Death Review:

Overview report:

Concerning the Death of Helen

(January 2019)

Independent Author: Mr Jon Chapman

Contents:

1. Timescales for completion

1.1 This review involves the untimely and tragic death of Helen, who was 30 years of age at the time of her death. 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 those problems behind her. She met Tony and was able to start caring for Frankie again, and through her relationship with Tony had a child, Freddy.

Before Freddy's birth Tony was convicted of a serious assault on Helen but they remained together.

1.2 After the birth of Freddy, Tony and his mother, felt Helen seemed a little more depressed and they thought she was suffering with what they would describe as the 'baby blues. This was their view as opposed to the view of any medical professionals, although at the time Helen was taking prescribed anti-depressants

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

1.4 Helen's death was identified by the police as a potential suicide and in September 2019, HM Coroner found that Helen died as a result of hanging, having suspended herself with an electric cable.

1.5 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.

1.6 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.

1.7 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.

1.8 At an initial DHR panel meeting held on 4th April 2019, the Chair clarified that although efforts would be made to complete the review process in a timely manner a short extension beyond six months would be likely, given the extenuating circumstances and the need to seek information across many agencies. This has consequentially extended across several counties.

1.9 The DHR panel discussed what was known at that time from the initial agencies scoping of information however, the meeting did not identify any urgent matters for action but noted that there was likely to be some learning. Importantly, there were no urgent safeguarding issues identified.

1.10 The following timescales were agreed by the DHR panel:

- 9th February 2019, Home Office informed of CSP decision to undertake review
- 9th February 2019. Chronology and IMR requests made.
- 28th February 2019 Family formally notified of DHR and process
- 4th April 2019. Panel meeting with appointed Chair/Author.
- 31st May 2019 - Deadline for submission of completed chronologies from agencies identified prior to the meeting of 4th April 2019.
- Deadline for submission of completed IMRs to DHR Chair by 4th June 2019. This included the additional agencies identified.
- June 2019 – Draft report to be circulated to panel members. Meetings with family members (Helens mother, father, husband and mother in law) for them to share information and views.
- 26th June 2019 –panel meeting, discussion of information within the IMR's and draft report.
- July 2019 third draft overview submitted to panel. Initial views shared with family members. (Helens mother, father, husband and mother in law)
- July 2019 final Draft Overview Report submitted by author and circulated for comment. Action plan to be circulated by DHR administrator to panel members.

- August 2019 Action plan completed by all agencies and returned to DHR administrator.
- August 2019 Report submitted to the Home Office. The report was not returned until April 2020, with the request for clarification on some matters and then re-submitted. The report was then returned once more to the CSP in July 2020 and re-submitted in August 2020.

2. Confidentiality

2.1 The findings of this review are confidential. Information is available only to participating officers/professionals, their line managers and the commissioning professionals. The versions include pseudonyms where necessary to protect the identity of the individual(s) involved. The choice of pseudonyms was left to the panel at the request of the family.

Terms of reference

3.1 The critical dates for this review have been designated by the panel as to reflect the background of domestic abuse within the life of Helen, which is likely to extend back to before 2009. The chair has asked agencies to ensure that the information is both relevant and contextual.

3.2 The timescales for this review will be from 1st January 2009 to 31st 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 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 areas: -

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

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 Helen's death 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 deaths 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 affected by the domestic abuse in the household?

4. Methodology

4.1 The purpose of this report is to ensure that the review is conducted according to good practice, with effective analysis and conclusions of the information related to the case. Also, to establish what lessons are to be learned from the case regarding how local professionals and organisations work individually and together to safeguard and support victims of domestic abuse, including their dependent children. 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 policies and procedures as appropriate; prevent domestic homicide and improve service responses for all domestic abuse victims and their children through improved inter-agency working.

4.2 The report has been compiled 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.

4.3 The author has also fulfilled a dual role and has chaired the panel meetings in respect of this domestic homicide review process. This is recognised as good practice and has ensured a continuity of guidance and context for the review. There have been a number of useful professional discussions arising and the panel meetings have been referenced and minutes taken appropriately, for transparency. The

author has made himself available for contact by professionals involved in this review throughout the duration of the review process.

4.5 It is important that this Domestic Homicide Review has due regard to the legislation concerning what constitutes domestic abuse which is defined as:

> *'Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members, regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological, physical, sexual, financial and emotional.'*

4.6 The Government definition also outlines the following:

> *'Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim*.'

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

4.7 Section 76 of the Serious Crime Act 2015 created the offence of controlling or coercive behaviour in an intimate or family relationship. Prior to the introduction of this offence, case law indicated the difficulty in proving a pattern of behaviour amounting to harassment within an intimate relationship.[2] The new offence, which does not have retrospective effect, came into force on 29th December 2015.

4.8 Where a victim takes their own life (suicide) and the circumstances give rise to concern, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable but should illuminate the past and be professionally curious to help to make the future safer.

5. Involvement of family, friends, work colleagues and community.

[2] The Statutory Guidance cites the following cases - Curtis [2010] EWCA Crim 123 and Widdows [2011] EWCA Crim 1500.

5.1 Unexpected deaths are tragic not just for the family, but for friends and work colleagues alike. In this case, there has also been some impact to the neighbourhood and community where Helen had been living for a short period before her tragic death.

5.2 The Home Office leaflet has been provided to family members and the accompanying letter emphasised the opportunity and encouragement for those individuals to participate in this review process. This letter and the subsequent meetings with the family (Helens mother, father, husband and mother in law) signposted and explained the role of the organisation Advocacy After Fatal Domestic Abuse (AAFDA).

The author has also emphasised the value of advocacy to the family to assist them in the process. Cambridgeshire and Peterborough Domestic Abuse Partnership have obtained funding to supply support and advocacy for children involved in the review process. In this case, an advocate has been appointed for Frankie in order to support her through the process and represent her views.

5.3 The author has also engaged with Helen's, and her partner's family. This has included Helen's mother and father and Tony's mother. Frankie has been provided with an opportunity to talk independently to the review through advocacy but has, understandably so far, only done this through family and professionals. Some of the information within the report will not be personally referenced, and the author has due regard for any confidentiality and sensitivities required. Equally, where individuals have asked to be quoted and have a voice on issues, those matters are identified accordingly within the narrative.

5.4 When meeting with the family the opportunity for gaining more information from other friends or associates was explored but these opportunities were limited. Other opportunities for information from the wider community was also explored by the panel, this focused on the direct neighbours.

5.5 Key matters pertaining to individuals will be addressed in the narrative of this report, but it is acknowledged by the review that they are survivors of this tragic episode, not least Helen's family and this review should be regarded as a way forward in identifying and supporting others who may have similar needs. Obtaining individual and sometimes personal views, may also identify intervention opportunities for agencies in future and similar cases.

5.6 Specifically, there are sensitivities, particularly in respect of Frankie and her recovery from the trauma of her mother's death. The panel has ensured that the strategies in place through education and children services have not been compromised by this review and is grateful for the information provided by those agencies.

6. Contributors to the review:

6.1 The following agencies have contributed to the review: Each of the agency authors is independent of any involvement in the case including management or supervisory responsibility for the practitioners involved. The review panel has extended requests to the relevant services and agencies within the other areas.

- 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)

All agencies were requested to provide Individual Management Reports (IMRs) or a detailed chronology.

7. Review Panel members

7.1 The following individuals and agencies comprise the DHR panel or have acted in an advisory capacity to the panel and independent chair.

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 Manager
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

8. Panel Chair and author of the overview report:

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

8.2 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 and Adult Safeguarding Reviews. He has extensive experience in partnership working within safeguarding environments and authoring Serious Case Reviews. He also has experience in conducting Domestic Homicide Reviews, MAPPA reviews and other safeguarding practice reviews, having authored numerous reviews across the country.

8.3 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.

8.4 Mr Chapman and RJW Associates have no connection with and never have had with the East Cambridgeshire Community Safety Partnership and are also independent of all agencies involved in this review.

9. Details of any parallel reviews:

9.1 The death of Helen was immediately reported to HM Coroner. This was following an initial investigation, completed by the Cambridgeshire Constabulary. A post mortem conducted shortly after the death, concluded that the death was entirely consistent with the hypothesis reached by the senior investigating officer, that Helen had taken her own life. The matter was determined as having no suspicious circumstances and the case file was referred to HM Coroner.

9.2 Her Majesty's Coroner for the district, was also been notified of the domestic homicide review process. The inquest was concluded in September 2019, with the cause of death being established as hanging.

10. Equality and diversity

10.1 Helen was 30 years of age at the time of her death. She was white woman of British heritage.

10.2 The author is satisfied that the IMR authors and the DHR Panel have addressed, where appropriate the protected characteristics under the Equality Act 2010 and in accordance with the terms of reference. Specific comment is made accordingly within the report narrative where appropriate in respect of those characteristics which are;

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

10.3 Evidence has shown that domestic abuse is a gendered crime. There evidence to support the theory that men commit more acts of domestic abuse than women. Statistically, women are more likely to be victims of domestic abuse. In the year ending March 2019, an estimated 2.4 million adults aged 16 to 74 years experienced domestic abuse in the last year, of which 1.6 million were women and 786,000 were men show that women were more likely to be repeat victims of abuse and men are more likely to be repeat perpetrators (Walby et al, 2004)[3]. The literature also shows that the reasons that men and women commit abuse are different and the abuse committed by men is more likely to be a demonstration of power and control (Johnson, 2006)[4]

[3] Walby, S. (2004). The Cost of Domestic Violence. London: Women and Equality Unit (DTI).

[4] Johnson, M. P. (2006) 'Conflict and Control: Gender Symmetry and Asymmetry in Domestic Violence', Violence against Women, 12 (2) pp. 1003-1018.

10.4 The characteristics of sex (gender) and pregnancy and maternity were considered and discussed by the panel. Whilst instances of suicide are more prevalent in men, there are more instances of self-harm in women.
Nearly one in three women who suffer from domestic abuse during their lifetime report that the first incidence of violence happened while they were pregnant[5]
Research strongly supports the links between domestic abuse and mental health[6]. Survivors of domestic abuse have been found to be at greater risk of having a diagnosed mental health condition: a three-fold risk of depressive disorders, four-fold risk of anxiety, and seven-fold risk of post-traumatic stress disorder (PTSD). The impact of domestic abuse on a person's mental health tragically leads to an increased risk of suicide.

10.5 Tony and his mother identify that since the birth of Freddy, Helen had suffered from low mood, but she was reticent to access support. This reticence may have been based on the fear that she would be judged, and this could impact on the perception of agencies on her ability to care for the children. It is also possible that domestic abuse was the reason for Helen's low mood. Research has shown that a large percentage of women with mental health difficulties have been subjected to domestic abuse.[7]

11. Dissemination

11.1 This anonymised report and executive summary will be prepared by the author for publication in accordance with the policy of the East Cambridgeshire Community Safety Partnership after the conclusion of the review process.

12. Background

12.1 Helen and Tony lived in a semi – detached property in small village in Cambridgeshire. They had lived in this address together since December 2017, having previously lived in a smaller property since 2015. They lived with Helen's child Frankie, from a previous relationship and Freddy, who was Helen's and Tony's child. Frankie and Freddy were 13 years and 18 months years of age respectively at the time of Helen's death.

[5] Lewis, G, Drife, J, et al. (2001) Why mothers die: Report from the confidential enquiries into maternal deaths in the UK 1997-9; commissioned by Department of Health from RCOG and NICE (London: RCOG Press)

[6] Safelives (2018) Spotlight Report Safe and Well - Mental Health and Domestic Abuse (accessed on line 05/01/21) –

Safe and Well Mental Health and Domestic Abuse

[7] SafeLives (2015), Getting it right first time: policy report. Bristol: SafeLives

12.2 On an evening January 2019, Helen and Tony were involved in a lengthy dispute. At a point late in the evening they separated to different parts of the house. In the early hours on of the next morning Tony discovered Helen hanging by an electrical cord in the utility room at the address. There was a note found close to Helen, addressed to the children which indicated that she had taken her own life.

12.3 The police, who referred this case as a potential DHR and the panel formed by East Cambridgeshire Community Safety Partnership formed the view that although the circumstances of the case indicated that Helen took her own life there had been a history of domestic abuse and there was obvious conflict at the time of Helen's death. In accordance with the Multi Agency Statutory Guidance for the conduct of Domestic Homicide Reviews a decision was made that a DHR should be undertaken.

'Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable'[8]

13. Chronology

13.1 Helen experienced a difficult period of her life between 2009 and 2011. During this time, she was involved in the misuse of class A drugs and was in a relationship where she was the victim of abuse at the hands of her partner at that time.

13.2 The partner is the biological father of Frankie, who was born in 2006. A total of five (non-crime) instances of domestic dispute are referenced involving Helen and ex- partner. The police record of the domestic abuse incidents were variously reported as Helen or the partner being the perpetrator.

[8] Assets.publishing.service.gov.uk. 2016. *Multi Agency Statutory Guidance for The Conduct of Domestic Homicide Reviews*. [online] Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

13.3 In 2009 and 2010, whilst living in Norfolk there was intervention from Children Social Services which resulted in Frankie residing with her maternal grandmother. This arrangement was supported by a Special Guardianship Order[9], which does not expire until Frankie attains the age of 16 years.

13.4 In December 2011, both Helen and the partner were imprisoned for an offence of robbery, both receiving a two-year sentence. On release, in August 2012, Helen informed her probation officer that she was in fear of the partner, who at that time was still in prison. As a result, Helen's case was heard at MARAC[10]. Records indicate that there was no immediate risk to her as the partner was still in custody and it would be addressed in the future should the risk re-present. There are no further records on this, so it can be assumed that there was no further interaction with the partner.

13.5 Family members confirm that it was the period of time that she spent in prison which provided the support for Helen to address the drug misuse and enable her to break her relationship with the partner.

13.6 Helen and Tony started a relationship in 2014. In December 2013, Tony had been arrested for a domestic abuse related assault on previous partner in Southend, Essex. After referral to the Crown Prosecution Service, no further action was taken. This incident is similar in circumstance to the one described below where Helen was assaulted.

13.7 In August 2014, Helen was seriously assaulted by Tony whilst they were staying in a hotel in Norfolk for the weekend. After being out, on their return to the room Tony assaulted Helen, causing serious bruising to her face.

13.8 Tony later attended a police station in Cambridgeshire and was charged with the offence of assault occasioning actual bodily harm, which was later varied by the Crown Prosecution Service to a charge of battery.

13.9 Throughout the following criminal proceedings Helen supported Tony despite there being in place bail conditions to prevent Tony from contacting Helen. Tony pleaded guilty to the offence and received a

[9] Special Guardianship Order (SGO) - A special guardianship order is an order appointing one or more individuals to be a child's 'special guardian'. It is a private law order made under the Children Act 1989.

[10] MARAC – Multi Agency Risk Assessment Conference - a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors to effectively manage risk.

sentence of 18 weeks imprisonment suspended for 12 months. Helen was offered support from an Independent Domestic Abuse Advocate on a number of occasions, which she declined. Although the Domestic Violence Disclosure Scheme (DVDS – commonly referred to as Clare's Law[11]) had at this time recently been launched, there does not appear to be any consideration of a disclosure to Helen regarding the previous Essex incident. It is not an unusual feature for victims of domestic abuse to support the perpetrator for a host of understandable reasons. Victims of domestic abuse often face a host of challenges when attempting to leave an abusive relationship such as fear, isolation and practical barriers. The point of leaving is often the most dangerous time for a victim and evidence from Women's aid (2019) reports that 55% of the women killed by their ex-partner or ex-spouse in 2017 were killed within the first month of separation and 87% in the first year.

13.10 Helen moved to the Cambridgeshire area during the latter part of 2014 or early 2015. She moved into Tony's home, which at that time was a one-bedroomed flat, and their intention was to re-unite Helen with Frankie, who at that time, was living with the maternal grandmother.

13.11 In early July 2015, Tony notified Sanctuary Housing Services Limited (SHSL) that Helen was now residing with him in his one bedroom flat and by late July, had asked for a house move due to overcrowding as Frankie had moved in with them. In September 2015, Tony sought clarity regarding the application to move, however Housing Solutions had not received a formal application.

13.12 In October 2015, Helen attended the hospital emergency department late in the night for a head injury. There is no mention as to whether she was accompanied or not and whether her attendance was of her own volition. The records show that she had a laceration above the right eyebrow, the explanation being that she had "tripped over the dog" and struck her head on a stair-gate.

13.13 Minimal social history was given, with Helen described as 'living independently with family'. She confirmed that she had had *"a couple of glasses of wine"* that evening but there was no comment in the medical notes as to her level of intoxication or other behaviour that might have alerted staff to further issues. There is no indication that domestic abuse was discussed or considered by the professionals. The notes do not indicate whether a safe space was created to facilitate this. It should be noted that Tony would, at that time, be subject of his suspended sentence for the assault of Helen for which he was convicted in December 2014. This was a missed opportunity to engage with Helen about potential abuse.

[11] Domestic Violence Disclosure Scheme (Clare's Law), allows people to find out if their partner has an abusive or violent past. It is named after Clare Wood, who was killed by her former partner in 2009.

13.14 In February 2016, a 'home swapper' application was approved however, it appears that this did not mean a move was imminent, but they would go on a list until an appropriate 'swap' could take place. In July 2017, a family worker from the East Cambridgeshire District Early Help team, contacted Housing Solutions supporting the fact that the family needed larger accommodation and that they should be moved to a two-bedroomed property. The Early Help worker had become involved to assist with the housing issue. The timing of this coincided with Helen giving birth to Freddy.

13.15 Helen was prescribed anti-depressant medication (sertraline) due to low mood, from October 2016. This prescription continued until after the birth Freddy. Tony stated, when interviewed that more latterly Helen had not been taking her medication and when this occurred her mood would noticeably change. There is no record that the potential prevalence of domestic abuse was explored at the time the medication was prescribed. This again was a missed opportunity to explore the potential of domestic abuse in Helen's relationship.

13.16 At the end of March 2017, the CCS Health Visitor (HV) in Helen's area received an ante-natal notification from the midwife that DF was pregnant.

13.17 In April 2017, a routine safeguarding referral to social care for Helen was made by a community midwife. She had been made aware that there had been involvement from children's social services in the past, when Helen's first child, Frankie, was on a Child Protection Plan under the category of neglect. Helen explained that at that time she was in an abusive relationship and this impacted on her lifestyle at the time. Helen was clear that she had not used drugs since 2010, and that her current relationship was stable and caring.

13.18 The response to the social care referral is contained within a letter to the community midwife in April 2017. Cambridgeshire County Council's Children's Social Care reported that they had triaged the concern raised about the unborn baby (Freddy) and did not deem further safeguarding action was warranted. The suggestion was made that the midwife refers to the Local Authority for an 'Early Help Assessment'. The midwife follows this through, and a worker is appointed to help the family. It is reported that Helen was grateful for this, as she had concerns over housing issues and for her and Frankie.

13.19 In July 2017, Freddy was born without complications. It is noted in hospital records that Helen and her partner were observed to appear to have a caring and loving relationship. Helen was discharged the next day with a plan for 28 days of post-natal care.

13.20 Following the birth of Freddy, there were ten face to face contacts with the Health Visiting Service between 27th July 2017 and 2nd October 2018. The first of these was the primary or 'new birth visit' which takes place between day ten and day fourteen following the birth of a baby.

12.21In December 2017, Tony and Helen took up tenancy of their new home with Frankie and Freddy. There were no concerns of domestic abuse known from a housing perspective.

13.22 Between October 2017 and October 2018 Helen attended the Well baby drop-in clinic at the local Children Centre. There were no concerns noted or recorded by staff.

13.23 There was little agency contact with the family during 2018. Helen's anti- depression medication was reviewed towards the end of 2018. There was nothing noted on this review to indicate any issues of domestic abuse were explored. This could be seen as a missed opportunity.

13.24 In January 2019, two days preceding Helen's death, Tony and Helen had been out for a meal with Helen's father and Tony's mother. Tony felt unwell on return to their home and decided to rest. This prevented friends being able to attend to celebrate Helen's birthday, as planned. This appeared, from what the family members have told the review, to have left Helen in a 'poor mood'. Helen's father and Tony's mother state that they did not witness any aggressive behaviour, although they describe the atmosphere between Tony and Helen as being 'uncomfortable'. The reasons for Helen's poor mood could be for any number of other reasons, including being unable to see her friends. This is difficult to understand what the cause was without being able to speak to her.

13.25 This 'poor mood' appears to have continued into the following day, which was Helen's actual birthday and Tony describes the day as *"getting progressively worse"* (in his view). It is important to note that the events of the evening are that of Tony's. Both Tony and Helen drank alcohol during the day and they continually had disagreements, culminating in Helen putting her fist into her birthday cake, but then apparently telling Frankie that Tony had actually pushed her face into the cake. Tony had in fact recorded some of the events on his mobile phone as he was concerned about, what he describes, as Helen's irrational behaviour. The panel wants to highlight that this is Tony's perspective and might not be how Helen would describe how she felt at this time.

13.26 Tony's mother who was at work on the day preceding Helen's death, received numerous phone calls and messages from her son during the course of the evening, asking her to help him as he told her that Helen was *"out of control".* Other members of the family were communicated with, including

Helen's father, however, it appears that the messages were probably not read until the following day. There is no evidence that any members of the immediate family or friends attended the address prior to Helen's death.

13.27 Communications appear to have extended across to other members of the family, including Tony's mother, who sent two text messages to Helen's father, asking him to intervene as things were *'kicking off'*. It was also inferred that Helen had threatened to harm herself, however that was not felt to have been her intention, according to family members. It appears that some of those messages were not received or read by the recipients at the time.

13.27 Tony states that he initially went to the ground floor front room to sleep. However, around 2 a.m. he then went upstairs to bed and slept in a bedroom with Freddy, remaining there until around 3.30 a.m., when he awoke as Freddy was crying. Tony then went downstairs intending to send Helen up to bed to look after Freddy as she was not upstairs. He checked the house but was unable to find her but noticed that the lights and heating were still on in the utility room. As he entered the utility room, he discovered Helen hanged from an electrical cable. Why did he find her to look after his son when he was awake – this may say something about the relationship and his view on gender roles

13.28 On the floor was a notebook containing what could be described as a suicide note – family members have identified other handwriting samples within the property as Helen's which appear to match this handwriting. The note read:

"To [Freddy + Frankie] I love you sooooo much babies Please don't blame yourselves xxx Mum xxx"

13.29 Having discovered Helen hanged in the utility area of the property, Tony, called the emergency services and was given CPR advice by the ambulance advisor, which he continued until the arrival of paramedics. Although resuscitation was attempted, Helen was declared deceased.

13.30 Police officers attended, and a senior on-duty detective also attended the death and led the initial investigation. Enquiries indicated at an early stage that the death was not suspicious, and the matter was discussed with HM Coroner by the area appointed senior investigating officer (SIO). The SIO identified that there was an apparent background of domestic abuse and that the matter should be referred under protocol to the Protecting Vulnerable Person's Department lead, for consideration of referral to the local Community Safety Partnership.

13.31 Members of both Helen's and Tony's family resided locally. Family also attended the home in support of Tony and the children.

13.32 The police investigation discovered digital media, which was presented by the deceased's partner and the wider family. It has been established that both Helen and Tony had been drinking a considerable amount of alcohol during the day preceding Helen's death.

13.33Tony recorded Helen's behaviour on his mobile phone. He states that this was in order to show that he was not the aggressor, although he admitted that he was swearing at her, and thereby being aggressive. This may also have caused Helen anxiety, knowing she was being recorded.

13.34 Although Helen had made threats that she would hang herself on the evening of her death, those threats were considered by Tony to be veiled. When asked for the purposes this review, Helen's mother and father did not feel that Helen would cause harm to herself. This was also the view of Tony and his mother. However, clearly there were concerns for her mental health, as expressed by Tony stating that she was out of control.

14. Overview

14.1 From the outset, although the police senior investigating officer has quite correctly, ensured that this case has been referred in accordance with the statutory guidance, the lack of information, to professionals and agencies, concerning any current domestic abuse concerns within the relationship is apparent. This lack of knowledge also extended to the family. Apart from the assault early in the relationship, family members are not aware of any signs of abuse in the relationship, although they recognise it could be volatile, especially since the birth of Freddy. It is not uncommon in domestic abuse cases that family, even close family are not aware the existence or extent of it.

14.2 There is though, an obvious history to the relationship between Tony and Helen that pre-dates the tragedy by more than 4 years, however the only reported and therefore known occurrence between Helen and Tony, is the assault that occurred in Norfolk in August 2014. 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.

14.3 Helen was offered opportunities to make disclosures about any current concerns on three separate occasions during her antenatal care. Once at her initial booking in December 2016 and January 2017, and on a further occasion in April 2017 at an outpatient's appointment. On each occasion her partner was not present. In terms of current practice by the CUHFT, maternity services require pregnant women to be

asked about potential domestic abuse at least three times during their care. This is regularly audited and reported upon within the organisation.

14.4 After the safeguarding concerns were made known to the maternity service, close observations of the patient and her interactions with her partner and with her baby were made and are the subject of several entries in Helen's medical records. Staff felt that the partner was supportive and caring. Helen was reported as being relaxed and engaged, with her care of Freddy being appropriate. It was noted that there were no tensions between Helen and the staff, which might be expected if she was concealing issues of concern. Her partner, although not always present, was in frequent and regular attendance and there are no recorded instances of him causing any concerns. It is important to note though that in domestic abuse cases perpetrators can present well to professionals and for this reason there should not be complacency in considering and exploring the potential of abuse in a relationship.

15. Analysis

15.1 The risk of Helen dying as a result of taking her life by suicide due to her being a victim of domestic abuse.

15.1.1 The review author would like to highlight and invite consideration by criminal justice agencies in the future, of research carried out in the report: *'Domestic abuse and suicide Exploring the links with Refuge's client base and work force'* by Ruth Aitken and Vanessa E. Munro on behalf Warwick Law school and Refuge.[12]

15.1.2 Within that report it states *'The suicide of Gurjit Dhaliwal, who took her own life after enduring years of physical and psychological abuse, was the impetus for this research. Dismayed at the apparent inability of the legal system to punish perpetrators who drive their victims to suicide, and by its failure to recognise the psychological injury which precedes it as a legitimate offence, we were moved to act*'.

15.1.3 The review author is not suggesting that this level of abuse is apparent in this case, but it does allow for wider consideration to be given to links between domestic abuse and suicide, which may be more prevalent in other cases. Agencies do need to challenge existing norms, to try and protect victims of domestic abuse and to not let perpetrators walk free of any punishment for their actions, no matter what form of abuse has taken place.

[12] Aitken, Ruth and Munro, Vanessa (2018) Domestic abuse and suicide: exploring the links with refuge's client Base and work force. London: Refuge. Available online (accessed) 05/01/21) - http://wrap.warwick.ac.uk/103609

15.1.4 In the Refuge research involving a sample of 3500 clients, 25% admitted to feeling suicidal and 18% had made plans to end their life. Within the sample group 22% were pregnant or had a child within the last 18 months. The report concluded *'there is a correlation between*

experiencing domestic abuse and suffering severe adverse psychological effects; and it attests to the need for professionals across a range of settings to be more aware and responsive to, the risk of suicidality in this population.'

15.1.5 The review panel identified the lack of recognition of domestic abuse and the impact on isolation and mental health in the Joint Cambridgeshire and Peterborough Suicide Prevention Strategy. There was a desire to ensure that domestic abuse is reflected in the strategy and that measures are in place to monitor and learn from cases when they occur and are not prevented.

15.1.6 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[13]. 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 but is recognised domestic abuse should be referenced.

15.1.7 Helen's mental health is discussed in more detail later in this section but there were no known indications to professionals that Helen had any suicide ideation or thoughts of taking her life. The same can be said of the discussions with her family, that there were no concerns that such extreme action was being considered, let alone undertaken by Helen. On this basis it would be difficult to say that the risk of suicide could be foreseen or anticipated. There is a the necessity for all professionals to be aware that the risk of suicide in a relationship where domestic abuse and or coercive control is a factor and this should be explored when the situation allows.

15.2 Establish what lessons are to be learned from Helen's death regarding the way in which local professionals and organisations work individually and together to safeguard victims.

[13] 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.

15.2.1. Helen was first seen by Health Visitors, after the birth of Freddy .There had been no ante-natal contact with a health visitor, the conclusion reached by the IMR author for the Cambridgeshire Community Services NHS Foundation Trust (CCS), is that the likely reason for the lack of contact was the capacity of the HV team where the priority for targeted ante-natal contact is to first time mothers and where there are additional and/or other safeguarding concerns. Had the service been aware of the Helen's history, it may have changed this view.

15.2.2 In a home visit by a HV following the birth, Helen was seen with both Freddy and Frankie, but not in the company of Tony. General advice was given by the health visitor and Helen was bonding well and was sensitive to the child's needs. There was no adverse comment from the HV although the CCS IMR author notes that the history was not explored at that time and there was no routine enquiry about domestic violence, possibly because Frankie was present. There seems to be a gap in the exploration of the wider family, for instance where was Tony and was there any consideration of vulnerabilities and risk. Tony was in fact not identified as the father by the CCS until after Helen's death. This leaves a significant gap in both knowledge and curiosity of the HV on that initial birth visit. Concern was raised about the fact that the family had a Staffordshire bull-terrier. Whilst that was an important consideration, the question of who the father is was not addressed and this was an obvious omission.

15.2.3 In a further home visit by a HV in August 2017, at the 6-8-week birth review, again the question of domestic abuse was not raised as another adult was present. The question of PND was raised and a questionnaire completed which indicated a Helen was a low risk. This may contradict the view of Tony, regarding Helen being low after the birth of Freddy.

15.2.4 In relation to this 6-8-week review, the IMR author observes that there was no enquiry about the sibling and her relationship with her step-parent and new brother. Tony is again not mentioned, and this is the second occasion for the visitor to have been professionally more curious concerning the functionality of the family unit. The home environment, however, was noted as being of a good standard and Freddy's development raised no concerns.

15.2.5 Freddy was seen regularly (on at least eight occasions) by HV's at Child Health Clinics. This was by three different HV professionals. The CCS IMR author comments that these are '*theoretically*' occasions where there were opportunities to explore and ask about maternal mental health and domestic abuse as well as other risk factors. Whilst the overview author accepts that those opportunities were not taken, there is no indication that Helen's behaviours or interactions raised any concerns and she had not intimated that she needed any additional support from the HV

15.2.6 In October 2015, when Helen attended hospital with an injury to her head there was the opportunity to be professionally curious regarding the nature of the injury. Although, what have may

appeared to be, a reasonable explanation was given there could have been follow up questions to explore relationships and thereby giving the ability for Helen to disclose any issue if she had wished.

15.3 Were there signs that there was domestic abuse or coercive control in Helen's relationship

15.3.1 Although Helen had a challenging early life, more recently she informed services that she viewed herself as being in a caring and stable relationship. This was also confirmed by the family, although they felt that her relationship with Tony could be turbulent at times.

15.3.2 There was, however, a clear indication that there had been domestic violence within their relationship which occurred relatively quickly in terms of how long they had known each other. The violent assault that occurred in Norfolk, within months of them becoming a couple.

15.3.3 Helen supported Tony during the investigation and family confirm that it was her wish to remain with Tony. Helen was offered the support of an Independent Domestic Violence Advocate but declined support. Norfolk Constabulary, under policy with the Crown Prosecution Service, were robust in their decisive approach to dealing with domestic violence offences and proceeding with a prosecution. The reasons why women suffering domestic abuse has already been explored but it may have been the case that Helen felt unable to leave the relationship. It was known that Helen was keen to care for Frankie and any she may have felt that any fractures in her relationship would jeopardise this.

15.3.4 At the time of the Norfolk domestic abuse assault on Helen, the police would have been aware of the similar incident perpetrated by Tony on another partner some months earlier in Essex. There was an opportunity at this stage to consider a disclosure under the Domestic Abuse Disclosure Scheme (DVDS). At the time of this offence the scheme had only been in place matter of months and was not as embedded as it is now. This would have allowed Helen to be informed of the previous incident under the 'Right to Know' and may have had an impact on her decision making. Consideration of this should have been given by the police officers dealing with Helen's case.

15.3.5 Cambridgeshire Constabulary has no record of any incident of domestic abuse involving Helen or Tony as a couple or indeed any incidents that they have attended at any of their current or previous addresses. The senior investigating officer for the suicide, quite properly raised a question concerning the picture of domestic abuse that emerged in the post death investigation as it does suggest a concentration of events that immediately preceded the death and indicated a potential for there being coercive and controlling behaviour on the part of Tony within the family dynamics.

15.3.6 The last officially recorded incident of domestic abuse between Helen and Tony was in August 2014 (occurring in Norfolk with a conviction in November 2014) and was seemingly, both the first and last recorded occurrence between them. However, indications from the family are that there were 'difficulties' within their relationship and that, as a couple, they would frequently argue, which could have caused Helen to feel the abuse was continuing. This is in the context that, as previously stated, it is known that only a small percentage of domestic abuse incidents are reported to police and indeed, other agencies.

15.3.7 When this the previous conviction, with Helen as the victim, was discussed with Tony, **he stated** took full responsibility for this incident, which he said he sincerely regretted. **He further stated** that since this time he has never resorted to physical violence but conceded that their arguments were volatile, and on the night of Helen's death he was being aggressive, this can be heard on the recording made.

15.3.8 This needs to be set against the backdrop of Tony having previously committed violent domestic assaults against a previous partner and then against Helen. Police records show that the previous partner had described Tony as being controlling, possessive and aggressive.

15.3.9 It is worthy of note that Helen's mother and father were both aware of the assault and confirmed it was Helen's wish to remain with Tony. They were not however aware that Tony had been convicted and sentenced for an offence of battery.

15.3.10 What is not clear from the information is how regular, if at all, such domestic incidents were occurring within the household. The family confirm that they had no suspicions or concerns in this area prior to Helen's death however, what took place outside of their knowledge is only known to those within the household itself.

15.3.11 There is a clear pattern in both the historical incidents and the most recent tragic incident that alcohol was a factor. This taken with mental health concerns and domestic abuse heighten the risk and are often referred to as multiple disadvantage. There is an increased prevalence of domestic abuse where the factor of substance misuse (alcohol in this case) and mental ill health are present. In this case it would appear that only the existence of potential mental ill heath was known and recognised by agencies.

15.3.12 There is information from family that in the days preceding her death and in particular on the evening prior to her death, Helen appeared to be acting, in their view, irrationally. The only reason for

this was given as her disappointment over her birthday celebrations. This, of course could be due to a number of other factors resulting in a culmination of anxiety for Helen. Behaviours such as increased the use of alcohol, acting in an anxious or agitated way, withdrawing or feeling isolated and extreme mood swings are all recognised as potential warning signs for suicide.

15.3.13 It is interesting to note that on the night of Helen's death, Tony chose to record the actions of Helen, this, he states was to show that he was not the aggressor however, the recording does reveal that Tony was using what many would deem to be aggressive language. The act of recording the incident may indicate that Tony felt he was going to be challenged regarding the incident.

15.4 To what extent was Helen's mental health an issue in this review?

15.4.1 Although Helen had not been seen by Mental Health specialists, it is believed by Tony that she was suffering from the 'baby blues'. Discussion with Tony reveals that he was very concerned about Helen's apparent low mood and encouraged her to visit the GP, leading to her being prescribed medication. As a person already taking the same medication, he stated he understood the effects of not being consistent in taking it. Helen not taking the medication, in itself, caused a stress within the relationship, to the degree that Tony would discreetly count the number of remaining tablets to monitor usage and compliance. Although Tony would claim that this was out of concern this could well be interpreted as controlling behaviour. The panel wants to highlight that these statements of 'baby blues' and low mood are Tony's perspective and might not be how Helen would describe how she felt at this time.

15.4.2 Helen was screened for post-natal depression and, when tested her risk was found to be low. Baby Blues and Post Natal Depression (PND) are two separate conditions and the difference is articulated by The Royal College of Psychiatrists.[14]

15.4.3 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. Although there was no diagnosis of PND, this review does allow for wider consideration on how this can be addressed in the future. Helen's mother does

[14] Post Natal Depression - https://www.rcpsych.ac.uk/mental-health/problems-disorders/post-natal-depression

acknowledge that Helen had struggled since Freddy's birth as he had been 'hard work' and Helen was not sleeping well. Due to Helen being unable to give an account the reason for this is not known.

15.4.4 The Named Nurse for Midwifery has reviewed the CUHFT IMR and Helen's medical record. Helen attended all her antenatal appointments, her mood remained normal, with no signs of decline in mental well-being. She was taking Sertraline 50 mg[15] 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.

15.4.5 The Cambridgeshire County Council, Early-Help IMR refers to the fact that In April 2017, Midwifery services contacted the Multi-Agency Safeguarding Hub (MASH) to enquire as to any previous social care involvement with the family and to raise concerns about the overcrowding of the family's accommodation at that time. The records indicate that both adults were noted as *"having mental health issues",* which were both being managed by their GP. Helen was being treated for anxiety and depression. The only tangible concern raised was the behaviour of Frankie and that she did not have her own room or space. There is no evidence that Early Help specifically enquired about the existence of domestic abuse and it would be considered good practice to do so.

15.4.6 Information, obtained with consent from the GP and from Tony himself indicate that he suffered from anxiety and depression from 2011, which was treated with Citalopram until 2014 and from then until the present time by being prescribed Sertraline.

15.4.7 In 2014, the patient records indicate that Tony was dependent on alcohol and that he had disclosed the domestic assault against Helen, but he stated she had forgiven him. In 2015, the notes indicate that his alcohol intake had reduced. In April 2017, the notes identify that Tony disclosed his alcohol intake as being 45 units per week.[16]

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[15] Sertraline, is an antidepressant of the selective serotonin reuptake inhibitor class. It is used to treat major depressive disorder, obsessive–compulsive disorder, panic disorder, post-traumatic stress disorder premenstrual dysphoric disorder, and social anxiety disorder. Sertraline is taken by mouth. starting dose is usually 50mgs but it can be increased to a maximum of 200mgs per day.

[16] Men and women are advised not to drink more than 14 units a week on a regular basis - https://www.nhs.uk/live-well/alcohol-support/calculating-alcohol-units/

15.4.8 Tony stated that his Sciatica had a profound effect on his work and therefore his income and there is no indication that Helen was working in any capacity. Consequently, the income into the household is likely to have been relatively limited. The factor of Tony not working and being at home for more extended periods, Tony felt, caused increased stress in the relationship and consequently this may have had an impact on Helen's mental health. There is no indication that there were undue financial issues that increased on anxiety felt by Helen or Tony.

15.5 What extent were the children affected by the domestic abuse in the household?

15.5.1 The various incidents in the household and the mood which must have accompanied the distressing domestic atmosphere obviously had an impact on Frankie. She communicated with family members and was obviously distressed and concerned for her mother. She reached out to her grandmother by text and the impact was obvious.

15.5.2 Frankie's attendance at school was 100%, up until the time of Helen's death. The school had no concerns regarding domestic abuse, although there were other associated issues which the school were working with Frankie on and this related to Frankie's autism.

15.5.3 Although Freddy was younger, discord and domestic abuse in a household is known to have an adverse effect on a child's development. Children and adolescents living with domestic violence are at increased risk of experiencing emotional, physical and sexual abuse, of developing emotional and behavioural problems and of increased exposure to the presence of other adversities in their lives.[17]

15.5.4 The impact and effect on children is to be recognised by the Domestic Abuse Bill 2020 which will introduce that where a child sees or hears, or experiences the effects of, domestic abuse and is related to the person being abused or the perpetrator is also to be regarded as a victim of domestic abuse in their own right.

[17] Holt S, Buckley H, Whelan S. The impact of exposure to domestic violence on children and young people: a review of the literature. Child Abuse Negl. 2008 Aug;

16. Conclusion

16.1 There were a number of opportunities where Helen was seen by professionals and there was an opportunity to explore the existence of domestic abuse. This was more relevant in her case as she had previously been the subject of domestic abuse.

- October 2015 – when Helen attended hospital following a reported fall.
- October 2016 – where Helen was seen by her GP and prescribed with anti-depressants.
- April 2017 – where Helen received limited support for Early Help with housing issues.
- At the end of 2018 – where Helen's medication was reviewed by her GP.

16.2 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.

16.3 Although the risk of Helen taking her own life may not have been apparent this case acts as a stark reminder to professionals to be aware of the link between domestic abuse and the potential of suicide.

16.4 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 and there is a history of domestic abuse.

16.5 It is felt by Tony and his mother 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 Sertraline, 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. There could have been more exploration as to the reasons for Helen's depression and anxiety when anti-depressants were prescribed and the prescription reviewed.

16.6 A national report by the government[18] identified that there is now greater awareness of the importance of mental health during pregnancy and in the first year after birth. But they state that there is still a long way to go in recognising symptoms, supporting women with mental health problems and providing access to specialist perinatal mental health care. It adds that there may still exist a 'postcode lottery' in respect of treatment opportunities.

16.7 There still remains a need to remind all professionals of the potential of domestic abuse or coercive control in any number of presenting conditions. It is incumbent on professionals to exercise the right level of professional curiosity to satisfy themselves that all could have been done to identify and offer support to this, often hidden and not obvious area.

16.8 The terms of reference for this review included 'What extent were the children affected by the domestic abuse in the household? '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.

16.9 Whilst there are references to the use of alcohol and mental health being features in this review, the panel wish to make it clear that these are not recognised as being causal factors for domestic abuse but can be symptoms of those who are being abused.

16.10 Although not within the remit of this review, it should be ensured that the appropriate level of support and care are in place for Frankie. She has, in her short life experienced recognised Adverse Childhood Experiences (ACEs), which research has identified are likely to lead to poor outcomes for children as they develop.[19] It is apparent that she is suffering from the trauma of her mother's death, and turmoil which preceded it, and it would be remiss of this review not to recognise this.

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[18] Preventing suicide in England. Fourth progress report of the cross-government outcomes strategy to save lives. Published January 2019.

[19] Adverse Childhood Experiences (ACEs) - *"intra-familial events or conditions causing chronic stress responses in the child's immediate environment. These include notions of maltreatment and deviation from societal norms"* - Kelly-Irving M, Lepage B, Dedieu D, Bartley M, Blane D, Grosclaude P, et al. Adverse childhood experiences and premature all-cause mortality. European journal of epidemiology. 2013;28(9):721-34.

17. Lessons to be learned

17.1 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.

17.2 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).

17.3 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.

17.4 This review gives the opportunity for further consideration of the effects of post-natal depression and the effects on new mothers.

17.5 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.

17.6 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.

Good Practice.

17.6 The CUHFT policy that has been adopted since 2017, is that maternity services require pregnant women to be asked about potential domestic abuse three times during their care. The outcomes of this policy are regularly audited and reported upon. This is now being audited quarterly.

17.7 The Cambridgeshire Constabulary has identified that since the December 2016, amendments to the Home Office Statutory Guidance, the police response to suicides has required the attending/reporting officers to enquire about domestic abuse within the victim's background. This approach ensures that appropriate referrals are made to the head of the Protection of Vulnerable People Department and that CSP's receive timely notification for consideration. The Cambridgeshire Constabulary IMR identifies that the force has referred a number of cases in 2018 and 2019 to the respective Community Safety Partnerships, for consideration. Including this case, there is one other 'live' review being conducted where the victim took their own life.

17.8 HM Senior Coroner for Cambridgeshire is ensuring that appropriate screening of sudden death by suicide is made with the reporting agencies to ensure that domestic abuse is examined, ahead of any formal Inquest proceedings. HM Senior Coroner for Cambridgeshire maintains a close working relationship with the safeguarding partnership for the County.

17.9 Cambridgeshire and Peterborough CCG are piloting Safeguarding Adult templates for use within GP record-keeping systems which will enable Primary Care Staff to capture and recall information about Domestic Abuse and a range of other risk factors. The aim is to facilitate improved information gathering and sharing to better support professional curiosity. This will include more exploration around the prescription of anti-depressant medicine.

18. Recommendations

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.