Overview report

FENLAND
Community Safety
Partnership

A Domestic Homicide Review concerning the death of Emily (pseudonym)

(February 2022)

Author – Jackie Dadd

Date completed - September 2022

Family tribute to Emily

Mum was someone who wore her heart on her sleeve. When she was happy, I felt that I got the real her; I could feel her joy for life and we could connect as mother and daughter should. Throughout her life, mum had hobbies and passions that brought her peace and happiness. When I think of her, I remember her in one of her gardens. Her garden would always be the most colourful and well-kept in the street, no matter where she lived. It was a point of pride for her. It allowed her to express herself in ways she couldn't with words; it was the place where she was able to be creative and find peace.

And this was important to her, finding peace. Mum had her demons. They were intrinsically a part of her, so I can't help but remember them. She fought hard to be well but the illness always ate away at her, and even the strongest rock is eventually worn away by the tide; this is when she was most vulnerable to herself and others. In the weeks leading up to her death she told me that she didn't want to die, and it breaks my heart to think that she must have been so vulnerable at the end.

This is why I want her to be remembered where she was well: in her gardens, surrounded by her beloved pets, or walking her dogs along the beautiful, hidden paths near where she lived that she always had a knack for finding. This is where she would be at peace, and we could talk and laugh, and we would be Mother and Daughter.

The Domestic Homicide Review Panel and the members of the Fenland Community Safety Partnership would like to offer their sincere condolences to the family of Emily, who have lost their loved one in tragic circumstances, and which has caused this review to take place. They have been left with a huge gap in their lives.

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Preface

The key purpose of any Domestic Homicide Review (DHR) is to examine agency responses and support given to a victim of domestic abuse prior to their death and to enable lessons to be learnt where there may be links with domestic abuse. For these lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. The victim's death in this case met the criteria for conducting a DHR according to Statutory Guidance1 under Section 9 (3)(1) of the Domestic Violence, Crime, and Victims Act 2004. The Act states that there 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 he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death".

The Home Office and the Domestic Abuse Act 2021 defines domestic abuse as:

Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if—

(a)A and B are each aged 16 or over and are personally connected to each other, and

(b) the behaviour is abusive.

Behaviour is "abusive" if it consists of any of the following—

(a) Physical or sexual abuse

(b) Violent or threatening behaviour

(c) Controlling or coercive behaviour

(d) Economic abuse

(e) Psychological, emotional or other abuse

and it does not matter whether the behaviour consists of a single incident or a course of conduct.

"Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to—

(a) Acquire, use or maintain money or other property, or

(b) Obtain goods or services.

For the purposes of this Act A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child).

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.

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. The term domestic abuse will be used throughout this review as it reflects the range of behaviours encapsulated within the above definition and avoids the inclination to view domestic abuse in terms of physical assault only.

Recommendations will be made at the end of this report, however, there has been an ongoing action plan introduced by the panel, parallel to this review to ensure that the areas that can be immediately addressed have not incurred unnecessary delay.

Since the initial submission of this report, whilst going through the Quality Assurance process, the Coroner's inquest has been held. The Coroner found that Emily's medical cause of death is

1a) Hanging

The conclusion of the Coroner was a Narrative. The details of this can be found at 1.6.1 of this report. This report will remain referring to the death as a suicide as this was the basis for all discussions, terms of reference and findings and was concluded prior to the Coroner's finding.

Section 1 - Introduction

1.1 The commissioning of the review

1.1.1 This review is into the death of Emily, a 62-year-old female, who was found deceased in February 2022 by Cambridgeshire Police at her home address. The Police have investigated the circumstances and have submitted a report to the Coroner with a finding that the death was non-suspicious and the cause was suspected suicide by hanging. The Coroner's inquest has been opened and adjourned awaiting the completion of this review.

Cambridgeshire Police made a referral to Fenland Community Safety Partnership on 10th March 2022 due to a history of domestic related incidents involving Emily on their records. A decision was made to undertake a Domestic Homicide Review on 14TH March 2022 as it was found that the definition in Section 9 of the Domestic Violence Crime and Victims Act (2004) had been met.

1.1.2 Contributors to the review

Agency	Contribution
Cambridgeshire Police	IMR, Panel member
Clarion Housing	IMR, Panel member
Fenland District Council	Oversight, Summary report
East of England Ambulance service NHS trust	Summary report, Panel member
NHS Cambridge and Peterborough Integrated Care Board	Panel member, IMR
Cambridge and Peterborough NHS Foundation Trust (CPFT)	IMR, Panel member
Adult Social Care – Cambridgeshire County Council	IMR, Panel member
GP surgery	Chronology
Refuge	IMR, Panel member
Cambridgeshire and Peterborough IDVA Service	Scoping
Change Grow Live (CGL)	IMR, Panel member
Cambridgeshire and Peterborough Domestic Abuse and Sexual Violence Partnership (DASV)	Oversight, Summary report, Panel member

1.1.3 Review Panel

The following agencies/organisations/voluntary bodies have contributed to the Domestic Homicide Review by the provision of reports and chronology. Individual Management Reviews (IMRs) have been requested and supplied:

1.1.4 The panel comprised of the following: -

Name	Area of responsibility	Organisation
Vickie Crompton	Domestic Abuse and Sexual Violence Partnership Manager	Cambridgeshire County Council
DCI Jenni Brain	Public Protection Lead	Cambridgeshire Police
Aimee Elener	Quality Lead	CGL Cambridgeshire (Change Grow Live)
Emma Foley	Peterborough City Hospital – Adult Safeguarding Practitioner	Northwest Anglian NHS Foundation Trust
Rebecca Cooke	GP practice representative. Deputy Designated Nurse for Safeguarding people	NHS Cambridgeshire and Peterborough Primary Care ICB
Julia Cullum	Domestic Abuse and Sexual Violence partnership manager – IDVA & MARAC Service	Cambridgeshire County Council
Rachel Robertson	Advanced Practitioner Safeguarding and Domestic Abuse Lead/AMHP	Cambridge and Peterborough NHS Foundation Trust (CPFT)
Martina Palmer	Senior Operations Manager	Refuge
Joseph Davies	Suicide Prevention Manager	Public Health department – Cambridgeshire County Council
Carolyn Shaw	Manager	Refuge
Pushpa Guild	MCU Review officer	Cambridgeshire Police
Lauren Mason	Domestic Abuse Champion Lead	Clarion Housing
Alan Boughen	Community Safety & Partnership Officer	Fenland District Council
Donna Glover	Assistant Head – Adult Safeguarding	Adult Social Care

1.1.5 All members of the panel and authors of the IMRs have complete independence from any subject in this review. Following careful consideration by the Chair and review panel, it was agreed that reports, chronologies, IMRs and other supplementary details would form the basis of the information provided for the overview. Thanks goes to all who have assisted and contributed to this review with their valued time and cooperation.

1.1.6 – Author of the Overview report

The chair of the review panel and author of this report is Mrs Jackie Dadd, an independent consultant who is independent of the organisation and agencies contributing to this report. She has no knowledge or association with any of the subjects in this report prior to the commissioning of this review. She is a retired Detective Chief Inspector with Bedfordshire Police with vast experience of safeguarding and domestic abuse related issues and has been involved in the DHR process since its inception in 2011. She has undertaken a number of DHRs having completed the Home Office online training, the CPD accredited AAFDA DHR Chair training and is a member of the AAFDA DHR network, regularly attending the monthly forums for CPD and discussion.

1.2 Purpose of the review

The purposes of a DHR are to:

a) Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

b) Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

c) Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

d) Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

e) Contribute to a better understanding of the nature of domestic violence and abuse; and

f) Highlight good practice.

DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for Coroners and criminal courts, respectively, to determine as appropriate. DHRs are not part of any disciplinary inquiry or process. Part of the rationale for the review is to ensure that agencies are responding appropriately to victims of domestic abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and domestic abuse. The review also assesses whether agencies have sufficient and effective procedures and protocols in place which were understood and adhered to by their staff.

This review will ascertain whether domestic abuse could have been a contributory factor to the death of Emily. It is not to apportion blame, but to view the circumstances through her eyes.

1.3 Timescales

1.3.1 Fenland Community Safety Partnership, in accordance with the December 2016 Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews commissioned this Domestic Homicide Review.

The decision to hold a DHR was taken on 14th March 2022. The Home Office was notified of the decision in writing on the same day.

Mrs Jackie Dadd was commissioned to provide an independent chair and author for this DHR on 18th March 2022. Three separate panel meetings then took place. The completed report was handed to the Fenland Community Safety Partnership on 22nd September 2022.

1.3.2 – Table outlining timeline of review

February 2022	Emily was found deceased at her home address
10/03/22	Police referred incident for consideration of DHR to Fenland CSP
14/03/22	Decision to commission a DHR made by Fenland CSP and partners
14/03/22	Home Office notified of decision to commission DHR
18/03/22	Mrs Jackie Dadd commissioned as Chair and Author
09/05/22	First panel meeting
13/07/22	Second panel meeting
14/09/22	Third panel meeting
22/09/22	Completed report handed to Fenland CSP by Author

1.3.3 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. The writing of this report had significant delays whilst waiting for the IMR from the Police and the SI (Serious Incident) Report from CPFT, both of which were pivotal as to how the report was written.

1.4 Terms of Reference

1.4.1 The full Terms of Reference can be found in Appendix A at the conclusion of this report. The Terms of reference were discussed and agreed upon during the first panel meeting on 9th May 2022.

1.4.2 It was agreed that the main areas of focus would be based on:

a) Domestic abuse in any form had been the causation or a contributory factor to Emily taking her own life
b) The availability and effectiveness of service and agency provisions for domestic abuse within the Fenland area, specifically for LGBTQ+, Older persons and vulnerable persons

c) The availability and effectiveness of services and agencies provisions for suicide and those contemplating taking their own life within the Fenland area
d) Establish the response to Emily's mental health and information sharing processes in relation to this

1.4.3 It was agreed by the panel that the review and research dates would be from 2009 as this was the known year that the domestic abuse involving Emily became known to multiple agencies, but any relevant information held prior to that should be included until the date of her death.

1.5 Subjects of the review/Family and friends' involvement

1.5.1 In accordance with Home Office guidelines to ensure confidentiality, pseudonyms have been utilised throughout this report for the following:

Emily - Deceased, who was a 62-year-old female at the time of her death.

Pauline – Ex-Partner of Emily, a 62-year-old female at the time of Emily's death

Susan – Daughter of Emily. Only child.

Daniel – Ex partner of Emily and Father to Susan.

Address – Name of area referred to as Fenland

1.5.2 The daughter of Emily wished to be fully engaged with the review and the author would like to express their gratitude for the significant contribution and assistance provided throughout. The pseudonyms used in this report were agreed by Susan as she did not wish to choose them herself.

Susan spoke to the author on a number of occasions over the phone, via teams and email which were her preferred methods. Susan was initially informed of the DHR via letter and was provided AAFDA information. Although she was reminded of this support throughout the review, Susan already had a counsellor and preferred not to engage with AAFDA as well. She declined the attendance at a panel meeting to preserve her own mental health.

1.5.3 The information in the background of Emily is as close to date order as it can be as it has been provided from Susan and Daniel from memory to assist with the understanding of Emily's life.

Susan has read this report and is happy with the content and reflections of her mother's life.

1.6 Parallel reviews

1.6.1 Coroner

The Coronial process is taking place parallel to this review.

Emily's death was reported to the Coroner by the Police and a file was opened in February 2022. The report submitted stated that the death was considered to be non-suspicious and was treated as a sudden and unexplained adult death, indicative of a suicide by hanging.

A Post-mortem was subsequently held.

The result of that post-mortem examination was: -

1) Death by unnatural causes due to hanging

At the time of her death toxicological analysis has shown that the deceased was intoxicated with alcohol. Her blood ethanol level was 203mg/100ml. Depending on her tolerance to alcohol this level of ethanol can be associated with coma. She was also found to have a high therapeutic concentration of the antidepressant Citalopram and a low therapeutic amount of the anxiolytic Diazepam. No other drugs were detected.

The only recent injuries found were those of ligature marks around the neck.

The coroner had suspended the coronial investigation pending the outcome of this review.

The inquest by the Coroner was held in August 2023 where the Coroner found the medical cause of death as

1a) Hanging

The conclusion of the Coroner was a Narrative including the following:

Emily suffered from longstanding mental health illness. She was discharged from the Fenland Adult Locality Team in September 2021. In January 2022 Emily presented to her GP with suicidal intent. She was referred to secondary mental health services and contacted the First Response Service for assistance. Emily was found deceased by her Recovery Coach on 1st February 2022. A Domestic Homicide Review was conducted after Emily's death which found that a number of factors contributed to her death.

1.6.2 Independent Office for Police Conduct - IOPC

A referral by Cambridgeshire Police was made to the IOPC on 4th February 2022. A parallel investigation is in progress regarding Cambridgeshire Constabulary's response and open investigation of a domestic related incident that occurred on 1st December 2021.

A decision has been made for this to be reviewed internally and any learning to be implemented by the Learning and Development Inspector who will take account of this review.

1.6.3 Cambridgeshire and Peterborough NHS Foundation Trust Serious Incident - CPFT SI

A parallel review has been conducted to investigate the care provided to Emily by Cambridgeshire & Peterborough NHS Foundation Trust (CPFT) in the year leading up to her death in February 2022.

The report received the Serious Incident Group approval on 18/07/2022 and was submitted to the commissioner on 26/07/2022. It reflects both good practice and areas for development which are captured in recommendations and an action plan which are referred to throughout this report where relevant.

1.7 Equality and Diversity

1.7.1 The review gave due consideration to each of the protected characteristics under Section 149 of the Equality Act 2010. All concerned are defined as white British. The relevant legislation that provided the context for the panel was The Care Act 2014, The Disability Act 2016 and The Equality Act 2010.

Throughout this review process the Panel has considered the issues of equality in particular the nine protective characteristics under the Equality Act 2010. These are:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership (in employment only)
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

Key considerations for the panel were found to be age, sex, mental health conditions and sexual orientation and whether they influenced how the various agencies dealt with Emily and influenced the support that she was offered.

It was considered that Emily's sex was relevant to the review as 3-10 women each week die of suicide where they have suffered domestic abuse and in 2017, eighty-three per cent of victims reporting coercive control to the police were female.[1] This information shows the correlation between suicide and domestic abuse and the vulnerability females face in relation to controlling and coercive behaviour.

As Emily is over 60 years of age, she is classed as an older person. With a lack of support provisions in this area, there was no specialist support that could be offered to address

[1] Office for National Statistics, 2017

areas that research has identified as additional vulnerabilities for that age category in relation to deterioration of physical or mental health, caring for others etc.

The same parallel can be drawn for Emily's sexual orientation with a lack of specialist support or knowledge by professionals in this area being available within the Fenland or close surrounding districts. Also, the lack of recording of a person's sexual orientation by more than one authority which could affect the response or understanding they receive. Public health does not record information specifically for LGBTQ+ to be able to analyse any patterns that may be unique to this community.

A news article in 'CambridgeshireLive' on 8th November 2022 reports that Cambridgeshire has one of the highest gay and lesbian populations in the country. Based on ONS surveys between 2013 and 2015, the research found that 1.8 per cent of the Cambridgeshire population identified themselves as gay or lesbian.[2]

A report following research by the Universities of Bristol and Sunderland in November 2006 compared domestic abuse in same sex and heterosexual relationships.[3] Some of their research identified that post separation abuse is a sizeable problem in same sex domestic abusive relationships and that most survivors of same sex domestic abuse do not report to public agencies as they see their experience as their own problem and partly, they do not believe they will receive a sympathetic response.

Disability is relevant to this review due to the mental health that Emily suffered with throughout her adult life and whether this overshadowed the DA matters that she disclosed when speaking with health professionals.

Although not listed within the Equality Act 2010 as a 'protected characteristic,' questions have to be asked in relation to the role of Emily as a carer for her father in his last year of life. This was known to both the GP and CPFT, yet there is no record of specific discussions with Emily as to how she was coping with this considering her symptoms of mental health apart from being offered a carers assessment by CPFT.

Equality is about ensuring everybody has an equal opportunity and is not treated differently or discriminated against because of their characteristics. **Diversity** is about taking account of the differences between people and groups of people and placing a positive value on those differences.

1.8 Dissemination

Recipients who received copies of this report prior to publication:

Panel Members (listed in 1.1)

Members of the Fenland Community Safety Partnership

[2] Ref Tom Pilgrim CambridgeshireLive 8 Nov 2022

[3] Ref Domestic Abuse in same sex and heterosexual relationships – Donovan, Hester, Holmes & McCarry 2006

Coroner's office

Susan, Emily's daughter

1.9 Contextual background

The Fenland area of Cambridgeshire is one of five district councils in Cambridgeshire and is mainly a rural area but encompasses Wisbech and March as the largest urban areas. The population for Fenland District Council recorded in 2020 was estimated at 102,080. Just over 50% of residents are female. The overall age distribution for those ages 60-69 years is 12,713. (ref. UK office for National statistic ONS)

The Fenland Community Safety Partnership have the legal responsibility for DHRs within their area. In April 2021, the Domestic Abuse and Sexual Violence (DASV) partnership commenced a centralised DHR process for Cambridgeshire and Peterborough. This enables them to analyse issues across Cambridgeshire and Peterborough for wider implementation and uniformed processes.

The term 'carer' within this report relates to those who care for relatives or friends due to circumstance rather than a paid professional carer.

The Care Act 2014 put in place significant new rights for carers in England including:

- A focus on promoting wellbeing
- A duty on local authorities to prevent, reduce and delay need for support, including the needs of carers.
- A right to a carer's assessment based on the appearance of need.
- A right for carers' eligible needs to be met.
- A duty on local authorities to provide information and advice to carers in relation to their caring role and their own needs.
- A duty on NHS bodies (NHS England, clinical commissioning groups, NHS trusts and NHS foundation trusts) to co-operate with local authorities in delivering the Care Act functions.

This report will refer to Situational couple violence (SCV) (situationally provoked violence). This is violence that occurs where the couple has conflict which turns into arguments that can escalate into emotional and possibly physical violence. SCV often involves both partners.[4]

It will also refer to overshadowing. This is defined as a lived experience of mental illness and is associated with compromised physical health and decreased life expectancy. Those suffering with their mental health face greater barriers to accessing treatment for physical

[4] ref: johnson A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and ... - Michael P. Johnson - Google Books)

illnesses and are less likely to receive appropriate physical care than those without mental illness. Physical illnesses may go underdiagnosed and undertreated in those who suffer with their mental health because clinicians tend to focus on the mental illness to the exclusion of other health problems, a phenomenon called diagnostic overshadowing. (ref: 2021 - Molloy, Renee1,2; Munro, Ian1,2; Pope, Nicole)[5]

Suicide rates in all districts within Cambridgeshire and Peterborough are statistically similar to England for the three-year period 2017-19. However, all have seen an increase in suicide rates from 2015-17 to 2017-19.

In Cambridgeshire, since May 2018, eight suicides relating to domestic abuse have been considered as requiring a DHR. This is the first that involves a same sex relationship.

The World Health Organisation undertook a multi-country study using population-based surveys. This showed that women with experience of physical or sexual violence were nearly 4 times more likely to attempt suicide than women without such experiences, but it provided no associations for men[1]. In addition:

1. Domestic Abuse is a factor in around 12.5% of female suicide attempts
2. 25% of those in Domestic Abuse services have felt suicidal due to the abuse
3. Domestic Abuse victims are eight times more at risk of suicide than the general population
4. 50% of Domestic Abuse victims who attempt suicide will undertake further attempts within a year
5. 20% of DA Victims attempting suicide are pregnant
6. A third of female suicides are subject to domestic abuse
7. "Suicidal acts…… are more likely where feelings of defeat and entrapment exist alongside beliefs that neither rescue nor escape are possible" Williams (2001)
8. 3-10 women a week die by suicide where they have suffered domestic abuse

Section 2 – The Facts

2.1 Background to death of Emily

(Information about Emily's early years has kindly been provided by her daughter, Susan and Susan's father and reflect their words and memories)

Emily was born in 1960 and during her early years, was adopted by her parents. They moved about a lot in her childhood and as Emily was severely dyslexic, this caused her difficulties

5 https://journals.lww.com/jbisrir/Fulltext/2021/06000/Understanding_the_experience_of_diagnostic.7.aspx)

[1] **Intimate partner violence, suicidality, and self-harm: a probability sample survey of the general population in England - The Lancet Psychiatry** Intimate partner violence, suicidality, and self-harm: a probability sample survey of the general population in England - The Lancet Psychiatry

with her education. She was abused by her mother throughout her childhood because she was 'not girly.' Emily never opened up to anyone about the extent and explicit details of the abuse but both her daughter, Susan and Susan's father, Daniel believe it to have been mainly emotional abuse with some physical abuse which Emily had told him, made her rebellious.

This treatment of her at a young age would impact on the rest of her life as she never had a good relationship with her mother and had a strained relationship with her father as she felt resentment that he never did anything to stop the abuse. She disclosed this a number of times to Susan and Daniel and professionals.

During her mid 20's, Emily became an au pair in Holland. The first significant occasion Emily manifested signs of any mental ill health was when she was 28 years old. Whilst on a holiday in Spain, Emily had a breakdown and her mother had to fly out to bring her back. Emily was immediately hospitalised.

A year later, Emily began a relationship with Daniel. They met one evening when Daniel popped into the local pub for a quick drink after a tiring day and Emily was in there having spent the day at the Strawberry Fayre, an annual event in Cambridgeshire. They began a relationship in which they got on well and Daniel states they never really had any altercations or arguments. Emily had difficulty managing her alcohol intake which could have been triggered by her frustration and upset with her illness and when she had been drinking, she would ring her parents and verbally abuse them down the phone which Daniel stated was not nice to hear. There was only one occasion one night in a packed pub when, for no reason at all, Emily slapped Daniel around the face and was immediately apologetic, showing remorse and had no idea why she had done it. This was the only time she ever showed any violence towards him.

Emily and Daniel had a daughter, Susan, when they had been together about two years and Emily was 31 years old. Their relationship was already strained by this point and after the birth, Emily suffered post-natal depression and was in and out of hospital. They continued to live in the same house for four years, with Daniel raising Susan as the primary carer. Emily struggled with the fact that the relationship was over but they remained on good terms.

Around 2001, when Susan was in primary school, Emily announced that she was gay as she had met Pauline and wanted to live with her. Pauline also had a history of alcohol misuse and mental health difficulties. This was the start of a downward spiral in Emily's mental health. Susan used to go and stay overnight each week, which had to be carefully monitored by Daniel as they lived in a one-bedroom flat, were both always drinking and then arguing. Pauline would always blame Emily although a lot of the time she would instigate arguments or they were both at fault.

When Susan was 13 years old, she went on a camping trip with Pauline and Emily and others including a small baby. She recalls the adults were all drunk for the whole trip and the relationship between Emily and Pauline was described by Susan as toxic, with Pauline winding Emily up and Emily having a short fuse. Susan had to contact her dad when they were all in the pub one night and ask him to come and pick her up as she didn't want to be

there, which he did. Pauline was jealous of the fact that Emily received benefits when Pauline couldn't work and got them both in debt by overspending.

In 2006, Emily took a serious overdose on Daniel's birthday. She had been to the pub and took prescription pills which resulted in her being in a coma for five days. She had gone for a walk as she had to get away from Pauline who was described as manipulative and seemed to have a hold on her by both Daniel and Susan.

Pauline and Emily had six recorded domestic related incidents with the Police between 2004 and 2010 in which both were recorded as suspects on differing occasions and mental health and alcohol were comparable factors. These included violence towards each other with alcohol having been consumed on most occasions.

In October 2009, Pauline entered a refuge stating that Emily had barged into the bedroom, threw herself on top of her and started punching her. When Pauline reached for the phone to ring for help, Emily hit her on the head with the phone. Pauline fled and stayed with the vicar in the village the night before she was accepted in the refuge, where she remained living in for the next eighteen months.

In March 2010, Emily reported unwanted messages from Pauline to the police which were being made whilst she was in refuge. She explained she was frightened of the mental bullying from Pauline at that time. Emily suggested that Pauline had alcohol and mental health issues, hence declined any police involvement, and did not support any further police action.

Susan reports that from about 2011, once Pauline had moved out, her mum seemed generally a lot happier and was willing to do things. She still struggled with her mental health but wasn't drinking as much alcohol. She had a few relationships with other women but they were 'normal' and not abusive.

From 2012 to 2018, the Mental Health team records show that Emily had a long history of bipolar affective disorder Type 2. She mainly suffered with episodes of depression over the years. In the past she has struggled with social stress and quite significant suicidal ideation and has responded by self-harming and suicidal intent, but from 2015 until 2018, she had managed to keep herself safe and not required any active intervention from mental health services.

In 2017, Emily's mother died. She had recently started speaking to her parents again, having fallen out with them one Christmas when Susan was 12 years old and hadn't spoken to them for a decade. This left her father living on his own. He was frail and struggling. Emily had a brother who she was not in contact with and who didn't visit their parents and so Emily moved to the same street as her father in order to look after him. This premises also happened to be the same street that Pauline lived in and had done so since 2011.

Pauline called police complaining that Emily had moved closer to her and attended her address and been abusive towards her, but examination of texts sent between them showed them to have been having an amicable conversation only moments before it was reported.

Emily found caring for her father very stressful and her mental health deteriorated further. Between the end of 2018 and June 2021, Emily made calls or had face to face contact with Fenland Mental Health services on at least 210 occasions.

In 2019, Emily was so overwhelmed at caring for her father that she tried to hang herself. She would tell her housing officer and health professionals how caring for him affected her mental health. She self-referred to Change Grow Live alcohol service to get support and assistance with her drinking which provided great support and focus with her managing to control and reduce her drinking at times when it became an issue.

When her father passed away in 2020, Emily had to sort out all of his belongings that were in his flat. Emily felt isolated where she lived without the need to care for her father and wished for a move back to Cambridge. Several requests and applications were made but she did not meet the criteria as no local connection could be made. This caused her great distress.

At the end of 2020, Emily was brought into a domestic dispute that Pauline had with her ex in which the police were involved. Pauline went to stay at Emily's as a place of safety. Emily was found to have no wrongdoing in the incident.

Emily received support from CGL throughout 2020 and 2021 in which her consumption fluctuated dependant on her mood with her increasing this when her mood was low and she felt anxious. She was hospitalised twice in this time for taking an overdose and was discharged from the mental health team towards the end of 2021 which caused her great anxiety.

During this time, the GP also spoke to Emily frequently and even though this was during COVID, Emily was still seen on a number of occasions rather than appointments over the phone as the GP was concerned for her.

2.2 Circumstances of the death of Emily

2.2.1 On 1st December 2021, Emily and Pauline were drinking together with another friend when they had an argument. Emily alleged that Pauline had punched her. Emily had no visible injury. Pauline alleged that Emily had punched her and then grabbed her. Pauline had a red mark on her neck. Emily disclosed that she had attempted suicide in the October. Neither were willing to pursue a complaint against the other or provide a statement. Emily was removed from Pauline's home and returned to her own address.

On 13th December, Emily contacted the police wishing to make a statement but owing to the fact that she was a named suspect for the assault on Pauline, a voluntary interview was arranged with Emily for 30th January 2022 at her home address.

On 1st January 2022, Emily was admitted to hospital having taken an overdose of Diazepam. She later discharged herself without being seen by the psychiatric liaison team. She had not had her anti-depressants over Christmas due to a mix-up by the surgery with her

prescription and had been in a very low mood. Throughout January, Emily contacted her GP on a number of occasions who had referred her to the Chronic Fatigue clinic and the Crisis team explaining that Emily felt suicidal and the situation seemed to be escalating.

On 27th January, Emily rang the First Response Service (FRS- mental health services) stating that she 'wants help. If I don't get it, I'm going to be dead. Had enough. All I have in my head is how to kill myself.' Emily was given time to express her frustrations.

2.2.2 On 28th January, Police contacted Emily to confirm the interview on the 30th which led to Emily attending Pauline's address shouting that she was getting arrested. The same day, Emily made two phone calls to FRS stating she felt low, let down and not supported. She spoke about her life and being adopted. She said that she had pills and the means to hang herself. She had a rope and was having thoughts about hanging herself saying 'If no one helps me I will do it whenever.'

Emily's diary entry for this day read[6],

'*One hell of a day woke up really anxious don't know why I'm having rang Dr. Told her I just want to be dead cannot cope with this anymore she said did I want to be in hospital I said yes. Got mad and put the phone down on her I just don't want to be here any more like living in hell. Dr rang back she said she called the crisis team but a lady rang from first response. I just could not stop crying and said I just wanted to be dead. Another lady rang in the afternoon from helpline she was very nice I had got some wine because I felt really scared.*

Great had the police ring me they want to come and interview me Sunday about Pauline and me when she hit me rang her she said she did hit me she was just getting the wine off me said I put my hands round her neck fucking liar.'

This was her last diary entry.

In early February 2022, a mental health services support worker who is trained but does not hold a professional registration visited Emily's address for a pre-arranged appointment. Upon her arrival, there was no response from Emily, which gave rise to concerns for her welfare. Due to Emily previously making suicide threats and self-harming in addition to her dog barking incessantly, which was highly unusual, the Police were contacted.

Officers duly attended the location. Upon entering the property, via a partially open rear door, which was blocked by an obstruction, they located Emily slouched on her knees in between the door and a cupboard with a noose (white rope) around her neck tied to a coat hook on the side of the wall. Emily was freezing to touch; rigor mortis had set in and there was no sign of life. Ambulance and the fire brigade also attended. No attempts were made to resuscitate. A note was located in the living room together with two other lengths of rope, which were seized for evidential purposes, as were a laptop and a mobile phone.

[6] Emily's diary entries were provided by her daughter, Susan for inclusion in the report

The Note left has been transcribed as follows:

'My Dear Susan, I so sorry that I have to do this but Pauline is making my life hell again. I love you more than anything but my life is always hell and I cannot stand it anymore.

I do hope and pray you will xxx I've been feeling very ill for a long time and this has just past me over again. Please forgive me. You have always been my life but I just cannot do this anymore my darling.

Love you so much. Please forgive me. Wish you a very happy life. Love you dearly

Mum xxxx

Pauline will have to have live with this for the rest of her life. She made my life a misery, what she did to me.'

There were no signs of third-party involvement or criminality. This incident was treated as a sudden and unexplained adult death, indicative of a suicide.

A second handwritten note addressed to Pauline was also retrieved, which read: "Pauline, will you please call me, I just need to talk to you…I'm frightened to death about this and I need your help please. I'm not going to have a go at you…I need your help please."

It is not known when either of these notes were written.

2.3 Individual management reviews (IMRs) inc: Best practice

Emily's contact with numerous organisations was constant throughout her life from 28 years old which was when her mental health difficulties first came to light.

Refuge

This IMR refers to the policies, protocols and support provided to clients who stay at their accommodation and is in response to the Terms of Reference.

Emily was reported to be the alleged perpetrator at the time of Pauline's referral in October 2009 which is why it was deemed relevant for inclusion in this review. However, no personal information of Paulines has been used.

During a stay at refuge, a client can be supported with

- Domestic abuse awareness
- Debt management
- Joint tenancy arrangement for previous property
- Mental health
- Physical health
- Emotional Support

There is no record that Pauline was signposted to LGBTQ+ specialist support. However, she was offered support from her key worker when she highlighted concerns about her sexuality and living in a communal refuge.

There is evidence in the case records that refuge staff offer support and sensitivity around a person's sexuality. The Refuge offers a safe space to talk about concerns and listens to them to provide possible solutions. Key workers are considerate of clients age and mental health diagnosis.

Refuge is a specialist Domestic Abuse Agency with the following to provide structure and guidance:

Referral policy
Adult Safeguarding Policy

The case management policy states that a risk assessment should be completed every 4 weeks or when there is significant change.

Those in Refuge who have suicidal ideations or are suffering from low mood and depression are supported appropriately by their workers with referrals made to MIND and Mental Health Services. All Refuge Workers are required to attend mandatory training on suicide prevention.

Best practice/Reflective considerations:

- Intense and appropriate support provided by the Key Workers
- Relevant agencies referrals made to support clients. There is evidence that Refuge Key Workers build up excellent relationships with these agencies and this enables clients to move on
- Clients concerns around their sexuality whilst living in a refuge are listened to and supported
- The case records are detailed, and all actions are recorded

Clarion Housing

Clarion Housing is the UK's largest housing association, owning and managing 125,000 homes: 350,000 people call a Clarion home their home. Clarion manages a wide range of housing stock, including mixed tenures, affordable housing, supported accommodation and general needs.

Clarion Housing is part of Clarion Housing Group, which is made up of both commercial and not-for-profit subsidiaries. The group undertakes a range of commercial activities in order to invest in the core mission to provide homes for those who need them most.

Emily

Emily lived in a one-bedroom bungalow on a supported Livesmart scheme in Fenland. The bungalow is adjacent to the rear of the main building. This property is unique to other bungalows on the scheme as it has a private contained rear garden, assailable from a side gate. All Livesmart properties offer residents 24/7 emergency warden alarm systems (Mimecast) within the property. Pull cords in every room and additional pendants for those who request them.

The schemes also have a designated Livesmart manager who attends the site most days as part of their role they are responsible for carrying out housing facility management compliance checks at sites. The Livesmart manager also carries out IHM (intensive housing management visits) to residents who may need additional support to maintain their tenancy. Emily would be seen and spoken to on most days. Reports state that she was a private, pleasant person who loved her dogs and her garden. She would often comment about meeting a friend for a coffee locally.

11/01/18 – Emily had an appointment with Livesmart manager (LSM) to sign tenancy agreement for new address. No housing application is held on the system or the housing register database to determine Emily's reason for moving. All tenancy forms are signed and Emily declined any tenancy support. She signed an Invicta telecare form naming 'friend' Pauline as her local contact/key holder.

07/11/18 – During a welcome visit, Emily declared being supported by the Richmond Fellowship but no other details were provided.

09/06/20 – The Warden alarm remote system was contacted - Emily was experiencing a low mood. They discussed wellbeing and had discussions around possible befriender, but she did not wish to engage at this time. Daily remote contact increased following low mood discussion throughout the week. Emily advised them of her improving mood over the week. Emily informed LSM that she had almost daily contact with GP & her CPN.

15/06/20 - Daily discussions were held over the telephone following Emily's low mood. She informed LSM her mood was improved and requested to return to weekly warden alarm system & telephone contact once restrictions lifted.

Contact remained in place daily until restrictions were changed.

17/11/20 - Telephone call received from Emily requesting information on Right to Buy scheme. Emily was advised she was not eligible.

04/06/21 - Telephone call received regarding ASB. Emily called to advise that her neighbour from a nearby Close was kicking on her door after midnight. This was notified to the local police by the Neighbourhood Response Officer and Emily was updated.

22/06/21 – A Mimecast activation report was received from formally Centra by Livesmart team. Mental health team onsite with resident.

28/06/21 – A property visit took place as there were concerns for welfare. Failed contact with Emily since 25th June (3 working days). Concern for welfare. The property was visited but the key was not located in key safe. Parcels were also found on front door. Escalated concern for welfare was made with Cambridgeshire Police. Cambridgeshire police confirmed to LSM- Emily was safe but not at the property. LSM contacted NOK (Next of Kin) and he informed her that Emily was admitted to hospital but discharged on Wednesday.

15/12/21 - Face to face home visit from LSM- Emily was in her garden. Talked about her dogs and when LSM would be at the scheme over the Christmas period.

16/12/21 - Homelink Fenland Housing Register- online housing application to join register completed. Stated the following reasons for applying for housing,

'I moved to care for my elderly parents both of now passes away. My social support network is in South Cambs. I suffer with mental health bipolar, a support network is necessary during long periods of low mood'

A Letter was sent to the applicant to provide additional documents to support her application. Emily called to ask about adding a local connection to South Cambs District Council (SCDC). Emily advised she does not have family in SCDC anymore. Home-Link Advisor explained that local connection not applicable as Emily has been living in Fenland since 2018 and no other connection reason apparent. Home-Link Adviser explained that resident could bid on SCDC properties in the Cross Partner section, explained how she can log in to online account and detailed how to bid on properties.

10/01/22 – A letter from Emily was sent to the Homelink team regarding her application. Emily's Doctors letter confirmed Bipolar diagnosis and supported a move back to Cambridge for Emily.

18/01/22 - A telephone call was made from Emily regarding her Homelink application. She called to advise she was upset that she could not bid on Cambridge properties. Home-Link Adviser explained how local connection is applied. Emily 'struggled to understand' and explained her doctors letter said she had to move back to Cambridge.

Home-Link Adviser discussed a mutual exchange, which Emily said she would look into. Home-Link Adviser also explained how Emily can bid for herself but agreed to keep her on Autobid.

'Important!' note added to journal to clarify that Emily wants a property in Cambridge or the surrounding villages, preferably a bungalow, but will consider flats and noting she has a dog.'

02/02/22 – Emily had a bid rejected for a one bedroom sheltered flat in Cambridge with the likely reason being because she had a dog and property that was no pets.

Best practice/Reflective considerations:

Clarion Housing had identified the appropriate housing for Emily to ensure that she has support and can be monitored which has been effective when they have instigated a

welfare check by the police when she hadn't been seen for a few days. They have also managed to get her close to her father to assist with her caring for him. However, she has been placed in the same road as her ex-partner who she has a history of DA with which Clarion Housing were not aware of.

Change Grow Live (CGL)

Change Grow Live provides a free and confidential alcohol service with a comprehensive website on services offered. CGL have three main sites in Cambridgeshire: Wisbech, Huntingdon and Cambridge City. Service users are offered appointments at the locality site closest to where they reside or at a CGL 'Hub' site in the community. All service users undergo a comprehensive assessment to assess the most appropriate treatment pathway. CGL have a dependant and non-dependant alcohol pathway and alcohol screening tools are used to determine dependency alongside physical health screening questions and service user disclosures regarding their alcohol consumption. Those that are deemed non-dependant are allocated a recovery coordinator for one-to-one support sessions and are referred to structured groups to help them identify triggers and cravings and develop coping skills and are provided with information on how to reduce their alcohol use safely as well as the risks of ongoing alcohol use. Those who are deemed alcohol dependant have access to the above and are also assessed by a specialist alcohol nurse to identify any further risks and physical and mental health needs. The detoxification and rehab pathway are also discussed with the service user and facilitated should they wish to access this in order to achieve abstinence. All service users work with their recovery coordinator to develop a recovery plan which identifies specific goals regarding their alcohol use, physical and mental health, and any social issues that they may wish to address. If a service user is alcohol dependant, CGL will liaise with their GP to ascertain liver function and blood test results. All service users also have access to peer led mutual aid groups such as Alcoholics Anonymous (AA) and SMART recovery and non-structured groups run by Cambridgeshire Recovery Service. Those wishing to access support for their alcohol use can self-refer to CGL or can be referred by partner agencies such as GPs, police, probation service, prison service, social care, domestic abuse services and mental health services.

CGL routinely ask at comprehensive assessment and at full risk reviews (a minimum of six-monthly intervals) if a service user identifies themselves as being at risk of harm from others. CGL also receives information pertaining to MARAC cases (Multi Agency Risk Assessment Conference) and police CAADA-DASH notifications (Coordinated Action against Domestic Abuse- Domestic Abuse, Stalking and 'Honour'-based violence). All CGL staff undertake Safeguarding Adults training (classroom and e-learning) as well as training relating to specific aspects of domestic abuse (stalking, strangulation and working with perpetrators- all delivered by the Independent Domestic Violence Advisor service). CGL staff are also trained in the use of the CAADA-DASH Risk Identification Checklist and CGL have representation at MARAC. CGL also have access to the Cambridgeshire and Peterborough Safeguarding training portal and CGL work with Women's Aid and make referrals as required.

All CGL sites have one or more safeguarding lead as well as domestic abuse champions (individuals who have expressed an interest in supporting those who disclose domestic abuse and who have been upskilled in identifying and supporting with domestic abuse cases). Safeguarding meetings take place monthly and cases are discussed, and actions highlighted. In addition, safeguarding cases are highlighted and reviewed in daily multi-disciplinary meetings to ensure actions are completed/followed up. CGL hold national safeguarding surgeries on a weekly basis where complex cases can be discussed.

At no time did Emily disclose any domestic abuse or incidents that could be identified as domestic abuse to CGL. Emily stated that she did not identify herself as being at risk of harm from others.

Emily was assessed as a non-dependant drinker. An alcohol use disorders identification test (AUDIT) and severity of dependence questionnaire were completed, scoring five and nine respectively indicating low risk alcohol use and very low physical dependency. As a result, she was offered psychosocial support to address the psychological aspects of addiction in the form of one-to-one sessions (frequency of sessions is based on risk/need and the service users wishes) and group work with the aim of reducing her alcohol use and being able to consume alcohol socially. Her GP was informed that she had accessed support from CGL.

Emily engaged well with support offered by her Recovery Coordinator both face to face in the locality where she resided and telephone appointments. However, Covid-19 restrictions and limitations due to Emily's mental health resulted in her contact with CGL primarily being over the telephone. She was however visited by CGL on two occasions in her own home.

Below is a chronology of significant dates but does not reflect all the contact between Emily and staff at CGL which averaged at least six forms of contact a month.

31.10.19 - A Comprehensive assessment was completed the same day Emily self-referred to CGL. She disclosed consuming eight cans of 5% lager daily (approximately twenty units). She stated her goal was to consume no more than four cans of lager on drinking days and not to drink daily. Emily was assessed as a non-dependant drinker. An alcohol use disorders identification test (AUDIT) and severity of dependence questionnaire were completed, scoring 5 and 9 respectively indicating low risk alcohol use and very low physical dependency. As a result, she was offered psychosocial support to address the psychological aspects of addiction in the form of one-to-one sessions (on a fortnightly basis) and group work with the aim of reducing her alcohol use and being able to consume alcohol socially.

Emily stated she experienced bipolar disorder and suffered from depression and anxiety and was engaging with her GP and the community mental health team. She disclosed current thoughts of suicide and self-harm (but reported no plans to act on these) and previous suicide attempts. She stated she suffered from 'heart issues' and was receiving support from her GP. Emily confirmed as part of the assessment that she did not feel at risk of harm from others. Her GP was informed she had self-referred for treatment.

06.11.19 - Emily attended the Welcome Group. This is a group that describes treatment options and expectations when engaging with CGL.

15.11.19 – Emily attended a 1:1 appointment with her recovery coordinator. Emily reported consuming five cans of lager daily and on one occasion since her last contact with CGL she also drank a bottle of wine on top of this due to feeling anxious and depressed. She reported feeling unsettled at present as Cambridgeshire Mental Health Team (CMHT) were reducing her amitriptyline and prescribing diazepam whilst this reduction was taking place and that she had also recently suffered from heart problems. She also stated she had made new friends.

20.12.19 – The Risk assessment was reviewed by the recovery coordinator. Emily presented as emotional and tearful and stated that her mood had dropped since her amitriptyline was stopped and she reported that she had contacted 111 option 2 as she was feeling suicidal. She was admitted to hospital where she stayed overnight and she was visited by the crisis team. She stated she was visited at home by her Community Psychiatrist Nurse (CPN) and a psychiatrist from the Crisis Team and had been prescribed Mirtazapine 15mg at night which she started on 19/12/2019. She stated she had experienced suicidal thoughts throughout the week although confirmed she was not experiencing current suicidal thoughts. It was agreed she would contact her CPN or Crisis Team if this changed. She stated a referral had been made to Mental Health Services for an assessment (adult locality for local area). Emily reported no alcohol use for seven days.

09.01.20 – Emily had a 1:1 appointment with her recovery coordinator. She stated her mental health had improved since her last contact with CGL. She stated she had been discharged from the Crisis Team but was being supported by her GP who was prescribing Mirtazapine 15mg and diazepam. She stated that she no longer wanted to be assessed by Mental Health Services at this time and that she had not seen her allocated CPN since before Christmas.

Emily stated she had only consumed alcohol once since before Christmas (four cans of lager). Emily was advised to engage with her GP and of the risks associated with prescribed medication and alcohol use.

30.01.20 – Emily had a 1:1 appointment with her recovery coordinator. She reported feeling low and advised her that her father had passed away and that she was being supported by her brothers. As a result, her alcohol use had increased to five cans of lager daily. It was agreed that she would try to reduce this to four cans daily. Emily stated that her friends had contacted her to check on her wellbeing so she felt friendships might be rekindling.

She advised that her CPN visited her the previous week and she had a GP appointment the following week.

March 2020 – Several texts were received from Emily to state that she had a very low mood for some time since her father passed away and her alcohol use had been erratic. Her CMHT face to face appointments had been suspended due to Covid-19 and were now on the telephone. She disclosed she had to re-home one of her dogs as she was unable to meet his needs due to her mental health and not wanting to venture out of her home had impacted on her low mood.

12.05.20 – Emily contacted her recovery coordinator by text message stating that her mood was up and down due to Covid-19 restrictions however reported she had been gardening. She advised that her alcohol use had increased and that she had been drinking daily for the past couple of weeks. Emily reported consuming four cans of lager one day and a bottle of wine the next day. She stated that she would like to reduce her alcohol use however did not feel she had the will power.

June 2020 – Emily had a telephone call with her recovery coordinator. She stated that she had been struggling with her mental health for several weeks and had seen her GP. She reported that her GP completed numerous blood tests and she was awaiting the results of these. She advised that her GP had prescribed Quetiapine and that over the last week her mood had started to lift. She stated she had a period of abstinence from alcohol for two weeks however had restarted drinking and reported drinking up to ten units on some days and not drinking on others. She also reported recent weight loss due to a lack of appetite and stated that she had not been in recent contact with friends or family.

In a further telephone call with her recovery coordinator, Emily stated that due to being very down she would stay in bed most of the time and did not want to drink alcohol and that this lasted for about two weeks. Since being prescribed Quetiapine, she reported that her mood had lifted slightly so she was consuming alcohol. She stated she had frequent contact with a new CPN.

She stated that some days she consumed two cans of lager and one bottle of wine or four to six lagers in the evening however was not drinking daily. A reduction regime was discussed and she agreed to buy only beer and keep a drink diary for a week.

24.11.20 – During a telephone call with her recovery coordinator, Emily stated that she was drinking no more than two cans of lager on drinking days and was not drinking daily as she was prescribed lots of medication for her mental health. She stated that she had been reviewed by a psychiatrist at Agenoria House the previous week and that he has prescribed Prozac and increased her Quetiapine. Emily was advised to inform mental health services of her alcohol use. Emily felt her mood had lifted over the last two weeks. She also confirmed continued contact with her CPN, weekly and that her heart scan showed no abnormalities.

Emily reported little contact with her siblings and stated she only had one good friend and was quite isolated. She said she would consider attending zoom groups.

03.03.21 - Telephone call with recovery coordinator. Emily stated she was in hospital and had been admitted the previous night with a racing heart and had been prescribed beta blockers, blood thinners and antibiotics as she had had a urine and chest infection. She stated her mental health had improved over the last month as her medication had been adjusted. She reported that she had not consumed alcohol for at least six weeks due to feeling unwell. She was encouraged to seek support from her GP if she felt unwell in the future.

08.04.21 – During a telephone call, Emily spoke of her recent hospital admission and stated she had not consumed alcohol since March, prior to her hospital admission. Emily reported that her CMHT support worker had not contacted her for several weeks.

15.06.21 – A telephone call was held with her recovery coordinator. Emily stated she had been consuming alcohol for the last two and a half weeks, four cans of lager daily. Prior to this she had not consumed alcohol for a long time which she attributed to not suffering from anxiety. She identified that alcohol was her coping mechanism. She stated she did not feel anxious when prescribed Quetiapine however could not tolerate this medication so had self-reduced. She reported her anxiety had returned and as a result she started to consume alcohol again. She advised that she had spoken to her GP who requested her CPN visit her and a home visit from the CPN had been scheduled for the following day.

July 2021 – Following an overdose where Emily was hospitalised, she reported that she had not had any alcohol since being admitted.

16.08.21 – A telephone call was held with her recovery coordinator. Emily stated that her mood had dropped significantly. She reported feeling an intense low mood and the feeling of not wanting to carry on. She reported drinking alcohol daily, one bottle of wine and four beers which gave her some respite from the feelings she was experiencing. She advised that she had contacted her CPN and was awaiting an appointment and knew how to contact 111 option 2.
Emily was to contact her CPN the following day if she had not had any contact prior to this. Emily was to contact CGL if she requires support with her alcohol use. 111 option 2 discussed and Samaritans. She was advised of the risks associated with prescribed medication and alcohol use. Next appointment made for 23/09/21.

23.09.21 - Recovery coordinator home visit- It was agreed that CGL would visit Emily at home as she as finding it hard to leave her home due to her mental health. Emily reported being very low in mood and extremely anxious. She stated that she was worrying about everything and had thoughts of not wanting to carry on. She stated she had a received a telephone call from the mental health team stating they were going to discharge her but she that she felt she required ongoing support. She reported drinking five cans of lager to help alleviate the anxiety. Emily reported having very few friends at this time.

Emily was provided with Crisis team details, Samaritans and CGL SPOC.CGL to contact Emily the following week.

14.10.21 - Telephone call with recovery coordinator. Emily stated she was very depressed and that she had not washed or dressed since her last contact with CGL. Emily was encouraged to call 111 option 2 however believed that they would not be able to help her and would send her to A&E where she did not want to go.

October/Nov 2021 – Emily had been discharged from CMHT and her GP was in regular contact. She spoke about her wish to move closer to Cambridge as she had done for some time. Her physical and Mental Health were both improving. She was maintaining abstinence from alcohol.

29.12.21 - Telephone call with recovery coordinator. Emily stated she was very low in mood and experiencing anxiety. She reported that she had contacted 111 option 2 the previous day as she could not cope with her feelings and had spoken to her GP earlier in the day as she did not have any anti-depressants. She stated that her GP had prescribed different medication to help with her anxiety. Emily reported consuming four cans of lager/cider daily. Advice – Emily to attend pharmacy to collect her medication.

30.12.21 - Telephone call with recovery coordinator. Emily stated she was finding it very hard to cope as she had not received her prescribed medication from her GP as her prescription was not at the pharmacy. Emily stated that due to feeling unwell she had contacted the GP and requested they deliver her medication to her home address. Emily stated she bought a bottle of wine the previous day and had consumed two glasses so far on 30/12/2021.

31.12.21 - Telephone call with recovery coordinator. Emily reported that she had not received her prescribed medication from her GP. The pharmacy reported that she was not home when they tried to deliver it and they would try again. Emily was very tearful but confirmed that she was not feeling suicidal. She did state that she telephoned the mental health helpline the previous day and that she felt they were supportive towards her. Emily stated she consumed two bottles of wine the previous day which helped her to get some sleep and that she had drunk two glasses of wine so far on 31/01/2021. Advised to contact pharmacy by 3pm if medication not received.

Jan 2022 – Lack of medication and overdose had increased Emily's alcohol intake but on the 19th of January, she reported that her mood had stabilised and she wanted to attend the Art group.

The last significant contact that CGL has with Emily was on the 24/01/2022. Her Recovery Coordinator telephoned Emily who reported that she continued to drink daily, five cans of beer or a bottle of wine and stated she wanted to start trying to reduce her consumption. A face-to-face appointment was booked for 27/01/2022 at 1pm in at the CGL Hub Site (Community Centre local to Emily). On 27/01/2022, Emily sent a text message to her Recovery Coordinator stating that she would not be able to attend her appointment and that she would telephone her Recovery Coordinator the following week to arrange a further face to face appointment.

Best practice/reflective considerations:

Consent was reviewed throughout Emily's treatment journey. Emily provided CGL with consent to liaise with her GP however did not give consent for CGL to liaise with any other professionals nor any family members.

It may have been beneficial to explore with Emily her reasons for not wishing to consent to CGL sharing information with those who were supporting her mental health.

Due to Emily's mental health CGL facilitated home visits where appropriate. The majority of contact was over the telephone due to Emily reporting experiencing anxiety when she left her home.

Cambridgeshire Police

Prior to writing this IMR the author has undertaken the below actions to ensure a good understanding of the incidents and to provide a comprehensive review. This review has been conducted by means of:

• Examination of Cambridgeshire Constabulary computerised records and databases, including Athena, crime, non-crime, case administration tracking system (CATS), which contains details of children and adults at risk, domestic abuse Command and Control system (Incidents), intelligence and Enterprise search systems

• Review of recorded crime reports

• Review of Domestic Abuse Stalking and Harassment (DASH) risk assessments

• Review of Adult at risk referrals

• Discussion with key staff and written or verbal responses from other relevant staff

• Review of the Coroner's report and associated documents

• Review of Cambridgeshire Constabulary policy and procedure, in particular domestic abuse, adults at risk and safeguarding

• Review of national policy and College of Policing's Authorised Professional Practice

• Review of legislation and legislative changes over the prescribed period

• Review of staff and organisational changes over the prescribed period

• Review of partnership practice, policy, and guidance

<u>Chronology for Emily</u>

10.09.04 – Emily and Pauline had been drinking in the pub and then had a fight, assaulting each other. Neither party wanted to make a complaint. Recorded as both living at an address in Cambridge.

27.09.07 - Verbal argument, Pauline recorded as victim and Emily recorded as suspect.

19.05.08 - Pauline and Emily had an argument, Pauline recorded as suspect. Alcohol and mental health present.

22.07.08 - Pauline and Emily had an argument, Emily recorded as suspect. Recently separated.

21.07.09 - Pauline and Emily had an argument after a bout of drinking alcohol. They had been in a relationship with each other, until four weeks previously, when they

separated but were still residing together at a different address in Cambridge to previously recorded. The incident was recorded as a verbal domestic dispute with Pauline recorded as the victim and Emily as the perpetrator. A risk assessment was completed, which met the MEDIUM criteria due to the fact, both were intoxicated and suffering from mental health difficulties. A referral letter was submitted for information sharing purposes and a letter advising of this action was sent to Pauline, dated 27/07/09. The referral process at that time necessitated the use of a DA version 7 SPECCS template, submitted on 23/07/09, for Adult Social Services to be notified. The relevant intelligence research was completed and there was compliance with force policy. No children were present.

03.03.10 - Emily reported an incident to police, whereby she was receiving unwanted text messages from Pauline. Emily explained they had previously been in a relationship for seven years, which deteriorated due to constant verbal arguments fuelled by alcohol abuse, resulting in Pauline moving out. Since then, Emily perceived Pauline's behaviour to constitute stalking and harassment, due to the incessant contact via text messages. Pauline was offering apologies and seeking to collect her belongings. A Domestic Abuse, Stalking and Harassment (DASH) risk assessment was completed with Emily. She explained she was frightened of the mental bullying from Pauline and at that time, Emily answered 'No' to suffering from depression and suicidal ideation. Emily was advised to contact Police to facilitate the collection of Pauline's belongings, to prevent a breach of the peace. Emily suggested that Pauline had alcohol and mental health issues, hence declined any police involvement, and did not support any further police action. Based on her responses, the DASH was graded as MEDIUM.

Whilst the incidents occurred on 27/02/10, they were reported at a later date, on 03/03/10 and a record was created on the police STORM database. No crime record was generated due to no offences being revealed.

23.08.18 - Pauline called police complaining that her ex-partner, Emily had moved closer to her home address in the same street, and she alleged that Emily attended the location on 20/08/18, hurling abuse towards her. The incident was dealt with by way of a diary appointment due to its retrospective nature. Officers examined Pauline's phone to view the contact exchanged between Pauline and Emily, and they noticed that just moments before the abusive episode, the messages between them both had been amicable and friendly. In accordance with the DA policy, a domestic abuse crime investigation was generated on the Constabulary's Athena database. Pauline was recorded as the victim and Emily as the perpetrator. A DASH risk assessment was completed and determined as standard, with a recommendation that contact between both parties should cease. Specifically questions 2 and 25 were posed to Pauline: "has abuser ever threatened or attempted suicide? Pauline's response was "YES SHE STOPPED TAKING MEDS, THEN TOOK THEM ALL AT ONCE AND WAS PUT IN A COMA."

Pauline did not wish to pursue a complaint and was reluctant to the notion of Emily being visited or contacted by Police. She believed such action had the potential to exacerbate the situation between them. The incident was finalised as a verbal dispute,

due to no specific criminal offences being revealed. Since the initial interaction between them, Pauline had received a card from Emily, suggesting they should end their friendship, which Pauline was agreeable to. Pauline intended to block Emily from her phone and cease contact, hence the risk of repeat incidents was deemed low. Whilst the activation of body worn video (BWV) was mandatory when responding to DA related incidents, it is unlikely that it featured during the response to this complaint, due to the manner in which it was resolved, in conjunction with the non-attendance of officers. Police records indicate that Pauline was managed by the local mental health team and suffered from anxiety, depression, and suicide ideation for which, she was medicated. Police records also indicated that Emily suffered from bipolar disorder, anxiety, and depression.

25.10.20 - A female called police reporting that she had been verbally threatened by a male, to leave Pauline alone and this had upset her because she considered Pauline to be a good friend. Until recently, VS and Pauline had been in a relationship. This call was followed by a silent 999 call made from Pauline's mobile phone and two females could be heard talking calmly in the background. When the police contacted Pauline to carry out a welfare check, she explained that she had sought refuge at Emily's home address. Pauline feared for her own safety after she informed VS, that she no longer wanted to be in a relationship with her.

28.06.21 - A member of staff from Clarion Housing contacted police to report concerns for Emily's welfare because Emily had recently been discharged from hospital to her home address. Emily had taken an overdose, which was treated as a suicide attempt. The staff member stated Emily had not previously missed a Monday visit and the last recorded contact with her, was on 16/06/21. She had also fallen out with her brother, resulting in no contact between them over the last four weeks. Emily was open to mental health services as an in-patient; hence the Integrated Mental Health Team (IMHT) reviewed the incident. Emily was located on OAK 1 ward, at the Cavell Centre and no further police action was required.

01.12.21 - Police responded to a report of a domestic dispute occurring at Pauline's home address. Officers from Cambridgeshire Constabulary's Specials Unit, attended in the first instance and activated their BWV devices, in accordance with policy. Emily and Pauline were making counter allegations of assault against each other, that occurred during a verbal dispute, and both had consumed alcohol. A third party was also present and witnessed the incident and was also the caller that reported the incident to police. Emily disclosed to officers that she had previously attempted suicide in October 2020. Crime records were subsequently generated based on each party's allegations and recorded as Actual Bodily Harm in respect of Pauline and common assault in relation to Emily. A DASH risk assessment was completed, pertaining to Pauline, and graded as medium. Emily was removed from Pauline's home and returned to her own address. An adult at risk referral (Form 102) was completed with Emily, which was submitted to the MASH for information sharing purposes. The MASH forwarded Emily's referral to her GP for further support and on 03/12/2021, MASH shared the referrals with the Adult

Referral Centre (ARC). Neither Pauline, nor Emily were willing to pursue a complaint or provide statements. Safeguarding advice was given and an individual vulnerable needs assessment (IVNA) was completed with Pauline. However, she was not supportive of the IVNA and safeguarding measures, which included, demonstrating the 'We Protect' and 'Brightsky' mobile phone applications. Pauline was satisfied with the safety and support of her friend (SJH), who was staying with her, and she also had access to her mobile phone. Following an evidential review by a Supervisor, the DASH risk assessment relating to Pauline, was lowered to standard.

03.12.21 - Upon receipt and review of the adult at risk referral relating to Emily, MASH contacted the original officer via email who had completed the F102 and attended the incident. The Special Constable was tasked to complete a DASH risk assessment pertaining to Emily, due to the incident being domestic related. The F102, clearly suggested that Emily was seeking additional support to manage her mental health difficulties. On 13/12/21, Emily contacted the Investigation Management Unit (IMU), requesting to make statement however, owing to the fact she was also a named suspect for the assault upon Pauline, a voluntary PACE (Police and Criminal Evidence Act) interview was arranged with Emily for 30/01/2022, at her home address.

28.01.22 - Pauline contacted police to report an angry and abusive phone call she received from Emily during which, Emily claimed she was being arrested on 30/01/22 and it was her intention to visit Pauline the following day on 29/01/22 to discuss and potentially resolve their dispute. Emily then proceeded to leave five voicemail messages however, Pauline failed to respond or engage with Emily. Pauline was reassured by the fact that the witness SJH was staying with her and declined any further police action. Pauline was suitably advised regarding safety measures and safeguarding.

29.01.22 - Emily called at Pauline's address as she indicated she would the previous day, resulting in Pauline contacting the Police. Pauline informed the operator that they used to be in a relationship several years ago and remained friends over the years. They recently had a falling out and Pauline did not wish to continue the friendship. Last night Emily called Pauline and a verbal argument occurred. That day Emily attended Pauline's address, repeatedly knocking on the front door. Pauline did not answer the door and reported the matter to Police, describing Emily as banging the door for 20 minutes at her address at 10am, then she returned about 11am. She described Emily's behaviour as erratic, and that she was possibly intoxicated. Pauline was registered as disabled and she was fearful for her own safety, as Emily had already attended her home twice, but left of her own accord.

A DASH risk assessment was completed with Pauline due to the argument they had the previous evening coupled with the recent encounter. No concerns were identified in relation to either party and safeguarding advice was given to Pauline. The incident was prioritised following consultation and review by both the Force Control Room Manager (referred to as Oscar 1), and the Early Intervention Domestic Abuse Desk staff (EIDAD), in line with DA policy. A police officer attended Emily's address that afternoon and issued words of advice regarding her conduct and behaviour, and BWV was activated.

The DASH was assessed as standard and reviewed by a supervisor. A non-crime domestic concern record was created. On 30/01/2022, the officer in the case, investigating the assaults that occurred on 01/12/21, attended Emily's home address to conduct a voluntary suspect interview with her. However, there was no response, and he was diverted to a knife related incident, categorised as an 'immediate response' required. There was no further contact between Emily and the investigating officer.

Following the death of Emily, the assault investigation was finalised as no further action. This was due to the fact that no statements had been obtained from the victim or witness and no suspect account had been obtained in compliance with the DA policy, due to the lack of co-operation from the parties involved, including the witness. This decision was subsequently reviewed and endorsed by a supervisor.

Early Feb 2022 - A mental health services team member (EC), visited Emily's address for a pre-arranged appointment. Upon her arrival, there was no response from Emily, which gave rise to concerns for her welfare. Emily had previously made suicide threats and self-harmed, and EC noticed her dog was barking incessantly, which was highly unusual. Police were contacted and officers duly attended the location. Upon entering the property, via a partially open rear door, which was blocked by an obstruction, they located Emily with a noose around her neck, tied to a coat hook. A suicide note was located in the living room together with two other lengths of rope, which were seized for evidential purposes, as were a laptop and a mobile phone.

The suicide note indicated Emily was down, unable to cope and asking for forgiveness from her daughter. There were no signs of third-party involvement or criminality. This incident was treated as a sudden and unexplained adult death, indicative of a suicide, hence investigated in compliance with the force's sudden death policy and Coroner's protocol. A supervisor and the Duty Detective Inspector also attended the scene to ensure adherence to local and national policy.

A second handwritten note addressed to Pauline was also retrieved, which read: "Pauline, will you please call me, I just need to talk to you…I'm frightened to death about this and I need your help please. I'm not going to have a go at you…I need your help please"

Intelligence enquiries on the force's databases, confirmed that Emily was open to mental health services, suffering from bi-polar affective disorder, she was a self-harmer, experienced suicide ideation and she had a history of substance and alcohol abuse, and she had been referred for counselling.

<u>Pauline</u>

25.10.20 - A female called police reporting that she had been verbally threatened by a male, to leave Pauline alone, and this had upset her because she considered Pauline to be a good friend. Until recently, she had been in a relationship with Pauline. This call was followed by a silent 999 call made from Pauline's mobile phone and two females could be heard talking calmly in the background. When the police contacted Pauline for a welfare check, she explained that she had sought refuge at Emily's home address, because Pauline feared for

own safety after she had informed her that she no longer wanted to be in a relationship with her.

Pauline had several incidents recorded of domestic abuse with this female over the next few months of which some included alcohol abuse.

The investigation into Domestic Abuse Incidents and Safeguarding of victims within Cambridgeshire is a key priority for the force and it promotes, that domestic abuse is everyone's business. The two districts are responsible for the initial response and ongoing daily management and investigation, whilst the MASH work with partners to share information to further safeguard. The guidance advocates that each officer and member of staff when dealing with a DA incident should constantly be reviewing the risk and identifying how it can be managed or reduced.

DA is investigated on a risk led approach, with the highest risk victims being allocated an Independent Domestic Violence Advisor and being referred to the Multi Agency Risk Assessment Conference (MARAC).

The majority of domestic related incidents are referred via calls to service, where officers will complete the DASH including Honour Based violence, risk assessment (DASH). These are quality assured by the Investigation Management Unit (IMU). The Constabulary also receives Co-ordinated Action against Domestic Abuse (CAADA) DASH risk assessments from partner agencies.

The risk assessment process is dynamic and dependent on the circumstances of the case but in general, the grading system works as follows:

• Standard – No current indicators of serious harm.

• Medium – There are indicators of serious harm, but they are unlikely to occur without a trigger event.

• High – There are current indicators of serious harm, which may occur without warning.

Risk of Serious Harm defined as (Home Office 2002 and OASys 2006):

'A risk which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible.'

All Medium and High DASH risk assessments are reviewed in the MASH, information is shared with partner agencies and cases are referred to the MARAC, as necessary. Sharing is often based on the risks, which have been identified within the DASH.

Domestic Violence Protection Orders (DVPO) should be considered from the outset of any DA investigation. Where a designated Gate Keeper or the Crown Prosecution Service makes the decision to "No further action a case" Domestic Violence Protection Notice (DVPN) should be considered.

The College of Policing, Authorised Professional Practice also provides some clarity regarding counter allegations and states that officers should avoid jumping to conclusions,

about which party 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 is not necessarily the person who was first to use force or threatening behaviour in the current incident. If both parties claim to be the victim, officers should risk assess both counter allegations.

Prior to 2018, the MASH staff were authorised to amend DASH risk assessments as part of the referral process and those assessed as Medium or High, were retained in accordance with the domestic abuse policy. Amendments made to the DASH referral forms in 2017 and 2019, now incorporate both the child safeguarding referral and adult at risk referral, which was a significant step-forward in ensuring that officers capture the wider picture, which could be overlooked when dealing with domestic incidents, as previously separate forms were used for each, referred to as F101 and F102.

The main function of the IMHT is to provide immediate and appropriate information sharing, to assist police decision making when responding to emergency mental health crisis situations. The objective is to ensure someone in crisis receives the right care at the right time and from the right service, at the first point of asking. This can be achieved by providing an improved response to persons in crisis, and reducing the time spent dealing with incidents, via improved initial assessments by qualified professionals. It also offers both police officers and mental health service staff the opportunity to benefit from cross over training, spotting early warning signs and to develop an understanding of the challenges faced by each agency.

The option of safe and effective short-term care, support and treatment will be at the heart of all decisions made regarding any follow up care that may be required. Clear information will be provided to inform access to alternative solutions to meeting the mental health crisis.

Healthcare and support needs will vary for each individual. It is now well accepted that abuse (both in childhood and in adult life) can be a main factor in the development of depression, anxiety, and other mental health disorders, and may lead to sleep disturbances, self-harm, suicide, and attempted suicide, eating disorders and substance misuse.

Cambridgeshire Constabulary officers and staff are reliant on other agencies within the health and adult social care to assist with accessibility of services for those contemplating suicide. In the event of a live incident there is a protocol in place, which may involve the deployment of specially trained negotiator and access to the IMHT staff. In Emily's case, she was already known to mental health services and engaging with them.

The intervening period of sixty days between the original DA incident on 01/12/21 and intended PACE interview with Emily, seems an unreasonable delay in these circumstances, to finalise the investigation. The term positive action suggests seeking timely outcomes to disputes. Furthermore, there is no information to suggest whether Emily's mental health was assessed prior to the PACE interview stage, to determine whether she required an

Appropriate Adult. DA is a force priority and as such, early resolution is fundamental to the process, in terms of victim care and public confidence.

Within Cambridgeshire Constabulary specific training related to domestic abuse, completion of DASH risk assessments, referrals to other agencies, DVPN and DVPO's is delivered to all officers and staff during their initial training to cover the subject of vulnerability holistically. There are also sessions over two days dedicated to mental health issues delivered by the force leads. However, there is no specific Suicide Prevention training for the workforce in Cambridgeshire whereas, such training is delivered to multiagency professionals by Hertfordshire County Council entitled HARMLESS, albeit it is optional to complete. Similar training is also offered within the Voluntary and NGO sectors.

Best practice/Reflective considerations:

There are sufficient and appropriate policies in existence, both nationally and locally, to address DA related incidents within Cambridgeshire Constabulary. However, there does appear to be a need for greater scrutiny and safeguards at Supervisor and Manager levels, particularly in respect of vulnerable adults where counter allegations are being made, and each subject is likely to be categorised as both suspect and victim. In Emily's case, there was a missed opportunity in terms of addressing her needs owing to the absence of a DASH risk assessment, which resulted in information not being shared with other agencies and organisations, which were better equipped to provide her with the requisite support.

National policy and Cambridgeshire Constabulary policy promotes the belief that DA is everyone's business and positive action must be taken. Guidance outlines the duty of officers to take positive action at all stages of the police response to DA to ensure that victims, including children are protected; criminal proceedings are pursued where appropriate; and that there are effective perpetrator management where criminal proceedings are not possible or suitable. Application and interpretation of the policy seems ineffective and inefficient in some cases such as Emily's and Pauline's, because at no stage, has there been any consideration of a DVPN or DVPO at any of the incidents between them, which demonstrates yet another missed opportunity to adequately safeguard Emily.

The Cambridgeshire Constabulary's domestic abuse policy has been continuously reviewed and updated since October 2018, following the Local Policing Review and currently reflects local and national policy. This policy is clearly defined and underpins the basic principle that Domestic Abuse is "Everyone's Business" and applies to all officers and staff whether employed full-time or part-time, fixed term, permanent, seconded or on a temporary basis who are employed by the Cambridgeshire Constabulary

The use of body worn video (BWV) is a requirement of attendance at incidents where there is an indication or suspicion of current and/or historical DA. The use of BWV has been in place since 2016, although this was on a roll-out basis until all front-line staff were equipped.

Cambridge and Peterborough NHS Foundation Trust (CPFT)

The information for this IMR has been extracted from the initial scoping document and the Serious Incident Investigation Report, shared for the purposes of the DHR from CPFT. This was a comprehensive Level 2 investigation and investigates the care provided to Emily by Cambridgeshire & Peterborough NHS Foundation trust (CPFT) in the year leading up to her death.

Fenland Adult Locality Team is a community-based team who can provide the following services to patients – Assessment and initial treatment advice, care plan development with patients, pharmacological interventions, medication management, and psychological therapies, it is aimed at patients who are experiencing symptoms of moderate to severe mental health illness, support to carers and families, care plan reviews, information and support with employment and activities of daily living, advice on health and wellbeing, crisis planning and relapse planning. Fenland Adult Locality Team do not take direct referrals from service users but do accept from CPFT services for example First 8 Response service, Crisis Resolution and Home Treatment Teams. The service runs Monday to Friday, 9 - 5 and operates a duty calling system between the hours 1- 5. The duty worker role is to ensure there is a guaranteed point of contact with a qualified member of staff for: urgent Crises, information and advice, support to admin staff, capacity to respond to emergency emails, capacity to respond/co-ordinate to emergency calls from clinics.

First Response Service provides 24-hour access, seven days a week, 365 days a year to mental health care, advice, and support. The service is available to anyone of any age currently living in Cambridgeshire & Peterborough in mental health crisis. Individuals can call the service themselves directly or anyone can call on their behalf e.g., carers, family, friends, GPs. Tele coaches will provide support, advice on the phone to the caller and organise where needed face to face meetings with either First Response Service workers or refer the case to other CPFT services for example Crisis Resolution and Home Treatment Teams for assessments. First Response service can take an average of 3000 calls a month.

Recovery Coach Team is a community service for people who are moving on from secondary community mental health services back to their GP and may find this transition challenging. The service offers coaching and peer support worker sessions to help identify what the service user needs to do and what support they may need to access to make the transition as successful as possible. The Recovery Coaches have been trained in coaching methods to empower the service user to take control of their journey by helping them to establish their own goals. Peer support workers are individuals with lived experience of challenges around mental health and are trained to support the individual to achieve their goals. Recovery Coaches aim to start supporting individuals when they are working towards transition from secondary mental health services back to the care of the GP. They will ensure that coaching is the right approach by having a conversation with the individual about what being coached means, what they can expect and what they expect from the individual.

Emily was a 62-year-old lady who had been known to Mental Health services since the age of 27 years when she was first admitted to hospital after experiencing panic attacks and believing that the devil or God was controlling her.

Emily initially lived in Cambridge but moved in 2017 to a house next door to her father to enable her to offer full time care to him after his physical health deteriorated following the death of Emily's Mum in May 2017. Emily provided care for her father until he passed away in 2019.

Emily had an established diagnosis of bipolar affective disorder and traits of Emotionally Unstable Personality Disorder and was treated with a combination of medication which over the years has helped but despite treatment there were times when she experienced depressive relapses which were usually in context of stressful events.

Emily's first contact with CPFT was in 2008 when she was assessed by the Community Mental Health Team in Cambridge and was referred to the crisis resolution and home treatment team (CRHTT) after presenting with poor sleep, reduced appetite, no motivation, and poor concentration.

2006 – Overdose of prescribed medication stating she would be better off dead. Dependent on alcohol, risks increase when Emily stops her prescribed medication.

2013-18/05/2015 - Emily was under the care of Cambridge South Intake and Treatment team. At the time of discharge, it was noted that Emily has a long history of Bipolar Affective Disorder and she suffered with episodes of depression. In the past Emily had struggled with significant suicidal ideation with intent but at the time of discharge she had managed to keep herself safe and had not required any active intervention from mental health services. Over the years Emily's dependence on alcohol had at times been a problem but she had been working with Inclusion services and her alcohol intake had for some time remained within the normal range.

2018 – Emily was referred to Fenland Community MH Team (FALT) due to moving house. She has no local support and is the carer for her father.

2018 to 2021 – Over the four years, Emily had the following contact with CPFT:

FALT - 185 recorded contacts. Note: 'contacts' can be visits, phone calls, reviews, appointments or administration tasks.

First Response Service (FRS) – 15 recorded contacts

Crisis Resolution Home Treatment Team (CRHTT) – 10 recorded contacts

26/02/2019 – Emily had contact with First response service. Emily felt that she needed some help, had difficulty with her accommodation and felt that her mental health had deteriorated but would not expand on this and said she could manage herself.

10/09/2018 – Emily was referred to Fenland Adult Locality team for a medication review due to stopping Lithium and amitriptyline She was allocated a care coordinator (CC) and commenced on medication. Emily tried to end her life prior to planned discharge. A

formulation meeting took place, and it was felt that Emily's recent hanging attempt and alcohol use was indicative of personality traits rather than bipolar disorder and it was agreed that the plan of discharge should go ahead. Emily was provided with a crisis plan on discharge.

Following discharge Emily had contact with FRS and was referred to the Fenland Adult Locality Team (FALT) on 28th oct 2019 where she was offered a medication review and allocation of care coordinator where she remained under their care.

Risk History

Emily has a long history of suicidal ideation and has attempted to take her own life on several occasions:

2006: Emily took an overdose of prescribed medication, amitriptyline, which resulted in a hospital admission. Emily was in a coma for 5 days.

2015: Emily took an overdose and was admitted to an Acute Hospital.

2019 – 08/05/2019: Emily reported thoughts of suicide triggered by her father becoming unwell. Emily agreed for the community Team to look after her medication but declined support from the Crisis Team.

12/06/2019 – Emily attempted to hang herself by using a dressing gown belt tied to a stairgate whilst under the influence of alcohol.

16/12/2019 - Emily attended the emergency department as she had been experiencing thoughts to hang herself, whilst at the emergency department, the thoughts stopped as she felt safe. However, she was worried that they may return and was fearful that she may act on these thoughts. Emily felt that this method of suicide would be successful as five of her friends had successfully completed suicide by hanging. A safety plan was discussed with Emily and on leaving the emergency department she denied any intent or plans to end her life

08/10/2020 – Emily expressed feelings of helplessness and hopelessness and was experiencing thoughts of suicide. Had thoughts of taking her prescribed medication as she could not see a future. Emily's pet dogs were a protective factor.

CPFT have provided the below information in relation to the terms of reference:

In September 2021, CPFT employed a full time equivalent dedicated domestic abuse lead (management banding) to take forwards the Trust's Domestic Abuse Strategy which includes:

- Launch the Trust wide domestic abuse strategy
- Increase staff awareness and skills in recognising and responding to domestic abuse,
- Ensure there are Trust policies and procedures on domestic abuse in place
- Ensure the Trust has mechanisms for counting numbers of patients and staff who experience domestic abuse
- Provide representative at DHRs.

1. Trust-wide Launch of DA Strategy
   The Trust's domestic abuse strategy was launched in November 2021 by the Chief Exec. In addition to the Chief Exec's promotional session to all staff, the DA leads provided promotional sessions to individual teams across the Trust. Not all teams had the opportunity for a promotional session due to limited resources caused by covid and the Christmas period. CPFT recognises that individual teams' sessions are both a popular and effective method for increasing staff knowledge, skills and confidence in the area of DA and will resume these as and where resources permit. CPFT have some very motivated DA Champions within the Trust but again, resources have been very stretched leading to this area not expanding as hoped. CPFT supports DA Champions to attend DASV meetings and training sessions.
   New DA patient leaflets have been designed and circulated so patients are better informed where they can seek support and advice locally and nationally. We have been clear with our message that it is safe to disclose DA to our staff.
2. Staff Awareness of Domestic Abuse
   CPFT has produced and circulated a large quantity of staff awareness material. We have designed a framework to assist staff; CPFT's 5Rs Domestic Abuse Process Model: Recognise and ask as Routine, Respond, Risk Assess, Refer, Record.
   CPFT have designed and circulated 5-minute guides on a number of DA topics for example the DASH, The 5 Rs, Why Referring Perpetrators to Couples Counselling is Not Appropriate.
   Guidance tools have been designed and circulated for Safety Planning and an awareness poster has been circulated highlighting support for staff who experience DA. There are several other DA related staff short guides planned for the next 12 months.
   Links to in-house and external DASV and the SAB information is available to all staff on the Trust intranet DA pages.
   The CPFT eLearning platform has a safeguarding training package and within the safeguarding training package there are dedicated DA slides focusing on recognising and responding to DA. The Trusts DA staff intranet page also has links to both the Safeguarding Boards training and the DASV training. The Trust DA training package is currently under review.
   In addition, the Trust promotes Bright Sky.
3. Trust DA Policies and Procedures.
   These have been updated and are in the Trust's ratification process
4. Trust DA Data Collection
   The Trust now has dedicated templates and read codes on System 1 (electronic record system) to ensure data collection on patients who disclose DA, and the range of responses taken can be counted. This will take some time to accurately reflect all that we do.
5. DHRs.
   There are 2 dedicated DA Leads who provide representation on behalf of the Trust on DHRs.

Best practice/Reflective considerations:

During the process of discharging a patient from secondary care to primary care there is a need to consider whether a professionals meeting is required between services that may be involved in their care such as GP and FRS to ensure there is a continuity of care throughout the service users' recovery. It is also essential that on discharge the service user has an individualised crisis / safety plan which includes the services which are available and the rationale for using them. It is also essential that all contacts between services and the service user is documented to reflect the discussion had.

FALT recognised that discharge was difficult for Emily and arranged a joint psychology session with her care coordinator to discuss the process and address any anxieties that she had. FALT responded promptly to concerns raised by FRS and GP and arranged for a duty worker to contact Emily. RCT worker identified areas of concern and sought advice from their manager, identified risks and escalated concerns to police.

Communication:

• It was highlighted that Emily had formed an attachment to her care coordinator and previous discharge attempts had been unsuccessful due to Emily attempting to end her life: therefore, during formulation it was agreed to continue with the plan of discharge with support from the Recovery Coach Team. At the time of discharge GP had expressed concerns regarding Emily risk of deteriorating due to stress around physical health investigations. GP was not involved with the discharge process and rationale for discharge was not communicated.

• Emily was aware that she had been discharged from FALT on the 8th of September 2021 however the discharge paperwork was not completed in a timely manner and due to staff sickness remained open to FALT until the 28th of September 2021. During this time, Emily was sent a letter in error informing her that her Care coordinator (CC) was off sick from work and that she would be supported by the team whilst she was off which led to confusion between services.

• RCT was not always notified about Emily's contact with FRS.

• On the 1/1/2022 Emily contacted FRS and disclosed that she had taken an overdose, she was advised to contact the emergency services and referral to FRS was closed. There is a need for FRS workers to consider whether they need to call the emergency service for the patient in discussion with the Clinical Lead.

• On listening to recordings from FRS contacts, key points in FRS discussions were not always clearly documented in clinical records for example on the 30/12/21 records report that Emily had not had medication for 6 days. On listening to the recording Emily had been taking all her medication except the antidepressant prescribed by GP.

Risk assessment and Management

• At discharge from FALT, risk assessment was partly updated, physical health concerns were not added as a risk for deterioration and formulation and risk management contained out of date information.

• At discharge from FALT, Crisis plan on Systmone (electronic recording system) was partly completed and crisis plan on Rio (electronic recording system) had not been updated since April 2021. Emily was not provided with an up-to-date crisis plan

• Emily contacted FRS on 01/01/2022 and disclosed that she had thoughts to end her life by overdosing or hanging. During the call, a safety plan was discussed however the removal of means was not discussed during the call.

• On the 27/1/2022. FRS had email contact with CC FALT regarding Emily presentation, advice was provided but this was not uploaded to medical records.

• Emily had a lot of contact with FRS expressing suicidal ideation, during this time FRS did consider re-referral back to secondary care however it was not always documented that this was considered or the rationale for not referring Emily back to secondary care documented.

GP Practices Records

Emily was registered at two separate GP practices within Cambridgeshire. The first was from 19/05/09 – 16/02/18 in which Emily was seen/contacted on 39 occasions and the second was from 16/02/18 until death in which Emily had 52 contacts.

Pt = Patient

In relation to two specific questions posed to Practice 2:

How did the problem with Emily's antidepressant medication manifest over Christmas 2021?

Her medications were issued on an automatic batch prescription every 2 weeks. This should have been issued on 22 December but for some reason was apparently not received at the chemist. According to her medical notes, the prescription was issued on the 22nd and should have been received by the Chemist immediately, however, occasionally there appears to be some sort of software malfunction whereby when other prescriptions on the repeat have been stopped (in this case Donavan and Sotalol), other medications on the same repeat sheet also appear to be cancelled. There is no way to see this on the medical notes. Usually when this happens it is not a problem because the chemist simply rings the surgery and says that the prescription has not been received and a new one is issued. On this occasion, it was over the Christmas period so this didn't happen. Another safety feature is that the chemist should be able to issue at least 3 days medication if somebody takes it regularly and there is a delay in getting the prescription. It is not possible to explain why the chemist did not offer this to the patient. When she attended the surgery on 29 December,

they immediately issued a further weeks' worth of medication to tide her over until her next repeat prescription.

Were any issues highlighted with communication during covid lockdown?

The Surgery can confirm that they continued to offer face-to-face appointments where they felt it was clinically necessary or beneficial for the patient. They would also arrange regular reviews themselves. They tried to be responsive to the individual needs of their patients rather than having a fixed policy for everyone. All patients were triaged by telephone initially during the pandemic, they did need to make sure that nobody had Covid symptoms or would be vulnerable if they came into the surgery. With Emily, they tended to do a mixture of face-to-face appointments and telephone appointments thus her appointment with her Doctor in January was face-to-face and also her appointment with the mental health practitioner on 12 January. The appointments in the last week of her life were by telephone because her Doctor was working from home due to having Covid-19.

<u>Practice 1</u>

2009
An online assessment was fully completed: There was a review of her medication. Emily was on the severe mental illness register and was having CBT. Emily was suffering from anxiety feelings/panic. She lived with her female partner whose mental health was having a detrimental effect on Emily. Emily was threatening to self-harm and it was identified that she required a 'mental health review' and a 'mental health personal health plan.'
September – Emily's mood remained low and it seemed to relate to relationship issues with her partner-effectively they 'split up but still lived together.' (Wording from Doctors notes)
October – Contact was to be made with Emily's Care Worker and CPN to assess her. Emily had feelings that she cannot cope since Pauline had left a few days prior though admitted it was for the best. She said that she was taking her medication but still felt tense/anxious and not wanting to eat and sleep.

2010
March – Emily had recent stress as her ex-partner was sending abusive texts which resulted in Police involvement.
July - A Mental health personal health plan was put in place including sleeping tablets at night. Emily contacted her CPN having become restless, agitated and tense. She had recently been discharged from psychiatric treatment.
August – Emily felt significantly better. She felt that panics were induced by her ex-partner saying she wanted to come and stay and when she was told this was not possible, she went to stay with someone else in the village. She was advised to start reducing Trazodone.

2015
March – Emily reduced her alcohol levels and appeared more stable. She reports that her childhood experiences have destroyed her self-confidence and self-belief for years and this is why she drinks. A Lifecraft request was made.

December – Emily had a mental health review. A mental health care plan was agreed. She had a new partner and life was better because she was not on her own. Emily was feeling better since she had met her new partner in July. She was able to control her alcohol intake and was sleeping better. Emily was attending art therapy classes which she enjoyed and was smoking 10-15/day. She stated she would consider stopping, though she was not deemed suitable for Nicotine replacement and patches as they caused a rash and she disliked the gum alternative. She had an e cigarette and stated she may try stopping smoking again. Emily was diagnosed with Bipolar affective disorder.

2016

October – Emily's mood dipped with no identified trigger. She had low motivation/concentration and her appetite dipped; her medication appeared to help her to sleep.

Bipolar disorder – There was agreement on her mental health care plan and Emily stated she would continue to take her lithium regularly. She was advised to contact inclusion about her drinking as she had felt her mood had lowered and she was anxious in the previous week. Emily had a new dog which had been aggressive towards other dogs. Her partner had depression and had not been so good recently which impacted on her. Emily agreed she was drinking too much and had a bottle of wine most days. Emily started counselling.

2017

August – Emily was doing ok overall but sadly, someone close to her died in May. She was coping ok although she needed bloods for lithium and also saw substance misuse recently starting new medication. She requested more diazepam which was issued and problems were discussed.

September – Due to her Bipolar Affective Disorder, Emily was spoken to. She had no thoughts of deliberate self-harm or ending her life but shared thoughts she had the previous day of people she knew in hospital who ended their life by hanging but she stated she had no thoughts of harming herself.

She attended the surgery having been in a low mood for two days. She had received 'nasty texts' from someone the week before but would not disclose who they were from. She had stopped drinking, then started again last week as she felt anxious, but had stopped again since the Friday (she would drink either a bottle of wine or four bottles of beer a day). Emily lived alone with her dogs and stated they were 'her life.' She was not expecting any new medication but just wanted to talk about her mood and make the surgery aware. She thought that talking to someone may help and was appropriately dressed, maintaining eye contact with the Doctor. She had a slight tremor in both arms and slightly slow speech. A plan was put in place for the following few days.

Emily attended the surgery a few days later but was unable to wait in the waiting room so she went home again. Consultation was done on the phone. Emily still felt low in the mornings and better as the day goes on. She was looking after herself and the dogs. Emily was sleeping well (with medication) - 9 hrs or so and had no thoughts of self-harm. Notes were put on her record that Emily can contact the surgery on any day and can wait in the private area in similar circumstances.

Copy record of relevant Doctors notes – practice 2 below

2019

June – The CPN was to refer Emily to the crisis team as she was very low and had tried to hang herself. CPN was concerned as she would not be around for the next two weeks. An alert was put on the computer system.

July – Emily was told by her keyworker that the Mental Health team were going to discharge her from their care. She was struggling with suicidal thoughts and her father was due to go into care the following week so she rang the FRS. She was struggling to look after her Dad and Pauline was not being helpful.

September – Emily was discharged from the Mental Health Service with a crisis plan to support her if her mental state deteriorated in the future. Emily was seen by a Cardiologist and had been self-medicating with alcohol which left her vulnerable (last time she tried to hang herself).

October – Emily had a medication review completed. She had been struggling with a heart condition and her Dad dying. The avenues she has turned to for help had not been able to provide support or continuity and she felt like she was being pushed from pillar to post. It was noted that a PCMHT may refer her back to FALT.

November – Emily booked into CGL, she was stopping amitriptyline and her psychiatric assistance, reducing.

December - Four separate contacts were made from Emily as her mood was low and she attended accident and emergency with suicidal thoughts.

2020

January – An alert was put on the system for if Emily called and requested an appointment, she was to be given this the same day. She was identified as a high priority.

February – Emily's dad had died the previous week and she was seeing Pauline again. Her mental health plan was under the care of CMHT with CPN observation.

2021

June – Emily was seen in accident and emergency following a medication overdose where she had taken them to try and sleep. This was the first occasion she had taken an overdose. She had come off her medication two weeks previously and her mood had been going down and she was feeling low.

August – A face to face appointment took place with Emily who appeared depressed and recognised that she had felt elated a few weeks prior, considered buying a convertible car and a caravan. When she realised she could not afford this, she got a ferret instead. Emily asked to go into hospital to get her medication reviewed as she had not been stable for two years. Emily felt slightly better having seen the GP and a safety plan was agreed with a further appointment booked and details provided for support provisions to contact.

A week later, Emily saw the GP again and advised she had been taken off the Aripiprazole by secondary services. She stated her mood was better when she was out and lowered when she went back to her bungalow on her own. A discussion was had in relation to grief over her Dad and the stages of depression. She had applied for a housing transfer and booked a holiday in Skegness with no suicidal thoughts.

September – Emily saw the Doctor and had a low mood. She was awaiting a hospital appointment for blood test results and had no energy, not being able to force herself to do

anything. Emily was worried about her German Shepherd as she was unable to walk and care for her and was paying a friend but could not continue this financially. Options were discussed. Further records were made throughout the month stating that her anxiety was 'rocketing' and the surgery attempted to contact FALT on ten occasions with no success. Her medication was not helping and her dog had to be re-homed. There was a patient consultation over video due to Covid-19 restrictions.
Emily had been discharged from FALT and had anxiety over a delayed scan.
October – A further two video calls were held where Emily stated she was feeling very ill. The GP noted Emily was in despair and at risk. The GP surgery was going to try and get her scan results as this was causing her distress. Emily asked for help with sleep. Her CGL worker was also concerned about her.
November – Emily had attended a group meeting and was feeling better. She managed to cut her grass and bought her daughter's birthday present. Emily wanted to move home and felt fatigued at times.
December – Emily was seen and stated she had felt for a week that she couldn't live like she was and was in a low mood with a note stating she was unsafe to be alone. Emily had received a letter for an appointment with a local surgical team and could not get hold of them to ascertain what it was in relation to. When Emily spoke about visiting her daughter and watching her open her presents, her facial expression and tone were animated. At the end of the month, a short text was sent to Emily apologising that her prescription had not been available and confirmed it was now with the chemist. Her medication was reviewed as she had been feeling worse again and much more anxious.

2022
January – Emily took an overdose in an attempt to end her life on the first day of the year. She attended the surgery a few days later where her mood was low and she expressed the desire to move home. She had not had her anti-depressants over Christmas due to a mix-up by the surgery with her prescription and had been in a very low mood. She had two further appointments within the week where she reported smoking heavily and having very poor sleep.
Later in the month, Emily contacted the surgery to say that she had been feeling anxious on and off for months but particularly since December. She had chronic fatigue and felt anxious for most of the day, struggling to do tasks around the house. This stemmed from being physically poorly and not being able to do anything. It was discussed how losing her confidence, not going out and doing things or seeing people had contributed. She was to be referred to the Chronic Fatigue clinic and a referral was made to the crisis team explaining that Emily felt suicidal and the situation seemed to be escalating.

Best practice/Reflective considerations:

Although not always seen by the same Doctor, there is a good record of the conversations and issues that have arose when speaking to Emily for future reference. There is good communication with CGL and referring to FALT to ensure the appropriate support is provided.
In the absence of the FALT caseworker, the surgery will put alerts on the system to ensure Emily is prioritised due to her suicidal ideations.

There are a number of times it is recorded that they had to try on several occasions to get hold of FALT before getting through due to unanswered phones and lack of response.

2.4 Summary of reports

In addition to the IMRs, certain agencies/organisations were requested to provide supplementary information into processes and provisions.

Fenland District Council

There are no support groups within the Fenland area for the LGBTQ+ community. However, many of the local support groups available within Fenland would signpost people to organisations that deal primarily with the LGBTQ+ community which are based within the more populated locations such as Cambridge, Peterborough and Norwich. One such support organisation is Encompass– info@encompassnetwork.org.uk.
Fenland District Council hold a diverse communities forum.

Cambridgeshire Public Health

Suicide training has been delivered to all specialist domestic abuse workers within the past 18 months by CPSL MIND and in the spring of 2022, domestic abuse training was delivered to Peterborough Samaritans and Lifecraft (who run a mental health helpline).

Cambridgeshire Public Health signpost suicide mitigation training to Zero Suicide Alliance training, which is available to non-health professionals, private health carers and anyone in contact with vulnerable people. It is online training and free of charge. They also commission a 'Stop suicide' workshop run by CPSL-MIND.

A Suicide prevention strategy is due to be published for Cambridgeshire and Peterborough, following approval by the Health and Wellbeing Board, which addresses a vast array of subject matters connected with mental health. It does not specifically address groups for elderly, carers or same sex relationships as it is led by data. Scrutiny in these areas would become more focussed if an increase is seen. The new strategy proposes that we take a collaborative approach to preventing suicide, with the mental health system and community being partners in ensuring that everyone in Cambridgeshire and Peterborough has access to the right care and support to ensure that they do not die by suicide.

Cambridgeshire County Council and DASV

At present, Cambridgeshire has no specialist support provisions specifically for older persons who are victims of domestic abuse. On completing a research project, they identified gaps for identifying risks specific to the older persons within domestic abuse which included carers and those reliant on financial support. They created a DASH to be used by professionals when dealing with DA victims who are older persons that asks questions to

ascertain the risks that have been identified as relevant to their age. These replace certain questions such as pregnancy to replicate the same questions on a DASH and therefore provide the accurate level of risk. The questions also include those around suicide and carers.

The initial three-month pilot was for Adult Social Care but was then expanded to all authorities apart from the Police who did not have capacity to complete two separate forms at an incident. The year-long pilot comes to an end in July 2022 having been well publicised on the website, incorporated within training inputs and heads of authorities being aware.

An agreement for the commissioning of Hourglass has recently been reached which will be the Hourglass Community Response model for older victim/survivors of DA. The service specification includes working with IDVAs and all DASV Partners to increase professional knowledge of the risks, assist with advising professionals and developing solutions. Also linking with specialist Older Persons organisations and raising public awareness to increase reporting from this age group.

The DASV partnership have disseminated recognised guidance in relation to Domestic abuse in older persons to all professional organisations within Cambridgeshire based on the Dewis Choice project but have made it more relevant to the Cambridgeshire area. Also, the Dewis Choice Working with Older LGBTQ+ Survivors of Domestic Abuse guidance is on their website and was in the newsletter to make it available to other partner agencies. The DASV lead on older persons currently sits on the Home Office Safer Care at Home Review project group which is due to report in November 2022.

Employment

Emily had several employers but due to her mental health illness, she found it difficult to cope and generally left the employment after a few days. She also found it difficult to apply for jobs. Due to these facts, no previous employers have been identified or approached in relation to this review.

Section 3 - Analysis

3.1 Family, friends' and others perspective

Susan

Susan has many memories of her childhood and has provided some of these to assist with the background of Emily's life outlined earlier in this report. Susan saw her mum as often as she could as she lives north of the country but whenever Emily was in contact, she leant on Susan which she found challenging. Emily was constantly crying, shouting and saying she wanted to kill herself. She would be inebriated and had a temper, but was never physically abusive, just verbal.

Susan felt that it was the alcohol that always caused it as she used it as a coping mechanism and crutch. She drank every day.

Susan received counselling in 2021 to help her cope with the phone calls she received from her mum and was advised to distance herself at times for her own protection when it got too much.

Susan's reflection on what has happened has been written as the following.

'As hard as it is for me to admit, I just want someone to blame and it doesn't feel fair to blame Mum. Even if there is no-one to blame, it's the direction my grief has taken me in. I've held onto blaming Pauline since I saw the note but in reality, she was probably just an outside factor. Ultimately, it was Mums mental illness that killed her.'

Susan does not want her mum to be painted as the abuser as she thinks it was a two-way street. There were only four entries in Emily's diary that related to Pauline and all were in mid-January. They seemed very casual and no indication that an argument was about to erupt.

Daniel

Daniel, father to Susan and partner to Emily for six years in all has nothing but empathy for Emily's illness and the torment it caused her throughout her life. He remained on good terms and in touch with Emily up until her death and although he witnessed her being verbally abusive down the phone to her parents at times, he never witnessed her being violent and she was never violent towards him apart from the one occasion she slapped him which is outlined at 2.1.

Daniel knows that Emily's illness caused her to drink which then accentuated her issues. Emily would tell him things that Pauline had done to her and how she had treated her and he was of the understanding that Pauline was the aggressor in the relationship. On one occasion, he went to their flat to mend the door which he believes was damaged through an act of violence. He always found Pauline to be 'well versed.'

Daniel last had contact with Emily two weeks before she died when he texted her to ask how she was and had a short text conversation with her that was not out of the ordinary.

Pauline

Pauline was spoken to briefly but then contacted the author to say that it was not good for her mental health and a decision was made based on this to not contact Pauline any further in relation to this review and support was arranged for her.

Pauline states that they were just friends in the last few years and were not in a relationship. She believes Emily took her own life due to her mental health issues which were not properly addressed by the Mental Health team or hospital.

On reflecting on the time that they were in a relationship, she states that they both loved each other, then didn't and were always going for each other but would always get back together. They both drank and went around with people who drank a lot. She stated Emily was a nice lady when she wasn't drunk but was very troubled and that her own behaviour was always in retaliation to Emily's behaviour.

Pauline was aware of at least five occasions when Emily tried to take her own life and felt they were a cry for help, sometimes happening when she 'didn't take her meds.' From conversations with her, it appeared Cambridge mental health helped her more than Fenland mental health as they never answer their phones, which is reflective of comments also made by the GP.

Pauline feels that Emily was troubled by not seeing her daughter Susan frequently as she was busy at work and could not come to visit and had the concern 'my daughter loves daddy more than me.'

She accepts there was a disagreement with the police involved two weeks before her death and that Emily tried to strangle her but states she didn't want to press charges and the police showed no compassion to the situation.

3.2 Terms of reference areas

3.2.1 Has domestic abuse in any form been the causation or a contributory factor to Emily taking her own life?

Emily and Pauline's relationship dates back to 2001 with the acknowledged relationship concluding in 2011 when Pauline went into refuge. During this time, incidents involving the police were recorded with both on separate occasions being recorded as the perpetrator and all incidents made note of mental health issues for both and occurred when alcohol had been consumed.

Situational violence should be considered as it may not always be possible to determine a definitive perpetrator and victim in a relationship involving DA. The association of mental health and alcohol difficulties for both indicates a central factor in their violence and abuse along with inadequate financial resources.

Both Susan and Daniel portray that from what they witnessed and heard within the dynamics between Emily and Pauline, that it was Pauline who seemed to 'wind Emily up' to gain a reaction and then portray to others a totally different perspective, being referred to as being 'well versed.' This could be identified as a form of both emotional abuse and also controlling and coercive behaviour.

It is poignant that in the years leading up to Emily's move to the same street as Pauline when they had no contact, Susan comments that her persona did improve and although there were still difficulties with alcohol and her mental health, these did not involve any confrontation with others and were not present in any other relationship. This is in contrast

to Pauline, who had ongoing issues recorded with Clarion Housing of turbulence between her and others on a regular basis, including relationships.

Although not recognised as a relationship, but more of a friendship in the last couple of years, once they had reinitiated contact, they resumed their behaviour towards each other which clearly disturbed Emily to the point where she named Pauline in the last note to her daughter, commenting on the way she had been treated.

The most recent DA investigation by the police undoubtedly had a detrimental and deteriorating impact on Emily's mental health. The handwritten notes are indicative of her decline, in conjunction with her repeated efforts to contact Pauline and resolve their issues, during the days that preceded her death. During the extensive research and interrogation of police databases, no information or intelligence has been retrieved to suggest coercive or controlling behaviour per se, was a contributory factor. There is, however, a significant history of domestic disputes between Pauline and Emily, both verbal and physical, held on the police systems.

Although there is comment on finances and Pauline leaving Emily in debt, it is not clear whether there was a deliberate act or if it was due purely to not having the finances to pay the rent.

3.2.2 The availability and effectiveness of service and agency provisions for domestic abuse within the Fenland area, specifically for LGBTQ+, Older persons and vulnerable persons

The Fenland area does not have any provisions specifically for older persons or LGBTQ+ locally and it was identified that the agencies represented on the panel had limited knowledge of who to signpost to. It also became apparent on review, that Safeguarding and DA training within the agencies does not include LGBTQ+ and therefore, there may be barriers to identifying needs, a lack of understanding and missed opportunities to signpost to support services. This may be related to the National Safelives statistics that only 1.4% of cases heard at MARAC are LGBTQ+ relationships. (Recommendations refer)

Of the DASH risk assessments and adult at risk referrals that were completed by the police, none appear to have reached any specialist domestic abuse services. Victims are asked if they would like support but it is not known whether Emily gave her consent. No specialist domestic abuse services have been identified as recently supporting her but it cannot be ascertained whether there was a missed opportunity to signpost victims to LGBTQ+ support groups or communities.

Throughout this review process, it has not been clear how the victim or perpetrator identified themselves from police records, in terms of sexual orientation, gender or any other protected characteristics. Records from CPFT show Emily to be heterosexual on the health electronic record keeping system. When this was probed, it was revealed that they were aware that Emily identified as a lesbian but staff did not know how to change it on the new systems. (Recommendation refers)

Whilst the submission of an adult at risk form by the police in respect of Emily, did lead to some intervention from mental health services, the failure/oversight in completion of a DASH risk assessment in her capacity as a victim of domestic abuse, is likely to have prevented interventions from other specialist support agencies. Emily's status as a perpetrator was prioritised on the basis that her counter allegation of common assault was finalised, no further action. No DASH risk assessment was completed in relation to Emily and no adult at risk referral was completed for Pauline. Despite the MASH requesting completion of a DASH on 13/12/21, enquiries with the relevant officers indicate this was not done and this omission was not discovered by any Supervisory/Review officers, despite a further two incidents being reported on 28/01/22 and 29/01/22. This is cause for concern as even when an omission was identified, it was still not rectified. (Recommendation refers)

When Emily requested a move so that she could be near to her father who was in ill health in order to care for him, she was not asked any questions on her application form that may alert Clarion Housing to any potential risks associated with the location that they subsequently placed her. However, had they done so, it would still have been reliant on disclosure from Emily in relation to her association with Pauline and the domestic abuse in the past making it inappropriate to house them in the same street. Also, Clarion Housing have no means to search any database that would alert them to any safeguarding risks when placing applicants into properties. (Recommendations refer)

3.2.3 The availability and effectiveness of services and agencies provisions for suicide and those contemplating taking their own life within the Fenland area

Cambridgeshire Public Health do not collate data for suspected suicides on same sex relationships or carers which are two significant areas relating to Emily alone. Attempts are being made to improve data collation on suspected suicides which should then hopefully include coverage of these areas in the future. The new Suicide Prevention strategy is a collaborative approach to preventing suicide, however, the omission of not collecting data within the LGBTQ+ community could be seen as a missed opportunity to monitor any patterns that would require a response or increase in provisions in Cambridgeshire. (Recommendation refers)

Regional work and the completion of a suicide prevention strategy and four-year plan evidences the realisation and commitment in this area. The DASV partnership work closely with the group to work towards the following:

1. All those who have made a suicide attempt to be asked about domestic abuse and sexual violence, and to be responded to appropriately.
2. Training in the impact of domestic abuse and sexual violence to all staff – in particular, those working in emergency medicine departments and liaison psychiatry
3. Wider understanding that those suffering domestic abuse and sexual violence who are expressing suicidal ideation, they are likely to be suffering psychological injury from the abuse, rather than having a psychiatric illness.

The recommendations and actions within the suicide prevention strategy are sufficient to progress and address the area of Domestic abuse and suicide within the area and will not be duplicated within this report. A member of the suicide prevention board from Public Health now sits on each DHR panel that relates to suicide.

Both a referral to Lifecraft and details of Lifeline were offered to Emily for additional support but she declined these.

3.2.4 Establish the response to Emily's mental health and information sharing processes in relation to this.

The police have made progress in their response to attending incidents that may have a person with mental health needs present. The main function of the IMHT is to provide immediate and appropriate information sharing, to assist police decision making when responding to emergency mental health crisis situations. The objective is to ensure someone in crisis receives the right care at the right time and from the right service, at the first point of asking.

This can be achieved by providing an improved response to persons in crisis, and reducing the time spent dealing with incidents, via improved initial assessments by qualified professionals. It also offers both police officers and mental health service staff the opportunity to benefit from cross over training, spotting early warning signs and to develop an understanding of the challenges faced by each agency. The option of safe and effective short-term care, support and treatment will be at the heart of all decisions made regarding any follow up care that may be required. Clear information will be provided to inform access to alternative solutions to meeting the mental health crisis. However, it is accepted that this will increase knowledge and awareness amongst their workforce and assist them in identifying suicide indicators: interpretation and identification of risks to individuals at the earliest opportunity and enable effective interventions to be considered at the earliest stage. (Recommendation refers)

There are nine recommendations made in the CPFT SI report relating to:

- Procedures of continuity of staff and discharging of patients
- Recording of information accurately and appropriately
- Communication between differing departments within the health authority
- Appropriate response to someone making contact with suicidal ideations

As they are already being addressed, this report will not duplicate these recommendations. However, the panel concur with the recommendations as these were issues that were independently identified and discussed during the panel meetings.

The term 'overshadowing' is defined as 'To appear more prominent or important than.' Emily had a long history of mental health difficulties and suicidal ideations. She often referred to her domestic issues but not always directly to actual incidents where an argument or physical act may have taken place. However, her medical and mental health

records reflect incidents where the Police have been involved due to domestic abuse. No referrals were made in relation to any information gained in her domestic situation and it is not apparent whether domestic abuse was considered by the health agencies supporting her. The incident that occurred in December 2021 shows the Police referring Emily in relation to her mental health but not completing a DASH as a victim of domestic abuse. These oversights could be because the symptoms of mental disorder that Emily displays when speaking to these professionals overshadows the need to address DA which may be the reason for some of the low moods, or it may be that DA is genuinely not being considered and referred appropriately.

On comparing the three separate records on Emily held by CGL, the Doctors practice and FALT, it is apparent that there has been good evidence of information sharing at times. It is also apparent that each record holds different narrative at times provided by Emily as she would partially tell them parts of her life each so none of them held the full picture as these were not shared amongst them. There are some barriers that prevent a full flow of information between the three organisations. CGL had consent from Emily to inform the Doctor that they were supporting her and ensured that they linked in with the doctor as often as possible. However, they did have to rely on what Emily was telling them to a large extent as information was not shared with them by FALT and in some cases, the Doctors surgery. They did have a good relationship with Emily as she had the same caseworker throughout her time with them and frequently had the same doctor as well who knew her history and had built a relationship of understanding. However, FALT strategically chose to respond to her with different caseworkers on each occasion as they felt she built up a reliance on one single person. Her relationship with FALT was fragmented as can be gauged by comments that she made to others.

When in crisis, Emily could often contact all three organisations on the same day with differing parts of disclosure. As this would not be shared amongst the three, this could have the potential of conflicting advice or Emily continuing to contact until her need was met to her own satisfaction.

Emily's mental health deteriorated over Christmas 2021 which coincided with a technical fault which prevented Emily obtaining her medication. Her mood became so low that she took an overdose on New Year's Day. The understanding as to why the technical fault occurred remains unknown as 'something that occasionally happens' and it cannot be identified on the medical records. (Recommendation refers)

3.3 Other areas for analysis

Effects of Covid

Medical notes from the Dr's practice, CGL and FALT, all comment on disclosures from Emily as to how isolated she felt during Covid 19 lockdown and the lack of face-to-face consultation available had a detrimental effect on her as telephone conversations do not

always fulfil her need. Their records show a vast dialogue of contact with Emily and reflect how different she leaves the consultation when she has actually seen someone.

This is a wider issue to review separately, but worthy of note that it was identified by panel members and was the period of time when her mental health has then reached a low point directly before ending her life.

Pressures of being a carer

The additional pressures of Emily caring for her father in his last years of life were disclosed and documented to both the GP and CPFT. Emily frequently disclosed how this additional responsibility had a detrimental effect on her mental health. Although CPFT offered Emily a carer's assessment which was declined, there were no referrals or advice provided as to where specific support could be obtained. (Caring Together offer this service in the area). Recommendations in relation to carers have been made to Cambridgeshire County Council Carers strategy refresh Board in another DHR involving an older person caring for a relative so will not be duplicated within this report.

Section 4 – Conclusions and Recommendations

4.1 Conclusions

Emily was adopted as a child and although the full details are not known, she experienced forms of emotional and physical abuse from her mother which affected her relationship with her for the rest of her life, alongside the anger she felt towards her father for not intervening. This appears to be the catalyst for her mental health difficulties as witnessed by Daniel and Susan by things that she would say and how she would act in certain circumstances.

Emily clearly loved her daughter very much as is shown in the note she left and her comments to her care workers. Her relationship with Pauline negatively impacted on her with alcohol consumption and her mental health from the outset. The relationship is described as toxic by Susan who witnessed a number of altercations and it is difficult to differentiate between who was the main aggressor. However, although both had their own mental health difficulties, Pauline does disclose to care workers and doctors of how this affects her both before and after the relationship showing a vulnerability on this matter. The Police must ensure that their recording mechanisms of who may be a perpetrator are not influenced by any previous incidents and treat each further incident with an open mind, whilst taking history into consideration for the wider picture.

Emily had a chronic history of suicidal ideation during times of heightened stress and to help manage these feelings she would often use alcohol as a coping mechanism however this would often intensify the feelings leading to her attempting to end her life. Emily had consumed alcohol prior to taking her life as referenced in the post-mortem report. Emily

expressed ongoing concerns of feeling isolated and having no friends but appeared to be making steps to address these issues.

She had expressed ongoing physical health concerns which were being investigated by her GP. She also found being discharged from secondary mental health services difficult as she described feeling alone and isolated. The CPFT SI investigation found that there were no direct acts or omissions by CPFT services that was a root cause. However, there were service factors that contributed as there was not a smooth discharge from FALT due to a delay in completion of documentation, and Emily was not provided with an up-to-date relevant crisis/safety plan. Emily's difficulties with discharge such as feeling like she was being abandoned was highlighted but key services such as GP and FRS were not made aware and directed to a Safety Plan individual to her needs. Communication between service was not always documented/uploaded and risk by removal of means to harm herself was not always discussed.

Her mental health needs overshadowed the identification or response to her disclosures about her personal relationship and consideration of domestic abuse when dealing with both her Doctor and FALT and there were missed opportunities to refer and to provide advice of pathways to support her for this.

Emily's sexuality did not directly affect the way in which she was dealt with by professionals but the lack of recording of her sexuality, lack of provisions in the area and lack of training within organisations about the LGBTQ+ communities needs is an area to be addressed to ensure that intervention to be able to provide a pathway to specialist needs in this area is available and recognised.

Both Emily's records and from her daughters' observations, it was clear that Emily did show a marked improvement when she was not with Pauline, albeit not eradicated. Therefore, the placing of Emily into accommodation in the same street as Pauline can be seen as a catalyst and risk to both her mental health and confrontations between the two whether in a relationship or just friends. Housing was not aware, but the records show that Emily was and at present, there is no database or process that would allow housing departments/associations to identify risk based on recorded data.

The most recent DA investigation by the police undoubtedly had a detrimental impact on Emily's mental health, along with the grief from losing her father, her lack of medication over Christmas, her anxiety about wanting to see her daughter and the confusion over what her relationship was with Pauline. All of these clearly contributed towards her state of mind. Emily specifically refers to Pauline in the note she left for her daughter but given the numerous attempts to die by suicide previously and the long history of mental disorder, the conclusion is that although DA was a contributory factor in Emily's death, it was not the sole causation.

4.2 Recommendations

National

1. **A database for research on safeguarding matters in order for Housing departments and associations to ably risk assess suitability of accommodation for applicant to be explored for feasibility.**
   As housing issues are now an intrinsic part of the Domestic Abuse Act, this will allow both the local council housing departments and housing associations who are commissioned to accommodate on their behalf, the ability to have access to information for informed decision-making taking regards of vulnerability and risk.

Local

2. **Victims and perpetrators should be asked directly to self-define their sexual orientation and how they identify themselves, for the purpose of signposting them to the appropriate additional support services, and this should be recorded appropriately and accurately.**
   This will increase referrals and specialist support that can be provided and will ensure the correct recording is made to identify any specific needs and responses.

3. **The Fenland Community Safety Partnership to ensure the promotion and wider publicity of LGBTQ+ support services within Cambridgeshire to provide awareness for professionals to signpost and utilise these services. Other CSP's in the area are to consider this.**
   There are no support services for the LGBTQ+ within the fenland district and a lack of knowledge of the support services available within Cambridgeshire and the surrounding areas. It is important that professionals know where to signpost those requiring the specialist support.

4. **Cambridgeshire Police and Adult Social Care to ensure compliance of the process for Supervisors, Gatekeepers, Managers and MASH staff to ensure all DASH risk assessments and any referrals pertinent to any subjects, have been:**
   - **Physically seen and endorsed accordingly**
   - **Reviewed and revisited alongside any significant developments or changes in the investigation for accuracy and recording purposes**
   - **Submitted to the relevant specialists and agencies for action**
   - **Decisions and amendments to the grading of STANDARD/MEDIUM/HIGH to reflect the circumstances of the victim at that time, and recorded on the investigation log**

   This will provide a robust scrutiny of the recording of assessments and the review of these for accurate risk assessing and appropriate referrals.

5. **Cambridgeshire Constabulary to speak with Public Health for an adaptation of their training programmes for suitability of the Constabulary's needs.**
   This will increase knowledge and awareness amongst their workforce and assist them in identifying suicide indicators: interpretation and identification of risks to individuals at the earliest opportunity and enable effective interventions to be considered at the earliest stage.

6. **Cambridgeshire Police Reinforcement of the DASH and DVPN/DVPO policies, particularly in cases of counter allegations, expectations, and standards across the workforce, to ensure consistency of practice and early intervention support services, for vulnerable victims and perpetrators of domestic abuse.**
   This will increase the use of such tools provided by legislation to address domestic abuse and provide safeguarding in such cases where a victim may not wish to support a prosecution and therefore, a criminal prosecution is not viable.

7. **Clarion Housing to revise the Homelink housing application to include the applicant to comment on 'You or a member of your household needs to move away from another area to escape violence or harm.'**
   This will then reflect the Fenland Housing application form and identify if there are 'risk' issues that need to be explored further before deciding on the suitability of where to re-locate.

8. **CGL Cambridgeshire will upskill staff to ensure they are aware of how consensual information sharing can support a service user throughout their treatment journey. Staff will feel confident in explaining and exploring consent with service users, particularly in relation to a change in their risk or circumstances.**
   To be achieved through team-based refresher discussions of CGL's consent policy and toolkit and exploration around how to effectively discuss consent. CGL staff will increase their information sharing where relevant to improve the quality of service and support they can offer from a wider understanding.
   This will ensure that the issue of consent is reviewed periodically in each case to provide confidence that the information held is current and reflects the wish of the subject and also, that staff are aware of the requirements of when to share information without consent.

9. **Domestic Abuse training must include reference to the needs of the LGBTQ+ community**.
   This will provide knowledge in this area, identification of needs, appropriate recording and increase referrals for specialist support where required.

10. **Stronger working relationships and communication channels are required between the GPs and pharmacists to prevent any delay in the administering of prescriptions with an escalation process or safety plan to address issues when a technical error occurs and is identified.**
    This will address the technical issue that the GP surgery is already aware of and how to prevent any delays in a person not receiving medication because it has not been identified that the prescription has not been transferred to the Pharmacy.

11. **A robust process to be established to prevent any delay in the signing of prescriptions and where a capacity concern is identified, there needs to be an escalation process to be able to re-act in a timely manner.**
    This will prevent unnecessary delay in someone receiving medication as the prescription had not been signed due to capacity issues.

12. **Cambridgeshire Public Health to progress and advance its data collation into suspected suicides of the LGBTQ+ community.**
    This data will identify any patterns or increases to provide a clearer and informed understanding as to whether the current support provisions are suitable and can be utilised to determine whether any immediate response is required within this community at any given time.

Appendices

Appendix A

Terms of reference

- The date parameters under consideration are from 2009 until present. However, if relevant information is held prior to this, can a summary be provided to provide context.
- This is to be reviewed as a suicide based on the investigation by appropriate authorities. The purpose is to establish if DA was a factor in the death of Emily.
- Ensure the review seeks to involve the family in the process and takes account of who the family may wish to have involved as lead members. Identify any other people the family think may assist or be relevant in the review process.
- Seek the involvement of employers and friends to provide contextualised analysis of the events.
- Establish whether communication in relation to DA support is available and effective within the LGBTQ+ community in Cambridgeshire
- How accessible were the services and pathways for referral for the deceased
- Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and whether these were acted upon. Recommend any changes following the review process.
- Establish accessibility of services for those contemplating suicide and whether training has been received in relation to the effects DA may have towards this.
- What provisions are available for those suffering from alcohol misuse? Were appropriate referrals made when it was established this was a factor with Emily?
- Establish the response to Emily's Mental Health and establish:
  Was it appropriate?
  Was DA considered by the professionals and spoken about with Emily?
  What sharing information processes and referrals are in place when multiple complex needs are identified and did these occur in Emily case?
- Identify the processes and risk assessing that Housing associations have available in relation to domestic abuse victims and perpetrators and whether they are effective.
- Were procedures sensitive to the ethnic, cultural, linguistic, and religious identity of the deceased and her ex-partner? Was consideration for vulnerability and age necessary? Were any of the other protected characteristics relevant in this case?
- Identify and highlight good practice for wider sharing
- Panel to have a parallel action plan for expedited implementation where practicable during the review
- Establish what processes are in place to record appropriately, decision make and provide support when it may be unclear who the victim and the perpetrator are within the relationship

Appendix B

Glossary

AAFDA: Advocacy After Fatal Domestic Abuse

CPN: Community Psychiatrist Nurse

CSP: Community Safety Partnership

CCG: Clinical Commissioning Group

CGL: Change Grow Live

CPN: Community Psychiatric Nurse

CPFT: Cambridge and Peterborough NHS Foundation Trust

DA: Domestic Abuse

DASH: Domestic Abuse Stalking and Harassment (Risk assessment)

DASV: Domestic Abuse and Sexual Violence partnership

DHR: Domestic Homicide Review

FALT: Fenland Adult Locality Team

FRS: First Response Services

GP: General Practitioner

IDVA: Independent Domestic Violence Advisor

IMR: Individual Management Review

MARAC: Multi Agency Risk Assessment Conference

MCU: Major Crime Unit

PCMHT: Primary Care Mental Health Team