DOMESTIC ABUSE RELATED DEATH REVIEW

UTTLESFORD COMMUNITY SAFETY PARTNERSHIP

Olivia died November 2022

Chair and Author – Katie Bielec

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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 Olivia died whilst living with her husband Frank (not their real names) in the Uttlesford area. Due to allegations of domestic abuse between the couple Uttlesford Community Safety Partnership (CSP) identified this met the criteria within The Home Office Multi-Agency Statutory Guidance for Domestic Homicide Reviews 2016[1].

1.2 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 Home Office Statutory Guidance.

1.3 This review is a statutory requirement which examined agency responses, intervention and/or support provided to Olivia and/or Frank prior to her death. The review aimed to highlight positive and supportive practice, any barriers in accessing services and any learning that could be shared to reduce the risk of such a tragedy happening in the future.

1.4 A timeframe was agreed by the panel between from 01/01/2018 to the date of Olivia's death, agencies were also asked to consider any events before 2018 and include if relevant to the review.

2. Glossary

2.1 **AAFDA –** Advocacy After Fatal Domestic Abuse, a charity supporting families who have experienced a loss due to homicide or suicide.

2.2 **Athena** - A single integrated police IT system to manage police investigations, intelligence, custody, and case file management.

2.3 **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.

2.4 **CPFT** - Cambridgeshire and Peterborough Foundation Trust.

[1] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

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

2.6 **CSP** – Community Safety Partnership

2.7 **DAIT** - Domestic Abuse Investigation Team investigate all domestic abuse related crimes assessed as Medium or High Risk following the application of the DASH RIC.

2.8 **DASH RIC**[2] – 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.

2.9 **DHR** – Domestic Homicide Review

2.10 **EPUT -** Essex Partnership University NHS Foundation

2.11 **FCR** – Force Control Room manage the deployment of police resources and record incidents reported to Essex Police a command-and-control system.

2.12 **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.

2.13 **GP** – General Practitioner.

2.14 **IDVA** – Independent Domestic Violence Advocate, for high-risk victims of domestic abuse.

2.15 **IMR** – Individual Management Review require agencies to look openly and critically at individual and organisational practice.

2.16 **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.

2.17 **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.

2.18 **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.

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

2.19 **PWS -** Psychological Wellbeing Service provides help to people aged seventeen 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).

2.20 **SETDAB** - Southend, Essex & Thurrock Domestic Abuse Board

2.21 **SILP -** Significant Incident Learning Process

2.22 **The Sanctuary** - This is a joint service partnered with Mind and supports people in mental health crisis.

3. Timescales

3.1 At the end of November 2022 Uttlesford CSP received a DHR referral from Essex Police after Olivia's death. There was a short delay to hold a core group meeting due to the festive break, however, the decision to carry out the review was made on 5th January 2023. An Independent Chair and Report Author was commissioned the same month.

3.2 Initial information was sought by SETDAB to ensure different agencies were aware of the review, were able to provide information of their involvement with the couple and invite them to an introductory panel meeting. Paragraph 46 of the statutory guidance states the target timescale for completion of the review of six months. 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. Panel meetings were held in March 2023, June 2023, and October 2023.

4. Confidentiality

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

4.2 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 Domestic Homicide Review.

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

4.4 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.

4.5 At the time of Olivia's death, she was 48 years old, and Frank was 50 years old, both were white British.

[3] https://www.legislation.gov.uk/ukpga/1998/29/contents
[4] https://www.legislation.gov.uk/ukpga/2004/28/section/9

5. 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[5] protected characteristics,
    - Alcohol use,
    - Mental Health concerns.
- Review agencies responses, 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?

6. Methodology

6.1 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.

6.2 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), SETDAB conducted scoping for information 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.

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

6.3 Various pieces of research were used within the analysis and referenced throughout the report.

7. Involvement of family/friends and colleagues

7.1 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.

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

7.3 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 advocate read the draft report and then met the chair face-to-face for the opportunity to ask questions and offer comments and/or suggestions prior to the submission to the Home Office.

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

8. Contributors to the review

8.1 The IMR and summary report authors and panel members were all independent of any direct work and or supervision/management with Olivia and/or Frank.

8.2 Agencies who provided and presented IMRs:

- 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

Summary reports:

- Goring and Woodcote Surgery
- Greene King Pubs

8.3 The panel comprised of agencies recommended within the statutory guidance and agencies with specialist knowledge of domestic abuse and suicide. All panel members were required to review each IMR, provide feedback at panel meetings and support the process. 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 Claire Jimson - Lead Nurse for Safeguarding – Think Family Safeguarding Team

9. Author of the Overview Report

9.1 Katie Bielec is an independent domestic abuse consultant, an accredited DHR chair with AAFDA and SILP, an accredited MARAC chair with SafeLives, has completed the Home Office Domestic Homicide Review Training and chairs Multi Agency Risk Management Meetings and stalking clinics. She is an associate trainer for SafeLives, Rockpool, The Hampton Trust, a guest lecturer at Bournemouth University, published guest author for the 'Social Work Practice with Adults – Transforming Social Work Practice' and is an accredited trainer delivering Coercive Controlling Behaviour and Stalking.

9.2 Katie was previously a Metropolitan police officer working in a variety of roles, she is a qualified IDVA, IDVA manager, ISVA[6] Manager and managed domestic abuse services for 11

[6] ISVA – Independent Sexual Violence Advocate, support for victims of sexual violence/abuse.

years. She is a member of AAFDA DHR Network, Standing Together Against Domestic Abuse Coordinated Community Response and The Employers Initiative on Domestic Abuse.

9.3 Katie is not associated in any way to any agency who have provided information for the review or had any personal or professional involvement with Olivia, Frank, or their families.

10. Parallel Reviews

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

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

11. Equality and Diversity

11.1 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 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 (CSEW) 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.

11.2 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.

11.3 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. The NHS describe 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.

11.4 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.

11.5 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.

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

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

12. Dissemination

12.1 Olivia's family and all agencies involved in the review are aware that the Overview Report and Executive Summary will be published once agreed by the Home Office. The action plan has

already been disseminated to ensure immediate action and learning can be taken forward. All other reports and IMRs remain confidential and will not be shared.

12.2 Following sign off from the Home Office Quality Assurance Panel, Uttlesford CSP will ensure the documents are disseminated to the Domestic Abuse Commissioner the Police and Crime Commissioner (PCC) for Essex, the Chief Executive (or equivalent) for all partner agencies and services represented on the panel.

12.3 The Overview Report, Executive Summary and letter from the Home Office Quality Assurance Panel will also be offered to the family and published on the SETDAB website[7].

13. Olivia's death.

13.1 In mid-November 2022, Frank alleged he and Olivia had had an argument at 19:00 hours, he left the couple's home and went to the pub which they both owned with Olivia remaining at their home address.

13.2 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.

13.3 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.

13.4 The ambulance arrived just after 01:00 hours, despite the efforts to save Olivia, she died at her home shortly after the ambulance arrived.

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

14. Family and relationship background

14.1 Olivia was born in Cambridgeshire and had one sibling. Frank was from greater London, his family is unknown. He had been previously married in 1995, it is unclear when he divorced, and he has two adult children.

14.2 Olivia was married to her first husband in 2000, together they had three 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 two children stayed with Olivia. After the separation Olivia started a new relationship, and her ex-husband returned to Cambridgeshire.

14.3 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, unexpectedly 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.

[7] https://setdab.org/

14.4 In late 2014 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.

14.5 Olivia met Frank on a dating website in January/February 2021, according to friends they had not spoken for 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.

14.6 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 Deliveroo courier.

14.7 In the 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.

14.8 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.

14.9 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'.

14.10 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.

14.11 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.

14.12 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'.*

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

15. Chronology

2017

15.1 Olivia contacted her GP on four occasions in 2017:

- On one occasion she informed them she had returned to the area, was feeling anxious, depressed, and asked for an emergency appointment. The GP notes indicated Olivia was a victim of domestic abuse (not her ex-husband or Frank) which had occurred that week and had been reported to Police.
- The other three contacts later that year were regarding her concerns for her anxiety and depression, intervention was not required, and she was given Samaritans and CRISIS details.

15.2 Cambridgeshire Social Services requested information from the Cambridgeshire Constabulary in respect of Frank, who was reported to have been in an intimate relationship with a female who had children (unconnected to this review).

15.3 Olivia was arrested following a domestic incident with her then partner (unconnected with this review), the case was dismissed, and a twelve-month restraining order was issued against her with no reported breaches.

2018

15.4 Frank's GP had sixteen entries on their system during 2018. Many of these were failure to attend appointments (all were followed up with phone calls from the GP) or general health concerns. There were several contacts to note:

- A discharge letter was received from hospital after he attended A&E with a fractured jaw and head injury after being assaulted (there is no reference of who assaulted him). He had several further appointments due to his injuries and attended A&E at the start of September after his jaw had been hit by a door that he was leaning on.
- Frank reported he had been experiencing low mood for six months, since his divorce and lost his business. He was experiencing poor sleep patterns, early morning waking, lack of appetite, feeling up and down and loss of enjoyment in normal activities. There were no recent thoughts of self-harm/suicide, had never suffered with low mood before and had not seen or spoken to anyone. The recent assault and injuries had not helped his emotions, he declined medication and was given details for Psychological Wellbeing Service (PWS). The GP made several attempts to make further contact, but he did not respond.

15.5 Olivia was seen in an outpatient clinic at hospital due to a persistent cough. Her liver function test results showed improvement and within normal ranges, the improvement was noted to be because of Olivia abstaining from alcohol and she was advised not to drink more than ten units a week.

15.6 In the autumn, Franks's ex-partner made a 999 call to the police reporting that she had been assaulted by him and he was still at the location. Shortly after, Frank made a 999-call making a counter-allegation of assault and criminal damage. When officers arrived, Frank had left the property, a DASH RIC was completed assessing his ex-partner as 'standard risk[8]', a domestic abuse action plan was created and flag for domestic abuse was placed on the location. The incident took place after the couple had separated two months earlier and Frank collected his belongings. There was an argument over possessions which resulted in Frank being scratched and him pushing a door against his ex-partner, causing bruising. A crime report was raised for an offence of actual bodily harm (ABH). Frank was voluntarily interviewed for assault and reiterated his counter allegation. Due to no independent evidence and in view of the counter allegation made there was insufficient evidence and no further action taken. Frank's ex-partner moved out of area and no further incidents recorded.

[8] Standard Risk – Current evidence does not indicate likelihood of causing serious harm.

2019

15.7 Olivia contacted her GP on two occasions, regarding her anxiety and seeking medication. She told them she was struggling, wanted further medication to help her through a difficult time (no details were recorded of what this was) and was worried she may turn to alcohol again. Change Grow Live (CGL) and Inclusion were discussed. She was concerned that she worked at a doctor's surgery and knew the team so did not want to make contact in the area and felt due to work she did not have time to go out of area. During the conversation she sounded tearful, it was suggested she have some time off work, but she felt work kept her 'sane'. There was a discussion around distraction techniques and that medication was not recommended as a long-term option. There was no further contact with Olivia and the GP that year.

15.8 Frank failed to attend two GP consultations and a hospital appointment during 2019. During a telephone consultation, he spoke of low mood, his divorce, loss of his job and experiencing chronic pain. He was signposted to mental health support services and advised to book follow up appointment if still struggling. The GP made attempts to contact him several days later however there is no record he returned the calls.

15.9 During 2019-2020 Olivia continued to be seen in Rheumatology outpatient clinics, she reported that she is experiencing pain and swelling in the small joints of her hand and with worsening fatigue over the last year. It was noted that Olivia had a history of back pain and stiffness since the age of 17 and she felt this has worsened over the last four years, even with continued physiotherapy. Olivia had an MRI which revealed evidence of degenerative changes (wear and tear) in the spine and some abnormalities in the vertebral bodies (spinal bones) in the thoracic spine which have been present since birth. After x-rays and a CT scan Olivia was informed that surgery would not benefit her symptoms. Olivia's GP was asked to refer her to the pain clinic for assessment at the hospital.

2020

15.10 In mid-March Frank was provided a Not Fit for Work note due to being high risk from COVID. Five days later there was a three-month national lockdown due to the COVID pandemic.

15.11 At the end of April during a telephone appointment with the hospital Olivia told them she was finding it difficult to manage the pain and difficult to exercise. She also spoke to her GP requesting medication for her anxiety.

15.12 In June there was a phased ease of restrictions from lockdown.

15.13 At the beginning of July Olivia had a phone call with her GP, where they agreed to reduce and change her medication, however, she spoke to them a week later raising her concerns about these changes. At the start of September during an email consultation Olivia told the GP she was feeling terrible and was provided information on what help was available. There were five further contacts that month to discuss her medication as she was struggling to sleep and was seen by the mental health team in September.

15.14 In September 2020 Frank was provided a fit note to return to work by his GP.

15.15 In September Olivia self-referred to PWS reporting intense low mood, intermittent suicidal thoughts, poor sleep and poor concentration, attempts were made to speak with her after

this call which were unsuccessful. During therapy she reported that once stabilised on antidepressants her alcohol consumption and suicidal thoughts had reduced. Olivia struggled to manage her alcohol to a level which did not impact on her mood or functioning. Olivia's discharge treatment plan from PWS included signposting to alcohol treatment specialist services with CGL and crisis support.

15.16 A month later during a discussion with her GP regarding her mood she told them she was waiting for her medication and was not drinking.

15.17 The nation went into a second lockdown on 05/11/2020 for two weeks.

15.18 At the end of November, Olivia contacted her GP asking for medication to help with her alcohol intake, she was directed to CGL. A few days later Frank was issued a not fit for work note due to being high-risk of COVID.

15.19 Olivia asked her GP at the beginning of December to increase her medication as she was "feeling awful", she was directed to alcohol services and her medication was increased. She was offered an online consultation with her the following month which she declined.

2021

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

15.21 During a telephone consultation in March after Frank had defaulted his maxillofacial[9] review, (he had progressive EPAI[10] in the fracture site), he reported pain chewing and some loss of facial sensation, he was re-referred to maxillofacial surgeon. It was also noted Frank's asthma was not well controlled, he had trouble sleeping which was impacting on his mental health. He failed to attend a follow up appointment; three attempts were made to contact him with no response. The following month he was seen by an Otolaryngologist[11] and attended A&E after dropping a heavy object on his leg.

15.22 Frank was seen in May in hospital due to moderate severe sleep obstructive apnoea and obesity. He was advised to stop driving, to contact DVLA and an arrangement was made to start CPAP. During the consultation Frank 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.

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

15.24 Shortly after this, Frank had a telephone consultation with his GP and expressed pain in his left foot which impacted his job, he failed to attend any follow up appointments regarding this. In mid-July Frank disclosed to his GP that he was in a new relationship and engaged, this was noted as a significant event.

15.25 Olivia and Frank married in September.

[9] Maxillofacial surgery is a medical and dental speciality that involves diagnosing and treating complications of the face, jaws, teeth, and neck.
[10] Enhanced Physical Activity Intervention
[11] Otosclerosis is a problem with the bones inside the ear which causes gradual hearing loss.

15.26 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[12] rather than bi-polar. Frank was also discharged from hospital after being diagnosed with pulmonary embolism[13].

15.27 Olivia contacted crisis support in October and was provided with support from Sanctuary. At the end of October during a consultation with her GP she disclosed she was drinking two bottles of wine a night; she was advised to reduce this amount and to continue with her medication. The following month she told them she was having suicidal thoughts after drinking alcohol and they advised to seek support from CGL. A week later she called 111 telling them she had been drinking alcohol for the last week but had stopped the day before. She had now taken excess medication to sleep but was experiencing black vomit (it is unclear what happened after this). She was seen the following day with her GP, where they noted she had low mood and was referred to mental health services.

15.28 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 two and four bottles of wine a day). Olivia told staff she and Frank had been married for two months and she had joined Frank to work in his pub. Frank reported Olivia drank secretly and he felt overwhelmed by her recent behaviours. The discharge plan included:

- Advised to restart her anti-depressants and to have this reviewed by the GP.
- Olivia's request for inpatient detox would be handed over to emergency department but also advised unlikely, and she should reduce her alcohol intake first.
- Olivia agreed to continue with CGL.
- Olivia to discuss request for rehab with CGL.
- Frank was advised to call 111 if he had further concerns.

15.29 Olivia was admitted to hospital eight 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.

15.30 Olivia contacted FRS 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 expressed at time of the call and agreed to self-refer to CGL. She was made aware she could contact FRS if she required further support.

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15.31 Olivia contacted her GP at the beginning of January informing them she was an inpatient for a detox and requested her prescription. A follow up call was arranged two weeks later, however, Olivia cancelled. A few months later in March, a request was made for a review of Olivia's medication and asthma (this is the first mention of asthma for Olivia).

[12] Emotionally unstable personality disorder

[13] A pulmonary embolism is when a blood clot blocks a blood vessel in your lungs. It can be life-threatening if not treated quickly.

15.32 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. The call was graded a Priority 2 (Rural Emergency), within minutes of the initial call Olivia called back stating that Frank had left. After a review by a Supervisor the incident was re-graded to a Priority 3 (Priority Response), after research was completed, it was identified there was no record of a restraining order on any system available to Police.

15.33 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.

15.34 An Athena Investigation was created, a statement was obtained, and a DASH RIC completed where Olivia was assessed as high risk[14]. During the assessment Olivia disclosed that a couple of days previously she had tried to hang herself. As a result, a secondary risk assessment was completed, and the risk was endorsed by a Domestic Abuse Safeguarding Officer within the Central Referral Unit (CRU).

15.35 Olivia also disclosed that she had been raped when she was 14 years old by a named male in Cambridgeshire. Basic details were obtained and recorded on Athena, the allegation was shared with the Child Abuse Investigation Team (CAIT) who arranged for the transfer of the investigation to Cambridgeshire Constabulary, Olivia was advised of the transfer of the investigation.

15.36 Attempts were made to arrest Frank, but he was unable to be located, and he was placed on Police National Computer[15] (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. Olivia called Cambridgeshire Constabulary the following day reporting Frank was using Class A drugs and hiding them at their pub and home address; this information was passed to Essex Police, and an intelligence report was created. (The result of the domestic abuse criminal investigation was not passed to the Cambridgeshire Constabulary).

15.37 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.

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

15.38 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 day and three days later without success. No messages were left as it was unclear if it was safe to do so.

15.39 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 who introduced the service, she told them she was safe and gave no concerns for her safety. It was agreed an email would be sent to Olivia with Next Chapter's telephone number and office opening hours, she also agreed for an IDVA to call her. An IDVA was allocated, and they spoke with Olivia two days later who was reported as very upset. They completed an individual support plan and agreed for a call the following day.

15.40 The IDVA contacted Olivia the next day, she was reported sounding 'very downhearted'. They supported her to call 101 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 to confirm the receipt of the Non-Molestation Order (NMO) application, a voice message was left along with a text. Olivia did not respond, a further attempt to contact her was made six days later, the call went to voicemail and a further text message was sent.

15.41 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, had drastically reduced alcohol intake from 5-6 bottles per day to 1 or 2 and had consumed a bottle and a half of wine prior to crew arrival.

15.42 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 since she was 14 years old, but nothing recent. Olivia expressed thoughts of self-harm and 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 crew providing information of their observations and disclosures requesting a mental health review. They also 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 that 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.

15.43 Essex Police received a non-emergency call from EEAST informing them of their attendance, Olivia attending hospital, and that Frank had been present at the address whilst bail conditions were in place. Ambulance control expressed concerns that should Olivia be released from hospital Frank may still be at the premises. The call was graded as a Priority 3 (Priority Response) with an update detailing Frank's bail condition.

15.44 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. They explained that due to Frank meeting her he had breached his conditional bail

and that they would have to attend and remove him from the property, this was accepted by Olivia. 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. An email was sent to the OIC advising them of the breach and the circumstances surrounding it. 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.

15.45 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.

15.46 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.

15.47 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. She told them she had drunk a bottle and half of wine which was not an abnormal volume for her as she was alcohol dependant. She informed them that she had not been compliant with her medication for two days, had recent black outs and had been discharged from hospital five days previously.

15.48 Frank was spoken to on the phone, he told them he was concerned about her deterioration, that he was not allowed to see Olivia, but they had spoken on the phone, and he had 'heard seizures.' 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.

15.49 Two days later EEAST received another 999 call from Frank with concerns that Olivia was having seizures and he was not with her. Olivia was spoken to; she said she did not require an ambulance and had not had a seizure since being in hospital. She alleged that Frank was trying to taunt her with an ambulance as he had just come out of prison from a domestic altercation, and he was not allowed to be at the address, the call was cancelled. Three hours 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.

15.50 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 requested Frank was contacted so he could care for her dogs whilst she was in hospital. Whilst at hospital Olivia reported she was struggling with her mental health and was not allowed contact with Frank. Olivia was discharged three days later, she refused inpatient drug and alcohol services and planned to engage in community drug and alcohol support services.

15.51 On 22/06/2022 the IDVA made two attempts to contact Olivia, both times the phone did not ring, and the message stated, 'call ended'. The IDVA emailed the OIC to ask about the bail conditions, they also contacted the NCDV regarding the Non-Molestation Order, who had not had any contact with Olivia since the referral. Shortly after this Olivia's GP surgery advised her to change to a closer surgery, a request for discharge medication was made and she was given support details (Olivia was reluctant to change surgeries and was encouraged to do so up until her death).

15.52 Five days after the IDVA had tried to contact Olivia and 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. Cambridgeshire Constabulary specialist officers also contacted Olivia on this day regarding the historical rape investigation, but she declined to pursue the allegation. She was signposted to independent support having declined to make a statement or provide details of the offence. Following a review, the investigation was closed in July.

15.53 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'. They recorded that Olivia had only called Police as she was annoyed, he had taken the car, no allegations were made, and she wanted no police action taken. The incident was reviewed by a Sergeant who amended the incident header from Domestic Abuse to Concern for Safety, the incident was closed with no further police action.

15.54 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. There were no concerns about Olivia's capacity to understand the risks and she signed a self-discharge form and was encouraged to return in the morning. Olivia returned to the department several hours later and was observed sleeping in the reception area. As a result of her injuries Olivia was referred to the plastic surgery team and was admitted to day surgery to wash and clean her wounds, Frank then collected her to take her home. (She did not attend her hand surgery follow up appointment in August, attempts were made to contact but she was discharged back to the care of her GP).

15.55 The IDVA tried to call Olivia at the start of July, there was no answer and no option to leave a message. They emailed the OIC in mid-July informing them they had had no contact for over a month, were considering closing the case and requested an investigation update.

15.56 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. She told them their relationship had been facing difficulties over the past few months since she had found out Frank had been taking drugs. 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.

15.57 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. A THRIVE risk assessment

was undertaken and given Olivia had requested the incident was logged it was graded as a Priority 6 (Appointment) with a phone appointment made for the following day.

15.58 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. The officer explained that a statement would need to be obtained detailing the incident and that she did not want to make a complaint. She was unavailable that day but free the following day. In response the officer suggested Olivia send an email detailing she did not want to make a complaint and would send her an email reminding her to do so (this was completed later that day with safety advice). Olivia agreed to this course of action. A DASH RIC was completed over the phone, and she was graded medium risk, an Athena investigation record was also completed.

15.59 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. Consequently, the investigation was passed to the North DAIT to continue with the investigation. The Detective Sergeant reviewed the investigation and recorded a Case Action Plan (CAP) within the log and including instructions to speak to Olivia to discuss the allegation and ensure that safeguarding, any necessary referrals and signposting to support organisations were completed along with instruction that Frank was to be interviewed.

15.60 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[16]' 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).

15.61 Later that day the IDVA emailed the OIC (from the original investigation) following up their previous email for an update, they were informed there was no further action on the case. Next Chapter reviewed Olivia's case, a decision was made to close, reasons provided:

- Not engaged for some time.
- Advise provided regarding civil options but decided not to pursue.
- No action taken by Police.
- Unable to update paperwork.

15.62 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.

15.63 Olivia contacted Cambridgeshire Constabulary on 11/08/2022, reporting Frank had been threatened by an individual that he owed money to and if he failed to pay, they would cause damage and disruption to the premises. The matter was recorded as an offence of malicious communications and filed as having no lines of enquiry (it is not apparent what, if any, further enquiries were made in response to the report, as some tentative lines of enquiry appear to have existed).

[16] To treat any further calls made by Olivia as urgent.

15.64 Olivia and Frank were heard at Essex MARAC two weeks after her allegation[17], information and risks identified:

- Olivia declined all safeguarding.
- IDVA unable to make contact since the last MARAC in June.
- The relationship was ongoing, and they were living together.
- Both misused alcohol.
- Olivia was open to the idea of support for her alcohol use.
- Olivia reported Frank was using cocaine which may be impacting his behaviour.
- Olivia had ongoing concerns with her mental health and previous information suggested she was hesitant to speak to her GP about this.
- Olivia felt isolated after her move from Cambridgeshire to Essex in February 2022 and did not know anyone. Her mother was elderly, and she did not want to speak to her about the situation. She reported she had one sister who she was estranged from, did not have any other family or friends and did not know any neighbours.

Actions set:

- Police - Due to concerns raised within the investigation and at MARAC, OIC to complete a SETSAF[18] and send to Adult Social Care (ASC) for consideration of assistance.
- 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 being currently involved with Frank, referrals could not be made without consent.

15.65 A SETSAF was completed at the end of August and sent to the Adult Social Care Triage Team for assessment, this was reviewed on the same day by an Adult Triage Officer within the CRU who determined the threshold for a referral to Adult Social Care was not met resulting in a referral not being made. Enquiries were made by Police to establish if Olivia was open to mental health support which she was not, details of Olivia's GP surgery was provided. Police sent an email to the GP the following day highlighting the safeguarding concerns raised at MARAC in relation to Olivia's mental health and alcohol misuse and requested they offer her any appropriate support.

15.66 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.' Due to the lack of any immediate or implied risk, the matter was recorded as a domestic incident, reviewed by a supervisory officer for potential escalation issues with none identified and transferred to Essex Police. Essex Police received the transfer which triggered the 'Flag' at the address highlighting Olivia as a high-risk domestic abuse victim. A THRIVE risk assessment was undertaken; the incident was graded a Priority 3 (Priority Response), and a summary of relevant information was updated.

15.67 The incident remained open with an officer calling Olivia the following day to discuss the incident, she expressed her anger that she had not been contacted the previous night, they explained units had not been available and asked to book an appointment to attend her

[17] IDVA, Police, MARAC chair and Admin and CSCS were present.
[18] Southend Essex Thurrock Safeguarding Adult Form

address to obtain a statement. Olivia told them all she wanted was her car to be returned and did not support any police action and then hung up. A Diary Car was requested to complete a 'cold call' at Olivia's address (next available appointment was three days later, this did not take place, and Olivia was called five days later by the officer with no reply).

15.68 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, the call was graded as a Priority 1 (Urban Emergency).

15.69 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. Given what had been initially reported he was advised that police would have to see him. 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.

15.70 Frank was seen by Police; he told them 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. The incident was recorded on Athena.

15.71 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. An appointment for a statement was scheduled the following morning as per Franks request.

15.72 In the meantime, Olivia was located at her home address by Police. She told them Frank had got lost on the way to the appointment and as a result, 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. All three matters were recorded on Athena and a DASH RIC was completed where she was assessed as medium risk. This was later reviewed and regraded to standard. A safety plan and safeguarding advice was provided. No statement was taken at the time as Olivia was unsure whether to make one, a photo was taken of the bruising to her right arm and Olivia was left to consider her decision. The investigations were allocated to an OIC, Case Action Plans were placed on both investigations giving the OIC direction regarding the lines of enquiry expected to be undertaken.

15.73 At the end of September Victim Support received an Automatic Data Transfer for Olivia from Essex Police. An attempt was made to contact Olivia a week later with no reply, however she was spoken to the following day, where she said it was inconvenient to speak. An unsuccessful attempt to speak with Olivia was made four days later with a successful call the following day.

The service was explained, domestic abuse was discussed, and support services explained and offered. Olivia agreed for details to be sent via text and understood she could call back any time. A text was sent with information on Restorative Justice details of support services with Essex Police updated of the action taken.

15.74 In the meantime, the investigation log relating to the assault 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.

15.75 At the beginning of October, the OIC updated the investigation log with a copy of an email they had sent Olivia, it stated that following a conversation on the telephone (when this call took place is not recorded), they understood she no longer wished to make a complaint or provide a statement and requested that she send them an email to confirm this. Later that month an officer spoke with Frank on the telephone (this was the first contact since he reported the assault by Olivia one month earlier). He told them he was unable to talk and that he did not want to pursue an allegation or make a statement. He was told a statement would need to be obtained to this effect and that an email would be sent to him providing him with an appointment. Two further 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.

15.76 At the end of October having not received an email from Olivia regarding not wishing to make a statement the OIC sent her an email reminding her to do so. Five 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, requesting she check for accuracy and sign it for inclusion with the case papers, this was never returned.

15.77 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.

15.78 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".*

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

16. Analysis by agency

16.1 Essex Police

16.1.1 The first call by Olivia to Essex Police was in May 2022 was correctly assessed as a domestic related incident and checks found no domestic abuse recorded between the couple or at the address. Checks on the PNC showed that both had previously come to the attention of the police. Frank had historical convictions none of which related to violence and Olivia's restraining order from 2017, with a warning marker for weapons (possession of a knife during the assault). Officers highlighted there was no record of a restraining order and provided instructions to officers to obtain a copy should there be one in existence. It does not appear this happened as there was no update on the system.

16.1.2 The attending officer was able to engage with Olivia in relation to a safety plan which included the 'flag' on her address and phone number and was able to obtain her consent to make a referral to the NCDV. However, there was no record contained within Athena that the officer supplied or offered Olivia with an 'Information for Victims of Domestic Abuse' leaflet[19] (PP75). A review of the officers Body Worn Video footage recorded during their interaction with Olivia that the PP75 was never offered or provided. Force Procedure makes it clear that:
'The ATH-RISK Support Leaflet (PP75) must be given to the victim without compromising the victim's safety, or to increase the risk to the victim. It is recognised that not all victims will accept the leaflet but either way this should be documented on the Athena record[20].'

16.1.3 The officer also obtained a written statement in relation to the allegations of assault and threats made by Frank; however, Olivia was not offered her options with regards to how her evidential account could be obtained. Due to the severity of the allegations and that Olivia may have been regarded as a vulnerable or intimidated witness under the Youth Justice & Criminal Evidence Act 1999[21], she may have been eligible for special measures. Special measures are intended to enable a victim or witness to provide best evidence and reduce the trauma of giving evidence in court. Specifically, Olivia may have been eligible to have her account video recorded, avoiding the requirement for her to provide evidence in person at court. With this in mind, it is essential first response officers give consideration whether a written statement is the best and most effective option in obtaining a victims account. This may have been an opportunity to further enhance the support Olivia received whilst obtaining her evidential account.

16.1.4 When Olivia disclosed that she had been the victim of a previously unreported historical rape in Cambridgeshire, the officer recognised that this needed to be recorded and obtained sufficient detail in order that an Athena investigation could be recorded in accordance with the National Crime Recording standards (NCRS) and to be transferred to Cambridgeshire Constabulary. However, the officer receiving the allegation of rape did not complete Part 1 of the Public Protection Investigation Booklet (PPIB) in accordance with Force Procedure. The PPIB is a booklet commenced at the beginning of an investigation into rape or serious sexual assault and completed during the life of an investigation. Part 1 records the personal information of the victim, the details of the suspect (if known) and the initial details of the allegation such as location date and time. Importantly it records in writing the initial account of the victim providing important information for the specialist trained investigators who will

[19] This leaflet provides details of the services available from partners to provide advice and support to victims of domestic abuse.
[20] Essex Police Procedure B1701 – Domestic Abuse initial Grading and Attendance
[21] Vulnerable Witness (Section 16) & Intimidated Witness (Section 17) of the Youth Justice & Criminal Evidence Act 1999 (Section 17 was amended under by the Domestic Abuse Act 2021))

subsequently assume responsibility for the investigation. It is the responsibility of the First Responding Officer (FRO) to commence the PPIB.

16.1.5 As per force procedure and expectations officers completed the DASH RIC and were able to identify Olivia as high risk of harm from Frank, the high-risk factors identified were:

- Injury
- Violence
- Depressed/Suicidal – she disclosed she felt that she could not cope with her domestic situation anymore.
- Isolated.
- Restricted her breathing.
- Threats to Kill.
- Financial Issues.
- Frank's mental health, alcohol, and drug concerns.
- Previous domestic abuse history.

16.1.6 Once this risk had been identified safeguarding processes were followed, and Olivia received enhanced support from a DASO within the CRU. A referral to MARAC was also made to explore the potential for wider partner agency support in the medium to long term. In addition, the officer completed a DV5[22] ensuring that immediate and medium-term safeguarding was in place in relation to personal safety.

16.1.7 Following Frank's interview, he was bailed with conditions (a DVPN/DVPO was considered but given that he was given conditional pre-charge police bail these were not applied for[23]). Frank breached the conditions at the beginning of June 2022, officers responded promptly to EEAST's concerns. Given the circumstances and explanation provided by Olivia and Frank, and that there had been no further offences disclosed, the attending officers appropriately and in line with Force Procedure[24] provided words of advice to both parties and ensured Frank left the property ensuring the OIC was made aware.

16.1.8 When Olivia told officers that she had placed a dogs lead around her neck, there is no mention within the records to indicate any discussion was had with Olivia regarding to her thoughts of taking her own life or the reasons why she felt this way. This would have been an opportunity to explore what support and intervention could have been offered.

16.1.9 When Olivia confirmed she wanted no further action to be taken in relation to the assault allegation, a negative statement was obtained. The investigation was live between mid-May and the end of June 2022 when the investigation was subject of a final evidential review by a supervisor. Whilst there were several regular supervisory reviews at Detective Sergeant level (at appropriate points within the investigation), a review by a Detective Inspector (DI) from DAIT was absent. In the absence of a DI review a decision was made for the investigation to be filed, and Olivia was contacted and updated with the decision.

16.1.10 Active domestic abuse investigations assessed as high risk are required to be reviewed by an officer of the rank of DI at seven days after initial report and at 28 days thereafter. Reviews are an important part of ensuring that there is the appropriate level of supervisory oversight of investigations and ensure that an investigation is progressing effectively. Whilst the absence

[22] Safety plan with the victim
[23] Essex Police Procedure B1706 – Domestic Violence Protection Notices and Orders
[24] Essex Police Procedure E0206 – Pre-Charge Police Bail

of a DI Review did not affect the outcome of the investigation a review should have none the less been conducted and recorded within the investigation.

16.1.11 Olivia's 999 call at the end of June 2022 (the day the investigation was closed) regarding the theft of her car was correctly recorded as a domestic incident. Attending officers were aware of the previous incident (in May), the outcome, that Olivia was a high-risk victim and had been heard at MARAC. With this information and after speaking with her they recorded that no offences had been disclosed or were identified and the incident was reclassified to 'Concern for Safety' and closed. Although there had been no update on the system from the Assessment Team the police response is considered proportionate and in accordance with to Essex Police Policy and Procedure[25]. However, with the knowledge the officers had regarding the couple this should have raised concerns as the incident happened within hours of the bail being removed. This was another opportunity to have offered her support services including exploring whether she was working with an IDVA for support. Although this was not classified as a domestic abuse incident, MARAC had only been heard three weeks earlier therefore consideration should have been made to re-refer as recommended by SafeLives[26] (a 'repeat' as ANY instance of abuse between the same victim and perpetrator(s), within 12 months of the last referral to MARAC) and Essex MARAC Protocol.

16.1.12 The call handler who took the 101 call by Olivia at the start of August 2022 regarding the second allegation of assault proactively identified the risks Frank posed and the previous history between the couple. With this insight along with the flag on the system they were able to explain why she would need to be seen, even though Olivia was clear she only wanted the allegation to be logged. A THRIVE assessment was completed, and Olivia agreed for a telephone call from an officer the following day. It was tagged for the attention of the assessment team who updated the system with relevant information. Considering Olivia had initially stated she did not want to see an officer the call handler appears to have been able to empathetically explain their reasons this was not possible and gain trust with Olivia to agree in the phone call.

16.1.13 The officer who called Olivia the following day recorded the conversation on their Body Worn Video, the call lasted eleven minutes. The officer was aware of the history between the couple and raised their concerns of the similarities after Olivia had explained what had happened. The completion of the DASH RIC over the phone was superficial in nature, when compared with what was said on Body Worn Video, several of the answers recorded within the DASH did not accurately reflect the responses provided.

16.1.14 Olivia's response to the question regarding her fear from future violence was hesitant, eventually responding 'not sure' with the officer recording the response as 'no'. They were aware of the previous DASH RIC from the incident having referred to it within their assessment of risk. When Olivia responded 'No' to whether she felt depressed or had suicidal thoughts the officer would have been aware that weeks earlier she had declared that she had depression, suicidal thoughts, and had tried to take her own life on a previous occasion, this was not explored further. Where Olivia was either hesitant in her answers or provided some answers in the negative there was a lack of further exploration.

16.1.15 A further high-risk factor which Olivia had disclosed was Frank dragging her across the floor by her throat and kneeling on her chest restricting her breathing. S75A and B of the Serious

[25] Essex Police Procedure B1701 – Domestic Abuse Initial Grading and Attendance
[26] https://safelives.org.uk/definition-repeat-marac

Crime Act 2015 (Non-Fatal Strangulation)[27] was amended to criminalise strangulation, choking and suffocation. The Training Institute of Strangulation Prevention[28] (2021) identified strangulation as one of the most lethal forms of domestic abuse with it resulting in possible unconsciousness and even death within minutes. They stress that when perpetrators choke (strangle) their victims, not only is this assault, but it may be an attempted murder. Strangulation is the ultimate form of power and control, and the impact can create significant fear and long-term health issues. Although Olivia stated she had no injuries, evidence, and research show that non-fatal strangulation frequently does not leave any physical marks or bruising may appear several days later. Even with no visible injuries this should not be a reason why it is not fully explored. If a face-to-face-statement had been taken it would have provided an opportunity for officers to visually see Olivia for possible external injuries and discuss possible internal injuries as well as observe her body language. As well as the missed opportunity for the officer to have explored non-fatal strangulation it would have also been an opportunity to have explored a pattern of behaviour and considered coercive control[29].

16.1.16 Both non-fatal strangulation and coercive control are high-risk factors and should be taken seriously especially with any additional concerns. When there are any disclosures that these behaviours are used in a domestically abusive relationship it helps support professional judgement with regards to level of risk and appropriate safeguarding pathways. This does not appear to have been explored or considered by the attending officers.

16.1.17 Olivia maintained she did not want to make an official statement the officer gave reasons that although they respected her wishes they would need to see her, take a statement of the incident and if she still did not want to pursue the complaint this could be included. Even though Olivia agreed to provide a statement the following day she was then given the opportunity to send an email stating she did not want to pursue the allegations and not be seen. After Olivia agreed to this course of action the officer then emailed requesting, she provided details of the assault, an explanation as to why she did not wish to progress with police action and some brief safeguarding advice. This course of action failed to meet organisational expectations and was contrary to Force Procedure.

16.1.18 During the officer's telephone call with Olivia, they did not discuss safeguarding (although later provided basic safeguarding advice via email), the DV5[30] recorded within the investigation log (recorded prior to sending an email to Olivia) records they discussed 999 advice, escape plans, compiling a log of interactions between herself and Frank and that Olivia was looking into obtaining CCTV. These discussions did not take place, furthermore, there were no discussions regarding the support available from partner organisations, different orders (such as Non-Molestation Orders) or referrals to the NCDV. This approach was inadequate did not accurately reflect their interactions with Olivia. As such there was a failure to provide appropriate support as a victim of domestic abuse during their initial dealings with her.

16.1.19 The attending officer assessed Olivia as medium risk, which with the presenting risks and known historical risk was misjudged and should have been high-risk with appropriate safeguarding pathways followed. However, after the allegation and risks were recorded on Athena it was sent by a Local Policing Team (LPT) supervisor to a Domestic Abuse Investigation Team (DAIT) supervisor. Both supervisors recognised the additional risks and escalated the officer's decision from medium to high. This serves to highlight the importance of the

[27] https://www.legislation.gov.uk/ukpga/2015/9/section/75A
[28] https://www.strangulationtraininginstitute.com/
[29] https://www.legislation.gov.uk/ukpga/2015/9/section/76/enacted
[30] A safety plan setting out the safeguarding advice provided.

secondary risk assessments undertaken by supervisors when determining risk levels following domestic abuse incidents.

16.1.20 Due to this escalation of risk the investigation was brought to the attention of the Crime Reduction Unit (CRU) resulting in a Domestic Abuse Specialist Officer (DASO) contacting Olivia to discuss enhanced safeguarding and or referrals. Whilst Olivia declined any further assistance in relation to referrals or wider safeguarding, a 'Flag'[31] was placed on her address and telephone number and the investigation was listed to be heard at the next available MARAC. The allocation to DAIT and the enhanced safeguarding undertaken by CRU were in keeping with Policy and Procedure and was able to provide further support and intervention to Olivia.

16.1.21 When Olivia was contacted by the Case Officer at the beginning of August 2022, she told them that she did not wish to provide a statement, would not be willing to attend court and declined any referrals. The officer asked Olivia to send an email confirming this, a week later she sent a short text by phone confirming she did not wish any action to be taken again expressing the wish that the matter be 'logged'. As a result, Olivia was informed the investigation would be filed, this course of action failed to meet organisational expectations and was contrary to Force Procedure, with regards to statements and review of investigations.

16.1.22 Olivia was a repeat victim of high-risk domestic abuse and was not seen in person by a police officer after being subjected to a violent assault. Whilst she expressed a wish not to pursue a complaint and physically seeing her may not have dissuaded her from this position, she should have been seen especially given her willingness initially to provide a statement. Furthermore, visiting Olivia would have provided the investigating officer an opportunity to properly engage and demonstrate Essex Police's commitment to supporting her. An in-person visit may also have enabled officers to better understand and address any barriers Olivia was experiencing in reporting abuse, with a view to assessing how these may have been overcome.

16.1.23 Again, had a statement been provided, even if it expressed a wish not to pursue a prosecution, it would have allowed investigators to properly assess her account and determine the appropriateness or otherwise of taking positive action against Frank, in the form of an arrest and interview (in line with the Case Action Plan set by the DAIT Supervisor). It would have also provided an opportunity for the potential to undertake an evidence-based prosecution or the obtaining of a DVPN/DVPO to provide Olivia with breathing space to consider her options. Despite the officer recording in mid-August that the investigation would be filed it remained open for several weeks during which safeguarding updates regarding the MARAC and the submission of the SETSAF to the CRU Adult Triage Team were recorded within the investigation log.

16.1.24 There were no further investigative updates placed within the investigation log until the end of October when the Case Officer recorded, that they had tried to call Frank (as a result of the MARAC action), to arrange a voluntary interview but had received no reply (when these attempts were made, are not recorded). Beyond the phone calls there are no records to show what other efforts or consideration was made to speak with Frank by the investigating officer, such as visiting his business or home address, both options that were available to them. Having failed to contact Frank on the phone, with the view to arrange a voluntary interview, the investigation was submitted to a supervisor for closure at the end of October 2022.

[31] A notification on police systems to treat all calls to the address as urgent.

16.1.25 The investigation was active between the start of August to the end of October 2022. Other than a supervisor's review when the investigation was allocated to the North DAIT, no further supervisory reviews were undertaken until the evidential review was completed to close the investigation. Force Procedure directs those reviews of high-risk domestic abuse investigations with an outstanding suspect must be reviewed every seven days by a Detective Sergeant (DS) and undertaken by a DI initially at seven days and every fourteen days thereafter during the lifetime of the active investigation. There was a failure to do so by both the North DAIT DS and DI in contravention of Procedure. As such the appropriate feedback should be given to the relevant supervisors.

16.1.26 The investigation commencing at the start of August 2022 lacked momentum and investigative depth with lines of enquiry not being effectively pursued and was allowed to stagnate particularly after the Case Officer's telephone contact. The lack of momentum was exacerbated by the apparent absence of supervisory oversight with a failure to undertake required supervisory reviews at appropriate points during the lifetime of the investigation. Whilst positive action was taken in relation to safeguarding of Olivia (through the offer of support from partners and referrals made to GP's and subsequent hearings at MARAC) the investigation itself did not meet the organisation's expectations in dealing with a high risk and vulnerable repeat victim of domestic abuse.

16.1.27 When Olivia made the allegation of theft of motor vehicle and bank card in September 2022 she called Police in the early afternoon; just before midnight that day the STORM incident log was updated with a system generated alert informing Force Control Room (FCR) staff that the incident dispatch target (1 hour or less from initial creation of incident) had not been met. This alert was not acknowledged by a FCR dispatcher or supervisor, no updates were placed upon the STORM incident recording the reason for the delay or when a response may take place. If it were the case that there were no available units to dispatch the local LPT supervisor should have been made aware of the incident to enable resources to be located from within the local policing area to respond, this did not take place.

16.1.28 It was not until 16.59 hours on the following day that an update was placed on the incident by an officer following a telephone call to Olivia. Olivia expressed her anger at having not been contacted the previous night. An explanation was provided why there had been a delay and suggested they arrange to obtain a statement. This was refused with Olivia stating she did not support police action and just wanted her car back (no mention was made of her bank card), Olivia then terminated the call.

16.1.29 Essex Police response was suboptimal, having been graded as a Priority 3, Olivia was a repeat high-risk domestic abuse victim, and a 'Flag' existed to treat all calls as urgent, the incident required an appropriate response. This did not happen and as such the initial management of the incident did not meet the expectations and highlights the need to communicate with victims to ensure they understand what is happening. There were no attempts to update Olivia and, from her reaction this had a negative impact on her view of the Police and how she engaged with the officer making the 'follow up' call.

16.1.30 The officer who spoke with Olivia before the call was terminated recognised, she needed to be seen in person and that a 'cold call' should be undertaken. They recommended that the 'Diary Car' undertake the 'cold call' at the address and an appointment was booked for the next available date which was days after the original call. This course of action was contrary to Force Procedure which states:

'Diary car appointments should ONLY be used for 'cold calls' as a last resort when all other avenues to contact a victim are exhausted and a rationale should be included on STORM. The incident must remain unallocated, and the appointment must not preclude earlier attendance if possible'.

16.1.31 The incident remained open and graded as a Priority 3 with an officer making one further attempt to call Olivia a week later with no reply and the 'cold call' failed to take place. Olivia was not seen until after Frank had made the separate allegation of assault which again did not meet Essex Police expectations.

16.1.32 When Frank called Essex Police via his mobile phone the flag created for Olivia was not activated as the 'flag' was on Olivia's phone and not Franks. That said due to the nature of the allegations the call was identified as a Priority 1 (Urban Emergency) which was appropriate. It was also identified as a domestic incident, and the relevant information was added from the assessment team. This highlighted that when a flag is put in place for victims of domestic abuse there should be consideration for the alleged perpetrators mobile phone to also be connected to the risks especially when there are counter allegations.

16.1.33 This was the first occasion Frank had been designated a victim of domestic abuse with Olivia as a suspect and therefore the first time, he completed a DASH RIC. It was during the completion of the DASH that Frank made several disclosures in relation to Olivia. He shared that he felt depressed and, a couple of weeks earlier had thought about suicide. The officer noted there had been two previous domestic incidents between the couple where Frank was named as the alleged perpetrator, that Olivia had been assessed as high risk and they continued to reside together, given this information Frank was assessed as standard risk. Frank declined to provide a statement that evening and requested to do so the following morning at the couples' pub, at this point the injuries to his wrist were not photographed.

16.1.34 A DV5 was not recorded nor were there any records indicating that Frank had declined to engage in the safety plan process or if any offer of support or exploration was made regarding his mental health. This is contrary to the requirements of officers and as such it is unclear whether safeguarding advice was given.

16.1.35 Additionally due to the incident relating to allegations in the context of a domestic incident and criminal allegations made of Actual Bodily Harm (ABH) the officer was required to record their interactions with Frank on their Body Worn Video, save and retain the footage in accordance with the Criminal and Investigations Act 1996 (CPIA) and Force Procedure. The footage of the interaction with Frank was not retained with no entry within the investigation log indicating that Body Worn Video had not been used. In addition, the officer was required to provide a 'Information For Victims of Domestic Abuse' leaflet, again there is no record of this having been provided. As a result, the officer did not comply with Force Procedure.

16.1.36 Franks's initial allegation was that Olivia had been drunk when she had taken the keys and driven off in the vehicle. It is not apparent within the available records whether the officers considered these potential offences in relation to the Road Traffic Act[32] (Drink Driving) when speaking with Olivia. In response to the review the officer stated that they could not recall the exact details of their dealings with Olivia given the passage of time, however, to the best of their recollection they did not remember having been informed that she had potentially been driving with access alcohol and she had not presented as intoxicated. This position is at odds with what had initially been reported to police which resulted in the incident labelled

[32] https://www.legislation.gov.uk/ukpga/1988/52/contents

'Domestic Abuse & Drink Driver'. The officer speaking with Olivia should have been aware of this having viewed and read the incident and personally manually inputting an update on the incident log prior to deployment. Given this, there may have been a failure on the part of the attending officer to fully appreciate the initial information provided and as a result meant they were unable to take the necessary steps to investigate and appropriately act.

16.1.37 When officers spoke to Olivia after Frank, they recorded offences of ABH and taking a vehicle without consent and theft of a bank card on Athena. Although Olivia declined to engage with the completion of the DASH RIC, the officer completed the assessment based on what they were able to establish from the reported incidents and previous risk assessments and she was at medium risk. Both incidents were allocated to an officer within the DAIT.

16.1.38 Olivia engaged with the completion of a DV5 including sharing her wishes for a referral to the Victim Support Service (VSS) and NCDV. Advice was provided with regards to support offered by other partners, including mental health support, and the option for her to seek legal advice (it is unclear if support was offered for substance misuse). Whilst the officer's approach to the DASH RIC and referral to VSS overall met expectations, it is unclear and not recorded whether a referral to the NCDV was completed. This was the first occasion where Olivia had accepted support and with these referrals it enabled her to have the opportunities to access services with the support of the Police. Olivia was not provided with an 'Information For Victims of Domestic Abuse', the Body Worn Video footage again was not retained in accordance with Force Procedure and CPIA requirements and was not available for review to see if this was provided.

16.1.39 Olivia also declined to give a statement and requested that she be given some time to consider her position before deciding if she wished to do so. By this point in the investigation both had made counter allegations of ABH and were similar in nature with both making additional allegations. At no stage were statements obtained. Consideration should have been given whether the option to arrest Frank and Olivia was open to the officers to allow for a prompt and effective investigation of the offence or of the conduct of them both[33]. Where counter allegations are made Force Procedure provides direction to officers in this regard:
'Where the nature of the allegations are similar and where the level of injury is the same with no obvious corroboration (such as witnesses/3rd parties), officers are to audit their rationale as to why one party was treated as the victim over the other. Consideration should be given to the arrest of both parties if unable to distinguish who will be treated as the victim'[34].

16.1.40 Whilst the decision to deprive somebody of their liberty will always be a matter for individual officers, in this case the arrest of both Frank and Olivia was an option given the range of potential offences being alleged (two ABH assaults, theft, TWOC[35] and potential drink driving). Had arrests been made it may well have led to a more effective investigation in relation to their conduct leading to an appropriate outcome. In any event, neither were arrested and both investigations were subject of supervisor's reviews. The investigations were subject of secondary DASH RICs by two separate supervisors resulting in both assessments being reassessed as standard risk. This resulted in the investigation being retained by the LPT and was allocated to a single officer to investigate.

16.1.41 The decision to reassess risk is a matter for individual supervisors, however, the decision to reduce the assessment of risk in this case was misplaced especially with the known high-risk factors. Olivia was a repeat victim of domestic abuse by Frank and had been heard at MARAC

[33] Section 24 PACE (arrest): Code G: Paragraph 2.9 (d) (e).
[34] Essex Police Procedure B1701 – Domestic Abuse Initial Grading and Attendance
[35] Taking Without Consent

only three weeks earlier, best practice should have been for Olivia to have been rereferred to MARAC. There is no doubt that any definition or guidance is open to interpretation and may be influenced by local protocols and pressures. However, it important to refer repeat cases back to MARAC especially if actions and intervention have not been effective or successful in reducing the risks and there is evidence of an escalation of abuse which was apparent in this case.

16.1.42 Due to the re-grading, the impact meant that the investigation was not brought to the attention of the CRU who had previous oversight of the couple. This would have been an opportunity for a specialist DASO within the CRU to have discussed the current allegations and safeguarding in relation to both Frank and Olivia. Had they have done this it would have ensured they could assess the investigation against the previous high-risk investigations to determine what, if any, further action relating to safeguarding could have been considered (including the reassessment of the DASH RIC from standard to medium or high) and whether, given there had been two previous MARAC meetings, wider partners needed to be aware. This would have been an opportunity to share information within the organisation and potentially wider with partners.

16.1.43 As such the allegations made by Frank remained with LPT, the first attempt to contact Frank did not take place until one month after the initial call to Police with an officer speaking to him on behalf of the case officer to arrange to take statement. With this time lapse any injuries Frank had sustained would not have been available to captured evidentially. The absence of contact with Frank was contrary to the Victims Code[36] or Essex Police procedure[37].

16.1.44 Although Frank told the officer he did not want to make a statement they were correct in informing him that a statement would be required to which he replied that it was not convenient that day. This resulted in the officer sending an email to Frank to arrange a date, over the following days two telephone calls were made to Frank to make further attempts to obtain a statement, however these were never answered with no facility to leave a message, as a result a statement was never obtained. Given that Frank's address was known it is not clear why, having failed to contact him on the telephone, an attempt was not made to visit his address to obtain the statement, an option that was clearly available and appears not to have been considered. An Inspectors review was required which did not take place, with the he investigation and was subsequently filed at the beginning of November 2022 following a supervisory review citing that Frank had been an '*uncooperative victim*' and that '*multiple attempts*' had been made to contact him but had been unsuccessful.

16.1.45 The use of language within the supervisory review could be viewed as victim blaming as Frank was considered the victim within this investigation. It would not be expected to see this within investigations, SafeLives DA Matters[38] programme encourages officers to understand the impact of language in reports. As such rather than 'uncooperative victim' the report could have read 'Frank *feels unable to engage with service because of……*' This would have evidenced the officer had explored the barriers with Frank.

16.1.46 The case officer with regards to Olivia's allegation updated the investigation log at the beginning of October 2022 with an email to Olivia. It stated that, following a phone call between them (it is not recorded within the victim contact log when this call was made) Olivia had taken the decision not to support police action in relation to her allegations. She was clear

[36] https://www.gov.uk/government/publications/the-code-of-practice-for-victims-of-crime

[37] Essex Police Procedure B1702 – Domestic Abuse Investigations

[38] https://safelives.org.uk/training/police

she did not want to provide a statement or sign the officer's pocketbook which resulted in the officer requesting she an email to this effect. After Olivia responded to the officer's final email at the end of October, she gave no explanation the reasons behind her decision not to pursue her complaint. Even with this omission the officer accepted the email, requesting her confirmation of the attached negative statement. This approach, in effect finalised the investigation and is contrary to procedure which sets out the requirement to obtain a statement from a victim when they do not wish to pursue an allegation.

16.1.47 Throughout all Essex Police interaction with Olivia and Frank coercive and controlling behaviour was never considered. Officers must be able to recognise controlling or coercive behaviour as it can be a warning sign of a risk of future violence towards a victim. Any behaviour or pattern which suggests controlling or coercive behaviour must be treated seriously and investigated to determine if an offence has been committed. Controlling or coercive behaviour towards another can also include or be committed in conjunction with a range of other offences (which would have been the case regarding ABH, theft and TWOC allegations). There was no record to suggest coercive or controlling behaviour was explored by either the investigating officer or their supervisor. Whether the recognition of the offence would have led to a different outcome to the investigation cannot be commented upon, however, the absence of the offence being recorded demonstrates and potential absence of professional curiosity and an investigative mindset.

16.1.48 When Frank made his counter allegation against Olivia Essex Police followed their Domestic Abuse procedure, within this there are Self Defence and Counter Allegations guidelines. Officers are encouraged to avoid jumping to conclusions about which of the parties in the relationship is the victim and which is the perpetrator. This applies to all types of relationships, whether heterosexual, same sex, transgender or familial (non-intimate partner). They should probe the situation and be aware that the primary aggressor may not necessarily be the person who called the police, nor was the first to use force or threatening behaviour in the current incident.

16.1.49 They should examine whether:

- The victim may have used justifiable force against the suspect in self-defence.
- The suspect may be making a false counter-allegation.
- Both parties may be exhibiting injury and/or distress.
- A manipulative perpetrator may be trying to draw the police into colluding with their control or coercion of the victim, for example by making a false incident report.

16.1.50 Counter-allegations require police officers to evaluate each party's complaint separately and conduct immediate further investigation at the scene (or as soon as is practicable) to determine if there is a primary perpetrator.

16.1.51 If both parties claim to be the victim, officers should risk assess both. There may also be circumstances where the person who is arrested requires a risk assessment, as in the case of a victim retaliating against an abuser. Officers should bear in mind the possibility that the relationship is a mutually abusive one.

16.1.52 When investigating counter-allegations, officers should note and record:

- Body language.
- Comparative severity of any injuries inflicted by the parties.
- Whether either party has made threats to another party, child or another family or household member.

- Whether either party has a history of abuse or violence.
- Whether either party has made previous counter-allegations.
- Whether either party acted defensively to protect him or herself or a third person from injury.
- What any third-party witnesses say.

16.1.53 Where the nature of the allegations is similar and where the level of injury is the same with no obvious corroboration (such as witnesses/third parties), officers are to audit their rationale as to why one party was treated as the victim over the other. Consideration should be given to the arrest of both parties if unable to distinguish who will be treated as the victim.

16.1.54 Overall, the investigations arising out of the allegations made by Olivia and Frank lacked investigative depth or momentum in the form of proportionate enquires, curiosity into coercive and controlling behaviour and lacked any meaningful supervisory oversight to address these issues. This ultimately led to an ineffective investigation and did not meet expectations.

16.2 Cambridgeshire Constabulary

16.2.1 Although Cambridgeshire Constabulary appears to have had limited contact with Olivia, little information concerning her vulnerability was known and greater information sharing could have enhanced her safeguarding information, specifically from her identification as a high-risk victim in May 2022.

16.2.2 Although active arrest enquiries were made by Essex Police requesting support from Cambridgeshire Constabulary after Frank was wanted and arrested for assaulting Olivia, there was an opportunity for Essex Police to have updated Cambridgeshire Constabulary with the outcome of the arrest. This would have enabled them to update their records and identify any safeguarding concerns for the couple.

16.2.3 Frank was identified on Athena as being a domestic abuse high-risk offender in mid-May 2022, in the immediacy of his arrest. Intelligence searches made by officers on his recorded nominal details would have identified a Police National Database[39] link to Essex Police, however, in comparison, there was no corresponding record that Olivia was a high-risk victim of domestic abuse. The inference is that a PND check may not have identified her as a victim through an intelligence search, however her PNC record did identify her arrest in 2017 for domestic abuse, but as a perpetrator.

16.2.4 Due to no information being shared, the records held by the Cambridgeshire Constabulary did not identify Olivia's vulnerability risks, her MARAC status and that she was a high-risk victim of domestic abuse. Considering her home being near the county of Cambridgeshire, her ownership of the public house and her admissions into the hospital in Cambridge this would have provided them with information and the opportunity to have intelligence within their system to highlight her vulnerabilities.

16.2.5 Although both Police forces use Athena and there were flags implemented as part of the safety plan (DV5) with Essex Police these were on the 'command and control call taking and dispatching system' used in Essex (STORM) and not Athena. This meant Cambridgeshire would not have seen these nor would they be able to search for it. Consequently, no flags appeared on addresses and locations within Cambridgeshire that were associated with either Olivia as

[39] Police can check national police records including allegations and arrests.

the victim, or Frank, as the perpetrator. These were missed safeguarding opportunities to have shared information cross-border to identify the high-risk of repeat victimisation.

16.2.6 When Olivia reported to Cambridgeshire Constabulary of the threats and malicious communications on Frank's behalf, there appears to be no 'solvability factors' from the initial report, with the crime raised and filed with no further action. It is unclear why Olivia was not spoken to by officers and the wider issues explored that had led to her calling the Police in the first instance. This would have been a possible opportunity to have explored possible coercive controlling behaviour and economic concerns within the relationship especially as calls to Essex Police escalated after this time. Although correctly recorded according to national standards, the response was superficial even though not a priority crime.

16.2.7 When Olivia reported the theft of her car and bankcard it was recorded as a domestic incident, which was good practice. Although a search was made of Olivia's details, no research was made of Frank, prior to it being transferred to Essex Police. This practice did not meet the expectations as checks should be carried out on each occasion. The MARAC in Essex had already occurred by this time, but this was unknown by Cambridgeshire Constabulary.

16.2.8 The communication between the two forces could have been better in terms of ensuring that any Cambridgeshire address connected with the victim, was also flagged for domestic abuse on the STORM system. Although this does not appear to have had a detrimental effect to the response and services provided by the Cambridgeshire Constabulary, it would be beneficial to share information for those who are high-risk to provide optimum safeguarding.

16.3 Essex MARAC

16.3.1 Olivia was referred and heard at MARAC twice in the summer of 2022, at both meetings there were very few agencies in attendance to share information or consider actions to reduce risk.

Those present were:

- MARAC Chair
- MARAC minute taker
- Essex Police
- IDVA
- Childrens Social Care

16.3.2 Substance misuse services, mental health, primary care, housing, or adult social care were not present and would have been expected to have attended. Cambridgeshire Constabulary were not invited to either meeting and the only information shared was by the Police, IDVA and Change Hub[40].

16.3.3 Within the notes of the first MARAC, it highlighted that Olivia stated she was depressed and having suicidal thoughts, she could not deal with Frank anymore and wanted a divorce. It recorded that Olivia accepted a referral from police to support her with her alcohol use, and an IDVA. The case was not open to mental health services and no information was available, the MARAC also did not have any GP information. Despite the limited information given an action was set for IDVA to offer Olivia a referral to Futures in Mind[41] and Essex ARC[42].

[40] https://www.thechange-project.org/the-change-hub/
[41] www.futuresinmind.org.uk
[42] www.phoenix-futures.org.uk

16.3.4 Risks were identified but it is not clear how these actions were mitigated, there is no evidence from the Police records that Olivia had requested a referral to alcohol services, or this had ever been made even though it is recorded it had been offered within the minutes. This was an opportunity for Essex Police and the IDVA to have explored this further. There was no discussion of the strangulation, her attempts to take her own life and/or coercive controlling behaviour which were high-risk factors and should have been explored further with Olivia.

16.3.5 During the second MARAC there were also very limited agency involvement or information sharing. Additional risk factors highlighted at the second MARAC were:

- Olivia reported the abuse was worse because of alcohol and drug use.
- Olivia was on a high dose of antidepressants but was reluctant to speak to GP.
- She had been provided with local mental health services, but it was unclear if these had been accessed.

16.3.6 The MARAC panel were evidently concerned about Olivia and actioned the OIC to complete a SETSAF and send it to Adult Social Care. Adult Social Care were also actioned in their absence to attempt a contact because of the SETSAF and re-offer services. The impact of the abuse was identified to be affecting Olivia's mental health and there were concerns regarding her use of alcohol. However, with the absence of specialist mental health and substance misuse services at the MARAC there were possible missed opportunities to action these services. That said, proactive attempts to seek alternative actions to support Olivia with the minimal information available.

16.3.7 By this stage it had been identified Olivia's GP was out of area which created difficulties and challenges accessing her records for the meeting. Although Essex MARAC has working partnership agreements with some bordering counties but unfortunately this was not where Olivia was registered. Without this information those in attendance and the GP had no knowledge of what intervention had been offered and therefore no actions could be set.

16.3.8 The lack of core agencies was evident at both MARACs and puts into question how these are robust multi-agency meetings with so few services present. When considering SafeLives 10 Principles for an Effective MARAC, it states:

What good looks like	Why it's important	How it's evidenced
Core agencies consistently attend and participate in the Marac (police, IDVA service, housing (statutory responsibility), children's services (statutory responsibility), National Probation Service and/or community rehabilitation company (CRC), primary health, mental health, substance misuse service, Adult Safeguarding)	The risks to high-risk victims and their families, and the management of perpetrators, are jointly and comprehensively assessed and addressed the impact of domestic abuse and other factors (e.g. substance and mental health issues), on victims and children is minimised.	Marac operating protocol Marac attendance sheet/minutes Marac observation (i.e. by the governance group, IDVA service manager, domestic abuse coordinator or peer review)

16.3.9 It is essential that core agencies, specialist services and agencies involved with those being heard are invited to the meetings to support a coordinated approach. Even if the primary care, mental health, substance misuse services had been present they did not have information as

she was accessing support in Cambridge which highlights again the challenges of cross boarder information sharing and the ability to scope for agency involvement.

16.4 Next Chapter

16.4.1 Olivia was first known to Next Chapter after the referral for an IDVA, within the referral it outlined the abuse including non-fatal strangulation, threats to kill and assault. Upon receipt of the referral the duty team attempted to contact Olivia to undertake an initial assessment to enable Olivia to be passed to the most appropriate team for support. Olivia was spoken to four days after receipt of the referral where she was informed what support could be offered and safety planning was completed, Olivia was allocated an IDVA after this call. This response was in line with the service policy, and they were initially able to engage well with Olivia.

16.4.2 Although Olivia was very upset when she spoke with the IDVA, they were able to speak with her in far more depth where she disclosed, she had sought support from her GP due to not sleeping because of to the incident and that she was on medication for depression (which she had been on for years). Olivia explained Frank had bail conditions to sleep at the pub and that she had tried to download the Hollie Guard app. At the time of the call Olivia, was unsure what support she needed but knew she needed some, as a result an individual safety and support plan was completed.

16.4.3 During the next conversation with the IDVA Olivia shared that her life savings had been invested in the pub, Frank was taking money out of the register and bank account daily to pay for his addiction to drugs. She also told them she had been trying to contact the business manager at Green King but had not heard back. The IDVA offered to call them, but this was declined with Olivia stating she would call them herself. Even Frank's bail conditions to the pub, meant there was a financial impact on Olivia as she was unable to attend her place of work. When Olivia raised these concerns the IDVA advised her to call 101 to speak to the OIC to inform them of the economic abuse and the coercive control that Olivia had alleged. Unfortunately, this does not appear to have happened, and these disclosures and concerns were never shared at the MARAC.

16.4.4 The IDVA ensured they called Olivia the following day as planned, she was very upset and downhearted, Olivia told them saying she was digging her head in the sand and felt she was not doing anything about the current circumstances. Due to Olivia's home being only three minutes from the pub as part of her safety plan she was keeping doors and windows locked and wanted to obtain a non-molestation order once the bail conditions were lifted. After this conversation, the IDVA found contact with Olivia very difficult and despite several attempts to call and texts no reply or contact was established.

16.4.5 At the MARAC, the IDVA was set several actions to support Olivia with her mental health. However, during a case file review several weeks later it was identified that the MARAC actions had not been completed within the five working day deadline in the organisational procedures. The Senior IDVA, attempted contact with Olivia a few days later with a view to discussing the non-molestation order (particularly given that the date for the bail to return had expired), the referrals for further support and any update from the OIC. The OIC did not share details of the bail conditions, their end date or when they ended with the IDVA. The importance of this information and the safety implications do not appear to have been recognised by the OIC as it impacted their safety and support plans with Olivia. Despite two further attempts to contact Olivia there was a recommendation to close the file.

16.4.6 Even though there was a further incident in August, a new referral to MARAC and the case only just being recommended for closure, there was no attempt to contact Olivia prior to the second MARAC. It would have been expected that pre-MARAC contact would be attempted to ensure Olivia's voice was represented at the meeting. Even at the MARAC meeting it was left with Adult Social Care to make contact to reiterate the offer of support from the IDVA service when there was no ongoing dialogue or support offered by Adult Social Care at the time. An IDVA's role should also make proactive attempts to speak with victims after the MARAC to update them of the outcome and support them with any actions.

16.4.7 It is unclear why there was no contact with Olivia after the second MARAC referral as at the time both the duty team and the IDVA team were sufficiently staffed to manage and respond to the referrals coming into the organisation. The IDVA team had been dealing with increasing numbers of referrals over the past year, but additional resources had been brought into the team and across the organisation to help manage the rising referrals therefore attempts should have been made to make contact pre and post MARAC.

16.5 Mereside Medical Cathedral Medical Centre GP Surgery

16.5.1 The GP surgery was aware that Olivia had been a previous victim of domestic abuse between 2017 – 2019, the impact this had on her mental health, that when her mental health deteriorated, and she turned to alcohol. In 2020 there were a total of twelve entries on Olivia's notes (five in September) all relating to her mental health and medication with alcohol discussed occasionally. During this time apart from the disclosures Olivia made there does not appear to have been any curiosity within their conversations regarding the causal factors behind Olivia's deterioration with her mental health and her drinking and whether alternative support options were available to her.

16.5.2 The GP was able to signpost Olivia to several mental health support services and alcohol services, however, there does not appear to have been an offer to make a referral to the service (or any other) or that they followed up whether she felt able to make these self-referrals (which was evident she had on a couple of occasions). The NHS was under extreme pressures during 2020 with the impact of the COVID pandemic and many consultations taking place over the phone or by other virtual needs. This restricted the interaction GPs had with their patients as well as time pressures to support multiple and complex ailments for many patients. During the conversations with Olivia there were no recorded notes on how Olivia was managing COVID-19, and it is unclear where she was living or working. The World Health Organisation[43] found that the pandemic increased the prevalence of anxiety and depression by 25% with the availability of services reducing due to access and availability.

16.5.3 The following year Olivia did not approach any agency until she spoke to her GP in May 2021 regarding struggling to sleep. Sleep is vital for the body to recover from our everyday activities, when sleep is interrupted it can impact the mental concentration and capacity of victims to complete even the simplest of tasks. Fear and stress can also impact the victims sleep as well as perpetrators using sleep deprivation tactics to abuse their partners. The impact this can have on victims can be devastating such as they are unable to function day today and become more vulnerable to gaslighting from the perpetrators subsequently increasing the risks to their mental wellbeing. This form or abuse and the impact of the lack of sleep can increase the use of alcohol as it may be used to try and aid their sleep, 30% of people with insomnia use alcohol to aid sleep[44]. It is not recorded why she was struggling to sleep and there is no record she

[43] https://www.who.int/news/item/02-03-2022-covid-19-pandemic-triggers-25-increase-in-prevalence-of-anxiety-and-depression-worldwide
[44] https://academic.oup.com/sleep/article/41/8/zsy091/4995573

was in a new relationship (she had been in a relationship with Frank between 4 – 5 months), if this had been explored it may have uncovered the circumstances Olivia was in and what she was being subjected to at home.

16.5.4 It was not until September 2021 (this was the month Olivia married Frank) after Olivia had seen mental health services that they recorded concerns for Olivia's alcohol consumption and her EUPD. With this information Olivia was spoken to (it is unclear if it was a face-to-face appointment or virtual) where she made her first disclosure to them regarding the extent of her drinking and her low mood. There was no exploration to the reasons behind Olivia drinking and she was advised to reduce her intake. It does not appear she was supported to access alcohol services or any other support services to help her reduce her intake. This would have been expected by the GP to ensure a holistic package of care is offered.

16.5.5 In November 2021 Olivia informed her GP that when she excessively drank, she had suicidal thoughts. Again, she was advised to seek help and support from CGL, with no record why she was feeling this way and how alternative support may be available. Only ten days later were they informed that Olivia had been discharged from hospital after her suicide attempt, no attempt was made to contact her to see how she was or offer support. It was not until January 2022 when Olivia called to inform them, she was in a detox that they offered her a follow up call. Even though this was cancelled by Olivia, no further follow up was carried out.

16.5.6 Olivia disclosed a significant rise in the amount of alcohol she consumed from her first discussion with her GP in October 2020 (when she reported not drinking) to then requiring a detox and suicidal attempts twelve months later. Within this time, she had started a new relationship, bought a new business, and had got married, none of these factors are recorded and can only be assumed as not known.

16.5.7 During 2022 there are seventeen notes entered onto Olivia's records all regarding mental health, alcohol, or medication. In June of that year the GP surgery was made aware of the domestic abuse, that she was in danger from Frank and there were conditions not to be near her and that she had moved to Essex. There was no discussion with Olivia regarding the domestic abuse, who the perpetrator was or if she required additional support regarding her alcohol, mental health, or suicidal thoughts. Instead, there was a 'fixation' that she should change her surgery to the area she was living even though she had raised her concerns about this. This would have been an opportunity to have offered her a safe space, to discuss the abuse, its impact and how she could be supported as well as her options moving to another surgery.

16.5.8 Olivia appeared to have trusted her GP, contacted them when in need and was reluctant to leave them. Many victims of domestic abuse believe their GPs can be trusted and can offer support. There is a risk with the pressures on surgeries that the limited time doctors have with patients restricts the opportunity to explore and discuss other concerns as well managing the presenting health concern. With these pressures and time restrictions it is essential surgeries have clear referral pathways and raise the prevalence of domestic abuse. This has been identified by the surgery and domestic abuse training is being offered to all practitioners throughout 2023/2024, included is domestic abuse, suicide, and mental health.

16.5.9 As we have already noted the GP surgery was not aware of the MARAC held for Olivia due to being out of the Essex area, which resulted in a lack of information sharing and them having the opportunity to work with other partner agencies.

16.6 Red House Surgery

16.6.1 Frank presented to the GP mainly with physical health concerns, with these needs addressed appropriately. When he raised low mood, he was not yet in a relationship with Olivia, did not want any medication or a referral to PWS all of which was appropriate.

16.6.2 During the time when he was in a relationship with Olivia, there was no cause for concern during Frank's consultations with GP which would have prompted them to enquire about domestic abuse. Frank did not complain of low mood post December 2019; thus, it is reasonable that the GP did not follow this up after this.

16.6.3 There was regular communication between the hospital and GP with regards to Frank's treatments. Throughout the COVID-19 pandemic, Frank had contact with his GP via telephone consultations and face to face where necessary. Frank was shielding during this period and therefore was unable to work and given several fit notes. There is no evidence that an enquiry was made about his mental wellbeing during this period nonetheless, it is difficult to arrive at any conclusion that enquiring about his mental wellbeing would have led to a disclosure of domestic abuse especially with Frank being the alleged perpetrator.

16.7 East of England Ambulance Service NHS Trust (EEAST)

16.7.1 The EEAST received six emergency calls for Olivia from January 2018 to her death, one was categorised as a 'No Send' and five had an emergency response dispatched.

16.7.2 The three 999 calls in November 2021 and June 2022 were all assigned priority code and a Category 1 (C1) response. C1 coded calls are for patients who are classed as life-threatening and needing immediate intervention and/or resuscitation. All ambulance trusts should respond to Category 1 calls in seven minutes on average. On each occasion the response time was outside the 7-minute target. This was due to the pressure and demands on the service at the time. Even so, EEAST staff were able to identify concerns for Olivia when they either saw or spoke to her.

16.7.3 When they saw her at the beginning of June 2022, the crew were able to identify the breach of bail conditions and were proactive in their response informing Essex Police. Additionally, due to their concerns they raised these with the GP informing them of Frank's arrest for domestic abuse, bruising to Olivia's arms, her expressing suicidal thoughts, drinking very heavily and bail conditions and requested Olivia's mental health was reviewed. The information shared by the ambulance staff was the first the GP knew of the abuse and ensured they were able to be aware of Olivia's home situation.

16.7.4 The crew were able to also identify further concerns two weeks later with regards to Olivia's alcohol misuse, signs of neglect and made a referral to the GP and Adult Social Care (there is no record the GP received this referral, and Adult Social Care did not open this case due to no consent and her not meeting the threshold). There was no record that domestic abuse was disclosed or raised within the discussions. The ambulance crew were clearly concerned for Olivia's welfare but as an emergency response are restricted in what support they can offer; however, they utilised the pathways available.

16.7.5 SCIE[45] states *'Self-neglect is an extreme lack of self-care; it is sometimes associated with hoarding and may be a result of other issues such as addictions'.* During the pandemic there was a rise of safeguarding enquiries for self-neglect and domestic abuse. Research and data[46] found that concerns rose by 5% during 2020 – 2021 but there was a 6% drop in statutory investigations undertaken[47] however, domestic abuse enquiries rose by 28% with a rise of 26% involving self-neglect. Many people who neglect themselves decline help from others and it can be difficult for professionals to intervene especially when the person has capacity to make decisions about their lives. That said this should not stop professionals in exploring what options are available and how support can be offered. During this time Frank was not staying with Olivia, and she was struggling with her mental health and alcohol misuse therefore, the not having him there, even though safer for her with regards to domestic abuse had a negative impact in other ways.

16.7.6 When EEAST received the call a day later (seizures and alcohol withdrawal) it was assigned as a Category 2 (C2) response, C2 calls are for patients who are classed as an emergency or a potentially serious condition that may require rapid assessment, urgent on-scene care intervention and/or urgent transport. All ambulance trusts should respond to Category 2 calls in eighteen minutes on average, Olivia was seen outside this target time.

16.7.7 The call was also coded for a clinician call back and Olivia was spoken to four minutes after the initial 999 call. She advised her blood sugars were high and that she had a recent diagnosis of a brain disorder (where her brain was dying). She had been diagnosed with pyelonephritis[48] the previous day at hospital and was now presenting with a spiked fever, lethargy, shortness of breath, sweating and inability to mobilise. The clinician requested a C2 face to face response due to possible sepsis.

16.7.8 When the ambulance crew arrived, Olivia told them that she had been in hospital the previous night, but self-discharged. She stated that she was told to go home and die, but then stated the doctor had wanted her to remain for a liver scan and a psychiatric review. She had not taken her medication for four days and was struggling with her mental health. She wanted help for her mental health, and they noted she was intoxicated and emotional. During the assessment, a friend arrived and had a discussion with the patient about going back to complete the assessment from the previous night and to get a psychiatric review.

16.7.9 A GP referral was made for mental health review due to no mental health support being in place, worsening depression since Frank's drug use started again and since her diagnosis of cerebral atrophy. Olivia was living alone with limited support networks and was not supposed to have contact with Frank due to his bail conditions even though he was still her next of kin. Again, there is no record that the GP received this referral or was aware of these concerns. There was also no record that EEAST were aware Olivia had been heard at MARAC and the concerns around the current risks. With this information it may have assisted the crew to speak with her about the IDVA support and alternative support options available to her.

16.7.10 In mid-July (seventeen days after the previous 999 call) EEAST received a further 999 call for alcohol withdrawal and was assigned a Category 3 response (C3). C3 coded calls are for patients who have potentially urgent conditions that are not life threatening but require treatment or transport. The regional level target aims to respond to nine out of ten patients

[45] https://www.scie.org.uk/self-neglect/at-a-glance/
[46] https://www.communitycare.co.uk/2021/09/23/rise-safeguarding-enquiries-involving-domestic-abuse-self-neglect-pandemic/
[47] https://www.legislation.gov.uk/ukpga/2014/23/section/24
[48] A sudden and severe inflammation of kidney due to a bacterial infection.

with the appropriate resource within 120 minutes. Due to surge levels at the time of this call, an ESOP48 critical incident was enacted and 'No send' Script was given to patient. This can only be implemented in line with the Trust's surge plan or on authorisation of the strategic commander. This procedure is implemented to allow EEAST to manage life threatening calls whilst identifying patient's that do not need an ambulance response, such as 'No Send' on C3 calls with limited exclusion criteria[49], as a result Olivia was not seen.

16.8 Cambridgeshire and Peterborough NHT Foundation Trust (CPFT)

16.8.1 Olivia had a history of contacting CPFT with regards to her mental health and alcohol misuse throughout 2016 – 2018 but due to the service not being able to engage with her it resulted in her cases being closed on each occasion. It is unclear what steps were taken to support Olivia engage with services during this time, however, from 2020 the notes demonstrate good practice with service flexibility when trying to engage Olivia and when she missed appointments.

16.8.2 When Olivia attended hospital in November 2021 disclosing continual drinking, threats of taking her own life and Franks allegation she was drinking secretly, there was no exploration for the reasons behind these thoughts and behaviours. Within the notes it states Olivia was agitated and irritable, but it does not explain why that was or whether this was explored further. With her presenting in this way and Frank being calm and stating he was struggling there was the risk that practitioners perceived Olivia as the disruptive person within the relationship rather than someone who was experiencing trauma and possible abuse. Although it is understood that when a patient attends hospital there presenting needs are the priority for practitioners there is an expectation further exploration of causal factors to support intervention.

16.8.3 It is unclear if Olivia was seen separately from Frank so she could speak freely as the notes indicate Frank had a voice within the meeting. The discharge plan was heavily focused on Olivia doing all the work with Frank seeking advice from 111. Frank presented as a caring and concerned husband and without the hospital having the information or knowledge of domestic abuse he was seen as a protective factor. They recorded Olivia's drinking and mental health had drastically deteriorated with the dates mirroring the same period she had been in a relationship with Frank. The mental health triage questionnaires and assessments asked about relationships and domestic abuse, demonstrating good practice, and although Olivia made disclosures of domestic abuse and her use of alcohol to manage what was happening at home, she was only signposted to alcohol reduction programmes and domestic abuse intervention was never explored.

16.8.4 When CPFT saw Olivia after her admission to hospital in June 2022, she told them that things had come to a head when she and Frank were arguing about his 'drug use and him watching homosexual pornography' which resulted in Frank pushing her and her falling over the settee. She explained she was very angry and called the police to report him assaulting her, he was arrested and released on bail. She claimed it was an isolated incident and requested police withdraw the charges. She reported they both had issues with alcohol dependency, but she was absolutely against the use of drugs and felt completely invalidated by his watching pornography. This was particularly difficult for her as she suffered from features suggestive of emotionally unstable personality disorder but this this had not been fully assessed in view of her ongoing alcohol dependency. When Olivia made the disclosure of domestic abuse, it

[49] All No Send calls are not closed until they have been reviewed by a Senior EOC Clinician

should have triggered a DASH RIC to be completed and offers to refer to specialist services and/or their numbers.

16.8.5 Olivia made a further disclosure which raised concerns regarding domestic abuse including Frank watching pornography and how this made her feel. The PLS practitioner commented '*Chronic emotional symptoms in keeping with EUPD[50]; denies Insightful that she needs to stop drinking due to significant risks to her health and exacerbation of emotional distress. Would like to try again to engage with CGL. Current suicidal intent. Exacerbation in distress related to husbands' use of cocaine and watching homosexual pornography. Information given for MIND Waves project to support symptoms around EUPD and Olivia was discharged once medically fit and PLS informed CGL of her treatment and discharge'.* With any disclosure like this and where there are also concerns regarding domestic abuse, professional curiosity should have been sparked and consideration made to complete the DASH RIC and or what support was available to her, as question 16 (of the DASH RIC), asks; *Does [name of abuser(s)] do or say things of a sexual nature that make you feel bad or that physically hurt you or someone else?* Even though Olivia made no disclosures of sexual abuse, she was very distressed by his use of pornography it would have provided an insight into the risk to her.

16.8.6 Over several months Olivia's alcohol intake had gradually increased and with her drinking up to 4-5 bottles of wine each day (280 - 350 units/week). She reported her increased intake was an attempt to escape her distress around Frank's behaviour. She expressed thoughts of wanting to not be alive but denied any intent of taking her own life. She told staff that she was hopeful she could work things out with Frank, described how he had visited their home to mow the grass and they were having productive discussions.

16.8.7 With every agency involvement (apart from the GP) Olivia had been intoxicated, this was evident not only from her presentation but also the impact on her body. The Institute of Alcohol Studies[51] found that alcohol use with victims is complicated, and they may turn to alcohol as a means of coping with their experiences of abuse as they cannot see any other way to escape the abuse which appears evident with Olivia.

16.8.8 During her disclosures she stated Frank was also alcohol dependent and had been drunk at the time of the assaults. The study highlighted that typically between 25% and 50% of those who perpetrate domestic abuse had been drinking at the time of assault. In some studies, the figure is as high as 73%. Cases involving severe violence are twice as likely to include alcohol and when alcohol is involved in domestic abuse, evidence suggests it is not the root cause, but rather a compounding factor.

16.8.9 The mental health services triage questionnaires and assessments all ask direct questions to assess the risk of suicide and protective factors which were all completed fully and demonstrated good practice; however, it is unclear what support and intervention was offered especially with the additional complexities of domestic abuse and alcohol.

16.8.10 When Olivia was heard at MARAC and was presenting to the mental health and alcohol services within the hospital due it being in Cambridgeshire, they were unaware of the high risk, agency concerns and plan to try to safeguard her. When Olivia made admissions of domestic abuse, no risk assessment or safeguarding referrals were completed, this may have been due to an assumption that other services had completed these. This reinforces the

[50] Emotionally Unstable Personality Disorder
[51] Home - IAS

reason why all organisations should (where possible) complete a DASH RIC with those who disclose domestic abuse to ensure the victim is appropriately safeguarded.

16.9 Cambridge University Hospitals NHS Foundation Trust (CUH)

16.9.1 There were several references to direct disclosures of domestic abuse from Olivia during her attendances and admissions to CUH, including Frank's bail conditions and detailed conversations regarding her safety at home. It was good practice that these conversations and concerns were documented. However, there is no record of a referral to or contact with the hospital adult safeguarding team. There is also no evidence in Olivia's medical notes that Olivia was offered referrals to domestic abuse services (these can be made directly by A&E, and out-patient teams). Additionally, no domestic abuse flag/alert were placed on Olivia's medical records which would have alerted staff on each attendance and would have prompted further exploration of the circumstances behind her attendance.

16.9.2 At the time of Olivia's hand injury in June 2022, the detail in how she sustained the injury was not explored with her description of falling downstairs carrying a glass being accepted and not questioned. This incident was only seven days after her attendance at A&E for an overdose and her disclosure of Frank's bail conditions. If her records had been flagged it could have prompted staff to have investigated further especially as he had driven her to the hospital and she appeared concerned about staying.

16.9.3 Despite documentation noting Olivia's previous and current history of domestic abuse the focus during her emergency department admissions were offers support to stop drinking. There was an absence of professional curiosity and several missed opportunities to talk to Olivia, to offer support and to make referrals to appropriate services.

16.9.4 There are no records on any hospital discharge summary of safeguarding or domestic abuse. Frank was named as her next of kin and whilst it may not have been appropriate to document the concerns on paperwork that the patient's husband may have had access to, it would have been appropriate to share information with Olivia's GP surgery.

16.9.5 The hospital had no record of the risk to Olivia, and they were never contacted by MARAC for information. This again highlights the need for there to be wider information sharing agreements with partner agencies across boarders where there is a safeguarding concern. This may have enabled the hospital staff to recognise and explore the signs of domestic abuse, how this was impacting her and then appropriately risk assess and safeguard her.

16.9.6 There are adult safeguarding, and domestic abuse polices and guidance available to all Trust staff. The hospital intranet details referral pathways to IDVA and domestic abuse services, including local services for patients who are living outside of Cambridgeshire. Even though these are available it is essential staff are reminded of the risks and expectations when there are concerns or disclosures.

16.10 Victim Support Service

16.10.1 The referral to VSS occurred due to the theft of the bank card and her being assessed as standard risk of domestic abuse. There were proactive attempts to speak with Olivia within five days of the receipt of the referral with the caseworker speaking with her the following day. Even though Olivia stated she was unable to talk they continued to try and engage with her.

This resulted in them signposting her domestic abuse support services via text. The action taken was in line with the organisational policies and processes.

16.10.2 At no stage was VSS aware that Olivia had been heard at MARAC on two occasions, even though this may not have changed the outcome of their interaction it may have sparked conversations with Olivia regarding the situation she was living in. And therefore, rather than signposting may have resulted in encouraging her to engage with the IDVA.

16.11 Greene King

16.11.1 Olivia and Frank were appointed by Greene King in June 2021 as tied pub tenants and not employees. They resided at the property on a 'Tenancy at Will' occupational agreement which converted to a Greene King Standard Tenancy in December 2021.

16.11.2 The relationship with Olivia and Frank was based on a landlord and tenant relationship. This type of arrangement required them to pay the pub owning business rent for occupation of the pub, and purchase products from the pub owning business, known as the 'tie'. The tenant operated the pub business as their own and thus the tenants were not employees of Greene King.

16.11.3 Olivia's alcohol use escalated once she and Frank had purchased the pub, she spoke of the economic abuse within the relationship especially associated to the pub takings, her taking out loans and her using her savings to purchase the business. Greene King confirmed they do not carry out checks on the health and welfare of our proposed tenants.

16.11.4 Their recruitment process verified their industry experience, business, and financial suitability. This process included undertaking credit checks as well as ensuring that independent professional advice had been taken by them in their decision-making and preparation of their business plan they were required to complete prior to the granting of the Standard Tenancy agreement. As part of their application, Frank included his notable experience within the industry and referenced during their tenure. This included the recruitment of their team members from previous establishments.

16.11.5 In addition, anyone operating a Greene King pub is required to hold a Personal Licence which must be obtained from the local authority. As part of obtaining a Personal Licence, the holder is required to request a basic DBS check, which Frank completed.

16.11.6 As part of the onboarding process as a new tenant, both Olivia and Frank attended the induction training, which introduces new tenants to the business support Greene King provides. It covers the key topics of running a pub to ensure tenants operate their business safely and within the law. It also helps new tenants to focus on the goals and targets of their business plan including a financial module which helps tenants to understand their profit and loss statement (sales and costs) and their cash-flow management.

16.11.7 When tenants are newly in their pub, Greene King provide a 'First 100 Days' programme. This programme is designed to provide an intensive level of support to ensure our new tenants have the best possible start in their new business. It also involves different representatives of Greene King visiting new tenants, such as property surveyors, learning & development partners, retail audit managers, as well as visits from the Business Development Managers. Both Olivia and Frank attended the First 100 Days programme.

16.11.8 There is no record within Greene Kings systems to indicate Olivia had reached out with help and support. Additionally, there are no records with regards to Police attending the property or any domestic abuse. Pursuant to the terms of their tenancy agreements, tenants are expected to notify Greene King of any matters which might jeopardise the Premises Licence of the pub, including for example a criminal conviction.

16.11.9 When Greene King becomes aware of any incident or issue that may impact the operation of a pub business, they will make attempts to understand the situation and assess what support or action may be required. Depending on the issue and its severity other Greene King departments may become involved to support any action. Where there is risk to the Premises Licence legal advisors are introduced to support any action, this may be to support the tenant or to support Greene King if a tenant has caused any risk, which may lead to forfeiture of the agreement.

16.11.10 If Greene King become aware of an issue that may have any personal impact on the tenant, they provide membership to the British Institute of Innkeeping (the BII), who offer a variety of support mechanisms, and promote the Licensed Trade Charity (the LTC), who provide mental health and well-being support to members of the licensed trade.

16.11.11 Due to Olivia and Frank not being employees of Greene King and appointed tenants Greene King's policies (including domestic abuse) and the opportunity to access the Employee Assistance Programme was not applicable to them.

16.11.12 Greene King's ongoing contact with its tenants is primarily made through the relationship they have with their Business Development Manager. The role of a Business Development Manager is to work with tenants in partnership to support the sustainability of their business. Greene King also provides business support through its property helpdesk and 'publine', which directs a tenant to different departments of Greene King, such as customer sales and cellar services, but the focus is very much on business support rather than wider support which might be given in an employer/employee relationship. It is unclear how Greene King become aware of any concerns regarding the tenants as there is no agreement with the Police to share this information and appears to be that of the tenants to inform them. If health and welfare check on tenants had been available, and Olivia had been seen there may have been an opportunity for her to have sought support regarding the pub and the financial strain she was experiencing.

17. Key themes

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

17.1.1 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.

17.1.2 The Domestic Abuse Act 2021[52] introduced a statutory definition of Domestic Abuse to ensure a coordinated response from agencies:

Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if—
"A" and "B" are each aged 16 or over and are personally connected to each other, and

[52] https://www.legislation.gov.uk/ukpga/2021/17/contents/enacted

the behaviour is abusive.
Behaviour is "abusive" if it consists of any of the following—
physical or sexual abuse,
violent or threatening behaviour,
controlling or coercive behaviour,
economic abuse (see subsection),
psychological, emotional, or other abuse,
and it does not matter whether the behaviour consists of a single incident or a course of conduct.

17.1.3 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[53] found that 92% of all the homicides (reviewed), the victim had experienced Coercive and Controlling Behaviour (CCB) within the relationship. These behaviours are the bedrock of any perpetrators control, Evan Stark states:

"If we're waiting to see acts of violence, we have missed the 98% of coercive control already experienced."

17.1.4 Section 76 of the Serious Crime Act 2015[54] came into effect at the end of 2015, introducing criminal legislation for coercive and controlling behaviour outlining behaviours that could be domestic abuse. Coercive controlling behaviour is defined as ongoing psychological behaviour, rather than isolated or unconnected incidents, with the purpose of removing a victim's freedom that is used to harm, punish, or frighten the victim.

17.1.5 The Government definition also outlines the following:

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

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

17.1.6 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)[55] and College of Policing[56] provide guidance with regards to different behaviours which should be considered when determining whether the offence of coercive control has been committed. The College of Policing outlines, coercive control can be a warning sign for future violence towards the victim and although the conduct may appear 'low-level', any behaviour or pattern suggestive of controlling or coercive behaviour must be treated seriously and investigated to determine whether an offence has been committed. The legislation is clear that coercive or controlling behaviour can be included, or committed in conjunction with, a range of other offences.

[53] https://www.glos.ac.uk/content/homicide-research-group/
[54] https://www.legislation.gov.uk/ukpga/2015/9/section/76/enacted
[55] https://www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship
[56] www.college.police.uk

17.1.7 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. In 2021 Economic Abuse replaced financial abuse within the definition as economic abuse encompasses many more ways in which an abuser may control someone's economic situation. This may be through sabotaging their employment or damaging their property, affecting their overall economic stability. The Domestic Abuse Act defines economic abuse as:

Economic abuse is defined as: any behaviour from person A that has a substantial and adverse effect on person B's ability to:
a) acquire, use or maintain money or other property, or
b) obtain goods or services

17.1.8 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.

17.1.9 Surviving Economic Abuse (SEA)[57] provides research and resources regarding the different behaviours of economic abuse and its impact. Their published report In Plain Sight states abusers control their victim/survivors to make them economically dependent on them. The behaviours rarely take place in isolation and are interwoven with other abusive behaviours (which were present within Olivia's marriage). Their research found that economic barriers to leaving can be that victims are isolated and intimidated resulting in them staying for longer and experiencing more abuse and harm as a result. Economic Abuse should be considered within every domestic abusive relationship and be part of any risk assessment and investigation.

17.1.10 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.

17.1.11 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[58] (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

[57] https://survivingeconomicabuse.org/about-us/
[58] https://www.vkpp.org.uk/assets/Files/Domestic-Homicide-Project-Year-2-Report-December-2022.pdf

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.

17.1.12 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 violence and abuse with his ex-partner.
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 died.

17.1.13 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.

17.1.14 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.

17.1.15 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.

17.1.16 Olivia's death was investigated and there were no apparent suspicious circumstances. Essex Police have a policy which ensures there is a robust investigation when there is a sudden death, within this policy 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.

17.1.17 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.

17.1.18 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.

17.2 Reliance on signposting

17.2.1 Olivia was 'directed' or 'signposted' to a variety of services by many agencies at different stages even thought 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 be able to engage which is not appropriate when they are in a state of crisis.

17.2.2 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 on occasion where she declined some support, but she was able to have the choice to make these decisions.

17.2.3 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.

17.2.4 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.

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

17.3.1 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[59], 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[60] describe how when practitioners who only work within these three heading miss other contributing risk factors which may be barriers to working with agencies and trauma' (all which Olivia had experienced), it is now called the 'Trio of Vulnerability'.

17.3.2 Olivia had experienced domestic abuse throughout her relationships, those who are subjected to this can experience Complex Trauma[61]. 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.

17.3.3 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 policies are often siloed and fragmented. Until these different layers are explored and pieced together, vulnerable people will continue to face the barriers.

17.3.4 Kimberlé Crenshaw first introduced the term intersectionality in 1989[62], 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 has their own unique experiences of discrimination and oppression, and we must consider everything and

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

anything that can marginalise people (ie gender, race, class, sexual orientation, physical ability).

17.3.5 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.

17.3.6 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 use 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.

17.3.7 Although domestic abuse was only mentioned within one of her GP notes it coincided with the increase 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.

17.3.8 The recent Domestic Homicide Oversight Report 2023[63] 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 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.

17.3.9 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

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

Monitoring System[64] (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.

17.3.10 SafeLives[65] 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[66].

17.3.11 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 could have been a way to have tried to help her with managing these areas of her life whilst exploring the domestic abuse at the same time.

17.3.12 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.

17.3.13 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[67].

17.3.14 Within Southend Essex and Thurrock (SET) 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 across SET. The SETDAB team also have a 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.

17.4 Agencies unable to engage with Olivia.

17.4.1 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.

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

17.4.2 Essex Police were reliant on Olivia answering the phone when there were investigations being undertaken. 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.

17.4.3 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.

17.4.4 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.

17.4.5 Agencies need to be able to understand the 'Cycle of Change[68]' 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 does 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.

17.4.6 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.

17.4.7 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.

17.4.8 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

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

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.

17.4.9 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

17.4.10 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.

17.5 Expectations, Process, and procedure not met.

17.5.1 Essex Police repeatedly failed to meet the expectations of the force with regards to the response to victims, investigations, and supervisory reports. Force Procedure[69] 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.

17.5.2 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.

17.5.3 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 took or pursued the obtaining of a written statement. APP[70] 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[71] and must explain to the witness the use of special measures and record the views the witness may express about applying for them.

17.5.4 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

[69] Essex Police Procedure B1701 – Domestic Abuse Initial Grading and Attendance.
[70] College of Policing APP – Domestic Abuse (Victim and Witness Evidence) – Essex Police Procedures B1701 – Domestic Abuse Initial grading and Attendance & B1702 – Domestic Abuse Investigations
[71] Ministry of Justice (2015) Code of Practice for Victims of Crime

interviews to secure best evidence and therefore affording vulnerable or intimidated domestic abuse victims' access to special measures at subsequent prosecutions.

17.5.5 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.

17.5.6 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[72] 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.

17.5.7 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).

17.5.8 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.

17.5.9 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.

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

17.5.11 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.

[72] Utilised by several forces within the UK and developed by the College of Policing in conjunction with Cardiff University

17.5.12 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.

17.5.13 The route the referral takes, still centres around the set of questions that are asked by the SPOC[73] 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.

17.5.14 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.

17.5.15 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.

17.5.16 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.

17.5.17 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.

17.5.18 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. 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.

17.5.19 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.

[73] Single Point of Contact

- Care that is more tailored to a patient's individual needs.

17.6 Evaluation of risk and sharing information

17.6.1 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.

17.6.2 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.

17.6.3 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.

17.6.4 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.

17.6.5 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.

17.6.6 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[74] 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.

17.6.7 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.

17.6.8 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.

17.6.9 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.'*

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

[74] Multi-Agency Safeguarding Hub

'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'.

17.6.11 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.

18. Organisational Learning and Recommendations

18.1 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[75] 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.

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

[75] 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.

Police should put in place a process to ensure that staff adhere to the requirements set out within Force Procedure.

18.2 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.

18.3 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.

18.4 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.

18.5 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.

18.6 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.

18.8 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.

19. 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.