SETDAB | Southend, Essex & Thurrock Domestic Abuse Board

Uttlesford CSP
Uttlesford Community Safety Partnership

DOMESTIC ABUSE RELATED DEATH REVIEW

UTTLESFORD COMMUNITY SAFETY PARTNERSHIP

Olivia died November 2022

Chair and Author – Katie Bielec

Completed May 2024

Published January 2025

Contents Page Number

Foreword

Olivia was a much-loved mother, daughter, sister, and friend. She brought joy and happiness to those who knew her and is missed every day by all that knew her. The family are devastated at her loss and believe she would not have died if she had not met Frank. Olivia remains in the families' thoughts, and they will never let her memory fade.

Preface

Uttlesford Community Safety Partnership, panel members and the author wish at the outset to express their deepest sympathy to Olivia's family. This review has been undertaken in an open and constructive manner with all the agencies engaging positively. This ensured the circumstances leading to Olivia's death were discussed and analysed in a meaningful way, addressing with candour any issues raised.

1 Introduction

1.1 This review is a statutory requirement which will examine agency responses and support provided to Olivia (not her real name) and that of Frank (not his real name) prior to her death. The Executive Summary summarises the events leading to Olivia's death and the conclusion of the panel's findings. For full analysis into the interaction agencies had with both Olivia and Frank please refer to the Overview Report.

2 Timescales

2.1 In November 2022 Olivia died at her home address whom she lived with Frank. Uttlesford Community Safety Partnership received a Domestic Homicide Review referral from Essex Police at the end of November. The decision to carry out the review was made at the start of January 2023 as it met the criteria within the Home Office Multi-Agency Statutory Guidance for Domestic Homicide Reviews 2016[1]. An Independent Chair and Report Author was commissioned the same month.

2.2 Due to the nature of Olivia's death this review has been named a Domestic Abuse Related Death Review. This new title is currently still going through legislation. The principles of the review have been followed in accordance with the Statutory Guidance.

2.3 Paragraph 46 of the statutory guidance states that the target timescale for completion of the review is six months. Initial information was sought by Southend, Essex, and Thurrock Domestic Abuse Board (SETDAB)[2] to ensure different agencies were aware of the review and the requirements as well as the introductory panel meeting. However, the review was unable to be completed due to the on-going challenges gathering the information required. Uttlesford CSP, the panel and family were updated and informed throughout the process.

3 Confidentiality

3.1 In line with paragraph 75 of the statutory guidance, to protect the identity of those involved and to comply with the Data Protection Act 1998[3], pseudonyms should be used.

[1] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews
[2] SETDAB - Southend, Essex and Thurrock Domestic Abuse Board
[3] https://www.legislation.gov.uk/ukpga/1998/29/contents

The family chose Olivia's name, and the pseudonym for Frank was chosen and agreed by the family and panel.

3.2 The sharing of information between agencies in relation to this review was underpinned by the SETDAB Information Sharing Protocol which is in place to facilitate the exchange of personal information to comply with the requirements of Section 9 of the Domestic Violence, Crime and Victims Act 2004[4] to establish and coordinate a review.

3.3 Panel meetings were all confidential and any sharing of information was carried out with the agreement of the responsible agency's representative, the panel and chair.

3.4 The Individual Management Reports (IMRs) are restricted to the authors, senior managers of the organisation and panel members. Uttlesford CSP has agreed the completion of the report and action plan and submitted to the Home Office Quality Assurance panel for final approval. Any initial learning identified has been acted on immediately.

4 Methodology

4.1 Section 9 of the Domestic Violence, Crime and Victims Act (2004) states a Domestic Homicide Review should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by:

a) A person to whom [she] was related or with whom she was or had been in an intimate personal relationship, or,
b) A member of the same household as [herself]; held with a view to identifying the lessons to be learnt from the death.

4.2 Due to their home being in Essex and close to the boarder with Cambridgeshire, along with their pub being in Cambridgeshire (close to the border of Essex), it was identified scoping for information would be carried out across Essex and Cambridgeshire. Agencies were provided the terms of reference, asked to review their involvement and interview staff where appropriate. All IMRs were quality assured and highlighted positive practice, learning, recommendations, and actions.

4.3 Pieces of research were used within the analysis and referenced within the report.

5 Involvement of family/friends and colleagues

5.1 Olivia's family were informed of the review by letter, the chair had several virtual meetings with Olivia's sister and spoke with Olivia's daughter and friend over the phone. The terms of reference were shared and agreed by the family.

5.2 Olivia's sister was referred to AAFDA[5] for support which was also offered to Olivia's daughters. As a result, the families advocate remained in regular contact with the chair for updates and sharing information with the family.

5.3 Olivia's sister attended a panel meeting, she shared memories of Olivia, the families hope for the review and an update on the family's wellbeing. The family and AAFDA

[4] https://www.legislation.gov.uk/ukpga/2004/28/section/9

[5] Advocacy After Fatal Domestic Abuse - https://aafda.org.uk/

Advocate read the draft report and met the chair (face to face) to ask questions and offer comments and/or suggestions prior to the submission to the Home Office.

5.4 The chair attempted to contact Frank; however, this was unsuccessful due to him moving to an unknown location and changing his contact details.

6 Contributors to the review

6.1 The authors of the IMRs and Summary reports and all panel members were independent of any involvement with Olivia and/or Frank.

6.2 Agencies who provided and presented IMRs to the panel:

- Essex Police
- Cambridgeshire Constabulary
- Essex MARAC
- Next Chapter
- Mereside Medical Cathedral Medical Centre GP Surgery
- Red House Surgery
- East England Ambulance Service (EEAST)
- Cambridgeshire and Peterborough Foundation Trust (CPFT)
- Cambridge University Hospitals NHS Foundation Trust (CUH)
- Victim Support

6.3 Summary reports:

- Goring and Woodcote Surgery
- Greene King Pubs

6.4 The panel comprised of agencies recommended within the statutory guidance and agencies with specialist knowledge of domestic abuse and suicide. The review panel consisted of:

Agency	**Representative and role**
Bielec Consultancy Ltd	Katie Bielec – Chair and Author
Uttlesford CSP	Fiona Gardiner - Community, Health and Wellbeing Manager
SETDAB	Emma Tulip-Betts – Specialist Wellbeing & Public Health Officer
SETDAB	Tasmin Brindley – Domestic Abuse Support Officer
Essex Police	DI Ben Pedro Anido – Head of Operational Development within the Strategic Vulnerability Centre.
Herefordshire and West Essex ICB	Roisin Gavin - Designated Professional Safeguarding Adults
Essex Partnership University Foundation Trust (EPUT)	Tendayi Musundire - Head of Safeguarding
Essex Adult Social Care	Elaine Oxley - Director of ASC Safeguarding and Quality Assurance Alison Clarke – Service Manager Safeguarding and Quality Assurance
Next Chapter (Domestic Abuse Service)	Bev Jones - CEO Ruth Cherry-Galal - IDVA Manager

Public Health, Essex Council	Gemma Andrew, Wellbeing and Public Health Manager, Suicide Prevention Lead
Essex Alcohol Recovery Community (ARC)	Stephanie Trevers, Service Manager
East of England Ambulance Service	Caroline Sexby - Safeguarding Sector Lead and Named Professional
Cambridgeshire Police	Jenni Brain, DCI Protecting Vulnerable People Department David Savill, DI Protecting Vulnerable People Department
Cambridge Adult Social Care	Julie Rivett, Service Manager/Strategic Lead for Safeguarding
Cambridge University Hospitals NHS Foundation Trust (CUH)	Tracy Brown - Adult Safeguarding Lead
Cambridgeshire and Peterborough Integrated Care Board	Linda Katte - Deputy Designated Professional for Safeguarding People and Mental Capacity Act Lead
Cambridgeshire and Peterborough Foundation Trust (CPFT)	Rachel Robertson - Advanced Practitioner Safeguarding: Domestic Abuse Lead and Trust DHR Representative Claire Jimson - Lead Nurse for Safeguarding – Think Family Safeguarding Team

7 Author of the Overview Report

7.1 Katie Bielec is an independent domestic abuse consultant, she is an accredited chair with AAFDA and SILP[6] and MARAC[7], has completed the Home Office Domestic Homicide Review Training, is a member for AAFDA DHR Network, Standing Together Against Domestic Abuse Coordinated Community Response and The Employers Initiative on Domestic Abuse. She is an associate trainer for SafeLives, Surviving Economic Abuse, Rockpool, The Hampton Trust, a guest lecturer at Bournemouth University and is an accredited trainer delivering Coercive Controlling Behaviour and Stalking. Katie was previously a Metropolitan Police Officer, she is a qualified IDVA, IDVA manager, ISVA[8] Manager and managed domestic abuse services for 11 years.

7.2 Katie is not associated in any way to any agency who have provided information for the review nor had any personal or professional involvement with Bob, Clare, or their families.

8 Parallel Reviews

8.1 In the spring of 2023, the coroner returned a decision of an open verdict.

8.2 There were no other reviews being conducted at the time of this review.

9 Equality and Diversity

9.1 Olivia was a 48-year-old white British female; Frank is a white British male and was 50 years old at the time of Olivia's death. Women are much more likely than men to be the

[6] https://www.reviewconsulting.co.uk/silp-reviews/
[7] MARAC – Multi Agency Risk Assessment conference.
[8] ISVA – Independent Sexual Violence Advocate, support for victims of sexual violence/abuse.

victims of high risk or severe domestic abuse: 95% of those going to MARAC or accessing an IDVA service are women. The Crime Survey for England and Wales (year ending March 2022) shows the following trends, an estimated 6.9% of women (1.7 million) and 3.0% of men (699,000) experienced domestic abuse in the last year. Therefore, due to Olivia's gender she was at higher risk of domestic abuse from Frank.

9.2 The couple were married for 14 months; shortly before Olivia's death she stated she wanted to separate, however the relationship continued up until she died.

9.3 Olivia was not diagnosed with any disability; however, she was diagnosed with cerebral atrophy just months before her death which she was struggling to come to terms with. Brain atrophy (cerebral atrophy) is a loss of neurons and connections between neurons. Generalized cerebral atrophy affects the whole brain almost equally throughout all regions, it can lead to a loss of skills like dementia or Parkinson's. Symptoms and severity of brain atrophy depend on the specific disease and location of damage. It is not clear why these conditions develop. Experts suggest a mix of genetic and environmental factors may be involved. It was evident that this recent diagnosis was having an emotional impact on Olivia as she voiced this to several organisations.

9.4 Olivia struggled with mental ill-health which was impacted after she was a victim of rape as a teenager and domestic abuse as an adult. Olivia's mental wellbeing deteriorated in the final 18 months of her life which impacted on her day-to-day activities.

9.5 Olivia struggled with an addiction to alcohol especially during the last year of her life. This impacted on her ability to work and will be further explored within the analysis.

9.6 Olivia was not pregnant, and no religious beliefs were made known.

9.7 Frank had asthma however this was not identified as a disability and he had no known religious beliefs.

10 Dissemination

10.1 Olivia's family and all agencies involved in the review are aware that the Overview Report and Executive Summary will be published on the SETDAB website[9] and shared with Uttlesford Community Safety Partnership Board, Essex Police Fire Crime Commissioner and the Domestic Abuse Commissioner once agreed by the Home Office; however, the action plan has already been disseminated with all relevant agencies to ensure immediate action and learning can be taken forward. Uttlesford CSP and the chair will work with the family and other partners with regards to any public/press interest.

11 Olivia's death

11.1 In mid-November 2022, Frank alleged he and Olivia were at home and had an argument at 19:00 hours, he left and went to the pub which they both owned, Olivia stayed at their home address. Frank returned home shortly after midnight and called EEAST via 999, where he reported he had found Olivia hanging from a tree, had cut her down and was unsure how long she had been there.

[9] https://setdab.org/

11.2 He started CPR during the call, meanwhile EEAST informed Essex Police of the call who then arrived at the couple's home within a few minutes and took over the CPR from Frank. The ambulance arrived just after 01:00 hours, despite the efforts to save Olivia, she died at her home shortly after the ambulance arrived.

11.3 Police investigated Olivia's death and determined that there were no suspicious circumstances.

12 Family and relationship background

12.1 Olivia was born in Cambridgeshire and had 1 sibling. Frank was from greater London, he had been previously married, and he has 2 adult children.

12.2 Olivia married her first husband in 2000, together they had 3 children, and they emigrated to New Zealand. Whilst in New Zealand Olivia and her husband separated, one child remained with their father and the other 2 children stayed with Olivia. After the separation Olivia started a new relationship, and her ex-husband returned to Cambridgeshire.

12.3 Olivia told her sister that the police in New Zealand had been notified concerning violent domestic abuse against her by her partner (not her ex-husband), however no further information was provided. In May 2014, Olivia and her two youngest children (her eldest child remained in New Zealand to work) returned to the UK. She did not give any details why they had returned, but they had few belongings which indicated a spontaneous decision to leave. Three months later, Olivia returned to New Zealand without the children, who remained with their father. Later that year Olivia returned to the UK to her mother's address, at this point she had no contact with her children. Olivia made an allegation to Police that the children were being brainwashed by their father, children social care found no evidence of this, and no concerns were raised regarding their care.

12.4 Olivia met Frank on a dating website in January/February 2021, according to friends they had not spoken for very long before they went on their first date. She told friends that he was handsome and coached rowing. After their second date Olivia returned with a black band on her wedding ring finger stating they had promised themselves to each other. Within a couple of weeks of meeting Frank moved in with Olivia, she explained to friends that this was to save money, and his flat was not good for his health. She gave up her nursing course and started driving him as he was a Deliveroo courier.

12.5 In April/May of 2021 Olivia sent a photo of her hand with her Mum's ring on her wedding finger to a friend asking, '*Are you going to congratulate me*?'. When asked 'why?' she told them they were engaged.

12.6 Her friends and family were shocked when Olivia and Frank purchased a pub (owned by Greene King) in June 2021 as she had never shown any interest in owning a pub and had given up her studies. They were concerned Olivia had used all her savings to purchase the pub, and Frank had not contributed financially even though he was named as the licensee. They recall the pub opened on Olivia's birthday, she worked behind the bar and Frank was 'front of house'. It had not been open long, Olivia was struggling with the running of the business, would become upset and stay upstairs whilst Frank continued to work. The family believe there were financial concerns as Olivia had taken a loan to pay staff due to Frank being 'blacklisted'.

12.7 Olivia had previously struggled with alcohol and her mental health but her friends and family state she was sober when she met Frank and was managing her mental health. After they purchased the pub, they noticed she started drinking again and her mental health deteriorated.

12.8 The wedding was planned for September, however before this Olivia called her best friend upset telling them that Frank had married his ex-wife twice and that she was having doubts about their marriage. Even with these concerns the wedding went ahead, with Olivia's friend as a witness at the ceremony.

12.9 Olivia's best friend remembers an occasion when they attended the pub after Olivia had fallen down the stairs. She asked Frank if Olivia had been drunk which he replied saying *'what do you think*?'. Once he had left Olivia told them that Frank was not coping with her drinking and that she had slipped, however he had told her to say *'it was the dogs'.*

12.10 It is unclear when Frank and Olivia moved out of the pub, however, Frank told agencies this was to assist Olivia to stop drinking.

13 Chronology[10]

2021

13.1 Olivia and Frank started to date in January/February of this year.

13.2 Frank was seen at hospital in May due to moderate severe sleep obstructive apnoea and obesity. During the consultation he disclosed he had recently started a new relationship (this was the first instance Frank mentioned his 'new' girlfriend to any professional), there was no documentation of any difficulty in the relationship. At the end of May Olivia had a consultation with her GP to discuss sleep as she was seeking sedative medication, sleep information was shared.

13.3 Olivia and Frank bought the public house in Cambridgeshire in June.

13.4 In mid-July he told the GP that he was in a new relationship and engaged, this was noted as a significant event.

13.5 Olivia and Frank married in September.

13.6 At the end of September mental health services contacted Olivia's GP stating that she would be better served engaging with alcohol services and felt she had EUPD[11] rather than bi-polar. Frank was also discharged from hospital after being diagnosed with pulmonary embolism[12].

13.7 At the end of October during a consultation with her GP Olivia disclosed she was drinking 2 bottles of wine a night; she was advised to reduce this and continue with her medication. The following month she told them she was having suicidal thoughts after drinking alcohol and they advised to seek support. A week later she called 111 telling them she had been drinking alcohol for the last week but had stopped the day before. She

[10] Full and detailed chronology can be found within the Overview report. This chronology has started from when Olivia met Frank.
[11] Emotionally unstable personality disorder
[12] A pulmonary embolism is when a blood clot blocks a blood vessel in your lungs. It can be life-threatening if not treated quickly.

had now taken excess medication to sleep but was experiencing black vomit, she saw her GP the following day, they noted low mood and her referred to mental health services.

13.8 In mid-November Olivia was taken to A&E by Frank after she drunk a bottle of wine in the morning and threatened to jump out of the window. Olivia stated she had a harmful use of alcohol since she lost the care of her children in 2011 but had been able to stop drinking for six months in 2018 when "life was good". Since then, she had continued to drink, and her consumption had increased over the last couple of months (between 2 and 4 bottles of wine a day). Olivia told staff she and Frank had been married for 2 months and she had joined Frank to work in his pub. Frank reported Olivia drank secretly and he felt overwhelmed by her recent behaviours.

13.9 Olivia was admitted to hospital 8 days later after she had taken an overdose, and a scan of her liver was requested. Her overdose was not intentional to harm herself, but she took too much codeine after stopping drinking while attempting to aid her sleep. The notes record that Olivia reported a series of abusive relationships but was now in a supportive marriage and wanted to take control of her drinking. She wanted to engage with services to help her to stop drinking and expressed a desire to seek bereavement support around the loss of her father.

13.10 Olivia contacted crisis support a couple of days after Christmas day, seeking support as she was struggling with her mental health and substance/alcohol misuse. She had no current suicidal plans or intent.

2022

13.11 Olivia contacted her GP at the beginning of January informing them she was an inpatient for a detox and requested her prescription.

13.12 In mid-May Essex Police received a 999 call from Olivia who was at her home address and reported that she had filed a restraining order against Frank, that he was inside the property refusing to leave and that she was covered in bruises caused by him. Within minutes of the initial call Olivia called back stating that Frank had left, after research was completed, it was identified there was no record of a restraining order on any system available to Police.

13.13 Police attended Olivia's home address, she alleged:

- In mid-April Frank had kicked her to the chest whilst in bed causing her to fall violently out of bed landing on her forehead. She sprained and twisted her spine causing pain and refused to call an ambulance whilst she begged on the floor in pain.
- In mid-May Frank had grabbed her by the neck pushing her over the sofa and pinned her down with his knee on her chest for around 40-50 seconds restricting her breathing causing her to have a panic attack. During this assault she had received bruising to her right forearm (observed and photographed), on both occasions Frank had threatened to kill her. Olivia also stated that Frank had punched her to the left side of her face causing no injury following a verbal argument.
- She had been raped when she was 14 years old by a named male in Cambridgeshire.

13.14 An Athena Investigation was created, a statement was obtained, and a DASH RIC completed where Olivia was assessed as high risk[13]. During the assessment Olivia disclosed that a couple of days previously she had tried to hang herself.

13.15 Attempts were made to arrest Frank, but he was unable to be located, and he was placed on Police National Computer[14] (PNC) as wanted. That evening Essex Police sent an arrest notification to Cambridgeshire Constabulary regarding their intention to arrest Frank at his parents address for the assaults and that Olivia was a high-risk victim of domestic abuse. Frank was not at the location; he later contacted the police by phone and agreed to hand himself into a police station in Cambridgeshire. The following day he surrendered himself, was arrested on suspicion of threats to kill and assault and transferred to Essex.

13.16 Frank remained in custody overnight, during the interview he stated that he and Olivia had got into an argument about content on his mobile phone and she had tried to harm herself using a dog lead around her neck. He had intervened and during this she had received bruising to her arms. He in turn had been assaulted by Olivia resulting to bruising to the arms, chest, and testicles (all of which were photographed whilst he was in custody). Frank was given pre-charge police bail with conditions to return in June which was extended to mid-August 2022.

13.17 A couple of days later Next Chapter (IDVA support) received a referral for Olivia, it was noted on the referral that Olivia was very upset and had no support around her. An attempt was made to contact Olivia that and a couple of days later without success.

13.18 Towards the end of May, Olivia discussed with her GP her struggles with sleep, her difficulties with Frank and that he had been arrested for domestic abuse. That same day Olivia answered a call from Next Chapter, she told them she was safe and gave no concerns for her safety. Olivia agreed for an email to be sent with Next Chapter's details and agreed for an IDVA call her. An IDVA was allocated, and they spoke with Olivia 2 days later who was reported as very upset. They completed an individual support plan and agreed for a call the following day.

13.19 The IDVA contacted Olivia the next day, she was reported sounding 'very downhearted'. They supported a call to Police for an update on Frank's bail conditions and reviewed her safety plan. She was spoken to again the following day, a referral to the NCDV was completed and sent. A few days later the IDVA attempted to contact Olivia a voice message was left along with a text. Olivia did not respond, a further attempt to contact her was made 6 days later, the call went to voicemail and a further text message was sent.

13.20 At the beginning of June EEAST received a 999 call from Frank with concerns that Olivia had taken an overdose (alcohol poisoning, extremities turning blue, shakes, nausea). During a second call Frank stated Olivia was shaking down her right hand but was no longer fitting (she had 5-6 30 second seizures). He told them Olivia had a history of alcohol dependence and had reduced alcohol intake from 5-6 bottles per day to 1 or 2.

13.21 When the ambulance crew arrived, they identified three small bruises on Olivia's arm, but she refused to disclose how they happened. Frank reported Olivia tried to set fire to herself that night and had made remarks about hanging herself from a tree. She had a history of self-harm, but nothing recent. Olivia expressed thoughts of self-harm and

[13] High: There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious.
[14] National Police information on any arrest/convictions/court orders.

suicide and told the crew there was a history of domestic abuse with Frank, she was then transported to hospital. A GP referral was completed by the requesting a mental health review. They noted Olivia was non-compliant with her medication and that Frank had breached his bail being at the home. Whilst in hospital Olivia told nursing staff, she was a victim of domestic abuse, that Frank was on bail, and he was staying at a pub which she owned. She shared they had been trying to talk and work on things together. Olivia was asked if she felt safe at home, she stated sometimes she did, and sometimes she did not.

13.22 Essex Police received a non-emergency call from EEAST informing them of their attendance, and that Frank had been present at the address whilst bail conditions were in place. Police attended the hospital and spoke to Olivia; she informed them that she and Frank had mutually agreed to meet to talk through their issues and that there had been no further incidents. Officers attended Olivia's home and removed Frank from the address, however, due to the circumstances of the breach of bail he was not arrested. A few days later Olivia was heard at MARAC, there was limited information, and no details of any other agencies involved with Olivia or Frank other than IDVA and Police.

13.23 Whilst in hospital Olivia was seen by CPFT, they recorded "*Ongoing interpersonal difficulties with her husband due to discovery that he was using cocaine and watching pornography including homosexual pornography*". Olivia was discharged from hospital accompanied by a friend.

13.24 In mid-June Olivia provided a statement withdrawing the allegations relating to the threats to kill and assault. She stated that both she and Frank were drunk on both occasions and had argued. She confirmed that a month earlier she had placed a dog lead around her neck and then alerted Frank, she could not recollect causing the injuries to him. She concluded the statement by saying she did not feel threatened by Frank or at risk from him and that she intended to continue their relationship. The day after making this statement EEAST received a 999 call from Frank with concerns that Olivia was experiencing frequent seizures, he was not with her and was unable to contact her. On arrival crew found Olivia in the garden, emotional and intoxicated. The crew recorded that Olivia appeared to be suffering from self-neglect and was not coping at home, the house was tidy downstairs but unliveable upstairs with no belongings and a mattress blocking one of the rooms. They were unsure if Olivia was eating normally, was at risk of domestic abuse and should not have contact with Frank. A GP mental health referral was made, she was taken to hospital, however after being advised to stay she self-discharged.

13.25 Two days later Olivia called an ambulance via 999 stating she was having seizures and alcohol withdrawal. She told the crew that she has a brain disorder, with a recent diagnosis where her brain was dying, there was a query of sepsis due to her symptoms. Olivia told the crew she had had two seizures during the day with loss of consciousness and was unsure how her seizures manifested. A friend arrived and it was agreed Olivia would be taken to hospital for assessment and a psychiatric review. Olivia was discharged three days later, she refused inpatient drug and alcohol services and planned to engage in community drug and alcohol support services.

13.26 At the end of June following an evidential review by a Detective Sergeant (DS) it was decided that due to insufficient evidence, no further action would be taken against Frank. Olivia was informed of this, and Frank was released from his bail. Later that day Essex Police were contacted via 999 by Olivia who reported Frank had 'gone wild' and stolen her car (he was insured to drive it). The call was graded as a Priority 3 (Priority Response);

a unit was allocated to the incident who spoke with Olivia. She told them Frank had left their home in the car after she had called his mother a 'witch'.

13.27 Olivia attended A&E the following day after she had fallen down 10 stairs at home whilst carrying a pint glass. There were several deep glass wounds on her left hand, she was intoxicated and unsure if she had hit her head. She was described as very anxious in the waiting room and left the department to wait outside in a car with Frank. Olivia was unwilling to wait to be seen, and a doctor explained the risks of leaving without medical treatment. Olivia had capacity to understand the risks and she signed a self-discharge form; she was encouraged to return in the morning. Olivia returned to the department several hours later and was observed sleeping in the reception area.

13.28 The IDVA tried to call Olivia at the start of July, there was no answer and no option to leave a message.

13.29 Essex Police received a non-emergency call from Olivia at the start of August 2022 reporting that she had been involved in an argument with Frank, who had dragged her across the room by her throat. He had left the address, and she believed he had gone to the pub they jointly owned, she had locked and bolted all the doors to their home and felt safe. She did not want anything done but wanted the call logged. Given the nature of the report and the flag on the system Olivia was informed that she would need to be seen by an officer and agreed to speak on the phone the following day.

13.30 As planned an officer called Olivia the next day, she repeated the allegation that following an argument regarding Frank taking drugs he had 'flown into a rage' grabbed her around the throat and dragged her across the room. She told them that at the time of the incident Frank had been drunk, she had not received any injuries and did not wish to make a complaint but wanted the matter recorded. A DASH RIC was completed over the phone, and she was graded medium risk, the DASH RIC was reviewed by a supervisor who elevated the risk to high given the previous incident and the circumstances surrounding the latest allegation being similar in nature.

13.31 Three days after her initial allegation a Domestic Abuse Specialist Officer (DASO) spoke with Olivia on the telephone to discuss wider safeguarding, she declined any offer of support but accepted that a 'Flag[15]' be placed on her address and telephone. The investigation was also listed to be heard at the next available Multi-Agency Risk Assessment Conference (MARAC).

13.32 Police contacted Olivia by phone five days after the original call, she again informed them that she did not want to provide a statement, would not be willing to attend court and declined all support options provided. A request was made that Olivia send an email confirming that she did not wish to pursue an allegation which was subsequently received the following week via text. She was contacted a couple of days later and informed the investigation would be filed.

13.33 Olivia and Frank were heard at Essex MARAC two weeks after her allegation[16], actions set:

- Police - Due to concerns raised within the investigation and at MARAC, OIC to complete a SETSAF[17] and send to Adult Social Care (ASC) for consideration of assistance.

[15] To treat any further calls made by Olivia as urgent.
[16] IDVA, Police, MARAC chair and Admin and CSCS were present.
[17] Southend Essex Thurrock Safeguarding Adult Form

- ASC - To reiterate the support available from IDVA regardless of the status of the relationship and encourage her to engage, with consent make a referral to Next Chapter.
- Frank had not been spoken to by Police at the time, consideration to be made if there is enough information to run an evidence-led prosecution, speak to him and exhaust all other lines of enquiry. Due to no known agencies currently involved with Frank referrals could not be made without consent.

13.34 Cambridgeshire Constabulary received a call from Olivia in the evening in mid-September stating Frank had taken her car without her permission three days previously and had not returned despite being asked to do so. She also claimed she had also allowed him to use her bank card which he had also refused to return. It was noted she appeared upset however, there was no indication of any immediate threat or risk of harm to her. Although Olivia referred to Frank as her 'ex-partner' she stated that he still stayed with her 'a couple of nights a week.' Essex Police received the transfer which triggered the 'Flag' at the address highlighting Olivia as a high-risk domestic abuse victim.

13.35 The incident remained open with an officer calling Olivia the following, she expressed her anger that she had not been contacted the previous night. Olivia told them all she wanted was her car to be returned, did not support any police action, and hung up. A Diary Car was requested to complete a 'cold call' at Olivia's address.

13.36 The day after Essex Police received a 999 call from Frank reporting that he had been involved in an argument with Olivia. She had accused him of hitting her, grabbed the keys to their car scratching Frank's wrist and driven off. He reported that Olivia was drunk, and he was concerned for her. Units were allocated to the incident and dispatched however, prior to their arrival Frank phoned the Police to cancel as he believed he had panicked and should not have called. He informed them he was on his way home and requested that officers call him on his mobile. Simultaneously an officer on the local Diary Car informed FCR that they were currently trying to contact Olivia regarding her allegations arising from the incident a week earlier. They were assigned to attend her home address to speak with her in relation to both the allegations.

13.37 Frank told Police that he and Olivia were having marital problems due to ongoing issues with Olivia's drinking. He described he had had been driving for an appointment, when he refused to go into the appointment Olivia had tried to grab the car keys from him causing the scratches to his wrist. Olivia had then begun to pull at his top, he had then hit her arm with his mobile phone to prevent her getting the keys to the vehicle. He then got out of the vehicle, threw the keys at her and she drove off. Frank went on to disclose that he had been assaulted on previous occasions by Olivia, that she had burnt some of his clothing, tracked his movements using an app on his phone and monitored him via CCTV installed at their pub. A DASH RIC was completed, and he was assessed as medium risk, this was later subject of a supervisor's review and reassessed as standard risk.

13.38 In the meantime, Olivia was located at her home address by Police. She told them Frank had got lost on the way to an appointment, he had become aggressive towards her at which point she had tried to get the car keys off him. He then punched her twice on the right arm causing bruising, he got out of the car, threw the keys at her, and she drove away. She also discussed the previous allegations regarding Frank taking her car and bank card and informed them the car had been returned but the bankcard (for a joint account) had not. A DASH RIC was completed where she was assessed as medium risk, this was later reviewed and regraded to standard.

13.39 The incident that occurred at the start of August was updated by the OIC recording that the DAIT Detective Inspector had instructed that Frank should have his account obtained in relation to the allegation. Several calls were made to Franks's mobile phone with no reply (and with no answer phone facility). As a result, the investigation was submitted for filing via the supervisor with no further action. Attempts were made to contact Frank over the following weeks by phone without success. As a result, a supervisor reviewed the investigation and given that there had been no contact the investigation was filed with no further action taking place.

13.40 At the end of October Essex Police had not heard from Olivia regarding not wishing to make a statement, the OIC sent an email reminding her to send an email stating this. 5 days later Olivia responded stating that she did not want to pursue an allegation and thanked the officer for their help. The officer replied with a negative statement, requested she check for accuracy and sign it for the case papers, this was never returned.

13.41 On the evening prior to Olivia's death in mid-November Frank reported he and Olivia had had an argument, and he had left her at home and gone to their pub. Upon his return just after midnight he found her in the garden, unresponsive. He called for an ambulance and started CPR until Police and paramedics arrived, Olivia died shortly after 01:00 hours.

13.42 At Olivia's home Police seized a diary, the notes read;

*'The way you talked me then twist it I can't bear it anymore you really are a twisted person. I adore my girls the way you would lie to my face about drugs. You took me for a fucking idiot, and like one I believe you, more for me. You only know how to lie it seems. I told you never to lie to me, but again and again you did. You broke me. Without always hold your hand ski my put in, I'll always snuggle with you. My heart breaks, but I have no choice he's killed me. You promised me so much yet took everything from me, everything. My sweet girls you are my everything and every reason I still slash was here. For everything he says, his actions, mean I cannot cope anymore my beautiful babies who love unconditionally I will forever love you too. Your fault your choices, your (**unreadable**), your fuck up ....again'.*

"you have broken me beyond anything I ever imagined you are a total lie and deceiving cunt yes again you have ruined everything I gave you so many chances plus you blew it out of the park goodbye you did this and you don't care".

13.43 The word CARPETS was written in different handwriting and a line drawn to it "*FUCK OFF IM DEAD"*

14 Key themes

14.1 Agencies understanding domestic abuse and suicide/self-harm.

14.1.1 Domestic abuse is complex and those who abuse use multiple behaviours to ensure they maintain power and control over those they are in a relationship with. For family, friends, and professionals it can be challenging to identify the abuse especially when there are other compounding factors. For those subjected to abuse it can be terrifying, confusing, difficult to understand and ultimately dangerous to escape from.

14.1.2 There were several occasions where Olivia had reported being physically assaulted by Frank and photos had been taken. However, there is also evidence that Olivia was subjected to other abusive behaviours such as emotional, psychological, and economic abuse. These behaviours can at times be so subtle, difficult to recognise, evidence and proceed with criminal action. The University of Gloucestershire' research into Domestic Homicides and Stalking[18] found that 92% of all the homicides (reviewed), the victim had experienced Coercive and Controlling Behaviour (CCB) within the relationship.

14.1.3 It would have been beneficial for officers to have explored coercive controlling behaviours with Olivia but there is no evidence to suggest this was ever considered. The Crown Prosecution Service (CPS)[19] and College of Policing[20] provide guidance with regards to different behaviours which should be considered when determining whether the offence coercive control has been committed.

14.1.4 Coercive control is crucial to understand the dynamics of economic abuse and its impact on survivors, with 95% of women who experience domestic abuse reporting experiencing economic abuse. Olivia voiced her concerns regarding the financial impact her relationship was having on her, with these disclosures economic abuse should have also been explored as part of the coercive control.

14.1.5 Olivia and Frank moved in with each other within a couple of weeks knowing each other to save money, she then left her nursing studies to drive him around as a delivery driver, she used her life savings to purchase the pub, she was taking out loans to pay staff, he was blacklisted and could not borrow money, Frank had taken the joint bank card and car and she reported he had been threatened due to owing people money. She was also unable to work as his bail conditions were at the pub which meant it was not safe for her to be there.

14.1.6 To enhance the opportunities of gathering evidence at the scene and any subsequent conversations body worn videos are required to be activated at any domestic incident. These videos capture and increase the awareness of the emotional and psychological impact the abuse has on the victim and can provide vital insight not only to the Police but also other services. Cambridgeshire Constabulary are embedding a policy with partners to facilitate the sharing of body worn video in support of referrals. A picture paints a thousand words, and it is believed this will be useful in moving forward particularly for partners in making initial assessments following such referrals.

14.1.7 Suicide and domestic abuse research is still in its infancy, however, Prof. Rachel Kelby's 2014 research found that up to ten women a week took their own lives due to domestic abuse with a further thirty women a week attempting suicide. For many women they feel this is the only way to be free of abuse which was apparent with Olivia. The recent Vulnerable Knowledge Practice and Programme[21] (VKPP) report into domestic homicides and suicides between 2020 – 2022 found that female victims were by far the most common to take their own lives (85%) with male perpetrators (84%), with 88% of all those who died being of white ethnicity. Also suicides during this period were higher than those who were murdered by their ex/partners of family members. It is therefore essential the impact is understood and responded to.

[18] https://www.glos.ac.uk/content/homicide-research-group/
[19] https://www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship
[20] www.college.police.uk
[21] https://www.vkpp.org.uk/assets/Files/Domestic-Homicide-Project-Year-2-Report-December-2022.pdf

14.1.8 The Suicide Timeline by Jane Monkton-Smith outlines 8 stages a victim's risk when there are thoughts of suicide. These are:

1. ***The perpetrator has a history of abuse:*** Frank had a history of domestic abuse.
2. ***The relationship starts quickly or intensely:*** Olivia and Frank were wearing rings to show commitment to each other by their second date, they had moved in with each other within a couple of weeks, they were engaged within 3 – 4 months of knowing each other, had purchased the pub within 5 months of meeting and married 4 months later.
3. ***There is a relationship dominated by control:*** Olivia shared how Frank was controlling, there was economic abuse, she was isolated from friends and family, was unable to work at the pub and had been subjected to several violent assaults.
4. ***The victim starts to disclose as they become more distressed by the abuse or violence:*** Olivia reported the abuse to different organisations.
5. ***The victim starts to actively seek help from agencies like the Police, Mental Health services, GPs or IDVAs:*** Olivia was seeking help from many of these services even though she was clearly struggling to engage.
6. ***The victim starts talking about ending their life as the abuse is persistent and intense:*** Olivia made multiple attempts to take her own life whether by placing the dog lead around her neck or with medication and alcohol.
7. ***The victim says they feel completely trapped by the perpetrator and will never be free:*** Olivia makes it clear that all her money is in the pub, and she is struggling to manage life and drinking to cope with abuse at home. In her final diary entries found by the police. She wrote "*My heart breaks, but I have no choice he killed me*". "*You have broken me beyond everything I imagined".* It appears Olivia could see no way out of the relationship.
8. ***There is a suicide:*** Olivia took her own life.

14.1.9 Olivia had told agencies she was suicidal, and although many agencies are aware of the risks of homicide to victims of domestic abuse the stages outlined above are not so prevalent within services risk assessments. Additionally, Olivia was also demonstrating the 3 steps of suicide:

- ***Stage 1 - The "ideation" stage;*** *During this stage, the person who takes their lives will consider the consequences and be unsure of whether they will go ahead*. Olivia tells Police that she does not feel she can continue to live but although she makes attempts tells agencies she does not feel suicidal. The notes found after she had passed away clearly display her devotion and love for her children and the pain, she felt at leaving them, clearly thinking of the consequences to them.
- ***Stage 2 – The "planning" stage;*** *The person feels compelled to plan suicide (thus moving into Stage 3) or not to at that time; a decision that most people do not discuss with loved ones and often wrestle with in isolation*. It is unclear whether Olivia had planned to take her own life the night she died; however, from her diary entries it appears she could not see any other way to be free from Frank's abuse.
- ***Stage 3 - The decision to suicide;*** *The moment the decision is made, it goes "unconscious", and the person goes on "auto-pilot." People in Stage 3 are imminently lethal; however, they seem more "normal" than they have seemed in a long time. At this point, the depression seems to suddenly lift because the person has made the decision to die and is no longer wrestling with the decision. Unfortunately, most mental health professionals and family members are not trained to recognise "auto-pilot," as the patient seems so much better, not realizing they will take their own life. People on "auto-pilot" typically attempt suicide within the next 48 hours*. No one knows what happened in the last hours of Olivia's life, what was said in the argument and what her thoughts were that evening. However, at the final moments of her life she made the decision that to die was the only option for her.

14.1.10 The Government Suicide Strategy 2023 – 2028 recognises that although there is ongoing work across government to address different presenting factors with regards to suicide, there are some specific factors (many of which are linked to these wider determinants) to be addressed as a priority, one of which is domestic abuse. The strategy suggests local suicide prevention and domestic abuse strategies work together to ensure a coordinated and collaborative approach to victims and perpetrators who are at high risk of harming themselves.

14.1.11 Essex has a Suicide Strategy (2019) which does not reference domestic abuse and its risks. In 2020 public health wrote a report to the Health and Wellbeing Board outlining the requirement for a new strategy to be developed. A member of SETDAB will attend this working group which will include domestic abuse. It is essential that the new Suicide Strategy includes domestic abuse with both strategies complimenting each other with the advice and information.

14.1.12 Olivia's death was investigated and there were no apparent suspicious circumstances. Essex Police has a policy which ensures there is a robust investigation when there is a sudden death, domestic abuse is highlighted as an area of enquiry with a requirement that all checks are completed on the history and risks present to the person who has died.

14.1.13 Cambridgeshire Constabulary assess for previous call history at the address, and this is shared by the radio operators with the attending officers. Every sudden death is attended by a Sergeant and where there are concerns regarding the circumstances or if there is a history of Domestic Abuse or other concerning factors, a Detective Inspector may be requested to attend.

14.1.14 It is essential that both forces ensure these policies and processes are put into practice with robust managerial oversight. To ensure there is a uniformed response to suicide and the possibility of domestic abuse the National Police Authorised Professional Practice should be revised to require parties to all apparent non-suspicious sudden unexplained deaths to be searched against police and partner agency databases to identify any history of domestic abuse, and where found, the investigation of the death should be led by a detective officer at the earliest opportunity.

14.2 Reliance on signposting

14.2.1 Olivia was 'directed' or 'signposted' to a variety of services by many agencies at different stages even though she was already clearly struggling to engage with services. It did not necessarily mean she did not want the support as she was surviving an abusive marriage and trying to manage her alcohol use and her business. Although signposting may at the time achieve a goal and meet a 'safeguarding target' the onus is put solely on the vulnerable person to engage which is not appropriate when they are in a state of crisis.

14.2.2 Agencies need to be able to work in a trauma informed and person-centred way. The IDVA was able to demonstrate this when they completed the individual support plan asking Olivia about her wishes. They were able to offer calling 101 or making the referral to NCDV which Olivia accepted. There were occasions where she declined some support, but she was able to have the choice to make these decisions.

14.2.3 Those in a state of trauma or 'crisis' reach out to those who they trust and seek support after the disclosure. For victims of domestic abuse asking them to call another service and repeat their need is re-traumatising and can create a barrier in them seeking help.

14.2.4 Victims of domestic abuse experience a power imbalance where their abuser has asserted their control and power over them. Organisations need to provide victims 'agency' over their lives and the ability to make a choice. Even though 'signposting' or 'directing' may appear to achieve this, where possible practitioners should offer to also refer victims to specialist services. Where practicable those working with vulnerable people need to be have the time to have in depth discussion about what is happening so a full picture can be gained and options discussed. The weight, fear, and struggle for victims to pick up the phone to services can at times be too much and if consent is given agencies should be proactive in referring to services.

14.3 Trio of vulnerabilities, intersectionality and how domestic abuse was lost.

14.3.1 Previously the term 'Toxic Trio', would have been used to describe the co-occurrence of domestic abuse, substance misuse and mental health. It was used to support professionals, however over recent years this term has been identified as narrow and does not acknowledge the wider complexities faced. A 2020 study from the National Children's Bureau[22], the University of Kent and the University of Cambridge found that there was little robust research or evidence to quantify whether a combination of the three factors resulted in an increased risk of abuse or neglect. The NSPCC[23] describe how when practitioners who only work within these three headings miss other contributing risk factors which may be barriers to working with agencies and trauma (all which Olivia had experienced), is now called 'Trio of Vulnerability'.

14.3.2 Olivia had experienced domestic abuse throughout her relationships, those who are subjected to this can experience Complex Trauma[24]. This involves a person experiencing repeated traumatic events over a period with each traumatic event compounding the impact of previous trauma experienced and because of the repetition, there is little to no time for recovery between incidents. Some people with Complex Trauma can become trapped in a stress response leaving them in a constant state of hyper-vigilance where they may present as they did with Olivia as agitated, uncooperative, argumentative, use alcohol and have 'mental health' issues.

14.3.3 Where domestic abuse, substance use, and mental ill-health intersect they can create challenges not only for the individual but also for agencies as practice and policy responses are often siloed and fragmented. Until these different layers are explored individually, yet pieced together, vulnerable people will continue to face the barriers.

14.3.4 Kimberlé Crenshaw first introduced the term intersectionality in 1989[25], intersectionality is the concept that all oppression is linked. More explicitly, the Oxford Dictionary defines intersectionality as "*the interconnected nature of social categorisations such as race, class, and gender, regarded as creating overlapping and interdependent systems of discrimination or disadvantage*". Intersectionality is the acknowledgement that everyone

[22] https://www.ncb.org.uk/about-us/media-centre/news-opinion/poor-evidence-around-toxic-trio-poses-questions-child-protection
[23] https://learning.nspcc.org.uk/news/why-language-matters/how-toxic-trio-is-unhelpful-and-inaccurate
[24] https://uktraumacouncil.org/trauma/complex-trauma
[25] https://en.wikipedia.org/wiki/Intersectionality

has their own unique experiences of discrimination and oppression, and we must consider everything and anything that can marginalise people – gender, race, class, sexual orientation, physical ability, etc.

14.3.5 Intersectionality is primarily a tool for understanding invisible power relations and how they shape inequality, not identity. Intersectionality looks at "interlocking" systems of oppression and how these play out in individual's lives. When we explore Olivia, she was:

- a woman,
- in her late 40's,
- a victim of domestic abuse,
- had cerebral atrophy
- alcohol addiction,
- mental ill-health

With these multiple layers, she faced not only battles with each individual factor, but they also compounded each other and the totality of her being.

14.3.6 Society does not treat all victims of abuse equally. Social biases influence how society perceives survivors of domestic abuse, and stereotypes often create barriers for care and assistance. When we consider Olivia and the different intersectional barriers, she faced in accessing support we can identify that her suicide attempts, alcohol use and her presentation influenced responses. Our unconscious bias makes it hard for us to recognise when someone may be vulnerable. Unconscious bias happens when our brains make incredibly quick judgments and assessments of people and situations without us realising. Often these are based on social stereotypes, which we may not even realise we hold. Everyone has unconscious bias, and it can impact in how we interact and respond to those we are working with. Olivia, presented with mental ill health and substance misuse and it is possible her presentation influenced the response she received. We all need to be aware of their unconscious bias, and how these impact on the interaction with others to ensure it does not create a barrier in the response we give to those in need of support.

14.3.7 Although domestic abuse was only mentioned within one of her GP notes it coincided with the increased presence and awareness of her drinking. Victims of domestic abuse may use alcohol as a coping mechanism to 'dull' the impact of the abuse. It can leave them vulnerable to further abuse due to the risk of being unable to protect themselves and the perpetrator using alcohol as a form of abuse. When professionals are working with people who use alcohol, take substances, or have 'unhealthy lifestyles' contributing factors behind the behaviour should be considered. Olivia had numerous contacts with her GP all regarding her mental health and alcohol, but she was never asked about the domestic abuse once they became aware. This was a missed opportunity to have fully explored the casual factors to Olivia's behaviours rather than dealing with those that could be seen.

14.3.8 The recent Domestic Homicide Oversight Report 2023[26] found that within the reviews in 2020 – 2021 61% of victims had a vulnerability, of these 34% were mental ill health and 28% problems with alcohol. Those that had a mental health vulnerability, 15% had

[26] https://www.gov.uk/government/collections/domestic-homicide-review

suicidal thoughts and even though all agencies were aware of the domestic abuse the focus remained on the mental health and alcohol rather than the possible causal issues.

14.3.9 For substance misuse service users across Southend, Essex & Thurrock, practitioners who complete an initial assessment for someone entering the treatment system are now required to ask specific questions around domestic abuse under the new National Drug Treatment Monitoring System[27] (NDTMS) requirements. In 2021 NDTMS published a Consultation on proposed amendments to the data set collected to include specific questions on domestic abuse. These have since been implemented and is monitored this quarterly. This will hopefully increase the identification and offer of support to those who are or have been subjected to domestic abuse and are using substances.

14.3.10 SafeLives[28] found that people with mental health needs were more likely to experience all forms of domestic abuse than those who did not. They were also more likely to have drug and alcohol misuse problems. In the last fourteen months of Olivia's life (when she was with Frank) her mental health deteriorated, her use of alcohol increased significantly and her calls to Police increased. SafeLives report 43% of victims who had mental health needs had self-harmed or planned/attempted suicide. Additionally, the impact economic abuse had on Olivia's mental health mirrored a Women's Aid study for the TUC 2015 with eight in ten women stating their mental health had been affected by financial abuse[29].

14.3.11 Although individuals have 'capacity' within the framework of the Care Act, it is and would have been beneficial for agencies to explore if and how the coercive and controlling behaviour impaired her capacity to safeguard herself and what interventions are/were available. With regards to Olivia's hoarding and self-neglect this could have been a way for professionals to have tried to help her with managing these areas of her life whilst exploring the domestic abuse at the same time.

14.3.12 SafeLives summarised their findings:
There is a link between domestic abuse and mental health problems. Mental health problems are a common consequence of experiencing domestic abuse, both for adults and children. Having mental health issues can render a person more vulnerable to abuse. It is therefore perhaps unsurprising that a significant proportion of people accessing mental health services have experienced abuse. Despite these strong associations, domestic abuse is often going undetected within mental health services and domestic abuse services are not always able to support people with mental health problems.

14.3.13 It appears the agencies working or responding to Olivia continued to focus on her mental health and substance misuse rather than the context and environment behind the presenting behaviours which was having a significant impact on her wellbeing and safety. This resulted in them responding to the presenting behaviours 'on the surface' rather than exploring the circumstances underneath[30].

14.3.14 Within Southend, Essex and Thurrock the Dual Diagnosis meeting has recently been reviewing its Terms of Reference which domestic abuse is included. Members are represented by statutory and voluntary organisations. The SETDAB team also have a

[27] https://assets.publishing.service.gov.uk/media/609d33c5d3bf7f2888d19031/NDTMS_Core_Dataset_Q_Consultation.pdf
[28] Spotlight 7 - Mental health and domestic abuse.pdf (safelives.org.uk)
[29] https://survivingeconomicabuse.org/wp-content/uploads/2020/11/Statistics-on-economic-abuse_March-2020.pdf
[30] The Iceberg analogy - https://www.simplypsychology.org/unconscious-mind.html

specialist domestic abuse worker who attends these meetings to ensure it continues to be on the agenda and is considered when any cases are discussed and/or reviewed.

14.4 Agencies unable to engage with Olivia.

14.4.1 Every service who had contact with Olivia had a history of struggling to engage with her and although they made repeated attempts to make contact these attempts were narrow in their way in which they were communicated.

14.4.2 Essex Police were reliant on Olivia answering the phone during their investigations. When these were not answered, they did not consider going to her home address to see if she was available to speak. On some occasions the notes record conversations that were had with Olivia however, it is unclear when or by what means these occurred.

14.4.3 Olivia continued to miss appointments and not engage especially with mental health services, and proactive steps were taken to contact her. However, when she was either re-referred or self-referred, she was never asked what the barriers were for her previously to engaging with the service.

14.4.4 Throughout Olivia's notes with all services the language of 'non engagement' or 'did not engage' was repeated time and again. But there were no discussions with Olivia or exploration why she felt she could not engage with the service at that moment. Victims who have experienced trauma, are subjected to abuse, and have additional complexities may not feel able to engage, this does not mean they do not want the support but that they are struggling to manage in the moment.

14.4.5 Agencies need to be able to understand the 'Cycle of Change[31]' for those who are subjected to domestic abuse and trauma where they are on the cycle. The Five stages are:

- **Precontemplation:** not aware that there is a problem and is not interested in change.
- **Contemplation:** beginning to recognise that there may be a problem and weighs the pros and cons of changing. In this stage, it can be hard to identify ways of changing or even imagine how to make the change.
- **Preparation:** recognises there is a problem and decides to make a change by making plans, seeking help from experts and professionals on how to change, and coming up with concrete steps for an action plan.
- **Action:** implements a plan for change and is actively working on changing. Continues to seek help from supportive people and professionals and adjusts the plan as needed.
- **Maintenance:** continues to maintain the change and progress made, recognising that change is a journey and not a destination and that relapse is possible.

14.4.6 As we can see Olivia moved between contemplation and action as the cycle is linear, and victims can go through the stage's multiple times. If agencies understand where someone is on the 'cycle' support can be adapted to meet the current need ensuring it is appropriate at any stage.

14.4.7 Trauma can be fundamentally life-altering, especially for individuals who experienced repeated and prolonged abuse. The experience of trauma can shape a person's way of viewing and being in the world; they may come to see themselves as fundamentally flawed and perceive the world as a pervasively dangerous place. Unsurprisingly, individuals who have experienced abuse can be reluctant to engage with services.

[31] https://www.genesisshelter.org/stages-of-change/

14.4.8 When agencies try to engage with those who have been subjected to abuse and have experienced trauma they require positive relationships for any recovery. Victims of trauma become vigilant and wary, which is an important and understandable self-protective mechanism when coping with exposure. These same ways of coping may also make it more difficult to feel safety and trust in those trying to help or in family and friends. More and more agencies are becoming aware of the prevalence and impact of trauma which has led to many adopting a trauma-informed approach which specifically work to make individuals feel safe and avoid re-traumatisation. When we consider Olivia, how did the trauma impact on her making choices at the time? What was the impact if she engaged with the investigation? She was isolated, dependent on him and ultimately frightened which would all have had a significant impact in how she engaged with services.

14.4.9 To try and mitigate these barriers and adopt a trauma-informed approach agencies, need to understand and accept that those who are traumatised may not meet criteria required for the service or support offered. Therefore, services need to ensure their policies and procedures can 'bend and flex' in how they respond to those in need and need to remain at the centre of the work we do. Additionally, they must understand the key principles that underline trauma-informed work which are:

- Safety
- Trust
- Choice
- Collaboration
- Empowerment

14.4.10 Once these are embedded in practice, policy, process, and the organisational culture, those who may have appeared not to have previously engaged may engage in the future.

14.5 Expectations, Process, and procedure not met.

14.5.1 Essex Police repeatedly failed to meet the expectations of the force with regards to the response to victims, investigations, and supervisory reports. Force Procedure[32] makes it clear that where a victim of domestic abuse does not wish to provide an evidential account or having provided an evidential statement wishes to make a retraction that a written statement explaining that they do not wish to provide an evidential account or wishes to make a retraction statement must be obtained.

14.5.2 On all occasions in which the victims, be that Olivia or Frank, they should be provided with an information for Victims of Domestic Abuse (PP75) leaflet this was not done or a reason for not doing so was not recorded within the Athena investigation logs, this is contrary to Force Procedure.

14.5.3 Officers investigating the allegation from May, August and September 2022 did not consider the use of an ABE interview to secure Olivia's evidence. Given the nature of the allegations and Olivia's mental health (depression and self-harm) and that on two of the occasions (May and August) had been identified as being at high risk she may have met the criteria of either or both a vulnerable and intimidated witness. Instead, officers either

[32] Essex Police Procedure B1701 – Domestic Abuse Initial Grading and Attendance.

took or pursued the obtaining of a written statement. APP[33] and Force Procedure highlights that investigators should, when dealing with victims of domestic abuse, be aware that they may be vulnerable and or intimidated and as victims of domestic abuse eligible for enhanced service under the Victims Code[34] and must explain to the witness the use of special measures and record the views the witness may express about applying for them.

14.5.4 This did not happen in any of the investigations and may be indicative of a wider lack of understanding by staff within the organisation (particularly on the LPT's) of the use of ABE interviews to secure best evidence and therefore affording vulnerable or intimidated domestic abuse victims' access to special measures at subsequent prosecutions.

14.5.5 Force procedure also makes it clear that officers should activate their BWV when dealing with incidents of domestic abuse and downloaded in the event of criminal allegations. This did not happen following the interactions with Olivia or Frank at the end of September 2022 with both officers failing to retain footage.

14.5.6 The current risk assessment process relating to domestic abuse is currently under review by Essex Police having recognised the limitations of the DASH RIC. The current DASH process has since been replaced with DARA[35] which all officers and supervisors have received specific training for. This evidence-based assessment reduced the question set and is intended to prompt fuller responses from those being assessed rather than providing Yes/No answers. It is hoped that with the introduction of DARA there will be greater disclosure from victims particularly around coercive and controlling behaviour by abusive partners (recognised as the precursor to most domestic abuse homicides between intimate partners).

14.5.7 When there are dual allegations made the process is reliant upon those individuals recognising the allegation amounts to a crime and that the matter requires recording followed by a proportionate investigation. To support officers and police staff in achieving this, training is provided and is subject of Continued Professional Development throughout their time with the service, including specific training when new legislation is enacted utilising Computer Based Training and/or traditional face to face training within a classroom environment. Specific Domestic Abuse training has been developed by Essex Police, this has been delivered to all frontline staff and an evaluation has been conducted which received extremely good feedback. This training consisted of presentations from several keynote speakers including psychologist Malcolm Hibberd, Luke Hart & Ryan Hart from Coco Awareness, Lucy Whittaker from Alpha Vesta, and input from specialist domestic abuse officers within Essex Police. Additionally, the force obtained over 350 licences for the Professor Jane Monkton-Smith (homicide timeline) training to support the learning and development of officers.

14.5.8 Essex Police are currently the only force to have a domestic abuse specialist investigators course (1 week) and they have shared the course timetable with the College of Policing to aid them in designing this as a national course.

14.5.9 Additional guidance and advice are contained within Policies & Procedures which are always available to staff and are updated regularly. Further guidance and advice can be

[33] College of Policing APP – Domestic Abuse (Victim and Witness Evidence) – Essex Police Procedures B1701 – Domestic Abuse Initial grading and Attendance & B1702 – Domestic Abuse Investigations
[34] Ministry of Justice (2015) Code of Practice for Victims of Crime
[35] Utilised by several forces within the UK and developed by the College of Policing in conjunction with Cardiff University

obtained from specialist teams including the Central Referral Unit, Domestic Abuse Investigation Teams, and Domestic Abuse Problem Solving Teams.

14.5.10 Even though these changes have been put in place this review has been able to identify there was no consistent response to Olivia and there were repeated failures by different departments to adhere to force procedures. Essex Police must ensure they do not become complacent in the work completed. Once the training has been completed, there must be provision to ensure processes and procedures are being followed, otherwise nothing will change.

14.5.11 EEAST were clearly concerned for Olivia and made several referrals to adult social care. In June 2022, the pathway for referral from EEAST to the Local Authority were different to what they are now. The main change is the referral is now able to be made using an integrated system straight to the Local Authority, rather than a trigger email.

14.5.12 The route the referral takes, still centres around the set of questions that are asked by the SPOC[36] staff member to the crew member who is reporting their concerns. On the three occasions that referrals were made for Olivia, the following question was asked "*Do your concerns relate to mental health and/or substance misuse?*". The answer to this question was "*Yes*", thus directing the referral as "*GP Support - Mental Health Referral*". The system would have superseded any Safeguarding referral based on the other answers provided to the other 'trigger' questions. The summary of the concerns is still seen by the GP, who has the option to refer on to Social Care if deemed necessary.

14.5.13 Every time EEAST attended calls to Olivia, their expected time of arrival was never met. These were due to service demands and other priority calls. Since September 2023, there is a new way in which Category 2 – C2 emergency calls (known as C2 segmentation) are managed. C2 segmentation is being introduced nationally, following approval by NHS England and the Emergency Call Prioritisation Group, and after successful trials and roll outs by the West Midlands and London Ambulance Services. Patients should receive a more clinically accurate response, and an ambulance will be dispatched where appropriate and based on clinical need. Certain C2 code sets have been identified nationally, to be of lower acuity and more suitable for a hear and treat response rather than a traditional ambulance response.

14.5.14 Under the new system, appropriate C2 calls will be quickly assessed by a clinician to identify the patient's immediate need, including if an ambulance is required. The two segments of Category 2 calls moving forward are:

- Immediate Dispatch: (Cat2A) The C2 call will receive an ambulance response as soon as a resource is available.
- Clinical Navigation: (Cat2 B and C) The call will be assessed by a clinician to ensure that an ambulance response is appropriate. Patients can be directed to alternative care pathways where appropriate.
- For the crews, nothing changes in terms of their response to, or treatment of, patients in the C2 category. All patients in the C2 category still require a blue light response if dispatched. The intention is to ensure that calls that are responded to by our crews within the C2 category are validated for an ambulance response.

14.5.15 The ECAT (Emergency Clinical Advice and Triage) teams already undertake this process with C3, C4 and C5 calls, with some predefined C2 code sets also managed in this way.

[36] Single Point of Contact

C2 segmentation will increase the number of patients receiving clinical contact by the ECAT team, this in turn will help ensure that crews attend the appropriate C2 calls.

14.5.16 The benefits of C2 segmentation are:

- More accurate assessment of calls in the C2 category to identify patients that require an ambulance response.
- Improved patient safety.
- Reduction in C2 mean response times.
- Care that is more tailored to a patient's individual needs.

14.6 Evaluation of risk and sharing information

14.6.1 Olivia was facing multiple factors which increased her risk, these were at times recognised by Police, also at times the risks were not identified and/or were 're-graded' as well as the supervisory review escalating the risk.

14.6.2 From the DASH Olivia disclosed:

- Injuries.
- It is not recorded that she was frightened, however she had sought help from the police and told officers she had a panic attack when he had his knee on her chest which would indicate some element of fear.
- She had no contact with her family and due to the stress at the pub struggled to go to work. She also spoke of not having any friends since moving to a new area.
- The domestic abuse was impacting her mental wellbeing.
- She was suicidal and made attempts to take her own life.
- The abuse was happening more often (this was apparent by the number of calls to Police over such as short period of time).
- There were significant allegations of assaults which appeared to be getting worse.
- He had threatened to kill her on numerous occasions.
- He was watching 'homosexual' pornography.
- He had grabbed her by the throat on several occasions (these were reported at different times to officers) and had restricted her breathing by kneeling on her chest.
- He had been hurt previous partners.
- There were financial issues with the pub and the use of the joint bank account.
- He was feeling depressed, using alcohol, and allegedly using cocaine.
- He had told his GP that he had thought about suicide.
- He breached orders.
- Frank had a history of domestic abuse perpetration.

Additional risk factors:

- The relationship became serious within weeks.
- Self-neglect.

14.6.3 It is evident that Olivia was at high risk of serious harm from Frank, and although a DASH RIC was completed on every occasion with the Police she was assessed as medium risk even though frontline officers were aware of the current or previous investigations. It is unclear why this was but indicates a lack of understanding of the risks Olivia faced. Once she had been heard at MARAC, every incident and subsequent DASH RIC should have resulted in her being re-referred. This would have enabled partners to look at previous

actions and how further interventions could have supported her; however, she was only heard twice.

14.6.4 Cambridgeshire Constabulary, the GP and the hospital were all unaware of the MARAC and therefore did not know the risks and concerns Frank posed to Olivia. Although it would not be reasonable to expect GPs and the hospital to attend the MARAC (due to their short notice and the pressures on GP practices) it would be beneficial if there was a system where information and risk could be shared with boarding services. For those coordinating the MARAC there are limitations in what they can share and scope due to the sheer numbers of cases and limitations regarding Information Sharing Protocols. However, these meetings have highlighted the importance of seeking a solution in how information can be shared for high-risk victims when there are such close links with boarding partners.

14.6.5 The Police and IDVA were the only organisations to complete the DASH RIC with Olivia even though there were disclosures of domestic abuse to hospital and ambulance staff. It would not be expected by EEAST crew, yet for those within the hospital they should have known when and how to complete the risk assessment and how to make any onward referrals. Again, with the pressures on the NHS this may have had a significant impact on how medical staff would be able to do this and also Olivia did not spend any significant amount of time in hospital, and it may have been impossible to have completed one in the time she was with them.

14.6.6 With the concerns regarding Olivia being high risk, the coercive control, physical violence, suicide threats and attempts, economic abuse, and the psychological impact on her there was a gap in how the two forces communicated information with each other. Although both have Athena the concerns and the risks went much deeper than just the information on Athena. The Cambridgeshire MASH[37] is intuitive at identifying risks in other counties and communicating that information, unfortunately Essex does not have a MASH function and therefore this mechanism is not available which is an effective way of triggering these concerns, which Athena does not do.

14.6.7 It was an opportunity that was overlooked by Essex to have shared further information with Cambridgeshire Constabulary when they had asked them to arrest Frank at the pub and provide them with further detailed information. With this additional intelligence they would have been able to respond to calls or have alerts on their systems with regards to the risks to Olivia.

14.6.8 This was explored with Essex Police in greater detail, the force borders with five forces, all of which utilise the same crime recording system; ATHENA, albeit only four of these five are currently visible to one another (Metropolitan Police Service is currently unavailable due to different systems). However, long term plans have been made to ensure this will be rectified. The sharing of information generally with bordering forces without any specific necessity would not be possible, as with over 30,000 domestic abuse reports each year in Essex, it would be disproportionate to share details each time with other forces. There is currently not the infrastructure to do this, there would be GDPR issues to consider, and finally forces are not set up to receive and handle this. All forces however have access to the PND which all investigations and intelligence is uploaded to and visible to all 43 forces nationwide. In Essex we update our feed every 24hrs, so our information is timely.

[37] Multi-Agency Safeguarding Hub

14.6.9 Essex, the Domestic Abuse Investigations procure requires (3.2.1) stated that:

'Every staff member and officer involved in any investigation must be satisfied that appropriate system checks have been completed and that the risk assessment and safety planning is appropriate. This includes the requirement to undertake PND checks in all DA cases where the victim and/or perpetrator live outside of Essex (or outside of an Athena Force area) or have previously done so. If a review of the risk assessment leads to the risk level being re-graded, then the Sergeant must ensure that the relevant support agency is notified.'

14.6.10 To ensure Essex officers and staff share information with partner agencies/forces where appropriate, the Domestic Abuse Initial Attendance and Grading Procedure states:

'Consideration should be given for the referral of the victim or children to relevant agencies for support and assistance, including refuge or other specialist support services as appropriate. Any referrals made should be documented on the Athena record or sent via tasks for other Departments to be aware of and act on. Local authorities have an initial duty to provide access to emergency temporary accommodation'.

14.6.11 There is a high level of confidence that this is achieved, and for all domestic abuse investigations which are or High or Medium risk, the safeguarding is reviewed and enhanced by the Domestic Abuse Review Team (DART+). The DART+ team will liaise and share information with internal and external agencies, partners, departments, and other police forces in respect of the initial safeguarding of victims, children, and vulnerable adults. The responsibility of the safeguarding will then be passed to the OIC working closely alongside an IDVA or any other partner agencies supporting the victim.

15. Learning and Recommendations

15.1 Essex Police

Learning 1 - Supervisory reviews are fundamental to ensure the effective, proportionate, and timely conduct of investigations particularly when, as in this case, a victim has been identified as being at high risk. It was not clear whether this was systematic across the organisation.

Individual recommendation 1 - The Senior Management Team for the North Local Policing Area should consider and provide the appropriate individual management feedback to the Detective Inspector responsible for undertaking reviews for the mid-May 2022 investigation into the allegations of assault and threats to kill and the need to undertake and record reviews at the appropriate times within the lifetime of an active investigation.

Individual recommendation 2 - In relation to the supervision from the allegation of assault at the beginning of August 2022 there should be a review by the Senior Management Team of the relevant Command and where necessary the appropriate feedback provided.

Organisational recommendation 3 - Essex Police should undertake analysis of concluded domestic abuse investigations across the organisation to determine if there is a systemic failing in the undertaking of Inspector Reviews at the appropriate times during the lifetime of

investigations. Dependent on the outcome action should be taken to address any identified issues.

Learning 2 - The officer initially obtaining an account from Olivia (during the May 2022 investigation) recognised the need to record the allegation of a historical rape in Cambridgeshire in 1988 however they did not obtain her account within a Public Protection Investigation Booklet (PPIB) in accordance with Procedure.

Individual recommendation 4 - The Senior Management Team for the North Local Policing Area should consider and provide the appropriate individual management feedback to the officer obtaining the allegation of historical rape reported during the incident in May 2022 regarding the requirement to complete Part 1 of the PPIB when receiving, as the FRO, an allegation of serious sexual assault.

Learning 3 - It is not clear if the practice of engaging with reluctant victims utilising text messages or emails to audit that a victim of domestic abuse does not wish to make an allegation has become accepted practice. If it has, it needs to be addressed by the organisation.

Organisational recommendation 5 – Essex Police should undertake an assessment of concluded investigations across the Force to determine if the practice has in fact become common practice and if necessary, take the appropriate action to address it.

Organisational recommendation 6 - Essex Police should, using CPD and/or the issue of internal communications, ensure that staff are aware that a victim of domestic abuse may meet the criteria for the obtaining of their evidence via an ABE and their responsibilities under the Victims Code to consider and discuss this as an option with victims.

Learning 4 - Body Worn Video is expected to be activated for all domestic abuse incidents and downloaded, which did not occur in September 2022.

Individual recommendation 7 - Appropriate feedback should be delivered to both officers in the form of reflective practice regarding their obligations to record and retain material during an investigation in accordance with the CPIA.

Learning 5 - The conduct and quality of the investigation regarding the assault at the beginning of August 2022 did not meet the force expectations and was inadequate. Additionally, although there are records that safety planning was provided these discussions did not happen, therefore the records are false and inaccurate.

Individual recommendation 8 - The Senior Management Team for the North Local Policing Area[38] should undertake a Severity Assessment by the Appropriate Authority of the relevant Command in relation to the actions of the officers and supervisors involved in the investigation into the allegation of assault made by Olivia in August 2022 and where necessary undertake the appropriate action.

Learning 6 - The conduct of the investigation into the allegations of assault, theft, and TWOC at the end of September 2022 did not meet the standards of Essex Police.

[38] Each LPA has a designated senior officer (Appropriate Authority) responsible for assessing the conduct of staff where potential issues regarding performance/conduct have been identified. Following an assessment, recommendations can range from staff being required to undertake 'reflective practice' to learn from incidents or in the case of significant misconduct a recommendation can be made to undertake disciplinary hearings resulting in sanctions including dismissal from the service.

Organisational recommendation 9 - The Senior Management Team for the North Local Policing Area should undertake a Severity Assessment by the designated Appropriate Authority in relation to the actions of the officers and supervisors involved in the investigation into the allegation of assault made by Frank and Olivia at the end of September 2022 and where necessary undertake the appropriate action.

Learning 7 - Victims not receiving the leaflet for victims of domestic abuse or the completion of a documented safety plan (Frank did not receive this in September 2022) has been previously highlighted in other Essex DHRs, and most recently in a DHR in which the victim took their own life. This reinforces an apparent systemic failing by the organisation to conform to the requirement to provide the PP75 victims of domestic abuse, the requirement to complete safety plans and a lack of supervision by line managers to ensure that this has been done.

Organisational recommendation 10 – Essex Police should in the first instance issue internal communications to staff reminding them of the requirement for Safety Plans (DV5) to be completed for all domestic abuse related investigations along with the requirement to provide a copy of the Athena Risk Assessment Information Leaflet (PP75) to all victims of domestic abuse. In addition, Essex Police should put in place a process to ensure that staff adhere to the requirements set out within Force Procedure.

15.2 Cambridgeshire Constabulary

Learning 8 - Although Cambridgeshire Constabulary were aware of the domestic abuse and that Olivia was high risk of harm, there was no update or sharing of information to enable the two Police forces to work in partnership with regards to disrupting Frank's behaviour and safeguarding Olivia.

Unfortunately, there is nothing in Athena to automate this process and on that basis, and Police are reliant on MASH staff identifying the fact that the DASH RIC falls within the defined area and sharing accordingly.

Organisational recommendation 11 - Where high-risk victims of domestic abuse have a proximity to county boundaries and which may involve having contact with the respective police forces and statutory agencies, it is imperative that information sharing between the statutory safeguarding agencies across those areas is made accordingly.

Learning 9 - Cambridgeshire Constabulary did not make the relevant checks as required with regards to the history or the risks relating to Olivia and Frank. Where there is an inference of domestic abuse in a recorded incident, relevant searches should be made of all persons named to ensure that safeguarding actions are comprehensively addressed.

Cambridgeshire Constabulary are confident this generally occurs as standard practice and believe this was an oversight on this occasion as a result of the crime being raised by Cambridgeshire and transferred to Essex for their investigation. Given that Cambridgeshire would not have investigated or participated in the investigation beyond raising it and transferring it, this appears to be why this research was not carried out. The incident was THRIVE assessed and it was determined that there was no immediate risk to Olivia in Cambridgeshire, hence the action taken. Had the incident remained as a Cambridgeshire case, research on all parties would have been completed.

15.3 Essex MARAC

Learning 10 - Both MARAC'S lacked the detailed information required to be able to identify risks and support Olivia with regards to a safety and support plan. This was mainly due to the core services who had detail of Olivia being in Cambridgeshire.

Organisational recommendation 12 - Explore the options of Information Sharing Protocols with partner counties, invite those who are identified to are involved with the victim/perpetrator or children, share the risk matrix, and explore actions to other geographical areas.

Learning 11 - There were only 4 people at both MARACs, with 3 of these being from Essex Police and the other an IDVA. Due to the lack of core and specialist services input and contribution to the meeting the chair and others were restricted in the different actions they could set.

National recommendation 13 - MARAC to be made statutory to ensure the core agencies and those who are identified supporting victims and perpetrators have a duty to share information, attend meetings, take actions, and make organisations accountable for these.

Local recommendation 14 – MARAC to carry out an annual review of agencies who attend and do not attend and present this to SETDAB with the aim for further discussions in how core and specialist agencies can be present in the future.

15.4 Next Chapter

Learning 12 - When Olivia's IDVA went on leave she was not informed of this, and the actions set from MARAC were not completed within the expected standards of the service.

Organisational recommendation 15 - To ensure that all practitioners are aware of their responsibilities to follow-up actions and that there is greater consistency across the team in relation to the effort put into engaging clients where contact is proving difficult, or they are wavering around accepting IDVA support.

Organisational recommendation 16 - To ensure that case actions are reviewed ahead of any period of leave to allocate actions to other IDVA's in the team to ensure that they are completed.

Learning 13 - As an IDVA it is important to keep regular contact or the offer of contact with the victim and that whilst they may appear to be disengaging with the service, the circumstances behind why they do not respond to calls or messages may be unknown. IDVAs need to be present and consistent in their offer of support to give victims the very best opportunity to accept the support on offer.

Organisational recommendation 17 – During case reviews victim engagement is explored and discussed to identify how this can be encouraged and supported by different means.

Learning 14 - There appeared to be a lack of communication between the IDVA and the OIC especially when the first investigation had been NFA'd and there was no update or response to the IDVAs email. Once this was known and after no further contact with Olivia, it was recommended her case was to be closed, even though there had been another referral to MARAC. It is important the IDVA keeps on top of updates from other services and requesting updates in a timely manner and where they are not forthcoming to ensure this is escalated to a supervisor for support.

Organisational recommendation 18 - To ensure that where second or subsequent MARAC referrals are received for clients, we have already supported that pre-MARAC contact is made to ensure that the victim is fully aware of the support that is available and that their voice is represented in the MARAC meeting.

Organisational recommendation 19 - During case reviews if the IDVA is having difficulty in contacting other agencies, which may impact on the safety, the supervisor provides support in escalating these requests.

15.5 Mereside Medical Cathedral Medical Centre GP Surgery and Red House Surgery

Learning 15 - Olivia was in regular contact with her GP regarding concerns around her health and wellbeing.

Organisational recommendation 20 - The practice will support clinicians in their confidence to enquire about domestic abuse when there are presenting concerns around mental health and substance misuse.

Organisational recommendation 21 - Domestic Abuse to be an agenda item at the practice weekly meetings to ensure any concerns regarding patients or updates regarding training/legislation/local policies are shared.

Learning 16 - Although the GP surgery dd not have any information to indicate Frank was an alleged perpetrator of domestic abuse, as part of the review the surgery has identified a need to upskill practice staff with identifying possible perpetrators and how to manage these concerns.

Individual recommendation 22 - To upskill workforce on engaging with and supporting perpetrators or alleged perpetrators of domestic abuse.

15.6 SETDAB and Essex Suicide Prevention Board

Board Recommendation 23 – Suicide Prevention and domestic abuse strategies and boards to work together ensuring a coordinated response to those who come to the attention of agencies where both are present.

15.7 Greene King

Learning 18 – No checks were completed on Olivia or Frank regarding their previous health and welfare (alcohol and substance misuse), and this is not routinely completed. It was apparent once the pub was purchased both started to drink more heavily and their finances appear not have been in a stable position. In addition, Greene King had no information of the police attendance or involvement at the pub, or the risk Olivia was at.

Organisational recommendation 24 - Although tenants are not employees it would be beneficial for the brewery to ensure tenants to have a pathway of support regarding domestic abuse, mental health, and substance use.

16. Conclusion

19.1 Olivia's suicide followed a period of escalating abusive behaviour from Frank which impacted her mental wellbeing and her use of alcohol. She was isolated from her family and friends, feeling there was no way out.

19.2 There were multiple incidents which we know of where Olivia reached out for help after physical and emotional abuse and when there was an increase in risk. However, for reasons only known to her she evidently struggled to engage with support from services.

19.3 It has been evident throughout this review that there were several opportunities to have provided Olivia with intervention and support, however, this were either overlooked or Olivia felt unable to engage. With Olivia's presenting complexities of alcohol and mental ill-health, the impact of the abuse at times was lost, creating further missed opportunities for Olivia to access support.

19.4 What has been increasingly apparent within the review is, that although agencies have processes, policies, and training in place, at times practice is not reflecting these. It must be said this was not on every occasion, however, there were multiple times where expectations were not met. It is essential that all services feel confident that their staff are competent within their role and all safeguarding processes are working well with the victims at the heart of any interaction.

19.5 Within this review agencies involved have been open and transparent with their reflections and learning and it is reassuring to know that all those involved strive to make a change to ensure all victims receive the best support possible.

Final word

With the families blessing the author would like to conclude this review with a few lines from Olivia's favourite song 'I don't want to miss a thing' by Aerosmith.

I could stay awake,
Just to hear you breathing.
Watch you smile while you are sleeping,
While you're far away and dreaming.
I could spend my life,
In this sweet surrender.
I could stay lost in this moment forever,
Every moment spent with you is a moment I treasure.

Don't wanna close my eyes,
I don't wanna fall asleep,
I don't wanna miss a thing.

APPENDIX 1

Terms of reference

5.1 Key Issues:

- Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community – including family, friends, and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control and economic abuse are also fully explored.
- Determine if there were any barriers Olivia or her family, friends and colleagues faced in both reporting domestic abuse and accessing services. To be explored:
    - The Equality Act 2010's[39] protected characteristics,
    - Alcohol use,
    - Mental Health concerns.
- Review agencies response, professional curiosity, interventions, care and treatment, risk assessing and safety planning around domestic abuse.
- Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards, domestic abuse and safeguarding policies, procedures and protocols and ensure adherence to national good practice.
- Review the communication between agencies, services, including the transfer of relevant information to inform risk assessment and management especially with regards to 'cross boarder' information sharing.
- Consider what is 'good practice' for agencies to achieve in their response to domestic abuse victims.
- Examine whether services and agencies ensured the welfare of any adults at risk, wishes and views of Olivia, family, friends, colleagues, or the community were considered with regards to decision making.
- Review if thresholds for intervention were appropriately set and correctly applied in this case.
- Was there any impact of the Covid pandemic on Olivia or Frank or services response?

APPENDIX 2

Glossary

- **AAFDA –** Advocacy After Fatal Domestic Abuse, a charity supporting families who have experienced a loss due to homicide or suicide.
- **Athena** - A single integrated police IT system to manage police investigations, intelligence, custody, and case file management.
- **CGL** - Change Grow Live is a nationwide charity, providing services which include drug and alcohol treatment programmes and support in Cambridgeshire. They provide both a community service and a CGL employee works within general hospitals.
- **CPFT** - Cambridgeshire and Peterborough Foundation Trust.
- **CRU** – Central Referral Unit all domestic abuse investigations assessed as High Risk must be referred to the Central Referral Unit (CRU) where multi-agency safeguarding

[39] https://www.gov.uk/guidance/equality-act-2010-guidance

plans will be formed and referrals made to partners such as the National Centre for Domestic Violence (NCDV) and represent Essex Police at MARAC.

- **CSP** – Community Safety Partnership
- **DAIT** - Domestic Abuse Investigation Team investigate all domestic abuse related crimes assessed as Medium or High Risk following the application of the DASH RIC.
- **DASH RIC**[40] – The nationally accredited SafeLives Domestic Abuse, Stalking and Honour Based Abuse Risk Indicator Checklist is a tool designed to provide a consistent way for practitioners who work with adult victims of domestic abuse to help identify those who are at high risk of harm and manage their risk.
- **DHR** – Domestic Homicide Review
- **EPUT -** Essex Partnership University NHS Foundation
- **FCR** – Force Control Room manage the deployment of police resources and record incidents reported to Essex Police a command-and-control system.
- **FRS** - CPFT First Response Team, supports people of all ages experiencing a mental health crisis. 24-hour, 7 days a week, 365 days a year access to mental health care, advice, and support. Support may involve telephone support or a face-to-face assessment and if appropriate referrals onto other CPFT services.
- **GP** – General Practitioner.
- **IDVA** – Independent Domestic Violence Advocate, for high-risk victims of domestic abuse.
- **IMR** – Individual Management Review require agencies to look openly and critically at individual and organisational practice.
- **LPS -** Liaison Psychiatry Service is a dedicated CPFT psychiatry team, providing rapid access to assessment of acute mental health needs within emergency department and medical wards in general hospitals. They provide a plan which may include advice, signposting and/or referrals to community mental health teams and partner agencies and/or treatment of mental health problems, for example medication review.
- **LPT** - Local Policing Teams uniformed officers (Teams), they provide a 24/7 response capability and primarily address all calls requiring an immediate police response such as 999 calls.
- **MARAC** – Multi Agency Risk Assessment Conference, discussed high risk domestic abuse cases with the aim to increase safety, reduce risk and interrupt the abusive behaviour of the perpetrator.
- **PWS -** Psychological Wellbeing Service provides help to people aged 17 and over (no upper age limit), who are experiencing common mental health problems such as depression and anxiety disorders. The main treatment offered is Cognitive Behaviour Therapy (CBT).
- **SETDAB** - Southend, Essex & Thurrock Domestic Abuse Board
- **SILP -** Significant Incident Learning Process
- **The Sanctuary** - This service can be accessed via FRS. It is a joint service partnered with Mind and supports people in mental health crisis.

[40] https://safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL_1.pdf?msclkid=770463f4ceac11ec8f0466908e13260a