Domestic Homicide Review:

Executive summary:

Concerning the Death of Helen

(January 2019)

Contents

1. The Review Process

This review involves the untimely and tragic death of Helen. Those that knew Helen well describe her as a loving child, partner and friend. She was a loving mother to Frankie and Freddy. There is no doubt that Helen experienced a troubled period in her life, but it is to her credit and to the credit of those who supported her that she was able to overcome these challenges. Helen had historically been involved in an abusive relationship and struggled with drug addiction but after serving a term of imprisonment was able to leave these behind her. She met Tony and was able to start caring for her daughter Frankie once more and through her relationship with Tony had a son, Freddy. Tony will say that the happiest time in their relationship was whilst she was pregnant with Freddy. After the birth of Freddy, Helen seemed a little more depressed and the family thought she was suffering with what they would describe as the 'baby blues. '

The panel which had oversight of this review would like to thank the family for their involvement at such a difficult time.

This report was commissioned by the East Cambridgeshire Community Safety Partnership (CSP). This statutory partnership brings together agencies with the aim of reducing crime, disorder and anti-social behaviour across the Eastern part of the County of Cambridgeshire.

Helen's death occurred in January 2019 and was reported and referred by the police to the East Cambridgeshire Community Safety Partnership (CSP), once it was established that there were no suspicious circumstances. The death was also referred to the HM Coroner. The Inquest was opened and adjourned until September 2019. The inquest concluded that Helen died as a result of hanging herself with an electric cable.

On the 9th of February 2019, the chair of the East Cambridgeshire CSP determined that a domestic homicide review was necessary in accordance with the 2016 Home Office statutory guidance for conducting domestic homicide reviews and, as a result, the Home Office and agencies were duly notified of the requirement to identify and secure relevant material.

2. Contributors to the review

This report has been complied based on the comprehensive Individual Management Reviews (IMR's) prepared by authors from the key agencies involved in this case and other relevant agency information, where IMR's have not been required. Each IMR author is independent of the victim and family of the victim and of management responsibility for practitioners and professionals, whom have been involved in this case.

Agencies involved

- East of England Ambulance Service NHS Trust
- Cambridgeshire Constabulary
- Norfolk Constabulary
- Essex Police
- Cambridgeshire and Peterborough Clinical Commissioning Group – GP Practice

- Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
- Cambridge University Hospitals National Health Service Trust (Addenbrookes Hospital)
- Cambridgeshire Community Services NHS Trust
- Cambridgeshire County Council- Children's Services
- Head Teacher's (for schools attended by Frankie)
- Cambridgeshire Education Authority
- Cambridgeshire County Council- Early Help.
- Sanctuary Housing Services Ltd.
- Cambridgeshire County Council (Adult Safeguarding)

3. The Review Panel Members

The following individuals and agencies comprise the DHR panel or have acted in an advisory capacity to the panel and independent chair. They are independent of the case being reviewed. The panel met on three occasions and there was ongoing and effective liaison and communication between the formal panel meetings.

Name	Agency	Role
Nathan Barlow Lorna Philcox	Sanctuary Housing	Area Manager/Operations Manager
Laura Koswiecski /James Bambridge	Cambridgeshire Constabulary	Head of Public Protection/Statutory Review writer
James Bambridge on behalf of Norfolk Constabulary	Norfolk Constabulary	Statutory Review writer
James Bambridge on behalf of Essex Police	Essex Police	Statutory Review writer
Paul Collin	Cambridgeshire and Peterborough Foundation Trust (CPFT) and mental health advisor to the panel	Safeguarding Lead
Joanne Brooks	Cambridgeshire Community NHS Trust (CCS) –	Named Nurse for safeguarding children
Toni Van Vorst Heather Ayles	Cambridge University Hospitals Health Trust (CUHFT) (Addenbrookes)	Named Nurses for Safeguarding
Julia Cullum	Cambridgeshire County Council Domestic Abuse and IDVA Service	Partnership Manager and Domestic Abuse Advisor to the panel
Jill Buckingham/James Burgess	Cambridgeshire County Council Early Help	Early Help Locality Managers

Carol Davies Linda Coultrup	Cambridgeshire and Peterborough Clinical Commissioning Group	Designated Nurses (Safeguarding Adults)
Caroline Sexby	East of England Ambulance Service NHS Trust	Safeguarding Lead
Chris Meddle	Cambridgeshire County Council Education Services	Senior Leadership Advisor Education Services
Kathy Hartly	Cambridgeshire County Council	Suicide Prevention Lead and suicide advisor to the panel
Shona McKenzie	East Cambs District Council	Community Safety Officer
Kevin Napier	East Cambs District Council	Community Safety Chair
East Cambridgeshire Legal services	Legal Advisor to review	Legal Advisor
Jon Chapman	N/A	DHR Chair and report Author

4. Author of the overview report

The Independent chair and overview author, Mr Jon Chapman, is provided by RJW Associates.

Mr Jon Chapman is a retired senior police detective and senior investigating officer. He was formerly the head of the Public Protection Department of the Hertfordshire Constabulary. He is also the Independent Chair of several child safeguarding Practice Reviews. He has extensive experience in partnership working within safeguarding environments and authoring Serious Case Reviews. He also has significant experience in conducting Domestic Homicide Reviews, MAPPA reviews and other safeguarding practice reviews, having authored numerous reviews across the country.

Mr Chapman is the independent safeguarding advisor to the Diocese and Cathedral of Ely. He was also the Chair of Trustees to a Charity involved in providing refuge and outreach work to survivors of domestic abuse.

Mr Chapman and RJW Associates have no connection with the East Cambridgeshire Community Safety Partnership and are totally independent of all agencies involved in this review.

5. Terms of reference for the review

The timescales for this review will be from January 2009 to January 2019.[1] The original timescales agreed for this review were to focus on the extent of domestic abuse within this household January 2014 - January 2019, however, the background information presented to the review panel on 4th April, led to the expansion of the criteria, given that the

[1] Agencies are invited to consider matters outside of theses parameters that they consider relevant.

victim suffering domestic abuse in her more distant background was considered to be of relevance and needed to be examined in respect of the wider issues.

The IMR authors to ensure consideration is given in all the below headings: -

a) The risk of Helen dying as a result of taking her life by suicide due to her being a victim of domestic abuse.
b) Establish what lessons are to be learned from the review regarding the way in which local professionals and organisations work individually and together to safeguard victims;
c) 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
d) Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
e) 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;

The further specific areas that this review would like to address are:

f) To what extent was Helen's mental health an issue in this review?
g) What extent were the children effected by the domestic abuse in the household?

6. Summary chronology

Between 2009 and 2011, Helen experienced a challenging period in her life. She became involved with a partner who was both abusive and an intravenous drug user. Helen developed a drug dependency, at this time and as a result, this period of her life could be described as chaotic. During this time Helen overdosed on drugs and made attempts to cause herself harm.

This partner is the natural father of Helen's daughter, Frankie who was born in 2006. Children Services became involved with the family and in 2010 Frankie was made the subject of an order to reside with Helen's parents.

During this turbulent relationship there were a number of domestic abuse incidents. In these both the partner and Helen were variously cited as the victim or perpetrator.

In 2011, both Helen and her partner were imprisoned for being jointly involved in an offence. It was during this period that Helen was able to escape from using drugs and break the relationship with her abusive partner.

In 2014, Helen met her current partner Tony. Close to the start of their relationship there was an incident where Tony assaulted Helen by punching her to the face, whilst they were staying at a hotel. Both Helen and Tony had been drinking heavily.

Tony was arrested and prosecuted for this offence and received a suspended sentence. Helen was offered but declined the support of domestic abuse services.

During the investigation and prosecution period of this offence Helen remained very supportive of Tony, despite bail conditions to limit Tony's contact with Helen. It is not an unusual feature for victims of domestic abuse to support the perpetrator for a host of

understandable reasons. Research shows that fear of further violence, isolation, shame, denial and practical reasons are all factors for victims.

Before the start of their relationship it is recorded that Tony was arrested by police for a similar incident involving a previous partner. This incident occurred in 2013, not long after the Domestic Abuse Disclosure Scheme (Clares Law)[2] was introduced. This matter was not proceeded with to court as the partner chose not to support a prosecution.

After the initial abuse in their relationship Helen and Tony moved into a home together and Helen's daughter Frankie returned to Helen's care to live with them.

Helen became pregnant and gave birth to Freddy in July 2017. Tony would describe the period during which Helen was pregnant as the happiest period of their relationship.

Helen and Tony both suffered with depression and were both on prescribed medication to assist to manage this, although it is fair to say that the levels of medication were low.

Tony did have periods where he had disclosed he was dependent on alcohol, but this dependency varied over time. Since the birth of Freddy, Helen was not a regular alcohol user but family did recognise that when she did, on occasions, drink to excess it would affect her mood adversely.

Tony and his mother both state that since the birth of Freddy, Helen had been in a particularly low mood and in their words suffering from the 'baby blues'

The weekend prior to Helen's death it her birthday. Helen and Tony had been out for a family meal and it was intended that they would see friends later. Tony felt unwell and as a result Helen's birthday plans were curtailed.

This left Helen in a poor mood and the tensions between them continued into the following day, this being Helen's actual birthday. Both Helen and Tony had been drinking and during the course of the evening a series of arguments took place between them.

Some of these were played out in front of the children, Frankie in particular; her distress is obvious, as during the course of the evening she sent a series of text messages to her grandmother describing the events.

Tony also contacted his mother and described Helen as being out of control, he also, at one stage, videoed Helen on his phone as he was concerned what he regarded as 'her irrational behaviour'

The panel would wish to highlight that this is Tony's perspective and may not reflect how Helen would describe how she felt at the time.

Tony went to bed upstairs with Freddy and left Helen downstairs. Tony went to check on her at around 3.30 a.m. and found Helen hanged.

Despite efforts made by Tony at the time and by attending emergency services, Helen died.

[2] DVDS – Domestic Abuse Disclosure Scheme (DVDS) 2016, Home Office, https://www.gov.uk/government/publications/domestic-violence-disclosure-scheme-pilot-guidance

On the floor was a note in handwriting identified as Helens addressed to Frankie and Freddy.

7. Keys issues arising from the review

Although Helen had a chaotic and turbulent past she, at the time of the birth of Freddy, described herself as being in a loving and supportive relationship.

After the initial assault for which Tony was prosecuted there were no further instances of recorded domestic abuse. Discussions with the family support this, although the relationship was described as turbulent at times. This is in the context that it is known that police reported abuse accounts for around one fifth of on actual abuse. According to The Crime Survey of England and Wales data for the year ending March 2018, only 18% of women who had experienced partner abuse in the last 12 months reported the abuse to the police.

There were periods of turbulence in Helen's and Tony's relationship but family members state that there was nothing to suspect that the relationship was controlling or abusive or that Helen was not happy. Some family members do state that Helen had been more noticeably in a low mood since the birth of Freddy.

Helen is described as good and loving mother to Frankie and Freddy. When she was pregnant with Freddy midwifery services identified the issues with her past, which Helen openly disclosed and the service made the appropriate referrals, after appropriate assessment the right level of support was afforded to Helen.

Helen was assessed for post-natal depression during her 6-8-week post birth review and she was scored as low. Helen attended all her antenatal appointments, her mood remained normal, with no signs of decline in mental well-being. She was taking medication for depression and in the postnatal notes she was described as 'emotionally well' at discharge from midwifery care in early August 2017. Midwives followed safeguarding procedures and asked about emotional well-being. Helen had extended 28-day postnatal visits to monitor for signs of postnatal depression, but no symptoms were determined.

The information regarding Helen's past was not effectively communicated to the health visiting service and knowledge of this history may have led to more targeted support.

The Joint Cambridgeshire and Peterborough Suicide Prevention Strategy 2017-2020 is comprehensive. However, there is no specific reference to suicide prevention in at risk groups that include victims of domestic abuse[3]. This fact is not relevant to Cambridgeshire alone and nationally there needs to be a steer towards the recognition of domestic abuse within suicide prevention strategies. The Suicide Prevention Strategy does include family breakdown and conflict including divorce and family mental health problems.

[3] The document does refer to 'survivors of abuse or violence, including sexual abuse', however domestic abuse is not otherwise identified or recognised as a specific consideration.

8. Conclusions

There appears to have been a missed opportunity by midwifery services to complete a thorough hand over to the health visiting service. For example, there was no check for domestic abuse, nor was the history of Helen fully explored as it could have been. Whilst the actual health visiting services delivered to Helen were of a high standard considering her post-natal physical health needs and those of her child/children, it is imperative that the question is asked where possible on each occasion by the practitioners to explore as to whether there is a background of domestic abuse, irrespective of the fact that it may be historical. In terms of health visiting this did not occur.

Although the Post-natal questionnaire was completed with Helen at the 6-8-week birth review, the question arising is, is this the most suitable time to target mothers or should there be a re-visit of the questionnaire at a later stage of the post-natal process. Particularly where, as in this case, the mother is being treated for depression.

It is felt by some of the family that Helen may have been further depressed following the birth of Freddy. This low mood may have been a contributory factor to her lived experience of how life was like for her. Helen was on a continuous prescription for anti-depression medication, from her GP practice. It is important to note that Helen's assessment for PND, at the time it was undertaken was low, she was not diagnosed with PND but was considered by those close to her to be in a low mood since she had the baby.

The PND assessment tool is s a simple but effective clinical tool that supports women to identify depression and anxiety but, as it is a self-assessment tool it depends on honest and self-aware responses. A difficult post-natal period can exacerbate existing depression or low mood.

Women may be unwilling to disclose or discuss their problem due to fear of stigma or negative perceptions of them as a mother. They may fear that there is a risk of agencies becoming involved with baby and this may have been more prevalent in Helen's case due to her history

The terms of reference for this review included 'What extent were the children affected by the domestic abuse in the household?' It it would have to be concluded that the events have had a significant impact on the children. In particular to Frankie, due to her age and greater ability to comprehend events at the current time.

The nature of the communications that Frankie sent on the night underline the fact that on that on the night Helen's death the ongoing conflict between Helen and Tony was causing Frankie significant distress.

9. Lessons to be learned

The visits to Helen and her engagement with health visiting services from CCS are well documented and show a focus to the interests of the child. What those visits are not so clear on is an insight into the family dynamics and there appear to have been several occasions when the respective practitioners could have been more professionally curious.

It is important to ensure that health visitors, and other agencies staff are kept up to date with current practices and trends and an input on coercive control and suicide prevention within training on tackling domestic abuse.

All agencies should be aware of the risks of historical domestic abuse and how this may impact of safeguarding in current situations. In this case both Helen and Tony had in their past, information relating to domestic abuse, including Tony inflicting domestic abuse to Helen. Due regard should be given to all measures available to protect victims or potential victims, this includes, in this case the DVDS (Clare's Law).

This case was referred to the CSP and Home Office on the basis that it involved Helen taking her own life with a history of domestic abuse and a current context of significant domestic turmoil. It has been recognised that domestic abuse should feature in the suicide prevention strategy.

There needs to be greater awareness of the Domestic Violence Disclosure Scheme and in particular the 'Right to Know'. This has potential to coincide with the guidance for DVDS being put on a statutory footing by the current Domestic Abuse Bill.

That professionals need to exercise more professional curiosity; this should include understanding the history of the person they are dealing with and how that history impacts on their current situation and risk. This would also include engaging with women who are pregnant about their relationship, potential of domestic abuse and controlling or coercive behaviour by their partner.

10. Recommendations from the review

Recommendation 1

The CSP should write a briefing note to all agencies highlighting the risks of historical domestic abuse and how this may impact on safeguarding in current cases.
(In this case both Helen and Tony had in their past information relating to domestic abuse, including Tony inflicting domestic abuse to Helen, that agencies working with them were not aware of).

Recommendation 2:

The CSP should recommend to:
i) The Joint Cambridgeshire and Peterborough Suicide Prevention Steering Group that they should update the Suicide Prevention Strategy to include specific reference to Domestic Abuse.
ii) The Suicide Prevention Steering Group could consider implementing a process to review a proportion of suicides, like the process already in place for reviewing childhood deaths. This will enable agencies to share and learn lessons with the intention of preventing future suicides, in particular those that involve Domestic Abuse.

Recommendation 3:

All agencies should be aware of the DVDS Scheme and have it included in their policies and training. Further awareness should be considered to coincide and complement the Domestic Abuse Bill 2019.

Further information on the DA bill available here:

https://www.gov.uk/government/publications/domestic-abuse-bill-2019-factsheets

Recommendation 4:

Cambridgeshire Community Services should ensure that the health visiting staff exercise appropriate professional curiosity when exploring the potential of domestic abuse and the relationships within their client groups.

Recommendation 5:

Cambridgeshire University Hospital Foundation NHS Trust should ensure that all staff within the Emergency Department exercise professional curiosity regarding potential domestic abuse when dealing with patients and the outcome of discussions is clearly recorded.

Recommendation 6:

Cambridgeshire University Hospital Foundation NHS Trust should ensure that the midwifery service is routinely asking pregnant women about domestic abuse and that there is a thorough handover of all relevant information to the health visiting service.