial affairs. Lucy and Dennis had separate bank accounts, and Lucy took care of all household bills. After the murder, Alex found papers indicating that Lucy had taken out a loan to pay for a new kitchen in the extension that had been built.

13.5.16 On 1 March 2022, Lucy attended an occupational health appointment initiated by her employer (She was absent from work through illness at this time). The OHU report stated that the possibility of Lucy reverting back to alcohol remained high. Should this be the case, she should be encouraged to sign an alcohol contract through which she could have regular blood tests to ensure that she was fit to drive, as this was part and parcel of her job. It was agreed that Lucy would return to work on 4 April 2022. Lucy signed an alcohol testing contract, giving written consent for random testing by a third-party company. Other measures were in place during Lucy's return to work, for example, Lucy was not in the office alone, and colleagues provided as much support as possible to assist her transition back to work.

13.5.17 On 4 April 2022, Lucy contacted Barnsley Recovery Steps to refer herself into treatment for alcohol misuse. This was followed up, and on 26 April 2022, Lucy attended (in person) for a full assessment. Lucy's case was allocated to a recovery navigator who then met with Lucy in the following days. In total, there were four face-to-face appointments in this episode of treatment before Lucy's murder. Lucy was accompanied by Dennis for all of them.

13.5.18 In early May 2022, whilst out on a work visit together, Lucy wanted to call at home to show Friend 2 the work that had been done on the house and some new furniture. When they called into Lucy's house, Dennis was sat outside (on the new decking) reading a book. Friend 2 commented that Dennis had

lost several stones in weight since she had last seen him before Christmas. Lucy and Dennis seemed content in each other's company on this occasion.

13.5.19 In early May 2022, Lucy sent a text to her nail technician to arrange an appointment. In this text, Lucy said that she and Dennis were 'giving it another go'.

13.5.20 In early May 2022, Lucy's nail technician visited Lucy at home. Dennis was present. Unusually, Lucy was fully dressed and made up: she was normally in her dressing gown with no makeup on during these appointments. The dining room, which was normally cluttered with tools and other things, was unusually tidy. Lucy disclosed that Dennis 'was on his best behaviour' and had been doing some work in the garden. During the appointment, Dennis went outside and was cutting some trees and hedges. Lucy said that they had bought new garden furniture, which she showed to the nail technician.

13.5.21 During an evening in May 2022, Lucy and Friend 2 had a telephone call covering a number of issues and made arrangements for work the following day. Lucy seemed fine during this call. Friend 2 was always concerned about Lucy due to Lucy's health issues, and on this occasion, their concerns were at a normal level. Friend 2 did not feel that there was anything additional to be concerned about during this conversation.

13.5.22 Later the same evening, Dennis telephoned his sibling and asked them to go to see him at Lucy's house. When the sibling arrived, Dennis answered the door and handed over a bag containing some paperwork. The sibling heard Lucy shouting in the background.

13.5.23 The following day, Lucy and Dennis were found dead in their home.

14 ANALYSIS

14.1 What indicators of domestic abuse did your agency have that could have identified Lucy as a victim of domestic abuse, and what was the response?

14.1.1 No agency had information that directly indicated that Lucy was a victim of domestic abuse prior to her murder. Lucy had never reported domestic abuse to the police or sought help from any known agency.

14.1.2 During Lucy's two periods of engagement with Barnsley Recovery Steps, Dennis attended every face-to-face appointment with Lucy. This level of attendance by significant others (to support an individual) is uncommon; however, the service encourages significant others to be involved in a person's recovery journey, to strengthen their sources of external support. Appointments were not all with the same staff member, and so a pattern was not identified at the time.

14.1.3 During an appointment for a blood test with Barnsley Recovery Steps, a health care assistant made an admiring comment about a large diamond ring that Lucy was wearing. Lucy replied, saying: "It's my engagement ring". Dennis then said: "That just proves how much I love her".

14.1.4 Dennis also attended many other medical appointments with Lucy. The panel discussed whether attendance at appointments could be construed as controlling behaviour. The panel concluded that whilst this could be one indicator of controlling behaviour, it could also be an indicator of a supportive partner. Taken in isolation, the panel found it difficult to come to any conclusion.

14.1.5 The panel also acknowledged information that after her return to work from illness in April 2022, Dennis often drove Lucy to work appointments. This was known to some work colleagues but not to her employer. The panel discussed whether this could have been a form of controlling behaviour and also whether it may have been a mitigation of Lucy's alcohol consumption, in order to reduce the risk of her committing a driving offence. Again, the panel found it difficult to come to any conclusion.

14.2 **What knowledge did your agency have that indicated Dennis might be a perpetrator of domestic abuse against Lucy, and what was the response? Did that knowledge identify any controlling or coercive behaviour by Dennis?**

14.2.1 No agency had any knowledge of information that indicated that Dennis was a perpetrator of domestic abuse.

14.2.2 The only time the couple came to the attention of the police was on 15 January 2022, when Dennis reported to the police his suspicion that Lucy had used his Facebook account to send messages. Lucy was recorded as the suspect. On this occasion, officers attended the incident and spoke with Dennis to ascertain whether there was a risk, and what action to take. Dennis noted that there were previous incidents; however, no action was taken, as Dennis would not disclose anything further when asked, noting that this occurred a long time ago. No controlling or coercive behaviour was identified in relation to Dennis. A DASH[4] risk assessment was conducted and recorded a standard risk. This was not sent to IDAS because only high-risk cases are referred without consent. Dennis did not consent to a referral. When officers spoke to Lucy over the phone following the incident reported by Dennis, no concerns or indicators of domestic abuse were noted to suggest domestic abuse was being perpetrated towards Lucy.

14.2.3 Lucy told family and friends that Dennis had arranged for the household utilities and her mobile phone to be cut off. This is a clear example of controlling behaviour but was unknown to agencies at the time.

14.2.4 During an appointment with a GP on 14 February 2022, Dennis said that he was suffering from stress. He said that he and Lucy had separated, as she had relapsed into using alcohol. Dennis was upset and wanted to be with Lucy and provide support, but Lucy didn't want him near her. Dennis disclosed historic physical and verbal abuse from Lucy, and he said that he had been told by the police it was not possible to take action as it was longer than six months ago. He was offered contact details for a domestic abuse support agency but declined.

[4] The Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model was implemented across all police services in the UK from March 2009, having been accredited by ACPO Council, now known as National Police Chief Council (NPCC).

The panel heard that GPs in Barnsley do not complete DASH risk assessments. Instead, where appropriate, the ask HARK questions are used.

The four HARK questions were developed as a framework for helping identify people who have suffered domestic abuse, and it was found to be a sensitive tool. HARK stands for:

- Humiliation: "In the last year, have you been humiliated or emotionally abused in other ways by your partner?" "Does your partner make you feel bad about yourself?" "Do you feel you can do nothing right?"
- Afraid: "In the last year, have you been afraid of your partner or ex-partner?" "What does your partner do that scares you?"
- Rape: "In the last year, have you been raped by your partner or forced to have any kind of sexual activity?" "Do you ever feel you have to have sex when you don't want to?" "Are you ever forced to do anything you are not comfortable with?"
- Kick: "In the last year, have you been physically hurt by your partner?" "Does your partner threaten to hurt you?"

Depending on the response to HARK questions, a GP may make a referral to IDAS. The panel thought that the actions of the GP in this instance were reasonable. The Review Panel was informed that meetings were taking place between the ICB (representing GP practices) and IDAS, with the aim of building on current GP responses to indicators of domestic abuse. This includes reviewing existing templates currently used to gather and prompt additional questions on indicators of abuse.

14.2.5 The panel considered whether the recognised side effects of the medication prescribed to Dennis (sertraline) could have affected his behaviour. The patient information leaflet for sertraline warns of an increased risk of thoughts of self-harm and suicide, particularly in the first two-weeks of taking the medication. The available research presents a mixed picture, but the most recent systematic review / meta-analysis[5] concluded that for adults, there was no increased risk.

[5] https://www.bmj.com/content/bmj/352/bmj.i65.full.pdf Suicidality and aggression during antidepressant treatment: systematic review and meta-analyses based on clinical study reports. Tarang Sharma, Louise Schow Guski, Nanna Freund, Peter C Gøtzsche

14.2.6 The Domestic Homicide Project, Vulnerability Knowledge and Practice Programme (VKPP), NPCC, College of Policing[6] year one report contains the following findings in relation to domestic homicides in the 12 months to 31 March 2021.

14.2.7 **Homicide-suicide** (where the suspect died by suicide after murdering their partner). Of a total of 22 deaths involving homicide followed by suicide by the suspect, 13 of these victims were killed by an intimate partner. All 13 victims of intimate partner homicide followed by suicide, are suspected to have been murdered by a male partner. These intimate partner homicide-suicide cases fell into two broad patterns: (a) older males killing their female partners then themselves, where both partners were aged 65 years or older (7 cases, 54%); and (b) younger males (28 to 56) killing their female partners and then themselves (6 cases, 46%).

With the older couples (a), none of the suspects were previously known to police for domestic abuse, and very little information was known about the history of the couple, in general. In three of these cases, the victim had chronic mental and/or physical health conditions, while one couple was known to mental health services, following reports that they had a suicide 'pact.' Overall, the six younger intimate partner homicide-suicide cases (b) included a varied history of high-risk domestic abuse perpetrated against a previous partner, recent separation, previous suicidality of the suspect, and previous attempts or threats to kill this, or a previous, victim. In three of the younger intimate partner homicide-suicide cases, the victim was between 28 and 30 years old (suspect 28 to 34 years), and there was greater police knowledge about the suspects than within the older couples' cases (a).

14.2.8 The panel reflected that Lucy and Dennis's case was similar to the profile of group (a) – 'none of the suspects were previously known to police for domestic abuse, and very little information was known about the history of the couple, in general'.

14.2.9 Following Lucy and Dennis's deaths, Lucy's adult child Alex began the process of dealing with Lucy's estate and in doing so cleared out Lucy's house. Alex found a note apparently written by Dennis on the back of an official letter

[6] https://www.vkpp.org.uk/assets/Files/Domestic-Homicides-and-Suspected-Victim-Suicides-2021-2022/VKPP-Domestic-Homicides-and-Suspected-Victim-Suicides-2020-2021.pdf

that he had received dated 21 December 2021. The note indicated that by the time Dennis was found he would be dead. The note expressed his regret to Lucy and her family for any distress. The panel could not be sure when this note was written. Lucy's family suspect that it was at around the time the couple split up in early 2022. The panel noted that such a note could have expressed a genuine intention. It could also have been an attempt to elicit sympathy from Lucy or coerce her to stay in the relationship.

14.3 **How did your agency assess the level of risk faced by Lucy? In determining the risk, which risk assessment model did you use, and what was your agency's response to the identified risk?**

14.3.1 No agency identified Lucy as a victim of domestic abuse; therefore, there was never a domestic abuse risk assessment of any kind completed in respect of Lucy.

14.3.2 Barnsley Recovery Steps completed a structured risk assessment on two occasions: 6 November 2018 and 26 April 2022. Domestic abuse forms part of the risk assessment template within the Safeguarding Adults, Safeguarding Children, Housing, and Criminal Justice and Offending sections, where there are prompts related directly to this. In both structured assessments, no risk was identified in relation to domestic abuse.

14.4 **How did your agency respond to any mental health issues, substance misuse, and/or self-neglect, when engaging with Lucy and Dennis?**

14.4.1 Lucy accessed Barnsley Recovery Steps for problematic alcohol use; consequently, this was a focus in every intervention provided. In both treatment episodes, Lucy was allocated a recovery navigator to support her with psychosocial interventions and was also in receipt of pharmacological support and assessment for relapse prevention medication.

14.4.2 In the first treatment episode (6 November 2018 – 17 January 2019), Lucy reported maintaining abstinence following a hospital admission, and the focus was around relapse prevention and harm reduction. Her treatment goals were to remain abstinent, and she was discharged as alcohol free on 17 January 2019.

14.4.3 In the second treatment episode (4 April 2022 – 11 May 2022), Lucy had commenced drinking problematically again and identified experiencing withdrawal symptoms. Interventions focussed on safe reduction (structured

reduction plan or preparing for detox), clinical assessment, and harm reduction. Lucy's treatment goal fluctuated from abstinence to social drinking, and Lucy did report a reduction in her alcohol consumption during this treatment episode.

14.4.4 Structured assessments and risk assessments completed in each treatment episode, identified issues relating to mental health. In the first treatment episode, Lucy identified a breakdown 10 years ago, an overdose of paracetamol and alcohol, but no current mental health issues, suicidal ideation, or self-harm. The risk management plan identified for this to be revisited and monitored during interventions. Identified low mood was discussed in one intervention, which Lucy related to a challenging incident with her GP surgery, but no further mental health concerns were identified prior to her discharge from the service.

14.4.5 In the second treatment episode assessment, historical suicide attempts were disclosed: 16 years previously, with an overdose of paracetamol and alcohol; and 13 years previously, using the same method. Lucy reported that the triggers were a previous relationship breakdown and feeling overwhelmed when completing a degree. Lucy stated that she received no aftercare support. Lucy described herself as 'depressed' but had not received a diagnosis, and she recognised the barriers of engaging in mental health services whilst using alcohol. The risk management plan identified a potential referral into IAPT[7] following alcohol reduction, awareness of crisis contacts, and ongoing monitoring at each intervention. Lucy's mental health was discussed following interventions, where she described her mood as 'fine' and 'OK'. Some stressors were identified, but no other concerns were highlighted.

14.4.6 During the second treatment episode, Lucy told her mum that she had visited Barnsley Recovery Steps and met a worker who Lucy thought could really help her. Lucy told her mum that on leaving Barnsley Recovery Steps, she had bumped into one of her own clients who was going in.

14.4.7 Lucy was treated as an inpatient and outpatient at Barnsley Hospital. All medical treatment is considered to have been appropriate. In August 2021, Lucy was initially seen by the alcohol care team at Barnsley Hospital whilst she was an inpatient. The normal process is for a referral to be made to Barnsley Recovery Steps on discharge. However, Lucy declined this, giving

[7] The NHS Talking Therapies, for anxiety and depression programme (formerly known as Improving Access to Psychological Therapies, IAPT) was developed to improve the delivery of, and access to, evidence-based, NICE recommended, psychological therapies for depression and anxiety disorders within the NHS.

the reason that due to her professional role, she might come into contact with people she would know at the outpatient clinics. In view of this, the alcohol care team agreed to support Lucy via the telephone. The team kept in touch with Lucy for a month after her discharge, when she said that she didn't need further support. The panel thought that this flexibility by the alcohol care team, which was outside normal policy, would have been helpful to Lucy. In January 2021, Lucy again contacted the team and was given some initial advice. This was followed up the following day with a phone call, which was not answered. A message was left, asking Lucy to make contact with the team; however, no contact was received.

14.4.8 Lucy's family told the Chair that Lucy did not easily accept the diagnosis of liver disease. Lucy complained of aching bones and general aches and pains, which she did not relate to the liver disease, and she appeared unsure of what the prescribed medications were for.

14.4.9 Lucy's family thought that there should have been a more coherent plan surrounding Lucy's discharge from hospital in September 2021. They did not feel that leaving Lucy to engage in services on her own was sufficient, and they thought that more help and guidance should have been provided. They were not aware that Lucy had declined a referral to Barnsley Recovery Steps or the role of the hospital alcohol care team.

14.4.10 The panel acknowledged the family's views and discussed whether a more assertive approach to helping Lucy engage with Barnsley Recovery Steps, or another agency, could have been helpful. In doing so, the panel referenced the Alcohol Change Blue Light project[8]. The panel was told that the professional experience of Barnsley Recovery Steps is that where people are motivated to make change, their engagement in service is improved**.** Successful outcomes are more likely where the individual is motivated to engage and make change.

14.4.11 The panel also explored whether an out-of-area referral to an alcohol support agency would have been possible, given Lucy's concerns about bumping into her own work clients at meetings, etc. Some alternatives were in place, for example, on Lucy's first engagement with Barnsley Recovery Steps: where she was visited at home in November 2018. The panel was told that an out-of-area referral was possible but did not happen often. There is no evidence that it was explored in Lucy's case. Barnsley Recovery Steps states that they were not aware of Lucy's concern until it was highlighted by her in relation to

[8] https://alcoholchange.org.uk/help-and-support/training/for-practitioners/blue-light-training/the-blue-light-project

attendance at external mutual aid meetings (for example Alcoholics Anonymous).

14.4.12 When asked by the police as part of the DASH risk assessment on 15 January 2022, whether he was feeling depressed or having suicidal thoughts, Dennis stated that he was feeling down but had no thoughts of self-harm. During the completion of the DASH, Dennis declined a referral to a domestic abuse helpline. A referral to Adult Social Care, for his mental health issues, was not made. No consent is required for these referrals, and he noted that he had been feeling down. The panel sought information from Adult Social Care as to what their involvement could have been if they had received a referral. The Adult Social Care head of service for mental health, reviewed the case and concluded that Dennis would have been contacted to discuss his consent for a further referral. If he had consented, then a referral would have been made to his GP for the GP to review Dennis and consider the involvement of secondary mental health services. The head of service concluded that there would have been no further role for Adult Social Care. The panel noted that Dennis attended a GP appointment on 14 February, when he received a prescription for appropriate medication for depression.

14.4.13 On 7 February 2022, following a concern raised by a colleague, an ambulance crew attended at Lucy's home. The ambulance crew asked Lucy to travel to hospital, which she declined. A mental capacity test was conducted, and Lucy was deemed to have capacity to make the decision not to travel to hospital. Written information was left with Lucy for an alcohol support service and details regarding a mental health support group. Lucy signed paperwork to confirm that she was remaining at home against medical advice. Lucy was seen alone and did not disclose to crew that she lived with Dennis, or that there were any issues in relation to her situation with Dennis.

14.4.14 Lucy had many GP appointments and was referred to appropriate services to help her. She kept appointments, and there were no signs of self-neglect beyond her liver disease. Her last consultation for anxiety was in 2009.

14.4.15 Dennis had a previous period of GP consultations for anxiety: this resolved in 2013, following the finalisation of a divorce from his wife.

14.5 **What services did your agency provide for Lucy and/or Dennis; were they timely, proportionate, and 'fit for purpose' in relation to the identified levels of risk?**

14.5.1 Services provided by Barnsley Recovery Steps have been described in previous paragraphs and are not repeated here. In the second treatment episode, the wait time for structured assessment from referral exceeded NDTMS (National Drug Treatment Monitoring System) guidelines of a maximum of 21 days. On review of other referrals during this period, they were completed within timeframes, and there were appointments available for assessment prior to the 26 April 2022. It is possible that the assessment date was agreed at the request of Lucy; however, no rationale for the delay is documented. Further interventions were provided in a timely and proportionate manner. No detriment to Lucy has been identified as a result of the delay.

14.5.2 Both Lucy and Dennis received regular treatment at Barnsley Hospital in relation to their medical conditions. All treatment is considered to have been appropriate. Both also attended their GP surgery regularly. Their treatment was appropriate according to their presenting conditions. No domestic abuse risk was disclosed by, or identified in relation to, Lucy. The single domestic abuse disclosure by Dennis has already been discussed at paragraph 14.2.3

14.5.3 In 2019, Dennis was supported by the dietetics service of the South West Yorkshire Partnership NHS Foundation Trust, for weight management in relation to his diabetes: he attended three appointments. He was also referred to a group education programme, at his request, for additional support in 2020, which he did not attend. No issues in relation to domestic abuse were disclosed or identified.

14.6 **When, and in what way, were the subjects' wishes and feelings ascertained and considered? Were the subjects advised of options/choices to make informed decisions? Were they signposted to other agencies, and how accessible were these services to the subjects?**

14.6.1 During Lucy's engagement with Barnsley Recovery Steps, recovery plans were completed collaboratively with Lucy at the commencement of both treatment episodes and updated as appropriate. Treatment options were identified and discussed during appointments, to enable Lucy to make informed choices and decisions. Additional recovery support, for example, attendance at Alcoholics Anonymous, was discussed in the first treatment episode; however, Lucy declined this support because she felt that she may come across some of her work clients. As noted at paragraph 14.4.6, Lucy expressed similar sentiments during a hospital admission in 2021; consequently, the hospital alcohol care team provided extended support outside their normal practice. During the

second treatment episode, the opportunity to attend groupwork was accepted, and a referral was made. Lucy booked to attend a face-to-face group meeting but did not attend. Lucy was also given details of how to contact Alcoholics Anonymous. Lucy's family told the Chair that following her discharge from hospital, Lucy joined an online Alcoholics Anonymous group and attended a number of meetings, which she did not find easy.

14.6.2 Lucy's wishes and feelings were clearly considered on the occasion that she was seen by the ambulance service. From the notes recorded on scene, it was clear that time was spent with Lucy. Ambulance staff were on scene in excess of 90 minutes, and their documentation supports that the outcome was what Lucy wanted and had requested. Her choice was respected, and she was given literature about support groups for her to access.

14.7 **Were single and multi-agency policies and procedures, including the MARAC, followed? Are the procedures embedded in practice and were any gaps identified?**

14.7.1 Barnsley Hospital has a domestic abuse policy in which it is stated that all patients over the age of 16, whenever possible, are asked about domestic abuse. This did not occur in the cases of either Lucy or Dennis. Staff across the Trust did not ask either Lucy or Dennis about domestic abuse, despite being provided with education (appropriate to their role) in relation to the domestic abuse policy.

14.7.2 Since Lucy's murder, BHNFT safeguarding team are reviewing and providing safeguarding oversight of the electronic records of all the Emergency Department attendees who have a domestic abuse flag, to ensure the correct procedures are followed. In addition to this, the safeguarding team provide bespoke training to specific areas across the Trust.

14.7.3 All other agencies have identified that their policies and procedures were followed appropriately. Multi-agency policies were not engaged.

14.7.4 There was one incident involving Lucy and Dennis that attracted a DASH risk assessment. This incident on 15 January 2022 was assessed as standard risk with Lucy being shown as the alleged perpetrator.

14.7.5 As no risk assessments were assessed as high risk, there was no automatic referral to MARAC. Referral to MARAC is possible either through volume of incidents or professional judgement. The incident was considered to be

standard risk and was correctly not referred to MARAC on professional judgement, as there were no high-risk features identified.

14.7.6 All DASH risk assessments completed by officers are currently secondarily risk assessed by the South Yorkshire Police DARA (Domestic Abuse Risk Assessment team). The team's specialist training enables them to identify risk and make appropriate referrals. The DARA manager is also an accredited trainer who provides guidance to any new staff and regularly reviews the training needs of staff within the department, ensuring that they are able to appropriately assess risk. Following both incidents, the risk assessments carried out by DARA, established that there was nothing recorded in the DASH (or research) that would suggest any risk of serious harm or injury, making these incidents standard risk and no additional referrals being made.

14.8 **Were there issues in relation to capacity or resources in your agency that affected its ability to provide services to Lucy and/or Dennis, or on your agency's ability to work effectively with other agencies? This should consider any impact of amended working arrangements due to Covid-19.**

14.8.1 No agency has identified capacity or resource issues that affected the services provided. Some hospital outpatient and GP appointments were conducted over the telephone, in accordance with Covid-19 working arrangements.

14.9 **What knowledge did family, friends, and employers have that Lucy was in an abusive relationship, and did they know what to do with that knowledge?**

14.9.1 Lucy's family were not aware of any physical abuse from Dennis prior to her murder. They feel certain that if there had been physical abuse, Lucy would have told them.

14.9.2 Lucy's family did, however, feel that Dennis had been a controlling presence in Lucy's life. Examples include:

- Lucy always had her phone on loudspeaker so Dennis could hear what was being said.
- The family gave examples of Dennis providing alcohol to Lucy, which they felt was one way of controlling her.
- Lucy's car was registered in Dennis's name, although she had paid for it, and he took it away when the couple split up.

- Dennis arranged for Lucy's mobile telephone, landline, and internet to be cut off when the couple split up.
- Although it was thought that Dennis was comfortable financially, Lucy appeared to pay for most things, including household bills. If the couple were out socially with family, Lucy would pay the bill.
- It was difficult to see or speak to Lucy on her own, as Dennis was always present.

14.10 **Were there any examples of outstanding or innovative practice arising from this review?**

14.10.1 There are no examples of innovative practice identified. The DHR panel identified two areas of good practice:

1. Continued support to Lucy from the hospital alcohol care team outside their normal practice.
2. The response of ambulance service staff to Lucy in which they spent over an hour and half making sure that she was safe and providing information.

14.11 **What learning has emerged for your agency?**

14.11.1 **Barnsley Hospital**

BHNFT has a policy for the management of domestic abuse in which it identifies that staff should undertake a routine enquiry for all patients attending, if safe to do so, as part of the clinical/health assessment. There is, however, no evidence that this is routinely occurring within the outpatient setting. Therefore, the learning that will be addressed is for all patients to be routinely asked if they feel safe at home. This will be addressed when patients undertake routine pre-clinic assessments, such as weight, height, or carbon monoxide testing.

Evidence of this being asked, will be documented in the individual's care records.

The panel heard that, recently, a trial has started in outpatients whereby patients are asked if they feel safe at home. During April 2023, 770 people were asked if they felt safe at home. Six of those people disclosed domestic abuse, with appropriate follow-up action being taken.

The Review panel acknowledged the work that had commenced by health agencies involved in this review, to address identified learning around the use of routine enquiry. However, the panel agreed that whilst work had commenced, those health agencies should provide evidence and assurances to Safer Barnsley Partnership on the implementation and use of routine enquiry. [Panel recommendation 5].

14.11.2 Barnsley Recovery Steps

The new NDTMS mandatory dataset (released in 2022) included a new requirement to record victim or perpetrator domestic abuse status and became mandatory within the BRS service on the 29 November 2022.

Full consent was provided from Lucy to share information with her employer, although no contact is recorded. Contact could have provided the opportunity to share information between agencies.

There was no evidence of professional curiosity in relation to Dennis's attendance at every face-to-face intervention that Lucy was present at. In isolation, these may not have highlighted concerns, but there was a pattern of behaviour. The attendance by family is encouraged to support an individual's treatment journey; however, some professional curiosity may have prompted an attempt to speak to Lucy alone and provided the opportunity for discussion/disclosure.

The service now has a specific assessment team to ensure that wait times are monitored effectively and that extended wait times, between referral and assessment, undertake exception reporting and a clear rationale documented within the notes. Choices calls are also made following referral, to discuss the recovery community activities available whilst waiting for structured assessment.

It is not known if Dennis was present during phone calls to Lucy; however, these could have been opportunities to explore relationships and support. The service could have enquired how Dennis specifically supported Lucy.

14.11.3 Safer Barnsley Partnership

The Review Panel was informed that building on previous learning and learning from this case, Barnsley Council is in the process of commissioning a comprehensive package of training for professionals. This is via their domestic abuse provider, who has many years' experience of delivering accredited training and has tested this model with other districts.

Titles include:

- Domestic Abuse Signs, Indicators, Assessment and Referral Pathways (DASH and MARAC)
- Coercive Control Workshop
- Honour Based Abuse, Forced Marriage and Female Genital Mutilation
- Supporting Male Victims of Domestic Abuse
- Supporting Older Victims of Domestic Abuse
- Supporting Young People and Domestic Abuse
- Supporting LGBT+ People and Domestic Abuse
- Supporting People with Disabilities and Domestic Abuse
- Substance Abuse and Domestic Abuse
- Supporting People with Mental Health and Domestic Abuse
- MARAC Representatives Training
- Safeguarding Children and Domestic Abuse
- Healthy Relationships Workshop
- Violent Resistance Workshop –
- Trauma and How it Affects Victims Workshop.

To promote this and raise awareness – targeting professional colleagues – Barnsley Council is increasing the levels of communications across the outlets. Training will be free at source, but partners will be encouraged to commission additional training for longer-term impact and change.

14.12. **Does this learning appear in other Domestic Homicide Reviews commissioned by Safer Barnsley Partnership Board Partnership?**

14.12.1 The learning for Barnsley Hospital is duplicated in DHR 'Julie'.

15 CONCLUSIONS

15.1 Lucy and Dennis had been in a relationship since 2011 and had lived together in Lucy's house for almost all that time.

15.2 During the course of the relationship, Lucy suffered from health issues related to alcohol. Dennis attended all related appointments with Lucy as well as many other health related appointments. The panel reflected that whilst this

itself may not be sinister, Lucy was consequently often not afforded the opportunity to speak to professionals privately.

15.3 Lucy's family were uncomfortable with some of Dennis's behaviour, for example, encouraging her to drink and listening in to her phone calls. However, no agency had knowledge of domestic abuse in the couple's relationship until concerns were raised by Dennis in January 2022. That incident was risk assessed by the police as standard risk, with Dennis recorded as the victim. Dennis intimated to both the police and his GP that there had been previous, historic incidents that had not been reported.

15.4 Dennis reported an incident to the police and relationship stress to his GP in January 2022. At the same time, it seems that he arranged for the utilities in Lucy's house to be cut off and her mobile phone contract cancelled. This behaviour was known by Lucy's family and friends, although it was not recognised as domestic abuse.

15.5 Lucy and Dennis later rekindled their relationship. Lucy proudly showed people the work that had been done on her home, together with new furniture. On the face of it (in May 2022), the couple were back together, and Lucy confided that Dennis was 'on his best behaviour'.

15.6 Lucy's family and friends who spoke to her in the days immediately before her murder, had no concerns for her safety beyond her existing health issues, and her murder was a great shock to them.

15.7 The panel would like to thank Lucy's family and friends for their input into the review.

16 LEARNING

16.1 Narrative

The panel acknowledged the potential benefits of people being supported by their partners at health and recovery appointments. The panel also highlighted that this involves risks.

Learning

The continuous presence of partners at health and recovery appointments may restrict the ability of a person to disclose safety concerns. Health and

recovery professionals are likely to be inhibited from asking routine enquiry questions when partners are present.

Recommendation 1

16.2 **Narrative**

This case illustrates the complexity of domestic abuse indicators. There were no overt indicators of physical abuse for Lucy.

Learning

Further work needs to be done with professionals and the community to provide education around the wider non-physical aspects of domestic abuse.

Recommendation 2

16.3 **Narrative**

As a professional working in the area, Lucy was inhibited from accessing some services due to her fear of seeing her own clients whilst accessing services.

Learning

Professionals need to be able to have confidence that they can access appropriate services and that reasonable steps will be taken to afford them privacy.

Recommendation 3 and 4

17 **RECOMMENDATIONS**

DHR Panel

17.1 Constituent agencies of the Safer Barnsley Partnership should provide evidence and assurance to the partnership that patients/clients are afforded privacy during some appointments in order to facilitate the use of routine enquiry and give patients/clients the opportunity to discuss safety issues.

17.2 The Safer Barnsley Partnership should refresh its training and communication strategy to ensure that information is available to professionals and the public around non-physical indicators of domestic abuse.

17.3 Agencies in Barnsley should provide the Safer Barnsley Partnership with assurance that they have a policy in place to ensure that professionals can be afforded privacy whilst accessing appropriate services.

17.4 The Safer Barnsley Partnership should consider how it can communicate to professionals working within its area, that services are available to them and can be accessed with an expectation of privacy.

17.5 That health agencies who contributed to this review, provide evidence to Safer Barnsley Partnership on how they are addressing the learning identified during the completion of this review in relation to the identification of domestic abuse during contact with patients. This could be achieved by the submission of a report detailing the actions and timescales to embed this learning into practice. It is recommended that the report includes statistical data to evidence the impact of the changes that are made.

Appendix A
Action Plans

No.	DHR Review Recommendation	Scope local or regional	Reviewers recommended action to take	Key actions	Lead agency	Completion deadline
1	That health agencies who contributed to this review, provide evidence to Safer Barnsley Partnership on how they are addressing the learning identified during the completion of this review, in relation to the identification of domestic abuse during contact with patients. This could be achieved by the submission of a report detailing the actions and timescales to embed this learning into practice. It is recommended that the report includes statistical data to evidence the impact	Local	Take a report on both reviews including action plans to the Safer Barnsley Partnership Board and Domestic Abuse Partnership to embed learning into practice. This will also ensure partners clearly evidence activity taken in response to this review through providing an additional level of accountability.	1.1 Development and implementation of action plans by Barnsley Hospital NHS Foundation Trust and NHS South Yorkshire Integrated Care Board.	Barnsley Council, Barnsley Hospital NHS Foundation Trust and NHS South Yorkshire Integrated Care Board.	15 December 2023.
				1.2 DHR reports and recommendations submitted to the Safer Barnsley Partnership Board and Domestic Abuse Partnership.	Barnsley Council	27 June 2024
				1.3 Submit reports to Home Office	Barnsley Council	15 March 2025

	of the changes that are made.			1.4. Submit further report to Domestic Abuse Partnership and Safer Barnsley Partnership Board which will include: progress/completion of actions and outcomes including statistical evidence.	Barnsley Council and partners	12 November 2024
2	That Safer Barnsley Partnership disseminates the learning on this case around the recognition and impact on individuals who are undertaking a caring role, including how support can be accessed.	Local	Improve information dissemination, awareness raising and communications campaigns to target harder to reach groups such as informal carers and elderly people. Such as through regular targeted events.	2.1 Establish a communications and campaigns plan for 2024/25 including generic communications, communications targeted at specific services and groups (including informal carers, AGE UK Barnsley) and hold in person events across the borough.	Barnsley Council, IDAS and partners	01 December 2024
				2.2 Review Domestic Abuse traning package and evaluate training delivered to a) identify any gaps in training, quality of training and impact of training.	IDAS and Barnsley Council	05 September 2024
				2.3 IDAS to deliver bespoke training/awareness raising with Barnsley's Carers Service (Cloverleaf) and develop referral pathways between the two agencies.	IDAS	31 September 2024

				2.4 Update Domestic Abuse Strategy webpage to ensure relevant information and advice is available, including what support is available and how to access this.	Barnsley Council	31 December 2024
				2.5 Multi-agency learning from reviews event to be held in Safeguarding Awareness Week 2024. This will cover learning from Domestic Homicide Reviews, Safeguarding Adult Reviews, Drug Related Deaths Review, Suicide Reviews and highlighting common themes.	Barnsley Council	21 November 2024
3	The Safer Barnsley Partnership should refresh its training offer and communication strategy to ensure that information is available to professionals and the public around non-physical indicators of domestic abuse.	Local	Comprehensive training programme commissioned for professionals across the borough that will also include invitations to NHS partners.	See actions 2.1, 2.2, 2.3 above	Barnsley Council, IDAS and partners	See actions 2.1, 2.2, 2.3 above

4	Agencies in Barnsley should provide the Safer Barnsley Partnership with assurance that they have a policy in place to ensure that professionals can be afforded privacy whilst accessing appropriate services.	Local	Table an item proposal to the Domestic Abuse Partnership.	4.1.All agencies to provide evidence of partner offer to staff seeking help and support via HR support stategies/policies.	All DAP and SBPB member agencies.	31 January 2025
				4.2. BMBC commissioners to meet with HR partner to discuss domestic abuse policy and support for employees.	Barnsley Council	01 September 2024
				4.3 Commissioners across South Yorkshire to work together to develop an out of area support process/protocol for domestic abuse providers to follow.	Barnsley Council	28 February 2025
				4.3 Communications to managers across services that out of area support can be arranged.	Barnsley Council	See above

5	The Safer Barnsley Partnership should consider how it can communicate to professionals working within its area, that services are available to them and can be accessed with an expectation of privacy.	Local	Full communication action plan rolled out across 2024	5.1.Key corporate buildings and partner agencies as well as transport networks shared into distribution of domestic abuse agency advert stickers and bus art showing contact details and pathway.	Barnsley Council and partners	30 August 2024
				5.2. See actions 2.1, 2.4 and actions in section 4 above.	Barnsley Council and partners	31 August 2024
6	That health agencies who contributed to this review, provide evidence to Safer Barnsley Partnership on how they are addressing the learning identified during the completion of this review in relation to the identification of domestic abuse during contact with	Local	Agree with the Domestic Abuse Partnership the format for recording and reporting framework.	6.1. Develop framework with partners for reporting progress against single agency DHR actions, this should include recommendation 3.	Barnsley Council	04 February 2025

	patients. This could be achieved by the submission of a report detailing the actions and timescales to embed this learning into practice. It is recommended that the report includes statistical data to evidence the impact of the changes that are made.			6.2. Submit report detailing progress against actions and changes implemented to working practices to ensure learning is embedded. This should include statistical data/evidence.	Barnsley Council. All key partners to provide relevant information/statistics.	04 February 2025
7	Barnsley Hospital NHS Foundation Trust to provide assurance that patients attending outpatient appointments are asked if they feel safe at home.	Local	Implement process of routine questioning of all patients attending outpatient departments including ophthalmology	7.1. Develop and implement a process to ensure the routine questioning of all patients attending outpatient departments including ophthalmology.	Barnsley Hospital NHS Foundation Trust	Ongoing until March 2025.

8	Ensure all staff receive, and are up to date with, regular adult safeguarding training.	Local	Ensure all staff receive, and are up to date with regular adult safeguarding training.	8.1 Identify staff training needs in relation to adult safeguarding. 8.2. Ensure staff have undertaken and are up to date with the latest safeguarding training, including refresher training.	NHS South Yorkshire Integrated Care Board – Barnsley (GP Practice)	There is no specific completion date. The safeguarding training is a mandatory training requirement and therefore this is on-going.