community safety partnership

A Review Overview Report DHR 006

Report into the death of a 20-year-old woman

'Florence'

in February 2018

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Independent Chair and Author

Amended: August 2025

Contents

List of Abbreviations

AAFDA	Advocacy After Fatal Domestic Abuse
AART	Mental Health Unit Acute Assessment and Recovery Team
A&E	Accident and Emergency Department.
CAMHS	Child and Adolescent Mental Health Service
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CMHT	Community Mental Health Team
COCP	Combined Oral Contraceptive Pill
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CPS	Crown Prosecution Service
CSC	Children's Social Services
CRHT	Crisis Resolution Home Treatment Team
DASH	Domestic Abuse, Stalking and Harassment Risk Assessment form
DAPIT	Domestic Abuse Prevention and Investigation Team of Northamptonshire Police
DHR	Domestic Homicide Review
EDS	Eating Disorder Service
EMAS	East Midlands Ambulance Service
FDL	Frances Dixon Lodge
GP	General Practitioner
HTT	Home Treatment Team
IDVA	Independent Domestic Violence Advisor
LPT	Leicestershire Partnership Trust
IMR	Individual Management Review
KBCSP	Kettering Borough Community Safety Partnership
KBCSPB	Kettering Borough Community Safety Partnership Board
KGH	Kettering General Hospital
LPTMHS	Leicestershire Partnership Trust Mental Health Services
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi-agency Risk Assessment Conference
NHFT	Northamptonshire Health Foundation Trust
NPH	Northampton Partnership Homes

OPA	Adult Outpatients Assessment
PPN	Public Protection Notice
TSPPD	Therapy Services for People with Personality Disorder
UAVA	United Against Violence and Abuse

Introduction and Background

The members of this review panel offer their sincere condolences to the family of Florence for the sad loss in such tragic circumstances.

Both parents understand the need for a Pseudonym to be used in DHR reviews and have chosen the name Florence to be used regarding their daughter. Her boyfriend will be referred to as her 'boyfriend'. He agrees with this.

1.1 Introduction

1.1.1 This Review concerns the death of Florence who was aged 20 at the time of her death in February 2018. She took her own life by stepping out in front of a train travelling at some 95 m.p.h. at a railway station in Northamptonshire. She died instantly. No charges have been brought against any person in relation to the death of Florence.

1.1.2 H.M. Coroner for Northamptonshire determined a narrative verdict on 26th September 2018:

> '[*Florence] had a diagnosis of emotionally unstable personality disorder and an eating disorder. She had a history of deliberate self-harm and overdose.*
>
> *She had been in an abusive relationship with her boyfriend.*
>
> *[In] February 2018, she took herself to the railway line at Kettering where she placed herself in front of an approaching train. She suffered multiple injuries which resulted in her instant death. In view of her "depersonalisation" problem I cannot ascertain what her intentions were at this time.*

1.1.3 Northamptonshire Police investigated Florence's death. There is no evidence of any third party being involved.

1.1.4 In accordance with Home Office Guidance[1] a Domestic Homicide Review (DHR) has been commissioned.

[1] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2016

1.2 Purpose of the Review

1.2.1 The Domestic Violence, Crimes and Victims Act 2004, establishes at Section 9(3), a statutory basis for a Domestic Homicide Review, which was implemented with due guidance[2] on 13th April 2011 and reviewed in December 2016[3]. Under this section, a domestic homicide review means 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"*

1.2.2 Where the definition set out in this paragraph has been met, then a Domestic Homicide Review must be undertaken.

1.2.3 It should be noted that an intimate personal relationship includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

1.2.4 In March 2013, the Government introduced a new cross-government definition of domestic violence and abuse[4], which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that domestic violence and abuse is:

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

1.2.5 In December 2016, the Government again issued updated guidance on Domestic Homicide Reviews especially regarding deaths resulting from suicide. The guidance[5] states:

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

[2] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews - Home Office 2011 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*
[3] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2016
[4] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office now revised again by 2016 guidance.
[5] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office revised again by 2016 guidance paragraph 18 page 8

1.2.6 The guidance[6] defines coercive and controlling behaviour as:

> '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: a continuing 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."

1.2.7 The circumstances of Florence's death meet the criteria under this section of the guidance.

1.2.8 Such Reviews are not inquiries into how a victim died or who is to blame. These are matters for Coroners and Criminal Courts. Neither are they part of any disciplinary process. The purpose of a review is to:

- Establish what lessons are to be learned from the homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses including changes to the policies and procedures as appropriate.
- Prevent domestic homicide and improve service responses for all victims and their children through improved intra and inter-agency working.
- Contribute to a better understanding of the nature of domestic violence and abuse.
- Highlight good practice.

1.3 Process of the Review

1.3.1 Kettering Borough Community Safety Partnership Board (KBCSPB) was notified of the death of Florence in February 2018. KBCPSB reviewed the circumstances of this case against the criteria set out in Government Guidance[7] and decided that a Review should be undertaken on 26th March 2018.

1.3.2 The Home Office was notified of the intention to conduct a DHR on 3rd April 2018. An independent Chair and Author was commissioned and appointed and a DHR Panel was appointed. At the first review panel terms of reference were

[6] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office revised again by 2016 guidance paragraph 15 page 8

[7] Home Office Guidance 2016 Page 9

drafted. On the 26th June 2019, KCSPB approved the final version of the Overview Report and its recommendations.

1.3.3 Home Office Guidance[8] recommends that reviews should be completed within 6 months of the date of the decision to proceed with the review. The Home Office has been notified of the reason for a delay in the process.

1.4 Independent Chair and Author

1.4.1 Home Office Guidance[9] requires that:

"The Review Panel should appoint an independent Chair of the Panel who is responsible for managing and coordinating the review process and for producing the final Overview Report based on IMRS (Individual Management Reviews) and any other evidence the Review Panel decides is relevant", and "…The Review Panel Chair should, where possible, be an experienced individual who is not directly associated with any of the agencies involved in the review."

1.4.2 Mr Malcolm Ross was appointed at an early stage of this review. He is a former Detective Superintendent with West Midlands Police where, as a Senior Investigating Officer, he was responsible for the investigation of around 85 murders many involving domestic abuse. Since retiring in 1999, he has 23 years' experience in writing over 80 Serious Case Reviews, and post 2011, performing both roles of Chair and Author on over 65 Domestic Homicide Reviews. He has also authored and chairs over 80 Child Protection Safeguarding Reviews and SARs. Prior to this review he was not involved either directly or indirectly with members of the family concerned or the delivery or management of services by any of the agencies. He has attended the meetings of the panel, the members of which have contributed to the process of the preparation of the report and recommendations and have helpfully commented on it.

1.4.3 Mr Ross attended the initial Home Office DHR training Course held in Bristol in 2011. He has since, of his own accord, attended two AAFDA (Advocacy After Fatal Domestic Abuse) DHR training courses in order to refresh his knowledge and keep updated. In 2024, Mr Ross attended the first of the new Home Office/AAFDA certified DHR training course and successfully passed and was accredited as a DHR Author and chair. He regularly attends AAFDA webinars and always attends AAFDA's annual conferences. He has an enhanced knowledge of domestic violence and abuse issues including so-called 'honour'-based violence, research, guidance and legislation relating to adults and children, including for example the Children Act 2004, the Care Act 2014 and the Equality Act 2010. He is completely independent of Northampton Community Safety Partnership and any other agency in Northampton.

1.5 Review Panel

1.5.1 In accordance with the statutory guidance, a Panel was established to oversee the process of the review. Mr Ross chaired the Panel and attended as the

[8] Home Office Guidance 2016 pages 16 and 35
[9] Home Office Guidance 2016 page 12

author of the Overview Report. Other members of the panel and their professional responsibilities were:

- Malcolm Ross, Independent Chair and Author
- John Kinloch, Community Safety Lead Officer, Kettering Borough Council / Kettering Borough Community Safety Partnership
- Richard Tompkins, Detective Superintendent, Northamptonshire Police
- Rose Lovelock, Northamptonshire Healthcare Foundation Trust
- Jacqui Barker, Kettering General Hospital
- Georgette Fitzgerald, Nene and Corby Clinical Commissioning Group
- Charlie Manning, Northamptonshire County Council Adult Social Care
- Lisa Walsh, Safeguarding Project Officer, Northamptonshire Safeguarding Children's Board and Northamptonshire Safeguarding Adult's Board.

1.5.2 The Panel members confirm they had no direct involvement in the case, nor had line management responsibility for any of those involved. The Panel was supported by the DHR Administration Officer. The business of the Panel was conducted in an open and thorough manner. The meetings lacked defensiveness and sought to identify lessons and recommended appropriate actions to ensure that better outcomes for vulnerable people in these circumstances are more likely to occur as a result of this review having been undertaken.

1.5.3 The review panel met on the following occasions: 17th April 2018, 17th May 2018, 22nd May 2018, 24th July 2018, 30th August 2018, 29th October 2018, 4th February 2019.

1.6 Parallel proceedings

1.6.1 The Panel were aware that the HM Coroner for Northamptonshire concluded the inquest on 26th September 2018.

1.7 Time Period

The time period for the review is from April 2010, being the date of Florence's 13th birthday when she was in some form of relationship with the boyfriend to the date of her death in February 2018.

1.8 Scoping the Review

1.8.1 The process began with an initial scoping exercise prior to the first panel meeting. The scoping exercise was completed by the Kettering Borough Community Safety Partnership (KBCSP) to identify agencies that was involved with Florence prior to her death. Where there was no involvement or insignificant involvement, agencies were requested to inform the Review by a report.

1.9 Individual Management Reports

1.9.1 Individual Management Reports (IMR) and comprehensive chronology were received from the following organisations:

- Nene and Corby Clinical Commissioning Group
- Kettering General Hospital
- Northamptonshire Police including the Sunflower Centre
- Community Mental Health Team (Francis Dixon Lodge)
- Serious Incident Investigation Report Leicestershire Partnership Trust
- Leicestershire Mental Health

1.9.2 Statements of Information to be provided by

- East Midlands Ambulance Service (EMAS)
- Northamptonshire Healthcare Foundation Trust (NHFT)
- Crown Prosecution Service (CPS)
- British Transport Police
- Leicester Royal Infirmary
- CAMHS (Child and Adolescent Mental Health Service)
- Leicestershire Education Services

1.9.3 Guidance[10] was provided to IMR Authors through local and statutory guidance and through an author's briefing. Statutory guidance determines that the aim of an IMR is to:

- Allow agencies to look openly and critically at individual and organisational practice and the context within which professionals were working (culture, leadership, supervision, training, etc.) to see whether the homicide indicates that practice needs to be changed or improved to support professionals to carry out their work to the highest standard.
- To identify how those changes will be brought about.
- To identify examples of good practice within agencies.

1.9.4 Agencies were encouraged to make recommendations within their IMRs, and these were accepted and adopted by the agencies that commissioned the reports. The recommendations are supported by the Overview Author and the Panel.

1.9.5 The IMR Reports were of a high standard providing a full and comprehensive review of the agencies' involvement and the lessons to be learnt. All IMR authors were independent of agency involvement with Florence.

1.10 Dissemination

1.10.1 The report had been disseminated to panel members, the KBCSPB, family members and the Home Office. There are no plans by the KBCSP to disseminated further by way of learning events.

[10] Home Office Guidance 2016 Page 20

2. Terms of Reference for the Review

2.1 The aim of the Review is to:

- 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.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses including changes to the policies and procedures as appropriate.
- Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- Contribute to a better understanding of the nature of domestic violence and abuse.
- Highlight good practice.

2.2 Scope of the review

The Terms of Reference for this DHR are divided into two categories i.e.:

- the generic questions that must be clearly addressed in all IMRs.
- specific questions which need only be answered by the agency to which they are directed.

2.3 The generic questions are as follows:

1. Were practitioners sensitive to the needs of the deceased, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator?
2. Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
3. Did the agency have policies and procedures for risk assessment and risk management for domestic abuse victims, Domestic Abuse, Stalking and Harassment Risk Assessment form (DASH) and were those assessments correctly used in the case of this victim / ex-partner?
4. Did the agency have policies and procedures in place for dealing with concerns about domestic abuse?
5. Were these assessments tools, procedures and policies professionally accepted as being effective? Was the deceased subject to a MARAC? (Multi Agency Risk Assessment Conference)
6. Did the agency comply with domestic abuse protocols agreed with other agencies, including any information sharing protocols?
7. What were the key points or opportunities for assessment and decision making in this case?

8. Do assessments and decisions appear to have been reached in an informed and professional way?
9. Did actions or risk management plans fit with the assessment and the decisions made?
10. Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
11. When, and in what way, were the deceased's wishes and feelings ascertained and considered?
12. Is it reasonable to assume that the wishes of the deceased should have been known?
13. Was the deceased informed of options/choices to make informed decisions?
14. Were they signposted to other agencies?
15. Was anything known about the ex-partner? For example, were they being managed under MAPPA? (Multi Agency Pub;ic Protection Arrangements)
16. Had the deceased disclosed to anyone and if so, was the response appropriate?
17. Was this information recorded and shared, where appropriate?
18. Were procedures sensitive to the ethnic, cultural, linguistic and religious identities of the deceased, the perpetrator and their families?
19. Was consideration for vulnerability and disability necessary?
20. Were Senior Managers or agencies and professionals involved at the appropriate points?
21. Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?
22. Are there ways of working effectively that could be passed on to other organisations or individuals?
23. Are there lessons to be learnt from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by ex-partners? Where could practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
24. How accessible were the services for the deceased and ex-partner?

2.4 There were no specific additional questions that agencies were asked to respond to.

Individual Needs

2.5 Home Office Guidance[11] requires consideration of individual needs and specifically:

> 'Address the nine protected characteristics under the Equality Act 2010 if relevant to the review. Include examining barriers to accessing

[11] Home Office Guidance 2016 page 36

services in addition to wider consideration as to whether service delivery was impacted'

2.6 Section 149 of the Equality Act 2010 introduced a public sector duty which is incumbent upon all organisations participating in this review, namely to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act.
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

2.7 The review gave due consideration to all the Protected Characteristics under the Act.

2.8 The Protected Characteristics are: age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation

2.9 The circumstances of this review indicate that Florence, being a female with mental health symptoms, who had a history of relationships with men with a significant age gap, was more likely to be vulnerable to domestic abuse. HM Coroner described Florence as having a '*diagnosis of emotionally unstable personality disorder and an eating disorder. She had a history of deliberate self-harm and overdose'.* It is clear from the history of Florence's lifestyle, that she experienced a troubled relationship with her own family as well as with her boyfriend prior to and at the time of her death. Florence was a very vulnerable person.

Family Involvement

2.10 Home Office Guidance[12] requires that:

> "Consideration should also be given at an early stage to working with family liaison officers and senior investigating officers involved in any related police investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide."

2.11 The 2016 Guidance[13] illustrates the benefits of involving family members, friend and other support networks as:

> a) assisting the deceased's family with the healing process which links in with Ministry of Justice objectives of supporting victims of crime to cope and recover for as long as they need after the homicide.
>
> b) giving family members the opportunity to meet the review panel if they wish and be given the opportunity to influence the scope, content and impact of the review. Their contributions, whenever given in the review journey, must be afforded the same status as other contributions. Participation by the family also humanises the deceased helping the

[12] Home Office Guidance 2016 page 18
[13] Home Office Guidance 2016 Pages 17 - 18

process to focus on Victims and perpetrator's perspectives rather than just agency views.

c) helping families satisfy the often expressed need to contribute to the prevention of other domestic homicides.

d) enabling families to inform the review constructively, by allowing the review panel to get a more complete view of the lives of the deceased and/or perpetrator to see the homicide through the eyes of the deceased and/or perpetrator. This approach can help the panel understand the decisions and choices the deceased and/or perpetrator made.

e) obtaining relevant information held by family members, friends and colleagues which is not recorded in official records. Although witness statements and evidence given in court can be useful sources of information for the review, separate and substantive interaction with families and friends may reveal different information to that set out in official documents. Families should be able to provide factual information as well as testimony to the emotional effect of the homicide. The review panel should also be aware of the risk of ascribing a 'hierarchy of testimony' regarding the weight they give to statutory sector, voluntary sector and family and friends contributions.

f) revealing different perspectives of the case, enabling agencies to improve service design and processes.

g) enabling families to choose, if they wish, a suitable pseudonym for the deceased to be used in the report. Choosing a name rather than the common practice of using initials, letters and numbers, nouns or symbols, humanises the review and allows the reader to more easily follow the narrative. It would be helpful if reports could outline where families have declined the use of a pseudonym.

2.12 Comments made by the family members have been included and referred to in this report. Please see section 'Views of the Family'.

2.13 Family members have been supplied with a redacted copy of the Overview report and the Executive Summary of this report. After repeated requests to engage the boyfriend and after several refusals by him and his mother, on 1st May 2019, the boyfriend agreed to see the Overview Author and Manager of the CSP at his home address.

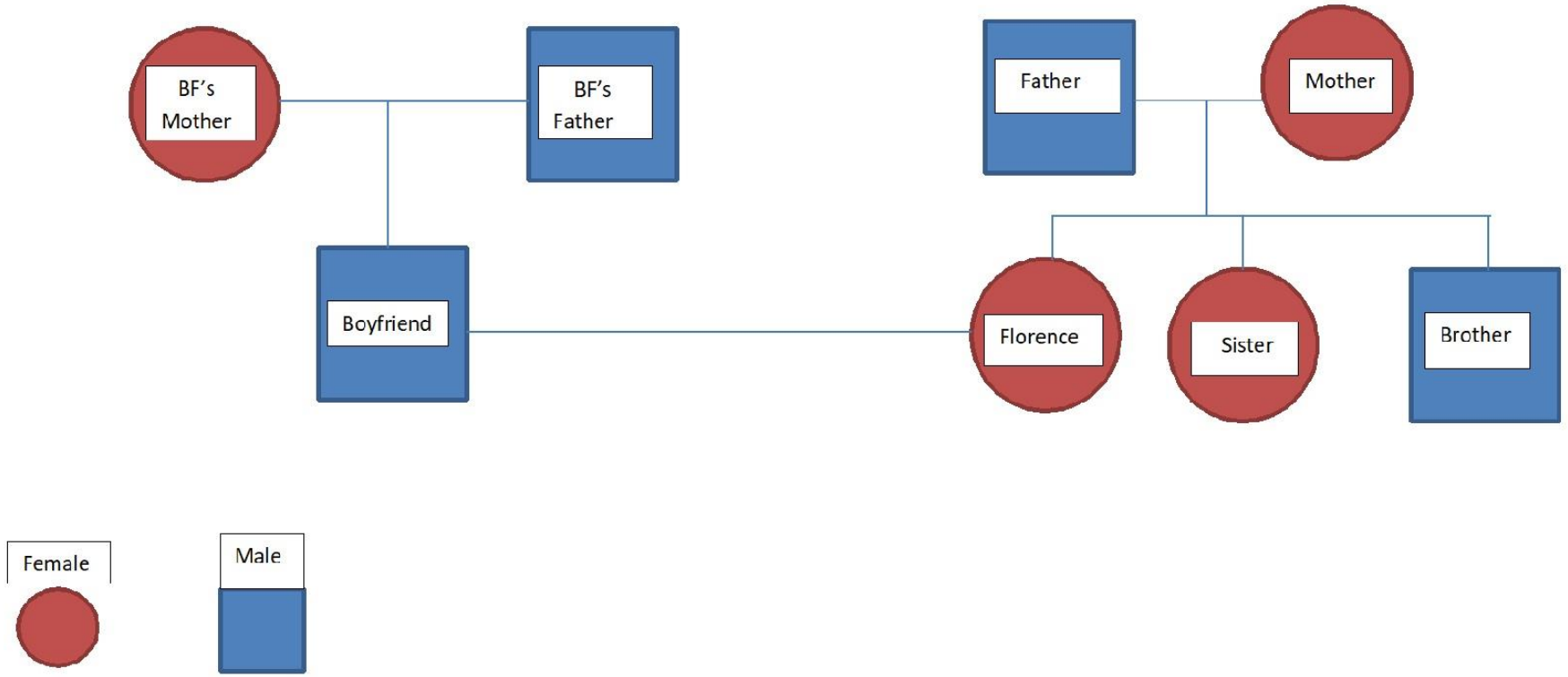
Subjects of the Review

2.14 The following genogram identifies the family members in this case, as represented by the following key:

Florence	The deceased
Mother	Mother of Florence
Father	Father of Florence
Boyfriend	Boyfriend of Florence
Sister	Sister of Florence

Brother	Brother of Florence
BF's Mother	Mother of the Boyfriend
BF's Father	Father of the Boyfriend

Genogram


BF's Mother
BF's Father
Father
Mother
Boyfriend
Florence
Sister
Brother
Female
Male

3. Summary of events.

3.1 Florence was the youngest child in her family. She had an older sister and brother. Her parents are professional people. Both older siblings live at home with their parents.

3.2 Florence was educated locally to her home address and at the age of 13 years or there about, she started a relationship with the boyfriend. At first the relationship was one of friends and according to her parents it remained like that for some time. When Florence disclosed that her and the boyfriend were 'an item', her mother expressed surprise at the news as she didn't think that the boyfriend would be the kind of young man that her daughter would be attracted to. Mother described how the relationship fizzled out after 6 months or so when Florence was around 18 years of age. There is more information about Florence in the fullness of this report and especially in the section 'Views of the family'

3.3 The chronology for this review commences in February 2010. Florence presented to her GP with eating disorders and making herself sick after eating meals. She had been referred to the school nurse. She had been receiving comments about her weight. The school nurse spoke to both parents who indicated that they were aware of the problem. Her Father was to arrange to take Florence to see her General Practitioner (GP) to discuss the matter further. However, there is no evidence to suggest that Florence was taken to her GP and nothing to indicate any follow up by the GP's practice. Her medical records were coded with the condition Bulimia.

3.4 Between February 2010 and October 2013 there followed another five presentations by Florence at her GP's surgery for unrelated physical complaints but there is nothing to indicate that her eating disorders or mental well-being or the letter from the School Nurse were ever discussed during these consultations. However, during that time Florence was progressing well at school and achieving well academically. The GP's practice felt that the issues had been dealt with appropriately and would await further contact from Florence and/or her family.

3.5 Florence attended an eating disorder appointment on 24th March 2013, where an assessment was carried out. She explained that she didn't get on with her mother and family relationships were troubled and the atmosphere at home was 'not nice'. She was having problems at school, and she described how she felt she had 'forgotten who she was' and she had trouble taking to people. She stated that she used to be a popular person, now she was self-harming, pulling her hair out, scratching herself and cutting her stomach. She vomited four times per day and continued to take laxatives. Her Mother, according to Florence says that Florence told lies and had said that she lived in Leicester as the father was in prison which was a fabrication. The report stated that the GP note indicated that Florence did not want her parents present apart from the developmental history part of the consultation.

3.6 It transpired that the eating disorder clinic would not see anyone under the age of 18 years and Child and Adolescent Mental Health Services (CAMHS) was suggested as an alternative. CAMHS replied that Florence's case would be considered at the next Single Point of Access meeting where she was put in the waiting list. It was necessary to arrange for blood tests from Florence to be done. These proved normal

3.7 On 1st October 2013, when Florence was 16 years of age, she attended on her own at her GP complaining of feeling anxious about 'silly things' and that had been so for some months. She explained that she was preparing for her 'A' levels and had the ambition of becoming a dentist and she felt under pressure at school. According to her mother, she had lost one and a half stone in weight. She also explained to the GP that her mother had medical problems and the relationship between her mother and Father was problematic. She said that she did not want to cause her parents any distress and did not want them to find out that she had been to the GP's. She was reassured about confidentiality. She had friends but did not want to spend time with them. She was sign posted towards Mind Gym, a web site that may be of use to her in controlling her anxiety.

3.8 The following day, 2nd October 2013, her GP contacted her and discussed the benefits of Cognitive Behaviour Therapy (CBT) and counselling from 'Good Thinking'. She was referred to 'Good Thinking' about which she said she was happy to engage.

3.9 On 15th October 2013, Florence again attended to see her GP, this time with her mother, who was unaware of the appointment on 2nd October 2013. Florence reported that over the weekend she had been making herself sick and taking excessive laxatives and had been doing this for the previous month. Her Mother requested a referral to a psychologist to which Florence agreed, and she was also referred to the Eating Disorder Services (EDS), but this referral was declined by EDS as Florence was still under the age of 18 years. The GP made a referral to CAMHS instead.

3.10 On 25th October 2013, Florence's GP received a letter from Leicestershire Partnership Trust (LPT) regarding Florence's eating disorder. The letter was acknowledged on 1st November to the effect that due to the number of referrals to the EDS an assessment could not be made at this stage. However, by 11th November Florence had been placed on the EDS waiting list.

3.11 During December 2013, the GP practice attempted to contact Florence but without success. It appeared that she was not engaging with CAMHS, but this does not appear to have been followed up by the GP practice.

3.12 On 13th February 2014, LPT sent a letter to Florence with an appointment for her to be seen by the EDS on 25th February 2014, four months after the initial referral.

3.13 CAMHS liaised with the GP's practice and included the practice in the correspondence sent to Florence regarding her appointments and her subsequent choice not to engage with the service. On 25th February 2014, Florence was seen by CAMHS, and she stressed she did not want her parents present at the assessment. She disclosed that home' was not a nice atmosphere' and she was having problems at school with peer friendships. She also disclosed a history of restricted eating, binging and vomiting. There was no safeguarding issues were identified. The risks identified at this stage were related to the symptoms of her eating disorder and potential physical risks as a result. Florence's parents joined the consultation and explained that Florence had been having difficulty with food since September 2013 and that she had recently become aggressive, intolerant and was isolating herself.

3.14 On 11th March 2014, the EDS sent a letter to Florence's GP summarising the appointment Florence had with the clinic on 24th February 2014. The letter

described how Florence had problems at home and that she did not get on with her mother and described the home experience as not a nice place. She had also described her school life, where at one time she used to be popular with other students, now she was anxious about 'who she was' and had forgotten how to talk to people. She had admitted self-harming, pulling her hair our, digging her nails into her skin and cutting her stomach. She binged with her food and then vomited, which she states she did about four times every day. Her Mother told the clinic that her daughter tells lies, and she had told everyone that she had moved to Leicester because her father was in prison. Her Mother added that Florence would become aggressive and isolated herself. She was intolerant.

3.15 On 28th May 2014, Florence's Mother contacted the EDS secretary requesting an urgent prescription for Prozac for Florence and a follow up appointment. She was given an appointment for 3rd June 2014 and a prescription for the necessary medication. The following day LPT records indicate that a letter was sent from the EDS to Florence's Father, but it was unclear why the letter was sent to her father and not to Florence who was now 17 years old at the time.

3.16 On 3rd June 2014, Florence attended her outpatient appointment with the EDS where it was recorded that she was tolerating the medication which had resulted in less troublesome suicide thoughts.

3.17 On 14th July 2014, Florence's Mother contacted LPT stating that Florence had no more Prozac left and, in any event, doesn't wish to continue taking it. It was unclear if there was a response to the mother's request that day or what the arrangements were regarding future prescriptions. There does not appear to be any evidence that her GP had received any notification of her prescribed medication. Two days later on the 16th July a similar message was left by Florence's Father stating that Florence had had no Prozac for two weeks and urgently needed some. An urgent prescription was posted to Florence the following day.

3.18 On 4th August 2014, the Clinical Nurse Specialist at the EDS wrote to Florence because she had not been seen for some time at the Eating Disorder Clinic. She was asked if she still required the EDS. A copy of that letter was sent to her GP.

3.19 On 21st August 2014, GP had a conversation with Florence's Mother where she told the GP that Florence was engaging with CAMHS but recently she had very few appointments due to pressure of workload with CAMHS, however Florence was happy to continue with CAMHS. The IMR author questioned why this conversation was with Florence's Mother rather than with Florence herself. Florence was by that time 17 years of age and given the reluctance for Florence to have her mother involved previously, it appeared strange that the GP should engage with the mother rather than the patient herself.

3.20 On 26th August 2014, LPT records indicate that Florence's Mother was concerned that Florence was not in a good state of health. The records also state that given Florence's age the Clinical Nurse Specialist was unable to discuss this matter with Florence's Mother. The records also indicate that the Clinical Nurse Specialist had stated that a letter had already been sent to Florence and copied to her GP at the beginning of August and as there had been no response; her case had now been closed.

3.21 On 15th September 2014, Florence telephoned the EDS asking for an appointment. An appointment was offered for 7th October 2014.

3.22 On 7th October 2014, the EDS received a telephone message from Florence's Mother cancelling the appointment and an alternative appointment was offered for 4th November 2014. However, on 10th October 2014, LPT records indicate that a letter was sent from the Clinical Nurse Specialist to Florence's GP indicating that Florence had been discharged from the service. The GP was advised that Florence could make contact in the future if the need arose. Florence was not engaging with them any further. Florence's Mother tried to talk to the EDS but was told that Florence was now 17 years of age, and they could not talk to her about her daughter's case.

3.23 On 14th November 2014, Florence saw her GP saying that she didn't think her situation had improved much and that she hadn't received any appointments with the EDS, which appears to contradict the information given on 10th October. She was again advised to engage with the EDS. She said that she didn't feel that CAMHS was helpful. Florence said that she did not have any thoughts of self-harming or suicide. On examination, Florence was observed to be thin, but she refused to be weighed. She was given the contact number of EDS and the GP noted that 'she may need to be re-referred'. As Florence was 17 years old by this time, the EDS would not engage with her mother, only Florence.

3.24 On 20th November 2014, Florence took an overdose of Doxylamine[14] tablets in an attempted suicide. She had obtained the tablets from a friend. She said that stressful life events had precipitated this. She was admitted overnight for observations and discharged the following day. Her Father's view of this incident was that she was attention seeking. An assessment was made by CAMHS, details of which were sent by her GP. From the assessment the plan was to refer to the Child and Adolescent Eating Disorder Service, her parents to consider private Cognitive Behavioural Therapy (CBT), the school to consider an input from the school nurse, all future correspondence to be sent to Florence herself and a further appointment for 24th November 2014.

3.25 On 24th November 2014, Florence was seen by CAMHS. She had no suicidal thoughts at that time, but she had poor self-esteem. She described that she was overwhelmed by her eating disorder, and she had gone home, binged and purged and began taking tablets and could not stop. She suffered hallucinations and it was then that she felt she no longer wanted to die and informed her mother of what she had done. She stated that she had never self-harmed but admitted previous episodes of cutting usually after binging and purging.

3.26 On 1st December 2014, CAMHS wrote to Florence's GP stating that Florence was a moderate risk of self-harm by cutting and had made a significant suicide attempt. The letter describes how Florence had recently been thinking of suicide, but she had managed to control these thoughts. At the time of the suicide attempt there had been an incident at school where she had experienced conflict from fellow students that had made her thoughts more intrusive. It was suggested that she should be referred again to CAMHS and that the parents should consider CBT, which she could access privately through her father's private medical scheme. (Subsequent enquiries with her father

[14] Doxylamine is an antihistamine, used to relieve symptoms of allergy, hay fever, and the common cold

showed that although he obtained all the necessary paperwork for private treatment, Florence did not pursue that course of action.) It was also considered that the School Nurse should be engaged with Florence. Arrangements were made for all correspondence to be sent to Florence.

3.27 On 3rd December 2014, LPT records indicate a referral being made to the school nurse as per the plan from the 20th November 2014, however, Florence did not attend.

3.28 On 8th January 2015, Florence was seen by CAMHS where she admitted self-harming before Christmas following an argument with her parents. She cut her own hair and used a razor to injure her stomach and thighs. Records also indicate that Florence stated that on occasions when she is cooking for herself, she hears her mother making vomiting noises.

3.29 On 26th January 2015, Florence was taken to her GP by her mother for an urgent appointment. Florence had deep cuts to her forearms caused by a razor blade in an attempt to kill herself. The cuts required stitching, and her mother was instructed to take her to the local Accident and Emergency (A&E) department for treatment. Florence's medical records were coded 'intentional self-harm by sharp object'.

3.30 Florence was referred to a Mental Health Unit Acute Assessment and Recovery Team (AART). It was noted that she wanted to be seen alone away from her parents. She that she had been having an on-line relationship with two men aged 25 years and 34 years. One of the men had called her fat and had shown her pictures of tiny girls which had affected her moods and self-esteem. Her self-harming had become more frequent, and she said that she was unwilling to help herself and get support to get better. She had thoughts about 'not wanting to be here'. Florence denied any history of physical or sexual abuse although admitted to emotional abuse by her ex-boyfriend which included insults and taunting about her physical size. She was diagnosed with a 'severe depressive episode with no psychotic symptoms. Florence was deemed to have capacity to make decision and understand what had been said to her. Her medication was reviewed, and she was referred to the Home Treatment Team (HTT) who was to liaise with CAMHS. She was to remain off school for a week[15].

3.31 On 1st February 2015, LPT records indicate that the Home Treatment Team visited Florence at home. Both of her parents were there. She disclosed that she had 'fleeting' thoughts of deliberate self-harm but had no plan or intention to do so. She was seen on her own without her parents present.

3.32 Florence was seen on 2nd February 2015 by a medic linked with the Crisis Team who came up with a clear plan following a discussion with the Consultant Psychiatrist within the Home Treatment Team. The plan was:

- No change to her medication
- A referral to FDL
- A referral to Community Psychiatric Nurse (CPN) if discharged from CAMHS
- CBT self-guide help

[15] The two men Florence was associating with online and the ex-boyfriend mentioned about are different people to her boyfriend at the time of her death.

- A Health Visitor to contact Florence to see if she would like a visit.

3.33 Florence was seen again by the Home Treatment Team on 25th February and 11th March 2015 but it is not clear as to why she was not seen in the end by the Adult Community Mental Health Team (CMHT).

3.34 On 3rd February 2015, Florence's GP received a letter from CAMHS. It appeared that Florence had fallen in love with the 'on-line' man, and she intended to go to the USA to live with him once she was 18 years of age. She had admitted smoking cannabis sometime previously and she denied having a current boyfriend. Despite the known history about her relationship with her mother, Florence had described her relationship with her parents as good. She continued to have suicidal thoughts and mentioned that should she try again she would hang herself because 'that works'. A conversation with Florence's Mother indicated that she also feared that she would not be able to keep Florence safe at home and requested an admission to a mental health facility. Her Mother added that Florence had met one of the on-line men at his flat to sleep with him. Her Father commented that he thought that if Florence had got the necessary funding she would be in the USA or alternatively she would be dead. Florence was diagnosed with severe depression and psychotic symptoms.

3.35 On 6th February 2015, LPT records indicate a referral was made to a Personality Disorder Service.

3.36 On 18th February 2015, a referral for Florence to Therapy Services for People with Personality Disorders was not accepted as Florence was open to CAMHS and under 18 years of age. The following day she was discharged from the Acute Assessment and Recovery Team as the plan was to await the outcome of Francis Dixon Lodge (FDL) and Adult Outpatients Assessment (OPA) referral, to engage with CAMHS and for Florence to remain concordant with her medication. This appears to have been arranged over the telephone with Florence by a member of the HTT. As a result of this consultation, Florence's medical records were coded 'Emotional Unstable Personality Disorder'.

3.37 In a letter of 25th February 2015 from Adult CMHT to Florence's GP following an appointment that day, the history of Florence's problems indicate that they re-emerged due to problems at home when she was about 15 or 16 years of age. The problems included her father receiving counselling for anxiety and Mother having alcohol issues. Both issues had an adverse effect on Florence's mental well-being.

3.38 On 11th March 2015, Florence attended at an Eating Disorder Clinic where she disclosed binge eating, purging and the use of laxatives to keep her weight down. Notes at this clinic indicate that Florence had already been referred to the Therapy Services for People with Personality Disorders (TSPPD), but she had been declined that service as she was not 18 years of age until April 2015. She was however invited to engage with that group in June 2015.

3.39 On 7th May 2015, Florence chose not to attend an appointment with the EDS and her case was closed on 25th May 2015.

3.40 On 4th June 2015, Florence attended at A&E with a blood blister to her uvula, the soft tissue at the back of the throat. She denied any trauma had taken place and was advised to see her GP if it persists.

3.41 On 10th June 2015, Florence again chose not to attend an outpatient's appointment with the EDS. A subsequent review by her GP showed that Florence was engaging with TSPPD, and she was invited to attend a four week 'Emotional Wellbeing Group therapy session in August 2015.

3.42 In July 2015, a letter was sent to the GP from Adult CMHT indicating that Florence had been seen, and it was considered a referral to Eating Disorder Clinic would be suitable. However, Florence declined despite this advice. Her mood was low, and she reported that she was cutting herself at least every two weeks. She continued to make herself vomit. She had secured a place at university, but she was unsure of she wanted to go. Notes indicate that she was going to start treatment with TSPPD and would be referred to Eating Disorder Clinic if she changed her mind. She had been invited to join an Emotional Wellbeing group, but she chose not to turn up at the meeting. She also did not attend at the TSPPD appointment. She was sent a letter saying that if she did not contact the service within the next two weeks she would be discharged from the service. There is no evidence that her absence was coded within the GP records and no indication of increased risk.

3.43 On 7th October 2015, Florence did not attend for an outpatient's appointment at the EDS.

3.44 On 27th November 2015, Florence attended at her GP for contraceptive services. There is nothing noted to indicate that she was asked about her mental health, eating problems or why she had decided not to attend the two appointments above.

3.45 Florence was reviewed by Adult CMHT on 26th January 2016. It was noted that she would not engage with the most appropriate service which was the TSPPD and therefore there was not another suitable service that she could be referred to. This was contrary to the view of the Psychiatrist. Eating was her main disorder as she stated that she did not want to be considered as being fat. The Community Mental Health Team was concerned about her restricting her diet, some days not eating at all. She didn't want to be considered fat.

3.46 Florence decided not to attend an appointment with Adult CMHT on 31st May 2016. A letter from the Psychiatrist to the GP stated that Florence continued to suffer from Emotionally Unstable Personality Disorder as well as an eating disorder and that despite efforts Florence continued to persist in declining engagement with services. (Following Florence's death her mother found a lever arch file in her bedroom with a comprehensive and updated list of names and contact details for all the support services she was known to, indicating Florence had been aware of how to contact services when needed).

3.47 On 26th July 2016, Florence presented at Kettering General Hospital (KGH) feeling unwell. She was initially seen by a locum doctor but left the hospital before being seen and treated. There are no other notes to indicate why she was feeling unwell. On the same day the GP wrote to Adult CMHT reporting that Florence had been away from her family for a short period of time and that had made her condition worse. She had stopped taking her medication (Duloxetine[16]) in November 2015, on the advice of her now ex-boyfriend, who thought it would stop side effects. Florence appeared to have a change of mind

[16] Duloxetine - mostly used for major depressive disorder, generalized anxiety disorder, fibromyalgia, and neuropathic pain.

and was now prepared to recommence her medication that day and was asking for more support and was keen to try the group therapy.

3.48 The following day Florence attended at her GP's surgery. She had had a bad reaction to the Duloxetine. She was monitored for a few hours and her medication was changed to Sertraline, a similar antidepressant to Duloxetine. This appeared to suit Florence better and by 19th August 2016 she reported feeling better and her mood had changed with the new medication.

3.49 In October 2016, Florence spoke to her GP by telephone talking about contraception. She stated that she is in a long-term relationship with her partner. She was told that she could not be prescribed combined oral contraceptive pill Combined Oral Contraceptive Pill (COCP) until it was sure there would be no risks involved. Within 3 weeks, she had been prescribed contraception but there is nothing to indicate that her mental health or her weight issues were taken into consideration at that time. She was asked to attend the practice for a review on 28th December, but she did not attend. There is nothing to say that any action was taken by the practice in respect of her not keeping the appointment.

3.50 In March 2017, Florence again saw her GP regarding other matters. Although she was described as not being suicidal, records indicate that she was anxious and paranoid the people were talking about her. She stated that she was concordant with her medication, but it was noticed that she had not requested further medication from the practice. This may have indicated that she was not compliant, and this does not appear to have been challenged. She was questioned about not attending the December 2016 appointment to which she explained that she had been working.

3.51 In April 2017, she again saw her GP. Notes indicate that she was still binging and vomiting several times per day. She had not self-harmed for some time but had taken to hitting herself. She refused to be weighed. She stated that she did not want to be referred to EDS but would rather address her personality disorder first. She still had problem controlling her behaviour.

3.52 The following month, Florence described to Adult CMHT that she felt empty and constantly thought of death. She also added that her relationship with her boyfriend was difficult and that he was financially dependent upon her. By June that year she had stopped taking her medication and she told her GP things were 'dreadful'. Her boyfriend had told her that he intended to finish with her. They were at that time living in the upper floor of his parent's house. She also said that she had been researching suicide by using an 'exit bag' which if she decided to end her life, would be the way that she would do it as research had stated that it would be a painless death. Her GP tried to communicate with Adult CMHT but that was difficult. The GP stated that they had concerns about Florence as she was adamant that she did not want to work with the Crisis Team. When she was at work, she appeared to be able to cope but when she got home things were very chaotic. She felt that if the Crisis Team were to become involved, because she lived with her boyfriend and his family, they would ask her to leave. The GP noted that it was felt that Florence was at risk to herself and the method of harming herself had already been researched. She was offered use of the medication Quetiapine, but she declined because of the possibility of weight gain. The GP suggested that she be assessed by TSPPD and had a review with the Adult CMHT.

3.53 The GP and Adult CMHT liaised together and concluded that she ought to be prescribed Lamotrigine[17]. Florence stated that the boyfriend was her main support wanted to break up with her and she mentioned that if she wanted to end her life, she would use an 'exit bag' and that she had been researching that for a couple of days. She re-assured the GP that she had not gone to the lengths of obtaining an 'exit bag''. The GP tried to telephone the Adult CMHT but there was no-one available to talk. It was 4 days later that the GP spoke to the Adult CMHT who agreed that Florence was a suicide risk, but she had capacity so supportive management was needed.

3.54 In July 2017, notes in Florence's records indicate that she felt that she had disengaged with services in the past as she had not received any letters and appointments which may have been because she had left her home address and was living with her boyfriend. She assumed that she had been rejected by services because she had not heard from them.

3.55 On 6th July 2017, at a follow up appointment at the TSPPD, Florence indicated how she longed for care and support. She perceived herself as vulnerable and being a victim but also acknowledged she had some strengths such as being competent particularly with support from others. It was considered however, that she saw the world through 'rose-tinted glasses'. She explained she had moved out of her parent's home a year before and that her parents had previously thrown her out of the home accusing her of being an 'MCAT' addict. She had moved in with her boyfriend only because there was nowhere else to live, and she couldn't afford to live independently but described her boyfriend as having angry outbursts which frightened her. She described their relationship as being verbally and physically abusive.

3.56 With regards to her parents she described them as having a horrible relationship with each other and she couldn't understand why they were still together. It was considered that she may benefit from group intervention at the Understanding Yourself Group. However, there was a 12-month waiting list, but there was an opportunity for her to have some interim appointments. With regards to her boyfriend, she stated that she disassociated herself from him regarding his rages and outbursts and whilst she was aware that they have a toxic relationship she could not see herself leaving him. Florence explained that her boyfriend had had an abusive relationship with his own Father and recently she and her boyfriend had argued resulting in him throwing her out of bed, up against a wall and calling her insulting names.

3.57 In August 2017, Florence went to her GP saying that Adult CMHT had increased her medication of Lamotrigine. This was questioned by the GP as the GP had no knowledge of this increase. Florence became upset and left the surgery. The GP subsequently discovered from Adult CMHT that there had not been an increase in medication, and it appears that Florence had been found to be misleading her GP in her request for an increased dose of medication.

3.58 On 14th August 2017, Florence had an appointment with the TSPPD. She reported that the relationship with her boyfriend was 'patchy': sometimes getting on but other times when he was physically, verbally, and emotionally abusive. It was thought that Florence formulated this in the context of her family history where there was a repeated pattern of her being drawn towards destructive and controlling relationships where she was left feeling as though her needs were not important. She stated that she hoped her boyfriend would

[17] Lamotrigine is used for epilepsy but can be used as an anti-depressant.

do something terrible and injure her then others would see what he was like and might do something about it. She said that she had no friends and nowhere to stay if she left him. She was totally isolated. She was offered the details of the organisation United Against Violence and Abuse (UAVA) but refused the leaflet but took down the telephone number and web address.

3.59 Florence worked at the local hospital in an administrative role. On 27th September 2017, she self-referred to the A&E department where she was seen by the hospital IDVA.[18] Florence was seeing support and although the IDVA spent half an hour with Florence but the DASH[19] form was not completed at that time as Florence was too upset and the IDVA wanted to build a relationship with Florence based on trust.

3.60 From the conversation the IDVA had with Florence at that stage the IDVA considered that she was of medium to high risk due to the emotional impact her life was having on her at that time.

3.61 Florence disclosed to the IDVA that she had been isolated by her boyfriend with whom she had been with for some 15 years. He had been physically abusive towards her, and he had recently grabbed her by the throat, pushed her and restrained her under a duvet cover. She described the boyfriend as being very clever and knowing not to hurt her where injuries would be noticed. She was provided with a Sunflower Centre handbook and a safety plan which she kept at work so the boyfriend would not be able to find it. She was given an appointment 7 days-time with the understanding that she could call an IDVA should she need to do so. She said that she would feel safe during that period of time.

3.62 On 2nd October 2017, Florence was seen by a doctor and diagnosed with Personality Disorder. Her mood problems had persisted, and she showed signs of paranoia. She felt that people were talking about her in 'muffled voices'. She was to continue with her medication, and she was invited to attend therapy Services sessions for people with Personality Disorder.

3.63 On 6th October 2017, Florence saw the IDVA and the IDVA considered that she was high risk. She had attempted suicide before and although she had suicidal ideation, she stated that she had no plans at the moment and would contact the crisis team if things changed. Florence was told that the case must be referred to MARAC[20] and may be reported to the police about which, Florence was fearful. It was decided that a named officer from the DAPIT[21] would be her link with the police.

3.64 On 11th October 2017, Florence again met with the IDVA and described in more detail the controlling and coercive relationship she had been in with her boyfriend since she was 13 years of age. She was, however, reluctant to give any details of her boyfriend fearing she would get him into trouble. The DASH risk assessment form scored 14.

3.65 Florence described how she lived with her boyfriend's parents and that she had a difficult relationship with her own parents. It appeared that there was abuse in both her own and her parent's relationships. She told the IDVA that she had

[18] IDVA – Independent Domestic Violence Advisor
[19] DASH – Domestic Abuse Stalking and Harassment Risk Assessment Form
[20] Multi-Agency Risk Assessment Conference
[21] Domestic Abuse Prevention and Investigation Team of Northamptonshire Police

been diagnosed with Bi-polar and she also had issues with anxiety. (She had not been medically diagnosed with Bi-polar). Florence was extremely depressed at that time and talked about her previous suicide attempts and, she had thought about jumping in front of a train, although she was not considering doing that at the moment. She also disclosed that her boyfriend had tried to smother her with a pillow and had put his hands around her neck. She said that he would push her into a wardrobe and drag her around the bedroom by her legs. He had made threats to kill her. She said, however, that she did not want to end the relationship. She agreed to meet the IDVA the following week.

3.66 The following day, 12th October 2017, following a referral from the Sunflower Centre, Florence met with a police officer. A record of the common assault upon Florence by her boyfriend was made. A mature assessment was made by the officer, together with a MARAC referral being completed by the IDVA, a DASH and a vulnerable adult PPN[22] submitted. Florence was offered the facility of a refuge but decline as she was considering taking a room at the hospital where she worked. The IDVA created a safety plan, and the arrangement was that Florence was to keep in touch with the IDVA on a weekly basis. The boyfriend was not arrested due to Florence being unwilling to support a prosecution and she thought that by doing so would be detrimental to her mental health, alienate her, and put her at a greater risk. Photographs were taken of her injuries.

3.67 On 13th October 2017, police records show that Florence was ready to leave her boyfriend should the need arise. She had a bag packed but wanted to give him one last chance to reconcile the relationship. Florence described the following morning how she had tried to talk to her boyfriend the previous night, but it had ended in an argument. She stated that she loved him and believed that he loved her. She was hopeful that the next evening when he came home would be better. She stated that she didn't think he would do anything but if he did, she would leave and call the police. She had a feeling that the boyfriend would break up with her and she said that would be his decision and not hers.

3.68 On 16th October 2017, Florence was contacted by the Sunflower Centre. She said that she had been pushed again by her boyfriend but didn't want to make a complaint. Apparently, her boyfriend had been to Scotland for a week and had been arrested for shoplifting. She confirmed that she wanted to give the relationship another chance. Her safety was discussed and the importance of answering calls from the Sunflower centre and the IDVA stressed.

3.69 On 20th October 2017, Florence was admitted to hospital for the day due to two episodes of blurred vision. She was advised to reduce her medication and discharged.

3.70 The Sunflower Centre was in constant contact with Florence and on 23rd October 2017, Florence stated that she was fine but still unsure of what to do about leaving or staying with her boyfriend.

3.71 On 31st October 2017, Florence reported to the Sunflower Centre that she felt better and that her and her boyfriend had booked a holiday to Amsterdam for 2 weeks' time, and she was confident that the relationship would improve. She was re-assured of the support that was available to her.

3.72 Florence had two appointments with her GP regarding the changing of her medication but by 6th November 2017, she had an appointment with LPT where

[22] PPN – Public Protection Notice

she described that her boyfriend had been physical and sexually abusive towards her and that she had moved back home to her parent's house, albeit they were away on holiday themselves. She was unsure of she wanted to report the matter to the police. She felt that she was unable to keep herself safe. She was referred to CRHT[23] and a taxi arranged to take her to A&E for an assessment. There she described being in crisis, having long term domestic abuse in her relationship and having suicidal ideations. She was expecting to be admitted into hospital, but this was thought not to be in her best interests and there being an absence of acute mental illness at that time. She was offered a further assessment with the CRHT to consider of there was a role for that service. It was noted that she was currently not engaging with the UAVA. She agreed to stay with her sister and was discharged.

3.73 She was seen by her GP because of her visit to hospital where her notes reveal long term suicidal ideations, lack of self-worth, blaming herself for the boyfriend's violent behaviour towards her and thinking that her boyfriend is the person that cares for her. She stated that she did not want her family to know about the violence within her relationship with her boyfriend. She said that she had been referred previously to CAMHS for her eating disorders, but she had not engaged with them. She had last overdosed because of her meeting up with a man she had met online. He had convinced her he loved her, and she had had sex with him. She later felt shame and guilt about the episode and her mother had found out. She felt that her parents were both too busy with their own jobs to pay attention to her and her older siblings. She alleged that her mother had cancer, and her father had an affair.

3.74 On 8th November 2017, Florence told the Sunflower Centre that once her boyfriend had returned from Scotland, she had found him looking at images of women on his telephone. She had confronted him and had had pushed her, grabbed her throat, and bruised her left wrist. She had retaliated but did not want the police involved. She had decided to leave him and at that time he had suggested that they have a 'break' from each other as living together was not proving to be a 'positive experience'. Florence disclosed her ex-boyfriend had always said he was going to kill her and now she wishes he had. On the previous Friday he had tried to strangle her. Florence described the relationship as toxic but that he was the only person who loved her.

3.75 Florence referred to difficulties in her relationship with her parents and blamed them for missing mental health appointments, stating that they had withheld her post. She expressed feelings of shame, guilt, and worthlessness. Florence felt she had suffered emotional abuse from her parents. Florence admitted to using cannabis along with her partner. Her parents had accused her of taking Ecstasy, which she denied. It was suggested that she be referred to the Crisis Team and Florence was in favour of that. She was offered a place in a residential unit in Rugby, and she was getting support from her supervisor at work. It was decided that to report the matter to the police despite the severity of the situation, would be detrimental to the mental health of Florence.

3.76 On 9th November 2017, Florence attended the GP's surgery for an appointment with a nurse from the Home Treatment Team. She reported that she had no plans to reconcile her relationship with her boyfriend and on reflection she was glad it was over. On 13th November the Crisis Team reported that Florence was

[23] CRHT – Crisis Resolution Home Treatment Team

positive and making progress and that she had spoken at length regarding her relationship with her partner and why he became violent.

3.77 On 19th November 2017, the Home Treatment Team nurse saw Florence at home. During this visit she stated that she was back with her boyfriend but not living with him and that she would not be pressing charges against him. Florence's view was that she could be discharged from the Home Treatment Team after a couple of more visits.

3.78 By 22nd November 2017, Florence had decided to move back in with her parents. She told the Sunflower Centre that she had moved on now and that she had no contact with her boyfriend. She reported that she had learned a lot during her sort stay at the residential unit around coping mechanisms. She also stated that she felt that she no longer needed support from the Sunflower Centre but would go back to them if the need arose.

3.79 On 25th November 2017, Florence had another visit from the Home Treatment Team where she was given CBT booklets regarding dealing with stress and pressure because of living with her parents. She admitted still seeing her boyfriend but stated she would never be able to live with him because their relationship she thought was volatile.

3.80 On 29th November 2017, Florence had a telephone conversation with the Crisis team where she stated she would be happy if she was discharged. She had returned to work and spoken to the Police and Safeguarding about physical abuse, and she had reported that it had all been sorted. Her discharge letter stated that she had been advised to engage with support from domestic abuse services, but Florence had said that she didn't want or need it and didn't want to talk about it.

3.81 On 1st January 2018, Florence complained to the police that her boyfriend had attacked her at his home. She alleged that he had grabbed her round her neck and attempted to smother her using his hooded top. She reported feeling herself going unconscious as the hooded top was tightened around her neck. The boyfriend's mother then came into the room and his grip on her was released. Florence managed to break free and call the police. The boyfriend was arrested and later charged with attempting to murder Florence. She was cautious about him being prosecuted and felt guilty. She was concerned that him going to prison. About her parents she said that they had an 'I told you so' attitude towards her getting back with the boyfriend as they had warned her against it.

3.82 A Police investigation commenced and an extension time for the boyfriend's detention was granted. However, after seeking advice from Crown Prosecuting Service (CPS), the Police were informed to bail the boyfriend while enquiries continued. The police objected to this decision but were overruled by CPS. Florence was upset when she was told and thought that no-one believed her. Florence was advised by the police and the Sunflower Centre as what to do in the event of the boyfriend breaching his bail conditions. She visited her GP and all injuries that were consistent with her allegation were photographed and recorded. However, there is nothing to suggest that a formal or informal risk assessment was carried out by the GP.

3.83 On 4th January 2018, LPT notes indicate that Florence was requesting some notes to support a prosecution against her boyfriend. She described how they had got into an argument, and he had beaten her badly and that she had

returned to her parent's house. She was told she would have to get the permission from the Information Governance to obtain copies of notes.

3.84 On 9th January 2018, Florence attended Adult CMHT for a review, during which she admitted having thoughts about taking her own life due to the stress of domestic abuse but did not admit to having a plan or action to act on this. She said that she was coping better and functioning well on her medication. She said that her boyfriend, who was at that time on bail, claimed that her injuries were self-inflicted as she was mad and suffering from a mental illness. She also stated that he had said that she made him do it and that she enjoyed it and that he would constantly out her down

3.85 On 16th January 2018, Florence was seen at work by a member of the Sunflower Centre. Florence seemed 'upbeat' and was focusing on the positive things in her life at that time. She was concerned about bumping into her boyfriend as he worked in a local store. She was advised what to do in that event. She expressed a wish to become involved with the Freedom Programme and said that she could organise time off work to attend.

3.86 On 24th January 2018, CPS decided to release the boyfriend from his bail under the provision RUI (Released Under Investigation). Florence was informed of this decision and although the boyfriend had not contacted her, she had removed him from her social media and they were by this time living separately, she felt very frustrated and let down by the police and she was convinced that he would not be charge with any offence. This day was her final attendance at her GP's surgery where it was noted that she had no suicidal thoughts and no thoughts of harming herself or others. A repeat prescription was issued.

3.87 On 1st February 2018, Florence told the Sunflower Centre that she was now feeling very angry with her boyfriend for what he had done to her and was questioning why she had stayed in the relationship as long as she did. She said that he was not feeling as low as she had been and that she had no intention of harming herself.

3.88 The following day her case was heard at a MARAC. Florence said that she was looking to the council to assist her with a housing application for Kettering or Market Harborough. She wanted some advice on obtaining a Non-Molestation Order. She was given various options to obtain such an order. The offer of support was also mentioned and Florence said that she was beginning to find her circle of friends again.

3.89 At 16.16 hours on the day of her death in February 2018, Florence stepped in front of a train travelling at 95 m.p.h. She suffered fatal injuries. CCTV examination of the scene prior to her stepping off the platform shows that she was alone at the time and no one else was anywhere near her. She was seen with her mobile telephone in her hand, but the phone was so badly damaged no evidence or information could be retrieved. The examination of the CCTV by the British Transport Police Fatal Investigator indicates that she may have been listening to music rather than holding a conversation with someone.

3.90 A Police investigation was commenced by British Transport Police which according to Crown Prosecution Service, revealed that there were no suspicious circumstances to the death of Florence. Florence's parents have written to Crown Prosecution Service asking them to reconsider their decision but have received a reply to the effect that the decision was in line with

thresholds and guidance. The Overview Author has also written asking for the rationale behind their decision and has received a similar reply.

3.91 HM Coroner for Northamptonshire opened and inquest and determined that Florence had taken her own life.

4. Views of the family members of Florence, the boyfriend, parents of the boyfriend and friends of Florence.

4.1 In accordance with Home Office Guidance of 2016, at a very early stage in this review process the Overview Report Author wrote to Florence's parents, the boyfriend himself, and two friends of Florence. As the review progressed a letter was also written to Florence's work manager.

4.2 Responses were received from Florence's parents, the mother of the boyfriend and Florence's manager.

4.3 On the 7th May 2018, the Overview Report Author visited Florence's parents at their home. They described Florence being the youngest of three children. They expressed their surprise when Florence started a relationship with her boyfriend at the age of about 13 years.

4.4 They described Florence as having an eating disorder and how she would take laxatives. She would often vomit. Her Father described how Florence always wanted to be seen as extra thin. He said that Florence had been diagnosed with borderline personality disorder, but she would call herself bi-polar as she thought that sounded better.

4.5 Both parents described Florence as being a person who constantly sought attention and they described how after self-harming by cutting her arms which necessitated hospital treatment, she told the hospital she had attempted to commit suicide when according to her parents she had only self-harmed.

4.6 Her parents explained how Florence would not engage with agencies and from the age of 13 they knew she was self-harming. Her GP, her school, the school nurse, and Leicester Hospital were all involved with her, but her parents said she would not engage with any of those agencies. They once asked her if she had attempted suicide, and she said she had, and it appears that she would always research self-harming before she did so. It also appears that the research was done whilst she was at work in the hospital.

4.7 As far as the boyfriend is concerned Florence's parents did not have a lot to do with him and as far as they were aware he only went to their house when both parents were out. To pacify Florence, they invited the boyfriend for a meal over Easter 2017, but he declined to go. Her parents are aware that Florence had told family members that her boyfriend was hurting her.

4.8 Florence's Mother worked at the same hospital as Florence and on one occasion her mother recalls Florence turning up in her mother's department screaming saying she wanted to come home because the boyfriend was hurting her. Florence said he was clever and left no marks after he had physically abused her. Nonetheless she always went back to the boyfriend.

4.9 Florence's parents understand from people who knew the boyfriend that his father controlled and physically abused him. Florence's parents recall that on

New Year's Day 2018 Florence telephoned from the boyfriend's house screaming, 'come and get me, he has tried to strangle me'. Florence's parents told the boyfriend's parents what had happened, and they didn't believe them.

4.10 On one occasion Florence called the Police to complain about the boyfriend. She wanted her mother to sit in on the interview, but her mother declined telling the Overview Author that Florence needed to do that on her own. But she did go and see Florence after the interview.

4.11 Florence's Mother said that there were letters from Florence's GP sent to the home address after Florence had moved out. Her Mother said that she gave Florence the letters each time they arrived.

4.12 Her parents are aware that for some reason Florence attended a Level 3 Safeguarding Course at the hospital which she did not need to attend and was not relevant to her administrative duties. In any event, following that course Florence contacted the hospital safeguarding IDVA.

4.13 On 5th October 2017, Florence text her mother at 19.47 hours asking her to collect her from the boyfriend's house because of the way he was treating her. Florence went home to her parent's house but quickly moved back in with the boyfriend.

4.14 Florence's parents were again seen on 29th October 2018 by the Overview Author and the Community Safety Manager where her parents described that any post that was sent for Florence to the home address was collected on a Monday when Florence would always visit her home address. She changed her home address to that of the boyfriend. Her Mother said she never opened any mail address to Florence except for one that was from a local college.

4.15 The parents described how Florence would dip in and out of CAMHS but when she was transferred to adult social care she became fully involved with that process.

4.16 According to her parents Florence's personality disorder was made up of nine traits and it was thought that she had all nine.

4.17 Regarding the online relationships her parents describe her relationship with a man from London. Her Father (ex-Police Officer) described how he had a savings fund for the children with the Police Mutual Assurance Society but when Florence's policy was due to mature, he extended the period as he was concerned that she would take the money and go to America.

4.18 According to her parents, Florence's friends did not like the boyfriend.

4.19 Her parents were asked if Florence's comments about trouble between her mum and dad were true and they stated that they had some general problems but nothing significant and they were perturbed by the comments made by Florence. Her parents stated that they considered that Florence always wanted them to split so she could have two homes to go to. They were asked if there was any pressure on Florence at home and stated that there was nothing but recalled an incident at school where Florence lay on the floor doing 'the dying fly' for attention. Her parents said that Florence often told lies. She once told school that her dad was in prison and the school had to be told that she was lying.

4.20 At that same meeting Florence's older sister was seen and was asked about Florence's illnesses and allegations that Florence's family life was troubled. She explained that 'when you lived with [Florence], you never noticed, and if you did, you just ignored it – that was [Florence]'.

4.21 The sister recounted several times when Florence indicated that she wanted to move back home which she did but then would suddenly change her mind and go back to the boyfriend. Her sister also recounted an occasion when Florence called her from a Leicester hospital to collect her and take her home as she was in 'a right state' and could not stay alone that night. On the journey home they stopped to get Florence chips and cigarettes, and her sister was under the impression that Florence wanted a free ride home from hospital. Her sister stated that she had no concerns for Florence's welfare.

4.22 Both Florence's Mother and sister are of the opinion that the boyfriend supplied Florence with drugs, and he had also supplied the antihistamines that Florence overdosed on.

4.23 Apparently, according to Florence's Mother, a lot of Florence's friends do not have anything to do with Florence's family and will ignore them if they pass in the street.

4.24 On the day Florence died, according to her Mother she appeared normal, she had ordered a top and had booked and paid for tickets for an event. It is the family's belief that she had not planned to take her own life as they would have expected her to use up all her expensive make up.

4.25 On 24th September 2018, the Overview Author and the Community Safety Manager visited the mother of the boyfriend at her home address. The Author had been specifically asked to meet only the boyfriend's mother and not the boyfriend or his Father as both the boyfriend and his Father were very upset and affected by the death of Florence and the boyfriend especially by the subsequent Police investigation.

4.26 The boyfriend's mother explained that it was Christmas Eve 2016 when Florence appeared at her house. The boyfriend and Florence had been an item for 3-4 months albeit they had known each other since school days. Both were 19 years of age at the time.

4.27 The Mother described how Florence was upset and was crying. She said that she had been thrown out of her house and had nowhere to live. The boyfriend asked if Florence could stay a couple of days and albeit the mother and Father hardly knew Florence, they said she could stay. The Mother gave her a hug and said she felt sorry for her.

4.28 The Mother described how suddenly all of Florence's possessions arrived at her house. She asked Florence why her parents had evicted her, but she could not understand the reason Florence gave. The Mother offered to go and speak to Florence's parents, but the boyfriend told her not to. According to the mother, Florence called her parents 'toxic'. The Mother tried to persuade Florence to speak to her own Mother at the hospital where she worked but she didn't.

4.29 Florence suddenly said she was going home and the mother thought 'great'. Florence went home for a week but was soon back at the boyfriend's house. She stayed for another two weeks, left and appeared again with all of her stuff and moved back into the boyfriend's house. The Mother spoke to Florence as she didn't know what else to do and Florence told her that her father had tried

to strangle her, and her mother hated her. The Mother thought that Florence was desperately insecure. The Mother described how on a couple of occasions she heard Florence screaming in her son's bedroom of their three-storey house. Her son told her that Florence was having 'one of her turns' and she was best left alone.

4.30 The Mother knew that Florence was seeing a psychiatrist but became defensive when the subject was raised other than to say that Florence had told the psychiatrist she was supported at the boyfriend's house, and she was happier there. Florence was insecure about her and the boyfriend splitting up. The Mother liked Florence and told her that there would always be a place for her at her house. Florence wanted to go away on holiday with the boyfriend, but he was reluctant to go unless his mother went.

4.31 In November 2017, the boyfriend and his friend went away to Scotland and the mother recalls an incident when Florence was upset and was running up and down the stairs with a picture of the boyfriend. The Mother was so concerned that Florence would hurt herself whilst the boyfriend was away, she called the Samaritans for advice. Florence showed the mother her phone and said that the boyfriend was looking at other women. When the mother challenged the boyfriend, he said that Florence was ruining his life, and he wanted to end the relationship. The mother told Florence, and her sister collected her and took her and all of her belongings away.

4.32 At the beginning of November 2017, Florence asked the mother to book a holiday for Florence and the boyfriend on her credit card without him knowing.

4.33 At the end of November, the boyfriend asked his mother if Florence could stay at their house on Christmas Day which she agreed to. On New Year's Eve, the boyfriend went to a party and on New Year's morning the mother saw Florence's shoes in the kitchen and thought 'not again'. From her son's bedroom she could hear doors slamming and what she described as laughing. She went to tell them to be quiet and Florence said, 'he's trying to kill me'. The Mother said she had had enough, and she called the Police and told Florence that she was calling her mother. Florence said 'no, the boyfriend tried to kill me'. The Mother said that she could see that Florence was not injured other than 'self-inflicted' hit marks. The boyfriend was arrested and was on bail for 6 weeks whilst the Police investigated, but after 28 days the Police said they were taking no further action.

4.34 The Mother stated that some time before November the boyfriend and Florence were driving along in his car when Florence had one of her turns and started to scream. Somehow the phone in the car had been connected to the Police but then it was disconnected. The Police traced the call and came to the house. Florence apologised to the officers, and she told the boyfriend not to tell his mother, but he did.

4.35 Just after Florence died, the Police came to the house and told the family that Florence was dead. The boyfriend was devastated. According to his mother, he adored Florence and is still very affected by her death. His Mother considers that her son genuinely loved Florence.

4.36 The boyfriend's mother specifically requested the Overview Author not to contact her son again as he was having trouble coming to terms with the death of Florence. She described also how her husband had had a breakdown over the whole incident.

4.37 At the beginning of this review the Senior Investigating Officer from the Police gave the Overview Author the details of two friends of Florence, one male and one female, who were supposed to be close friends. Both people were written to but neither of them replied for quite some time.

4.38 Contact was made by the Author with the male friend who explained that he and the female friend were at university, and it would be difficult to arrange a weekday appointment, but he and his female friend were willing and anxious to engage with the review.

4.39 The male friend was spoken to by the Author on 10th December 2018 and arrangements made to see him in Kettering on 4th January 2019 with or without the female friend being present. On 30th December 2018, the Author left the male friend a voicemail message asking if the 4th January was still viable. There was no reply. A similar message was left on 2nd January 2019 and there was no reply. On 4th January 2019 a similar message was left, the Author telling the male friend that he was in Kettering as per the arrangements and asked him to respond but there was no reply. Since then, a further letter has been sent to the male and female friend asking them to respond and whether they wish to engage with the review. To date, no reply has been received.

4.40 At the end of April 2019, the boyfriend's mother contacted the Overview Author to report that her son, had been contacted by Florence's Mother which had caused the boyfriend some concerns. The Overview Author corresponded with the mother and stated that the report was almost complete but despite writing to her son in the previous month inviting him to engage, no answer had been received, and the report was relying on accounts from Florence's family, work colleagues and agency reports. The mother considered the situation, spoke to her son and they both agreed to the boyfriend engaging with the process. Accordingly, on 1st May 2019, the Overview Author and the Community Safety Manager from Kettering Borough Council visited the boyfriend at his home address.

4.41 First to be seen was the boyfriend's father who stated that he and his wife had taken Florence into their home at the request of their son after she had been asked to leave her own family home following a fall out with her parents. She had moved into their son's bedroom which is directly above the father's office where he worked most of the time, (often working from home). The Father said that he never heard any arguments, fights or disagreements between his son or Florence and would have if there had been any as he was directly underneath the son's bedroom, specifically pointing out that a new house has very thin walls and floors. The Father was unaware of the fact that the Author had written to his son on several occasion requesting to see him. The Father was aware that his son used cannabis on occasions but never in the house.

4.42 On seeing the boyfriend, the Author explained the purpose and process of the review which results in publication on the CSP web site. The boyfriend was very nervous about the publication aspect until it was explained that the report would be redacted and anonymised.

4.43 The boyfriend stated that he was in the same school as Florence but different years. He had stated to talk to her, and she told him that she was going out with an older man from Birmingham. He was shocked at this and kept his distance from her. In the 6th form they were closer because of schoolwork but there was no relationship between them. He stated that he noticed that Florence would not turn up for school on some days, which he said he found

'strangely attractive' about her. He became aware that Florence had an eating disorder. He was also impressed with Florence's IT ability and how she was in contact with a man in Denmark who she wanted to meet. Florence told him that the man from Birmingham was stalking her but on occasions, the times she said he was stalking her, Florence was with the boyfriend, so he began to doubt what she was saying sometimes.

4.44 The boyfriend said that Florence had told him that her family would 'gang up on her' and bully her. She told him that her father was a Child Protection Officer in the police and that had had tried to choke her.

4.45 According to the boyfriend he wanted to make an impression with Florence's parents, and he would often see them in the town, so he would dress smartly. He had a car and a job, and he felt good with himself. He said that Florence's mum would just stare at him and her Father would look at the ground as if he was embarrassed. He said that he believed that the reason for Florence's parents 'kicking her out of the family home' was they believed she was taking amphetamines.

4.46 When asked about the use of drugs, the boyfriend stated that he and Florence would use cannabis as it made them feel relaxed. They would use it in his bedroom and elsewhere. They also used MDMA (commonly known as ecstasy) with other friends. The boyfriend denied ever supplying drugs to Florence but stated that he would get drugs from contacts he knew. When asked directly if he had ever given Florence any drugs he said 'No'.

4.47 The boyfriend explained that as he matured and got a job and a car, he had a growing feeling of nurturing affection, similar to looking after a dog and that is how he felt towards Florence. He recalls one day in particular when she called him. She was very upset. She was by his car, and he went to her. Her parents had 'kicked her out' as her mother thought she had been taking drugs. He moved to console Florence, but she pulled back from him which surprised him. That is when he took her home and she started to live with him and his parents.

4.48 Both he and Florence were working at the time they were together and when asked if he was financially dependent upon Florence he was taken aback and confused saying that he was not dependent on her at all. He was confused by the term financially dependent and gave an example to illustrate what he thought it meant by him lending money to a friend on a regular basis.

4.49 The boyfriend was asked if Florence had ever mentioned taking her own life and he said that she had especially when she returned from trips to Manchester where she went to see a friend. He went on to explain that Florence was very jealous of any attention he received from other girls. He had lots of girlfriends and when they would hug and kiss on meeting, Florence didn't like this, and she would go to see her friend in Manchester. He said that when she came back it would always 'end in horror' because she was always upset. On one occasion he recalled how Florence was upset because her friend in Manchester had accused her of taking a liking to her friend's boyfriend. The boyfriend commented that Florence had said that she was frightened about taking her own life in case she failed, and she 'ended up as a vegetable'. She had told him that she had tried to take her own life before and he said he had comforted her and told her that he would always look after her.

4.50 The boyfriend said that he had threatened to break up with Florence because he could not stand living with her anymore. He described how there were often

very harsh words said between them and that Florence would taunt him by using silly voices, but the next day she would be totally normal.

4.51 The boyfriend described that when they argued he would try to get out of the room, but she would be shouting, pushing him back so he couldn't leave. He described how when he had had enough, he would physically move her, but he would never hurt her. When asked about his parents possibly hearing these episodes, he stated that he would try to hide the instability between him and Florence as he didn't want them to know about it.

4.52 The boyfriend explained that Florence would irritate his parents by staying upstairs in the bedroom and not coming down to the rest of the house. His parents would be 'nit-picking' everything that happened.

4.53 The boyfriend was asked about the allegation Florence made to her IDVA that he had grabbed her round the throat and made threats to kill her. He replied that he was not aware of that and had never threatened to kill or hurt her. He said that when they argued, four times out of five, he would walk away from the situation but on the fifth time he would give her back what she was giving to him. He did not elaborate on that comment.

4.54 He was asked about his visit to Scotland when he was arrested and, on his return, she found him looking at pictures of girls on his phone which caused a fight between them. He had no recollection of any of that whatsoever.

4.55 The boyfriend agreed that he had paid for a holiday to Amsterdam, but he couldn't face going with Florence, so he went on his own instead. When Florence moved out in November 2017, he had no recollection of being abusive towards her.

4.56 The boyfriend went on to say that he is a very private person and when Florence moved in, he was concerned that his parent would realise that he had a girlfriend, something that he wanted to keep private. He considers that he should have ended the relationship earlier as he 'never had the experience to deal with Florence'.

4.57 When asked about Florence making threats to take her own life, he stated that he was frightened by her threats and now realises that he should have told someone as he now feels foolish.

4.58 He said that Florence had told him that she had a lifetime of problems, and it made him feel uncomfortable when she told him things about her life. Coming from a stable family and secure home life with no problems, he couldn't understand the family Florence came from.

4.59 He stated that he found out that Florence was taking his Roaccutane tablets he used for his acne, and he also knew that these tablets are not to be taken by people with mental health problems. He knew he had three tablets left and that she had taken them. He asked for them back and she have him only two, so he assumed she had taken one of the tablets. He feels that this was a contributory factor in Florence taking her own life.

4.60 When asked about the text contact that he had recently with Florence's Mother, he showed the Author and CSP Manager a text he had received asking why he had emailed Florence and what was he thinking of. He explained that he, in a drunken state, had thought it was a good idea to email Florence's email

address. He did not include a message just emailed the address. He said that a mutual friend of both him and Florence does the same.

4.61 The boyfriend wanted to make it clear to the Home Office that he is worried about any repercussions and reprisals resulting from the publication of this report.

4.62 As a result of seeing the boyfriend, on 17th May 2019, the Review Author and the CSP Manager visited Florence's parents again in order the keep them updated with the progress of the report. They were told that the boyfriend had been seen and the reason why he had contacted Florence's email address. Both parents were upset that he would have done such an insensitive thing. When they were told that the boyfriend had stated that another of Florence's friends had done the same, the response from the parents was that was a long time ago and there had not been any contact from the friend for a long time.

4.63 The parents were content with the findings if the review thus far and attended a panel meeting on 12th June 2019.

5. Analysis and recommendations

5.1 Florence entered a relationship with the boyfriend who she had known from their school days. She was unhappy at home and felt the need to move out of the family home. There were incidents of her taking drugs in the family home to which her parents understandably objected to. She was suffering from an eating disorder, and she was known to CAMHS. She was also self-harming. She left and moved in with her boyfriend, into his family's three storey house, where he lives with his Mother and Father.

5.2 It was May 2017 when Florence went to her GP stating that she had contemplated suicide and that she had researched using an 'exit bag'. It was then that she mentioned that her boyfriend told her that he wanted to finish with her. Florence explained that her boyfriend had had an abusive relationship with his own Father and recently she and her boyfriend had argued. She stated he had thrown her out of bed, up against a wall and calling her insulting names.

5.3 In August 2017, Florence disclosed to TSPPD that her boyfriend was sometimes physically, verbally and emotionally abusive and that she felt isolated. She said that she had no friends and nowhere to stay if she left him.

5.4 Research by Dr. Jane Monckton-Smith,[24] shows that control was seen in 92% of domestic killings, obsession in 94% and isolation from family and friends in 78%. Dr. Monkton-Smith considers that these types of behaviour can lead to a victim having no life of their own, and no privacy from their abusers, who will frequently monitor them by day and by night.

5.5 Lisa Arson Fontes[25] describes coercive control as:

> 'a situation in which one partner is usually isolated and afraid to anger her partner because of the punishment that might ensue. One member of the couple, usually the female, is deprived of the resources she needs – such as money, friends, and transportation – to have

[24] Coercion and Control: fighting against the abuse hidden in relationships. Dr Jane Monckton-Smith Gloucestershire University 2017 Guardian Society

[25] Invisible Chains: Overcoming Coercive Control in Your Intimate Relationship Lisa Aronson Fontes 2015

> autonomy. She loses her own perspective. Over time many victims feel like they cannot 'think straight'. People's lives are ruined by coercive control. They often lose their jobs, their self-esteem and freedom to make even the minutest choices in their lives'.

5.6 Stark[26] states:

'This sort of power is somewhat contingent on social position because persons with money or political influence are better situated to produce effects congruent with their intentions than persons without these advantages'.

5.7 In relation to controlling, Bancroft[27] states:

> 'Control usually begins in subtle ways. He drops comments about your clothes or your looks, is a little negative about your family or one of your good friends, starts to pressure you to spend more time with him or quit your job, starts to give too much advice about how you should manage your own life and is impatient when you resist his recommendations'.

5.8 During these disclosures, there was no suggestion that she had been considered a victim of domestic abuse or that she had been sign posted towards a support agency.

5.9 It wasn't until she had made further disclosures of abuse by her boyfriend, she was referred to the Sunflower Centre in September 2017. She then admitted that her boyfriend had tried to strangle her and details of more serious episodes of abuse were forthcoming, including sexual abuse. She had also had the 'online' relationships that had resulted in her being abused by other men.

5.10 Reported abuse from her boyfriend continued during the following months with some events being reported to the police. However, these often resulted in no further action being taken because of Florence deciding not to pursue a criminal prosecution.

5.11 At a recently held Quality and Inclusion Partnership workshop entitled 'Protecting our Families and Safeguarding our Future' held jointly by Equip Equality and Warwickshire County Council, barriers around talking about domestic abuse was the subject of a particular workshop which is replicated in a document published by Equip Equality, Autumn 2018. The barriers identified were:

Shame

It was interesting that the feedback here was not around being embarrassed it was more the sense of shame or being ashamed. As in the feedback from events there was a feeling that the subject was still taboo, and you would not talk about.

The feedback was similar in that that it was felt that the victim blamed themselves and that it was their fault that this was happening.

[26] Coercive Control: How Men Entrap Women in Personal Life. Evan Stark 2007
[27] Why Does He Do That? Inside the minds of angry and controlling men. Lundy Bancroft 2002 page 117

Awareness

This did not feature highly in the community workshops. What was highlighted, similarly again to the events was that the victims do not know who to turn to for support and are not aware of services that exist to support them. The fact that this is not talked about might mean that the victim feels isolated in the belief that it only happens to them.

Fear

Again, there was fear that the victim might not feel that they would be believed. It was felt that they may be too frightened to speak up. There was also a fear of not having anywhere to go.

Financial Control

There was a feeling that victims could be financially controlled. Whether it was itemised calls, no personal mobile phone or no money for bus fares, this could be a barrier for the victim to talk about the abuse.

5.12 All of these headings, according to Florence, were experienced by her and she stated during conversations her reluctance to report and pursue prosecutions were for these reasons. It is of interest to note that the LPT report contains the following comment made by Florence:

> '[Florence] said that there was love between them [her and the boyfriend] and that he was taking care of her. She said that she had nowhere to stay if she left him.'

5.13 The suggestion that the boyfriend was coercive and controlling in his relationship with Florence comes from information received from Florence's family and her work colleague that point towards Florence being controlled and abused mainly whilst in his family home.

5.14 The Home Office Guidance[28] states that Coercive and Controlling behaviour is defined as being:

> "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: a continuing 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."

5.15 In addition the Serious Crime Act 2015 defined the behaviour as:

> "A person (A) commits an offence if—
>
> (a) A repeatedly or continuously engages in behaviour towards another person (B) that is controlling or coercive,
>
> (b) at the time of the behaviour, A and B are personally connected,

[28] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Home Office 2016 Page 8

(c) the behaviour has a serious effect on B, and

(d)A knows or ought to know that the behaviour will have a serious effect on B.

A's behaviour has a "serious effect" on B if —

(a) it causes B to fear, on at least two occasions, that violence will be used against B, or

(b) it causes B serious alarm or distress which has a substantial adverse effect on B's usual day-to-day activities

5.16 On the evidence that has been made available to the review through agency IMRs and accounts from Florence's family and colleagues, it is strongly suspected that the boyfriend displayed coercive and controlling behaviour towards Florence albeit he denies doing so. Following her death, however, the British Transport Police together with Northamptonshire Police undertook a thorough investigation into the circumstances of her death and submitted case papers to the Crown Prosecution Service (CPS). It was decided that there was insufficient evidence to warrant a prosecution. Florence's Father wrote to CPS asking for a review of their decision, but the decision remained unchanged. The Author of the Overview Report wrote to CPS asking for the details behind the rationale in deciding to take no further action against the boyfriend and received a similar response. None the less, coercive and controlling behaviour can still take place irrespective whether it reaches the threshold for criminal prosecution.

5.17 According to Florence, the boyfriend abused her physically, emotionally, and economically. According to Sharp-Jeff's and Learmonth[29], economic abuse involves behaviour that interferes with an individual's ability to acquire, use and maintain economic resources such as money, transportation and somewhere to stay. It is both controlling and coercive. Florence couldn't leave her boyfriend's house because she had nowhere else to go. Economic barriers to leaving can result in an individual staying for longer experiencing more abuse and harm as a result. Webster[30] concludes:

> 'When individuals experience economic abuse within the context of coercive control they are also at increased risk of domestic homicide'.

5.18 De Becker[31] considers survivors may be afraid that:

- Their [abusers] will kill them if they leave, or they have the [abusers] leave
- The violence will increase, based on their past experiences
- Their partners are not able to survive alone or may commit suicide

5.19 Survivors are at increased risk when they are leaving an abusive relationship. Those who have tried to leave may know they are at increased risk of severe violence if they try again. This "separation" violence may include:

- Stalking, harassment, or threats
- "Teaching them a lesson" for trying to leave

[29] Surviving Economic Abuse – Into Plain Sight Nicola Sharp-Jeffs and Sarah Learmonth December 2017

[30] Understanding Domestic Homicide Webster Neil 1999.

[31] The Gift of Fear Survival signals that protect us from violence. Gavin De Becker 2000

- Even homicide.

5.20 Most of these issues featured in Florence's life with her boyfriend. She was a very vulnerable young woman with significant emotional and mental health illness. It must be stressed again that no one has been charged with any offence in relation to Florence's death.

5.21 It also needs to be stressed that the boyfriend denies causing Florence any harm whatsoever and the allegations that he abused her are strenuously refuted by him and his parents.

5.22 Florence was known to Leicestershire Partnership Trust Mental Health Services (LPTMHS) and was under the care of South Leicestershire Community Mental Health Team and the Therapy Services for People with Personality Disorder Team. Her diagnosis is recorded as Emotionally Unstable Personality Disorder, Eating Disorder and Deliberate Self-harm. LPTMHS Serious Investigation Report comments about Florence describing herself as Bi-polar:

> 'It is unclear where the diagnosis of bipolar has come from as there is no evidence in any of her paper and electronic notes of bipolar being discussed'.

5.23 After a thorough examination of Florence's contact with LPTMHS, the Serious Investigation Report concludes that Florence was deemed to have capacity to make decisions for herself, even if some of those decisions were not in her best interests, for example not pursuing criminal prosecutions of her boyfriend for abuse. The investigation was unable to find a single root cause for Florence's death and states:

> '[Florence] had a history of emotional instability, and it was suggested that this was triggered by psychological factors of domestic violence; however, it is unclear if this was a contributory factor to the incident'.

5.24 The investigation found that there had been good communication between mental health and health agencies as well as with Florence herself. There was evidence of good multi-disciplinary approach being made and good liaison throughout. The Serious Investigation Report makes four internal recommendations:

- The Serious Investigation Report to be shared with the relatives once signed off by commissioners
- The report to be shared with staff involved in the incident
- Finding of this investigation to be shared with the Adult Mental health and Learning Disabilities Team
- Sharing a copy of the report with the GP.

5.25 With regard to Florence's contact with her GP, her notes date back prior to the scope of this review, but it is of interest to note that Florence presented with mental health problems at the age of 10 years and with problems with food at the age of 12 years. It is noted that her family were particularly active in seeking help for her and her mother and twice requested Florence be admitted under a psychiatrist as the mother did not think she could keep Florence safe at home.

It is also noted that at times, possibly due to the nature of her diagnosis, Florence gave conflicting historical information and on one occasion described her childhood as being happy.

5.26 The Nene and Corby Clinical Commissioning Group GP IMR, (on behalf of Leicestershire GP Services), comments on the coding used in Florence's records over the years and suggests that some codes used which would have highlighted and improved the visibility of Florence's increasing vulnerability were not used. In her childhood years, Emotionally Unstable Personality Disorder was coded as active problem in 2015 along with Anxiousness in 2013, but Overdose of drug in 2014 and Intentional Self-harm in 2015 were coded and views in significant past. All other mental health codes added in her childhood remained significant so were obvious and clearly visible. In November 2017, the practice was informed that Florence had been discussed at MARAC, but this was not coded on her medical records. The IMR states:

> 'Coding of this problem may have helped to build a clearer picture of the safeguarding risks she was experiencing and may have increased her visibility as a vulnerable person'.

In addition, the GP's practice has reviewed its policy on coding and all adults who fail to attend CMHT appointments are having this DNA code placed on their medical records.

5.27 The GP's however stress that the MARAC notification process needs urgent examination as they find communication between MARAC and GP difficult. The IMR makes two recommendations regarding MARAC:

- The practice feel in order to improve their response the MARAC information, the process for sharing information between the CCG/GPs and the MARACs should be reviewed with some urgency. The practice is mindful that this work has commenced with GPs and police and the Practice Safeguarding Lead GP is involved in this work.

- The Practice Safeguarding Lead has already received MARAC training which is being cascaded. Key practice staff should continue to receive awareness training relating to MARAC.

5.28 With regard to Florence keeping GP appointments, the GP IMR states that as an adult, Florence was not one to fail to attend (DNA) appointments. She was seen by a number of GPs albeit the practice operates individual lists and patients are encouraged to consult with their own doctor for routine appointments. The IMR points out however that Florence was usually seen as an urgent patient in crisis and the practice would rather see someone in crisis immediately rather than insisting that such patients wait to see their own doctor. This accounts for the number of different doctors that Florence saw.

5.29 Florence had disclosed in 2015 to her GP, the emotional abuse she was suffering from the' online' relationship she was having and again in 2016 she disclosed issues around her 'controlling ex-boyfriend' with whom she later reconciled. 'Victim of Domestic Violence' was coded onto her records in October 2017 when, in a therapy session, she expressed suicidal ideations. Florence should have been considered a victim of domestic abuse in 2015 and again in 2016. She was only just 18 years of age at the time of disclosing

domestic abuse and should have been referred to professional and specialist domestic violence support by the GP as per the General Practitioners Guidance of 2012.[32]

5.30 The GP IMR does state that Florence was not viewed as a vulnerable adult due to being a victim of domestic abuse, and that she was not on their safeguarding register nor had been discussed at the practice multidisciplinary team meeting. However, the practice is of the opinion that Florence was always recognised and treated as being a vulnerable person although it was not explicitly coded on her records. Learning from this review has been appreciated by the practice and now all patients with personality disorder and all those who are victims of domestic abuse are coded as being a vulnerable adult and are discussed at the practice Adult Safeguarding meetings.

5.31 Regarding Domestic Abuse policies, the GP practice has moved forward recently. It now has a formal locality based Domestic Abuse Policy and the Safeguarding Lead for the practice has attended a Domestic Abuse training session and disseminated that knowledge throughout the practice. There is now a better interaction between the Safeguarding Lead and MARAC and the CCG had appointed a Designated Nurse for Safeguarding Adults. The practice regularly reviews criteria by which people are added to the list for discussion and acknowledges that Florence would have fitted these criteria. All clinicians are up to date with their safeguarding children qualification.

5.32 The GP IMR makes three further recommendations for Leicestershire GP Services:

- All Adult Community Mental health Team DNAs should be coded by the practice and discussed at their Adult Safeguarding meetings.
- All Victims of Domestic Abuse should be coded as vulnerable adults and discussed at Adult Safeguarding meetings.
- All patients diagnosed with Emotionally Unstable Personality Disorder will be coded as vulnerable adults and discussed at Adult Safeguarding meetings.

5.33 Florence presented at Kettering General Hospital with vision problems and with low mood. There was nothing to suggest that there was anything significant that would have prompted an enquiry about domestic abuse. However, there is nothing recorded indicating that when she presented with low moods, she was asked if she was in any relationships. Florence did not make any disclosure of domestic abuse to any of KGH's staff.

5.34 The KGH IMR indicates that there was appropriate escalation to mental health services for Florence on her presentation to the Emergency Department and that she was properly admitted to exclude organic causes for her presentation. There is a comment that when she presented with her low moods there may

[32] Responding to Domestic Abuse – Guidance for General Practices Royal College of General Practitioners, IRIS and CAADA 2012

have been further exploration regarding the causes and that documentation could have been better regarding who Florence attended with.

5.35 There are 3 recommendations made in the KGH IMR:

- KGH will continue presenting education and maintaining mandatory levels of training at the expected requirement.
- KGH is currently re-launching and promoting the new IDVA service in the county,
- Increased advertisement in the acute and emergency areas about domestic violence.

5.36 Leicestershire Partnership Trust Eating Disorder Service had significant dealings with Florence since she was 16 years of age. She was later referred to the Personality Disorder Service.

5.37 Florence disclosed her abusive circumstances as she attended appointments with both services. It is recorded in the LPT IMR that she considered herself to be a vulnerable victim. The IMR author however stated that she:

> 'had a strong desire to rose tint her world and create the perfect family'.

5.38 The Personality Disorder Team decided on 21st July 2017, to contact the LPT Safeguarding Advice Team who advised:

- To discuss with [Florence] what actions she would like staff to take
- Sign post to UAVA (United Against Violence and Abuse)
- Sign post to housing options for housing advice.

but there was no DASH Risk Assessment completed, which in hindsight should have been.

5.39 At the time of Florence's disclosures, LPT was working to a policy 'Responding to Domestic Violence/Abuse Experience by Clients' which outlines the responsibilities of Specialist Nurse Domestic Violence and Clinical Staff information sharing and the identification of victims and vulnerability factors.

5.40 The LPT IMR highlights 13 lessons learned:

- When medication is prescribed via outpatient appointments, written information and updates should be sent to General Practitioners to ensure continuity of prescriptions.
- When DNAs occur for appointments prior to discharge to patients from the service, LPT staff should consider any safeguarding concerns/risks and document the considerations.
- When patients transfer between LPT services, particularly during transition from children to adult mental health services a robust handover process should be evidenced

- Information regarding Safeguarding concerns or concerns of domestic violence/coercive control should be shared internally and externally as appropriate
- Clinical records should evidence exploration of any safeguarding/domestic violence disclosures.
- Every effort should be made to provide consistency of workers involved in a patients care, particularly at times of crisis
- Clarity of advice from safeguarding Practitioners working for LPT Safeguarding Team should be recorded in the patient's clinical record by the safeguarding practitioner to avoid any misunderstanding
- DASH risk assessments should be completed by LPT staff following Domestic Violence disclosures, as per LPT Policy, cases of High Risk or use of professional judgement through the strangulation incident should have led to a MARAC referral in Leicester.
- All Clinical staff should have access to Domestic Violence training, information and support
- Follow up of any actions as a result of referrals made to Adult Social Care should not rely solely on feedback of outcomes from patients
- Clarity should be sought with the patient by practitioners before transferring risk history information on to new documents to ensure accuracy
- When patients are under the care of the Crisis home treatment team consistency of worker needs to be looked at
- Safeguarding practitioners working in the LPT Safeguarding team should write directly into patient records the advice they have given to other practitioners in relation to the safeguarding of patients.

5.41 The LPT IMR makes two recommendations:

- The Transition Policy covering transition between Child and Adult Mental Health Service should be reviewed, to ensure that LPT staff are clearly aware of their responsibilities in line with the Policy. This should include ensuring clarity is sort with the patient when transferring risk history information.

- Lessons learned from this review will be circulated across the trust to reinforce and remind staff of the importance of following organisational policies and processes including:
    - Notifying GP's if there has been a change to the prescribed medication
    - Documentation and record keeping of Safeguarding and Domestic Violence disclosures
    - Evidencing consideration of safeguarding risks prior to discharging patients from a service and including documentation of this consideration.
    - Ensuring updates regarding care, treatment, incidents and safeguarding concerns are shared with other teams and departments internally within LPT when a patient is open to more than one service.

- To ensure that outcomes are requested by practitioners from the LA when making a safeguarding referral.
- Domestic Violence training and the availability of LPT DV Specialist and Safeguarding team in providing advice and support to be re-promoted to LPT staff, which should include the importance of the use of the DASH risk assessment in supporting the management of risk and supporting MARAC referral.

5.42 There are occasion when Florence had various health appointments, and her mother cancelled the appointments on behalf of Florence. The panel are concerned that the 'voice of the patient' was not heard on these occasions. Albeit Florence was over 17 years of age at the time, it is thought that health professionals ought to have considered that on previous occasions Florence had insisted that her mother was not involved in Florence's consultations and particularly requested that her mother was not present at her appointments. In addition, in May 2014, when Florence would have been 17 years of age, the Eating Disorder Service wrote a letter to her but addressed the letter to her father. Three months later, a GP had a conversation with Florence's Mother about Florence not attending CAMHS. The IMR author questions why that conversation was not conducted with Florence as opposed to her mother.

5.43 With the above in mind the following recommendation is made:

Recommendation No. 1

Leicestershire Partnership Trust, Eating Disorder Service and GP's review policies and procedures to ensure consent to discuss and disclose information about a patient with others, parents or not, is obtained prior to disclosure.

5.44 It is also noted that Florence had an emerging Personality Disorder diagnosis when she was a child under the age of 18 years and therefore a referral was required to the appropriate Adult Services, but because of her age, she was not seen by Children's Services, and she could not be seen by Adult Services. She in fact, fell through a gap between the two services. In an addendum to the LPT IMR mentions the opportunity to implement the Care Programme Approach[33] and states that there were no real times when all services were involved at the same time. This was partly due to Florence disengaging from services and records do not indicate that the CPA was ever considered.

Recommendation No. 2

Leicestershire Partnership Trust to review the procedure for the implementation of the provisions of the Care Programme Approach even when the patient does not engage with services.

[33] Care Programme Approach (CPA) in the United Kingdom is a system of delivering community mental health services to individuals diagnosed with a mental illness. It was introduced in England in 1991https://en.wikipedia.org/wiki/Care_Programme_Approach and by 1996 become a key component of the mental health system in England. The approach requires that health and social services assess need, provided a written care plan, allocate a care coordinator, and then regularly review the plan with key stakeholders, in keeping with the National Health Service and Community Care Act 1990.

5.45 There were several missed opportunities for Florence to be referred to Children's Social Care (or Adult Social Care as she became an adult) and the trigger points for these referrals were several in number:

- At the age of 13/14 years she was talking about domestic abuse within the family home
- She was not taken/did not attend to numerous health appointments
- She had suicidal ideations and a 'child'.
- She was referred to the School Nurse on occasions when there were concerns expressed about her well-being
- She was self-harming
- As she became involved with her boyfriend there were comments made by her that indicated she may be being exploited.

5.46 Florence was known to numerous agencies during this period of her life and the fact that she was not referred to Children's Social Services (CSC) meant that there was a missed opportunity to engage with a 'core group' of professionals to share information and discuss the best outcomes for her.

5.47 In January 2015, when Florence was still under the age of 18 years and thereby a child, she was seen by CAMHS after self-harming. The agreed plan was for her to have an urgent assessment by CAMHS CPN and a Social Worker. She was also referred to Adult Mental Health Crisis Team. Later in January 2015, Florence was seen by Adult Mental Health Acute Assessment Team and again referred to Adult Home Treatment Team. It appears that she was not seen as a child even though she was just still under 18 years of age. There was no safeguarding referral made to CSC.

5.48 There was a missed opportunity to explore the domestic abuse she was being subjected to by her boyfriend in May 2013. She was seen at the LPT outpatient's clinic and discussed the poor relationship she had with her boyfriend, and she mentioned that she thought he was financially dependent upon her. This aspect of domestic abuse was not explored further which may have added another significant piece of information to the predicament that Florence was in at that time. There were also missed opportunities to signpost Florence towards domestic abuse support services.

5.49 In similar circumstances, in July 2017, Florence was seen by the Personality Disorder Service where she disclosed her boyfriend had hit her so hard she thought that she would die. It is recorded in a risk assessment that:

> 'She was vulnerable sexually due to her low self-esteem and she was placing value on her looks and sexuality. She had been putting herself at risk by talking to men online. She had met a man in London and had been emotionally abused by another man online'.

5.50 It was agreed that the Safeguarding Advice line would be contacted, and that Florence was making choices and that she had the capacity to do so. She was pointed in the direction of UAVA (domestic abuse and sexual abuse advisors). She was also signposted towards housing for advice. There is no suggestion, that having all this information a referral to Adult Social Care was made rather than signposting Florence and leaving the onus upon her to move towards seeking help herself. She had made the disclosures, and she could have been referred directly. It is clear that at this time she was a high-risk victim of abuse.

5.51 The LPT IMR points out that at the time of Florence making these disclosures LPT had a policy in place that outlined exactly what staff should do when armed with such information and that included turning to a Domestic Abuse flow chart and a MARAC flow chart. It appears that neither were considered in Florence's case. Is it pointed out however, in the LPT IMR that at the time of these disclosures training of staff on Domestic Violence was limited to a short session included with mandatory safeguarding training. There is no evidence that there was any consideration of a discussion with the Trust's 'Specialist Nurse Domestic Violence that sat as part of the LPT's Children's Safeguarding Team, which again highlights the problem of not thinking of Florence as a child or as a victim of domestic abuse.

5.52 In October 2017, Florence was seen by an LPT Medic (5). She described symptoms that included hearing voices which she was unsure if they were real. She was reassured that these symptoms related to her personality disorder diagnosis. There is nothing to suggest that her relationship with her boyfriend was mentioned or discussed at this appointment. There was a lack of professional curiosity when dealing with Florence. Her notes contained the disclosure she made in August 2017 and the root cause of her problems were not explored.

5.53 The candid LPT IMR illustrates that the November 2017 meetings Florence had with the AHP was a missed opportunity again to make a positive referral to specialist domestic abuse support services and more especially a missed opportunity to consider completing a DASH Risk Assessment, which on the information Florence disclosed, would more than likely triggered a MARAC. There was no suggesting of consideration of taking any action that may have prevented the abuse happening again in the future or any signs of support being offered. The fact that she returned to her parents was seen as her being safe, but her history would have indicated that that was probably far from the truth due to the coercive and controlling hold the boyfriend had over her.

5.54 It cannot be denied that Florence was offered numerous services from various agencies and professionals. However, that situation had its negatives. In one 24-hour period, Florence was seen by 3 different professionals, and she was required to repeat her 'story' over and over again. This is also illustrated regarding what information LPT knew and what Northamptonshire agencies knew. There was a lack of information exchanged between agencies, again causing Florence to repeat details of her predicament and abuse which must have been painful for her.

5.55 All of the issues raised in the preceding paragraphs are addressed adequately in the respective IMRs and the recommendation are set out below. In each case where agency workings during the years involving Florence have been identified as below the agency's acceptable standards, it has been confirmed that the agencies concerned have now implemented policy, practice and guidance that ensures that those 'shortcomings' have been addressed.

5.56 There are no recommendations from East Midlands Ambulance Service or the British Transport police reports.

6. Conclusions

6.1 Florence was 20 years of age when she stepped out into the path of a moving train in Northamptonshire in February 2018. She had been known to numerous health services for her mental illnesses. She was in a relationship with the boyfriend for some time and it is known that there existed a fractious and often violent relationship between them.

6.2 Despite the boyfriend and his parent's denials, from the information Florence disclosed to her family, her work colleagues and numerous professionals, the relationship was one of coercive and controlling behaviour on the part of the boyfriend. Florence appeared trapped in that relationship and despite attempts to break away from the boyfriend she always returned. Both Florence and the boyfriend used drugs both in the boyfriend's house and elsewhere. Florence was asked to leave her family home due to her drug use. She stated that she could not leave the boyfriend as she had nowhere else to go.

6.3 Her dealings with the medical professionals mainly consisted of focusing on her mental illness. There was very little emphasis on her being subjected to domestic abuse from her boyfriend. It was not until she was introduced to the IDVA and following on from that, the DV Police Officer, that she started to receive the proper care and attention a victim of domestic abuse warranted.

6.4 What prompted her to step out in front of the moving train will never be known. According to her parents, Florence had planned to go to a forthcoming concert, had bought tickets and there was no mention of doing what she did. The boyfriend will say that she did on occasions, mention jumping in front of a train or taking her life by some other means and he feels upset that he didn't do anything about that. There were no indications that day that she wanted to end her life.

6.5 What is clear from the information gained in this review is that there were missed opportunities by various agencies and professionals to sign post Florence to support for domestic abuse, or to make a referral to Children's Social Care when she was below 18 years and to Adult Social Care once she had reached 18 years. In addition, referrals to MARAC and support agencies were missed.

Recommendations

Overview Report Recommendations

Recommendation No. 1

Leicestershire Partnership Trust, Eating Disorder Service and GP's review policies and procedures to ensure consent to discuss and disclose information about a patient with others, parents or not, is obtained prior to disclosure.

Recommendation No. 2

Leicestershire Partnership Trust to review the procedure for the implementation of the provisions of the Care Programme Approach even when the patient does not engage with services.

IMR Recommendations

CCG - GP

- The practice feel in order to improve their response the MARAC information, the process for sharing information between the CCG/GPs and the MARACs should be reviewed with some urgency. The practice is mindful that this work has commenced with GPs and police and the Practice Safeguarding Lead GP is involved in this work.

- The Practice Safeguarding Lead has already received MARAC training which is being cascaded. Key practice staff should continue to receive awareness training relating to MARAC.

- All Adult Community Mental health Team DNAs should be coded by the practice and discussed at their Adult Safeguarding meetings.

- All Victims of Domestic Abuse should be coded as vulnerable adults and discussed at Adult Safeguarding meetings.

- All patients diagnosed with Emotionally Unstable Personality Disorder will be coded as vulnerable adults and discussed at Adult Safeguarding meetings.

Kettering General Hospital Recommendations

- KGH will continue presenting education and maintaining mandatory levels of training at the expected requirement.

- KGH is currently re-launching and promoting the new IDVA service in the county.

- Increased advertisement in the acute and emergency areas about domestic violence.

Leicestershire Partnership Trust Recommendations

- The Transition Policy covering transition between Child and Adult Mental Health Service should be reviewed, to ensure that LPT staff is clearly aware of their responsibilities in line with the Policy. This should include ensuring clarity is sort with the patient when transferring risk history information.

- Lessons learned from this review will be circulated across the trust to reinforce and remind staff of the importance of following organisational policies and processes including:

    - Notifying GP's if there has been a change to the prescribed medication
    - Documentation and record keeping of Safeguarding and Domestic Violence disclosures
    - Evidencing consideration of safeguarding risks prior to discharging patients from a service and including documentation of this consideration.
    - Ensuring updates regarding care, treatment, incidents and safeguarding concerns are shared with other teams and departments internally within LPT when a patient is open to more than one service.
    - To ensure that outcomes are requested by practitioners from the LA when making a safeguarding referral.
    - Domestic Violence training and the availability of LPT DV Specialist and Safeguarding team in providing advice and support to be re-promoted to LPT staff, which should include the importance of the use of the DASH risk assessment in supporting the management of risk and supporting MARAC referral.

LPT Serious Investigation Report internal recommendations:

- The Serious Investigation Report to be shared with the relatives once signed off by commissioners
- The report to be shared with staff involved in the incident
- Finding of this investigation to be shared with the Adult Mental health and Learning Disabilities Team
- Sharing a copy of the report with the GP.

Bibliography

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Nicola Sharp-Jeffs and Sarah Learmonth December 2017

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Action Plan

(Please note this action plan is a live document and subject to change as outcomes are delivered)

Overview Recommendations

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
Recommendation No 1 Leicestershire Partnership Trust, Eating Disorder Service and GP's review policies and procedures to ensure consent to discuss and disclose information about a patient with others, parents or not, is obtained prior to disclosure.	Julie Quincey Acting Lead Safeguarding LPT	The LPT Lead for the Eating Disorder Service will review the current policy to ensure issues of consent are considered	LPT Lead for Eating Disorders	Feb 28th 2020	Task sent to LPT Lead for Eating Disorders Dec 2019	-
Recommendation No 2 Leicestershire Partnership Trust to review the procedure for the implementation of the provisions of the Care Programme Approach even when the patient does not engage with services.	Julie Quincey Acting Lead Safeguarding LPT	Lead Nurse for Adult Mental health Nursing will review CPA policy in line with DHR recommendations	Lead Nurse for Adult Mental Health and Learning Disabilities	Feb 28th 2020	Task sent to Lead for AMH/LD Dec 2010	-

IMR Recommendations

CCG - GP

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
Recommendation No 1 The process for sharing information between the CCG/GPs and the MARACs should be reviewed with some urgency.	CCG Designated Nurse and GP Practice	This work had commenced whilst the review was being carried out, with GPs and police and the Practice Safeguarding Lead GP is involved in this work	Leicester, Leicestershire, and Rutland (LLR) CCG's	**Complete**	A group of LLR GPs met with the local police and Designated Nurse for Safeguarding on several occasions and agreed an improved pathway for sharing information between GP practices and MARAC.A template notification for MARAC to inform GPs about GP registered patients whose cases have been discussed at a MARAC is now in use.	-

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
Recommendation No 2 Key practice staff should continue to receive awareness training relating to MARAC.	GP Practice	Key practice staff should continue to receive awareness training relating to MARAC.	Practice Safeguarding Lead GP	Complete	The practice safeguarding lead GP has cascaded the MARAC training to key staff. On receipt of a MARAC notification a meeting takes now takes place with relevant team members and any additional training needs will be identified as part of this process.	-
Recommendation No 3 All Adult Community Mental health Team DNAs should be coded by the practice and discussed at their Adult Safeguarding meetings.	GP Practice	To be discussed in team meetings with immediate action	GP Practice	Complete	This has now been implemented across the practice	-
Recommendation No 4 All Victims of Domestic Abuse should be coded as vulnerable adults and discussed at Adult Safeguarding meetings.	GP Practice	To be discussed in team meetings with immediate action	GP Practice	Complete	This has now been implemented across the practice	-
Recommendation No 5	GP Practice	To be discussed in team meetings	GP Practice	Complete	This has now been implemented across the	-

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
All patients diagnosed with Emotionally Unstable Personality Disorder will be coded as vulnerable adults and discussed at Adult Safeguarding meetings.		with immediate action			practice; all patients with this diagnosis are now coded as an adult at risk and discussed at the practice adult safeguarding meetings.	
Recommendation No 5 All patients diagnosed with Emotionally Unstable Personality Disorder will be coded as vulnerable adults and discussed at Adult Safeguarding meetings.	GP Practice	To be discussed in team meetings with immediate action	GP Practice	Complete	This has now been implemented across the practice; all patients with this diagnosis are now coded as an adult at risk and discussed at the practice adult safeguarding meetings.	-
Recommendation No 6 Leicestershire Partnership Trust, Eating Disorder Service and GP's review policies and procedures to ensure consent to discuss and disclose information about a patient with others, parents or not, is obtained prior to disclosure	DHR Panel	Review existing policy to ensure clear process consent to discuss and disclose information.	GP Practice	Complete	The practice has reviewed its consent policy and now new patients are routinely asked who they would be happy for information to be shared with, and this is logged on the patient's record. If a relative/friend calls	-

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
					asking for information this is referred to prior to sharing.	

Kettering General Hospital

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
Recommendation No 1 KGH will continue presenting education and maintaining mandatory levels of training at the expected requirement.	-	-	Jacquie Barker	Completed May 2018	All staff receive DA training, particular focus on asking patients if they are subject to DA, additional DASH training has been provided and will continue to form part of the training schedule. Training is at 94% within the Trust	-
Recommendation No 2 KGH is currently re-launching and promoting the new IDVA service in the county.	-	-	Jacquie Barker	Completed June 2018	Relaunch of DA services available has taken place. A new referral form and pathway have been launched	-
Recommendation No 3 Increased advertisement in the acute and emergency areas about domestic violence.	-	-	Jacquie Barker	Completed June 2018	Updated contacts referral pathway and process shared with all staff. Referral process discussed in training and available on the intranet under a dedicated DA section	-

Leicestershire Partnership Trust

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
Recommendation No 1 The Transition Policy covering transition between Child and Adult Mental Health Service should be reviewed, to ensure that LPT staff is clearly aware of their responsibilities in line with the Policy. This should include ensuring clarity is sort with the patient when transferring risk history information.	Julie Quincey Acting Lead Safeguarding LPT	CAMHS Community Lead will review the transitions policy in line with recommendations from the DHR	CAMHS Community Nurse Lead	Feb 28th 2020	Task sent to CAMHS Community Nurse Lead Dec 2019	Julie Quincey Acting Lead Safeguarding LPT
Recommendation No 2 Lessons learned from this review will be circulated across the trust to reinforce and remind staff of the importance of following organisational policies and processes including; • Notifying GP's if there has been a change to the prescribed medication	Julie Quincey Acting Lead Safeguarding LPT	Via Safeguarding Newsletter Notification to GPs will be included in January 2020 trust wide safeguarding briefing A facility has been developed on the RiO (mental health) electronic record keeping system) to record	Trust Lead for Safeguarding	Jan 2020	Overview of recommendations from the DHR has been written and will be circulated in the January 2020 trust wide briefing action complete action complete	-

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
• Documentation and record keeping of Safeguarding and Domestic Violence disclosures • Evidencing consideration of safeguarding risks prior to discharging patients from a service and including documentation of this consideration. • Ensuring updates regarding care, treatment, incidents and safeguarding concerns are shared with other teams and departments internally within LPT when a patient is open to more than one service. • To ensure that outcomes are requested by practitioners from the LA when making a safeguarding referral. • Domestic Violence training and the availability of LPT DV Specialist and Safeguarding team in providing advice and		safeguarding and domestic violence information securely. This facility is as a 'drop down' link under the 'significant events' heading. Where risk has been identified then the DASH risk assessment will be completed staff are advised of this in the Whole Family Training which is Mandatory and in the bespoke Domestic Abuse Training, There is a link to an electronic version of the DASH RiC both in Rio and in system1. LPT staff will all be migrating to the systm1 electronic patient record keeping system in 2020. The systm1 record has a safeguarding icon			action complete Expected completion of migration of All staff to system1 is by Autumn 2020, in the meantime the learning from the	

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
support to be re-promoted to LPT staff, which should include the importance of the use of the DASH risk assessment in supporting the management of risk and supporting MARAC referral.		which alerts practitioners to access the safeguarding notes section of system1 where domestic abuse issues and correspondence are saved. Therefore, by the completion of the migration from Rio to system1 all staff teams will be able to access information relating to domestic. This will also be flagged in the safeguarding briefing. The Whole Family Training which is mandatory flags that referrers must follow up outcomes with the local authority. DVA and Risk Assessment			DHR will be highlighted in the January Safeguarding Briefing. action complete action complete	

Recommendations	Agreed by	Required Action	Agency Lead	Timescales and Dates for Completion	Summary of Action Taken	Information for Audit
		training is available for practitioners to book via U Learn. The monthly Safeguarding Briefing that is shared with all practitioners, provides contact details for the specialist nurse domestic violence, safeguarding practitioners and the safeguarding advice line.				

Home Office Letter

Shaun Sannerude

Safer Communities Officer

Safer Communities Team

North Northamptonshire Council

Cedar Drive, Thrapston

Northamptonshire

NN14 4LZ

6th August 2025

Dear Shaun,

Thank you for resubmitting the report (Florence) for North Northamptonshire Community Safety Partnership to the Home Office Quality Assurance (QA) Panel.

The report was reassessed in June 2025.

The QA Panel noted that the author had submitted a reference document outlining the changes made in response to the QA Panel's feedback, which was helpful.

Overall, most of the QA Panel's feedback has now either been addressed, or an explanation has been provided where that is not the case. Areas that still require amendment are set out below.

There were aspects of the report which the QA Panel felt needed further revision. On completion of these changes, the view of the Panel is that the DHR may now be published as they understand that this has been requested by the family.

Areas of Development.

• The executive and overview reports cite conflicting train speeds—95 mph and 125 mph. This discrepancy should be resolved.

• The report contains some hearsay allegations, which do not appear to have been verified. For instance, Florence claims her boyfriend was arrested in Scotland - something that could have been confirmed via police records. In future DHRs undertaken please ensure that statements such as this are confirmed as accurate.

- The author advises that recommendations have not been made due to the time elapsed and policy changes. Please include a brief explanation clarifying that such actions are now standard practice.

- The report currently offers no comment or analysis on the quality of the police investigations or whether any learning was identified. If no learning or recommendations emerged, this should be clearly explained. Notably, paragraph 3.82 states that no risk assessment was undertaken following the alleged attempted murder of Florence, with no mention of safety planning, IDVA involvement, or refuge options.
- Paragraph 3.71 remains ambiguous. It's unclear whether the trip to Amsterdam took place, whether Florence accepted the residential placement mentioned in November 2017, or whether she instead returned to live with her parents. Please clarify this.
- The report requires a thorough proofread prior to publication.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel

DHR Author's response to the HO QA Letter dated 6th August 2025

The executive and overview reports cite conflicting train speeds—95 mph and 125 mph. This discrepancy should be resolved.

Answer: This has been changed to 95 m.p.h.in both Overview and Executive

The report contains some hearsay allegations, which do not appear to have been verified. For instance, Florence claims her boyfriend was arrested in Scotland - something that could have been confirmed via police records. In future DHRs undertaken please ensure that statements such as this are confirmed as accurate.

Answer: The comments about the boyfriend's trip to Scotland where he and his friend were arrested for shoplifting are not hearsay. Florence had mentioned this to family

members and friends. When the author and CSP manager interviewed the boyfriend in the presence of the boyfriend's father he readily admitted that he had been arrested for theft along with his friend, confirming what Florence had been told by him.

The author advises that recommendations have not been made due to the time elapsed and policy changes. Please include a brief explanation clarifying that such actions are now standard practice

Answer: Para 5.55 now reads - All of the issues raised in the preceding paragraphs are addressed adequately in the respective IMRs and the recommendation are set out below. In each case where agency workings during the years involving Florence have been identified as below the agency's acceptable standards, it has been confirmed that the agencies concerned have now implemented policy, practice and guidance that ensures that those 'shortcomings' have been addressed.

The report currently offers no comment or analysis on the quality of the police investigations or whether any learning was identified. If no learning or recommendations emerged, this should be clearly explained. Notably, paragraph 3.82 states that no risk assessment was undertaken following the alleged attempted murder of Florence, with no mention of safety planning, IDVA involvement, or refuge options.

Answer: Para 3.82 now reads: 'However, there is nothing to suggest that a formal or informal risk assessment was carried out by the GP.' Para 5.31 reads 'The practice regularly reviews criteria by which people are added to the list for discussion and also acknowledges that Florence would have fitted these criteria. All clinicians are up to date with their safeguarding children qualification.' – indicating that practice and policies are now in place to manage circumstances as they were in 2018.

Paragraph 3.71 remains ambiguous. It's unclear whether the trip to Amsterdam took place, whether Florence accepted the residential placement mentioned in November 2017, or whether she instead returned to live with her parents. Please clarify this.

Answer: On 31st October 2017, Florence told the KGH staff that everything was OK between her and her boyfriend and that she had booked a holiday in Amsterdam for 2 weeks' time. The chronology indicates that Florence was then in contact with various agencies, GP, LPT, SFC, Northants Healthcare Safeguarding Team on a regular basis up to and beyond 14th November, so the Amsterdam trip clearly did not take place.

The report requires a thorough proofread prior to publication.

Both Overview and Exec Summary have been proofread