SAFER Cheshire East Partnership

Domestic Homicide Review

Executive Summary for the death of Emma November 2021

Parminder Sahota: Independent Chair and Author
Completed: 27 April 2023

Preface

The Independent Chair and Review Panel send their deepest condolences to all those impacted by Emma's (pseudonym) untimely death and thank them for their involvement and support in this process.

The primary objective of a Domestic Homicide Review (DHR) is to permit the learning of lessons from the death of a person in a relationship where domestic abuse was known to have occurred. Professionals must understand the events in each instance to fully and effectively absorb these lessons and identify the necessary changes to reduce the probability of domestic abuse-related deaths.

The chair thanks the panel and persons who submitted chronologies and materials for their time and cooperation.

"Emma was bubbly and confident and always there for everyone."
Sarah

"*Emma was fun-loving, bubbly, kind and caring, and he stated she was my best friend."*
Toby

"Emma was bubbly and lucky and would talk about college, excited about her future."
Laura

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Section One: the Review Process

1.1.1 Introduction and Agencies Participating in the Review

1.1.2 The summary outlines the procedures the Safer Cheshire East Partnership (SCEP) took to review the death of Emma, who died in November 2021; she was a thirty-year-old White British female resident of Cheshire.

1.1.3 The following pseudonyms have been used in the review, as approved by Emma's ex-partner:

- The victim: Emma
- Eldest Child: Child A, eleven years old
- Middle Child: Child B, eight years old
- Youngest Child: Child C, six years old
- Ex-Partner: Scott
- Sister: Laura
- Friend: Jean
- Friend: Toby
- Friend: Rebecca
- Paternal aunt: Kirsty
- Ex-Boyfriend: Ian

1.1.4 Emma was discovered deceased by Scott–pseudonym at her home address.

1.1.5 The coroner's office confirmed that the coroner would likely set a date for the inquest once the domestic homicide review (DHR) was complete.

1.1.6 SCEP commissioned the DHR on 20 April 2022, following the Multi-Agency Statutory Guidance for Domestic Homicide Reviews (2016).[1]

1.1.7 The independent chair was commissioned on 1 August 2022. Safer Cheshire East Partnership approved the completed report on 27 April 2023.

1.1.8 The panel convened for the first time with the chair on 12 October 2022. The review panel received its final feedback on 12 April 2023.

1.1.9 The review exceeded the six-month deadline outlined in the statutory guidance. The reason for this was as follows:

[1] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

- The Local Authority must implement a procurement process to appoint an independent chair and author. The commencement of the Review is delayed until this process is completed, which necessitates a certain amount of time.
- The necessity to reconcile agency demand and the number of current reviews.
- The coroner was asked to furnish the council with material that would enable them to understand Emma's history comprehensively.
- Emma's family was granted additional time to review the report and provide and receive feedback.

1.1.10 SCEP informed Scott, Emma's ex-partner and father to their three children, about the review and the process for participating in a letter dated 16 September 2022. The chair contacted Scott via telephone, and he provided details of Emma's family and friends.

1.1.11 Scott and Laura, Emma's sister, approved the terms of reference. The chair contacted Kirsty, Emma's paternal aunt and three of her friends, Jean, Toby and Rebecca. Emma's mum was contacted via phone and letter; however, no response was received.

1.1.12 Scott and Laura were provided with a copy of the overview report and encouraged to provide feedback. The report was appropriately modified in response to their feedback.

1.1.13 The following agencies and independent panel members contributed to the review:

Name	Role	Organisation
Jill Broomhall	Director Adults Social Care	Cheshire East Council
Richard Christopherson	Locality Manager – Community Safety	Cheshire East Council
Sandra Murphy	Head of Adult Safeguarding	Cheshire East Council
Emma Storey	Domestic Abuse & Sexual Violence Development Lead Advisor	Cheshire East Council
Nicky Brown	Detective Constable Review Officer	Cheshire Constabulary
Sarah Martin	Associate Director of Safeguarding	NHS Cheshire Clinical Commissioning Group
Bev Wrighton	Operations Manager	My CWA (Cheshire Without Abuse)
Lindsay Ratapana	Designated Nurse – Adult Safeguarding	NHS Cheshire and Merseyside Integrated Care Board (ICB)
Sara Scott	Head of Safeguarding	Cheshire and Wirral Partnership NHS Foundation Trust
Veronica Clarke	PA to Jill Broomhall, Director of Adult Social Care	Cheshire East Council
Kathryn Royal (joined the panel following the 1st overview draft report)	Research Officer	Surviving Economic Abuse

1.1.14 Parminder Sahota, an independent reviewer with eleven years of experience in Safeguarding and Domestic Abuse, completed DHR Chair training from Advocacy After Fatal Domestic Abuse in 2021.

1.1.15 She had been employed as a Mental Health Nurse in the NHS for more than two decades, with a particular emphasis on crisis work and working with individuals diagnosed with personality

disorders. She was also the Director of Safeguarding and the Prevent and Domestic Abuse Lead for an NHS Trust in London.

1.1.16 Before this review, Parminder Sahota had no contact with the family members. She is independent of the Safer Cheshire East Partnership and participating agencies.

1.2.1 The Purpose and Terms of Reference

1.2.2 The statutory guidance sets out the purpose of domestic homicide reviews to:

- Establish the facts that led to the death in November 2021 and whether any lessons can be learned from the case about how local professionals and agencies worked together to safeguard Emma.
- Establish what lessons will be learned from the death regarding how local professionals and organisations work individually and together to safeguard victims.
- Identify these lessons, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change.
- Apply these lessons to service responses, including changes to inform appropriate national and local policies and procedures.
- Prevent domestic violence and related deaths and improve service responses for all domestic violence and abuse victims by developing a coordinated multi-agency approach to identify and respond to domestic abuse at the earliest opportunity.
- Contribute to a better understanding of the nature of domestic abuse.
- Highlight good practice.
- Ensure that Emma’s voice is heard regarding her lived experiences and the impact of the domestic abuse on her mental health. Allowing her journey to be told and identifying the lessons that may be learnt.

1.2.3 The review assessed Emma's final years (March 2019–November 2021) to identify any history of abuse, access to community support, and obstacles faced in obtaining that support. The goal was to develop strategies to reduce the risk of deaths related to domestic abuse.

1.2.4 The panel agreed on fifteen terms of reference for this case.

Section Two: Background, Agency Contact and Evidence of Domestic Abuse

2.1.1 Background

2.1.2 Emma was one of seven siblings, with her mum having four children from a previous relationship. After six months together, Emma's siblings moved to their father's home, leading to minimal contact. Emma and her two sisters, including Laura, were raised by her parents, who lived outside Cheshire.

2.1.3 Emma's childhood was unstable due to her dad's heroin addiction and his domestic abuse towards her mum. Despite the abuse and her troubling experiences, including visiting crack homes, Emma defended and loved her dad and viewed the experiences as the norm. Laura believed that children's services, which were aware, should have intervened but left them in a dangerous environment.

2.1.4 Emma was accommodated in supported housing at fifteen or sixteen after telling her mum about her stepfather's abuse, prompting her mum to tell her to leave.

2.1.5 Emma and Scott met in 2009 and have three children. Following their separation in 2019, Scott maintained an active role in their children's lives and remained close friends.

2.1.6 Emma moved to Cheshire in 2009 to be closer to her dad, with whom she maintained a close relationship and who would offer her emotional support. In 2019, her dad died by suicide. Emma's family and friends reported that she continued to experience prolonged grief until her death in November 2021.

2.1.7 Emma met Ian in 2019; he relocated to Cheshire to live with her and her three children.

2.1.8 Emma's family and friends were aware that she would self-harm, a behaviour that had intensified since her dad's death. They urged her to seek support from services, and she would inform them that she had seen her and discussed this with her GP and was prescribed antidepressants.

2.1.9 Two days before Emma died, her cat was fatally injured, and she informed Ian that she required solitude. However, Emma’s family reported Ian went out drinking and inundated her with abusive messages, which prompted her to block him and end the relationship.

2.1.10 Emma agreed that Ian should spend the night in her shed as he had no alternative accommodation. She left the shed key outside for him to use and explicitly stated that he could not access the house.

2.1.11 Ian returned to Emma's home in the early hours of the morning the day before she died. He used a ladder to climb into the bathroom, entered Emma's bedroom, and was reportedly aggressive. Emma contacted the police to report that Ian had broken into her home.

2.1.12 The police arrested Ian for harassment and possession of a bladed article after they located him in the shed with a knife among his possessions. The following day, he was released on police bail, with the condition that he does not contact Emma or visit her home.

2.1.13 The children were with Scott as scheduled, and Emma met with her friend the evening before she died.

2.1.14 Ian contacted Scott on the day Emma was discovered deceased, as he conveyed concern about his inability to contact her. Scott arrived at Emma's home and found her deceased.

2.2.1 Agency Contact

2.2.2 Emma received input from the following agencies during the period under review:

1. Cheshire and Wirral Partnership Foundation Trust Liaison Psychiatry
2. GP Practice
3. Leighton Hospital, Emergency Department
4. Police
5. School

2.2.3 In March 2019, Emma reported to the police that a female individual, who was wearing an electronic monitoring tag, was at her door, threatening to harm her and damage her vehicle. Emma described the female as "obsessed" with her and reported that they had previously argued about the female's former partner. The female was arrested for a public order offence. The female had made a false claim that Scott assaulted Emma, and Emma had assaulted her children. The outcome was no further action, and Emma was satisfied with this.

2.2.4 Cheshire and Wirral Partnership Foundation Trust, Liaison Psychiatry assessed Emma in June 2019 after she visited the Emergency Department (ED) at Leighton Hospital because of a self-harm incident.

2.2.5 The risk of suicide was assessed by liaison psychiatry, which determined that the self-harm was a reaction to her dad's death the week prior. Emma cited her children from her previous relationship and her positive relationship with her boyfriend of a few months as protective factors.

2.2.6 She was referred to Change Grow Live[2] (CGL) for alcohol support, and the Mental Health Re-Enablement Team[3] at Cheshire East Council: Adult Social Care (ASC) for financial assistance. The mental health re-enablement team supports individuals with goal planning, self-esteem, social inclusion, and coping. It also includes housing, debt, social clubs, and volunteering support.

2.2.7 CGL discharged Emma due to their inability to communicate with her.

2.2.8 ASC conducted three home visits but received no response. They sent Emma a letter to encourage her engagement but did not receive a response, so they closed her to the service.

2.2.9 Psychiatry contacted the school nurse to enquire about the children's welfare, and the assessment was shared with them and Emma's GP. Emma was informed about the Well-Being Hub[4] (talking therapies) and DOVE bereavement counselling.[5] She was subsequently

[2] https://www.changegrowlive.org/drug-alcohol-service-cheshire-east/crewe
[3] https://www.cheshireeast.gov.uk/livewell/living-independently/homecare/reablement.aspx
[4] https://livewellservices.cheshireeast.gov.uk/Services/5576/The-Wellbeing-Hub-I
[5] https://thedoveservice.org.uk/

discharged from Cheshire and Wirral Partnership Foundation Trust and had no further contact with Emma.

2.2.10 No information was provided to the panel to confirm that Emma had contacted bereavement services.

2.2.11 In November 2019, North West Ambulance Service contacted the police to report that Emma had consumed alcohol and drugs and might need their assistance. She was taken to the ED by ambulance; no police intervention was required. Emma did not wait to be seen at the ED, prompting the staff to call the police. Police contacted her the next day, and she expressed her intention to visit her GP.

2.2.12 Emma told her GP she took seven aspirin due to anxiety about her dad's inquest. She received antidepressants and reported she had a supportive partner. The practice referred her to Children's Social Care (CSC) for a welfare check, and no immediate safety concerns for the children were found.

2.2.13 CSC informed the children's school of the above, and they subsequently engaged in a conversation with the children to discuss their wishes and feelings, a toolkit to encourage them to express their thoughts, feelings, and experiences. No issues were identified.

2.2.14 The school continued to support the children using the toolkit and conducted home visits during the COVID-19 pandemic.

2.2.15 Emma continued to experience symptoms of depression following her dad's death. In October 2021, she disclosed this information to her GP and initiated a trial of antidepressants. She reported that she had increased her medication dosage to good effect, as she had found it beneficial, and her last visit to her GP was nine days before her death.

2.2.16 The school contacted Emma three days before her death about child B's lateness. She was offered free access to the breakfast club, and they discussed arranging a meeting to discuss punctuality support.

2.2.17 Emma's cat was hit by a car two days before her death. She called Scott to say Ian had not paid the vet bill, forcing her to use her Christmas savings. The children did not attend school. The school contacted Emma and informed them they had received distressing news. The family link worker called Emma and left her a message.

2.2.18 The children did not attend school the following day, and Emma advised the school that they were still processing the news. The family link worker attempted to call Emma but received no response.

2.3.1 Evidence of Domestic Abuse

2.3.2 The school completed the feelings and wishes toolkit with Child A and B in March 2020. Child A reported that Ian was *"not very nice; he ignores me*." Child A was recommended for the next steps of intervention, and the school agreed to continue monitoring the children.

2.3.3 In November 2020, Emma sought police help to remove Ian from her home, feeling vulnerable and fearful due to his controlling behaviour, where he limited her time with family and demanded her attention. Emma reported they had both been drinking; however, she was dissatisfied with the relationship and had difficulty ending it.

2.3.4 Emma declined to make a complaint about the controlling and coercive behaviour, believing their relationship would last since there was no violence. The police completed a Vulnerable Person Assessment[6] (VPA), which was recorded and recorded. Emma repeatedly said, *"You have to see it to believe it,"* but offered no details, expressing difficulty ending the relationship.

2.3.5 Ian stated Emma called the police out of spite and was experiencing mental health issues. Emma reported suicidal ideation and depression after completing the domestic abuse, stalking and 'honour'- based abuse risk assessment[7] (DASH), a standard risk was identified, with no further references to domestic abuse or controlling and coercive behaviour. Referrals were made to Cheshire CARES[8] (enhanced support for victims to cope and recover from crime) and CSC.

2.3.6 CSC notified the school of the above. They completed the toolkit, and Child C described Ian as "Angry; he is unkind to me. He keeps shouting, and when I ask for a cookie, I say, "Please," and he says no. Mummy—She cuddles me." The school shared the information with CSC.

2.3.7 In August 2021, Emma told her friend Toby that Ian was becoming controlling and obsessive after cheating on her and installing an Alexa, hallway and bedroom cameras, and a Ring doorbell. Toby discussed the cameras with Ian and noted that while Ian was a gadget enthusiast, Emma was unfamiliar with these devices.

2.3.8 Emma told Toby she had ended the relationship with Ian.

2.3.9 Emma phoned the police the day before her death after her ex-boyfriend broke into her home. The police conducted a DASH risk assessment and referred her to the domestic abuse hub.

Section Three: Key Issues

Coercion and Control

3.1.1 Victims/survivors or agencies do not always recognise coercion and control and the tactics used in this. The offence of controlling or coercive behaviour is defined under Section 76 of

[6] https://www.cheshire.police.uk/SysSiteAssets/media/downloads/cheshire/hyg/sharing-assessments-about-vulnerable-people.pdf
[7] https://safelives.org.uk/resources-for-professionals/dash-resources/
[8] https://www.cheshire-pcc.gov.uk/support-for-victims/cheshire-cares/

the Serious Crime Act 2015.[9] Consequently, the statutory guidance for coercion and control[10] must be implemented with a focus on the identification of the offence.

3.1.2 Coercion and control is referenced in Part 6 of the Domestic Abuse Act 2021,[11] thus emphasising the need for agencies to be aware of this as domestic abuse. Women's Aid[12] emphasises that domestic abuse is not always physical, as is commonly believed by victims/survivors. Coercive control is an assault, threat, humiliation, intimidation, or abuse designed to damage, punish, or intimidate the victim. This controlling behaviour is intended to make a person reliant by isolating them from assistance, exploiting them, robbing them of independence, and dictating their daily behaviour.

3.1.3 Controlling and coercive behaviour is a high-risk factor and is highlighted in the suicide and homicide timeline. It is, therefore, essential to identify this critical risk factor and empower victims/survivors with the understanding that coercion and control is a crime and to improve the collective response of agencies that engage with victims/survivors.

Self-Harm and Domestic Abuse

3.1.4 Emma had one ED visit following self-harm; she was assessed by psychiatry, and the self-harm was viewed as a response to her dad's recent death. At this assessment, Emma reported a positive relationship with her partner. Emma's family and friends reported there had been additional instances of self-harm, which they believed she had sought help for.

3.1.5 Self-harm is a behaviour that some people employ to cope with internal anguish. According to research, there is a link between domestic abuse and self-harm. In addition, females who had separated from their partners were more prone to taking overdoses.[13]

3.1.6 The NICE guideline recommends that individuals who present with comparable symptoms to Emma receive routine enquiries regarding domestic abuse. The review determined that Emma had described her partner in a positive light during the presentation to ED and the subsequent psychiatric assessment. Furthermore, she had communicated the same to her GP. Therefore, the enquiry may not have felt appropriate.

Familial Suicide

3.1.7 Parental suicide has been linked to increased suicide and suicide attempts.[14] Emma's dad's death was a substantial risk factor, and according to her family and friends, she felt lost without him. Psychiatry had notified Emma of bereavement counselling, and her GP had prescribed anti-depressant medication.

[9] hhttps://www.legislation.gov.uk/ukpga/2015/9/section/76
[10] https://assets.publishing.service.gov.uk/media/642d3f9e7de82b001231364d/Controlling_or_Coercive_Behaviour_Statutory_Guidance_-_final.pdf
[11] https://www.legislation.gov.uk/ukpga/2021/17/part/6/crossheading/controlling-or-coercive-behaviour
[12] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/coercive-control/

[13] Dalton TR, Knipe D, Feder G, et al Prevalence and correlates of domestic violence among people seeking treatment for self-harm: data from a regional self-harm register emergency Medicine Journal 2019;36:407-409.
[14] https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/offsprings-risk-for-suicidal-behaviour-in-relation-to-parental-death-by-suicide-systematic-review-and-metaanalysis-and-a-model-for-familial-transmission-of-suicide/C450526CAF5F329AF48E656660DEB6A7

3.1.8 Emma informed her GP in November 2021 that she had increased her antidepressant medication and continued to be affected by her dad's death, which occurred in May 2019. The record did not contain any discussions regarding bereavement counselling or whether she had independently accessed it.

3.1.9 Cheshire and Merseyside have issued their suicide prevention strategy[15] (2022-2027), which addresses several risk factors, such as family-related difficulties. Locally conducted workshops to raise awareness of suicide, risk factors, and how to make the community safer were part of the strategy.

Section Four: Conclusion

4.1.1 The purpose of the review is to determine the circumstances behind the death of Emma in November 2021 and 'articulate life through the eyes of the victims.'[16]

4.1.2 Emma was a single parent of three children, and their father, Scott, continued to provide and care for them. Since 2019, Emma has been in a relationship with Ian.

4.1.3 Emma experienced a challenging childhood; her dad had a heroin addiction, and she and her siblings frequently accompanied him to crack houses. The siblings also observed domestic abuse that her dad inflicted on their mum.

4.1.4 Emma attended three primary and two high schools; however, she was frequently absent due to her parent's inability to take her to school. The children remained in the family home, though the children's social care was aware of her and her siblings and the home environment. Consequently, Laura and her siblings lost confidence in the organisations that were supposed to protect them, as they were left in an unsafe environment.

4.1.5 Emma was forced to leave home at fifteen or sixteen after her mum learned about her stepfather's physical abuse. Emma's mum disbelieved her and instructed her to leave.

4.1.6 Emma's friends and family all felt that her dad's passing in 2019 was a significant risk factor for her. Emma kept her dad's ashes because she wanted to be buried with them and felt lost without him. Her friends and family had encouraged her to seek support.

4.1.7 Emma's friends described her as sociable, but after her dad died and with the lockdown, she spent more time at home and was isolated. Following her dad's death, her family and friends also observed an increase in her self-harm. Emma informed her friend, Kirsty, that she had discussed self-harm with her GP. The GP, however, did not have a record of this.

4.1.8 A report exploring the impact highlighted isolation as a significant risk factor for victims of domestic abuse and the lack of face-to-face contact.[17] A study also discovered that restrictions kept victims in abusive situations and that partner and family abuse worsened. In addition, the

[15] https://champspublichealth.com/wp-content/uploads/2022/11/Suicide-Prevention-Strategy-2022-2027-compressed.pdf
[16] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf
[17] https://www.womensaid.org.uk/wp-content/uploads/2021/11/Shadow_Pandemic_Report_FINAL.pdf

lockdown permitted the perpetrators of domestic abuse, controlling, and coercive behaviour to increase or hide their abuse.[18]

4.1.9 Laura, Emma's sister, observed that Emma would seek emotional support from her dad; however, his death rendered this support obsolete. The lockdown further exacerbated Emma's isolation, which diminished her opportunities to interact with others and remained in the house with her children and Ian. School staff visited the family at their doorstep following the lockdown regulations.

4.1.10 Emma had told her friends and family about Ian's relationship, describing him as controlling and verbally aggressive. She had instructed him to leave but let him stay in the shed because he had nowhere else to go. However, he continued interacting with her via Alexa and monitored her coming and going from the house via the Ring doorbell. She was encouraged to seek support from her family and friends, but they were unaware of any additional ways in which they could intervene or provide support.

Section Five: Recommendations

5.1.1 Recommendation One: Coercion and Control

Cheshire Police

1.a Cheshire police to implement training for officers focused on recognising indicators of coercion and control, as well as ensuring adherence to domestic abuse risk assessments for all victims and survivors of domestic abuse.

Cheshire Police, Cheshire and Wirral Partnership Foundation Trust Liaison Psychiatry, GP Practice, Leighton Hospital, Emergency Department, and My CWA

1.b To provide their staff access to the review to facilitate their responses and raise awareness of the use of coercion and the various strategies employed by perpetrators. With a particular emphasis on the mental health of the victims/survivors being targeted by perpetrators and the significance of coercion and control within the homicide and suicide timeline.

Safer Cheshire East Partnership (SCEP)

1.c SCEP to collaborate with victims/survivors of domestic abuse to create awareness campaigns/resources that highlight and address the realities of coercion and control.

5.1.2 Recommendation Two: Self-Harm and Domestic Abuse

Safer Cheshire East Partnership (SCEP)

[18] https://www.ukri.org/about-us/how-we-are-doing/research-outcomes-and-impact/esrc/how-the-covid-19-lockdowns-affected-the-domestic-abuse-crisis/#:~:text=Key%20findings%20and%20recommendations&text=domestic%20abuse%20problem-,restrictions%20kept%20victims%20in%20abusive%20relationships%20for%20longer,partner%20and%20family%20abuse%20increased

2.a SCEP and DAFSU to develop supplementary guidance to the DASH risk assessment for risks associated with suicide.

Cheshire Police, Cheshire and Wirral Partnership Foundation Trust Liaison Psychiatry, GP Practice and Leighton Hospital Emergency Department

2. b When self-harm or suicidal ideation is identified in individuals experiencing domestic abuse, services should have established protocols/resources to support the response to the disclosure. This may include facilitating referrals for the victim/survivor or making referrals on their behalf. Additionally, it is essential to consider reporting victims/survivors to MARAC and obtaining guidance for those who do not consent to domestic abuse agency referrals.

5.1.3 **Recommendation Three: Familial Suicide**

Public Health

3.a. Continue to deliver training on the suicide strategy and raise awareness of the risks that may lead to suicide.

Cheshire Police, Cheshire and Wirral Partnership Foundation Trust Liaison Psychiatry, GP Practice and Leighton Hospital Emergency Department

3. b. To identify familial suicide as a risk factor for self-harm and suicide and to share the assessment/information with appropriate partners to facilitate a coordinated response.

Cheshire and Wirral Partnership Foundation Trust Liaison Psychiatry, GP Practice and Leighton Hospital Emergency Department

3. c. To provide accessible information on support services to at-risk people and identify potential barriers to accessing support.