Three Rivers Community Safety Partnership

Domestic Homicide Review

Overview report into the death of Fiona

December 2021

Independent Chair and Author of Report: Luke Kendall

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1. Preface

1.1. Domestic Homicide Reviews (DHR) became statutory under Section 9 of the Domestic Violence, Crime and Victims Act 2004 and came into force on 13 April 2011. The Act requires a review of the circumstances in which the death of a person aged sixteen or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were either related, in an intimate personal relationship with or living with in the same household.

1.2. The purpose of a DHR is to:

- establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
- prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.
- contribute to a better understanding of the nature of domestic violence and abuse;
- and highlight good practice.

1.3. This DHR report examines agency responses and support given to Fiona, a resident of Hertfordshire, prior to her death at home. Fiona was found dead at her home in late December 2021. Fiona died by suicide. East of England Ambulance Service (EEAS) attended, as did Hertfordshire Police Service, but tragically, Fiona was pronounced dead at the scene.

2. Introduction

2.1. Fiona was 53 years old. Fiona reported she left school at 13 years old and that she had attended Hertfordshire University. Fiona had two adult children and grandchildren. In 1997, Fiona was struggling to care for her two young children, and one went to live with her sister, and the other with her father. Fiona also had two sisters and a niece. Fiona lost her mother to COVID in January 2020. It is understood she was survived by her father, who had social care needs because of vascular dementia and physical health problems. Fiona had sporadic contact with her family and some interactions appeared to result in difficulties. Fiona had diagnoses of F20.0 Paranoid Schizophrenia and Personality Disorder, however she only received a diagnosis for the former in the year leading up to her death. She did not agree with the diagnosis of Schizophrenia and attributed her distress as a result of George's abuse. At the time of Fiona's death, she was living within the confines of substance dependency and an abusive partner. Fiona was subject to physical and sexual assaults, emotional abuse and financial abuse during this relationship with George. Fiona also suffered with bouts of

mental and physical ill health and suicidal ideation. At the time of her death, she was mourning the loss of her mother and feeling isolated.

2.2. Fiona met George met in 2009, but agencies did not hold records of concern about the relationships until 2013. There are no records that Fiona or George worked throughout the duration of the relationship. There are no records advising that Fiona and George were registered as each other's carer. Therefore, they relied on government based financial support. Information shared by agencies advised of Fiona's family having concerns about George's behaviour towards Fiona, and them being concerned about her welfare. Fiona also expressed to agencies that she had, from time, experienced difficulties in her relationships with her family members.

2.3. Since 2012 until the time of her death, Fiona was accessing various support services for both health related, mental ill health and substance misuse; moreover, she was suffering with a prolapsed bowel, depression, paranoid personality disorder, Paranoid Schizophrenia, drug and alcohol abuse.

2.4. In 2013 Fiona first discloses George's behaviour towards her as "evil" and emotionally abusive to a member of hospital staff, following her admittance for an overdose. In 2014, she reaches out for support to 111 expressing suicidal ideation, saying she has a "horrible life" and that she has a violent partner who "beats me up". She details George giving her pills and telling her to "go kill yourself."

2.5. George also experienced health and social needs; namely; mental ill health, ill health and substance misuse. In 2014 he reached out to his GP, and latterly Hertfordshire Partnership Foundation Trust (HPFT), for support with his 9 year heroin addiction, anxiety and counselling for "past experiences of trauma". A year later he discloses to HPFT his suicidal ideation, suffering insomnia for 10 years and his thoughts of being extremely violent to people. It is not until 2018 that George details more information about his needs, reporting multiple significant childhood traumas. He notes night terrors and extreme anxiety and has overdosed 3 times in the last 18 months. He describes himself as a "Jekyll and Hyde" character.

2.6. In 2016 Fiona is seeking support from mental health services, advising that she is bed bound and has not left George's address for 18 months. Fiona describes experiencing domestic abuse from childhood and having had a "horrible life". She feels "lonely" and "unhappy". Fiona discloses being vulnerable from others and being exploited for money and physically abused by drug dealers.

2.7. During 2017 support services observe Fiona and Georges poor living conditions. Their door lock is broken, and the door is held in place by a chair. There is no electricity and therefore likely no heating or means to cook meals or heat water. Fiona presented as unwashed, with dirty nails and with skin that was sticky and clammy. She advised having no money for food, no money to get to appointments or phone credit to call anyone. She is suicidal and has been searching for ways to end her life online. She advised that George can't cope with her anymore as he has mental health problems. Fiona also advises that she has to watch him "all the time" because of his suicide risk.

2.8. Increases in George's risk to Fiona and others is observed in 2019. Police attend on a number of occasions following George threatening to "rip people's heads off", to "send people round to stab [Fiona's family]". Fiona discloses that George has strangled her, held a knife to her throat and threatened to kill her. On another occasion she discloses to Police "He hit me", "Punched my head off the wall", "He has battered me" and "He has dragged me down the stairs where I think I was unconscious". Despite this, Fiona was not referred to MARAC, as these incidents were not graded by attending officers as high risk. Dacorum Adult Community Mental Health Service (ACMHS) are made aware that Fiona has no food or gas at the property as she gives all her money to George.

2.9. In October 2019 Fiona engaged with Crisis Assessment and Treatment team (CATT). Professionals observe self-neglect, poor chronic personal hygiene and that Fiona is underweight. Fiona discloses domestic abuse, with George assaulting her twice in the past 5 months, causing broken ribs. It is not until late October where a clear account of George's perpetration of coercive control, and other abuses, and Fiona's vulnerabilities, are detailed by HPFT CATT who complete a home visit. It is recorded that Fiona is "emancipated" and "unkempt" "struggling with the general activities of daily life" and this could be "long term". George is taking her money to buy drugs and regularly assaults her. Drug dealers attend the address and recently, a friend of George was aggressive and abusive towards her. She is "unable to freely express herself in the presence of her partner and seemed to be in a state of fear as though any open communication about her situation may lead to some form of repercussion". Fiona was whispering when explaining what she was going through and was using the television as a mirror to try and locate George when she was talking, to ensure he would be out of range to hear. The first recorded referral to specialist domestic abuse services ensues.

2.10. Throughout 2020 Fiona and George are suffering with mental ill health. They both alleged that Fiona's family members and their neighbours are being harmful towards them, trying to break up their relationship. Fiona discloses paranoid thoughts increasing during this time. Following George overdosing, he seeks to engage with HPFT, advising that he has been abstinent from drugs for 5 years, which is incongruent to the information shared by panel members. He accepts a referral to counselling to explore his past trauma, yet there is no further record of this treatment taking place.

2.11. At the start of 2021 Fiona and George are both experiencing unstable housing. Fiona's mother passes away. In the month following Fiona overdoes and is admitted to hospital. In the summer, George overdoses following Fiona ending the relationship. He advises ambulance crew "can't take anymore and wanted to kill himself". Four days post George's overdose, Fiona overdoses and is conveyed to hospital. Following this Fiona briefly engages with CGL, and advises that she is not dependent on substances, but is influenced by her partner, as he was dependent on crack and heroin and purchases it for her. She associates her suicidal ideation to her family and friends: "I don't want to live anymore. I have had enough of what they are doing to me".

2.12. In the summer of 2021 Fiona is working with the IDVA service. She discloses is terrified of George and is suffering physical, emotional, financial, and sexual abuse from him; but states "Can't cope with the pain if I leave". In September George strangled Fiona, dragged her around by the hair, kicked her in the ribs and head. Fiona is left with a black eye, cut to the

head, a tooth missing and a loss of consciousness. During this viscous and prolonged assault he calls her a “pussy”, “an ugly dirty cunt” and said “I don’t fucking love you” and “I don’t want to live with you”. DASH risk assessment is completed resulting in an actuarial score of 15 – high risk. MARAC and IDVA referral made. This is the first MARAC referral on record. Ambulance attends to transfer Fiona to hospital. HPFT trigger section 42 safeguarding. George arrested, but went ‘no comment’ under interview. He is bailed with condition not to contact Fiona. At the MARAC, which was convened the week following the incident, coercive control is identified as being one of many risk factors.

2.13. In the following weeks Fiona engaged with psychological support services. During this support session she attributes her schizophrenia diagnoses as a symptom of her abusive relationship with George. She details repeated traumatic experiences under the influence of crack and heroin, often injected by George. Fiona disclosed waking up in a state, with no recollection of events and that George would invite other men and she was not certain what happened in their company.

2.14. Mid-October, and Fiona makes contact with her IDVA seeking an update on George’s bail conditions as she understands them to have ended. She also calls police following an argument with a family member whom allegedly calls her a 'shit mother', a 'cunt' and threatened to “fucking kill you and beat the shit out of you”. She also discloses that George controls her finances and she cannot access her own money. Later this day Fiona overdoses, and is conveyed to hospital for treatment.

2.15. In November there are two breaches of bail, one of them resulting in him “kicking down the neighbours door”. Fiona discloses that George recently raped her, but later withdraws this allegation, advising that this was consensual sex. The same day, Fiona’ sister makes contact with police following Fiona posting the following message on social media: Facebook “I Can’t take no more pain; I have had enough pain for a million people I am just so fucking lonely in my heart. It’s unreal WTF was I put on this world for just to be totally abused no matter what I do no matter how much I fight, no matter how kind I am and let people get away with abusing me or not loving me? Fuck my life. I want my mum”. A welfare check is completed by police, and Fiona advises she does not intend to harm herself.

2.16. In November, George has an initial assessment with HPFT, where he discloses that he “hit” Fiona, is feeling guilty and wants to be “a better person”. Here George offers a rare insight, potentially feeling remorseful and wanting to take action. There is no record of discussion specialist domestic abuse perpetrator provision with George.

2.17. Towards the end of November, Fiona advises New Hope that she is in a “bad place”, “heartbroken” and her family have ”turned against” her. She discloses to HPFT and Refuge that she has been in contact with her ex-partner, who is now being nice to her, telling her he loves her “to drop the charges against him”.

2.18. 8th December, Three River Housing are advised that Fiona has spoken to the solicitor they share, who advised that “he does not deserve it and has tried to kill himself twice”. This is concerning practice, and a conflict of interest under the Solicitors Regulation Authority

(SRA) Standards and Regulations[1]. Fiona feels that George doesn't deserve prison, but needs therapeutic support. 5 days later, she advises New Hope that she has dropped her support for the charges against George. Fiona fears she may have cancer, and is awaiting a diagnosis.

2.19. The day before her death, after an argument with George, Fiona overdoses, taking 2-3 times more of her prescribed medication and George's medication too. Ambulance attend and complete a capacity form with Fiona. She was assessed as able to understand, retain and use information to communicate against crew concern and decision that they wanted her to attend hospital. She was given worsening advice which included if she felt any pain, any vomiting, or loss of sensation then she should call 999.

Incident summary

2.20. In late December 2021, Hertfordshire Police were contacted Fiona's sister, who was concerned, having not heard from Fiona for a couple of days. An hour after this call, police attended the home address of Fiona and after no response, forced entry. Fiona was located in the bathroom, unconscious and unresponsive. CPR was administered by officers, but no signs of life ensued. An hour after gaining entry, East of England Ambulance Service arrived, and pronounced Fiona deceased.

2.21. The Post Mortem, completed in January 2022, two weeks following Fiona's death listed the cause of death as a Tramadol overdose, with other drugs significantly contributing to the death: gabapentin, diazepam, quetiapine and cyclizine.

2.22. Police sought evidence of foul play, via reviewing CCTV footage between the respective timeframes of concern, which confirmed that nobody approaches the address other than neighbours. Fiona phone was also reviewed, and there was no evidence of assisting or encouraging suicide.

3. Terms of reference

3.1. To provide an overview report, which articulates the reality of Fiona's experiences, and to centralise the domestic abuse she was subjected to by George as a significant factor in her suicidal ideation and behaviours.

3.2. The key lines of enquiry

- Review of any the information held by agencies that indicated the victim could be at risk of suicide as a result of any coercive and controlling behaviour.
- Review of any barriers experienced by the families in reporting any abuse or concerns, including whether they or anyone else involved knew how to report coercive control, intimate partner abuse and stalking had they wanted or felt able to.
- Review national best practice in respect of protecting adults from coercive control, intimate partner abuse, stalking and suicide.
- Evaluate training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of coercive control, intimate partner abuse and stalking process and/or services in Hertfordshire.

[1] https://www.lawsociety.org.uk/topics/client-care/conflict-of-interests

- Whether the work undertaken by the services in this case is consistent with its own professional standards, compliant with its own protocols, guidelines, policies and procedures in relation to victims of coercive control, intimate partner abuse, stalking and suicide – to build up a picture of what should have happened.

4. Involvement of family, friends and wider community

4.1. Following the decision to conduct a DHR in March 2022, Three Rivers Community Safety Partnership (CSP) notified Fiona's sisters Antonia and Carol of this decision by letter in October 2022, along with information about support services; and again in May 2023, when no response was returned. Following no responses from the sisters, and sensitive to the time that elapsed, the Review Panel sought information on suitability of making further contact attempts from the Officer in Charge (OIC) of the case from Hertfordshire Police, who had built rapport, and had a pre-existing relationships with Antonia. Following a suitability assessment, the chair made contact with Antonia, via telephone on 29.02.24.

4.2. Following the conversation with Antonia on 29.02.24 and again on 01.03.24, it was deemed that she would act as the point of contact for the family. However, Antonia advised that she was ambivalent about involvement in the review. It was agreed that she would be left with the contact details of the chair (telephone and email), and that the Chair would await contact from Antonia. However, the Chair would contact Antonia again on completion of the report. At said time, the author made contact attempts with Antonia on 24.01.25, 25.01.25 and 30.01.25 without reply.

4.3. Consideration was given to approaching friends, work colleagues, neighbours and wider community. However, it was not possible to identify any other contacts who could be approached.

4.4. Consideration was given by the panel to involve the perpetrator. However, owed to the significant level of need that George presented with, and the risk he posed to Fiona's family members, it was deemed not suitable to make contact with him.

5. Summary of agencies involved and their contact

5.1. Hertfordshire Police advised that George had been known to the police since 1993, involved in crimes including common assault, malicious communications, carrying an offensive weapon, theft, shoplifting, breach of orders, criminal damage, supply of class A drugs, drink and drug driving offences and causing harassment, alarm or distress. Since 2004, police hold over 200 incidents in which they have attended concerning Fiona. Domestic abuse, violence, drugs and alcohol have been the main cited crimes. A number of these related to an ex-partner, who is also listed as a perpetrating domestic abuse against Fiona. They held information advising that Fiona and George's relationships commenced in 2009, with the first recorded domestic incident in 2010, where George calls the Police following an argument over monies owed between them. The vast majority of incidents recoded are from 2013. From (and including) 2013, a further 23 crimes are reported and recorded, 11 calls to the address. George has a further 10 crimes recorded, with 5 further calls to the

address. The crimes/incidents recorded range from rape, malicious communications, concerns for welfare, ABH, drugs activity, overdose and threat with a firearm.

5.2. HPFT provided information since 2012 on Fiona, when she was referred to service by her GP for depressions and paranoid personality disorder. George was first known to service in 2014, whereby he self-referred for psychological support on helping him with childhood trauma. From 2012 to the date of Fiona's death, there are over 300 recorded contacts with both parties. HPFT were, at various times, supporting Fiona with Emotionally Unstable Personality Disorder, Paranoid Schizophrenia, depression, suicidality and bowel related health issues. HPFT were supporting George with (self-professed) emotional regulation/anger, suicidality, childhood trauma and paranoia. There were sustained period of non-engagement which hindered the level of support that HPFT were able to offer both parties.

5.3. Fiona was first known to Refuge in November 2019, as referred by HPFT for concerns around domestic abuse. At this time, contact was not deemed safe and despite efforts to support Fiona in the community, Refuge were not able provide support. There is then a further referral from hospital in August 2021, for concerns around domestic abuse. From this date, until the month of her death, Fiona receives support from her Independent Domestic Violence Advocate (IDVA) and continues to disclose a wealth of abuse that George has subjected her to, both recent and non-recent. There are a total of 21 contacts between the IDVA and Fiona.

5.4. East of England Ambulance Service (EEAS) had 21 contacts with Fiona and George from January 2013 to the time of Fiona death in December 2021. On 8 occasion, ambulance crews attended to Fiona, where she was assessed and transported to hospital. The range of support offered were around domestic assault, overdoses, pain to abdomen, stroke symptoms and self-harming with a knife. On 6 occasions EEAS attended in relation to George. On one occasion, they conveyed George to hospital. They supported him with overdoses, chest and leg pains, self-harm using a knife and a broken arm (non-DA related). There was the one singular attendance on 14th September 2021 for a domestic assault. EEAS paramedics attending do not raise any safeguarding concerns with regards to domestic abuse on any other occasion.

5.5. Change, Grow, Live (CGL) first were referred to Fiona's Community Psychiatric Nurse in May 2015 for poly substance misuse. Following numerous failed attempts to engage Fiona, CGL closed the case within a month. In November 2020, Fiona self-referred into CGL for support with her heroin and crack cocaine use – which ranged from 2-6 weekly. Following more failed attempts to engage Fiona, she was once again closed to service. In August 2021 and again in November of that year, Fiona was referred into CGL by Spectrum's Hospital liaison team and Dacorum Adult Community Mental Health Team (ACMHT), respectively. Fiona denied having substance dependency, associating her drug use to George who was dependent, and her increased in suicidal ideation to her issues with family and neighbours. She declined support in August, but she accepted support for her alcohol use, linking an increase consumption due to the breakdown of her relationships and feelings of isolation. Mid November, Fiona declined ongoing support from CGL and was closed to service.

5.6. Three Rivers District Council Housing provided support to Fiona from September 2021 to the time of her death. Refuge referred owed to her homeless status after leaving George, fleeing domestic abuse. Three Rivers District Council had a total of 15 contacts with Fiona, aiding her with safe temporary accommodation in Rickmansworth. They also provided a starter pack, including bedding, kitchen equipment and toiletries to help Fiona settle into her temporary accommodation. At the time of her death, Three Rivers District Council were still supporting her with the process of finding more permanent housing.

5.7. Survivors Against Domestic Abuse (SADA) were open to Fiona from September 2021, referred to by Dacorum Borough Council for safe refuge provision. SADA had contact with Fiona on 6 occasions with the aim of seeking safe housing for her in Safer places refuge. Fiona also shared that she would like support around re-building her confidence, independence, and resilience as she felt had not dealt with her trauma's. In October 2021, Fiona had accepted safe accommodation with Three Rivers, and this therefore concluded their service offer in October 2021.

5.8. The National Probation Service were only open to George. They held records dating back to 1991. Whilst it is unclear if the record related to Fiona, in 2008 George mentions that his partner had an overdose and that they are trying for a baby. In 2010 he advises that he has only known his fiancé 10 months, but they have been trying for a baby and she has miscarried 4 times in this time. Again, it is unclear if he was referring to Fiona. 2010 is the first mention of Fiona, who attends some probation appointments with George. In December 2015 a pre-sentence report is completed, which details daily alcohol use. George advises he has been clear of illicit drug use for 7 years, which is at odds with the previous convictions in this time period which indicate continued drugs use and acquisitive offending to fund. George discloses he was diagnosed with bi-polar in 2014. In August 2015, George advises that a past partner has a non-molestation order out against him. He also advises of an 11 year old child. Drug use, suicidal ideation and potential pregnancies continue to be discussed in the meetings with Probation until the last contact in 2016. There were only 7 recorded meetings in this timeframe.

5.9. Adult Social Care records show a total of 4 referrals, from their first records in 2012, until their last in 2019. Upon receipt of each referral, ASC referred to HPFT, as at the time of each of these referrals HPFT were working with each party.

6. Conclusions

6.1. Whilst it is impossible to accurately divide up the proportion of responsibility for Fiona's death by suicide, what is clear is the impact of George's abuse towards Fiona as a significant factor. Fiona's suicide brought the end to any future with her beloved sisters, children and grandchildren. The Review Panel extends its deepest sympathy to the family of Fiona.

6.2. The Review Panel has endeavoured to understand the historical and more recent context in which Fiona's suicide occurred. The author wishes to extend his gratitude to all that helped in constructing Fiona's experience, in order to illuminate her life, analyse where lessons can be learned and subsequently present the lessons to be learned in order to enhance their response to victims of domestic abuse. These lessons are detailed in section 7.

6.3. The Review Panel is satisfied that the Terms of Reference have been fulfilled and that discussions did take place at the Panel meeting to consider what was known prior to Fiona's death in December 2021.

6.4. The Review Panel is of the opinion that the agreed recommendations suitably address the matters arising under 'lessons to be learned' below, which are presented as themes.

7. Lessons to be learned

7.1. Theme 1: Defining domestic abuse. Mental ill health was well defined in this case, but the domestic abuse was less well defined. This raises a number of practice concerns. The context in which the mental ill health and suicidality is presenting, is somewhat missed. Amongst, and no doubt symptomatic of, suicidality is the domestic abuse and coercive control that George is subjecting Fiona to. The tragic outcome of Fiona needs to be a stark reminder to appropriately realise and respond to the abusive relational context that suicide so often takes place within. This increased risk for suicide is not only to the victim of DA[2], but also the perpetrator[3].

7.2. On the note of definition, the language we choose reflects our attitudes and beliefs; thus, care should be taken with regard to the chosen descriptive language. it is important to reflect on the sanitising of the domestic abuse, which was frequent in this case. Such terms are used as "difficulties at home", "psychosocial issues", "very unhappy relationship", "difficult" relationship and threats to kills being referred to as a verbal argument are noteworthy in this case. Essentially, this language demonstrates a lack of adequate assessment and understanding of the impact of domestic abuse.

7.3. Theme 2: **Missed opportunities to safeguard**. It is the duty of each agency to independently and collectively safeguard victims of domestic abuse. After all, domestic abuse is everybody's business[4]. Throughout the years of abuse Fiona suffered at the hands of George, there were a significant amount of missed opportunities to safeguard not only her, but vulnerable others too.

7.4. Occasions to arrest, put in place protective orders like DVPO's, DVDS and enforcement of multiple breaches of bail conditions were missed.

7.5. Situations where vulnerable children, new partners (some of whom were pregnant) and also other vulnerable adults were known to be at risk from George, weren't safeguarded.

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[2] Matias, A., Gonçalves, M., Soeiro, C., & Matos, M. (2020). Intimate partner homicide: A meta-analysis of risk factors. Aggression and violent behavior, 50, 101358

[3] Knipe D, Vallis E, Kendall L, Snow M, Kirkpatrick K, Jarvis R, Metcalfe C, Eisenstadt N, Bickham V. Suicide Rates in High-Risk High-Harm Perpetrators of Domestic Abuse in England and Wales. Crisis. 2023 Aug 22. doi:10.1027/0227-5910/a000925.

[4] https://domesticabusecommissioner.uk/domestic-abuse-is-everyones-business/

7.6. Instances to put in place bespoke suicide intervention plans, which are cited as reducing risk of suicide by almost half[5], were also not taken in the majority of circumstances.

7.7. On average high risk victim of domestic abuse suffer for 3 years and for a total of 50 incidents before getting effective help[6]. An arrest by police in 2021 appeared to be a significant event and helped facilitate effective IDVA support. However, this support was only in place for a handful of months before Fiona's death. It appears that Fiona suffered for almost a decade before getting effective specialist domestic abuse support and a more robust criminal justice response to the coercive control she was subject to. However, this report not only details the many barriers that Fiona experienced in accessing and supporting police prosecution, and therefore the challenges that police were faced with in trying to bring George to justice were multiple.

7.8. Theme 3: **Domestic abuser as a protective factor.** Those who perpetrate domestic abuse should not be seen as a protective factor for their victims suicidality; they will be directly responsible to contributing to the victims symptoms of suicide. Therefore, a more nuanced stance is required. To obtain a more accurate understanding of the role in which an abusive partner plays in the victims suicidality, we need to locate and consider them as first of all, a contributory factor to the clients suicide (as well as a protective factor, if there is evidence of this) and enquire with the victim as to their specific role they play within the suicidal ideation.

7.9. Theme 4: **Bespoke suicide interventions plans save lives**. The National Institute for Health and Care Excellence (NICE) guidelines suggest 'Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm'[7] and emphasise a shift to assessment of client need and implementation of a bespoke suicide safety plan. Indeed, it has been shown that collaborating on a bespoke suicide intervention plan can reduce risk of suicide by up to half[8]. Therefore, practitioners should seek to collaborate on bespoke safety plans with both victims and perpetrators of abuse that profess to suicidality – given their heightened risk.

7.10. NICE[9] and lead academics in the field[10], advise that bespoke suicide prevention plans should incorporate the following:

- establish the means of self-harm
- recognise the triggers and warning signs of increased distress, further self-harm or a suicidal crisis
- identify individualised coping strategies, including problem solving any factors that may act as a barrier

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[5] Nuij C, van Ballegooijen W, de Beurs D, et al. Safety planning-type interventions for suicide prevention: meta-analysis. The British Journal of Psychiatry. 2021;219(2):419-426. doi:10.1192/bjp.2021.50

[6] SafeLives. (2022). Insights Outreach dataset 2021-2022. SafeLives: Bristol.

[7] https://www.nice.org.uk/guidance/ng225/chapter/Recommendations#risk-assessment-tools-and-scales

[8] Nuij C, van Ballegooijen W, de Beurs D, et al. Safety planning-type interventions for suicide prevention: meta-analysis. The British Journal of Psychiatry. 2021;219(2):419-426. doi:10.1192/bjp.2021.50

[9] https://www.nice.org.uk/guidance/ng225/chapter/Recommendations#interventions-for-self-harm

[10] O'Connor, R. (2021). When it is darkest: Why people die by suicide and what we can do to prevent it. Random House.

- identify social contacts and social settings as a means of distraction from suicidal thoughts or escalating crisis
- identify family members or friends to provide support and/or help resolve the crisis
- include contact details for the mental health service, including out-of-hours services and emergency contact details
- keep the environment safe by working collaboratively to remove or restrict lethal means of suicide.

7.11. Whilst the Hertfordshire suicide prevention strategy[11] details that almost half of those people who died by suicide in Hertfordshire between 2017-2019 note that relational problems were a risk factor, and there is also a body of knowledge[12] that advises of suicide risk in DA cohorts. However, domestic abuse is not one of the 9 key priority areas in Hertfordshire's suicide prevention strategy. The author suggests that this is reconsidered in the next suicide prevention strategy.

7.12. Theme 5: **Coercive Control involves fear, duress and therefore compromised decision making**. The Care Act (2014) puts adult safeguarding on a legal footing. Under The Care Act, an adult at risk is someone over 18 years old who:

- has care and support needs
- is experiencing, or is at risk of, abuse or neglect
- as a result of their care and support needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

7.13. Evident from this report is the severe care and support needs of Fiona, and how they amounted to requiring support of safeguarding stakeholders to protect her from abuse and neglect. Yet, further consideration around impaired mental capacity as a consequence of cumulative trauma and abuse is required. Therefore, a skilled assessment should incorporate whether a person is making unwise or unsafe decisions, or whether decisions are taken under duress, coercion, and control. There is limited evidence of this taking place on this case.

7.14. Theme 6: **Offering opportunities for Perpetrator to change**. Despite all agencies knowledge that George is a perpetrator of domestic abuse, he was not offered opportunities to engage with behavioural change programmes designed to reduce/eliminate his domestic abuse risk to Fiona. Therefore the approaches taken were to place all the focus, and therefore accountability for change, onto Fiona with regard to the domestic abuse. This strategy has a number of flaws; essentially, the problem (George) doesn't change and the domestic abuse risk remains present.

7.15. There were a number of missed opportunities to probe into George's self-disclosed harmful behaviours, and therefore refer to specialist domestic abuse help. George advises he gets

[11] https://www.suicidepreventionherts.org.uk/media/hertfordshire-suicide-prevention-strategy-2020-25-final.pdf

[12] Christie, C.,Rockey, J. C., Bradbury-Jones, C., Bandyopadhyay, S. & Flowe, H. D. (2023). Domestic Abuse links to Suicide: Rapid Review, Fieldwork, and Quantitative Analysis Report. Home Office Report. Retrieved from osf.io/4t9ab

very agitated and gets "very argumentative in a very aggressive way" and he also discloses that he "hit" Fiona, is feeling guilty and wants to be "a better person". There are numerous other incidents where he discloses relational discord. There is no evidence that any of these are met with probing or an offer of specialist support.

7.16. Opportunities to target harden George, via his illicit drug use and (potential) supply were also missed. These may have prevented opportunities to hold him account for his criminality, acting as potential intervention points around his use of abusive behaviour (very much like what we have been effectively executed on programmes like the Drive Project[13]) and importantly, give Fiona some respite and increase opportunities for her to engage with support services. Confronting the abuser at all available opportunities also sends a clear message to the victim, that the system can protect her and will hold her abuser to account – this is not only a route to safety but also somewhat of an antidote to the hold that psychologically manipulating, coercive and controlling abusers also have over their victims.

7.17. Theme 7: **MARAC is a space to make victims safer, by addressing the perpetrator.** SafeLives MARAC Principles explicitly outline the necessity to intervene with the perpetrator as an effective tactic to make the victim safer. Interventions like Drive[14] and MATAC[15] are showing promise in this area of work, bringing together statutory and non-statutory agencies to focus on perpetrator management and intervention, showing risk reductions of physical abuse by 82%, sexual abuse by 88%, harassment and stalking behaviour by 75% and jealous and controlling behaviour by 73%[16]. IDVA's reported risk reduction in 82% of cases.

7.18. Theme 8: **Ineffective outreach**. Fiona's difficulties accessing community based services are well documented throughout this report. Consistently, agencies took the stance that Fiona had to attend appointments in community based settings, despite being in chronic pain, having mobility issues, no access to money for transport owed to being financially abused and suffering with an anxiety of leaving the house. Whilst there was evidence of successful assertive outreach (attending Fiona's home address) this was not a consistent or standardised approach – despite it rendering the most success with regard to engaging Fiona in support.

7.19. Regrettably, Fiona was not able to access specialist domestic abuse support with any positive effect until the year of her death. In 2019 there were referrals to IDVA services, but owed to a rigid stance on no home visitations, or lateral thinking on how IDVA could co-work more closely with other professionals who were doing house visitations, Fiona was not supported by IDVA on these occasions. These are missed opportunities.

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[13] Hester, M., Eisenstadt, N., Ortega-Avila, A. G., Morgan, K. J., Walker, S. J., & Bell, J. (2019). Evaluation of the Drive Project:–A Three-year Pilot to Address High-risk, High-harm Perpetrators of Domestic Abuse.

[14] https://drivepartnership.org.uk/

[15] Davies, P. (2018). Tackling domestic abuse locally: paradigms, ideologies and the political tensions of multi-agency working. Journal of gender-based violence, 2(3), 429-446.

[16] Hester, M., Eisenstadt, N., Ortega-Avila, A. G., Morgan, K. J., Walker, S. J., & Bell, J. (2019). Evaluation of the Drive Project:–A Three-year Pilot to Address High-risk, High-harm Perpetrators of Domestic Abuse.

7.20. Theme 9: **Working with those still in a relationship**. There is a hive of multi-agency working at the point in 2021 where Fiona wishes to separate from George and this activity consist of some effective practice from many multi-agency safeguarding partners. However, services need to reflect upon their ability to help people who are also remaining in a relationship. As referenced by SafeLives[17], dominant organisational cultures develop around domestic abuse cases which focuses on separate and isolate as a long-term strategy to manage risk – this often results in agencies missing opportunities to engage with clients who are still together and a reluctance to and/or lack of tactics to do so.

8. Single agency recommendations

8.1. The single agency recommendations are listed below, many of which were made by the respective agency within their IMR.

Police

8.2. Reinforcement of DVPN/DVPO policies, to ensure consistency of practice, and early intervention for vulnerable victims and perpetrators of domestic abuse.

8.3. Officers to be reminded of their responsibility to investigate where reports are received of breaches of bail.

8.4. Supervisors to be reminded of their responsibility to monitor crimes and ensure breaches of bail are investigated thoroughly.

8.5. PNC admin to examine the process of bail conditions being granted and put on Athena and subsequently being placed on PNC.

8.6. Officers to revisit their requirements, as per the victims code, to update victims about bail conditions in a timely manner.

8.7. Officers to consider multiple breaches of bail to be a course of conduct offence amounting to harassment or stalking.

8.8. Current training on the nuance of the coercive control, and how this phenomenon impacts the victims capacity, free will and therefore ability to keep herself safe to be reviewed.

8.9. Current intervention strategies (like case management and multi-agency coordinated approaches of Drive or MATAC for example) to tackle persistent DA offending and/or persistent DA call outs to an address (identified by a recency, frequency and gravity assessment) to be reviewed.

8.10. Current training on assessing counter allegations or unclear abuse dynamics to be reviewed.

Hertfordshire Partnership Foundation Trust

[17] https://safelives.org.uk/training/engaging-those-who-harm

8.11. Training opportunities for staff that address assessment of risk of social media platforms and other technologies will build upon practice in this specialist area.

8.12. Further promotion of existing resources on cuckooing, in order to ensure staff knowledge is up to date.

8.13. Existing training on domestic abuse could be reviewed to consider what specific value Section 9 Care Act and Carer assessments could offer adults at risk of domestic abuse.

8.14. The HPFT Safeguarding Team should continue to promote awareness of a Think Family response which would encourage staff to consider the needs of others within the family network. This could include consideration of family members who may also present with care and support needs.

8.15. It is recommended clearer guidance be issued on how service users and staff can submit Clare's Law applications and when is appropriate to consider this.

8.16. The reviewer found multiple missed opportunities to report safeguarding concerns. It is recommended training on Essential Safeguarding Adults Training is reviewed to further build on the emphasis of engaging in reporting processes and why this is important.

8.17. Domestic Abuse training and guidance to include further information on safety planning, particularly where IDVA's are not engaged in direct work with clients could reduce risk following contact with health professionals.

8.18. Clearer guidance to be issued for investigating managers concerning the principle of proportionality and respecting an adult's individual autonomy in making decisions about their experience of abuse.

8.19. The Policy section on domestic abuse relating to perpetrators could be revised to highlight more explicitly to staff that the needs and risks of service users who are perpetrators, according to research, increases at the time of separating in the relationship, and must not be confused as a 'historic' risk.

8.20. The review found professionals agreed with Fiona to transfer her to another ACMHS in the Trust because of links the perpetrator shared with the team. It is recommended guidance is shared with safeguarding leadership networks/ forums to discuss the appropriateness of introducing additional disruption to survivors of domestic abuse known to secondary mental health services.

8.21. HFPT to review its policy with regard to care pathways for those who require medical operations but who have insecure housing status.

Refuge

8.22. To review agency policy and stance around outreach to clients whom face significant disadvantage to accessing community based support.

Change, Grow, Live

8.23. To review agency policy and stance around outreach to clients whom face significant disadvantage to accessing community based support.

National Probation Service

8.24. Probation Officers to revisit domestic abuse training, specifically looking at its vast implications for victims and survivors (loss of pregnancies, substance abuse and suicidality to name but a few), therefore increasing their ability to identify (and thus respond) the more subtle symptoms of abuse.

8.25. Probation Officers to receive training on their adult safeguarding duties and options when they identify adults at risk of harm and abuse.

9. Multi-agency recommendations

9.1. **Recommendation 1:** Hertfordshire DA Partnership to raise awareness with professionals of the link between domestic abuse and suicide, enabling better risk identification, assessment and intervention.

9.2. **Recommendation 2:** Hertfordshire DA Partnership to raised awareness with professionals around best practice suicide intervention , which includes role of bespoke suicide intervention plans and how to implement them collaboratively with clients.

9.3. **Recommendation 3:** Hertfordshire DA Partnership to advocate for domestic abuse being listed as a 'priority' in the Hertfordshire Suicide Prevention Strategy 2025-2030.

9.4. **Recommendation 4:** In line with the SafeLives MARAC principle 6, Hertfordshire DA Partnership Risk Management Subgroup to review the effectiveness of the MARAC to safeguard victims by addressing perpetrators risks and needs.

9.5. **Recommendation 5:** Hertfordshire DA Partnership Risk Management Subgroup to reflect on the impact of not having a common assessment framework for risk assessing domestic abuse across Hertfordshire. There is evidence of some of the key organisations using differing risk assessments (DARA & DASH) and whilst there may be some strength to this model, there will be weaknesses that will require mitigation.

9.6. **Recommendation 6:** In light of the impending Perpetrator Strategy, as part of the DA Act 2021 Hertfordshire DA Partnership to review their local VAWG strategy, and resulting operational tactics around tacking perpetrators of domestic abuse more robustly.

9.7. **Recommendation 7:** Hertfordshire DA Partnership to raise awareness of the need for agencies to be able to intervene in cases where domestic abuse is present and the parties involved are still in a relationship. Such programmes like Engage by SafeLives are designed as part of a remedy for this particular issue.

9.8. **Recommendation 8:** The Home Office, in collaboration with relevant criminal justice partners to review and reflect upon policies and practices which allow the same solicitors to take on legal representation for both victim and perpetrator.

9.9. **Recommendation 9:** All agencies involved in the DHR to review their module on safeguarding and domestic abuse, including what role and powers their respective organisation has in relation to safeguarding victims of domestic abuse and how they can hold perpetrators to account for their behaviour.

9.10. **Recommendation 10:** All agencies involved in this DHR to review their engagement policy, especially for clients who face multiple and severe barriers to accessing community based service provision. Services need to find ways to safely and effectively engage clients in need who are living with an abusive partner.

9.11. **Recommendation 11:** Agencies now reviewing available research relating to the Covid Pandemic on victims of domestic abuse is evident. Agencies should therefore update their emergency operating procedures accordingly, resulting in enhanced practice in the face of future pandemics.

9.12. Upon conclusion of a DHR, Hertfordshire CSP will be responsible for embedding the learning detailed above, and the recommendations detailed below, across the local agency partners. Indeed, there is both individual agency learning and across multi-agency/collective learning for consideration. This is relevant to agencies both individually and collectively. Hertfordshire County Council has a strategy and action plan, which the finding of this DHR will feed into and therefore is the basis of development of local processes, systems and partnership working. The Review Panel asserts that it is all agencies responsibility to robustly tackle domestic abuse: we all have a significant duty and stakehold in making the future safer.