Inquest finds multi-agency failures before the death of Jessie Laverack

27 June 2022

Before Area Coroner Miss Lorraine Harris
Hull and the East Riding Coroner's Court

20 – 27 June 2022

Jessica Louise Laverack ("Jessie") was found dead on 2 February 2018. After hearing five days of evidence the Coroner returned her conclusions on 27 June 2022. She found that the underlying cause of Jessie's mental illness was domestic abuse and that a lack of a coordinated approach to her care by professionals together with inadequate information sharing contributed to her decline.

In her powerful conclusion Miss Harris stated that *"agencies had institutional blinkers, and a "not my agency not my problem" approach to parts of Jessie's care, even in multi-agency forums. Instead of standing alone they should have been holding hands to form a protective circle around Jessie".*

The Coroner concluded that she did not consider that she had enough evidence of Jessie's intention to make a finding of suicide. As part of her conclusion she stated that "*the lack of an appropriate, co-ordinated approach to her issues, which was further hampered by inadequate information sharing, while not directly causative of her death, would have affected the state of her mental health and contributed to her decline".*

The Coroner also indicated that she intended to make a report to prevent future deaths to the Home Secretary, the Minister for Justice and the Minister for Health to ensure that the link between domestic abuse and suicide was better understood. She stated the following evidence had caused her concern that future lives may be lost:

- A lack of a system to appropriately identify and care for vulnerable adults who had not been recognised as "high risk";
- A lack of information sharing and a need for there to be complex case forums on a national level;
- A lack of a single point of contact to coordinate a structured approach to people with dual or multi-diagnosis;
- That police officers needed better training in domestic abuse and suicide and whether the deployment of frontline officers to deal with domestic abuse was appropriate;
- The standard form used to asses risk in domestic abuse cases needs to be revisited and updated to address developments in the understanding of domestic abuse;

- The risk of sleep deprivation and its impact on mental health and suicide needs to be recognised.

Background

Jessie was a vibrant, artistic young woman who was a talented hairdresser with a love of animals. She was very close to her family. She also faced many challenges in her life, suffering from disabling anxiety, dyslexia, night terrors, a fear of leaving the house and a severe alcohol addiction.

During the summer of 2017 Jessie left Rotherham to escape a violent and abusive relationship. She was identified as being a high risk domestic abuse case and was referred to a MARAC (a Multi-Agency Risk Assessment Conference for high risk victims of domestic abuse). The Rotherham MARAC had heard evidence of the very serious domestic abuse that Jessie had been subjected to, including serious physical and sexual assaults. Her ex-partner had been charged but Jessie had withdrawn her support for the prosecution out of fear of repercussions.

In the East Riding area, Jessie received support from her GP, a domestic abuse worker from East Riding of Yorkshire Council (the Council), an alcohol worker from the East Riding Partnership which was part of the Humber Teaching Foundation NHS Trust (the Trust), a social worker from alcohol services within the Council, Crisis Services within the Trust. Her case was also transferred from the Rotherham MARAC to the Beverley MARAC.

The inquest heard that in September 2017 the situation escalated when her ex partner contacted Jessie to say that he was watching her and was “coming for the dog”. The dog was identified as a site of control by her ex partner and the family attempted to report to Humberside Police the harassment and ongoing abuse that Jessie was suffering. Despite having been identified as high risk by the MARAC and the domestic abuse worker the police downgraded her risk and she wasn’t re-referred back into to the MARAC process.

Coroner’s factual findings

After hearing 5 days of evidence the Coroner made a series of factual findings as follows:

- Jessie was a victim of domestic abuse and she was vulnerable. She had a dual diagnosis which meant that she suffered from both alcoholism and a mental health condition. She suffered from high anxiety.
- Jessie moved from Rotherham to Beverley to escape domestic abuse which caused her isolation which was not properly recognised by agencies.
- Uncoordinated working, silo working and seeing snapshots of her treatment was a recurrent theme in her care. No one person took the lead and there no multi-agency coordination or structured integration plan which meant that the benefits of what work was being done was lost.
- Information sharing between agencies, even where procedures existed, was lacking. An up to date, rounded assessment of Jessie was never truly available. Better information sharing would have led to better understanding which would have affected the ability to treat her mental health.
- Jessie’s family were proactive in helping her to obtain the best care but it was inappropriate for a family member to be responsible for coordinating her care.
- At the time the Trust did not have a dual diagnosis practitioner and so Jessie did not receive support appropriate to her needs. Although it was right to prioritise Jessie’s alcohol addiction, her other mental health condition was not properly assessed.
- The police who attended her in September 2017 felt that they were not properly trained in domestic abuse and the risk assessment was therefore down-graded. Insufficient

weight was given to the fact that the ex-partner had contacted her and knew her address, and the impact of this upon Jessie's mental health.

- The MARAC in Beverley did not function adequately. They closed her case prematurely and there was confusion about who was responsible for referring the case. Jessie was not re-referred to the MARAC. There was a lack of information sharing both internally and externally. GPs weren't invited to attend the MARAC.
- The majority of cases are not identified as being high risk and "*therefore there is a gap in caring for a large group of vulnerable people".*
- The risk assessment for domestic abuse forms (known as DASH forms) were created approximately 12 years ago and may not be fit for purpose as more is learnt about domestic abuse.
- Despite Jessie giving a history of suicidal thoughts, agencies tended to look at her current thoughts rather than whether there was a pattern of behaviour that could repeat itself at any given time. Agencies did not properly share evidence of her suicidality.
- Neither Jessie's agoraphobia or insomnia were properly recognised as part of her mental health condition. There was no recognition on the barriers faced by Jessie in leaving the house.
- The recognition of suicidality and its link to domestic abuse was given insufficient weight.

Mrs Phyllis Daly, Jessie's mother, said: *"It has taken four and a half years but we finally feel that the Coroner has listened to us and recognised the link between domestic abuse and suicide. Jessie felt that she had no escape from the domestic abuse that she was suffering and this had a terrible impact on her mental health. The failure of agencies to provide her with appropriate joined up care also impacted on her mental health and led her to feel that there was no way out.*

Jessie had a right to feel protected and stay safe. We lost count of the times that we went to agencies to beg for support for Jessie. We need professionals to comprehend the link between domestic abuse and suicide and to understand the importance of proper information sharing and cooperative working. Robust examinations of the actions of state agencies is essential to identify ongoing systemic failings and to ensure that women fleeing domestic violence are afforded better support, from both perpetrators and from themselves.

I know that we are not the only people experiencing this battle. Many other families are desperately fighting to get professionals to listen and hear victims' cries for help. I can only hope that Jessie's story will make change on the ground. If the Coroner's findings can help other families our long struggle to have Jessie's voice heard will have been worth it.

The family's solicitor, Sophie Naftalin of Bhatt Murphy Solicitors said:

"Domestic abuse presents a risk to life that authorities often fail to acknowledge let alone address. The Coroner has recognised what families and front line practitioners have been saying for years: that for victims of domestic violence to be properly protected there needs to be a proper understanding of the risks they face. If domestic abuse is not seen or understood and information not properly shared then we will see more needless deaths, either in the context of domestic homicide or suicide following domestic abuse.

We have heard five days of highly complex and distressing evidence about a woman in crisis struggling to access support. This inquest has provided a real opportunity for professionals to consider how systems can be improved to properly risk assess, work collaboratively and therefore protect vulnerable victims. The Coroner's conclusion and her report to prevent future deaths vindicates the family's concerns and sends a powerful message to the agencies working in East Riding and nationally that there is much more work to be done to understand domestic abuse and its impact on mental health.

It is notable that despite six other interested parties having fully funded legal teams, this family were only granted legal aid shortly before the inquest having initially been refused funding. The suggestion that this family should have acted for themselves in a week long inquest which raises highly complex issues is yet another reason why legal aid for inquests requires further reform to ensure equality of arms".

ENDS

NOTES TO EDITORS

For further information, interview requests and to note your interest, please contact Sophie Naftalin at s.naftalin@bhattmurphy.co.uk

The family are represented by Sophie Naftalin of Bhatt Murphy and Aswini Weereratne QC of Doughty Street Chambers. They also received support from the charity Action After Fatal Domestic Assault (AAFDA).

Journalists should refer to the Samaritans Media Guidelines for reporting suicide and self-harm and guidance for reporting on inquests.