**CUMBERLAND COMMUNITY SAFETY PARTNERSHIP**

**EXECUTIVE SUMMARY**

**Of the Multi-Agency Review[[1]](#footnote-1)**

**Into the death of Hannah[[2]](#footnote-2)**

**In January 2022**

**Independent Chair and Author of Report: Paula Harding**

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# The Background

* 1. This review concerns the circumstances leading to the death by suicide of a 39-year-old woman, Hannah, who had been experiencing domestic abuse in her relationship prior to her death.
	2. Hannah experienced adverse childhood experiences, including sexual and physical abuse and parental domestic abuse. She was a lesbian and went on to experience domestic abuse in her significant relationships as an adult and, as a result, experienced anxiety and depression, self-harm and problematic alcohol use
	3. Hannah was a registered nurse and worked in the hospitals close to where she lived. Hannah worked in a qualified, professional capacity.

# Summary of Chronology

* 1. In July 2018 Hannah left a violent relationship and returned to her hometown and entered a new relationship.
	2. When this relationship ended, she was returning intoxicated from the funeral of a friend who died by suicide, and similarly attempted suicide by hanging herself. Hannah declined further assistance whilst at hospital but responded to her GP who had followed up the hospital notification. The GP prescribed anti-depressants and made an urgent referral to the Community Mental Health Team.
	3. Meanwhile, Hannah called the police saying that there was “a verbal and physical fight” with her ex-partner with whom she continued to live despite their relationship having ended a few months previously. The police found Hannah heavily intoxicated, and arranged to visit her the next day, asking her ex-partner, who had a prior history of domestic abuse, to stay elsewhere. On the following day, Hannah advised that she was safe, as she was living next door to her father.
	4. During a mental health assessment, Hannah attributed her lifelong struggle with her mental health to childhood trauma and felt that she had symptoms of PTSD since returning to her hometown. Her risk of suicide continued during the psychotherapy which followed but she continued to engage well with psychotherapy and as the months progressed, this risk diminished.
	5. However, Hannah was experiencing escalating abuse and harassment from her ex-partner. Her father contacted the police who assessed Hannah as facing medium risk despite there being indications of high risk, but they made a safeguarding referral in view of her risk of suicide. She had told the police that she felt that her only way out of the abusive relationship was through suicide. Although the police investigated the harassment, they were unable to find enough evidence to prosecute.
	6. By July 2019, Hannah felt that her mental health issues were resolved, and she had started a new relationship. The psychotherapist wanted to keep Hannah in therapy for a period of stabilisation, but she was confident that she had support networks around her, and she was discharged from mental health services at her request.
	7. In 2019, a close family member died from a drug overdose, but it was nearly a year before Hannah came into contact with services again.
	8. In August 2020, Hannah self-harmed with a kitchen knife, causing wounds to both wrists which required sutures. She denied that this was a suicide attempt and declined mental health services. Sick notes were provided by her GP who appeared unaware of the discharge summary from the hospital.
	9. In January 2021, Hannah called the police to report that her partner was “smashing the house up”. When the police attended there was no sign of any damage and those present, which included one of Hannah’s friends, confirmed that it had been a drunken argument without violence. A domestic abuse risk assessment (DASH) was completed with Hannah who was assessed as facing standard risk from the domestic abuse. During the assessment she advised that she was not feeling depressed or suicidal and she declined victim support services.
	10. Aside from routine GP appointments, no other services were involved with Hannah before her death by suicide one year later.

# Key Findings

### Experiences of Abuse

* + 1. Hannah experienced abuse for most of her life. She disclosed that she had experienced childhood sexual abuse from one relative and physical abuse from two others. Her childhood was also impacted by living with domestic abuse. More recently, these experiences would be characterised as Adverse Childhood Experiences and left her vulnerable to domestic abuse, mental ill-health and alcohol misuse in adulthood.
		2. Hannah experienced domestic abuse in each of the three relationships that she had in recent times and benefitted from the trauma-informed therapy which she received. She was not always routinely asked about domestic abuse in health settings when she presented with self-harm, but improvements have been made to routine enquiry since and an Independent Domestic Violence Advisor is also now based within the Emergency Department and Domestic Abuse champions recruited across primary care.
		3. When her previous partner continued to harass her, it was not recognised that the harassment, combined with her vulnerability, meant that she was facing a high risk of harm and could have been considered for MARAC. The Police have since introduced the Domestic Abuse Risk Assessment (DARA) which has been shown to be more accurate in assessing risk. They have also delivered Domestic Abuse Matters Training to ensure that coercive control and its impacts are more widely understood and responded to effectively.

### Suicide and Domestic Abuse

* + 1. Hannah had attempted suicide when her previous relationship ended but her ex-partner continued to harass her. The relationship between domestic abuse and suicide is becoming better understood. Domestic abusers use coercive and controlling strategies that result in low self-confidence and self-worth, feelings of hopelessness, emotional exhaustion and entrapment amongst their victims who often see no way out.

**Learning Point: Suicide and domestic abuse**

Coercive control, isolation and entrapment are tactics used by perpetrators of domestic abuse which can lead to low self-worth, hopelessness, despair and suicide in their victims.

Women presenting to services in suicidal distress or after self-harm should always be asked about domestic abuse (*The Lancet, 2022*).

* + 1. Domestic abuse risk assessments need to incorporate the risk of suicide and vice versa and be accompanied by safety plans and safety netting, particularly where there are co-occurring conditions of domestic abuse, mental health and alcohol or drug misuse. The ‘Violent Resistance Timeline’ provides a tool for understanding and responding to the incremental escalation of risk towards suicide for victims of domestic abuse (Monckton-Smith et al. 2022).
		2. Cumbria have merged Professor Jane Monckton-Smith’s Suicide Timeline within the DASH Risk Assessment.

**Learning Point: Consider co-occurring conditions**

Research has shown that the intersection of domestic abuse, mental ill-health and substance misuse is often present in deaths by suicide (Woodhouse, 2022). Practitioners should pay particular attention to the suicide risk in cases where the co-occurring conditions are present.

* + 1. Although Hannah minimised her use of alcohol when questioned by professionals, it was noteworthy that her two suicide attempts were made when she was intoxicated.

**Learning Point: Alcohol, Domestic Abuse and Suicide**

Practitioners need to be aware that the risk of suicide could be eight times higher for someone who is abusing alcohol (Addictions UK). Women experiencing domestic abuse are at least three times more likely to be alcohol or substance dependent. Practitioners need to be enquiring about both suicide and domestic abuse when they suspect someone has issues with alcohol use.

* + 1. Hannah’s attempted suicide in 2018 followed her attendance at a friend’s funeral. There is some evidence to suggest that those who have known someone who has died by suicide may be at a greater risk of suicide themselves.
		2. Research undertaken by Kent and Medway Public Health using Real Time Suicide Surveillance (RTSS) data showed that 30% of all suspected suicides in their area over a three year period had been impacted by domestic abuse, either as a victim, perpetrator or child. Their local area recommendations can strengthen the response to suicide and domestic abuse and form the first recommendation.

### Domestic Abuse in LGBT+ Relationships

* + 1. Hannah’s risks of both suicide and domestic abuse were increased because she was a lesbian.

**Learning Point: LGBT+ victims of domestic abuse** are:

* More than twice as likely to self-harm
* Almost twice as likely to attempt suicide
* Twice as likely to have experienced childhood abuse by a family member
* Almost twice as likely to be abused by multiple partners (SafeLives,2018:7)
* Lesbian relationships are often characterised by relationships escalating in intensity quite quickly which is also an indicator of domestic abuse
	+ 1. These factors resonate with Hannah’s own experiences. Moreover, LGBT+ people do not face domestic abuse in isolation and she may have faced a lifetime of prejudice and discrimination resulting in a range of institutional, structural and interpersonal abuses, combining to create additional barriers to their help seeking and safety. LGBT+ people experiencing domestic abuse may be further isolated from support networks in more rural areas.

### Domestic Abuse and the Workplace

* + 1. As a Professional, Hannah may have experienced additional barriers to disclosure and help seeking for both her mental health and domestic abuse, fearing the potential impact upon her employment. Despite her employer actively encouraging staff to talk with them when they are experiencing domestic abuse, Hannah did not seek help from them. However, this may have been because her partner was also good friends with members of her team at work.
		2. Colleagues and managers are uniquely placed to help spot the signs of abuse and employers have a duty of care to consider the impact of domestic abuse upon their employees

**Learning Point: Workplace Support for Domestic Abuse**

Work colleagues and managers are uniquely placed to spot the signs of abuse. All workplaces should have dedicated domestic abuse workplace policies and practice guidance and offer a sanctuary and source of support for victims of domestic abuse.

# Recommendations

### Multi-Agency Recommendations

**Recommendation 1: Suicide and Domestic Abuse**

Cumbria Domestic Abuse Local Partnership Board (DALPB) to promote the connection between suicide and domestic abuse and work with Cumbria Suicide Prevention Leadership Group to jointly consider the recommendations for local areas promoted by the Zero Suicide Alliance, as follows:

* Include domestic abuse as an explicit priority within your local multi-agency Suicide Prevention Strategy.
* Work with domestic abuse commissioners to ensure that mental health and suicide prevention training is completed by all domestic abuse staff.
* Work with Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust to ensure that domestic abuse training is completed by all mental health staff
* Work with the Integrated Care Boards and Police to ensure that the local Real Time Suicide Surveillance-RTSS- system asks specific questions about domestic abuse including: victim, perpetrator, children; the type of abuse; whether current or former relationship.
* Review the availability of provision of recovery (including trauma aware elements) programmes for female and male victims of domestic abuse in the months and years after the abuse has stopped and consider prioritising resources when available to address any gaps identified
* Undertake a detailed analysis of RTSS and consider establishing suicide review panels
* Enable detailed data held by Mental Health Services to be analysed by the Suicide Prevention Leadership Group
* Consider revising risk assessments to ask the following questions of both the victim and the perpetrator: have you self-harmed? Have you felt suicidal? Have you made a suicide attempt? (and over different time periods). This is now in place.
* Ensure that local suicide bereavement services are trained / experienced in supporting families after the suicide of a domestic abuse victim or perpetrator (Adapted from Kent and Medway Public Health, 2022)

**Recommendation 2: LGBT+ Victims of Domestic Abuse**

Cumbria Domestic Abuse Local Partnership Board to:

* Continue to raise awareness with the public that domestic abuse can happen to anyone regardless of sexual orientation and/or gender identity and that services are available
* To ensure that Outreach Cumbria is fully integrated into the local operational and strategic responses to domestic abuse
* Seek evidence-based assurance from partner agencies that services are visible, accessible and responsive to the needs of LGBT+ victims

**Recommendation 3: Workplace Support for Domestic Abuse**

Cumbria Domestic Abuse Local Partnership Board should ensure that all its partner agencies have up-to-date, robust workplace domestic abuse policies that enable employers and colleagues to both support victims and deal with perpetrators of domestic abuse within their workforce.

**Recommendation 4: Panel Representation**

Cumbria Community Safety Partnership should ensure that specialists in suicide

prevention are included as panel members in all Domestic Abuse Related Death

Reviews involving suicide. This is now in place.

### Individual Recommendations

* + 1. **Cumbria Constabulary**
* to provide assurance to the Community Safety Partnership that there is consistency in submitting SAF reports
* To ensure a greater understanding of the domestic abuse risk assessment process to ensure risk is graded appropriately.
	+ 1. **Primary Care**
* To improve the new patient registration process in GP practices so that people with vulnerabilities are identified and offered appropriate support
* To increase the number of times that selective enquiry about domestic abuse is asked in primary care and ensure that this is considered in all relationships, regardless of gender or sexuality
* To enhance knowledge and skills about suicide prevention in primary care
* Clinicians need to take into account the impact of ACEs when undertaking assessments
	+ 1. **North Cumbria Integrated Care NHS Foundation Trust**
* To ensure that routine enquiry into abuse is carried out and recorded at every contact in the Emergency departments, where those accessing our services are asked:
* How safe do you feel?
* Do you have any caring responsibilities for anyone?
* Does anyone care for you on a regular basis?
* Are you open to any other health, social care or support services?
* That the trust considers training for emergency department staff on trauma informed care.
* That training on Domestic Abuse is offered to front line ED Staff
* Suggest move this so its not identifying she was a nurse That occupational health and partnership HR departments give due consideration to how Domestic Abuse affects their workforce, and a toolkit is developed to support employers to recognise and respond to domestic abuse

# Appendix 1: The Review Process

1. ***Summary***

The decision to undertake a domestic homicide review was made by the Chair of West Cumbria Safer Communities Partnership[[3]](#footnote-3) in consultation with affected agencies on 24.02.2022, and the Home Office was notified of the decision on 09.03.2022. An independent chair and review panel were appointed, and the review was managed in accordance with the relevant statutory guidance.

The review panel members are listed below and included representation from Victim Support who deliver domestic abuse services in the area. They provided expertise on domestic abuse and the broader ‘victim’s perspective’ to the panel. The panel further drew upon the expertise of the Suicide Prevention Lead from Cumbria County Council’s Public Health. The panel members were all independent of this case.

Terms of reference were drawn up and incorporated key lines of enquiry as featured below Agencies participating in this review are featured below as well as those who had no contact.

The review panel met on four occasions. The Independent Chair sought engagement with the victim’s family but they declined.

The Overview Report was endorsed by the Cumberland Community Safety Partnership in December 2023 before being submitted to the Home Office for approval on 28 November 2024.

1. ***Review Panel Members***

|  |  |
| --- | --- |
| Name | Role/Organisation |
| Paula Harding | Independent Chair |
| Alison Goodfellow | Cumbria County Council, Domestic Homicide Review Co-ordinator |
| Amanda Boardman | NHS North-East and North Cumbria Integrated Care Board, GP Lead for Safeguarding |
| Daniel Crooks | Cumbria County Council Adult Services,  |
| James Bailey | Cumbria Constabulary, Inspector |
| Kelly Marsden | North Cumbria Integrated Care NHS Foundation Trust,  |
| Sarah Edgar  | Cumbria Constabulary, Domestic Homicide Review Co-ordinator |
| Sarah Place | Operations Manager, Victim Support Cumbria Specialist Services including IDSVA Service  |
| Sheona Duffy | Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust,  |

1. ***Key Lines of Enquiry***

The review sought to address both the ‘generic issues’ set out in the Statutory Guidance, and the following specific issues identified in this particular case:

* **Individual Practice: How effective were agencies in identifying and responding to the needs and risks faced by Hannah?**

*Reflective Questions. In responding agencies are asked to consider:*

* *Providing a pen picture of how each agency saw Hannah*
* *Providing a summary of their agency’s involvement before the period in scope*
* *What knowledge did the agency have about the relationship between Hannah and her partner?*
* *What needs did the agency identify and how did they respond?*
* *How were decisions made and actions taken by agencies to reduce risk and prevent harm, including the follow-up of presentations of self-harm*
* *If domestic abuse was not known, how could the agency have identified the existence of domestic abuse from other issues presented to them? For example, were there policies and procedures for routine or selective questioning on domestic abuse and how well were they implemented in this case?*
* *What barriers to engagement did agencies face and how did they seek to overcome these barriers?*
* *How effective was management oversight?*
* *Did resource issues impact upon services offered?*
* *How the Covid-19 pandemic impacted upon agencies’ responses?*
* **How did agencies recognise and respond to issues of equality and diversity? Was there any evidence of unconscious bias in the assessments, decisions or services delivered?**
* **To what extent were services trauma-informed?**
* **Multi-Agency Practice: how effective were agencies in working together to prevent harm and to meet individuals’ needs?**

*Reflective Questions. In responding agencies are asked to consider:*

* *How roles and responsibilities were understood and multi-agency protocols adhered to?*
* *Was there a shared ownership and approach?*
* *How effective was the co-ordination of services?*
* *How effective was communication, information sharing and sharing records?*
* *How effective was escalation between agencies?*
* **What good practice can be identified?**
* **Improving services:**
* *what lessons can be learnt to prevent harm in the future?*
* *what recommendations are you making for each organisation and how will the changes be achieved?*
* *what system-wide, multi-agency recommendations do agencies consider need to be made?*

The following agencies were also requested to consider specific additional questions:

* For Hannah’s employer to also consider how, at the time, they provided opportunities for staff to disclose issues that may carry stigma, including domestic abuse and mental ill-health?
* Cumbria County Council Adult Services to analyse their responses to two notifications received by other agencies concerning Hannah in 2018 and 2019
* North-West Ambulance Service to analyse the contact the service had with Hannah in 2018, what information was shared in referrals to other agency, what was expected of the referral and what response received
1. ***Agency Involvement in the Review***

Agencies were asked to provide chronologies, information reports or Individual Management Reviews, dependent upon their degree of involvement as follows:

Individual Management Reviews and chronologies were requested from the following organisations:

* Cumbria Constabulary
* Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
* North-East and North Cumbria Integrated Care Board (for primary care)
* North Cumbria Integrated Care NHS Foundation Trust

The following agencies were asked to provide briefer information reports and chronologies

* Cumbria County Council Adult Services
* North-West Ambulance Service

The following agencies were contacted but confirmed that neither Hannah nor her partner were known to them, or that their involvement was not relevant to this review:

* Allerdale Borough Council
* Cumbria County Council Children’s Services
* Probation Service
* Unity Drug and Alcohol Recovery Services (Greater Manchester Mental Health NHS Foundation Trust)
* Victim Support
1. For redaction: Domestic Homicide Review [↑](#footnote-ref-1)
2. Pseudonym [↑](#footnote-ref-2)
3. Cumberland Community Safety Partnership took over the role of West Cumbria Community Safety Partnership on 01.04.2023 [↑](#footnote-ref-3)