



Dorset Community Safety Partnership
Victim: Eve (DHR D16)
Executive Summary
Date of Death: July 2022.

Author: Paul Northcott

Date the review report was completed: July 2026

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1.0 THE REVIEW PROCESS

1.1 This summary outlines the process undertaken by the Dorset Community Safety Partnership in reviewing the death of Eve who was a resident in their area.

1.2 The following pseudonyms have been used in this review for the victim and other parties as appropriate to protect their identities and those of their family members:

- Eve - Deceased female.
- Nathan – Deceased female’s ex-boyfriend.

1.3 Eve was found asphyxiated at her home in January 2022. While her ex-partner was arrested for assault, theft, and coercive and controlling behaviour, these incidents resulted in a no further action decision by Dorset Police, and there are no criminal proceedings in this case.

1.4 The death of Eve was referred to the HM Coroner’s office. An inquest has yet to be held regarding this case, and the date had not been set at the time the report was submitted.

1.5 The Chair of the Dorset Community Safety Partnership made the decision to commission a review on 23 September 2022. All agencies that potentially had contact with Eve prior to her death were contacted and asked to confirm whether they were involved with her or her family.

1.6 Thirteen of the fourteen agencies contacted confirmed contact with the victim and/or perpetrator and were asked to secure their files.

2.0 CONTRIBUTORS TO THE REVIEW

2.1 The contributors to the DHR were.

- Avon and Somerset Police (A&S Police)- IMR
- Dorset Police – IMR
- Devon and Cornwall Police - information
- NHS Dorset – General Practitioner (GP) - IMR
- The Private Clinic – IMR, risk assessments and care plans
- University – Information
- SWAST – Information
- Hospital (Devon) – Information
- Local Mental Health Services (Dorset Health Care)- IMR
- Mental Health Liaison Officer (Custody) – Information
- Dorset Police Investigation team (post Eve’s death) – information

- Eve's School – Information
- CPS – Information

- 2.2 Specialist domestic abuse advice and scrutiny was provided by the members from the Director of The YOU Trust (Paragon), which is a charity that provides specialist support to those who have been affected by domestic abuse and sexual violence.
- 2.3 All of the IMR writers were independent. None of the writers knew the individuals involved, had direct involvement in the case, or had line management responsibility for any of those involved.

3.0 THE REVIEW MEMBERS

- 3.1 The panel for this review were made up of the following representatives, all of which were independent and had no direct involvement in the case.

Paul Northcott	Independent Chair.	
Stewart Balmer	Force Review Officer	Dorset Police
Punita Bassi	Safeguarding Review Author	A&S Police
Kirsten Bland	Designated Professional for Adult Safeguarding	NHS Dorset
Karen Maher	Head of Specialist Services – Adult Safeguarding, MCA/DoLS Service and SUFRA	Adult Social Care, Dorset Council
Diane Evans	Community Safety Business Manager	Community Safety Partnership, Dorset Council
Sunita Khattra- Hall	Interim Head of Quality Assurance and Partnerships	Children's Social Care, Dorset Council
Alison Clark	Head of Safeguarding	Dorset Healthcare University NHS Foundation Trust (known as DHC)
Joe Ennis	Deputy Head of Service for Dorset, Devon and Torbay	Probation Services
Annmarie Milliken	Head of Safeguarding	The Priory Group

Su Parker	Detective Inspector – Major Statutory Crime Review Team	A&S Police
Jane Stuart	Principal Social Worker	Children's Social Care, Dorset Council
Tonia Redvers	Director of Paragon, Young Lives and Counselling	The YOU Trust
Neil Wright	Chief Inspector- Safeguarding Hub	Dorset Police

- 3.2 The Dorset Community Safety Partnership ensured scrutiny and accountability throughout the DHR process, particularly concerning independence and impartiality. The review panel convened on five occasions. All members were independent and had no prior knowledge of the individuals involved, direct involvement in the case, or line management responsibility for any of the professionals involved.

4.0 AUTHOR OF THE OVERVIEW REPORT

- 4.1 The Dorset Community Safety Partnership appointed Paul Northcott as the Independent Chair and author of the overview report in December 2022.
- 4.2 Paul is a safeguarding consultant specialising in conducting reviews. He currently provides training on all aspects of safeguarding, including domestic abuse. Paul is a former police officer with thirty-one years of experience. During that time, he served as the Head of Public Protection, collaborating with partner agencies that implement policies and practices concerning domestic abuse. He has also previously acted as the senior investigating officer for domestic homicides. Paul has not previously worked for either of the police forces or any of the other agencies involved in this review.
- 4.3 Paul has been trained as a DHR Chair, is a member of the DHR network and has attended AAFDA¹ webinars.

5.0 TERMS OF REFERENCE FOR THE REVIEW

- 5.1 Dorset Community Safety Partnership agreed on the following terms of reference.

The review should.

¹ Advocacy After Fatal Domestic Abuse.

- Establish the facts that led to the incident in January 2022, considering the period from January 2020 to January 2022, as *these dates provide a timeframe during which agencies had the most contact with Eve*. Additionally, assess whether there are lessons to be learned about how local professionals and agencies collaborated to safeguard the family.
- Identify the lessons learned, how they will be implemented, and what changes are anticipated as a result.
- Implement these lessons in service responses, including necessary changes to policies and procedures.
- Prevent domestic violence and abuse homicides and enhance service responses for all domestic violence and abuse victims and their children through improved intra- and inter-agency collaboration.

The terms of reference also specified that the scope of the review should:

- Consider the two-year period preceding the event, subject to any new information that may prompt a review of earlier incidents or events.
- Request Individual Management Reviews (IMRs) from each agency specified in Section 9 of the Act and invite feedback from any other relevant agencies or individuals identified during the review process.
- Engage family, employers, neighbours, and friends to supply a thorough analysis of the events.
- Consider the coroners' inquest regarding timing and communication with the family.
- Produce a report that summarises the chronology of events, including the actions of involved agencies, analysis and comments on those actions, and any necessary recommendations regarding the safeguarding of families and children in cases of domestic abuse.
- Aim to produce the report by the end of March 2023, *considering* any criminal proceedings and responding sensitively to the family's concerns, particularly regarding the inquest process, the completion of individual management reviews, and the potential identification of issues that may require further review.
- To find out whether Eve's partner was subject to a Domestic Violence Protection Notice or a Domestic Violence Protection Order.
- Were there any disclosures under 'Right to know' or 'Right to ask'?

In addition, the following areas Dorset Community Safety Partnership requested that the individual management reviews and the overview report address the following:

- *Did all services thoroughly explore their engagement strategies with the victim to identify and exhaust all possible options?*
- *What impact did the views and experiences of the victim and their family regarding the services that they received have on their confidence in those services? What could have been done differently to minimise any detrimental effects?*
Were there any barriers experienced by the victim, their family, friends or colleagues in reporting the abuse?

- *Was the HRDA process adequately robust to meet the needs of the victim? How could a more coordinated approach have been employed to potentially improve effectiveness?*
- *Did COVID-19 impact the ability of the GP to satisfactorily engage with, understand and respond to the victim when the use of online e-consult services is limited in opportunities to understand underlying and contextual influences? Could more have been done with the information available?*
- *Is there potential learning in exploring opportunities with the Crown Prosecution Service (CPS) around victimless prosecution using third-party evidence (victimless in terms of the victim not wishing to engage with prosecution)? Could an approach where the use of victimless prosecution might have been explored by the police?*
- *Where private health services were secured directly by the family, what benefits did the victim receive?*
- *Should there have been a better connection between services in Dorset and Avon and Somerset, where the victim resided for a period that falls within the scope of this Review? What actions could have improved information flow?*

6.0 SUMMARY CHRONOLOGY

- 6.1 The chronology date set for this review was from January 2020 to January 2022. These dates were chosen as they provide a sufficient period that captures the deterioration in Eve's health and the allegations of domestic abuse that were reported to agencies.
- 6.2 The panel and the IMR writers were flexible in terms of considering events which had occurred outside of these parameters, which they felt were important to the review. Only specific issues of relevance that relate to the content of this report have been included in this section.

Date	Event
	Eve met Nathan at the age of twelve. Within weeks of starting school, Nathan had followed Eve home and was frequently texting her, stating that she was his "only friend".
2017	After Eve completed her GCSEs, her mother decided to withdraw her from school due to concerns about her inappropriate relationship with Nathan. Within six to eight weeks, Eve expressed a strong desire to return to her previous school, and the relationship persisted. According to Eve's mother, Nathan 's coercive and controlling behaviours began to intensify during that period.
March 2019	The staff at Eve's school intervened when she became agitated and physically assaulted Nathan. The relationship between Eve and Nathan had deteriorated, as Nathan had been seeing another individual.
June 2020- November 2020	Eve was employed on an international superyacht.

December 2020	Nathan met Eve in Lyme Regis, whilst knowing that her mother would not allow him in her home. Eve returned with red roses and described to her mother how he had proposed marriage to her and that they would move to Australia after his graduation. Eve stated to her mother that she should accept him as they were in a committed relationship. Within weeks Nathan had ended their relationship as he had started to see an ex-girlfriend.
04/04/2021	Eve was apprehended for driving under the influence of alcohol following a traffic accident. Eve's mother believes that the incident was an attempt by her daughter to take her own life and escape from the abuse she had reported. On the way home from the custody centre, Eve had attempted to jump from the car.
22/04/2021	Eve's GP was unable to secure an NHS bed for her, so they made an urgent referral to a private clinic at her family's request. Eve was exhibiting a serious mental health condition at that time.
23/04/2021	Eve's GP was notified that the private clinic had no beds. The GP requested an urgent S2WB assessment ² .
27/04/2021	Eve was admitted to the private clinic as a voluntary patient.
April 2021 (date not known)	Eve's mother was present during a phone call where Nathan and a girlfriend told Eve to cut her wrists and hoped that she would " <i>bleed out</i> ."
11/05/2021	Eve was discharged the private clinic, and risk assessment and crisis management plans were made for her anxiety.
12/05/2021	Eve stayed with Nathan in a family-owned property in her hometown. According to disclosures made to Eve's mother, it was reported that Nathan had encouraged Eve to self-harm during her stay.
13/05/2021	After a report raised concerns for Eve's welfare, A&S Police attended the scene and found Eve being restrained by her friends. It was initially reported that she had consumed alcohol, which reacted badly with her medication. Eve was unable to engage with officers at that time, and they took her to a family member's address for safety. The officer dealing with Eve spoke with the Mental Health Crisis Team and discussed if she should voluntarily attend a local hospital for a psychiatric assessment, but it was deemed unnecessary at that time. The officer also completed a BRAG assessment. The assault had not been reported at that time but was later investigated by Dorset Police. Eve's mother states that her daughter was assaulted by Nathan, which was witnessed by others. Following this event, Eve attempted to take her own life by threatening to jump off a bridge.
14/05/2021	Eve's general practitioner (GP) contacted the Community Mental Health Team (CMHT). The CMHT subsequently contacted Eve on the same day, and an assessment was scheduled for 27 May 2021.
15/05/2021	Dorset CMHT spoke to Eve and referred her to S2WB.
27/05/2021	An initial telephone assessment was conducted by the CMHT where Eve reported risky behaviours like alcohol binges, drug use, and impulsive suicide attempts, which she attributed to a difficult relationship. She also expressed fear of abandonment and feeling overwhelmed. Eve believed she had borderline personality disorder and described her boyfriend as manipulative. The CMHT document

² S2WB is a free, NHS talking therapies service for adults over 18 years old in Dorset.

	noted domestic abuse reported by Eve and highlighted her relationship as a major trigger for her behaviour. After the initial assessment, the CMHT tried to contact Eve seven times without success. They sent her four letters asking her to reach out to the service.
08/07/2021	Eve's mother contacted Dorset Police to express concerns regarding her daughter. She reported that Eve was the victim in a controlling and abusive relationship.
09/07/2021	Dorset Police attended Eve's home address. Eve felt unable to make a formal report as she didn't want to get Nathan into trouble. She also stated that the relationship had ended.
10/07/2021	Dorset Police referred Eve's case for a HRDA conference.
13/07/2021	Eve's case was referred to the safeguarding adult's department by the police. The matter was discharged, and the matter referred to the police for MARAC/ HRDA referrals to be completed.
14/07/2021	The crime report that was taken by Dorset Police was referred into and accepted by A&S Police.
15/07/2021	The HRDA conference was held. It was concluded that all the offences occurred in the Avon and Somerset area, thereby giving them primacy in the investigation, despite the victim now residing in Dorset. Eve's case was included in the safeguarding meeting list.
15/07/2021	A Detective Sergeant from Operation Bluestone (Avon & Somerset Police) reviewed Eve's case and indicated that they were unable to progress the investigation due to the absence of a statement from Eve. Eve's mother was informed that the investigation could not move forward without Eve's participation.
17/07/2021	Eve's mother reported to A&S Police that Nathan used Eve's bank card without permission, making multiple transactions. This crime was designated for desktop investigation. A DASH was not completed as the police were unable to effectively engage with Eve at this time. Eve's mother stated that her daughter had fled the relationship due to the increasing episodes of abuse and returned home.
20/07/2021	An Operation Bluestone ³ supervisor contacted Eve's mother and explained that an onward investigation would be very difficult without the consent of her daughter. The officer described that Eve's mother was frustrated at this but accepted the advice that was given. Eve's mother stated that Eve was not very well at that time due to the current situation and suggested that it may not have been the right time for a police investigation. The officer provided advice about restraining orders to Eve's mother and advised her to seek advice from a legal representative.
22/07/2021	A&S Police asked Dorset Police for another approach to be made to Eve to see if she would provide a statement. A Sexual Offences Liaison Officer spoke to Eve but she felt unable to report the matter at that time. A text message was also received from victim's mother by the Dorset Sexual Offences Liaison Officer which reiterated her

³ Specialist rape and sexual offences investigation team.

	disappointment at the action taken by the police and that she was emotionally exhausted due to the support that she was providing to her daughter. Eve's mother asked the police to stop contacting her. The officer offered to provide additional support, apologised for the fact that Eve's mother had been given the wrong impression by officers and stated she would work with her daughter to gain the necessary consent to progress the investigation.
End of July 2021	Eve left the UK to work on a superyacht as a means of escaping from Nathan and the abuse that she was suffering.
09/08/2021	The HRDA Chair made the decision that there was nothing further that could be done at that time as " <i>A&S was aware and responding</i> " and Eve had declined to proceed with a prosecution.
31/08/2021	Eve was discharged from the CMHT as she had not attended a RELAY course.
End of November 2021	Eve returned from working abroad.
07/12/2021	A detective Inspector from A&S Police conducted a review of the crime that had been recorded for rape. The crime was filed as Eve had felt that she was unable to report the matter and had been signposted to support services.
18/12/2021	As a result of the investigation conducted by Dorset Police it was known that Eve was assaulted by Nathan. Nathan had reportedly punched her in the face whilst she was driving. (<i>These details were not known or reported to services at the time but were established by the investigation following Eve's death as it had been witnessed by a friend</i>).
12/01/2022	Eve contacted a friend who she had started a relationship whilst on the yacht. Eve informed them that Nathan had hit her on that evening and threatened to send intimate pictures.
January 2022	Eve spent her final few days of life in her family home. Nathan had been present for some or all this time as they were seen together by neighbours. Nathan left the property early on the morning of her death. Family members later found Eve who had died following asphyxiation by hanging. This was seven weeks after her return to the UK. Dorset Police later identified that there were four WhatsApp calls from Eve to Nathan and three from Nathan to Eve between 05.05 and 05.22hrs that same morning. The last call was one minute and thirty-seven seconds. Eve's fitness tracker when digitally examined showed that she did not move after 05.25hrs.
June 2022	As a result of the inquiries that were made as part of the coronial investigation Dorset Police identified further evidence and subsequently arrested Nathan for offences of; assault, theft and controlling and coercive behaviour.

7.0 KEY ISSUES ARISING FROM THE REVIEW

- 7.1 Eve was a young woman who experienced multiple vulnerabilities that compounded her risk. At just 21 years old, she fell within the age group most at risk of intimate partner violence and abuse. Her experiences were shaped not only by gender-based violence but also by increasing mental health needs, which may have constituted a disability under the Equality Act 2010.
- 7.2 Eve endured domestic and physical abuse as a child, which resulted in intervention from Children's Services.
- 7.3 She met Nathan at twelve, and their relationship was instantly characterised by manipulation, coercion, and emotional abuse.

Education Eve's School

- 7.4 School staff were aware of Eve's relationship with Nathan but did not recognise any domestic abuse. A March 2019 incident was addressed as a peer-on-peer conflict. The review found that school staff can, on occasion, fail to identify abusive behaviours between pupils as domestic abuse, suggesting a need to update domestic abuse policies and training in educational settings (**Recommendation 1**).

Initial police response

- 7.5 On 8 July 2021, Eve's mother reported serious abuse to Dorset Police, based on Eve's disclosures. This abuse included physical, sexual (including rape), emotional, and financial abuse. Although the initial response was appropriate and a high-risk DASH assessment was completed, Eve felt that she could not pursue the matter. Officers from Dorset Police obtained a disclosure statement from Eve's mother, which was then referred to A&S Police for further investigation.

HRDA Conference

- 7.6 Eve's case was discussed at the HRDA (High-Risk Domestic Abuse) conference, and actions were planned; however, due to human error, some steps remained incomplete. After the meeting, and after multiple phone calls from a Domestic Abuse Adviser to Eve went unanswered, she received an email, to which she replied that she did not need any support. Since Eve felt unable to engage with services at that time, professionals at the conference chose to close the case.
- 7.7 Effective cross-border communication was lacking, and the review panel recommended enhanced cooperation between police forces in such cases (**Recommendation 2**).

Subsequent Investigations and Support

- 7.8 Eve's mother later reported financial abuse by Nathan, who pressured Eve into giving him money. Clear signs of coercive control were evident, including threats, emotional abuse, and blackmail. He would persistently gaslight her by telling her that she was worthless

and encouraging her to self-harm. Nathan's influence was so strong that Eve seemed to lose her sense of self and normalised the abuse, which became a major barrier to seeking help.

- 7.9 Eve shared her experiences with friends, who saw social media evidence supporting her claims. She stated that she was coerced into non-consensual sexual acts, and Nathan often assaulted her during sex. His behaviour exhibited patterns of high-risk abuse identified in research by Dr Monkton Smith (2018)⁴.
- 7.10 Eve attempted to escape by taking the drastic step of working abroad and cutting off contact, but Nathan continued to reach her, even leaving abusive messages through bank transfers and his mother's mobile phone. A&S Police relied heavily on hearsay evidence and did not pursue additional witness statements. Although Dorset Police had gathered more information, A&S Police believed that since Eve felt unable to engage, this limited their ability to act.
- 7.11 Dorset Police believed that after receiving the initial disclosure statement, A&S Police should have considered additional statements from the named witnesses. They were fully aware that without any additional evidence, any consideration of proceeding with an investigation would be limited since the disclosure statement made by Eve's mother constituted hearsay evidence⁵.
- 7.12 Officers from Operation Bluestone⁶ later reviewed the case but found no grounds for further action. Dorset Police and the CPS later questioned why witness statements and *res gestae* evidence⁷ were not considered. A&S Police have since recognised that greater professional curiosity could have been demonstrated, and witness accounts could have been explored further to establish all the facts.
- 7.13 While A&S Police claimed they could not support Eve in Dorset due to a lack of knowledge or access to local domestic abuse support structures, the YOU Trust confirmed they operated in both counties. Eventually, as Eve continued to feel unable to seek help from specialist services and the police, no further attempts were made by A&S Police to contact her. From the information reviewed, it appears that while Dorset ensured Eve was safeguarded and collected evidence that could have led to other lines of inquiry, there remained assumptions that A&S Police would investigate the matter.
- 7.14 Despite reviewing the rape case, the A&S Police did not explore coercive control charges. Since then, numerous changes have been made to policies and processes to ensure a more robust approach to such investigations. These changes include the

⁴ Homicide Timeline

⁵ Hearsay evidence is inadmissible in criminal proceedings except where there is some statutory provision which renders it admissible or where a common law rule making it admissible is preserved by section 118 CJA, or by agreement of all parties to the proceedings, or where the court is satisfied that it is in the interests of justice for it to be admissible (section 114(1) CJA 2003). (Crown Prosecution Guidelines)

⁶ Operation Bluestone

⁷ Evidence amounts to *res gestae* when "the statement was made by a person so emotionally overpowered by an event that the possibility of concoction or distortion can be disregarded" Section 11(4) Criminal Justice Act 2003.

introduction of an NFA scrutiny panel to monitor cases involving rape, domestic abuse, coercive control, stalking, and harassment. The lessons learned from this DHR should be circulated to the NFA scrutiny panel as part of the ongoing work in that Force area **(Recommendation: 3)**.

- 7.15 After Eve's death, a renewed investigation led to the arrest of Nathan. This raised questions about why these steps had not been taken earlier. A&S Police defended their actions as compliant with policy, given the information and resources available at the time.
- 7.16 Conflicting views emerged between Dorset and A&S Police regarding the adequacy of A&S Police's response. A&S Police have conducted a thorough review of their policies and procedures, which was finalised in February 2023. In October 2022, the Force introduced a tailored policy on evidence-led prosecutions. It is essential to ensure clarity in policy concerning responsibilities when victims cross borders, and the insights gained from this case and others should be utilised to enhance current practices **(Recommendation: 4)**.
- 7.17 Eve's mother believed an investigation was promised but never conducted, leaving her disillusioned. A&S Police maintain that their decisions were consistent with policy and, according to records, adhered to the requests made by both Eve and her mother (who asked them not to make further contact). Eve's mother insists that her response stemmed from her frustration with the reporting systems and the investigation process.

Health Services and Domestic Abuse Recognition/Referrals

- 7.18 The review identified opportunities for GPs to exhibit professional curiosity during their contact with Eve.
- 7.19 GPs missed opportunities to explore domestic abuse during consultations, particularly during the pandemic when 'a validated consultation tool' was used. Although the relevant GP practice has moved away from this consulting style, care navigation software has been utilised more frequently in primary care to facilitate patient triage and care navigation. While GP practices only employ NHS-recommended providers for care navigation software, it is crucial that these programmes enable all healthcare professionals to investigate safeguarding issues, including concerns about domestic abuse. **(Recommendation: 5)**.
- 7.20 A toolkit for GP enquiries had been launched but had not been fully adopted by Eve's death. Training should be implemented across practices **(Recommendation 6)**.
- 7.21 Although Eve was referred to various health services, records show no referrals to safeguarding or domestic abuse services or any efforts to assess her capacity to make decisions **(Recommendations 7/8)**. Mental health staff did not refer to the DASH tool, though training has since been implemented to improve this **(Recommendation 9)**.

- 7.22 The private clinic that Eve attended lacked a domestic abuse policy and failed to share vital disclosures. They are now conducting internal training based on Eve's case and plan to monitor outcomes (**Recommendation 10**).
- 7.23 There was no effort to involve Eve's family in discharge planning or to warn her about the escalating risks of abuse. Additionally, missed opportunities existed to refer her to community support groups (**Recommendations 11/12**). The clinic is revising its policies and will audit their implementation (**Recommendation 13**).

Health/Welfare - Treatment and Support

GP Involvement

- 7.24 Pandemic-related changes reduced in-person GP access. Eve's GP acted supportively and coordinated with other professionals but was unaware of her drug use, which was known by the private clinic. Communication with a private counsellor also omitted key safeguarding concerns. This case highlights the need for private providers to effectively direct patients to other relevant agencies and organisations to help reduce the risk of missing safeguarding or diagnostic opportunities. Those providers also need to ensure that all relevant details are sent to the patient's GP (**Recommendation: 14**).
- 7.25 Eve had initially been referred by her GP to the Steps to Wellbeing (S2WB) service after expressing suicidal ideation. From that point, her case was managed by the Community Mental Health Team, which later completed the initial and core assessments. Eve and her mother were informed about the expected delays in accessing mental health services. The family felt that this wait was unacceptable, so they sought treatment and support from a private provider.

Mental health services /CMHT Involvement

- 7.26 Eve initially appeared eager to engage with mental health services, making and attending her scheduled appointments. She also committed to the S2WB referral and assessment by the CMHT.
- 7.27 Eve's core assessment was completed by telephone on 10 June 2021, during which it was identified that there remained "*potential for impulsive suicide risk*." This presented a dilemma for professionals, as the ongoing relationship with Nathan could have constituted both a protective factor and a risk factor in her life. Despite being offered the opportunity, Eve did not wish to consider further psychological interventions. Practitioners appeared to be sensitive to Eve's needs and referred her to the available services at the earliest opportunity. The response was timely and proportionate in relation to the current and ongoing pressures on mental health services to implement crisis interventions.
- 7.28 Eve's assessments revealed that she needed support to manage her mental health needs and substance misuse. However, the professional planning of her care and

support was hindered by the agencies' inability to encourage her to utilise the available services. This ultimately resulted in Eve's discharge from mental health services.

- 7.29 The mental health services IMR writer identified that, during certain periods when Eve's case was open to mental health services, there was no clear direction or plan.

Capacity

- 7.30 Eve's anxiety increased over time, affecting her decision-making. Nathan's influence appeared to impair her ability to make informed choices; however, this was not fully considered by the agencies supporting her. A mental capacity assessment carried out under the Mental Capacity Act 2005 (MCA) could have clarified her ability to consent to or decline support. This, in turn, could have guided decisions regarding her engagement with services such as mental health, safeguarding, or domestic abuse support.
- 7.31 Professionals should assess mental capacity when abuse victims decline services, particularly if they exhibit signs of impaired decision-making (**Recommendation 15**). Although Eve sometimes seemed capable, Nathan's influence would have undoubtedly impacted her decisions.
- 7.32 While there may have been times when Nathan's presence and influence impaired Eve's ability to make decisions, professionals felt that she often demonstrated capacity. In discussions with Eve, she showed that she could make her own decisions, and it is unlikely that an assessment leading to more restrictive interventions would have suggested otherwise.

Risk Management

- 7.33 On each occasion that health professionals saw Eve, her immediate needs were appropriately assessed, and support was offered. The risks associated with her taking her own life were considered, and decisions were based on her presentation and perceived capacity to rationalise her behaviour.
- 7.34 The identified risks were weighed against the protective factors in her life, which included the ongoing support from her immediate family, particularly her mother. There was clear evidence that the support mechanisms were discussed on multiple occasions. During assessments, no immediate risks were found, and Eve indicated that she wasn't suicidal.
- 7.35 When Eve presented for services, professionals concluded that there was no immediate need for care and control. Eve was deemed to have capacity and, therefore, did not meet the thresholds established by the Act for assessment. These decisions appear to have been proportionate and in line with agency policies and practices.

The impact of COVID on Eve

- 7.36 During this period, several protective factors were present in Eve's life, including her mother, father, and friends. However, GP records indicate that she struggled to maintain contact with some key individuals due to COVID restrictions imposed by the government. This lack of connection seems to have heightened her vulnerability.
- 7.37 The true impact of COVID-19 on Eve's mental health has been hard to determine. Based on available records and disclosures from Eve and her friends, she felt isolated and struggled to cope with the demands placed on her life during the pandemic. Consequently, Eve increasingly spent time with Nathan.

8.0 CONCLUSIONS

- 8.1 At the time of Eve's death, she had a history of self-harm and was experiencing increasing bouts of anxiety.
- 8.2 Over the years, prior to her death, records indicate that Eve's mental anxiety increased. During this time, Eve was referred to various therapeutic and counselling services and had also been an inpatient at a private clinic. Despite these interventions, no single professional fully understood the coercion, control, and abuse in her life, as Eve felt unable to discuss it. The disclosures made to her mother revealed that Nathan had been abusive throughout their relationship and exhibited coercive and controlling behaviour. Eve's mother had observed the control that Nathan exerted over her daughter.
- 8.3 From the facts presented, Eve suffered domestic abuse during her relationship with Nathan. This abuse was psychological, physical, sexual, emotional, and financial. There was also clear evidence of technological abuse, coercion, and control.
- 8.4 There were several occasions when Eve felt unable to engage with services or make any formal report against Nathan. Her age, along with her lack of previous exposure to services, likely contributed to this. Despite Eve's reluctance, agencies encouraged her to seek support and directed her to several organisations, including specialist domestic abuse workers. Agencies identified opportunities where professional curiosity could have uncovered additional information useful for assessing the risk, threat, and harm to Eve.
- 8.5 Barriers were identified during the review that prevented Eve from freely communicating with professionals and reporting her status as a victim of abuse. The primary barrier was Nathan, who exerted a high degree of control over her life, causing Eve to feel reluctant to get him into trouble with the police. Nathan had also criminalised Eve by possessing photos and media clips that showed her using illicit drugs. These were sent to her mother, and both she and Eve believed that this contributed to their struggle to speak openly to services.

- 8.6 Eve initially disclosed her abuse to her GP. GPs are often uniquely positioned to address IPVA. As this review shows, it is crucial that these services are well-trained and trauma-informed so they can offer a flexible approach to meet the needs of victims.
- 8.7 Eve's case was managed by the HRDA process, which assessed her risk and ensured that the relevant specialist domestic abuse services were available to support her. Following the initial assessment, numerous unsuccessful attempts were made to contact and engage with Eve, resulting in the closure of her case. The process effectively identified the immediate issues associated with Eve's situation and ensured that it was referred to A&S Police. The review panel deliberated on whether the role of the HRDA could be strengthened to provide oversight in similar cases; however, it was concluded that this would be impractical due to the high volume of cases requiring review. Those involved in the process felt that implementing a review of cases where victims had not engaged and which had been referred to other forces for investigation would hinder effective oversight of other high-risk cases.
- 8.8 Although Eve felt unable to file a formal report against Nathan to the police, she disclosed several incidents to her mother. Dorset Police took a statement from Eve's mother, which was good practice. However, A&S Police believed that without Eve's support, an effective investigation could not progress. They deemed the reliance on hearsay evidence insufficient. Although some limited lines of inquiry could have been pursued, A&S Police felt these were not viable without Eve's support. This case highlights the daily challenges officers face, as they often cannot follow up on all lines of inquiry that may enable them to prove a case, owing to the need to balance their resources against competing demands.
- 8.9 From the records, professionals made appropriate decisions regarding Eve's capacity and acknowledged that she was able to make informed decisions about her own care and support. However, they did not consider whether her executive functioning had been impacted by abuse.
- 8.10 When Eve sought help from health professionals during a crisis, they conducted appropriate assessments and encouraged her to accept referrals to other specialist support services. When possible, referrals for additional assistance were made, and support was provided once Eve consented and felt ready to engage.
- 8.11 While professionals generally recognised her capacity to make decisions, they did not fully consider how coercive control might have impaired her executive functioning. This highlights the importance of applying an intersectional lens when safeguarding young adult victims of abuse, recognising the interplay between age, gender, trauma, and mental health.
- 8.12 In this case, the level of information sharing among agencies was inconsistent. However, while some opportunities were missed, there were also many instances in which agencies submitted relevant referrals to one another and discussed Eve's case.

- 8.13 The impact of COVID has also been evident in this case, particularly regarding its contribution to increasing Eve's isolation and her reliance on Nathan. This, in turn, led to heightened anxiety. Agencies offered Eve help and support during this time, but it was limited due to the restrictions in place, and consultations were primarily conducted remotely. Eve's mother has expressed that she felt this was a significant barrier to her disclosing the abuse.
- 8.14 Young people experiencing IPVA face specific challenges unique to their age group. Services supporting these individuals must provide a specialist response that considers their diverse needs. All agencies involved in this case have identified lessons that can be applied to support victims of abuse like Eve in the future. The Community Safety Partnership will monitor progress toward addressing the recommendations from this review.

9.0 LESSONS TO BE LEARNED

Learning point 1: The review identified that staff working in educational settings often do not recognise child-on-child abuse as domestic abuse. Therefore, consideration should be given to ensuring that schools and colleges have sufficient information about domestic abuse and that, through training, pupils are regularly encouraged to discuss what constitutes abusive behaviour in relationships.

Learning point 2: The HRDA Conference did not have a representative from the A&S Police, as Dorset was handling Eve's case and believed their attendance was unnecessary at that time. In this situation, there were evident cross-border issues that required effective information and intelligence sharing. The presence of a representative from that Force would have facilitated the identification of emerging risks, and if there were concerns about either the investigative or safeguarding process, they could have been addressed through a partnership approach.

Learning Point 3: A&S Police continues to monitor its approach to the investigation of domestic abuse (DA) cases, including those involving coercive control investigations. Furthermore, work is underway to understand the barriers to reporting in NFA cases, which is being conducted through a scrutiny panel. As part of its efforts to improve investigation standards, it would be beneficial for the scrutiny panel to review this report to determine whether there is a need to enhance current force policies and practices based on the themes and lessons identified in the report, particularly regarding the necessity of ensuring that all relevant lines of inquiry are either pursued or considered, promoting evidence-led policing, and fostering cross-border collaboration with victims.

Learning Point 4: Feedback from review panel meetings has identified that when investigations cross Force boundaries, victims can still receive varying levels of support from officers. There is an ongoing need to ensure that cases are effectively

coordinated. In this instance, Dorset Police referred the crime to A&S Police in accordance with National Recording standards, believing they would advance the investigation; however, this did not happen for the reasons mentioned in this report. While it is acknowledged that each Force has its own policies and practices, there remains an opportunity to learn from this and other current cases to further enhance practice.

Learning point 5: GP practices are increasingly utilising care navigation software in Primary Care to facilitate patient triage. While GP practices exclusively rely on NHS-recommended providers, it is crucial that these programmes enable the exploration of safeguarding presentations, promote appropriate enquiry, and avoid creating additional barriers to reporting.

Learning point 6: Although the GP Practice in this case has introduced awareness training regarding domestic abuse and the importance of appropriate enquiry, it is unclear whether this practice is widespread. The surgery must quality assure the quality of current practices.

Learning point 7 (recommendations 7/8): During her initial and core assessments, Eve had been referred by mental health services to appropriate health services. However, there is no record of similar referrals being made for local authority safeguarding and domestic abuse services. This omission occurred despite professionals knowing that Eve had been a victim of domestic abuse. Current practice needs to be quality-assured to ensure this happens.

Learning point 8: The use of the DASH risk screening tool was not mentioned in the details recorded by mental health services staff. The completion of this document should have been discussed with Eve, or the rationale for not using it should have been recorded. In recent years, substantial work has been done within mental health services to encourage the use of DASH risk assessments. The quality of the submissions made to HRDA should be reviewed to ensure compliance with expected practices.

Learning point 9: The private clinic safeguarding team identified that Eve had discussed her relationship with Nathan only in group sessions and not with the other health professionals involved in her care. This information should be routinely shared with those caring for similar patients.

Learning point 10/11 (recommendations 10/11): In the risk assessment process at the private clinic, there was no consideration of including her family in managing the risks identified before Eve's discharge. This represented another missed opportunity to recognise risks in the community and ensure that Eve was aware of the potential for further abuse or escalation in Nathan's behaviour. Involving family members, where appropriate, would enhance this procedure.

Learning point 12: The private clinic IMR writer noted that the clinic lacked a domestic abuse policy and practice when Eve was a patient. A policy should be developed, communicated to staff, and its effectiveness evaluated.

Learning point 13: This case highlighted the importance of information sharing among all agencies, including private providers, where care may be divided between the private sector and the NHS. Such providers should be encouraged to inform GPs (with the relevant consent) about the treatment and welfare needs of individuals using their services. This will help furnish GPs with additional information to support patients and ensure safe care, including risk assessment.

Learning point 14: Eve's ability to make decisions was influenced by her life circumstances and the coercion and control she experienced in her relationship. Mental health services indicated that to thoroughly evaluate a person's capacity for informed decision-making, practitioners should conduct mental capacity assessments with patients who meet the two-stage capacity test. This is particularly crucial in cases where victims of domestic abuse refuse services. Policy and practice have changed within mental health services, but the effectiveness of these changes requires evaluation.

10.0 RECOMMENDATIONS

- 10.1 The learning opportunities identified in this case have resulted in the recommendations that are listed below. Dorset Community Safety Partnership has oversight of the implementation and completion of the action plan to address these recommendations.

Recommendation 1: Dorset Community Safety Partnership to provide a briefing paper for circulation to all education providers in the County and in Somerset, identifying the learning from this case. (*This learning brief should inform them of their responsibilities to ensure that their domestic abuse and child protection policies and guidance for staff and pupils include references to coercive and controlling behaviour*).

Recommendation 2: Dorset CSP to review the current HRDA operating protocol to ensure that it includes the requirement for a Police representative from another Force (where there is more than one Force involved) at relevant meetings if it is expedient to do so.

Recommendation 3: A&S Police to circulate this DHR to the NFA scrutiny panel and Force DA Lead.

Recommendation 4: Dorset Police, A&S Police and the You Trust to convene a meeting to identify and explore review panel concerns that existing practices may not be meeting the needs of current victims where investigations cross borders

Recommendation 5: The Home Office panel to liaise with DHSC who should seek national assurance that primary care electronic consultation platforms and care navigation platforms that are being introduced across the country are inclusive of all relevant safeguarding needs.

Recommendation 6: Dorset CSP should seek assurance from the ICB that training is being delivered across all GP practices in relation to appropriate enquiry and that practice is embedded.

Recommendation 7: Mental health services to include the learning from this review in their DA training to re-emphasise the importance of onward referral to DA services and adult social care.

Recommendation 8: Mental health services to conduct an audit of completed DASH assessments for a twelve-month period to check if victims have been referred to appropriate support services.

Recommendation 9: Mental health services to audit the DASH risk assessments that are submitted to HRDA to ensure compliance with policy and National best practice. Where necessary areas for improvement should be identified and mental health services should ensure that the learning is implemented.

Recommendation 10: The private clinic management team should assure itself that processes are implemented which ensures that all relevant safeguarding information and risks are shared with the professionals managing a patient's case. The implementation and outcomes of this process should be assessed and quality assured within six months of all relevant cases in that period.

Recommendation 11: The private clinic management team to ensure staff are trained in the 'Think Family' approach and in appropriate cases their views should be incorporated in any discharge or risk planning.

Recommendation 12: The private clinic management team to audit relevant safeguarding cases to ensure that all vulnerable patients are provided with community support options via guidance to domestic abuse agencies should the patient require this.

Recommendation 13: The private clinic to circulate and implement domestic abuse policy/practices within the service. The implementation and outcomes should be assessed and quality assured within six months.

Recommendation 14: NHS Dorset to identify a suitable forum to work with private providers and identify information sharing opportunities to inform GPs of the treatment and welfare needs of those people who use services.

Recommendation 15: Mental health services to conduct an audit of completed DASH assessments for a twelve-month period to check if mental capacity has been considered, assessed and recorded.

GLOSSARY

A&S	Avon and Somerset
ABE	Achieving Best Evidence
ACE's	Adverse Childhood Experiences
AFFDA	Advocacy After Fatal Domestic Abuse
A&S Police	Avon and Somerset Police
AMHP	Approved Mental Health Professional
ASC	Adult Social Care
CCB	Controlling and coercive behaviours.
CMHT	Community Mental Health Team
D&C	Devon and Cornwall
DASH	Domestic Abuse, Stalking and Honour Based Violence
DH	Domestic Homicide
DHC	Dorset Health Care
DHR	Domestic Homicide Review
DVA	Domestic Violence & Abuse
ED	Emergency Department
EDS	Emergency Duty Service
EI	Early Intervention
GP	General Practitioner
HO	Home Office
ICB	Integrated Care Board
IMR	Independent Management Review.
IPVA	Interpersonal Violence and Abuse
MARU	Multi Agency Referral Unit
MCA	Mental Capacity Act.
MHAA	Mental Health Act Assessment
NCRS	National Crime Recording Standards
NHSE	National Health Service England
RE	Routine enquiry.
SOLO	Sexual Offences Liaison Officer
S2WB	Steps to Wellbeing