FENLAND
Community Safety
Partnership

Domestic Abuse Death Review

Executive Summary

Deceased Barry (55 years)

Died: September 2020

Independent Panel Chair and Author: Dr Russell Wate QPM
(August 2021)

1. The Review Process

1.1 This summary outlines the processes undertaken by Fenland Community Safety Partnership Domestic Homicide Review Panel in reviewing the tragic death of Barry, who was a resident in their area. This review focusses on his death, after he was found at his home address in a town in Fenland in late September 2020, having, as it transpired, taken his own life.

1.2 Pseudonyms are used in this executive summary to protect the identity of the deceased and his ex-partner Sally and estranged wife Christina. Barry, a pseudonym chosen by his family, was at the time of his death 55 years old. He had been married for almost twenty years to Christina, a pseudonym she chose, and although they were not divorced, he was not in a relationship with her, 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. He had in the past 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 described by others as someone who was easy going and happy. Barry though ,was also described by his family as a troubled man, often feeling depressed, frustrated and angry, this went on for most of his life with him suffering, 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 Sally was in a 16-month relationship with Barry until there was a domestic abuse incident in August 2020, when she says they split up as a couple, but kept in contact until he died.

1.4 Officers from Cambridgeshire Constabulary were called to Barry's address by Sally at 11.18pm in late September 2020, as 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.

1.5 The death was reported to HM Coroner and the inquest was opened in October 2020, with an intention to conclude the inquest process later in 2021.

1.6 The Domestic Homicide Review (DHR) process began with Cambridgeshire Constabulary on 6th November 2020, notifying the Chair of the Fenland Community Safety Partnership (FCSP) that the death of Barry was being investigated as suicide, it was confirmed that a DHR would be undertaken. The review was commissioned and the Independent Chair and Author appointed in November 2020. Agencies that had involvement with Barry, Sally and their

families were identified and contacted and asked to contribute to the DHR by way of compiling an Individual Management Report (IMR) or by providing information. Nine agencies have contributed to the DHR.

2.Contribution to the DHR Process

2.1 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)

2.2 All the agency IMR authors are independent of any involvement in the case, including management or supervisory responsibility for the practitioners involved.

3. The Review Panel Members

3.1 DHR 2020 Review Panel Members.

Independent Overview Report Author / Chair Support to Chair	Russell Wate Ian Tandy
Cambridgeshire Constabulary	Jenny Brain
North West Anglia Foundation Trust	Sam Hunt
CCC Children's Early Help	Ellen Tranter
Independent Safeguarding Partnership	Dave Sargent
Domestic Abuse SV Partnership IDVA Services	Vickie Crompton
Cambridgeshire and Peterborough CCC	Helen Duncan (Corresponding)
Refuge (Service Manager)	Mandy Geraghty
CCG and Primary Care	Linda Coultrup
Cambridgeshire and Peterborough NHS Foundation Trust (Mental Health Advisor)	Paul Collin

FCSP/ FDC	Alan Boughen
Suicide Advisor	Dr Kathy Hartley
Substance Misuse Advisor	Selina White (Corresponding)

3.2 A total of five meetings were held with the review panel. The first was to consider the information received and agree that a DHR was appropriate and to consider the Terms of Reference and set time frames. The second panel meeting saw the presentation of the IMR/Summary reports and discussed the findings and the third panel meeting was to present the draft Overview Report and ensure that it fairly represented the information of the agencies that had contributed. The fourth and fifth were to agree any proposed changes to the report. The family of Barry were contacted consistently throughout the process to establish their views.

4. Chair and Author of the Overview Report

4.1 Dr Russell Wate QPM is a retired senior police detective. He is currently the Independent Scrutineer of the Cambridgeshire and Peterborough Safeguarding Children and Safeguarding Adults Boards. 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. Dr Wate has authored several national publications, contributed to several specialist publications, in particular concerning the investigation of child deaths and homicide. He has no connection with the Fenland Community Safety Partnership other than previously providing professional and independent services in connection with three previous DHRs.

5. Terms of Reference for the Review

5.1 The following Terms of Reference were agreed by the chair and the panel:

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) 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?

6. Background Information

6.1 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 agreed that he often talked about suicide and had threatened this in the past and that they had always urged Barry to seek specialist professional help, but he didn't appear to them to have done so. Both Christina and Sally told the panel chair that they had also constantly asked Barry to go and seek help.

6.2 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 losing consciousness for a few seconds. At the hospital Barry was very agitated, he was intoxicated but he calmed down after treatment. The pain from his head injury stayed with Barry for many months causing him distress.

6.3 In October 2019, Barry attended his GP practice with low mood and this was thought by the GP due to Barry stopping his Sertraline[1] of his own accord five months earlier. He had been on a high dose of this in the past.

[1] 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)

6.4 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.

6.5 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 she stated that she could not remember what had happened, but she did not believe Barry would have deliberately assaulted her and she would 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

6.6 Sally had been in the past 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 on who might be at risk from her violent behaviour.

6.7 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 is available. There was no enquiry into who she had the argument 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.

6.8 On the 20th 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[2] was added in for this mood with a review at the beginning of June 2020. The review found him doing okay, and if anything, slightly better.

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

6.9 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.'*

6.10 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.

6.11 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 had been 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.

6.12 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 and wanted help.

6.13 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[3].

6.14 Sally attended the emergency department on the 20th 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.

6.15 Sally was contacted by the police after the incident and claimed that she had broken her wrist, so the allegation against Barry became the more serious offence and the injury needed verifying.

6.16 Towards the end of August 2020, Barry was contacted by IDVA in relation to the assault on the 19th of August and Barry confirmed that he knew he needed to contact DV Assist[4] if the ex-partner's presumed bail conditions were breached. There were however no bail conditions as Sally had been released under investigation so that DV Assist could have moved forward with an injunction at that time anyway. Barry confirmed no incidents had recently taken place as he wasn't going out due to his poor health.

6.17 On the 30th 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 (she was in fact released under investigation) 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.

6.18 In this assault, in the early hours of the morning, Barry had called the police, reporting that Sally was shouting at him and 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.

6.19 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.*

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

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

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'.

6.20 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 was part of a pattern of the criminal behaviour directed towards him by Sally.

6.21 This assault was not linked to the one on 19th 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.

6.22 On 3rd September, the 30th 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.

6.23 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 her alleged broken wrist. The earlier August 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.

6.24 Barry was eventually spoken to, following a delay of three weeks. 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.

6.25 These comments are regarded by the police IMR author as a particular 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. To support her claims, she said that If one was being alleged, why hadn't the police spoken to her about it.

6.26 The tragic events of late September 2020 have already been documented within this report.

6.27 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. Over six weeks later, and after his death on 3rd November, the IDVA service were still unaware that Barry had died as 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.

7. Summary Chronology

7.1 The chronology of contact and services provided covers a 20-month period and is detailed for the relevant timescales between 1st February 2019 and 23rd September 2020. These dates were selected as it is 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.

8. Key Issues Arising from the Review / Lessons Learned

8.1 Research of police systems identified three recent Domestic Abuse incidents in 2020 between Barry and Sally. The first was in February 2020 where initially Barry was the suspect and Sally, the victim. She 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 Barry was the victim and Sally the perpetrator. These two separate investigations were still not completely finalised at the time of Barry's death.

8.2 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 an older brother contacted the police to check on him. Christina, Sally and other family members told the panel chair that there were numerous occasions when Barry mentioned to others his suicide ideation.

8.3 Barry stated to the attending police officer on the 30th 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.

8.4 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 attended a counselling session with him,

but Barry refused to talk freely with the counsellor and the session and further sessions were cancelled.

8.5 There are five learning themes arising from this review:

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

8.6 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 the updated strategy includes specific mention of DA and what is needed for professionals to consider locally.

8.7 In 2019 Professor Jane Monkton-Smith and the University of Gloucestershire published research titled the Homicide Timeline. It stated [5] *'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

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

Homicide - the perpetrator kills his or her partner, and possibly hurts others such as the victim's children

8.8 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.

9. Conclusions

9.1 The purpose of this review is not to stray into the Coroner's role in determining Barry's cause of death. However, this review is about Barry, and his suicide, which was probably brought about by him suffering DA. His family have told the panel chair that throughout most of his adult life he did often have 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 himself 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, 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*'. It is therefore safe to say that this review process has identified that DA and suicide are inextricably linked in Barry's life.

9.2 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

9.3 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 for which he was a victim, reported eleven days apart during August 2020. Although Barry had told the 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, but 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.

9.4 The findings of this review have identified learning in the two investigations for which Barry was a victim. 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 she was already under investigation for the earlier August offence, a charging decision by CPS for the assault on 30th August could have been possible. The service that Barry received from Cambridgeshire Constabulary in August and September were certainly one of the missed opportunities.

9.5 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.*

9.6 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.

9.7 Issues around identifying and supporting male victims are common and this is an area that specialist services need to consider further. The Respect Toolkit for working with male victims is a resource that may be helpful.

> *'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 early 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 have 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 will focus on Male Victims, with a presentation by Respect.'*

9.8 There were no issues of disability, diversity, culture, or identity revealed during the reviewing process.

10. Recommendations

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 individuals life. (The Cambridgeshire and Peterborough Safeguarding Partnership have already developed a briefing paper which could be used or adapted[6]).

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

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,
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.