HUNTINGDONSHIRE DISTRICT COUNCIL

COMMUNITY SAFETY PARTNERSHIP

DOMESTIC ABUSE DEATH REVIEW

EXECUTIVE SUMMARY

LOUISE AGED 28

DIED AUGUST 2020

REVIEW PANEL CHAIR AND REPORT AUTHOR

HELEN COLLINS BA (Hons) PGCE PCET

Preface

Huntingdonshire Safety Partnership and the Review Panel wish at the outset to express their deepest sympathy to Louise's family and friends. This review has been undertaken in order that lessons can be learned.

This review has been undertaken in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of Louise's death in a meaningful way and address, with candour, the issues that it has raised.

The review was commissioned by Huntingdonshire Community Safety Partnership on receiving notification of the death of Louise in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

It was subsequently agreed to title this report as a Domestic Abuse Death Review.

Contents

1. The Review Process

1.1 This summary outlines the process undertaken by Huntingdonshire Community Safety Partnership ('the CSP') Domestic Abuse Death Review panel in reviewing the death of Louise who was a resident within their area prior to her death.

1.2 The following pseudonyms have been used in this review for the victim and perpetrator to protect their identity and those of their families:

> The deceased in this case will be known as Louise. She was a white British woman who was only 28 years old at the time of her death.
> Her partner of the time will be known as Paul. The couple had been in a relationship since 2016 and lived together sporadically, however they were not living together at the time of Louise's death.

1.3 On a day in August 2020, Police were contacted by Louise's mother reporting welfare concerns for her daughter after she had failed to attend work that day. On Police attendance Louise was found deceased, along with a note stating 'He' had ruined her life and had taken her phone and keys. Louise had hanged herself.

1.4 In the weeks before the loss of Louise, she had been described by friends as happy and very excited about moving into her new home with her children, without Paul. On the night before her death a gathering/party had been held at her house. Present at this event were her partner Paul, and three friends/relatives of Paul. Louise did not know the guests very well.

1.5 From enquiries made and accounts taken by the Police, during this evening Louise became agitated and went upstairs. Sometime later she contacted Paul by text message, and he reportedly went to one of the children's bedrooms where he found her with a length of electrical cord around her neck, threatening to harm herself.

1.6 Paul removed the cord, and assisted her to her own bed, where he reassured her after she apologised for her actions. Paul then removed all of the extension leads from the upstairs of the house as a preventative measure.

1.7 No further interventions were made with Louise by the attendees at the gathering. No Calls were made to her family to inform them of her state of mind and no professional agencies were contacted.

1.8 At some stage Paul left the house with Louise's youngest child, leaving Louise alone in the premises, this is believed to have occurred the following morning.

1.9 At this time no inquest has currently been held and a copy of the Domestic Abuse Death Review has been provided to HM Coroner. Louise's mother feels that the Police dismissed an available evidence to show that Louise was subject of abuse. Police recorded the death as 'non-suspicious'.

1.10 It is within this context that this review is set.

1.11 The process of this review began in February 2021 when Huntingdonshire Community Safety Partnership appointed a Chair/Author. A meeting to discuss the case was held on 23rd February 2021.

1.12 All local agencies were scoped for prior contact with the victim. The agencies who were found to have had relevant prior contact secured the records that were available to them.

2. Contributors to the Review

2.1 Two agencies contributed to the Review by way of IMR. They were:

- Cambridgeshire Constabulary
- Cambridgeshire and Peterborough Clinical Commissioning Group – Safeguarding Adults

2.2 The independence of the IMR authors was confirmed through the review process.

2.3 Specialist support to the review was provided by:

- Adult safeguarding – Cambridgeshire and Peterborough NHS Foundation Trust
- Cambridgeshire County Council – Health Improvement, Drugs and Alcohol Team
- Cambridgeshire County Council -Domestic abuse and sexual violence partnership

2.6 The Review was assisted by Louise's mother who engaged throughout the process and provided a pen picture of her daughter to the review.

2.7 A number of Louise's friends gave accounts of events however Paul and those that attended the evening at Louise's home before her death did not co-operate with the review and the Coroner attempted to mediate this position to no avail. Throughout both the investigation and review processes these individuals have refused to engage in any meaningful way.

3. The Review Panel Members

3.1 The members of the original Review Panel were:

Name	Organisation and role
D H (initials only for anonymity)	Mother of Louise
Mandi George	Lead officer for Domestic abuse and safe accommodation for Huntingdonshire District Council
Claudia Deeth	Community Safety Team Leader · Huntingdonshire District Council
Vickie Crompton	Cambridgeshire County Council -Domestic abuse and sexual violence partnership manager
Jenni Brain	Cambridgeshire Constabulary - Police*
Alex Dopadlik	Cambridgeshire Constabulary – Police*
Pushpa Guild	Bedfordshire/Hertfordshire/Cambridgeshire Major Crime Unit – Review Officer, Investigation Review Team
Linda Coultrup	Named nurse safeguarding adults primary care* - Cambridgeshire and Peterborough CCG
Susie Talbot	Cambridgeshire County Council – Senior Health Improvement Specialist, Drugs and Alcohol Team Manager
Nicky Vidgeon Paul Collin	Joint Heads of Adult safeguarding – Cambridgeshire and Peterborough NHS Foundation Trust

3.2 All members of the panel and IMR authors were independent of direct involvement with either Louise or Paul.

3.3 Louise's mother were offered, at their first meeting with the Chair and Report Author, the opportunity to meet the review panel. At this point, she did not feel the need to do this as she felt that a meeting would be more meaningful once they had had time to consider the contents of the draft report.

3.4 Louise's mother was updated at every stage of the review and held the position she did not wish to meet panel members. This process and resulting discussions with her resulted in appropriate amendments to the report.

3.5 The recommendations made were fully discussed with Louise's mother, she has been provided with a copy of the draft report and has an AAFDA[1] advocate assisting her through the coroner's process. Although initially offered this support along with other advocacy agencies, she initially declined this offer.

4. Domestic Homicide Review Chair and Overview Report Author

4.1 Helen Collins served with Surrey Police rising to the rank of Temporary Assistant Chief Constable, retiring in 2019. During their career, as well as leading high-profile investigations, they undertook college of policing level 4 complex case management and undertook the role of 'Head of Crime' – responsible for all Public Protection matters. These include introducing the risk management processes relating the Domestic Abuse into the force.

4.3 She has completed, or is currently engaged upon, a number of Domestic Homicide Reviews across the country in the capacity of Chair and Overview Author. Previous Domestic Homicide Reviews have included a variety of different scenarios: suicide; murder/suicide; familial domestic homicide; a number which involve mental ill health on the part of the offender and/or victim; and reviews involving foreign nationals. In several reviews, they have developed good working relationships with parallel investigations/inquiries, including reviews relating to children and vulnerable adults.

4.4 She is not associated with any of the agencies involved in the review nor have, at any point in the past, been employed by any of these agencies. There were no conflicts of interest.

4.5 Helen Collins has completed the Home Office online training on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing overview reports, as well as DHR Chair Training provided by AAFDA. They have also recently completed work for the Home Office training prospective chairs and participants relating to Offensive Weapon Homicide Reviews (OWHR). Continuous professional development is undertaken regularly through government and advocacy communications.

5. Terms of Reference

5.1 The full terms of reference are set out within the overview report, however, specifically, this review sets out to:

[1] [1] Advocacy After Fatal Domestic Abuse

- Explore the specific nature of suicide, and what can be learned from this case to protect others in the future.

- Explore any specific barriers for victims of coercion and control that may prevent them from seeking support.

6. Summary Chronology

6.1 This section summarises the information known. Full details are contained within the overview report.

6.2 Louise was a 28 year old woman, her partner Paul was of similar age at the time of her death. Louise had three children, two with her previous husband and one with Paul. These children were all under the age of 10 years at the time of the Panel sitting.

6.3 Louise's previous husband was not spoken to during the review at the request of Louise's mother.

6.4 Louise had 3 siblings, two older and one younger, and with them she attended local schools. On leaving school she attended a local college to study Beauty, on leaving college Louise went straight into the workplace and was described as being very hard working and having a strong work ethic.

6.5 Louise married her first husband at the age of 23yrs. During the marriage Louise and her husband had 2 children. When the relationship came to an end Louise and her ex-husband had joint care of the children by mutual agreement. Since Louise's death, he has full custody of his children and both he and they have a full and meaningful relationship with Louise's family.

6.6 Louise met Paul through a mutual friend, and they began a relationship in 2016, together they had a further child. It appears that this relationship started to show signs of strain from the outset. Louise and Paul did not live together at the time of her death but had co-habited intermittently.

6.7 During the evening prior to the death Louise became agitated and went upstairs. Sometime later she contacted Paul by text message, and he reportedly went to one of the children's bedrooms where he found her with a length of electrical cord around her neck, threatening to harm herself.

6.8 Paul removed the cord, and assisted her to her own bed, where he reassured her after she apologised for her actions. Paul then removed all the extension leads from the upstairs of the house as a preventative measure.

6.9 No further interventions were made with Louise by the attendees at the gathering. No Calls were made to her family to inform them of her state of mind and no professional agencies were contacted.

6.10 Police were contacted by Louise's mother reporting welfare concerns for her daughter after she had failed to attend work the following day. On Police attendance Louise was found deceased, along with a note stating 'He' had ruined her life and had taken her phone and keys.

6.11 In 2015 Louise's mother reported safety concerns to the police relating to depression and stated that Louise had attempted to take her own life two weeks previously. This incident meant Louise was reported as a missing person. Louise was found in her car, on the same day as the report, in a semi-conscious state and transferred to Lincoln hospital.

6.12 Louise also reported she had been assaulted by her then husband but was unwilling to report the matter fully. A Domestic Abuse Stalking and/or Harassment Risk Assessment (DASH) was completed, and an investigation commenced. Having applied the evidential full code test to this case a decision was made by the Crown Prosecution Service (CPS) to take no further action.

6.13 During this year Louise complained to medical practitioners of low mood, and received medication and input from the Crisis team and stated she was feeling reassured about this intervention and referral for counselling.

6.14 2017 saw Louise become pregnant and no record is made of any depression/anxiety or suicidal thoughts.

6.15 A Patient Health Questionnaire was completed with Louise in August 2018 which scored low, with only 2 positive answers in her responses. This resulted in a review of her medication and a new medication strategy. The antidepressant medication that had previously been effective in successfully managing Louise's symptoms were recommenced, namely Fluoxetine 20mgs. At this time there were no concerns for Louise recorded.

6.16 Later in the year Louise expressed concern about her youngest child being removed from her and was reassured this was not the case. There is no record to show how she had concluded this could happen.

6.17 In 2019 Louise confided in her GP that her mood was worsening and that she had split from Paul, leaving her with 3 children. She further disclosed traumatic events during her childhood and stated she had received counselling as a teenager and was keen to pursue further counselling help. These notes state she was able to care for her children and had no suicidal thoughts, demonstrating this issue was clearly explored by the GP. Louise's medications were also discussed as she had previously found some of the medications unhelpful. A different medication was started, venlafaxine 75mg, and she was encouraged to self-refer to the Psychological Wellbeing Service.

6.18 Louise reported that she had noticed a positive difference within one week of starting the new medication. There were no side effects and no negative thoughts, this medicine was added onto her repeat prescriptions.

6.19 In February 2020 Louise reported, to the police, a verbal domestic incident with Paul where she described him as controlling and manipulative. She also stated he had the potential to become violent. Police attended and it was recorded that this incident related to attempts by Paul to gain his property from her premises. A DASH assessment was completed (recorded as medium risk) and a referral was made to the Multi-Agency Safeguarding Hub (MASH), this was also shared with children's services due to the presence of the children in the household.

6.20 At the beginning of 2020 Louise again changed GP practice and this coincides with her move of residence.

6.21 Between March and July Louise had nine interactions with the surgery which were predominantly medication requests, however in April, a telephone consultation occurred. (Due to the implications of the Covid pandemic and lockdown most consultations occurred over the phone at this time). During this consultation, Louise disclosed she was beginning to feel symptomatic again and that her tablets were not working as well as they had been. Consequently, her medication was increased from 75mg to 112.5mg.

7. Key issues arising from this Review and lessons identified

7.1 This Review has identified several key issues that it has sought to explore, identify lessons that can learned and make recommendations that will help keep others safer in the future.

7.3 The Review has sought to identify any trail of abuse that existed within the relationship between Louise and Paul. It seems apparent that Louise realised that she was being subjected to abuse (coercive control). Her conversations with friends and some members of her family make this abundantly clear. The fact that she was planning to live alone with her children and had made attempts to do so previously is further evidence that she knew he needed to get away. This is supported in conversations with her friends and family.

7.4 What we also know is that Louise did not report the abuse to anyone, although she alluded to it with her mother and close friends, albeit she did call the police when the couple were arguing.

7.5 We have sought to understand why Louise felt unable to report the abuse and exit the relationship for good. To that end, this review has sought specialist advice about coercive control and psychological abuse from Domestic Abuse specialists, referencing the work of Jane Monkton Smith.

7.6 The Review examined the role that services played when they were called. The Cambridgeshire Constabulary were called twice within the time frame the review analysed by Louise where she stated Paul had the ability to become violent and was controlling.

7.7 On one occasion Police were informed by Louise's mother that she was a vulnerable missing person.

7.8 On the last occasion of police attendance it was recorded that this incident related to attempts by Paul to gain his property from Louise's premises. A DASH (domestic abuse stalking and honour-based violence) risk assessment was completed (recorded as medium risk) and a referral was made to the Multi-Agency Safeguarding Hub (MASH), this was also shared with children's services due to the presence of the children in the household.

7.9 Louise's mother challenged the standard of the police investigation following her death and is working with the Coroner to understand the events of the 24hours prior to her daughter's death.

7.10 As a result of the review the police again examined their response to the death of Louise and the subsequent investigation. However, an examination of their records by a senior detective concluded there was no realistic prospect of a charge being brought against Paul in relation to Louise's death.

7.9 This Review has had the opportunity to examine that investigation through the lens of the specialist domestic homicide review panel. The panel was concerned that there did appear to be a lack of recognition that Louise could have been a victim, particularly in relation to coercive and controlling behaviour by Paul.

7.10 Coercive and controlling behaviour does not have to have consequences to prove evidence, and this appears to have been misunderstood by agencies. This review would suggest that there was evidence that show that Louise's state of mind was affected by abuse before she took her life.

7.11 The evidence that this review has been able to attain and the specialist lens through which it is viewed would suggest that the relationship may well have contributed more than minimally to Louise's state of mind at the time she took her life.

8. Recommendations

8.1 Several improvements in service have already been undertaken by the agencies involved with Louise and Paul.

8.2 **Community Safety Partnership**

8.3 A deep dive review of training relating to the need for professional curiosity, record keeping, rationale recording and holistic problem solving should be conducted and should pay close attention to Statutory partners training programs complimenting each other to ensure seamless transition between partners.

8.4 The new suicide prevention strategy should be embedded in all partner agencies working in the domestic abuse field. This should specifically relate to vulnerable persons suffering from suicidal ideation and should work towards end to end and seamless partnership working to keep those most vulnerable safe.

8.5 Exploration at Partnership level should take place, in relation to the use of Alcohol by those struggling with suicidal ideation as a potential coping mechanism. This should l link with the Suicide Prevention strategy and embedded in any updated version. Further work should be commissioned to enable appropriate support training to be delivered to professionals working in this field.

8.6 Although the suicide prevention strategy deals with self-harm and healthy coping strategies, this is not a topic of research, and conversations with partners should be ongoing in relation to this. This issue goes to link with the need for professionals for example the police to fully investigate the circumstances around any call to a domestic situation and to be curious in relation to all the presented information.

8.7 **GP Surgery (Health)**

8.8 Common myths exist that children are a preventative factor in relation to suicide, but on this occasion, Louise had also tried to take her life the day before, once her children were away from the premises. This needs to be explored further and communicated to staff working with vulnerable people at the surgery.

8.9 Specific training for staff working within the GP surgery where Louise was registered should be implemented to further embed 'professional curiosity' within general day to day practice – this relates particularly to telephone GP consultations which appear perfunctory based on the notes recorded.

8.10 This is over and above the generic recommendation at point 8.3 above. Telephone appointments make it difficult for GPs to assess who is listening to the call and pick up on other cues. The percentage of cases cleared by telephone as opposed to face to face should be reviewed. It was acknowledged that this change from face to face to telephone consultation was a direct consequence of the Covid Pandemic.

8.11 **Cambridgeshire Constabulary**

8.12 The use of Clare's Law and the embedding of the principles held within the legislation should form part of DA training for all agencies dealing with victims and potential victims of coercive control and DA. The use of the legislation should be reviewed by Cambridgeshire Constabulary to ensure continuation of the trajectory they are already on, and this should be combined with the use of the DVPN legislation.

8.13 In conjunction with the above at point 8.11, there is a requirement to increase the public's understanding of their rights to pursue disclosures under this legislation. A

wide-reaching communications strategy across all associated partnerships should be considered by the police and monitored/published by the CSP.

8.14 The use of Body Worn Video and adherence to both local and National guidance should be consistently reinforced by Cambridgeshire Constabulary, monitored, and regularly reviewed through performance monitoring processes. The author has been informed that since this incident this takes place regularly, but the CSP must ensure that this does not slip in the future.

8.15 Information access relating to Domestic Abuse and action to be taken in the reporting of such within the Huntingdonshire area is difficult to navigate from the Huntingdonshire website. This should be reviewed, simplified and provide improved clarity. Although already addressed in some ways, e.g., the CSP adding Clare's law to their web page this should be fully reviewed to ensure accessibility for all no matter what their needs and be compliant with the 'plain English' ethos.

8.16 **Home Office**

8.17 In relation to point 8.15 Huntingdonshire is not alone in this regard and the lack of accessibility and clarity of Domestic Abuse advice and guidance on local authority websites has been highlighted previously in reviews.

8.18 Nationally, there is also the issue of accessibility of information in relation to the reporting of suspicions relating to persons suffering from Domestic Abuse. This is not something this local council can contend with, and it is the recommendation of this panel and author that this issue is looked at from a more holistic viewpoint and not just through individual reviews.

9. Conclusions

8.1 This review has looked to see what lessons can be learned from the tragic death of a much-loved mother, daughter and friend.

8.2 There is unequivocable evidence that Louise took her own life and an inquest into her death will ultimately rule on a cause of death, what drove her to that decision has been the focus of this review.

8.3 Louise was a young woman with three children and a life to look forward to. She appeared to enjoy and relish her life; however, this review has uncovered that she was involved in a difficult relationship with Paul. Calls to police were recorded as relating to 'property disputes', and no prosecutions arose from those calls.

8.4 The police have since reviewed these calls for service, alongside allegations of controlling and coercive behaviour, these reviews have not resulted in prosecutions.

8.5 This review is able to shed light on Louise's thinking in the run up to her death, but it is unable to report with certainty the full facts leading up to her death.

8.6 The review panel are confident that the recommendations we have made will help secure a safer future for others who may be suffering in a similar way.

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