



# Dorset Community Safety Partnership

Victim: Eve (DHR 16-2)

Date of Death July 2022.

Author: Paul Northcott

Date the review report was completed: July 2025

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## Preface

Eve will be dearly missed by her family and friends and her loss has had a lasting and enduring impact on those that knew her. The following paragraphs have been provided by Eve's mother, who has been left devastated by her daughter's death.

*"Eve was just 21 years, 4 months and 1 day old when she died. I believe that she had been subjected to a prolonged coercive and controlling relationship which started at the age of 12, during her time at an independent school, where she had been awarded a scholarship. She was a talented artist, a national athlete and an academic who was admired by all who knew her.*

*To my family and I she was our deeply loved first born child and was the front and centre of our world. We watched in awe as her many talents unfolded throughout her short life. She was amazing fun and was always full of playful energy. She was tall and slender but was so strong and brave. She pushed through her natural shyness to stretch herself beyond the scope of many others. Whilst not the loudest voice in the room, her beautiful presence naturally drew others to her, and she made friends wherever she went.*

*At aged 19, she embarked on a career in Super Yachts. We were so proud of her as she travelled the world and lived vicariously through her wonderful experiences. Six weeks prior to her death, she crossed the Atlantic Ocean, a huge milestone for one so young and proved herself to be of strong constitution on a very rough and prolonged passage. Her days were lit up when dolphins and whales made an appearance, that had been a passion of hers since a young child. She was proud to be initiated as a true "sailor" when her vessel crossed the equator. Without hesitation, she took part in a tradition that involved jumping overboard, to swim in those deep azure waters.*

*We cannot comprehend that her life has ended, she had such huge aspirations for a promising future and was enveloped in our love and support. We will forever be lost without our sweet little girl."*

The Independent Chair, Review Panel members, wish to express their sincere condolences to the family, friends, and all those affected by the tragic death of Eve. We recognise the profound loss and lasting impact that this has had on those who knew and loved Eve. We are grateful to the family for their contribution to the review process and hope that this review honours Eve's memory by seeking to understand the circumstances surrounding her death and by identifying opportunities to improve practice and help prevent similar tragedies in the future.

## 1.0 Introduction

- 1.1 This report was commissioned by the Dorset Community Safety Partnership and examines the interactions that local agencies had with Eve prior to her death in 2022. The primary purpose of undertaking a Domestic Homicide Review (DHR) is to facilitate learning from those deaths where a person has died and where domestic abuse was or could have been a factor.
- 1.2 In this case, the Dorset Community Safety Partnership aimed to review Eve's death to determine if there had been effective interventions by agencies and whether she had been a victim of abuse prior to being found asphyxiated. The report will examine the past to identify any relevant background or patterns of abuse and propose appropriate solutions through a holistic approach to make the future safer.
- 1.3 This report will examine the contact and involvement that agencies had with Eve from January 2020 to January 2022. Members of the Panel selected these dates because they represent a period during which agencies had the most extensive contact with Eve. Panel members sought to understand Eve's experience with agency contact and to establish the support provided to her.
- 1.4 Every effort has been made to conduct this review process with an open mind and to avoid hindsight bias. Those leading the review have worked to manage the process with compassion and sensitivity.

## 2.0 Timescales

- 2.1 The decision to commission a review was made by the Chair of the Dorset Community Safety Partnership on 23 September 2022. The Home Office was also notified of the decision to conduct a review on the same date. The review was carried out in accordance with the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016).
- 2.2 This review commenced in February 2023. A delay occurred between commissioning the report and initiating the process, due to ongoing discussions with His Majesty's (HM) Coroner, scoping, and appointing a Chair. This stage of the process also considered the family's representations regarding the impact that the timing of this process would have on them.
- 2.3 The Home Office Statutory Guidance advises that, where practically possible, the review should be completed within six months of the decision to proceed with the process. Consequently, an initial timetable was created to ensure that agencies complied with this request. However, the review could not be completed within the six-month timeframe due to an ongoing police investigation into the abuse suffered by Eve and the need to ensure that this process was not prejudiced by the lead reviewer through contact with witnesses. Additional time was also needed to allow for appropriate representation from Eve's family.

- 2.4 The first panel meeting was held in September 2022. During this meeting, the draft terms of reference were discussed, and the members of the DHR panel agreed upon their content.
- 2.5 The review concluded in July 2025. The Dorset Community Safety Partnership actively oversaw the progress of the review throughout the process.

### 3.0 Confidentiality

- 3.1 This review's findings are confidential. The information obtained as part of the review process has only been made available to participating professionals and their line managers.
- 3.2 Before the report is published, the Dorset Community Safety Partnership will circulate the final version to all members of the review panel, the Chief Executives of their agencies, and the family members. The family will be notified of the publication date.
- 3.3 The overview report's content has been anonymised to protect the identities of Eve, relevant family members, and all others involved in this review. The family was consulted about the pseudonyms used in this review, and the following was agreed upon.

Family composition and pseudonyms used;

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

- 3.4 Eve was aged twenty-one at the time of her death, and in terms of ethnicity, she was a white European. Nathan was also twenty-one at that time, and in terms of ethnicity, he was a white European.

### 4.0 Methodology

- 4.1 Domestic Homicide Reviews were established on a statutory basis under section 9 of the Domestic Abuse, Crime and Victims Act (2004). The Act, which came into force on the 13 April 2011, states that a DHR should be a review 'of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:
- a. A person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship or;
  - b. A member of the same household as him/herself; held with a view to identifying the lessons to be learnt from the death.

4.2 The methods for conducting DHRs are prescribed by the Home Office guidelines<sup>1</sup>. These guidelines state;

*‘Reviews should illuminate the past to make the future safer and it follows therefore that reviews should be professionally curious, find the trail of abuse and identify which agencies had contact with the victim, perpetrator or family and which agencies were in contact with each other. From this position, appropriate solutions can be recommended to help recognise abuse and either signpost victims to suitable support or design safe interventions’.*

In addition to the above Dorset Community Safety Partnership also agreed that the review should;

- 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 coroner’s 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.

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<sup>1</sup> Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews; Home Office: Dec 2016

- 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?*

- 4.3 To ensure a thorough review, the Dorset Community Safety Partnership contacted fourteen agencies to determine whether they had interacted with the family.
- 4.4 All agencies identified as having contact with the family were asked to secure relevant documents, and appropriate professionals were invited to join the DHR panel. The relevant agencies were then requested to complete chronologies, and where applicable, Individual Management Reviews were also requested (as specified in Section 6.0).
- 4.5 The review panel chair also reviewed additional information, including reading local and national DHRs, policies and procedures, and an incident Investigation report completed by Dorset NHS Foundation Trust<sup>2</sup>. The Dorset Domestic Abuse Strategy

<sup>2</sup> This report identified two recommendations. 1. CMHT should review the established process of alerting a clinician to a PPN when it is received, to ensure timely review. 2. The addition of a question in the core assessment of electronic patient record

2021-2024 and the composite action plan (January 2025) were also considered in terms of current and future progress being delivered locally.

- 4.6 Additional interviews were conducted with the IMR writer, the regional safeguarding lead for the private clinic (PH), the police (the post-death investigation team), and a Mental Health Liaison Officer who had contact with Eve while she was in custody (see chronology). This contact aimed to clarify the information submitted to the review and to gather further details about the case.
- 4.7 The Independent Chair also contacted two senior representatives from the Crown Prosecution Service. Meetings were held to discuss the points raised in the terms of reference.

## **5.0 Involvement of family, friends, neighbours and the wider community**

- 5.1 Eve's family was approached and asked if they would play an active part in the review process. Her mother represented the family's interests, ensuring that the other members were kept informed of the review's progress. Eve's mother received regular updates from her advocate (see 5.2 below).
- 5.2 Eve's mother received a leaflet prepared by the Home Office regarding the DHR process. She also received additional support from a representative of Advocacy After Fatal Domestic Abuse (AAFDA) and was provided with the terms of reference for the review.
- 5.3 Eve's mother attended a review panel meeting supported by an AAFDA representative. During the meeting, she believed it was important to show a media clip that provided insight into her daughter and her life experiences.
- 5.4 The contents of the police statements taken from Eve's friends were also considered in this review process. Regarding her employer, the police provided notes from their contact with a senior crew member on the superyacht where she worked. The reviewer could not identify any neighbours, as per the terms of reference, who may have had relevant information for this review.
- 5.5 Following representation from Eve's mother, contact was also made with her school Headteacher and the Dedicated Safeguarding Lead (DSL).
- 5.6 The review panel considered whether the report author should meet with Nathan. Due to the sensitive nature of this case and the fact that he had been interviewed by the police, it was deemed inappropriate and unnecessary. Dorset Police were able to provide the details of the account that he had provided about his relationship with Eve.

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(RIO/IAPTUS/S1) should be explored so that the question is routinely asked – Are you experiencing any form of harm/abuse in a relationship. These recommendations have not been duplicated in the review.

- 5.7 Eve's mother was provided with a copy of the draft report and had the opportunity to comment and make amendments. Suggested changes were incorporated in the report.

## 6.0 Contributors to the Review

- 6.1 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

- 6.2 Specialist domestic abuse advice and scrutiny was provided by the members from the Director of The YOU Trust (Paragon), which is a charity that offers specialist support for those who have been affected by domestic abuse and sexual violence.
- 6.3 Attempts were made to contact a private counsellor whom Eve had seen during the period specified for this review. Despite the enquiries, agencies were unable to gain any additional information from this individual.
- 6.4 A member of Devon and Cornwall Police's custody staff was interviewed as part of this process.
- 6.5 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.

## 7.0 The Review Members

- 7.1 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                                                    |

- 7.2 The Dorset Community Safety Partnership maintained scrutiny and accountability throughout the DHR process, especially regarding independence and impartiality. All members were independent and had no prior knowledge of the individuals involved, no direct involvement in the case, or line management responsibility for any of the professionals involved. Agencies confirmed this at the initial panel meeting.
- 7.3 Responsibilities directly relating to the commissioning body, namely any changes to the terms of reference and the agreement and implementation of an action plan to take forward the recommendations in this report are held by the Dorset Community Safety Partnership.

- 7.4 The review panel met formally on five occasions. Regular communication was maintained with panel members to clarify issues and ensure accuracy regarding their agency's involvement with the family. Documents, including draft reports, were circulated electronically to members and discussed individually, along with the themes identified during the review process.

## 8.0 Author of the Overview Report

- 8.1 The Dorset Community Safety Partnership appointed Paul Northcott as Independent Chair and author of the overview report in December 2022. Paul was unable to commence the review until February 2023.
- 8.2 Paul is a safeguarding consultant specialising in undertaking reviews. He currently delivers training in all aspects of safeguarding, including domestic abuse. Paul was a serving police officer with thirty-one years of experience. During that time, he was the Head of Public Protection, working with partner agencies, including those working to deliver policy and practice in relation to domestic abuse. He has also previously been the senior investigating officer for domestic homicides.
- 8.3 Paul retired from the police service in February 2017. Before this date, Paul had worked in London for three years on a National Programme of work.
- 8.4 Dorset Community Safety Partnership is aware of the Home Office's requirements around commissioning an independent Chair and report writer and felt that Paul had the requisite skills and experience to undertake this case. Paul has not previously worked for either of the Force's involved in this review.
- 8.5 Paul has been trained as a DHR Chair, is a member of the DHR network and has attended AAFDA<sup>3</sup> webinars.

## 9.0 Parallel Reviews

- 9.1 Following the police investigation, the death of Eve was referred to the HM Coroner's office. In this case, Dorset Police acted on behalf of the HM Coroner in that area and commenced an investigation (legal inquiry) under Section 5 of the Coroners and Justice Act (2009). The investigations led Dorset Police to re-examine all the evidence that was available in this case, some of which had only become apparent after Eve's death.
- 9.3 An inquest has yet to be held in this case, and the date was not set when the report was submitted.
- 9.2 Mental health services had conducted an Incident Investigation, which was signed off in July 2022. The findings of this report were considered as part of the DHR process.

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<sup>3</sup> Advocacy After Fatal Domestic Abuse.

## 10.0 Equality and Diversity

- 10.1 The review complies with the Equality Act 2010, and the review panel considered all nine protected characteristics (age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion and belief, sex, or sexual orientation) as part of the terms of reference and throughout the review process.
- 10.2 Eve and her ex-boyfriend were white English nationals and, from the available information, were believed to be heterosexual. Eve was aged twenty-one when she died following asphyxiation. Nathan was also aged twenty-one at that time.
- 10.3 Domestic abuse perpetrated against women by men is a form of violence against women and girls (VAWG). Research often links it to broader issues of gender inequality, misogyny, and perceptions of harmful gender norms.<sup>4</sup> While interpersonal violence and abuse (IPVA) affects a significant number of individuals, families, and communities<sup>5</sup>, it is disproportionately experienced by women and perpetrated by men<sup>6</sup>. The Crime Survey for England and Wales estimated that 6.9% of women and 3.0% of men aged 16 years and over experienced domestic abuse in the year ending November 2022 (1.7 million women and 699,000 men).
- 10.4 Research has shown that women are more likely to encounter repeated, systematic and more severe Interpersonal Violence and abuse (IPVA), leading to injury and/or death<sup>7</sup>. Statistics<sup>8</sup> also reveal that almost all perpetrators convicted for controlling and coercive behaviour in England and Wales in the year ending December 2020 were male (97%).
- 10.5 There is also a corresponding impact of Domestic Violence and Abuse (DVA) on the mental health of female victims, leading to suicide and suicidal ideation. Research has shown that women who have experienced Intimate Partner Violence and Abuse (IPVA) are three times more likely than those who have not encountered abuse to have made a suicide attempt in the past year. In cases involving sexual abuse, women are seven times more likely than those who have not experienced sexual Intimate Partner Violence (IPV) to have attempted suicide in the past year. IPVA, which includes sexual violence, is ten times more prevalent in women than in men.
- 10.6 There is a complex interplay between domestic abuse and alcohol and drug dependency. Evidence of misuse in a victim's life should be viewed not as a causal factor for domestic abuse" but rather as a "*symptom*" of that abuse. International evidence reveals that it is predominantly men who tend to perpetrate more severe assaults when they have been drinking<sup>9</sup>, while women are more vulnerable to victimisation when they, too, are intoxicated<sup>10</sup>. Such research also shows that the use

<sup>4</sup> 89 Guedes. A, Bott. S, Garcia-Moreno. C., Colombini. M.(2016) Bridging the gaps: a global review of intersections of violence against women and violence against children

<sup>5</sup> Baker et al, 2013; Ali et al, 2016

<sup>6</sup> Stark, 2007; Hester, 2013; Walby et al, 2017

<sup>7</sup> Long et al, 2021; Monkton et al, 2014

<sup>8</sup> Womens Aid 2021

<sup>9</sup> Graham et al., 2011; Reno et al., 2010

<sup>10</sup> Iverson et al., 2013

of alcohol and/or illicit drugs is a form of “self-medication”<sup>11</sup> and a way for the victim to escape their life experiences.

- 10.7 Substance misuse is a factor in approximately half of all domestic homicides in the UK. Since 2011, substance use has been identified among domestic homicide perpetrators more than four times as often as it has among their victims<sup>12/13</sup>. While similar data is not readily available regarding suicides linked to abuse, it is thought to be comparable.
- 10.8 Age is a significant factor in this review. Research has shown that young people (18–25) are at particular risk of intimate partner violence and abuse (IPVA) by a current or former partner<sup>14</sup>. National UK crime surveys consistently report that young women are at a greater risk of victimisation than those over twenty-five (ONS, 2021). Rates among adolescents and young people are high, with a reported prevalence of up to 97% for emotional and psychological violence. According to the latest figures from the Office of National Statistics for England and Wales (2022), the prevalence of IPVA is highest in the 20–24 years group (6.3%), compared to the age 35–44 group, which has the next-highest prevalence (4.2%)<sup>15</sup>.
- 10.9 'Disability' has a special legal meaning under the Equality Act, which is broader than the usual interpretation. The Equality Act states that people have a disability if they 'have a physical or mental impairment that has a substantial, adverse, and long-term effect on their ability to carry out normal day-to-day activities'<sup>16</sup>. While a dependency on drugs and alcohol isn't classed as a disability, it could become so if the addiction causes an impairment. In Eve's case, her impairment, in terms of her suffering from mental anxiety, was long-term (longer than twelve months), and the combination of her symptoms linked to alcohol and drug use, coupled with mental anxiety, meant that her ability to cope with day-to-day life was severely impaired. Arguably, Eve would have also met the Care Act (2014) definition of being an adult at risk because she had care and support needs and was experiencing and at risk of abuse. This will be explored further in the analysis section of this document.
- 10.10 After considering all the factors in this case, it was concluded that there was no evidence that Eve or Nathan were directly or indirectly discriminated against by the services or individuals with whom they came into contact in terms of the nine characteristics. There was also no evidence of intersectional issues.

## 11.0 Dissemination

- 11.1 Following approval from the Home Office, the final report will be disseminated to the following organisations/partnerships.

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<sup>11</sup> AFFDA (2022)

<sup>12</sup> Home Office, 2016

<sup>13</sup> Graham et al 2011

<sup>14</sup> Stonard et al., 2014

<sup>15</sup> Barnes et al 2023

<sup>16</sup> MIND (2022)

- Community Safety Partnership, Dorset Council
- A&S Police
- Dorset Police
- Police and Crime Commissioner – Dorset and A&S Police
- Police and Crime Commissioner – Devon and Cornwall Police
- Adult Social Care, Dorset Council
- Children’s Social Care, Dorset Council
- The You Trust
- Dorset Healthcare University NHS Foundation Trust
- Probation Services
- The Priory Group
- Eve’s School
- Somerset CSP
- Domestic Abuse Commissioner

- 11.2 In accordance with Home Office guidance, all agencies and Eve’s family are aware that the final overview report will be published. Although key issues have been shared with specific organisations, the overview report will not be disseminated until clearance has been obtained from the Home Office Quality Assurance Group.

## 12.0 Background Information (The Facts)

- 12.1 Eve was a twenty-one-year-old white British woman who excelled academically and was talented in art and various sports, including netball and athletics. She was also a competent horse rider and show jumper. Eve’s mother described her as having a wide circle of friends and being popular with everyone she met. Additionally, her mother characterised Eve as a complex, sensitive, and humble individual who felt vulnerable due to bouts of anxiety. Eve experienced these periods of low confidence and anxiety throughout her teenage years. Her mother noted that she was *“passionate almost to an obsession.”*
- 12.2 Eve and Nathan met when they were both twelve years old, and they attended the same school. Nathan initially approached Eve in 2016, and they began an intermittent relationship over the years leading up to her death. In the months before Eve left school, she was described as happy and delightful to be around. Eve’s mother stated that it was after finishing her GCSEs and attending her prom that her emotional and mental state started to decline severely.
- 12.3 While studying for her A levels, Eve became depressed and experienced increasing episodes of anxiety. She also became very self-critical and self-conscious, which made her feel vulnerable. Due to these pressures, Eve was unable to achieve the grades she desired in school. Consequently, she left school and worked at a ski school and then as a junior stewardess on a superyacht (between June 2020 and November 2020). Eve travelled extensively around the world and enjoyed the independence that these roles provided her.

- 12.4 As an adult, Eve lived at home with her mother but frequently visited her boyfriend (Nathan), and they often stayed at each other's homes. Eve's mother described the relationship with Nathan as unhealthy and toxic, noting that her daughter was in a constant state of unease due to his behaviour towards her. Eve confided in her mother that Nathan had a drug addiction, which had led to him being in debt.
- 12.5 Eve's mother has stated that she believed the drink-drive incident that occurred in April 2021 marked the beginning of her daughter's mental health decline, during which Eve attempted to take her own life. A court hearing was scheduled following the incident, but Eve's GP had to write to the court requesting that she not attend due to her mental health, which was granted. Her mother states that this clearly demonstrated the level of mental distress her daughter was suffering from.
- 12.6 On the 8 July 2021, Eve's mother contacted the police to report that her daughter had been assaulted by Nathan. Because Eve was unavailable at that time, she was seen by the police three days later, and during that interaction, she felt unable to accept support or make a formal report (the reasons for this are discussed in section 15). A statement was, however, taken from Eve's mother in which she described, in detail, the way that her daughter had been treated by Nathan. Eve's mother described a pattern of behaviour which had been described by her daughter, although she had not witnessed the abuse herself. The abuse that Eve described included rape and being pressurised into committing sexual acts, including the sending of nude images to Nathan. Due to the pressure exerted by Nathan, Eve felt that she had no option but to support her boyfriend by giving him money to pay for his drug debts. The disclosures that Eve had made to her mother had led to an allegation of rape being recorded as a crime, and this had been sent to A&S Police for further investigation. The officer who had obtained the information from Eve's mother had graded Eve's case as high risk.
- 12.7 As a direct result of the abuse that occurred in July 2021, Eve sought further employment on a superyacht but returned in November 2021 due to ongoing coercion and control from Nathan, as well as a decline in her mental health. Eve's mother stated that she had taken this job as it was a desperate attempt to keep herself safe from Nathan.
- 12.8 Following an assessment on the 12 July 2021, Eve's case was presented at a High-Risk Domestic Abuse Conference (HRDA) on the 15 July 2021. The HRDA is a multi-agency forum that deals with high-risk domestic abuse cases. The Chair of that meeting instructed that A&S Police should lead the investigation into the reported offences and that Dorset should oversee the safeguarding of Eve, who was residing with her mother at that time.
- 12.9 Following the HRDA Conference, an Independent Domestic Abuse Advisor (IDVA) made numerous attempts to contact Eve. On the fourth attempt, Eve stated that she did not want any additional support at that time. In accordance with Eve's wishes, Dorset Police closed the case from a safeguarding perspective.

- 12.10 Eve's mother has stated that there was a steady decline in her daughter's mental health during her relationship with Nathan. Throughout the review period, it was evident that she experienced a substantial amount of stress and developed anxiety and depression (evidence from GP records 2019).
- 12.11 Due to concerns raised by her family, Eve was contacted remotely by her GP on 26 April 2021 for an assessment. Her GP urgently referred her to S2WB 17; however, despite her mental health needs, Eve was, according to her mother, informed that she would have to wait for an assessment.
- 12.12 Approximately six weeks had elapsed since the drink-drive incident, and frustrated by the lack of inpatient services offered by the National Health Service, Eve's family felt they had no option but to fund a placement at a private clinic. During that time, her mother had been desperately seeking help, fearing that her daughter would harm herself. When assessed at that hospital, Eve expressed suicidal ideation, and it was initially agreed that she needed to be treated for approximately six weeks. After about two weeks, health professionals treating Eve deemed her suitable for discharge. Eve also agreed to the discharge, and Nathan collected her from the clinic. Within forty-eight hours, Eve began to self-harm, and according to her mother, she attempted to take her own life due to harassment from Nathan. Eve and Nathan continued to see each other and stayed overnight at each other's houses (the exact dates are unknown). Eve returned to live with her mother after further incidents of abuse, which Eve disclosed to her mother.
- 12.13 On the 18 July 2021, Eve was assessed by a Hospital Psychiatric Liaison Team after presenting at the Emergency Department due to an incident of self-harm. This occurred following police attendance at her home address after concerns were reported regarding her mental health, which led to the submission of a Public Protection Notice. After Eve's discharge from the hospital, she was referred to a Community Mental Health Team (CMHT) for follow-up care.
- 12.14 Eve's care and treatment plan was reviewed in August 2021. Health services were unaware that Eve was abroad at that time, and after numerous unsuccessful attempts to contact her, she was discharged from NHS mental health services.
- 12.15 In the days leading up to her death, Eve had been staying at her mother's house while the rest of the family was away on a short break. During that time, Eve had been in contact with Nathan, who had seen her at home in the hours before she died. There were also four WhatsApp calls from Eve to Nathan and three calls from Nathan to Eve between 05:05 and 05:22 on the morning of her death. The last call lasted one minute and thirty-seven seconds. Eve's fitness tracker, when digitally examined, indicated that she did not move after 05:25.
- 12.16 In 2022, Eve died from asphyxiation by hanging at her family home. Earlier that day, she had contacted one of her friends and stated, "*I can't do it anymore*." After a brief conversation, Eve ended the call. Her friend attempted to contact her again but was unsuccessful. Eve's body was later discovered by her mother.

- 12.17 Following her death, Eve's mother raised concerns that she believed Nathan may have contributed in some way to her daughter's death. Dorset Police commenced a lengthy criminal investigation, during which Nathan was arrested for offences of assault, theft, and coercive and controlling behaviour. This investigation led to no further action being taken by the police due to insufficient evidence to meet the threshold for a realistic prospect of conviction. The case was also referred to the Crown Prosecution Service for advice, which similarly deemed that there was insufficient evidence to prosecute. In parallel with the criminal investigation, Dorset Police initiated an investigation on behalf of HM Coroner.

### 13.0 Chronology

- 13.1 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.
- 13.2 The review panel and the IMR writers were flexible in considering events that occurred outside of these parameters, which they felt were important to the review. This included any adverse childhood experiences and trauma from Eve's past that could have impacted her life. Where relevant, these events have also been included in this report to provide additional context about Eve's life. Only specific issues of relevance related to the content of this report have been included in this section.

| Date                        | Event                                                                                                                                                                                                                                                                                                                                                                                     |
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|                             | 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.                                                                                                                                                                                    |
| 17/09/2019                  | Eve spoke with her GP by phone about her anxiety, mentioning that her mental health had worsened due to several factors, including a breakup with Nathan.                                                                                                                                                                                                                                 |
| June 2020-<br>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.                                       |

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|                             | 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. While in custody, a risk assessment was conducted, revealing a history of depression. Eve indicated that she had no intention of self-harm and declined to see a mental health and diversion worker. A Mental Health Liaison Officer visited Eve during her time in custody. Eve felt unable to accept support at that moment and did not consent to further contact upon release. 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's mother described her daughter as being in a terrible state and that Eve had attempted to jump out of the moving vehicle. |
| 11/04/2021                  | Eve took an overdose. She was advised to go to the hospital but she felt unable to do this.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 13/04/2021                  | During an e-consult with her GP, Eve mentioned experiencing relationship problems but did not provide further details.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| 14/04/2021                  | Eve had a telephone consultation with her GP about her depression. Records indicate she experienced a traumatic breakup that week. She mentioned her partner used drugs, was mentally unstable, and was seeing someone else.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| 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. Eve was described at that time as being <i>"full of self-loathing."</i> Records state that Eve had taken <i>"a further overdose."</i> Her records state that she had been in a <i>"long term stormy relationship with a partner who was involved in drugs and was mentally unstable."</i>                                                                                                                                                                                                                                                                                                     |
| 23/04/2021                  | Eve's GP was notified that the private clinic had no beds. The GP requested an urgent S2WB assessment <sup>17</sup> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| 26/04/2021                  | A GP referral was sent to S2WB, requesting an assessment of Eve due to her expression of suicidal ideas. The GP noted the referral was made to S2WB because there were no beds available at the private clinic. Eve was admitted to the private clinic and therefore was not seen by S2WB.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 27/04/2021                  | Eve was admitted to the private clinic as a voluntary patient. Her records indicate that she experienced suicidal thoughts three days before admission. Eve's triggers were associated with her intermittent relationship with Nathan.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| 28/04/2021                  | During a one-to-one assessment at the private clinic Eve stated that she had lost her identity, and that Nathan had <i>"influenced her through drugs and also cheated within their relationship four times which did not help her mental state of mind."</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| 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>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

<sup>17</sup> S2WB is a free, NHS talking therapies service for adults over 18 years old in Dorset.

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| 04/05/2021 | Eve participated in a therapy session at the private clinic, where she discussed the abuse that she was being subjected to. She also expressed feelings of self-hatred and inadequacy.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 11/05/2021 | During a consultant review, Eve stated she planned to move in with Nathan. They discussed the pros and cons, and Eve acknowledged the risks. The consultant identified early warning signs of relapse. Eve was discharged the same day, and risk assessment and crisis management plans were made for her anxiety. Nathan met Eve at the clinic, and staff describe how she appeared highly excitable and eager to see him.                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| 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 has stated that following the assault on her daughter, which had been witnessed by others, Eve had attempted to take her own life by threatening to jump off a bridge. |
| 14/05/2021 | Eve's GP contacted the Community Mental Health Team (CMHT) and informed them that Eve had been referred to S2WB in April 2021. However, she was not seen due to her admission to a private clinic. The GP further stated that Eve had been discharged from the private clinic the previous evening and had expressed suicidal ideation, specifically threatening to jump off a bridge. The CMHT subsequently contacted Eve on the same day, and an assessment was scheduled for the 27 May 2021.                                                                                                                                                                                                                                                                                                                                                                                               |
| 15/05/2021 | Dorset CMHT spoke to Eve and referred her to S2WB. They noted an increase in her alcohol intake, but when sober, Eve did not feel suicidal. Based on her information, CMHT assessed Eve as having a low risk of suicide.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 17/05/2021 | Eve's support worker received an urgent message from her GP and contacted the CMHT. The CMHT duty worker discussed Eve's case with the support worker, noting a lack of clarity regarding her care. It was agreed that the support worker's referral would remain open while the CMHT offered Eve an assessment.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 27/05/2021 | The CMHT conducted an initial telephone assessment 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. Eve's short-term suicide risk was considered low, but there was a medium risk of impulsive suicide, especially with alcohol or drug use. A follow-up assessment was scheduled for two weeks later. Meanwhile, Eve was referred to CMHT                                                                                                                                                                                                                                                                               |

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|            | and Connections for support. The CMHT document 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.                                                                                                                                                                                                      |
| 10/06/2021 | A core assessment was completed by the CMHT via the telephone.                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 16/06/2021 | A multi-disciplinary team (MDT) meeting was conducted to discuss Eve's case. It was determined that Eve posed a medium to high risk when under the influence of alcohol.                                                                                                                                                                                                                                                                                                                                                    |
| 23/06/2021 | A CMHT assessment letter was sent to Eve's GP. This letter highlighted the potential risks associated with Eve's mood changes, including the risk of self-harm. Eve's behaviour was noted to be influenced by the breakups in her relationship with Nathan. Eve reported to the CMHT an imbalance of power in their relationship and described her partner as manipulative. She also mentioned feeling worse when not with him. Domestic abuse resources were not considered at that time.                                  |
| 25/06/2021 | A CMHT assessment letter was sent to Eve's GP. The summary of risk stated that: <i>"On bad days she [Eve] thinks about suicide such as jumping off a cliff, hanging herself or jumping out of a car and she says that she doesn't see a future."</i> Eve also stated that she didn't want the responsibility of making decisions about her future. It was noted that the difficulties that she was experiencing in her relationship with Nathan had a significant influence on her mental health.                           |
| 07/07/2021 | Eve's mother called the Connection service <sup>18</sup> and reported that she had gone to pick up her daughter after her relationship with Nathan had broken down. At that time Eve was distressed and reporting suicidal thoughts. There were no immediate risks identified during that conversation and arrangements were made for her to contact the CMHT the following day. Both Eve and her mother were signposted to support services.                                                                               |
| 08/07/2021 | Eve's mother contacted Dorset Police to express concerns regarding her daughter. She reported that Eve was involved in a controlling relationship where her partner was abusive and that she had returned to the family home on that day. Her mother described incidents where Nathan had previously assaulted her daughter and had instructed her to commit suicide. Her mother was contacted by Dorset Police but stated that her daughter was unlikely to report anything as Nathan <i>"has got his teeth into her."</i> |
| 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.                                                                                                                                                                                                                                                                                                                                   |

<sup>18</sup> Mental Health Support telephone line.

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| 14/07/2021 | The crime report that was taken by Dorset Police was referred into and accepted by A&S Police.                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 15/07/2021 | A&S Police requested that Dorset Police complete an Achieving Best Evidence (ABE) interview. A Sexual Offences Liaison Officer was allocated to conduct this procedure, but Eve stated that she did not want to participate in the process at that time.                                                                                                                                                                                                                                                        |
| 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 attempted to take her own life. Dorset Police attended and safeguarding measures were put into place. A Public Protection Notice (PPN) <sup>19</sup> was submitted.                                                                                                                                                                                                                                                                                                                                         |
| 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.                                                                                                          |
| 18/07/2021 | Eve was assessed by Psychiatric Liaison services at Hospital. She felt unable to discuss her concerns or the reasons for self-harm. After the assessment, she was discharged to stay with her aunt. The CMHT was informed and advised Eve to contact them for support. They attempted to reach her after discharge but failed, and Eve felt unable to return their calls. This led to the closure of her case.                                                                                                  |
| 20/07/2021 | The HRDA panel requested additional information from A&S Police. A&S Police stated that they had asked for an officer to re-approach Eve. An officer documented.<br><br><i>At the moment the incident has not been given an OIC due to the high workload levels the officers currently have and with it being the summer period the lack of numbers, but it remains in the team tray and an open investigation.</i>                                                                                             |
| 20/07/2021 | An Operation Bluestone <sup>20</sup> 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 |

<sup>19</sup> An incident report detailing police interaction with vulnerable people which includes domestic abuse incidents.

<sup>20</sup> Specialist rape and sexual offences investigation team.

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|                  | orders to Eve's mother and advised her to seek advice from a legal representative.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| 21/07/2021       | A&S Police were informed about concerns regarding Nathan's new partner and potential safeguarding issues. At that time, only the first name of the partner was known, making it difficult for the police to identify her.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| 22/07/2021       | <p>A&amp;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 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.</p> <p>The officer to provide additional support, apologised for the fact that Eve's mother had been given the wrong impression by officers and stated that she would work with her daughter to gain the necessary consent to progress the investigation. Eve's mother replied.</p> <p><i>"....at this time, she won't engage with you and I want to leave matters. It causes me huge distress at home .... As I say, no further contact would be appreciated please."</i></p> |
| 22/07/2021       | Eve's mother contacted A&S Police and asked them to file the report of the theft. She stated that following a conversation with Nathan's mother the money had been returned to Eve. Eve's mother requested no further communication by the police at that time.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 28/07/2021       | A CMHT MDT Team meeting was held to discuss Eve's case. The outcome of that meeting was that they would wait to see if Eve attended a RELAY group <sup>21</sup> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 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. Eve had asked her mother to find her work overseas as she was <i>"feeling so hopeless."</i> Eve blocked Nathan on all social media and changed her mobile before leaving. Nathan continued to contact Eve through electronic means like Instagram, and by using his mother's mobile phone. Eve commenced a relationship with another male and her mother later found a message on her phone where Nathan had threatened to share sexual photos and videos with her new boyfriend.                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| 09/08/2021       | The HRDA Chair made the decision that there was nothing further that could be done at that time as <i>"A&amp;S was aware and responding"</i> and Eve had declined to proceed with a prosecution. They acknowledged                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |

<sup>21</sup> Regulating Emotion and Looking After Yourself (RELAY) Group. This is a 12 week group that is helpful for people who experience self-criticism and shame associated with depression and/or trauma.

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|                      | that A&S Police had the responsibility for the wellbeing of Nathan's new girlfriend.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 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.                                                                                                                                                                                                                                                                                                                                                                                                                                |

## 14.0 Overview

- 14.1 This overview will summarise the information known to the agencies and professionals who were involved with Eve and her family.

### Eve's School

- 14.2 Eve and Nathan both attended the same school. They were known to be in a relationship, and staff were aware that the two had split up in March 2019 after it was reported that Nathan had started seeing another woman. Eves's mother has stated that her daughter had become very distressed as Nathan had posted images online of him in a state of undress in a bedroom with the female. This led to an altercation

between the two, prompting staff to intervene. The staff were not aware of any issues relating to domestic abuse, coercion, and control.

### **Dorset Police**

- 14.3 Eve first came to the notice of Dorset Police when her mother reported her as a missing person in April 2021. Police enquiries revealed that Eve had been involved in a minor road traffic collision on the Devon and Dorset border whilst under the influence of alcohol, which had led to her being arrested. Eve was dealt with for this offence by D&C Police and then charged and bailed. Whilst in custody, Eve had been assessed by a Mental Health Liaison and Diversion Team, and whilst she had stated that she had anxiety, she denied any thought of self-harm. As previously stated, Eve's mother strongly believes that this was an attempt to take her own life, but this was not known to the police at that time.
- 14.4 Dorset Police first became aware that Eve was the victim in an abusive relationship in July 2021. At that time, Eve's mother reported to the police that Nathan had subjected her daughter to physical assaults, non-consensual sexual acts, financial abuse, and controlling and coercive behaviour. The police learned from Eve's mother that this abuse had increased over the past seven months, but unhealthy behaviour patterns had been occurring for many years. Eve's mother also expressed her belief that Nathan was dependent on illicit drugs and that he was supplying them to her daughter. Due to this dependency on drugs, she believed that Nathan had significant debts.
- 14.5 Eve's mother stated that her daughter had given Nathan large sums of money to help him pay his drug debts. She believed that Eve had only given him this money because she was under duress, as he was manipulative and controlling. A statement detailing what her daughter had disclosed to her was taken by an officer from Dorset Police.
- 14.6 Eve had confided in officers about her mental anxiety, self-harm, and thoughts of taking her own life, but she felt unable to make a report about the abuse at that time. The reasons for this will be explored in section 15.0.

### **Avon and Somerset Police**

- 14.7 A&S Police were aware of the details of all the allegations that were recorded in Eve's mother's disclosure statement. They were also aware of Eve's mental distress and the risks of self-harm.
- 14.8 A&S Police had previously worked with Eve regarding safeguarding related to her childhood experiences of domestic abuse.
- 14.9 Between January 2019 and January 2022, prior to Eve's death, A&S Police were involved with Eve on three occasions, two of which related to domestic abuse (reported by her mother) and one related to a response to a mental health crisis.

- 14.10 During a self-harm attempt by Eve, the police identified that she was suffering from poor mental health and had stopped taking the medication prescribed by her GP. Eve admitted to self-harming, although she stated that this was not a daily occurrence. She also mentioned that she was experiencing stress and couldn't cope with life.

### **Primary Care**

- 14.11 Eve's GP had thirty-three direct or indirect contacts with her. Between January 2017 and April 2021, Primary Care contacted Eve on ten occasions, either through E-consult or by telephone.
- 14.12 In September 2019 GP records show that Eve had stated that she was struggling to cope in her life due to relationship problems. None of this contact was directly linked to domestic abuse.

### **Mental Health Services**

- 14.13 Between January 2019 and January 2022, Dorset Health Care had fifty-one recorded entries relating to Eve on their systems, nine of which related to injuries stemming from domestic abuse. This figure includes six contacts with the Psychiatric Liaison team, resulting in information-sharing and follow-up appointments from CMHT services. The period covering Eve's contact with mental health services totalled slightly less than four months before she was discharged, which was almost five months prior to her death in January 2022.
- 14.14 Eve was initially referred to mental health services in April 2021 by her GP. She was referred for psychological intervention with S2WB and subsequently assessed by the Community Mental Health Team. In July 2021, Eve was also assessed by the Psychiatric Liaison Service following a self-harming incident in Dorset, which occurred after an admission to an Accident and Emergency department. Staff were aware that Eve was being abused by Nathan.
- 14.15 Practitioners in mental health services would have been aware that she was the victim of abuse from the letter shared with them by a doctor at the private clinic she had attended. Eve's case history from her GP and the details of the HRDA conference were also available on the mental health service IT systems. During assessments, the professionals working with Eve had also become aware that she was a victim of abuse involving Nathan.
- 14.16 Following Eve's death, mental health services conducted an internal investigation. This investigation resulted in two recommendations, which will be discussed in this report. Mental health services will oversee the implementation of these recommendations, which have not been duplicated in this report.

### **The Private Clinic (PH)**

- 14.17 The private clinic that Eve attended offers inpatient treatment for various addictions and mental health conditions, including alcohol and drug rehabilitation, as well as treatment for depression.
- 14.18 Members of the hospital staff had determined, through assessment, that Eve had been self-harming for about twelve years and that she had attempted suicide due to relationship issues with Nathan. Eve mentioned that she had been using illegal substances and that her alcohol consumption had increased because of this relationship.
- 14.19 Throughout her inpatient stay at the hospital, Eve actively participated in the assessment and treatment process. She attended numerous therapy sessions and individual consultations. Eve expressed to the staff that she had a poor self-image and was struggling with low confidence.

### **Hospital (Devon)**

- 14.20 Eve visited the A&E department of a hospital in Devon on 4 April 2021 following a road traffic collision. She was seen immediately and discharged twenty-five minutes later. At that time, Eve had not disclosed any details regarding her relationship with Nathan.

### **Bristol University**

- 14.21 Bristol University had no information regarding the issues raised in this review. They were unaware that Nathan was being abusive to Eve.

## **15.0 Analysis**

- 15.1 This section of the overview report will examine how and why events occurred while addressing the terms of reference and key lines of enquiry within them. It also highlights examples of good practice. The information provided by Eve's friends and family has been included in this analysis. Much of Eve's story has had to be conveyed through the details provided by her mother, as Eve disclosed the abuse to her.
- 15.2 When completing this section, previous local DHRs were considered to determine whether the themes and lessons from similar tragic events had been integrated into frontline practice.
- 15.3 There would appear to be no single identifiable factor that led to Eve's decision to take her life, but there was a culmination of several issues which contributed to the decline in her mental health and her actions on the day in question.
- 15.4 **Domestic Abuse**
- 15.4.1 The first area for analysis is determining the extent to which Eve experienced abusive, coercive, or controlling behaviour in her relationship with Nathan.

- 15.4.2 As a child, Eve witnessed domestic abuse directed at her mother by a male partner. Police records also indicate that Eve was subjected to physical abuse from a very young age. Due to this exposure to domestic abuse, Eve's case progressed through child safeguarding procedures. It is difficult to determine from the existing records how these Adverse Childhood Experiences (ACEs) and trauma affected Eve's life in the years leading up to her taking her own life. ACEs are defined as "highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence. They can be a single event or prolonged threats to, and breaches of, a young person's safety, security, trust, or bodily integrity." (Young Minds, 2018). Adverse Childhood Experiences are recognised to have lifelong impacts on the long-term health and behaviour of those exposed to them.
- 15.4.3 Eve's relationship with Nathan started when they met at school at the age of twelve years old. Eve's mother stated that from the disclosures that had been made by her daughter and from what she had seen, it was apparent that Nathan had been controlling and manipulative from the time that he had met Eve. Within weeks of her first term being underway, Nathan had followed Eve home. Eve was described by her mother as a shy person, and Nathan's behaviour and his obsessive attention had scared her. Eve had her first mobile phone when she started school, and she had ten pounds of credit. This credit had been used within forty-eight hours because Nathan had been constantly texting her about being his friend.
- 15.4.4 Nathan was the one who insisted that they get together, and by the age of fifteen, the intensity of his behaviour had made Eve feel overwhelmed. Nathan would bombard her with text messages and emotionally blackmail her, again stating that he needed her as she was his only friend. SafeLives data shows that the abuse young people experience can be different from that experienced by adults, and frequently, they can experience abuse through technology and social media, which can be used as a monitoring or harassment tool by the perpetrator<sup>22</sup>. This form of abuse was evident in this case and significantly increased in the years leading up to Eve's death.
- 15.4.5 Eve's mother had to remove her from school in 2017, after her GCSEs, due to concerns about an ongoing unhealthy relationship with Nathan. Her mother could see the adverse impact that the relationship was having on her daughter's mental health. Although she intended to end their relationship, she was unsuccessful. Within six to eight weeks, Eve became desperate to return to her former school, and the relationship with Nathan resumed. Eve's mother stated that from this point, the abusive behaviours began to escalate once again.
- 15.4.6 At seventeen, Eve became aware that Nathan was in a relationship with another woman, which left her feeling increasingly depressed. Nevertheless, her relationship with Nathan continued, although her family remained unaware. During this time, Eve became socially isolated, with Nathan constantly messaging her and monopolising her time.

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<sup>22</sup> SafeLives

15.4.7 The extent and levels of abuse will be described in the following paragraphs.

#### Education Eve's School

- 15.4.8 Staff were aware of the relationship between Eve and Nathan, and its subsequent breakdown. They were not aware of any concerns relating to domestic abuse or coercive and controlling behaviour. On one occasion (March 2019), the staff had intervened when Eve had become angry and physically assaulted Nathan. Staff recognised the need to keep both engaged at that time as they were just about to take examinations. The school conducted a risk assessment (relating to physical behaviour), offered pupil support in the form of counselling (which Eve declined), and they also instigated a behaviour plan. This was a proportionate response at the time, given the information known, and should be seen as good practice.
- 15.4.9 Following discussions with the DSL and Head Teacher, it was established that the altercation between Eve and Nathan would not have been regarded by staff as a domestic abuse incident (due to their age), and therefore, additional questions were not asked. Discussions with staff at the school have highlighted that their knowledge of safeguarding issues has broadened in line with the guidance outlined in Keeping Children Safe in Education 2024. Staff receive regular training in Safeguarding (ten of them to an advanced level), which includes domestic abuse.
- 15.4.10 Statutory education guidelines in England regarding relationships (Department of Education, 2019) state that schools must provide instruction on acceptable and unacceptable behaviour in relationships and address IPVA and controlling behaviour sensitively and clearly. Teenage relationship abuse training has been offered to Dorset Council staff, including school staff, covering coercive, controlling, and grooming behaviours, among other topics. Qualitative feedback indicates that this training has been well received by attendees thus far. This input is now integrated into the overall training provided to all staff. In 2024/25, STARS (Sexual Trauma & Recovery Service) will deliver guidance and education to 15-20-year-olds in all educational settings, town centres, and other relevant community environments regarding alcohol and consent, bystander training, and respectful relationships. This initiative should be seen as good practice.
- 15.4.11 At the time of writing this report, the school did not have a domestic abuse policy. However, the Head Teacher has instructed his lead DSL to review and update their policy and guidance to ensure that it includes such abuse, as well as issues related to coercion and control.
- 15.4.12 This review has identified that it is unlikely for school staff to view physical and verbal confrontations among pupils in a relationship as domestic abuse, even if they fall within the national definition. Such incidents are typically categorised as child-on-child abuse. Therefore, it would be prudent for all educational settings in Dorset and Somerset to review their domestic abuse policies and staff training, considering the issues raised by this case (**Recommendation: 1**).

### Initial police response

- 15.4.13 The earliest disclosure of domestic abuse to the police was on 8 July 2021, when Eve's mother reported to Dorset Police that her daughter had been subjected to physical, sexual (including rape), emotional, and financial abuse. Eve's mother had not witnessed the abuse herself, but her daughter had confided in her and was clear that it had occurred. Eve's mother also spoke to one of her friends who had concerns about the relationship and had witnessed bruising on Eve's body. Eve's mother had also seen injuries on her daughter, including frequent bruising on her legs. On one occasion, Eve showed her mother a black eye, stating it had been inflicted by Nathan. Eve had also disclosed this abuse to two of her friends, although this was not known to the police.
- 15.4.14 The initial police response to these allegations was effective, with contact established with her mother and arrangements made to speak with Eve the following day. This delay was due to Eve's availability at that time. When officers eventually saw Eve, she felt unable to report the matter, stating that the relationship had ended and that she didn't want to get her partner into trouble. Research has shown that young people who experience domestic abuse in their relationships may find it more difficult to recognise abusive behaviours, or they may not always see themselves as victims due to the control or coercion the perpetrator exerts over them<sup>23</sup>. Furthermore, fear of authority or getting a partner or ex-partner into trouble with the police may also be a barrier to reporting abuse, as in this case.
- 15.4.15 Due to these circumstances, the police ensured that Eve was safe and not at further risk, and they obtained a disclosure statement from Eve's mother. The officers recognised that there might be the prospect of pursuing an evidence-based prosecution using the details provided by her mother, other family members, personal friends, and other evidence, such as call handling logs. This approach should be seen as good practice.
- 15.4.16 When Dorset Police met with Eve, they adhered to policy and conducted a DASH risk assessment. At one point, officers noted that Eve hesitated when they asked if Nathan *"had ever attempted to choke, suffocate, strangle, or drown her."* The officers demonstrated professional curiosity by questioning her reaction. Eve then indicated that the incident didn't specifically fall into any of those categories but chose not to elaborate further. She also hesitated when asked about their sexual relationship and did not provide any additional information. Officers believed that Eve struggled to answer some questions on the risk assessment due to her reluctance to implicate Nathan. Consequently, based on their concerns and the information that Eve provided, the matter was classified as high risk, reflecting the officers' strong understanding of risk and thresholds. The actions taken were in accordance with policy, and the case was referred to A&S Police for further investigation, as per National Crime Recording Standards (NCRS). This is standard practice, as crimes are typically investigated in the Force area where the offences occurred.

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<sup>23</sup> SafeLives (2017) Safe Young Lives: Young People and domestic abuse, pp. 22 & 38.

15.4.17 Eve's mother has since stated that her daughter was unaware her case had been classified as high-risk and that this only came to light after her death. Eve's mother mentioned that if she had known, she could have been more vigilant. She also indicated that Dorset Police had raised expectations regarding a victimless prosecution when they took details from her. She feels the police failed to update her on their actions and that she hadn't been informed that the matter was being passed to A&S Police. The two Forces involved have been unable to confirm from their records whether Eve was specifically told she was classified as a high-risk victim on the DASH assessment or if there were discussions about the viability of an evidence-led prosecution. Dorset police believe Eve would have been aware from the conversations held that they were seriously concerned about her welfare. This information would not routinely be shared with Eve's mother without consent; in this case, consent had not been given. Eve's mother felt the police were disinterested in her daughter's case, though both Forces would refute this, as detailed later in this report.

#### HRDA Conference

15.4.18 Five days after receiving the initial referral, Eve's case was heard at the HRDA (High-Risk Domestic Abuse) conference<sup>24</sup>. This was in line with the HRDA protocol and had only been delayed due to the number of high-risk cases being managed at that time, as well as the inability of the Domestic Abuse Advocate (DAA) to contact Eve despite repeated attempts. Eve was staying with her mother in Dorset when the meeting was held. A request was made for Eve's case to be added to the GP safeguarding meeting list. This is a practice which triggers in-house meetings where information is discussed alongside medical records. This process was never actioned due to human error, and therefore, the information was not shared in accordance with accepted best practice. The review panel felt that, in their experience, the current process works well and that this was an isolated event that did not warrant any further change to policy. On review, the Independent Chair agreed with this assessment.

15.4.19 The HRDA forum had considered using Clare's Law<sup>25</sup>, as it was alleged that Nathan had commenced a new relationship with another female, although her details were not known. The concerns were passed on to A&S Police, which should be seen as good practice.

15.4.20 The HRDA agency records document that five attempts were made to contact Eve by the DAA (by telephone), and these went unanswered. Eve was then sent an email, to which she responded by saying she did not need any support. In this case, professionals felt that the risks had been reduced as Eve was living at home with her mother, and Nathan lived in another county. As far as the professionals were aware, the relationship had also finished.

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<sup>24</sup> In general MARAC's or HRDA in this case are held in the area where the victim resides.

<sup>25</sup> Clare's Law, also known as the Domestic Violence Disclosure Scheme (DVDS) is a police policy giving people the right to know if their current or ex-partner has any previous history of violence or abuse.

- 15.4.21 The actions allocated in the HRDA meeting included identifying Nathan's new partner and for the DAA to continue to try and engage and obtain updates from A&S Police. These actions were finalised after updates had been received. The matter was closed by a supervisor on 12 August 2021. This was in accordance with the HRDA Protocol, which states that *"there is no ongoing role for the HRDA once cases have been discussed and actions allocated."* The actions taken were proportionate and in line with policy on what was known to professionals at that time.
- 15.4.22 The HRDA protocol also states that in cases where risk is escalating and partnership working is ineffective, the HRDAP (Plus) monthly Management Meeting can consider these cases. In this instance, professionals felt that the risks had been reduced; therefore, Eve's case did not meet the criteria for the HRDAP (Plus). Upon review by the Panel, this appears to have been a proportionate decision based on what was known at that time.
- 15.4.23 An A&S Police representative had not been invited to attend the HRDA as Dorset was managing Eve's case at that time. The review panel felt that, due to issues of cross-border working, it was imperative that liaison between the two Forces occur regularly to prevent confusion regarding roles and responsibilities. In this instance, their attendance was deemed unnecessary since A&S Police had accepted the crime report and were believed to be progressing with the investigation. The review panel believed that in cross-border cases, a representative from the relevant Force should attend the HRDA whenever feasible. This would need to be evaluated on a case-by-case basis. In pertinent cases, if a Force representative does not attend, a report outlining the actions taken should be made available for consideration by the HRDA panel and the Chair of the forum (**Recommendation: 2**).
- 15.4.24 In this case, Eve felt unable to engage with services (the reasons for this will be discussed later in this report), resulting in her case being closed. Some professionals involved in the review believed that the HRDA process did not adequately address the potential risks associated with the case, particularly if she were to return to Nathan. Panel members felt that members of the HRDA panel should continue to ensure that agencies adopt a flexible approach and consider the coercion and control that may have influenced a victim's decision before finalising a case. The review panel examined the current HRDA policies and practices and found that this consideration does take place, but acknowledged that the insights from this case emphasised the significance of doing so and ensuring that these considerations are thoroughly documented.

#### Subsequent Investigations and Support

- 15.4.25 Following the initial contact by A&S Police, Eve's mother informed them that her daughter had also been a victim of financial abuse. Nathan reportedly took large sums of money from Eve under duress. Eve's mother described how Nathan would use her daughter *"as a personal bank service, getting her to give him large sums of money to pay for his drug debts."* On one occasion, Eve told her mother that Nathan had marched her to a cash point, forced her to withdraw a large sum of money, and then

threw her out of their home, stating that he no longer wanted to be with her. Eve's mother explained how Nathan had "*a hold over her daughter*," and in her words, he appeared to have "*brainwashed her*." Eve had used her savings to pay off Nathan's debts. Economic and financial abuse has severe, long-lasting consequences that hinder a victim's ability to leave the abusive relationship. In this case, it is difficult to assess the actual impact that this had on Eve, as she had the support of a strong family network. What is clear is that Nathan's behaviour did prevent Eve from gaining her own independence and reinforced his ability to dominate her. Research has shown that economic abuse increases risks for depression, PTSD, and anxiety<sup>26</sup>, and this was evident in this case.

- 15.4.26 Controlling or coercive behaviour does not relate to a single incident; it is a purposeful pattern of behaviour which takes place over time in order for one individual to exert power, control or coercion over another. The Cross-Government definition of domestic abuse and abuse<sup>27</sup> outlines controlling or coercive behaviour as follows;

*Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.*

- 15.4.27 There was clear evidence of coercive and controlling behaviour in the relationship, although the true extent of this was not known to agencies at that time. Eve had confided in her mother that Nathan could be coercive and controlling in several different ways. Eve stated that Nathan would tell her to cut her wrists "*because she was worthless*" (gaslighting<sup>28</sup>), and this had driven her to periods when she would self-harm. Eve's mum stated that Nathan would appear to have derived some enjoyment from watching and encouraging her to self-harm. Eve had also recounted an argument during which she reported that Nathan had punched her in the face. Nathan had then spat in her face whilst telling her that she meant nothing to him and that she should kill herself. Nathan had exerted such an influence that Eve had been forced to adopt Nathan's perspective on her life, and her mother felt that she had lost her own voice, identity, and self-determination. This is a common reaction to those victims who are gaslighted and subjected to such psychological abuse. Persistent manipulation erodes confidence, causing feelings of worthlessness and self-blame. Such abusive behaviour also contributes to heightened stress, hopelessness, and, in severe cases, suicidal ideation<sup>29</sup>.

- 15.4.28 Eve's mother remarked that her daughter had normalised Nathan's behaviour and had emotionally invested in him to such an extent that she could not recognise him as an abuser. This represents one of the significant barriers that prevented her from reporting the situation to the police and other services.

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<sup>26</sup> Adams et al (2015)

<sup>27</sup> Domestic abuse; Home Office (2016)

<sup>28</sup> Gaslighting is an extremely effective form of emotional abuse that causes a victim to question their own feelings, instincts, and sanity, which gives the abusive partner a lot of power (and we know that abuse is about power and control). Once an abusive partner has broken down the victim's ability to trust their own perceptions, the victim is more likely to stay in the abusive relationship (Tracey, N; 2021)

<sup>29</sup> Dickson et al (2023)

- 15.4.29 Eve had confided in her friends about the abuse and her sexual experiences and they had also seen evidence on social media that corroborated some of her accounts. Her friends described Nathan as aggressive and vicious in the way that he treated Eve. Eve explained that she hadn't consented to many of the acts but felt compelled to perform them due to his influence over her. Nathan would also physically assault her during sex and while under the influence of drugs<sup>30</sup>. From the disclosures that were made to her friends, sexual acts occurred regularly against Eve's will and without her true consent. On one occasion, Eve described herself "*as feeling like she was trapped inside her own body and just froze.*" This type of reaction in rape and sexual violence offences is common and serves as an automatic response allowing victims to reduce physical and psychological pain and to protect themselves<sup>31</sup>. Such a response can also be used as a coping mechanism to pacify the abuser.
- 15.4.30 From the information that was provided by Eve and from the behaviour that she had witnessed in the early stages of their relationship, her mother felt that Nathan was persistently emotionally and psychologically abusive. Examples of this included him constantly calling and texting Eve and blackmailing her regarding the sharing of intimate images and the destruction of her possessions. Eve's mother has stated that Nathan had taken intimate images of her daughter from an early age in their relationship whilst they were at school, and he had constantly threatened to share these and other images with other people, which was a tactic that he used throughout their relationship. He had even threatened to share images with Eve's new boyfriend in the hours prior to her death.
- 15.4.31 Eve's mother also stated that Nathan would use his relationships with other females to manipulate Eve and exert further control. There was a pattern of behaviour in which he would reject Eve, taunt her by establishing another relationship and then declare his love for her.
- 15.4.32 Nathan's behaviour towards Eve was obsessive, and she consistently demonstrated a desire to control all aspects of her life. Many of his high-risk behaviours were evident in the research conducted by Dr Monkton Smith (2018), and the eight-stage timeline was apparent in the relationship that Eve had with Nathan. Whilst this timeline is specifically designed to analyse femicides and intimate partner homicides, its framework can offer insights into suicide risk in abusive relationships. In this case, the two quickly developed a serious relationship (stage 2), which became dominated by coercive control and violence (stage 3). At various stages in that relationship, which will be described in the following paragraphs, there were trigger events, such as Eve and her family attempting to distance themselves from him, leading to retaliations and an increase in the intensity and frequency of the control tactics that Nathan employed to regain control (stage 4). This included further threats, continued gaslighting, and the use of other relationships to make Eve feel jealous. When Eve returned to him, the cycle of abuse would begin again (stage 3). This abuse resulted

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<sup>30</sup> There is a complex link between IPA and substance use; substance use can increase both the frequency and severity of IPA-Gilchrist, et al. (2023).

<sup>31</sup> Rape Crisis (2023)

in a deterioration of Eve's mental health and caused her to live in chronic fear of his potential actions.

- 15.4.33 Eve took the drastic step of travelling abroad to work on a superyacht to escape the coercion and control she was experiencing. Her mother described how this was a desperate attempt to distance herself from Nathan. She also changed her mobile phone and blocked Nathan on social media. Despite these efforts, Nathan bypassed these protective measures by using his mother's mobile. He even created an Instagram account with Eve's name in the handle, which he used to facilitate contact. Dorset Police seized evidence of these conversations as part of their investigation, and this was submitted as evidence to the CPS for consideration.
- 15.4.34 Eve informed her mother that whilst working abroad, Nathan would frequently call her and use other methods of communication to stay in touch. Often, their conversations lasted for hours throughout the night. This behaviour had deprived her of sleep, which in turn affected her mental health. Nathan attempted, on multiple occasions, to persuade Eve to return home, often threatening self-harm. On one occasion, he claimed that he had been hospitalised due to a cardiac arrest (there was no evidence presented during the review process to support this claim). Nathan had also proposed marriage.
- 15.4.35 Eve repeatedly tried to distance herself from Nathan and changed social media accounts several times throughout their relationship, but Nathan kept finding ways to engage with her by using new handles. Occasionally, Nathan had deposited small amounts of money into Eve's bank account and then wrote in the comments box, "*Kill yourself.*" Eve stated to her mother that because of these tactics, she felt pressured into talking to him.
- 15.4.36 Eve's mother has remarked that while agencies believed there were several protective factors in Eve's case, such as being abroad and later at home, they failed to understand how those perpetrating abuse use social media to maintain control over their victims. She pointed out that in a world where people, especially young people, always have their phones with them, it is easy for abusers to regain control through electronic means. Research<sup>32</sup> has described technology-facilitated abuse in intimate relationships as a significant power and control technique that enables abusers to enhance the monitoring of their victims. In this case, much of this abuse was unknown to agencies at the time of the initial report and only became apparent following the Dorset Police investigation. The police have confirmed that technology-facilitated abuse is extensively covered in their domestic abuse training.
- 15.4.37 Nathan consistently engaged in coercive and controlling behaviours to exert influence over Eve, even while she was receiving treatment at the private clinic. Within two days of her admission, Nathan repeatedly called Eve. Concerned about the effectiveness of her daughter's treatment given this pressure, Eve's mother contacted the clinic but was told they could not intervene unless Eve agreed to a 28-day addiction programme that would allow them to confiscate her phone. Eve's mother

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<sup>32</sup> Rogers et al (2022)

also stated that she had seen videos of Nathan instructing her daughter to remove her clothes while she was in the clinic for sexual gratification.

- 15.4.38 Eve confided in one of her friends that Nathan was demanding and controlling, describing their relationship as toxic. She expressed a craving for attention and love while feeling trapped by him. Uncertain about how to navigate the situation, Eve recounted instances where Nathan self-harmed during Facetime sessions and subsequently blamed her for his behaviour. Her friend observed that Nathan “*exploited Eve’s emotional vulnerability* (mental health condition).” These details only emerged after Eve’s death.
- 15.4.39 Dorset Police felt 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 evidence<sup>33</sup>.
- 15.4.40 Upon reviewing the statement provided by Eve’s mother, A&S Police requested that their counterparts in Dorset should approach Eve to determine if she wanted to make a formal report of rape. Dorset maintained that they had clearly communicated with the A&S Police that Eve felt unable to accept support at that time and alternative approaches would be necessary to progress the case. This response is not unusual among victims of abuse as they often feel shame and are too frightened of the consequences should they report the matter. Victims may also depend on the abuser (as, in this case, the abuser ensures that they are isolated from friends and family), or they feel that they have no other support available to them. In this case, not only was Nathan coercive and controlling, but he also had video footage which could be used to incriminate Eve to exert even more pressure and to dissuade her from pursuing any reports of abuse.
- 15.4.41 Initially, records show that the case was not allocated to an officer in A&S Police “*due to the high workload levels the officers currently have and, with it being the summer period, the lack of numbers.*” (A&S Police email dated 20/07/2021). However, the case remained “*in the team tray and an open investigation.*”
- 15.4.42 Within A&S Police, the initial case triage was conducted by the Incident Assessment Unit (IAU). However, due to the case being high-risk, the matter was later reviewed by Operation Bluestone<sup>34</sup>. On review, A&S Police concluded that the review process that was completed by Operation Bluestone officers was appropriate, recognised the high-risk nature of the case and aligned with their force procedural guidance.

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<sup>33</sup> 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)

<sup>34</sup> Operation Bluestone

- 15.4.43 A specialist sexual abuse offence-trained detective (SOLO) from Dorset Police contacted Eve on 22 July /2021, which should be considered good practice. However, Eve felt unable to accept support at that time and chose not to make a report against Nathan. Eve's mother also expressed exasperation about the investigation's progress, which led her to disengage and request no further contact at that time. Eve's mother stated that she was overwhelmed by the process and felt misled by officers regarding their ability to advance the investigation without a complaint from Eve.
- 15.4.44 The contact on 22 July 2021 led to officers completing a PPN. This notice was later shared with partner agencies, and on this occasion, Eve's consent was overridden to enable the details to be passed to Adult Social Care and her GP. The concerns at that time were regarding Eve's declining mental health.
- 15.4.45 The incident investigation into mental health services highlighted that the PPN information was not shared promptly with the CMHT. The investigation revealed that the CMHT did not receive the details until 06/08/2021. Furthermore, the discussions held at HRDA were also not communicated to them while Eve was under their care. The CMHT has since reflected on this and believes that if this information had been shared and considered, a safeguarding concern would have been raised, and support relating to this would have been offered. However, they also recognised that this may not have altered the therapies and treatments provided to Eve. The report has recommended that clinicians should be promptly notified upon receipt of a PPN to ensure timely review. This recommendation has not been duplicated in this review, and the review has confirmed that there are systems in place to ensure that all relevant agencies receive updates from the HRDA process.
- 15.4.46 Dorset Police have since reviewed the delay in the PPN for this case, and whilst they accept that due to queues in their systems, the notice wasn't shared in a timely manner, they have highlighted that the processing of the PPN shouldn't have been relied upon to disseminate the safeguarding concerns. Eve had been seen in a hospital on 17/07/2021, and there would have been an expectation that established health reporting mechanisms should have been used to communicate with the CMHT. The Health Care Trust had contributed to the HRDA, which demonstrates that they had received the information from the PPN. The CMHT were updated on 18/07/2021 by Psychiatric Liaison Services.
- 15.4.47 The review has also highlighted that the PPN is not routinely shared with the HRDA panel. Dorset Police have confirmed that, in suitable cases, the PPN information is utilised to populate the referral to the HRDA. The details contained in previous PPNs are then summarised, and these details are presented to the HRDA panel, so the individual PPN is not required.
- 15.4.48 Following a review by a specialist team supervisor who was working on A&S Police Operation Bluestone team, a decision was made that the Force could take no further action at that time (5 August 2021) as "*the Victim Declined to Prosecute [VDTP]*." A&S Police recorded in their records;

*“It is not clear what evidence we will have for any victimless prosecution as it will need to be direct evidence and not hearsay.”*

- 15.4.49 The Dorset Police representative on the panel has since questioned the assumptions that were made by A&S Police about the interpretation of hearsay and those of *res gestae*<sup>35</sup>. Stated cases in UK courts have shown that *“There is no absolute principle that a conviction based solely or decisively on hearsay evidence is unfair as there are counterbalancing measures in the hearsay framework of the CJA to make the trial fair”*, (*R v Horncastle*[2010] 2 AC 373)<sup>36</sup>. The CPS representatives who were contacted as part of the review process also commented that they ask officers to think beyond a statement from a complainant and use other direct or indirect evidence to support a possible prosecution. These other forms of evidence can potentially be admissible as *res gestae* evidence. In this case, all available evidence had not been considered at this point, or if it was, then it was not recorded.
- 15.4.50 Before the case was closed, an A&S Police Detective sent an email to the Dorset HRDA Panel to ensure that the case was reviewed in terms of support for Eve. It was believed that a Local Safeguarding Unit (LSU) Team Support Officer had made it clear that the Force could not support Eve while she was in Dorset, as they had no knowledge of or access to local domestic abuse support structures in the area. The YOU Trust representative on the review panel confirmed that this was not the case, as they provide services across both Dorset and Somerset. An additional email was sent by the LSU to ensure that Eve was directed to local services. There were no further attempts made to contact Eve at that time by A&S Police, and it was assumed that she had the support of a trained Independent Domestic Abuse Adviser (IDVA). A&S Police were also contacted by an officer from the Sexual Offence Liaison Officer (SOLO) Unit in Dorset, who confirmed that they would reach out to Eve via her mother. This communication occurred, but Eve declined the offer of support at that time. From the information reviewed, it appears that while Dorset ensured that Eve was safeguarded and collected evidence that could have led to other lines of inquiry, there continued to be assumptions that A&S Police would investigate the matter.
- 15.4.51 A&S Police were aware of one potential witness, Eve’s housemate, who had seen bruising on her friend. A police officer spoke to Eve’s friend on the telephone, and she recalled seeing Eve with self-harm marks and bruises on her body. Bluestone supervisors concluded that, despite the evidence provided by this witness, there was still a need for direct evidence from Eve and her support. The supervisor recorded that the *“standard threshold test to consider an evidence-led prosecution had not been met.”* The Police IMR writer for A&S Police stated that, based on the records

<sup>35</sup> 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.

<sup>36</sup> This means that it is not always wrong or unfair to convict someone using only hearsay (second-hand) evidence. This is because the law (specifically the Criminal Justice Act) includes rules and protections to make sure the trial is still fair, even if hearsay is used. The case mentioned, *R v Horncastle (2010)*, confirmed that courts can rely on hearsay evidence if proper safeguards are in place. In this case the evidence obtained from other sources could have been considered alongside Eve’s mother statement, which later occurred post the Dorset investigation.

held, the Force did not want to contradict Eve's wishes, which had been an overriding factor in the decision-making process.

- 15.4.52 In addition to Eve's housemate, other potential witnesses were also named by Eve's mother in her statement. A&S Police has since recognised that greater professional curiosity could have been demonstrated, and witness accounts could have been explored further to establish all the facts. Had this occurred, a more balanced decision could have been made.
- 15.4.53 Although the rape investigation had been reviewed by a specialist team, there is no record indicating that they had specifically considered pursuing the offences relating to coercion and/or control. This was a missed opportunity to demonstrate that all lines of inquiry had been considered, even if they were discounted for operational and evidential reasons. Research has shown that there can be a perception that controlling or coercive behaviour is a complex offence and that it has a high evidence threshold to successfully charge and prosecute. This research has also demonstrated that the police response to controlling, or coercive behaviour (CCB) has shown *"that the likelihood of arrest in such cases was influenced by the likelihood of a successful prosecution, which was also influenced by perceptions that controlling or coercive behaviour is 'hard to prove.'"*<sup>37</sup>
- 15.4.54 The A&S Police IMR writer has established that *"the threshold for CCB was high back in 2021, and it was difficult to get convictions; now in light of training such as DA Matters, CCB is getting more traction and numbers in terms of convictions are rising."* This submission appears to demonstrate that improvements have been made in cases like this, but as part of the A&S Police's existing quality assurance processes, conviction rates need to be monitored further. The Chair of the review panel has since confirmed that A&S Police has set up a NFA scrutiny panel to monitor cases involving rape, DA, CCB, stalking and harassment. This process has been set up following a recommendation from another DHR (Bristol DHR 1/12/22) and has led to two cases being re-opened, which had been previously filed as NFA. These arrangements should ensure that the investigation standards expected in these cases are maintained. The Force DA lead has also confirmed that further work will take place to understand the barriers to reporting. The learning from this DHR should be circulated to the NFA scrutiny panel as part of the ongoing work in that Force area **(Recommendation: 3)**.
- 15.4.55 Although an officer from Operation Bluestone spoke to Eve's mother on 20/07/2021 and explained restraining orders, there is no recorded evidence that DVPNs or DVPOs were considered. In this case, the IMR writer established that A&S Police did not perceive any ongoing threat, and therefore, those measures would not have been relevant at that time. A&S Police also stated that in such cases, where victims like Eve feel unable to engage in an investigation, it can be difficult to obtain preventative measures such as DVPNS or DVPOS.

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<sup>37</sup> Barlow. C (2019) Policing Coercive Control Project Report, The British Academy and Lancaster University Law School, p.2.

15.4.56 Those involved in the case believed that Eve had ended the relationship and that they had no further intelligence or reports indicating any ongoing domestic abuse. Eve's residence in Dorset with her family and Nathan's location in Bristol were also seen as protective factors. Additionally, Nathan was known to be in another relationship. There was evidence that the threat, risk, and harm had been assessed based on the facts presented at the time. This appeared to be a proportionate response at that moment. There has since been recognition that civil orders could have been appropriate, but it remains unclear whether these were discussed with Eve at that time.

15.4.57 The Dorset HRDA panel considered the use of 'Clare's Law' regarding Nathan's current partner and passed details to A&S Police. At that time, only her first name was known. Later, the full details of Nathan's partner were ascertained, and in November 2022, a DVDS was completed.

15.4.58 After Eve's death, Dorset Police launched a criminal investigation that included lines of inquiry from the initial report. As a result of the inquiries, additional information emerged about the abuse Eve had suffered. This led to a further police investigation that resulted in the arrest of Nathan. Consequently, a question has arisen as to why such an investigation could not have been conducted initially. ACPO guidance states:

*If the third party identifies the alleged offender by name or makes them identifiable by other means, the IP should consider further investigation and make an arrest if there is reasonable suspicion that an offence has taken place and that the alleged offender is reasonably suspected of having committed it."* (ACPO;2010)<sup>38</sup>

15.4.59 Upon review, A&S Police officers based their decision on the information available at that time and Eve's response regarding further contact. Those involved in the decision-making balanced this against competing demands related to threat risk, harm, and the resources at hand. The email dated 20/07/2021 from A&S Police indicates that there were pressures on the service concerning resources. The decisions made by A&S Police were consistent with their policy but were driven by capacity constraints. Such decisions are reflected in the outcomes of other national research, including one that examined police investigations into rape and other serious sexual offences, which highlighted that:

*Increasing pressures associated with officer capacity and demand linked to austerity and increased reporting have hindered efforts to deliver a consistent approach.* (Lovell, C; 2022)

15.4.60 The investigation by Dorset Police has required additional time and resources, which all Forces would like to allocate to cases such as Eve's. These investigations are resource-intensive and necessitate a significant commitment in the initial stages. While Forces wish to consistently sustain this level of investigation, they are hindered by the resources at their disposal and the competing demands they must address. In

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<sup>38</sup> [Guidance-Investigating-Prosecuting-Rape-\(Abridged-Edition\)-2010.pdf](#)

this instance, the subsequent investigation was triggered by the need to produce a comprehensive report for His Majesty's Coroner.

15.4.61 There have been differences of opinion between the two Forces involved in this review process regarding the actions that A&S Police should have taken to advance an evidence-led prosecution. These differences only emerged after the review process began and once additional information was obtained from the Dorset Police investigation. Dorset Police had passed the case to A&S Police in accordance with National Recording Standards. National policy and standards do not specify that the referring Force must monitor the case progress in the other Force. From the moment Dorset handed over the case, there was a professional acceptance that it would be investigated according to national standards.

15.4.62 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. This policy encompasses all aspects, from an offender-centric approach to considerations for attending and investigating officers, including Res Gestae and the use of hearsay evidence. Although these changes have been implemented, the review panel noted that there are still instances where the response to victims in cross-border cases varies. It is essential to ensure clarity in policy regarding the responsibilities when victims cross borders, and the insights gained from this case and others should be used to enhance current practices (**Recommendation: 4**).

15.4.63 There was also an allegation of theft involving money that Eve's mother reported against Nathan. This incident was reported to A&S Police on 17/07/2021, as it had occurred in their jurisdiction. The allegation stated that Nathan had used Eve's bank card without her permission. Additionally, reports indicated that there were multiple transactions on her card. On the 22 July, 2021, Eve's mother emailed the OIC to state:

*Following our call and likelihood of no action, I contacted his mother, and I can confirm that [Nathan] has returned the money he took relating to this particular theft. I suspect you have already filed the case, but if not please do so.*

15.4.64 The police's decision to take no further action was reviewed, and the matter was not filed immediately. According to records, the officer in charge of the case had been waiting for evidence to be emailed by Eve's mother, but this did not materialise. The records indicate that Eve's mother was very clear at that time that she wanted the matter closed and that her daughter did not want any further action.

15.4.65 Eve's mother believed that the allegation of theft was classified as a third-party report and stated she was informed it would be handled as a separate investigation. She felt that the police had shown little incentive to pursue the matter. The officer assigned to the case confirmed that there was a related case and that ongoing safeguarding measures were being implemented in Dorset. They also recognised that the DASH assessment had been graded as high. Another DASH concerning the theft was considered but not completed, as Eve felt unable to speak directly with the police. At

that time, there was no indication of why she felt that way. The officer managing the theft had also been in contact with the officer overseeing the allegation of rape, making them aware of the additional complexities involved in this case. The report of the theft presented another opportunity to potentially advance an investigation into coercive and controlling behaviour; however, without complete details or further support from Eve, who felt overwhelmed at that time, there would have been limited opportunity to progress the matter.

15.4.66 There continues to be a difference of opinion between Eve's mother and the police regarding their response. The officer from Dorset Police, who initially spoke with Eve's mother, recognised that coercion and control were significant factors in this case and took a detailed statement from her with the hope that a viable evidence-based prosecution could be considered. While this approach should be regarded as good practice, Eve's mother felt that the discussion led her to believe an investigation would follow, and she was bitterly disappointed when this did not happen.

15.4.67 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 had asked them not to make further contact). Eve's mother maintains that her response was driven by her exasperation with the reporting systems and the investigation process. She felt that she hadn't been treated in accordance with the principles in the victim's code<sup>39</sup> regarding respect, sensitivity, compassion, and courtesy. Much of this concern stemmed from her belief that an evidence-led prosecution was going to be pursued. This shows that the management of expectations in the initial stages of an investigation needs to be effective, and communications need to be clear to prevent victims and third parties from feeling misled. Such experiences can create barriers to reporting abuse in the future.

#### Health Services and Domestic Abuse Recognition/Referrals

15.4.68 Seeking help from GPs or other health professionals for help can often be challenging for young people, and they rarely feel comfortable discussing their problems<sup>40</sup>. Eve had mentioned '*relationship disharmony*' in the e-consultations with her GP. Despite Eve raising this issue, there was initially a lack of professional curiosity and no further exploration of domestic abuse. There were two occasions (29 March 2021 and 13 April 2021) when GPs could have explored the underlying issues relating to the presenting complaint. Eve had discussed relationship triggers that impacted her mood, but again, these were not explored further.

15.4.69 The consultations occurred during the pandemic when 'a validated consultation tool' was used to assess the presenting complaint. However, it did not provide an opportunity for an appropriate enquiry about domestic abuse, as recommended at a national level. There is a recognised need for continuity in healthcare. for individuals, particularly young people, to ensure that they feel confident discussing abuse.

<sup>39</sup> [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/979234/victims-code-crime-leaflet-web.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/979234/victims-code-crime-leaflet-web.pdf)

<sup>40</sup> Barnes et al (2023)

According to feedback from Eve's mother, she felt intimidated by those in authority and unable to effectively communicate via e-consults. National Guidance for Professionals<sup>41</sup> identifies poor mental health as a potential indicator for domestic abuse, with a low threshold for domestic violence enquiry suggested within the guidance.

- 15.4.70 Although the relevant GP practice has moved away from this style of consulting, care navigation software has become more prevalent in primary care to facilitate patient triage and care navigation. While GP practices only utilise NHS-recommended providers, it is crucial that these programmes enable all healthcare professionals to investigate safeguarding issues, including concerns about domestic abuse. Therefore, the Dorset CSP should write to the Home Office to seek assurance that this has been integrated into the current IT rollout (**Recommendation: 5**).
- 15.4.71 The safeguarding lead at the practice has assured the GP IMR writer that the need for a domestic abuse enquiry during mental health consultations is now routinely recognised, especially in cases where antidepressants are prescribed. However, the GP IMR writer has emphasised the necessity for broader awareness and suggested that the thresholds for inquiring about domestic abuse should be lower when appropriate. GPs and other clinicians must understand that some patients, particularly young people, may present with mental health issues or symptoms of depression or anxiety, and they might also be experiencing Intimate Partner Violence and Abuse (IPVA) or have a history of domestic violence in their families. As in this case, victims may be hesitant to identify abuse as the primary reason for their visit.
- 15.4.72 The GP IMR report highlighted that it is vital for professionals to feel comfortable facilitating direct referrals for support and/or signposting to services based on patient wishes and circumstances. A toolkit was launched in October 2021 for GPs regarding appropriate enquiry following a previous DHR (DHR7). From the launch of the toolkit to the time Eve took her own life, there was insufficient time to fully embed the changes in practice across all relevant GP practices. Dorset CSP should seek assurance from the ICB that training is being delivered across all GP practices regarding appropriate enquiry and that these practices are embedded (**Recommendation: 6**).
- 15.4.73 The investigation report on mental health services emphasised the importance of appropriate enquiry, suggesting that an extra question should be included in the core assessment of a patient's electronic record. This recommendation has not been replicated in this review.
- 15.4.74 In April 2021, Eve was involved in an accident that resulted in her arrest. The police took her to a hospital in Devon for an assessment to ensure she was fit to be detained. While at the A&E Department, Eve spoke to the staff but did not disclose any abuse. The staff in this department did not make any inquiries due to the circumstances of the incident and her condition on arrival. This department has domestic abuse procedures in place, and questions would have been asked if it were deemed

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<sup>41</sup> [Recognizing domestic violence and abuse | Recognition | Domestic violence and abuse | CKS | NICE](#)

appropriate and proportionate to do so. This approach was in line with their policy and practice and seemed reasonable under the circumstances.

- 15.4.75 While in custody, Eve was interviewed by a Health Care Professional (HCP) with considerable experience in social work. They have received training in addressing mental health concerns and trauma. This is a consent-based service. Upon entering the custody centre, Eve did not indicate that she was vulnerable regarding abuse, and she was given the opportunity to speak independently to another person about her health and welfare. A custody sergeant asked a standard set of questions to gather this information. Eve was also asked if she wished to speak privately with a staff member about any matters concerning her personal health or welfare needs, but she declined at that time. Eve was later referred to the HCP after she became upset. This should be regarded as good practice.
- 15.4.76 When asked by the HCP, Eve reported issues at home with her mother and indicated that the two had argued the previous day about her boyfriend. She stated that there had been “*ongoing issues for some time.*” Eve did not want any support or further referrals to services at that time, and she denied any thoughts of self-harm. She confirmed that she felt safe upon release, and those working with her believed that there were several protective factors in her life, including friends and family. Although Eve had been asked about general risks, she had not been specifically questioned about domestic abuse. The HCP had been trained in domestic abuse and was aware of coercion and control. They stated that Eve felt unable to accept support at that time and did not wish to provide any specific information, which is not unusual given her circumstances. Their experience has shown that additional questioning can become oppressive, and in this case, Eve simply did not want to talk at that moment. Her views were respected.
- 15.4.77 Devon and Cornwall police have an established practice of assigning an individual to the same detention officer throughout their stay, whenever possible. This approach fosters rapport and has led to disclosures of abuse in the past, which should be regarded as good practice. During her time in the custody centre, Eve indicated that she had access to services in Dorset should she need additional support.
- 15.4.78 Eve was considered capable of making her own decisions while in custody, and she did not consent to the sharing of her information or to notifying other services. The HCP's response was person-centred and aligned with best practices. The level of care demonstrated to Eve should be regarded as exemplary practice.
- 15.4.79 Eve's mother has stated that Eve was clearly traumatised at that time and mentally unwell. She believed that the accident was an attempt by Eve to take her own life, and her GP recognised this in a letter to the court to request dispensation due to the deterioration in her mental health. While the review has identified that those in custody were responsive to the fact that Eve may have additional welfare and support needs, her mother has reiterated the importance of professionals recognising that mentally unwell individuals can't always advocate clearly for themselves. Research<sup>42</sup> in the UK

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<sup>42</sup> Ledden et al (2022)

suggests a strong link between alcohol misuse, including drink-driving, and suicidal behaviour, with alcohol consumption potentially increasing impulsivity and reducing inhibitions, thereby leading to a heightened risk of suicide.

- 15.4.80 During her initial and core assessments, Eve was referred by mental health services to other health services, although there is no record of similar referrals to Local Authority safeguarding and domestic abuse services. This omission occurred despite professionals being aware that Eve had been a victim of domestic abuse. While it is acknowledged that Eve's consent would have been necessary for the involvement of these services, records did not indicate that this had been requested or whether staff had considered her capacity to make these decisions. (**Recommendation: 7/8**).
- 15.4.81 The use of the DASH risk screening tool was not mentioned in the details recorded by mental health service staff. Although the police had already completed this, the local Partnership accepts that it should not be a single-use document, as an individual's exposure to and experience of risk can change over time. The completion of this document should have been discussed with Eve, or the rationale for not using it should have been recorded. Work has been completed in mental health services to improve the submissions of DASH risk assessments by staff, which has been promoted through training. The quality of these submissions should be checked to ensure compliance with current practice (**Recommendation: 9**).
- 15.4.82 When discussing her situation with staff at the private clinic, Eve focused on her relationship. In records, it was reported that there was a significant need and a high dependency on Nathan. The records contained no evidence to determine whether staff responded to Eve's descriptions of her partner's behaviour towards her and whether this was linked to domestic abuse. This represented a missed opportunity in terms of supporting Eve and managing risk.
- 15.4.83 During a session with the consultant psychiatrist, Eve discussed her desire to move back in with her ex-boyfriend. The consultant addressed the potential risks associated with this decision; however, this was not directly linked to domestic abuse. The IMR writer from the private clinic noted that the clinic did not have a domestic policy and practice in place when Eve was a patient.
- 15.4.84 The private clinic's IMR writer and regional safeguarding lead confirmed that Eve's discharge had been planned. In preparation for her discharge, Eve was involved in creating her community crisis support plan, which focused on mental health organisations, although there was no signposting to domestic abuse organisations. When this was discussed with the IMR writer, it was noted that Eve had only spoken about the relationship in group sessions and not with the other professionals in the clinic who were involved in her care. To address this, the private clinic should ensure that all relevant information and risks are shared with the professionals managing a patient's case. Without this information, areas of risk cannot be identified and addressed. The private clinic has updated its policies and scheduled sessions with the DSL for their staff, which will include case studies related to domestic abuse,

including Eve's case. The outcome of this training and the changes in practice should be monitored (**Recommendation: 10**).

15.4.85 There was also no consideration of including her family in managing the risks identified before Eve's discharge. While it is recognised that Eve was an adult and had the capacity to make informed decisions, professionals could have explored this option with her. This was another opportunity missed to identify risks in the community and ensure that Eve was aware of the potential for further abuse or escalation in Nathan's behaviour. As the service provided inpatient care, it would have been possible to signpost Eve to specific organisations in the community that could have supported her (**Recommendation: 11/12**).

15.4.86 The private clinic lacked processes to identify and address domestic abuse issues efficiently. The hospital has since updated its practices and staff training. There is now an emphasis within the organisation to develop its leadership team to ensure a clear understanding of domestic abuse and coercive and controlling behaviour. All staff members are trained to Level 3 in safeguarding, which includes training on domestic abuse and coercive and controlling behaviour. Appropriate inquiries are now conducted when individuals first enter the hospital as part of the admissions process. DASH risk assessments have also been implemented for eligible individuals using the service.

15.4.87 At the time of writing the review, the private clinic is assessing its domestic abuse policy, aiming to establish one that relates to internal staff support and another for the individuals who use their services. Discharge planning processes are also under review to ensure they acknowledge the risks associated with domestic abuse. These policies must be finalised, widely circulated among staff, and fully implemented throughout the facility. Any such implementation should be followed by effective supervision and audits to ensure that best practices are embedded (**Recommendation 13**).

15.4.88 The private clinic has also agreed to offer community support options to patients, including services for domestic abuse. The private clinic's guidance has been updated on the intranet.

## 15.5 **Health/Welfare - Treatment and Support**

15.5.1 Eve's life experiences seem to have significantly influenced her mental well-being. When examining the trauma that might have occurred in her early life, the only identified issues were recorded in 2011 and concerned her exposure to domestic abuse as a child. The review could not ascertain whether this trauma had a direct effect on her mental health as she matured. Health records indicate that Eve had a history of depression and self-harm starting at the age of thirteen. Assessments conducted between 2005 and 2007 revealed that Eve had a long-standing history of alcohol-related problems.

- 15.5.2 Eve's mother has stated that her daughter first showed signs of depression and anxiety during her A Levels, as she became overwhelmed by her relationship with Nathan. According to her mother, Eve's mental health and increased anxiety could be attributed to Nathan's coercive and controlling behaviour within their relationship, as well as her exposure to illicit drugs through that connection. This situation led to what her mother described as periods of "*self-loathing and despair*."
- 15.5.3 Eve had received counselling for depression over several years, including cognitive behavioural therapy (CBT). This counselling was provided by both the NHS and a private clinic. While a voluntary patient at the private clinic, she continued to receive CBT and attended individual and group therapy sessions. Although Eve found some aspects of her treatment useful, there were occasions when she stated that it was ineffective.
- 15.5.4 It could be argued that Eve met the Care Act 2014's definition of an adult at risk because she was accessing mental health services and had prolonged exposure to alcohol dependency. Her mental ill health could also qualify as a protected characteristic under the Equality Act 2010. Eve had been referred through the PPN to the safeguarding adults' team (13 July 2021), but the matter was discharged back to the police for HRDA referrals to be completed. This decision was appropriate at that time due to Eve's specific needs and the nature of the referral. A S42 Enquiry would have duplicated the HRDA process that was being initiated at that time.

#### GP Involvement

- 15.5.5 Eve's interactions with her GP occurred during a time when e-consult was integrated into practice nationally. Face-to-face care only took place when clinically necessary. Subsequently, the safeguarding lead for Primary Care identified that the pandemic created barriers to face-to-face appointments, which would normally be encouraged for individuals in a mental health crisis. Upon reflection, the GP IMR writer noted that in both current and pre-pandemic times, Eve would have been encouraged to attend the GP practice. Eve's mother has mentioned that her daughter could be quite shy, and it is likely that the use of remote contact would have hindered her ability to discuss her life experiences.
- 15.5.6 There was evidence that Eve's GP provided proactive and responsive care while maintaining effective communication with other professionals. Examples included appointments being offered within twenty-four hours of patient contact or on the same day. This was also demonstrated on 14 May 2021, when immediate support was offered to Eve's mother, and a direct discussion was initiated with the CMHT worker. Referral letters to private providers and the CMHT were sent to expedite Eve's access to care. The GP IMR writer stated that there was no instance where Eve or her mother had to wait more than twenty-four hours for support or a reply regarding any mental health-related contact with the surgery. The IMR writer identified this level of service as good practice, given the pressures placed on primary care during the pandemic.

- 15.5.7 Eve's GP made decisions based on the information available to them. However, they were unaware that she had started taking illicit drugs, a fact known to the private clinic. This indicates deficiencies in information sharing, which was vital for risk assessment and the development of treatment plans. This issue has since been addressed through changes in the private clinic's working practices; therefore, no further recommendation is required.
- 15.5.8 There was written communication between the private counsellor and Eve's GP, though there was no mention of domestic abuse. This case has, however, highlighted 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**).
- 15.5.9 Following an incident of self-harm in May 2021, Eve's mother contacted her daughter's GP and inquired about the possibility of sectioning her (see paragraph 15.6). The GP indicated that they would make an urgent referral to the mental health crisis team. This team reached out to Eve by phone, but at that time, she felt unable to engage with them.
- 15.5.10 On 24 May 2021, a one-month supply of antidepressant medication was issued directly to Eve by the GP administrative team. At that time, Eve was awaiting an appointment with the crisis mental health team due to an increased risk of self-harm. The health IMR writer has pointed out that best practice typically involves providing reduced quantities in such cases, such as a one or two-week supply. The GP Practice has since implemented safe prescribing processes for high-risk drugs or situations. This change in practice aligns with national guidance on how prescriptions should be issued by non-prescribers.
- 15.5.11 Eve had initially been referred by her GP to the S2WB service after expressing suicidal ideation. From that point, Eve's 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.
- 15.5.12 While Eve was at the private clinic, the CMHT continued to follow up on her referral and completed her assessment within two months of S2WB recording the initial referral. This action aligned with current practices and met the expected time frames.

#### Mental health services /CMHT Involvement

- 15.5.13 Eve had initially seemed eager to engage with mental health services, making and keeping her planned appointments. She had also committed to the S2WB referral and to an assessment by the CMHT, which was offered and initiated within two weeks of her initial contact with her GP.

- 15.5.14 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 if subjected to life stressors such as a relationship breakdown.*' 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. Eve continued to be medicated for low mood and panic attacks. Despite being offered the opportunity, Eve did not wish to consider further psychological interventions. Regarding mental health support and treatment, the mental health services IMR writer found that practitioners appeared to be sensitive to Eve's needs and had referred her to the available services at the earliest opportunity. The response was timely and proportionate relative to the current and ongoing pressures on mental health services to implement crisis interventions.
- 15.5.15 Despite being offered psychological therapies and counselling, Eve declined them at that time, stating that she had not found them helpful in the past. However, she agreed to a referral to the RELAY (Regulating Emotions and Looking After Yourself) online programme. Additionally, Eve was directed to the Connection service, which allowed her to access telephone mental health support at any time within a twenty-four-hour period. Records indicate that Eve was aware of the psychological therapies available to her and that she could access them if she chose to.
- 15.5.16 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 inability of agencies to encourage her to use the services that were available. This ultimately led to Eve's discharge from mental health services whilst she was working abroad. Those seeking to treat her were unaware that she had left the UK. Records from mental health services indicate that practitioners, particularly the CMHT, were trauma-informed and understood the possible reasons for Eve's reluctance to engage with services. Staff consistently attempted to maintain contact with her. Eve frequently changed her mobile number (to avoid Nathan), which hindered services from reaching her, and she often felt unable to respond to calls. The RELAY service tried to be flexible in their approach to communicating with Eve; they emailed her (unsuccessfully) and sent written correspondence.
- 15.5.17 The mental health services IMR writer identified that there were, however, periods of time while Eve's case was open to mental health services when there was no clear "*direction of travel,*" sequence of interventions, or plan. Eve's mother has also commented that there would appear to have been a lack of timely and joined-up communication between services at that time. The mental health IMR reiterated that, in these circumstances, robust clinical supervision is required. It is the responsibility of case holders and team managers to ensure that these cases are addressed and then either held open for active casework or closed if no interventions are being offered. If the case is closed, the individual using the service should clearly understand how to initiate a referral process when they encounter a problem or situation requiring professional intervention. In this case, Eve had been given the details of the services available to support her, but overall scrutiny and oversight were intermittent, reinforcing the need for robust supervision practices to be followed.

These practices are implemented within mental health services, and assurance has been provided regarding quality assurance processes.

#### Private clinic

- 15.5.18 The review of the private clinic's records identified several areas of good practice and person-centred care. This included Eve's significant involvement in her care and support plans, including the risk assessments.
- 15.5.19 While at the hospital, Eve was assigned a designated nurse responsible for her care. This nurse regularly contacted Eve to ensure her stay was positive and supported her with any concerns or issues that arose regarding her assessment and treatment. The work conducted at the hospital also evidenced a person-centred approach, with Eve playing an active role in her discharge planning. This is considered good practice.
- 15.5.20 The previous section of this report examined the deficiencies in the policies and practices concerning the recognition and support of domestic abuse.

#### Police

- 15.5.21 The Dorset and A&S Police response to Eve's immediate welfare needs during her times of crisis appears to have followed established policy and practice. Throughout their interaction with Eve, officers identified that she was self-harming, suffering from anxiety, and struggling to cope with life. Eve had mentioned that she experienced suicidal thoughts, stating that she would most likely hang herself or "*throw herself off something tall*". She was referred to appropriate services, including the Samaritans and SHOUT, and suitable safeguarding referrals were made.

#### Multi-Agency support

- 15.5.22 Eve's mother has stated that there were times in her daughter's life when she was in crisis, including instances of self-harm, and these events would frequently follow periods of abuse or agency intervention. Her mother felt that there was a lack of timely and coordinated communication between agencies, which affected the way professionals approached her. An example of this, according to her mother, occurred on 18 July 2021, when Eve presented to the Emergency Department after self-harming. This reportedly occurred after her case was closed by the IDVA service, which would have been unknown to those treating her; however, agency records have been unable to confirm this. While incidents of poor communication between agencies have been highlighted in this report, professionals involved in Eve's care have continually stated that despite their best efforts, they were unable to secure her confidence, which prevented them from seeing her case from a holistic perspective and dealing with her effectively.

### 15.6 Capacity

- 15.6.1 Over the years, evidence in the records indicated that Eve's mental anxiety had increased. Her mental health had declined due to her life experiences, impacting her ability to make rational decisions at times. Sometimes, Eve would make decisions that some might consider unwise when declining support. In such circumstances, professionals may have needed to consider whether Eve had executive capacity<sup>43</sup>. This is a complex issue for any individual, involving not only their ability to understand the consequences of their decisions but also the ability to execute those decisions. A person's capacity to make such decisions may be adversely impacted by factors such as coercion and control. Where decisional capacity is not accompanied by executive capacity, then it is recognised that action may be required by professionals in that person's 'best interests'<sup>44</sup>.
- 15.6.2 Eve's capacity to make decisions about her own welfare and support was, at times, impaired by the presence of Nathan, which does not seem to have been considered by the professionals attempting to assist her. If this was noted, it was not documented. At times, this resulted from their unawareness of her situation, as Eve felt unable to disclose the abuse to them. As Eve's mental anxiety and alcohol intake increased her ability to make rational decisions would sometimes fluctuate. Professional curiosity and effective oversight of all the factors affecting her life may have revealed that she lacked true executive capacity<sup>45</sup>, and therefore, on some occasions, she was unable to make informed decisions about her own care.
- 15.6.3 The Mental Capacity Act 2005 (MCA) clearly states that professionals should always assume that clients have capacity<sup>46</sup> unless they can establish otherwise. Under the MCA, professionals are required to assess an individual's capacity before carrying out any care or treatment if they have a reasonable belief that they lack that capacity. The Act sets out a two-stage test that must be used to demonstrate incapacity. The first part of the test would be to establish if Eve was unable to make a particular decision due to an inability to understand, retain, use, weigh up and communicate her decisions (the functional test). The second part would have been to ascertain whether Eve was unable to decide due to an impairment or disturbance in the functioning of the mind or brain (the diagnostic test)<sup>47</sup>.
- 15.6.4 Considering Eve's mental state and her belief that she had a borderline personality disorder, a mental capacity assessment might have been useful in determining whether she had informed capacity. This, in turn, could have guided decisions regarding her engagement with services such as mental health, safeguarding, or domestic abuse support.

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<sup>43</sup> The assessment of executive capacity is described as the ability to act on a decision and to manage any consequences of it.

<sup>44</sup> A Best Interests decision is a decision made by applying the Best Interest principle, as set out in the Mental Capacity Act 2005. A Best Interests decision is a decision made for and on behalf of a person who lacks capacity to make their own decision.

<sup>45</sup> Executive Capacity is about the ability to use or weigh information. The Mental Capacity Code of Practice (para 4.21) notes: 'For someone to have capacity, they must have the ability to weigh up information and use it to arrive at a decision. A person must accept the information and take it into account.'

<sup>46</sup> Having mental capacity means being able to make and communicate your own decisions.

<sup>47</sup> PC and NC v City of York Council [2013] EWCA Civ 478.

- 15.6.5 The balance between meeting someone's needs, particularly when they are considered to have the capacity, and the need to intervene with treatment and care can often be difficult for professionals to judge. Limited resources, time constraints, lack of training, awareness, and legal literacy frequently prevent professionals from considering the wider implications of coercion, control, and the mental impact of abuse on an individual's ability to make rational decisions, including their ability to engage. One example highlighted in the private clinic IMR involved Eve's refusal of routine blood tests. The IMR writer noted that their case records state Eve was informed that the tests would benefit her health. However, the records do not demonstrate how the staff interacting with her understood her capacity to make this decision. The private clinic has addressed this issue by conducting a workshop with clinical staff focused on capacity and the refusal of treatment.
- 15.6.6 To enhance this practice within the NHS, the mental health services IMR writer identified that practitioners should carry out mental capacity assessments with patients who meet the two-stage test of capacity and are known victims of domestic abuse but are declining services (**Recommendation: 15**).
- 15.6.7 While there may have been times when Nathan's presence and influence impaired Eve's ability to make decisions, on many occasions, professionals felt that she had capacity. In their discussions with Eve, she demonstrated that she was able to make her own decisions, and it is unlikely that an assessment leading to more restrictive interventions would have shown otherwise.
- 15.6.8 Eve's status as an adult and her ability to make informed decisions obviously affected what agencies could communicate to her mother. Eve's mother claimed that she believed her daughter had consented to professionals discussing her treatment and welfare needs with her. The review panel members confirmed that, according to the records, it was evident that Eve had not given that consent, and as an adult, it would have been unlawful for them to share that information and breach her privacy.

## 15.7 **Risk Management**

- 15.7.1 Controlling or coercive behaviour is a risk factor in domestic homicides, especially for female victims of intimate partner homicide and a significant precursor to suicides<sup>48</sup><sup>49</sup>. In this case, agencies were aware of the risks to Eve through the DASH risk assessment and the HRDA process.

<sup>48</sup> Wolford-Clevenger. C et al (2017) Associations of Emotional Abuse Types with Suicide Ideation among Dating Couples, Journal of Aggression, Maltreatment & Trauma, Volume 26, Issue 9, p.1042-1054

<sup>49</sup> In 2020 the Domestic Homicides Project was established by police and government in England and Wales to collect, review, and share quick-time learning from all police-recorded domestic homicides and also from suspected suicides of individuals with a history of domestic abuse victimisation in the wake of the Covid-19 pandemic and restrictions. The project published its findings in the Home Office, Vulnerability and Knowledge Programme, NPCC, College of Policing (2021) Vulnerability Knowledge and Practice Programme (VKPP): Domestic Homicides and Suspected Victim Suicides During the Covid-19 Pandemic 2020-2021. The report draws on the following sets of data gathered for the project: case submissions from police relating to 208 incidents, Home Office Homicide Index data covering the period of 2005/06 to 2019/20, a written survey of all 43 English and Welsh police for

- 15.7.2 On each occasion Eve was seen by health professionals, she was appropriately assessed for her immediate needs, and support was put in place in relation to the identified risk factors. On many occasions, professionals used her case history and multi-agency information to inform the process. The risks of her taking her own life were considered, and the decisions that were made were based on her presentation and her perceived capacity to rationalise her behaviour. Studies<sup>50</sup> have found that domestic abuse survivors experience higher than average rates of suicidal thoughts, with as many as twenty-three per cent having attempted to take their own lives, compared to three per cent among populations without prior exposure to domestic abuse.
- 15.7.3 The identified risks were weighed against the protective factors in her life, which included the continuous 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. This makes professional decision-making regarding risks difficult.
- 15.7.4 Despite her attempts at taking her own life, Eve did not reach the threshold for section 2 and 3 detentions under the Mental Health Act 1983/07<sup>51</sup>;

*(1) A patient may be admitted to a hospital and detained there for the period allowed by subsection (4) below in pursuance of an application (in this Act referred to as "an application for admission for assessment") made in accordance with subsections (2) and (3) below.*

*(2) An application for admission for assessment may be made in respect of a patient on the grounds that—*

*(a) he is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and*

*(b) he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.*

*(3) An application for admission for assessment shall be founded on the written recommendations in the prescribed form of two registered medical practitioners, including in each case a statement that in the opinion of the practitioner the conditions set out in subsection (2) above are complied with.*

*(4) Subject to the provisions of section 29(4) below, a patient admitted to hospital in pursuance of an application for admission for assessment may be detained for a*

<sup>50</sup> Aitken, R & Munro, V. E (2018), DomesticShelter.Org (2016).

<sup>51</sup> Mental Health Act 1983

*period not exceeding 28 days beginning with the day on which he is admitted, but shall not be detained after the expiration of that period unless before it has expired he has become liable to be detained by virtue of a subsequent application, order or direction under the following provisions of this Act.*

- 15.7.5 When professionals involved with the Mental Health Act discuss individuals with mental health issues and the possibility of them being sectioned, they often refer to the term mental disorder. The Act defines this as “any disorder or disability of mind” (section 1).

Mental disorders can include:

- any mental health problem normally diagnosed in psychiatry.
- learning disabilities - if the disability makes you act in a way which may seem "abnormally aggressive" or "seriously irresponsible."

- 15.7.6 When Eve presented to 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 assessment thresholds established by the Act. These decisions appear to have been proportionate and consistent with agency policies and practice.

- 15.7.7 The agencies that had contact with Eve have established risk management processes. While each agency examined risk factors relevant to its own organisation, there was also, on many occasions, a collective understanding of the issues Eve faced (although some evidence of silo working was identified as described earlier in the report). Although discrepancies existed in multi-agency information sharing regarding Eve's health (i.e., GP records indicating no previous concerns about alcohol issues and documented gaps in information sharing between NHS services, the police and the private health sector), there was, overall, evidence of good practice among the statutory agencies in managing the risks they encountered.

- 15.7.8 Eve's alcohol consumption during crises heightened her vulnerability. Research<sup>52</sup> has identified that substance abuse, when combined with mental health issues, this also increases vulnerability for victims and the risk of domestic abuse. Eve's relationship with alcohol seems to have been driven by her desire to cope with her anxiety and life circumstances. Health professionals were aware of this issue, and her GP attempted to support her after reviewing the available information. They discussed this with Eve, and she informed them that she understood the risks and would keep her drinking to a minimum.

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<sup>52</sup> Gadd et al (2019), SafeLives (2019)

- 15.7.9 Eve's drinking had increased in the months leading up to her death. Research<sup>53</sup> on intimate terrorists<sup>54/55</sup> has shown that some victims who suffer intimate partner violence<sup>56</sup> will use alcohol to "*manage depression that the daily anticipation of violence engenders.*"
- 15.7.10 Eve's use of alcohol was not considered significant enough to warrant a referral by any agency to drug and alcohol services, as she did not meet their thresholds. While this was in line with policy and was appropriate in this case, it appears there was no signposting to other support agencies that could have assisted her in managing this behaviour. This represented a missed opportunity for intervention to reduce the risks associated with her self-harming behaviour. Current policy and practice encourage staff to provide such support; consequently, this reflection did not result in a recommendation. The lessons learned from this case, when shared with all relevant staff, should emphasise the importance of effective signposting.
- 15.7.11 Eve was considered medium risk by the professionals at the private clinic, and the interventions outlined in her care plan were deemed suitable to address the identified issues. Subsequently, this risk was evaluated as low in later assessments. In that setting, Eve consistently informed professionals that she had no suicidal thoughts.
- 15.7.12 Eve's behaviour immediately before her death gave no indication that the tragedy would happen. Her family stated that Eve had made plans, including attending a horse-riding event with a friend, and she had mentioned looking forward to her mother's upcoming birthday.
- 15.7.13 The review panel considered whether there were alternative forums that could have managed Eve's case after it had been closed by the HRDA process. The review panel had considered whether a further Section 42 referral should have been made or if the matter should have been escalated through the Multi-Agency Risk Management Process (MARM)<sup>57</sup>. Professionals felt that the circumstances of this case would not have met the criteria for the MARM, and the Section 42 referral would have concluded the right processes had already been followed.
- 15.7.14 Dorset police have developed a process for high-harm perpetrators that aligns with the HRDA. This process should be considered good practice and will aid in the trauma-informed management of cases where there is a clear indication of significant risks to individuals like Eve, even when there is insufficient evidence to advance an investigation.

## 15.8 **The impact of COVID on Eve**

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<sup>53</sup> Stark (2007)

<sup>54</sup> Intimate terrorism, or coercive controlling violence (CCV), occurs when one partner in a relationship, typically a man, uses coercive control and power over the other partner, using threats, intimidation, and isolation (Bogat et al 2016)

<sup>55</sup> Johnson 2008

<sup>56</sup> (WHO) defines IPV as "any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours.

<sup>57</sup> MARM

- 15.8.1 During this period, several protective factors existed 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.
- 15.8.2 The true impact of COVID-19 on Eve's mental health has been difficult to determine. Based on available records and disclosures from Eve and her friends, she felt isolated and struggled to cope mentally with the demands on her life during the pandemic. As a result, Eve increasingly spent time with Nathan. Her family also felt unable, due to the restrictions, to see her and provide additional support. Her mother described how Eve's relationship with Nathan essentially went underground.
- 15.8.3 The consequences of COVID are only just beginning to emerge on a national level post-pandemic<sup>58/59</sup> however, the evidence seems to suggest that abuse and anxiety related to mental health have increased during this period, which is evident in Eve's life story.
- 15.8.4 The issues identified regarding face-to-face health care have been discussed earlier in the report.

## 15.9 **Operational Practice, Policy, and Procedure**

- 15.9.1 As part of the review process, the IMR writers and review panel members have confirmed that their domestic abuse policies and practices are up-to-date and have been reviewed in accordance with their organisational guidelines. The Independent Chair was satisfied with the evidence presented.
- 15.9.2 Although there were opportunities to enhance information sharing in this case, there were also notable examples of effective multi-agency interaction and practice across all agencies. Overall, mental health services were found to be compliant with their own organisational domestic abuse policy and the local Safeguarding Adults Board's multi-agency policies. Information from mental health services was shared successfully and in a timely manner between Eve's GP, S2WB, the Community Mental Health Team, and the Connection Service. However, case recording has indicated that the Local Authority safeguarding service or local domestic abuse support services were not involved in that information-sharing process.
- 15.9.3 Following a previous DHR (DHR7), the Dorset CSP Strategic Priority Delivery Group has met and agreed that further opportunities for information sharing need to be explored and barriers identified. At the time of writing the review, the partnership had just reviewed the policies and practices relevant to information sharing but acknowledged that ongoing efforts will be necessary to reinforce the standards expected by operational staff. This recommendation continues to be evaluated and

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<sup>58</sup> The Office of National Statistics reported that domestic abuse rose by 7% in the period of March to June 2020, compared to 2019 and by 18% comparatively from 2018, with a month on month increase of 9% being reported between April and May 2020 (Domestic abuse during the coronavirus pandemic, England and Wales: November 2020 [www.ons.gov.uk](http://www.ons.gov.uk)).

<sup>59</sup> Local Government Association (2021)

is part of the ongoing work related to training, case management, and supervision. The review panel felt that additional recommendations were unnecessary, as this would duplicate the current efforts underway. The insights gained from this review will be cross-referenced with that work.

15.9.4 DHR D7 also recommended that agencies collaborate to establish a unified process for managing individuals with multiple complex needs who are either unable or unwilling to engage with services. This recommendation is still under review and, therefore, has not been replicated for this process.

15.9.5 The learning from this review needs to be cross-referenced in the 'Composite Action Plan' held by Dorset CSP.

## 15.10 **Training**

15.10.1 Representatives of the agencies involved in this review have confirmed that training and awareness regarding domestic abuse, coercion, and control are ongoing for all staff to enhance their knowledge and understanding.

15.10.2 There are several recommendations in previous Domestic Homicide Reviews (DHRs) within Dorset regarding training and awareness. These recommendations are clearly documented in the DHR 'Composite Action Plan' (January 2025), and updates have been provided. The review Chair had access to this information. The latest update indicates that action is being taken, and that training has been, and continues to be, delivered throughout 2025. As a result of the action plan and ongoing measures to address these recommendations, no further recommendations have been made as part of this review.

15.10.3 A&S Police have confirmed that their officers across the force have received Domestic Abuse Matters training [Safelives], Non-fatal Strangulation training [Safelives], and Coercive and Controlling Behaviour training [Safelives]. They also have a substantial cohort of Domestic Abuse Influencers who review Domestic Abuse cases and provide feedback to officers [as needed] about the quality of the service that has been delivered.

15.10.4 The A&S Police panel member has confirmed that evidence-led policing is included in the DA Matters and foundation training for all frontline staff, and there is now a specific remote learning package on the subject. This has been completed by 1905 officers and staff members at the date of submitting this report.

15.10.5 The review panel member for that force has examined other DHRs involving A&S Police related to the investigation of coercive control cases. They confirmed that coercive and controlling behaviour is now included in all safeguarding training and that training and awareness initiatives have been implemented to enhance officers' ability to recognise and investigate such cases.

## **16.0 Conclusions**

- 16.1. At the time of Eve's death, she had a history of self-harm and was experiencing increasing bouts of anxiety.
- 16.2. 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.
- 16.3. 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.
- 16.4. 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.
- 16.5. 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.
- 16.6. 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.
- 16.7. 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.

- 16.8. 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.
- 16.9. 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.
- 16.10. 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. Referrals for additional assistance were made when possible, and support was provided once Eve consented and felt ready to engage.
- 16.11. 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.
- 16.12. 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.
- 16.13. 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.

## **17.0 Learning**

**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 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.

## 18.0 Recommendations

- 18.1 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.

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**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                                 |

## Bibliography

Adams, A.E., Beeble, M.L., & Gregory, K.A. (2015). Evidence of the distinctiveness of economic abuse among intimate partner violence victims. *Journal of Family Violence*, 30(5), 573–586. <https://doi.org/10.1007/s10896-015-9705-y>

Agenda Alliance (2023) Under examined and under reported. Briefing by Agenda Alliance.

Aitken R, Munro V (2018) Domestic Abuse and Suicide: Exploring the Links with Refuge's Client Base and Work Force. London: REFUGE.

Baker, N., Buick, J.D., Kim, S.R., Moniz, S. and Nava, K.L. (2013) Lessons from Examining Same-sex IPV, *Sex Roles*, 69(3-4): 182–92. doi: 10.1007/s11199-012-0218-3

Barnes, M., Barter, C., Herbert, A. *et al.* Young People and Intimate Partner Violence: Experiences of Institutional Support and Services in England. *J Fam Viol* (2023). <https://doi.org/10.1007/s10896-023-00591-x>

Bogat, G. Anne; et al. (2016). "Intimate Partner Violence". In Friedman, Howard S. (ed.). *Encyclopaedia of Mental Health* (2nd ed.). Academic Press. p. 411. ISBN 978-0-12-397045-9

Danger, S., Munro, V., Andrade, L. (2022) "Learning Legacies: An analysis of Domestic Homicide Reviews in Cases of Domestic Abuse Suicide. Warwick University.

Domestic Violence and Abuse: Multi Agency Working; Public Health (NICE) Guideline [PH50]; 2018.

David Gadd, et al. (2019) "The Dynamics of Domestic Abuse and Drug and Alcohol Dependency." *The British Journal of Criminology* azz011, <https://doi.org/10.1093/bjc/azz011>

Dickson, Prashansa, Ireland, Jane Louise and Birch, Philip (2023) Gaslighting and its application to interpersonal violence. *Journal of Criminological Research, Policy and Practice*. ISSN 2056-3841

Dorset Domestic Abuse Strategy 2021-2024([Dorset DA Strategy](#))

Dorset, Bournemouth and Poole multi-agency safeguarding adults' policy.

Ferrari, G., Agnew-Davies, R., Bailey, J., Howard, L., Howarth, E., Peters, T., Sardinha, L. M., & Feder, G. (2014). Domestic violence and mental health: A cross-sectional survey of women seeking help from domestic violence support services. *Global Health Action*, 7, 1. <https://doi.org/10.3402/gha.v7.25519>

Gilchrist, E , et al. (2023) "Substance Use and Intimate Partner Abuse (IPA): A Descriptive Model of the Pathways Between Substance Use and IPA Perpetration for Men." *Journal of Family Violence* 38:855–868 <https://doi.org/10.1007/s10896-022-00395-5>

Graham K, Bernardis S, Wilsnack SC, Gmel G. Alcohol may not cause partner violence but it seems to make it worse: a cross national comparison of the relationship between alcohol and severity of partner violence. *J Interpers Violence*. 2011 May;26(8):1503-23. doi: 10.1177/0886260510370596. Epub 2010 Jun 3. PMID: 20522883; PMCID: PMC3142677.

Graham K. Bernardis S., Wilsnack, and Gmel, G. (2011), 'Alcohol May Not Cause Partner Violence But It Seems to Make It Worse' *Journal of Interpersonal Violence*, 26:1503–23

Home Office. (2015) Controlling or Coercive Behaviour in Intimate or Family Relationship Statutory Guidance Framework; Dec 2015; London. Home Office.

Home Office (2016) Domestic abuse and Abuse guidance; London.Home Office

Home Office. (2016) Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews; December 2016; London. Home Office.

Home Office (2020) Domestic Abuse during the coronavirus pandemic, England and Wales: November 2020 [www.ons.gov.uk](http://www.ons.gov.uk)

Home Office (2022) Controlling or Coercive Behaviour; Statutory Guidance Framework - [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/1072673/MASTER\\_ENGLISH -  
Draft Controlling or Coercive Behaviour Statutory Guidance.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1072673/MASTER_ENGLISH_-_Draft_Controlling_or_Coercive_Behaviour_Statutory_Guidance.pdf).

Iverson, K.M., Litwack, S.D., Pineles, S.L., Suvak, M.K., Vaughn, R.A. and Resick, P.A., 2013. Predictors of intimate partner violence revictimization: The relative impact of distinct PTSD symptoms, dissociation, and coping strategies. *Journal of traumatic stress*, 26(1), pp.102-110.

Iriss (2020) Using Evidence for Change: Domestic Abuse; Iriss 17 June 2020.

Kertesz, Margaret, Larissa Fogden, and Cathy Humphreys. "Domestic violence and the impact on children." *The Routledge International Handbook of Domestic Violence and Abuse*. Routledge, 2021. 128-140.

Lahav, Y. (2021). Painful bonds: Identification with the aggressor and distress among IPV survivors. *Journal of Psychiatric Research*, 144, 26-31.

Landa-Blanco, M., Vásquez, G., Portillo, G., Sproviero, F. and Echenique, Y., 2024. The impact of adverse childhood experiences on mental health, sexual risk behaviours, and alcohol consumption in adulthood. *Frontiers in Psychiatry*, 15, p.1352824.

Ledden S, Moran P, Osborn D, Pitman A. Alcohol use and its association with suicide attempt, suicidal thoughts and non-suicidal self-harm in two successive, nationally representative English household samples. *BJPsych Open*. 2022;8(6):e192. doi:10.1192/bjo.2022.594

Local Government Association (2021). COVID-19 Adult Safeguarding Insight Project Second Report. Local Government Association.

Michael P Johnson. A Typology of Domestic Violence intimate terrorism, violent resistance, and situational couple violence (Boston: Northeastern University Press, 2008).

National Society for the Prevention of Cruelty to Children (2019). Learning from case reviews: disguised compliance. Available at: <https://s.iriss.org.uk/3Rm7hs6>

Tracey, N (2021). Gaslighting Definition, Techniques and being Gaslighted, Healthy Place.

Office for National Statistics (ONS), released 25 Month 2022, ONS website, statistical bulletin, [Domestic abuse in England and Wales overview: November 2022](#)

ONS (2018b) 'Homicide in England and Wales: Year ending March 2017', available online at <https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/yearendingmarch2017#which-groups-of-people-are-most-likely-to-be-victims-of-homicide>.

Reno, J., Marcus, D., Leary, M.L. and Samuels, J.E., 2010. Full report of the prevalence, incidence, and consequences of violence against women. Department of Justice. Available online at: <https://www.ncjrs.gov/pdffiles1/nij/183781.pdf>.

Rogers MM, Fisher C, Ali P, Allmark P, Fontes L. Technology-Facilitated Abuse in Intimate Relationships: A Scoping Review. *Trauma Violence Abuse*. 2023 Oct;24(4):2210-2226. doi: 10.1177/15248380221090218. Epub 2022 May 10. PMID: 35537445; PMCID: PMC10486147.

SafeLives (2015) Getting it right First time.

SafeLives (2015), Insights Idva National Dataset 2013-14. Bristol: SafeLives

SafeLives (2017) Safe Young Lives: Young People and Domestic Abuse.

SafeLives. (2019) Safe and Well: Mental Health and Domestic Abuse.

Smith, L (2018) Impact on Children of Witnessing Coercive Control, IRISS

Stanley, N., Barter, C., Bracewell, K., Richardson Foster, H., Martin, K and the Roadmap Team. (2021). *Roadmap Evaluation for System Change in Domestic Abuse Final Report. Women's Aid and Safe- Lives*. [https://www.womensaid.org.uk/wp-content/uploads/2021/10/Roadmap\\_Report\\_280921.pdf](https://www.womensaid.org.uk/wp-content/uploads/2021/10/Roadmap_Report_280921.pdf)

Stark, E. (2007) *Coercive Control: How Men Entrap Women in Personal Life*, Oxford: Oxford University Press.

Stonard, K. E., Bowen, E., Lawrence, T. R., Price, S. A. (2014). The relevance of technology to the nature, prevalence and impact of adolescent dating violence and abuse: A research synthesis. *Aggression and Violent Behaviour*, 19(4), 390–417. <https://doi.org/10.1016/j.avb.2014.06.005>

Women's Aid (2019) *The domestic abuse report 2019: The Economics of abuse*. Bristol Women's Aid.

Women's Aid. (2021) *Mental health and domestic abuse: A review of the literature*. Bristol: Women's Aid.

Women's Aid (2023) *The Domestic Abuse report 2023; The Annual Audit*

World Health Organisation (2012) *Understanding and Addressing Violence against Women: Intimate Partner Violence*.

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