FENLAND
Community Safety
Partnership

Domestic Abuse Death Review

Overview Report

Deceased Barry

Aged 55 years

Died: September 2020

Independent Panel Chair: Dr Russell Wate QPM

SECTION ONE-INTRODUCTION

1. Introduction

1.1 The review author and panel, feel it is important, at the very beginning of this report, to highlight the person who died. The name Barry, used within this review, is a pseudonym and is the name that his family feel an appropriate one for him to be called within the report. The review author and the panel would like to convey their sincere condolences to his family and friends for the tragic death of Barry and thank them for their help in assisting the review process at such a difficult time for them. Barry's estranged wife is called at her request, a pseudonym of Christina. Barry's ex-partner is called at her request, a pseudonym of Sally.

1.2. The following information has been shared with the review by Barry's family and friends. Barry was 55 years old at the time of his death. He had been married for almost twenty years and although they were not divorced, he was not in a relationship with his estranged wife Christina, but they were on pleasant terms together. They have two children. Barry was, at the time of his death, a courier driver, working for himself, having hired a van. In the past he had had various driving jobs, including, for a short period in the recent past, as an ambulance driver. Barry was a kind and giving man. He was extremely close to his father before his father died and very close with his mother right up until the time Barry died. His family clearly loved him. He was also described by those outside of his immediate family as someone who was easy going and happy. Barry was though said to be a troubled man, feeling depressed, frustrated and angry for most of his life, he had in their view poor mental health. He often mentioned suicide ideation and had taken overdoses in the past. He also used alcohol at times to try and cope with his feelings.

1.3 Barry and Sally became a couple approximately 16 months before he died. They met through a previous partner of Sally's who was friends with Barry. Sally informed the review chair that they had never lived together but were in a relationship until the first August domestic abuse incident, when she says they split up as a couple, but kept in contact until he died.

1.4 This report has been commissioned by the Fenland Community Safety Partnership (FCSP). They are a statutory partnership which brings together agencies with the aim of reducing crime, disorder and anti-social behaviour across the Fenland area. These agencies work together to improve the safety of residents and visitors by information sharing and partnership activity. One of the key safeguarding roles of the partnership is that of tackling domestic abuse.

1.5 On the 6th of November 2020, Cambridgeshire Constabulary notified the Chair of the Fenland Community Safety Partnership that the death of Barry was being investigated as a suicide. He had been found attempting to take his own life at an address in Fenland and died of his injuries the next day in hospital. This notification was in accordance with the Domestic Homicide Review Protocol. The Chair of the Partnership Board considered the case, in conjunction with other key agencies that had had contact with him and concluded that the case did meet the criteria and justification for a Domestic Homicide Review (DHR). The Home Office were notified accordingly. In terms of cases where the person, like Barry, has died as a result of suicide the Home Office guidance 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. Reviews are not about who is culpable*.'

1.6 The FCSP held initial scoping in November 2020 and commissioned the review, appointing as the Independent Chair and author, Dr Russell Wate QPM, who has compiled this overview report.

1.7 At the beginning of December 2020, Christina and other members of Barry's close family including his older brother were contacted in writing and sent the Home Office leaflet and also informed of their right to have independent advocacy if they wished, highlighting the advocacy charity 'Advocacy After Fatal Domestic Abuse' (AAFDA) to them. Contact was made with Barry's friend's and also the people who lived in the community where he lived at the time before he died.

2. Timescales for completion

2.1 In order to ensure the review into the circumstances that led to the death of Barry was dealt with in a timely manner, FCSP and the panel made a decision to keep the review active through both the second and third extensive national COVID-19 lockdowns. IMRs were completed, meetings held, family communications commenced within this period and a first draft report was completed by the 12th of April 2021.

3. Confidentiality

3.1 The findings of this review are confidential. Information is available only to participating officers/professionals and their line managers. Pseudonyms are used in the report to protect the identity of the individuals involved.

4. Terms of reference:

4.1 The following Terms of Reference were agreed by the chair and the panel. The family were not consulted at the Terms of Reference setting stage, but they were asked subsequently and had nothing that they wished to add:

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

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

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

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

e) To what extent was Coercive Control in Domestic Abuse an issue in this DHR

f) To what extent was the suicide of Barry effected by his lived experience of Domestic Abuse? What could have been done by agencies to prevent him taking his own life?

4.2 The critical dates for this review have been designated by the panel as 1st February 2019 to 23rd September 2020; however, the panel chair asked the agencies providing IMRs to be cognisant of any issues of relevance outside of those parameters which will add context and value to the report. These dates were selected as it was believed this is the period that Barry and Sally were in this coercive, controlling and violent physical relationship. Sally has since informed the panel chair that the relationship began sometime after April 2019.

4.3 These dates were felt to be the most relevant and appropriate in the life of Barry and his close family. At the panel meeting in March 2021 the panel reviewed the timeframe, and all agreed the most appropriate time period.

5. Methodology

5.1 The aim of the IMRs is to:

- Allow agencies to look openly and critically at individual and organisational practice and the context within which people were working to see whether the homicide indicates that changes could and should be made.
- To identify how those changes will be brought about.
- To identify examples of good practice within agencies. (Multi- Agency Statutory Guidance for the conduct of DHR's, para 8.2)

5.2 The purpose of this Domestic Homicide Review overview report is to ensure that the review is conducted according to good practice, with effective analysis and conclusions of the information related to the case. To then establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually, and together, to safeguard and support victims. To then 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. To then apply these lessons to service responses, including changes to policies and procedures as appropriate and to prevent domestic violence and homicide. To improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working, to ensure that such abuse is identified and responded to effectively and at the earliest opportunity.

5.3 This overview report has been compiled with reference to the comprehensive Individual Management Reviews (IMRs) prepared by authors from the key agencies involved in this case. Each author is independent of the victim and family and of management responsibility for practitioners and professionals involved in this case. Where IMRs have not been required, reports from other agencies or professionals have been received as part of the review process.

5.4 The overview author fulfilled a dual role and has chaired the panel meetings in respect of this case. This is recognised as good practice and has ensured a continuity of guidance and provided context for the review. There have been several useful professional discussions arising and the panel meetings have been referenced and noted appropriately for transparency.

5.5 The review author also made several requests to agencies and individuals for clarity of issues arising and is grateful for the participation of individuals and agencies throughout. The professionalism of the panel members and the overall quality of the responses has been of a high standard.

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

> *'Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate*

partners or family members, regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological, physical, sexual, financial and emotional.'

5.7 The Government definition also outlines the following:

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

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

5.8 Section 76 of the Serious Crime Act 2015 created the offence of controlling or coercive behaviour in an intimate or family relationship. Prior to the introduction of this offence, case law indicated the difficulty in proving a pattern of behaviour amounting to harassment within an intimate relationship.[1]

5.9 Where a victim takes their own life (suicide) and the circumstances give rise to concern, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable but should illuminate the past and be professionally curious to help to make the future safer. This review report is titled on its front page as a domestic abuse death review. This follows advice from the Home Office QA panel in other suicide death cases as the best way to call them for the sake of families.

5.10 In support of the information received from agencies, the author has engaged on five separate occasions with the family of the deceased and his friend's and the immediate community where he lived.

5.11 The author has also sought additional information outside of the date parameters, this has assisted in context to examine some background history.

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

6.1 Unexpected deaths are tragic not just for the family, but also for friends, and this review process has worked hard to include their thoughts and views throughout.

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

6.2 The Home Office leaflet has been sent to family members and the letter that accompanied it also emphasised the opportunity to access an advocate (including the assistance of AAFDA) to assist them in the DHR process in getting their views and feelings across. None of the family members wished to have any advocacy support including the children. The review author has also had communication with the family and friends opening up regular communication channels if there is anything that they would wish to add, contribute further, or know about the review.

6.3 Key matters pertaining to individuals have been addressed in the respective narrative of this report, but it is acknowledged by the review that they are survivors of this tragic episode, not least the family of Barry, and this review must be seen as a way forward in supporting others who may have similar needs and obtaining individual, and sometimes personal views, may identify intervention opportunities for agencies in future cases.

6.4 As already stated in this report the family have been consulted on a regular basis to ensure ongoing dialogue during the entirety of the review process.

7. Contributors to the review:

7.1 The following agencies have contributed to the review with, in almost all cases, the provision of an IMR: Each of the agency authors is independent of any involvement in the case including management or supervisory responsibility for the practitioners involved.

- Cambridgeshire Constabulary *(IMR)*
- Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) *(IMR)*
- North West Anglia Foundation Trust (NWAFT) *(IMR)*
- GP Medical Practice *(IMR)*
- DASV Partnership IDVA Services (*IMR*)
- CCC Children's Early Help (*IMR*)
- East of England Ambulance Service *(statement of fact)*
- Fenland District Council (FDC) (IMR)

8. Review Panel members

8.1 The following individuals and agencies comprise the DHR panel, they are all totally independent of the case and have had no involvement with the practitioners involved or Barry or any of his family.

Agency	Panel Member	Role
Cambridgeshire Constabulary	Jenni Brain	DCI Protecting Vulnerable People Department
North West Anglia Foundation Trust	Sam Hunt	Named Nurse safeguarding children
CCC Children's Early Help	Ellen Tranter	Head of Service
Independent Safeguarding Partnership	Dave Sargent	Strategic Lead CCE
Domestic Abuse SV Partnership	Vickie Crompton	Domestic Abuse and Sexual Violence Partnership Manager (IDVA Services)
Cambridgeshire and Peterborough CCC	Helen Duncan (Corresponding)	Head of service Safeguarding Adults
Refuge	Mandy Geraghty	Service Manager
CCG	Linda Coultrup	Named Nurse Safeguarding Adults, Primary Care and GP's
FCSP/FDC	Alan Boughen	Community Safety and Partnerships Officer
Cambridgeshire and Peterborough NHS Foundation Trust	Paul Collin	Safeguarding Adults Manger (Mental Health Advisor)
Cambridgeshire and Peterborough Department for Public Health	Dr Kathy Hartley	Suicide Advisor
Aspire-Change Grow Live	Selina White	Substance Misuse Advisor
DHR Chair/Author		
RJW Associates	Russell Wate Ian Tandy	DHR Chair and report Author Support to Chair

9. Panel Chair and author of the overview report:

9.1 Dr Russell Wate is a retired senior police detective. He was formally the Independent Scrutineer of the Cambridgeshire and Peterborough Safeguarding Children and Safeguarding Adults Executive Board. This board has no representation or involvement with FCSP or any

other CSP within the area. He has extensive experience in partnership working within safeguarding environments and authoring Serious Case Reviews. He also has extensive experience in conducting Domestic Homicide Reviews; having authored several such reviews across the country as well as internationally.

9.2 Dr Wate has authored several national publications, contributed to several specialist publications, in particular concerning the investigation of child deaths and homicide.

9.3 Dr Wate is totally independent having no connection with the Fenland Community Safety Partnership other than previously providing professional and independent services in connection with three other unrelated Domestic Homicide Review.

10. Details of any parallel reviews:

10.1 The death was reported to HM Coroner. The incident in September 2020 was attended and dealt with by Cambridgeshire Constabulary.

10.2 The Coroner's inquest was opened in October 2020, with an intention to conclude the inquest process later in 2022.

11. Equality and diversity

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

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation

11.2 Barry was 55 years of age at the time of his death. He was a white man of British heritage. He was heterosexual and had no self-professed or registered disability. He was at

the time of his death married albeit estranged from his wife. There has been no feedback from his family that he professed to any religion or faith.

11.3 Barry suffered with Chronic Obstructive Pulmonary Disease (COPD) and was being treated for this by his doctor and it was reported in the GP IMR that in 2020 he was responding well to treatment. Due to COPD raising his risk of serious implication from COVID-19 the GP practice kept in touch with him during the first lockdown. COPD wasn't seen by Barry's family to be a barrier for him, but as seen at section 14.8 of this report he was struggling with his COPD so much that he was unable to make a statement.

11.4 Evidence has shown that domestic abuse is a gendered crime. There is evidence to support the theory that men commit more acts of domestic abuse than women. Statistically, women are more likely to be victims of domestic abuse. In the year ending March 2019, an estimated 2.4 million adults aged 16 to 74 years experienced domestic abuse in that year, of which 1.6 million were women and 786,000 were men, it showed that women were more likely to be repeat victims of abuse and men are more likely to be repeat perpetrators (Walby et al, 2004)[2].

11.5 In this case though, the victim of the DA and the person who took their own life by suicide is male. This review process has established that there is specific learning for individuals and agencies from the victim's gender being male.

12. Dissemination

12.1 This anonymised report and executive summary have been prepared by the author and panel for publication in accordance with the policy of the Fenland Community Safety Partnership at the conclusion of the review process.

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

> *'Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the*

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

relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable'[3]

12.3 As already stated earlier in this review report, the process took the form of a domestic abuse death review. This follows advice from the Home Office QA panel in other suicide death cases as the best way to call them for the sake of families. The family in this case appreciated that advice.

SECTION TWO- THE FACTS

13. Background Information:

13.1 This review focusses on the death of Barry who was found at his home address in a town in Fenland in September 2020, having, as it turned out, taken his own life.

13.2 The police were called by Sally. At 11.18pm in September 2020, she called the police, stating she believed that Barry was going to kill himself by hanging. This followed a telephone conversation that she had just had with Barry. She further stated that he had threatened suicide before. At 11.50pm the police attended Barry's home, where he was found hanging in the bathroom. He was cut down and CPR commenced. He remained unconscious and was subsequently taken to hospital where he sadly died the following day.

13.3 Research of police systems identified three recent Domestic Abuse incidents that had occurred in 2020 between Barry and Sally. The first was in February 2020 where Barry was recorded as the suspect and Sally the victim. Sally would not provide a statement or support police action and the investigation was finalised as no further action. In this incident when Barry was spoken to by the police he told them he was acting in self-defence. The two most recent incidents were in August 2020 where it is recorded that Barry was the victim and Sally the perpetrator. These two separate investigations were still not completely finalised at the time of Barry's death.

13.4 In November 2020 the Fenland Community Safety Partnership held a scoping meeting to discuss the case and agree terms of reference for the review. In accordance with the 2016 Home Office Statutory Guidance for conducting domestic homicide reviews, the

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

circumstances surrounding the death of Barry led the partnership to conclude that a domestic homicide review would be commissioned.

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.

13.5 Subsequently, Dr Russell Wate was appointed as the Independent DHR chair and overview author. Further panel meetings have taken place in the interim to structure and agree the terms of reference and a presentation day was held in March 2021, where the respective agencies discussed the findings of their IMR's with the DHR panel.

14. Chronology

14.1 Although outside the agreed timescales for this review, it is considered to be relevant as Barry had threatened in the past to take his own life by suicide. His GP said he had a previous history of intended self-harm and depression. There is a recorded case from December 2017, when an older brother called the police, reporting that Barry was trying to take his own life by suicide. Barry had sent this older brother a text message which stated that, '*the police had evicted him from his house after he was arrested for assault and this had ruined his life, so he was currently trying to take his life'*. His brother took the threat seriously, believing Barry may be at an address in the London area staying with a cousin of theirs. He further stated that Barry had tried to take his own life by suicide in the past. The phone call and concern were reported to the Metropolitan Police who took ownership and subsequently found him unharmed. On 25th December 2017, a 'Warning Suicidal' marker was placed on his Cambridgeshire Constabulary nominal record. Barry's family agree that he often talked about suicide and had threatened this in the past. The family told the panel chair that they had always urged Barry to seek professional help, but he didn't appear to them to have sought specialist treatment in order to seek the help they felt he needed. Both Christina and Sally told the panel chair that they also had constantly asked Barry to go and seek specialist help.

14.2 On 1st January 2019, Barry attended the hospital emergency department, having been brought in by ambulance after allegedly being assaulted when out with a friend celebrating New Year. A person assaulted Barry by punching him, causing Barry to fall to the floor and hit his head and lose consciousness for a few seconds. At the hospital Barry was very agitated,

and he was intoxicated but he calmed down after treatment. The pain from his head injury stayed with Barry for many months causing him distress.

14.3 In October 2019, Barry attended his GP practice with low mood, this was thought by the GP due to Barry stopping his Sertraline[4] of his own accord a few months earlier. He had been on a high dose of this in the past.

14.4 In the early morning of 8th February 2020, Sally's son (16 years), called the police to report that Barry was hitting his mother. When the police attended, they found Sally drunk and very aggressive towards them, and due to her intoxication, she could not remember exactly what had happened. She had a black eye but stated she didn't know how she got it but said that although she had been fighting with Barry, he did not cause the injury. Barry was arrested on suspicion of assault, and a Domestic Abuse, Stalking and Honour based Violence (DASH) assessment was completed with Sally with the risk level assessed as 'Medium'. This was reviewed and assessed to be correct. In addition to the DASH assessment, Sally received an Initial Victim Needs Assessment (IVNA) in which she denied being vulnerable or needing support.

14.5 The DASH assessment was further reviewed by the Cambridgeshire Constabulary Multi Agency Safeguarding Hub (MASH) and no further referral was made. In interview Barry denied the assault, stating that Sally took medication with alcohol and as a result became violent. She was aggressive towards him, and he acted only in self-defence and to protect himself. Sally was spoken to when she was sober and stated that she could not remember what had happened, but she did not believe Barry would have deliberately assaulted her and would therefore not make a statement. The son of Sally likewise would not provide a statement, he said that he had not witnessed any assault, but had seen his mother hit her head on a door. As there were no other witnesses and Barry had provided a plausible account that could not be refuted, the decision was taken to take no further action. A Significant Interest Marker (SIG) was placed on the address where the incident had occurred by the police control room.

14.6 Sally had in the past been referred for Antiphospholipid antibody syndrome (APLS) for her aggressive behaviour towards health staff and for her own suicidal ideation, stating she would, " jump off the building". There is no information on whether a risk assessment took place or of who might be at risk from her violent behaviour.

14.7 In April 2020, Sally attended the Hospital Emergency Department with a finger injury. This had happened after punching a wall following an argument. No fracture was seen, and no other information was available. There was no enquiry into who she had the argument

[4] Sertraline is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI). It's often used to treat depression, and also sometimes panic attacks, obsessive compulsive disorder (OCD) and post-traumatic stress disorder (PTSD)

with or any enquiry in relation to DA. During 2020, Sally had eight telephone appointments (due to COVID 19 restrictions) with CPFT mental health staff during the year.

14.8 On the 20th of May 2020, Barry attended the GP practice with one of his daughters and the notes describe him as struggling with mood, unable to switch off, and with shooting pains and headaches. At the time he was living alone, and he denied any suicidal ideation but did describe previous attempts in 2017. Mirtazapine[5] was added in for this mood with a review at the beginning of June 2020. The review record stated that they found him doing okay, if anything, slightly better.

14.9 During the morning of 19th August 2020, Barry called the police to report that he was having a domestic dispute with Sally. The police attended and spoke with Barry, they recorded that he stated to them the following comments: *'He had been assaulted by his partner. He had problems all day with the attitude of the ex-partner and a female family member of his own. This had resulted in him being assaulted.'*

14.10 This DA situation started at a local storage container where Barry had been working with a friend. The incident started after Sally had taken Barry's house keys and gone to his home to take some items of property. Barry and his friend had followed them back to the address and once there, an argument had taken place as Barry wanted his keys back, but Sally refused to do so. This led to Sally punching and kicking Barry to the back and head area multiple times. Sally also caused some damage by slamming the front door into the wall and throwing a phone at the wall.

14.11 Barry then revealed that he had been subject to domestic abuse since they started having a relationship approximately one and half years ago. The family told the panel chair that Barry told them he knew Sally as she had been in a relationship with a friend of his. This information was agreed by Sally when she spoke to the panel chair. Barry said that the abuse he had been suffering was getting worse and getting more physical. Sally often blamed her mental health on the amount of medication she was on, and she was also smoking cannabis on a regular basis. Barry said that he had tried to finish with her but was scared of her and often took her back just to keep the peace, but after this incident he did not want her back and wanted to be free from her. He made a statement recording this. The DASH assessment recorded that he had been subject to domestic abuse from Sally for over six months and the risk level was assessed as 'Medium'. After professional judgement was used in the police MASH a High-Risk referral for Barry was received and the case allocated to IDVA. An appropriate referral for support was made to the IDVA Service and support offered and accepted. The IDVA liaised with DV Assist (to support with a non-molestation order) and also with the police MASH to confirm bail conditions. The referral for Barry did not meet the

[5] Mirtazapine is an antidepressant of the atypical antidepressants class primarily used to treat depression.

criteria for a MARAC referral, as was still regarded as 'Medium' risk for the purposes of MARAC.

14.12 Barry accepted Independent Domestic Violence advisors (IDVA) support and wanted help with gaining a non-molestation order. He had stated that the relationship was over and that he had not gone out since the incident because of his anxiety, also saying that he had mental health conditions. In addition to the DASH assessment Barry received an IVNA and confirmed that he was vulnerable and would appreciate support and wished to end his relationship with the ex-partner.

14.13 Sally, when interviewed whilst in custody, denied assaulting Barry and made counter allegations against him. When Sally spoke to the panel chair, she re-iterated that she had not carried out the assault as alleged. A female family member was interviewed a few days later and made denials about being present at a domestic abuse incident. Barry's friend witnessed Sally assaulting Barry and the family member being aggressive towards him. Sally was released under investigation[6].

14.14 Sally attended the emergency department on the 20th of August 2020, following what she was alleging was an assault by Barry. She did have bruising to her right wrist. She also had pain in her right foot caused by her kicking the cell door whilst in custody. A picture of the bruised wrist was taken, and an X-ray showed no acute bony injury, however, this type of injury can take two weeks to show if it was a break. Her third toe did have a metatarsal fracture.

14.15 Sally was contacted by the police after the incident and claimed wrongly that she had broken her wrist. This allegation, in the police's opinion, against Barry then became the more serious offence due to the alleged injury being a GBH injury. However, the injury needed verifying.

14.16 Towards the end of August 2020 Barry was contacted by IDVA in relation to the 19th of August assault and Barry confirmed that he knew he needed to contact DV Assist[7] if the ex-partner's believed bail conditions were breached (Sally was not on bail but released under investigation, but all agencies believed she was on bail). DV Assist would move forward with an injunction. Barry confirmed no incidents had recently taken place as he wasn't going out due to his poor health.

[6] Release under investigation (RUI) is used by the police instead of bail – but unlike pre-charge bail it has no time limits or conditions.

[7] Domestic Violence Assist. A registered charity arranging; Non-Molestation Orders, Prohibited Steps Orders & Occupation Orders.

14.17 On the 30th of August 2020 Barry was again assaulted by Sally. The assault was recorded by the police as ABH on him with Sally as the named suspect. Although Barry told the Police call handler that Sally was on bail for a previous assault on him, the investigating officer was not made aware and did not find out about the previous incident, so neither of the two investigations were linked.

14.18 In this assault on the 30th of August, in the early hours of the morning, Barry had called the police, reporting that Sally was shouting at him and told them that she was currently on bail for assaulting him. He stated he was scared of her and wanted police assistance. Details of previous incidents were not recorded on the Incident log, neither was any information passed to the attending officers. The police attended and spoke with Barry who said that earlier that day he had been headbutted by Sally, his ex-partner, causing a cut to his right eye and he had been pushed by a man she was with. A statement was not taken immediately from Barry as he was struggling with his Chronic Obstructive Pulmonary Disease (COPD) and was going to seek medical advice.

14.19 A DASH assessment was completed, and the risk level was assessed as 'Medium'. Barry's vulnerability was recorded on the assessment as follows: *'Male has COPD and anxiety. Currently does not have medication for anxiety but does have an inhaler for COPD. Male has also been subjected to domestic abuse for approximately 6 months. Male has also said that he has thought about suicide recently, however, it's only his mum being alive that is keeping him going. He did state however that he doesn't have these thoughts at the moment*'.

14.20 This, according to the local police records, is the only occasion that Barry had mentioned suicide directly to them, and it appears that the suicide marker on his record (from 2017) had not been picked up during any of the incidents within this review timescale. During the IVNA Barry said again that he was vulnerable and what had happened was part of a pattern of the criminal behaviour directed towards him.

14.21 This assault was not linked to the one on 19th of August 2020. It was referred to the MASH and sent to the Refuge services, but the referral did not include any details of the previous referral from ten days earlier.

14.22 On 3rd September 2020, the 30th of August assault on Barry by Sally was reviewed by a sergeant and the case officer was directed to speak with Barry, obtain a statement, gather further evidence, via medical records, and to arrest and interview Sally. The investigation had by now been allocated to another officer who was currently on annual leave, so when this officer returned from leave a week later, the police have recorded that they then tried to contact Barry who did not respond to calls and messages.

14.23 On 16th September 2020, Sally contacted the police saying that she did not want any further police action regarding her injury, she had not provided any supporting evidence regarding what she alleged was a broken wrist. The assault investigation was referred for a final decision, but prior to the decision being made Barry had died. This investigation was finalised NFA a few days later after his death.

14.24 Barry was eventually spoken to about the 30th of August assault, following a delay of three weeks, at the end of September 2020. Barry by now did not want to provide a statement as it had been three weeks since the incident and Sally had not been a problem to him since then and he did not want things to flare up again. As a result of this, the case officer took the decision not to contact the suspect in case it made matters worse and recommended that the investigation be finalised NFA (no further action). It was recorded by the officer that it was one person's word against another's and if the suspect denied the offence during interview, it would be finalised NFA anyway. These comments are regarded by the police IMR author as a particularly negative way of investigating a crime. When Sally spoke to the panel chair, she denied that there was a further DA incident later in August. If one was being alleged against her she questioned with the panel chair, why hadn't the police spoken to her about it.

14.25 The tragic events at the end of September 2020 have already been documented within this report.

14.26 On 23rd October 2020, DV Assist made contact with IDVA, by email, stating that Barry had stopped engaging with them and asking him to get in touch if he still wanted to proceed with the non-molestation Order.

14.27 On 3rd November, the IDVA service were still unaware that Barry had died when they sent an email to the police MASH asking for an update on the case and Sally's bail conditions. They were notified on this occasion of the death.

SECTION THREE – OVERVIEW AND ANALYSIS

15.0 Overview:

15.1 There are three occasions within 2020 that agencies have records of DA within Barry's and Sally's relationship.

15.2 There is one documented previous occasion when suicide ideation was mentioned by Barry, on this occasion the concern for his safety was so great that his brother contacted the police to check on him. Barry's brother, Christina, Sally and other family members told the

panel chair that there were numerous occasions when Barry mentioned to them his suicide ideation.

15.3 Barry stated to the attending police officer on the 30th of August assault that the DA over the last 6 months had made him suicidal, but he did not have that thought at that present time.

15.4 Barry suffered for many years from low mood and depression, and he was being treated through the usual prescribed drugs by his GP. He was not known to any specialist mental health services. According to his family he kept himself below the radar. He knew he needed specialist help but wouldn't ask for it and if he did, he played down the significance of his depression. Christina told the panel chair that they had attended a counselling session with him, but Barry refused to talk freely with the counsellor and the session and further sessions were cancelled.

16. Analysis:

16.1 This analysis seeks to explore the terms of reference in general terms as opposed to referencing each of them specifically, other than where this has relevance to learning.

16.2 In the February 2020 incident, appropriate action was taken by the attending police officers by promptly arresting Barry who was subsequently interviewed later that day. The incident was dealt with based on the available evidence and facts. Safeguarding issues were addressed by the MASH and a SIG warning marker placed on the address where it had occurred. NFA was taken against Barry as Sally didn't make a complaint.

16.3 What though is not understandable, is what happened to the counter allegation by Barry, where he describes himself as being the one that was assaulted. Nothing was done to progress this allegation as it should have been.

16.4 The second police recorded incident of domestic violence between Barry and Sally was on the 19th of August 2020. The February incident was identified by the Force Control Room. On this August occasion Barry was the victim and Sally the suspect. Officers attending the incident wore Body Worn Video (BWV), recording the account given by Barry, and positive action was taken, with Sally being arrested and statements taken from Barry and the witness. The incident was recorded as Common Assault and a DASH assessment was completed along with an IVNA. The officers dealing with this incident took the decision to interview Barry's family member at a later date. This happened five days later and the reason for the delay is not recorded. This account should have been taken straight away, or as soon as possible.

16.5 A few days later the police contacted Sally, who had been released, to update her regarding the investigation. During this update she informed the police that she had attended hospital about her injured wrist, and it had been confirmed as broken. She had not mentioned this before as her previous examination only revealed bruising. The focus of the investigation then appears to have been focused on the alleged injury to the suspect, and if evidence was available to support the allegation this should have been recorded as a separate crime and dealt with accordingly. There is no mention on the crime report of any victim update to Barry since he provided his statement.

16.6 Despite the initial positive action and compliance with the Domestic Abuse Policy and prompt review by MASH, there appears no immediacy to progress the investigation, and there is an absence of victim updates. Sally being released under investigation and not on bail was a missed opportunity and left Barry as a victim exposed. There is a lack of victim focus and too much focus on Sally. The police IMR author felt that a more experienced investigator may have formed the opinion that the alleged GBH on Sally was a tactic to influence the police investigation into her assault on Barry. This is especially the case with the absence of medical evidence to support the assault on her and no victim statement. However, the report author and panel felt there was at the same time no evidence that Sally's allegation was malicious. Sally herself told the review author that she had sustained this assault when she spoke to him. The review author and panel felt that the GBH allegation should have been recorded as a crime and investigated as a separate offence, although linked within the one incident. The investigating officer was recorded by the police IMR author as not experienced in dealing with a crime where the suspect alleged, they were themselves the victim, and as such should have been supported by a more experienced officer and supervision to them actively provided to progress both crimes.

16.7 This investigation was also not linked to the assault which occurred on 30th of August. Given both victim and suspect were the same, they should have been linked. Both crimes were reviewed by Cambridgeshire Constabulary Information Management Unit (IMU) and both DASH assessments reviewed by MASH with referrals made to IDVA on the first assault in August. Given their linkage, and a case of domestic abuse, these crimes should have been swiftly concluded. The crime was referred for a final decision on 17th September 2020. It was not subsequently finalised with a decision until three days after Barry's death. This crime should have been referred for a charging decision following the interview of the family member and the Domestic Abuse Policy had not been fully complied with. This was due to a lack of proper investigation and not given the priority it should have. It was also not actively managed.

16.8 The end of August incident was the third of domestic violence between Barry and Sally that was reported to the police, and the third where Barry stated he was a victim, and that Sally was the perpetrator. Despite historical information being viewed by the police control

room these previous incidents were not identified and there is no evidence on the incident log that the attending officers were informed. Throughout this review there is a lack of intelligence contained within the incident logs. The police IMR states that Cambridgeshire Constabulary's Control Room does not have their own dedicated 24/7 Intelligence Cell, so when they require intelligence checks they contact the Cambridgeshire Centralised Intelligence Bureau (CIB). Other police forces do have this facility, such as Hertfordshire Constabulary, so when an incident is reported they are immediately available to conduct the necessary research on all corporate systems and incident logs updated with the outcome of that research. The police IMR author recommends that a dedicated intelligence cell would have linked both assault crimes, incidents and really importantly for the domestic abuse, death nominal markers, such as the suicide marker on Barry's Cambridgeshire nominal record placed in 2017.

16.9 Officers attending the end of August incident wore BWV which recorded the account given by Barry of what had happened, naming Sally as the suspect, but a statement was not taken immediately as he was struggling with COPD and was going to seek medical advice. The crime was correctly recorded as ABH, although this was not linked to the Common Assault on 19th August, which was still ongoing. Opportunities to link these crimes were missed by IMU, MASH and the response team supervisor, which also meant that the IDVA was not informed of this repeat offence. It would appear that no other investigative opportunities were completed, such as CCTV or seeking other witnesses and corroboration. As already mentioned earlier in this report, Sally totally denied to the panel chair that there was a second incident of DA in August, she backed her assertion up to this by the police never mentioning it to her.

16.10 On 1st September 2020, safeguarding issues were promptly addressed by the MASH and a referral was sent to Refuge as assessed as "medium" risk. Refuge noticed there had been a previous incident in August, so called the IDVAs to ask if the case was open to an IDVA. The IDVA service assumed it to be a duplicate referral based on the earlier August referral, rather than another incident. All the police officers in the MASH are able to, and do, make referrals to IDVA. The referral itself is a copy of the DASH and emailed to all relevant partners. Referrals need to include brief details of previous referrals regardless of whether medium/high risk as the recipient may not immediately make a link, resulting in a lower priority for arranging a meeting.

16.11 There was a prompt referral by the MASH to the IDVA in the earlier August incident. The MASH needs to consider including brief details of previous incidents when making IDVA referrals. The referral for the assault included details of the February incident but the referral for the assault on 30th of August did not.

16.12 This late August investigation definitely lost momentum when the crime was allocated to an officer who was on annual leave. On 3rd September, the investigation was reviewed by

a supervisor who directed the case officer to obtain a victim statement and to arrest and interview the suspect. This investigation should have been given a higher priority and therefore allocated to an officer available to deal with it immediately. The new case officer returned from leave a week later and apparently tried to contact Barry. If this is the case, alarm bells should have been ringing if numerous attempts were made and he could not be contacted. He was not spoken to until three weeks after the incident. He was the victim of two assaults, neither of which had satisfactorily been concluded. The case officer recommended that the investigation be finalised NFA but was not aware of the previous assault until after the investigation had been filed. The Domestic Abuse Policy had not been fully complied with, showing a lack of positive action, and the investigation had not been given the priority it should have, and overall, it had not been managed along with the previous assault. The officer's comments saying it was one word against the other, so it would have been NFA anyway, lacked, in the police IMR author and in the panel's view, proper judgement. The police IMR author quite rightly states that there is more to an investigation that can be discovered other than in the comments of the victim and the suspect, bearing in mind the suspect on the third occasion was not even spoken to. The chair of this panel has discovered on enquiries from in the area that neighbours could have greatly assisted in the investigation.

16.13 When Sally was brought into the Emergency Department (ED) by the police there was good documentation for this attendance. However, ED staff did not pick up on the impact of the potential domestic abuse on her child who was under the age of 18. This attendance was later identified by the Safeguarding Team and a concern form was completed and the Children's Action Plan completed on the child. This concern form automatically adds a Safeguarding Flag to the child, so if he were to subsequently attend ED or the hospital, staff are aware there has been a historic safeguarding issue.

16.14 It is known that domestic abuse is a highly gendered issue and women are disproportionally affected. The IDVA service does though support both male and female victims but would adopt a more cautious approach with a male victim to ensure that they are not a perpetrator posing as a victim, as in their experience can often be the case. Because of this it may be that professionals sometimes assume that a female is the victim and the male the perpetrator. In this instance it does not seem that this was the case and Barry was still supported, but the level and severity of the impact of domestic abuse on him was not identified, in particular as the IDVA was not informed of the second DA case in August 2020.

16.15 The key issue for IDVA appears to have been about whether Barry was a victim of domestic abuse or whether there was situational couple violence within the relationship, and/or perpetration of abuse towards Sally. This is a difficult area and on reflection more work could have been undertaken at the time to understand this.

16.16 There is research that helps a little with this understanding, Professor Marianne Hester in June 2009, had a paper published. 'Who Does What to Whom? Gender and Domestic Violence Perpetrators.[8] 'Where she tracked 96 cases over 6 years comparing male and female perpetrators. In the paper she states:

> *'While the majority of incidents of intimate partner domestic violence recorded by the police involve male-to-female abuse, little is known about the nature of the incidents where men are recorded as victims and women as perpetrators, nor about the circumstances where both partners are recorded as perpetrators.'*
>
> *'The alcohol use of one or both partners can also impact on the boundaries between victim and perpetrator with subsequent difficulties in assessing risk and in determination of who is the primary aggressor.'*
>
> *'Dual perpetration cases also included the greatest number of instances where both partners were heavy drinkers or alcoholics and where the circumstances appeared quite chaotic. Alcohol abuse by partners in some instances made it unclear who the perpetrator was.*
>
> *This example shows some of the difficulties in identifying the main perpetrator, especially when the focus by the police is on definable crimes. The example indicates the tendency to see as the perpetrator the individual who is abusing alcohol.'*

The learning from the paper fits the circumstances, and is relevant, that Barry and Sally were in when there was situational couple violence and their use of alcohol.

16.17 'Respect'[9] has a toolkit for work with male victims of domestic violence, which has a checklist to help identify who is doing what to who. Although this is best practice in the IDVA Service this doesn't appear to have been considered in this case. It is recommended that this should be undertaken with all male victims, either as part of the initial duty call or within a week of support being accepted. The result of this risk assessment should be discussed with the IDVA's line management, and any decisions made should be documented in the case notes.

16.18 An appropriate referral for support was made to the IDVA Service and support offered and accepted. The IDVA liaised as expected with DV Assist (to support Barry with a non-molestation order) and also with the police MASH to confirm bail conditions. The referral for Barry did not meet the criteria for a MARAC referral, which would have involved a multi-agency discussion.

[8] Hester M (2009) 'Who Does What to Whom? Gender and Domestic Violence Perpetrators', Bristol: University of Bristol

[9] Respect is a charity working in the area of domestic violence. It is a national organisation, it provides services, including helplines, for male and female perpetrators of domestic violence, **for male victims of domestic violence**, and for young people who are violent in the home or relationships.

16.19 The case remained open, with the intention of offering support to gain the non-molestation order once Sally's presumed police bail conditions had ended, or, if she breached them, which she did, but the IDVA was not informed. There was in fact no bail and as a result, no bail conditions. It was a month after Barry had died that the IDVA Service found out about his death. This seems like a lengthy delay in notification and asks the question of the local agencies to ensure that the IDVA service is updated on such a matter. Their lack of knowledge about Barry's death was seen as highly embarrassing for them and also caused a misuse of their time in continuing with a matter that wasn't required anymore.

16.20 Public Health England (2019[10]) have published a suicide prevention profile and within this they highlight related risk factors that professionals should be aware of when working with people who have these vulnerabilities:

- *Depression.*
- *Substance misuse – alcohol.*
- *Long-term health problems and disability. (Barry had chronic pain from an assault on New Year's Eve. Pain from a previous car crash injury and COPD)*
- *Domestic abuse.*
- *Marital breakdown (in particular males who have separated)*
- *People living alone.*
- *Unemployment. (Barry was constantly worried about unemployment he lost his job as an ambulance driver in this period.)*

16.21 The panel chair has selected the relevant vulnerabilities for this review and as can be seen from the list Barry had numerous risk factors that professionals could easily have been aware of and to safety plan accordingly.

16.22 The Samaritans[11] say that in their experience:

'Many people struggle to cope at one point or another of their lives. Experiencing a range of emotions during these times is common. Professionals might not always be able to spot these signs, and these emotions show up differently in everyone.'

Situations for professionals to look out for are: ■ Relationship and family problems. ■ Loss, including loss of a friend or a family member through bereavement. (all family members state that Barry got more depressed after his father died and he felt his death greatly) ■ Financial worries. ■ Job-related stress. ■ Loneliness and isolation. ■ Depression. ■ Painful and/or

[10] Public Health England (2019) Suicide Prevention: Resources and Guidance. Public Health England. London.
[11] WWW.samaritans.org/

disabling physical illness. ■ *Heavy use of or dependency on alcohol or other drugs.* ■ *Thoughts of suicide.*'

16.23 This is important learning that professionals need to take account of. Barry's family, including Christina and Sally all told the panel chair that Barry was greatly affected by the death of his father and all feel that bereavement support would have really helped him.

16.24 The panel chair has been supplied with and reviewed the *'Joint Cambridgeshire and Peterborough Suicide Prevention Strategy 2017-2020.'* Within the strategy there is no specific mention of Domestic Abuse and the risk factors for suicide associated with it. There is a mention at Appendix 1 of a pathway developed by Peterborough Mind which states *'Domestic Violence when a SOVA approach is required.'* The DHR panel request that an updated strategy includes specific mention of DA and what is needed for professionals to consider locally.

16.25 For those professionals who work in criminal justice agencies, it is worth considering further the research described in the report 'Domestic Abuse and Suicide: Exploring the links with Refuge's client base and work force' by Ruth Aitken and Vanessa E Munro on behalf of Warwick Law school and Refuge. It states:

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

This report also highlights certain information that local areas need to include, if they don't already, the risk factor of domestic abuse in suicide:

> *'Domestic abuse is a high-risk situation, whether this refers to the immediate risk of serious, physical harm from the perpetrator, or to the longer-term risk to the victim's psychological well-being, to their life chances in terms of lost opportunities and potential, or significant damage to 'the self'. Domestic abuse is also a risk to life, either through homicide or suicide of the victim. Although domestic abuse is mentioned as a risk factor within the national suicide strategy, neither suicide nor suicidality are mentioned within the Government's most recent violence against women and girls (VAWG) or domestic abuse strategy. It seems clear that any meaningful integration of policy or practice across both spheres is lacking'*

16.26 In 2019 Professor Jane Monkton-Smith and the University of Gloucestershire published research titled the Homicide Timeline. It stated [12] *'The eight steps she discovered in almost all of the 372 killings she studied were:*

- *A pre-relationship history of stalking or abuse by the perpetrator*
- *The romance developing quickly into a serious relationship*
- *The relationship becoming dominated by coercive control*
- *A trigger to threaten the perpetrator's control - for example, the relationship ends, or the perpetrator gets into financial difficulty*
- *Escalation - an increase in the intensity or frequency of the partner's control tactics, such as by stalking or threatening suicide*
- *The perpetrator has a change in thinking - choosing to move on, either through revenge or by homicide*
- *Planning - the perpetrator might buy weapons or seek opportunities to get the victim alone*
- *Homicide - the perpetrator kills his or her partner, and possibly hurts others such as the victim's children*

16.27 Professor Monckton-Smith has just received Home Office funding to examine approximately 100 suicides related to domestic abuse in order to pick out the patterns and identify the red flags.[13] She states:

> *'The fear of not being believed or properly supported can play a huge part in driving a suicide, says Dr Jane Monckton-Smith, a forensic criminologist who specialises in homicide, stalking and coercive control. Domestic abuse has a higher rate of repeat victimisation than any other crime, says Monckton-Smith, who has written a book about coercive control. "If you're not believed, then you can't get safety," she says. "It means the police can't help you, the court can't help you – and the abuser can act with impunity. It means there's no way out."*

16.28 A question the panel chair poses, which is in essence unable to be answered is, did Barry get to the stage, as the police informed him of NFA at the end of September 2020, where he believed no one could help him to safety out of his life of DA with Sally?

16.29 Professor Monckton-Smith believes that her eight - stage plan can fit DA deaths through suicide. In this case the evidence from the death of Barry would support her theory and there is a need for professionals to understand this eight-stage homicide timeline in order to intervene earlier and prevent future deaths.

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[12] The Homicide Timeline - University of Gloucestershire (glos.ac.uk)

[13] Fatal truth: how the suicide of Alex Reid exposed the hidden death toll of domestic violence | Domestic violence | The Guardian

SECTION FOUR – CONCLUSION

17. Conclusions:

17.1 The purpose of this review is not to stray into the Coroners role in determining Barry's cause of death. However, this review is about Barry and his suicide, which was brought about by him suffering DA. Barry's family have told the panel chair that throughout a lot of his adult life, he often had a suicide ideation. This report has highlighted three reported incidents of DA in the seven months before death. Family and friends say that it was happening on a regular basis throughout almost all of Barry's relationship with Sally. A family member told the panel chair, that Barry told them, he was desperate to get out of his abusive relationship. Following the end of August reported DA incident, he told the police, which they recorded as '*Male has also been subjected to domestic abuse for approximately 6 months. Male has also said that he has thought about suicide recently, however its only his mum being alive that is keeping him going. He did state however that he doesn't have these thoughts at the moment'*. It is therefore safe to say that this review process has identified that DA and suicide are inextricably linked in Barry's life.

17.2 The decision by the Fenland Community Safety Partnership to conduct a domestic homicide review under the circumstances as presented by this case was the correct decision and made in accordance with the 2016 Home Office Guidance. The application of the guidance is a particularly positive aspect of the manner with which the Partnership examines the multi-agency statutory roles, responsibilities, and its overall safeguarding principles.

17.3 The review has identified the following learning themes, which have been shared with and are supported by Barry's family

Learning Themes

- Professional understanding of the risks of suicide in cases of DA.
- Professional curiosity of patients with mental health issues suffering DA.
- Professional awareness of male victims of DA and to make use of the 'Respect' tool
- Improved police practice in relation to investigating DA incidents
- Suicide prevention strategies to explicitly include suicide risks from DA.

17.4 Coercive control or behaviour is an act, or a pattern of acts, of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. Barry, the victim, took his own life and blamed Sally for this. There were two reported

incidents, reported eleven days apart during August 2020. Although Barry had told police that he was also the victim in the February incident and during both his IVNA that he had been a victim of domestic abuse for approximately six months, he had not previously reported any of those incidents to the police. The pattern of behaviour, escalated from common assault to ABH, which was only just becoming apparent to the police a month before his death. It will never be known exactly what was going through Barry's mind that ultimately caused him to take his life, however, the ongoing domestic abuse he suffered by Sally may have been a contributory factor.

17.5 The findings of this review have identified learning in the two investigations during August 2020. Cambridgeshire Constabulary should have dealt with his crimes more diligently and expeditiously. The assault on 19th August 2020 could have been referred to the Crown Prosecution Service (CPS) for a charging decision following the interview of the family member. The assault on 30th August 2020, should have been linked with the earlier one and tasked with greater importance. There was sufficient evidence on 30th August 2020 to arrest Sally immediately, and this would have been necessary and proportionate given the previous assault and Barry's IVNA. A statement should have been taken from Barry following him seeking medical treatment for his COPD, although, in its absence, his account given to the officers which was recorded on BWV would have been sufficient to effect the arrest of Sally. Given that the partner was already being investigated for the earlier August offence, a charging decision by CPS for the assault on 30th August would have been possible. The service that Barry received from Cambridgeshire Constabulary in August and September were certainly missed opportunities. The alleged broken wrist assault by Barry on Sally should have also involved a separate crime being raised and investigated.

17.6 The police have provided evidence to the review that they are learning and making strides to improve their approach to tackling DA. Provided below are two of these initiatives:

> *Demand Hub DA desk: This desk will sit within the Force Control Room and aims to provide early intervention by improving victim engagement (through the call taker) and providing advice on minimising attrition of evidence and will also provide a research package for dispatched officers.*
>
> *Vulnerability Focus Desks (VFD): The VFDs consist of a team of Tactical Advisors from the Protecting Vulnerable People (PVP) department who operate daily from Parkside and Thorpe Wood police stations. Their role is to scan for Domestic Abuse incidents and other incidents where there is a concern for the vulnerability of the involved parties. The advisors will liaise directly with the attending officer to ensure that they are making the appropriate risk assessment of the incident and conducting the correct investigative and administrative actions required. They provide guidance on DVPN applications and other civil orders and will assist with safeguarding considerations*

such as issuing TecSOS devices. They provide a bespoke suite of options for the Officer in the Case (OIC), which should enable wider thinking about possible alternative opportunities when considering an early No Further Action (NFA) outcome. They also ensure that high risk outstanding suspects are made divisional priorities and drive forward the attempts to locate them. The implementation of the VFDs is intended to support an inexperienced frontline who may previously have lacked confidence in applying for DVPNs or not known where to go for information.

17.7 There still remains a need to remind all professionals of the potential of domestic abuse or coercive control in any number of presenting conditions. Barry's family, and also Sally, were keen to point out to the panel that as much as they tried, they couldn't get Barry to seek the specialist professional help that they felt he required. It is incumbent on professionals to exercise the right level of professional curiosity to satisfy themselves that all could have been done to identify and offer support to this, often hidden and not obvious area.

17.8 Issues around identifying and supporting male victims are relevant in this case and this is an area that all agencies and practitioners need to consider further. The Respect Toolkit for working with male victims is a resource that may be helpful and would have been particularly helpful to the police officers investigating the DA offences.

'Positive action has been taken to learn from this case and following Barry's death, the local DASV Partnership paid for 72 members of frontline staff, including ALL domestic abuse specialist staff, to attend Respect Male Victims training. In December 2020, ALL domestic abuse and sexual violence specialist staff attended Suicide Prevention Training from MIND, paid for by Public Health. In January / February 2021 Domestic Abuse Awareness sessions were held with staff from MIND- Lifecraft, Lifeline and the Samaritans. In June 2021, CPFT are launching their domestic abuse strategy and have a new "Domestic Abuse Lead" post across the organisation. Domestic Abuse Champions sessions in January featured a session on Domestic Abuse and the risk of suicide (by MIND), this was attended by over 100 DA Champions In June 2021, the Domestic Abuse Champions sessions focussed on Male Victims, with a presentation by Respect.'

SECTION FIVE –RECOMMENDATIONS

18. Recommendations:

18.1 The agency IMRs raise a number of recommendations. The FCSP should also on a regular basis seek assurance in written form and/or inviting attendance at a CSP meeting from individual agencies that they are implementing their recommendations.

18.2 These recommendations are:

For CPFT:
i) Where patients inform CPFT staff of domestic abuse this should be fully discussed and follow up options considered with them.
ii) CPFT to develop and deliver a Domestic Abuse training package for all staff relevant to their roles by summer 2021.

For IDVA:
iii) All specialist Domestic Abuse Services to use the Respect Toolkit when working with male victims and to record when the checklist is completed, and any decisions made following this.

For NWAFT:
iv) Continue teaching front line staff to be professionally curious and encourage routine questioning around domestic abuse in all attendances where this could be a factor.
v) Continue to teach and embed the 'think family' agenda and consider potential risks to children and young people.
vi) Share learning with Emergency Department staff relating to raising concerns at the time of attendance so consent can be obtained for sharing the information.

18.3 Police recommendations:
i) When a decision is taken not to arrest a suspect, then arrangements should be made to interview that suspect as soon as possible.
ii) Officers to be reminded of their obligation to record crimes correctly and promptly.
iii) Officers to be reminded of victim focus, and in particular providing updates on progress during investigations.
iv) The IMU to review processes for the management and supervision of crime by both IMU staff and supervisory police officers.
v) The FCR to consider setting up a dedicated Intelligence Cell which would be available 24/7.
vi) MASH to review their processes for reviewing DASH assessments and associated crimes, and in particular, to include previous DA incidents when referrals are made to MARAC.
vii) Victim statements must be obtained as soon as possible.

18.4 This DHR report has, in addition to the above, identified learning, and during the analysis and research that the panel carried out, the learning that flowed from this case has resulted in the recommendations as detailed below. The implementation of these will assist the

Fenland Community Safety Partnership to deal with similar circumstances in the future, resulting in the improved safety and welfare of victims of domestic abuse.

Recommendation 1: The Fenland Community Safety Partnership should engage with the Countywide DA/SV strategic partnership to put together a briefing paper that raises awareness for professionals of the risks of suicide in cases of Domestic Abuse. They should follow up this briefing six months later with a practitioner questionnaire to judge the level of renewed understanding and ask for examples where this change in awareness has made a difference to practice.
Recommendation 2: The Fenland Community Safety Partnership should work with The Cambridgeshire Clinical Commissioning Group to brief health practitioners that when they work with patients with mental health issues that they use professional curiosity regarding the potential for domestic abuse in that individual's life. (The Cambridgeshire and Peterborough Safeguarding Partnership have already developed a briefing paper which could be used or adapted[14]). The CCG should follow up this briefing twelve months later with a practitioner questionnaire to judge the level of renewed understanding and ask for examples where this change in awareness has made a difference to practice.
Recommendation 3: The Fenland Community Safety Partnership should work with the Countywide DA/SV strategic partnership for all practitioners to ensure they use the Respect Toolkit when working with male victims and to record when the checklist is completed, and any decisions made following this. An audit to be undertaken in 12 months will reveal if the toolkit is being used in appropriate cases.
Recommendation 4: The Fenland Community Safety Partnership should seek written assurance from Cambridgeshire Constabulary that the changes that they have made to the management and investigation of domestic abuse offences is delivering the outcomes, impact and changes they propose to make a difference to the lives of DA victims.
Recommendation 5: The Fenland Community Safety Partnership should recommend to The Joint Cambridgeshire and Peterborough Suicide Prevention Steering Group

[14] https://safeguardingcambspeterborough.org.uk/portfolio-item/professional-curiosity-opportunities-to-be-curious-briefing/

i) that when they update the Suicide Prevention Strategy, they include specific reference to Domestic Abuse. ii) The Suicide Prevention Steering Group could also consider implementing a process to review a proportion of suicides, like the process already in place for reviewing childhood deaths. This will enable agencies to share and learn lessons with the intention of preventing future suicides, in particular those that involve Domestic Abuse.
Recommendation 6: The Fenland Community Safety Partnership should request that the Countywide DA/SV strategic partnership carry out awareness raising with frontline practitioners of the Professor Monckton-Smith's homicide timeline including how this could be applied to prevention of suicide in Domestic Abuse cases.