South Nottinghamshire Community Safety Partnership
Working together to make Broxtowe, Gedling and Rushcliffe Safer

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Domestic Homicide Review Report

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Review into the death of Chloe
in August 2020

Chair: Gary Goose MBE
Report Author: Christine Graham
February 2023

Preface

The South Nottinghamshire Community Safety Partnership and the Review Panel wish at the outset, to express their deepest sympathy to Chloe's family and friends.

This review has been undertaken in an open and constructive manner, with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of this incident in a meaningful way and address, with candour, the issues that it has raised.

The review was commissioned by the South Nottinghamshire Community Safety Partnership on receiving notification of the death of Chloe in circumstances that appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

This overview report has been compiled as follows:

Section 1 begins with an **introduction to the circumstances** that led to the commission of this review, and the process and timescales of the review.

Section 2 **sets out the facts** in this case, **including a chronology** to assist the reader in understanding how events unfolded that led to Chloe's death.

Section 3 looks in detail at **agency involvement.**

Section 4 explores the **evidence of domestic abuse.**

Section 5 analyses **suicide and domestic abuse.**

Section 6 brings together **other issues considered.**

Section 7 sets out the **lessons identified,** and **Section 8** brings the **recommendations** together.

Section 9 draws together the **conclusions.**

Appendix One provides the **terms of reference** against which the panel operated.

Appendix Two sets out the **ongoing professional development** of the Chair and Report Author.

Where the review has identified that there was an opportunity to intervene, this has been noted in a text box. Examples of good practice are highlighted in italics.

Contents

Section One – Introduction

1.1 Summary of the Circumstances Leading to the Review

1.1.1 Chloe was a young woman, only 33 years old, when she died in August of 2020. She was a mother of two children and had been in a relationship with the youngest child's father, George, since July 2017. At the time of Chloe's death, they had separated but were still in contact, as they shared parental responsibility for their child.

1.1.2 Only two days before she died, Chloe reported that she had argued with George after he came to her home. He became angry when she told him that the relationship was over. Later, after Chloe had gone out, George damaged items in her house. This was reported to the police and was being investigated at the time of her death. Chloe left the property following this incident and went to a hotel in a neighbouring town as she was frightened that he might return.

1.1.3 At the time, Chloe was under the care of the local mental health service's Crisis Resolution and Home Treatment Team and spoke with them about the incident, concerns for her children, and her plans to go to a hotel. Due to concerns about Chloe's children, the Crisis Team contacted Children's Social Care, who in turn contacted the police about the incident.

1.1.4 Chloe suffered physical issues including severe pain, with regular seizures and paralysis. She had vocalised ideas of suicide, had overdosed on her prescribed medication on a number of occasions and, only a few weeks before her death, had overdosed on prescription medication in what appeared to be a genuine attempt to take her life. Chloe's family believe that this was a cry for help and an attempt to get back into hospital.

1.1.5 Chloe had been suffering with her physical health since the birth of her eldest child, and this worsened after the birth of her second child. She experienced fits and convulsions that would leave her in severe pain and often unable to walk. In October 2019, her physical health deteriorated and her relationship with George began to break down. Her family noted a significant change in her at this time. At times, Chloe's condition was so bad that she had to use a wheelchair and could feel nothing from the waist down. She had a commode in her kitchen and was trying to get a hospital bed at home, and she would also have the use of crutches. Her car had been modified so she used her hands only.

1.1.6 Chloe checked into the hotel, initially for one night, and was expected to check out the next morning. However, in the early hours of the morning, she requested to stay for an extra night and was due to leave at midday on that day.

1.1.7 The following day, the hotel received a call from an unknown male who didn't give his name but left a phone number. He explained to the manager that he was concerned about Chloe. The manager and another member of staff went to Chloe's room and gained access using the master key and discovered Chloe deceased in the room. There was evidence of medication in the room, and at the time of her death, the circumstances suggested that she had taken her own life.

1.1.8 At the inquest held on 18th May 2022, HM Coroner found that Chloe had taken her own life. The cause of her death was recorded as an overdose of prescribed medication together with evidence of cocaine use.

1.2 Reasons for Conducting the Review

1.2.1 This Domestic Homicide Review is carried out in accordance with the statutory requirement set out in Section 9 of the Domestic Violence, Crime and Victims Act 2004.

1.2.2 The review must, according to the Act, be a review 'of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or
(b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'.

1.2.3 The Statutory Guidance[1] states that: '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.'

1.2.4 In this case, HM Coroner found that Chloe had taken her own life, and as there had been prior reports of domestic abuse within her relationship, the criteria were met.

1.2.5 The purpose of the DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses, including changes to policies and procedures as appropriate.
- Prevent domestic violence and homicide and improve service responses to 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 possible opportunity.
- Contribute to a better understanding of the nature of domestic violence and abuse, specifically in this case, as experienced by male victims.
- Highlight good practice.

1.2.6 The Terms of Reference for this review also set out to:

- Consider any additional pressures that may have been placed on the relationship by the creation of the blended family.

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

- Consider the impact of the COVID-19 lockdown on the relationship and on Chloe's mental health.
- Consider Chloe's death in light of the national/local suicide prevention strategies, their implementation, and practice.

1.3 Methodology and Timescale for the Review

1.3.1 On 21st August 2020, Nottinghamshire Police wrote to the South Nottinghamshire Community Safety Partnership advising of Chloe's death. Being a matter of days after her death, this was a timely referral and demonstrated a good understanding of the legislation, particularly in relation to suicides.

1.3.2 The Strategic Group of the Community Safety Partnership decided on 1st September 2020 that, based on the information provided by the police, the criteria had been met, and a DHR would be held. The Home Office was notified of this decision on 18th February 2022.

1.3.3 An Independent Chair and Report Author were appointed in September 2020. Agencies were asked to secure and preserve any written records that they had pertaining to the case. Agencies were reminded that information from records used in this review were examined in the public interest and under Section 115 of the Crime and Disorder Act 1998, which allows relevant authorities to share information where necessary and relevant for the purposes of the Act, namely the prevention of crime. In addition, Section 29 of the Data Protection Act 2018 enables information to be shared if it is necessary for the prevention and detection of crime, or the apprehension and prosecution of offenders. The purpose of the Domestic Homicide Review is to prevent a similar crime.

1.3.4 Initial chronologies were gathered from agencies, and the first panel meeting was held on 6th October 2020 on Microsoft Teams, when the following agencies were present:

- Broxtowe Borough Council
- Derbyshire Healthcare NHS Foundation Trust
- Nottingham University Hospital
- Nottinghamshire Healthcare Trust
- Nottinghamshire Police

1.3.5 Apologies were received from the Department of Work and Pensions.

1.3.6 At this point, Derbyshire Police were still investigating Chloe's death, and a file had not been submitted to the coroner. Chronologies were sought from additional agencies that it was identified had been involved with Chloe, but it was agreed that IMRs would not be commissioned until the file had been passed to the coroner.

1.3.7 When the panel met for the second time in July 2021, the police investigation was completed, and no criminal charges had been brought. At this point, Individual Management Reports (IMRs) and summary reports were commissioned from:

- Derbyshire Healthcare NHS Foundation Trust – IMR
- DWP – Summary report
- EMAS – IMR
- GP for Chloe through Derbyshire CCG – IMR

- Nottingham University Hospital – IMR
- Nottinghamshire County Council (Children's Social Care) – IMR
- Nottinghamshire Healthcare Foundation Trust (NHCT) – Summary report
- Nottinghamshire Police – IMR
- South Yorkshire Police – Summary report

1.3.8 The Review Panel met four times, and the review concluded in May 2023.

1.3.9 The review could not be completed within six months for the following reasons:

- The review waited for the completion of the police investigation and the coroner's inquest.
- The production of IMRs was delayed due to the COVID-19 lockdown and the pressures on agencies.
- Time was allowed for Chloe's family to be ready to meet the Chair and Report Author.

1.4 Confidentiality

1.4.1 The content and findings of this review are held to be confidential, with information available only to those participating officers and professionals and, where necessary, their appropriate organisational management. It will remain confidential until such time as the review has been approved for publication by the Home Office Quality Assurance Panel.

1.4.2 To protect the identity of the deceased, and their family and friends, the following pseudonyms have been used:

The subject of the review will be known as Chloe.
Her ex-partner and father of her youngest child will be known as George.
The father of Chloe's oldest child is referred to as her ex-partner or the father of Child 1.

1.5 Terms of Reference

1.5.1 The review set out to:

- Consider any additional pressures placed upon relationships by the creation of a blended family.
- Consider the impact of the COVID-19 lockdown on the relationship and Chloe's mental health.
- Consider the death in light of national/local suicide prevention strategies, their implementation, and practice.

1.5.2 The full Terms of Reference can be found at Appendix One.

1.6 Dissemination

1.6.1 The following individuals/organisations will receive copies of this report:

- Chloe's family
- Members of the DHR Review Panel
- Members of the Community Safety Partnership
- Domestic Abuse Commissioner

1.7 Contributors to the Review

1.7.1 Those contributing to the review do so under Section 2(4) of the statutory guidance for the conduct of DHRs, and it is the duty of any person or body participating in the review to have regard for the guidance.

1.7.2 All panel meetings included specific reference to the statutory guidance as the overriding source of reference for the review. Any individual interviewed by this Chair or Report Author, or other body with whom they sought to consult, were made aware of the aims of the Domestic Homicide Review and were referenced to the statutory guidance.

1.7.3 However, it should be noted that whilst a person or body can be directed to participate, the Chair and the DHR Review Panel do not have the power or legal sanction to compel their co-operation, either by attendance at the panel or meeting for an interview.

1.7.4 The following agencies contributed to the review:

- Derby and Derbyshire CCG – Panel member
- Derbyshire Healthcare NHS Foundation Trust – IMR and panel member
- Derbyshire Police – Chronology
- DWP – IMR and panel member
- EMAS – IMR and panel member
- GP for Chloe through Derbyshire CCG – IMR and panel member
- Juno Women's Aid – Panel member
- Nottingham University Hospital – IMR and panel member
- Nottinghamshire County Council, Children's Social Care – IMR and panel member
- Nottinghamshire Healthcare Foundation Trust (NHCT) – Summary report and panel member
- Nottinghamshire Police – IMR and panel member
- Probation Service – Panel member
- South Yorkshire Police – Summary report and panel member

1.8 Engagement with Family and Friends

1.8.1 When the panel first met in October 2020, it was agreed that, as the police investigation had not concluded, it was too early to contact Chloe's family.

1.8.2 When the file had been passed to the coroner and no criminal charges had been brought, the Chair and Report Author wrote to Chloe's family in March 2021. They were provided

with the Home Office leaflet and information about AAFDA (Advocacy After Fatal Domestic Abuse).

1.8.3 The Chair had an initial meeting with Chloe's stepfather in June 2021, when he introduced the review and explained its purpose.

1.8.4 Shortly after this meeting, the Chair and Report Author were contacted by AAFDA, who were now supporting the family, and liaison commenced with the advocate. The family needed some time as they were busy discussing the inquest with the coroner. Therefore, it was agreed to delay meeting them again.

1.8.5 In February 2021, the Chair and Report Author met with the AAFDA advocate: firstly, with Chloe's father and stepmother; and secondly, with Chloe's mother, stepfather, and sister.

1.8.6 Chloe's family have shared with the Chair and Report Author the statements that they made to the inquest, and these have helped to provide their thoughts.

1.8.7 The Chair and Report Author sought, through the AAFDA advocate, the views of the children's grandparents regarding whether the children should be spoken to as part of the review. They felt that this would not be helpful for them; therefore, this was not pursued any further.

1.8.8 Once the draft report was prepared, this was shared with Chloe's family. They were given time to review the report and, supported by their AAFDA advocate, to feedback their comments.

1.8.9 Through the family, the review was made aware of a friend of Chloe's, Friend 1. The panel did not speak to him directly and his insights have come from members of her family. Chloe's family were also able to provide information from a previous partner that is included in this report, but the review did not speak to him directly.

1.8.10 The panel considered speaking to George but, in light of the delicate relationships in the family and for the welfare of the children, it was decided that such an approach would not e made.

1.9 Review Panel

1.9.1 The members of the Review Panel were:

Gary Goose MBE	Independent Chair	
Christine Graham	Independent Report Author	
Marice Hawley	Chief Communities Officer	Broxtowe Borough Council
Gail Stansbury	Job Centre Leader	Department of Work and Pensions
Michelle Grant	Designated Nurse, Safeguarding Adults/MCA Lead	Derby and Derbyshire CCG
Vicki Baxendale	Assistant Director, Safeguarding Adults	Derbyshire Healthcare NHS Foundation Trust
Lucy Gascoigne	Head of Safeguarding	East Midlands Ambulance Service

Stuart Prior	Head of Regional Review Unit	East Midlands Special Operations Unit (EMSOU) Regional Review Unit
Rebecca Smith	Head of Services – Accommodation and Central Operations	Juno Women's Aid
Nick Judge	Associate Designated Nurse, Adult Safeguarding	Nottingham and Nottinghamshire Clinical Commissioning Group
Maggie Westbury	Adult Safeguarding Lead	Nottingham University Hospitals
Julie McGarry replaced by Julie Gardner	Associate Director for Safeguarding	Nottinghamshire Healthcare Foundation Trust
Clare Dean replaced by Mark Dickson	Chief Inspector	Nottinghamshire Police
Lisa Adkins-Young	Deputy Head	Probation Service

1.9.2 All members of the panel were independent of any direct contact with Chloe and were of the necessary seniority within their organisation.

1.9.3 Chloe's family were offered the opportunity to meet the panel but did not feel the need to do so.

1.10 Domestic Homicide Review Chair and Overview Report Author

1.10.1 Gary Goose served with Cambridgeshire Constabulary, rising to the rank of Detective Chief Inspector: his policing career concluded in 2011. During this time, as well as leading high-profile investigations, Gary served on the national Family Liaison Executive and led the police response to the families of the Soham murder victims. From 2011, Gary was employed by Peterborough City Council as Head of Community Safety and latterly as Assistant Director for Community Services. The city's domestic abuse support services were amongst the area of Gary's responsibility, as well as substance misuse and housing services. Gary concluded his employment with the local authority in October 2016. He was also employed for six months by Cambridgeshire's Police and Crime Commissioner, developing a performance framework.

1.10.2 Christine Graham worked for the Safer Peterborough Partnership for 13 years, managing all aspects of community safety, including domestic abuse services. During this time, Christine's specific area of expertise was partnership working – facilitating the partnership work within Peterborough. Since setting up her own company, Christine has worked with a number of organisations and partnerships to review their practices and policies in relation to community safety and anti-social behaviour. As well as delivering training in relation to tackling anti-social behaviour, Christine has worked with a number of organisations to review their approach to community safety. Christine served for seven years as a Lay Advisor to Cambridgeshire and Peterborough MAPPA, which involved her in observing and auditing Level 2 and 3 meetings, as well as engagement in Serious Case Reviews. Christine chairs her local Safer off the Streets Partnership.

1.10.3 Gary and Christine have completed, or are currently engaged upon, a number of Domestic Homicide Reviews across the country in the capacity of Chair and Overview Author. Previous Domestic Homicide Reviews have included a variety of different scenarios: male victims; suicide; murder/suicide; familial domestic homicide, a number of which involve mental ill health on the part of the offender and/or victim; and reviews involving foreign nationals. In several reviews, they have developed good working relationships with parallel investigations/inquiries, such as those undertaken by the IOPC, NHS England, and Adult Care Reviews.

1.10.4 Neither Gary Goose nor Christine Graham are associated with any of the agencies involved in the review nor have, at any point in the past, been associated with any of the agencies.[2]

1.10.5 Both Christine and Gary have completed the Home Office online training on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing overview reports, as well as DHR Chair Training (Two days) provided by AAFDA (Advocacy After Fatal Domestic Abuse). Full details of ongoing professional development are available at Appendix Two.

1.11 Parallel Reviews

1.11.1 The inquest was held in May 2022. The coroner explored the following issues: Chloe's access to medication; the care she received for her mental health; her state of mind at the time of her death; and whether Chloe should have been readmitted to hospital.

1.11.2 The coroner concluded that the allegations of domestic abuse would not feature in the inquest other than where these were relevant to her state of mind at the time of her death.

1.11.3 The coroner concluded that Chloe had died as a result of suicide, and that Chloe took the medication with the intention to take her own life. It was noted that, whilst Chloe had not left a note, she had searched on her phone (days before her death) for how to take her own life. The ironing board had also been propped up against the door of the hotel room.

1.11.4 There were no other parallel reviews undertaken.

1.12 Equality and Diversity

1.12.1 Throughout this review process, the panel has considered the issues of equality. In particular, the nine protected characteristics under the Equality Act 2010. These are:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership (in employment only)
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

[2] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (para 36), Home Office, Dec 2016

1.12.2 **Physical and mental health**

1.12.3 Chloe was known to have a functional neurological disorder, borderline personality disorder, and suffered with panic attacks and anxiety.

1.12.4 The impact meant that, at times, Chloe was not able to get about without the aid of family or the use of a wheelchair. There were times when, despite her best efforts, she was unable to care for her children without the help of family.

1.12.5 Women's Aid state: '*domestic abuse perpetrated by men against women is a distinct phenomenon rooted in women's unequal status in society and oppressive social constructions of gender and family*'.[3] According to a statement by Refuge, women are more likely than men to be killed by partners/ex-partners, with women making up 73% of all domestic homicides, and with four in five of these being killed by a current or former partner[4]. In 2013/14, this was 46% of female homicide victims killed by a partner or ex-partner, compared with 7% of male victims.[5]

1.12.6 The National Confidential Inquiry into Suicide and Safety in Mental Health Annual Report 2022[6], examined data from 2009-2019 of those who died by suicide whilst under the care of mental health services. They found that most patients who died had a history of self-harm (64%) and 25% had a comorbid major physical illness. 9% of deaths in this time were of women with a history of domestic abuse (9%). The majority (81%) had a history of self-harm, and previous drug misuse (47%) was common. Nearly one third (29%) had been diagnosed with a personality disorder.

1.12.7 The following statistics demonstrate the link between domestic abuse, mental health, and suicide:

- Women who self-harm are 75 times more likely to experience domestic abuse[7]
- Every day in the UK, 30 women attempt suicide as a result of domestic abuse[8]
- 3 women a week in the UK take their own lives to escape domestic abuse[9]
- 1 in 8 female suicides/attempts are due to domestic abuse.[10]

1.12.8 These issues will be explored further in this report: from section 4 onwards.

[3] (Women's Aid Domestic abuse is a gendered crime, n.d.)
[4] ONS (2018), 'Domestic abuse: findings from the Crime Survey for England and Wales: year ending March 2018'. https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusefindingsfromthecrimesurveyforenglandandwales/yearendingmarch2018#the-long-term-trends-in-domestic-abuse November 2018.
[5] (Office for National Statistics, Crime Statistics, Focus on Violent Crime and Sexual Offences, 2013/14 Chapter 2: Violent Crime and Sexual Offences – Homicide, n.d.)
[6] The National Confidential Inquiry into Suicide and Safety in Mental Health. Annual Report: UK patient and general population data, 2009-2019, and real time surveillance data, 2022, University of Manchester
[7] Walby S, The cost of domestic violence, Women and Equality Unit, 2004
[8] Walby S and Allen J, Domestic violence, sexual assault and stalking: Findings from the British Crime Survey, London, Home Office, 2004
[9] ibid.
[10] ibid.

Section Two – The Facts

2.1 Introduction

2.1.1 Chloe was 33 years old at the time of her death. She had separated from her partner, George, who was the father of her second child, in November 2019. She was still in contact with him, and the father of her first child, around contact to the children. Chloe had recently moved into a new home close to her parents.

2.1.2 Above all else, Chloe is described by those who knew her as a loving mother who thought the world of her children and wanted the best for them. Her family were very important to her, and she was thrilled when her sibling's babies were born.

2.1.3 Chloe had a professional career, working for a financial company for more than 10 years. She had progressed well at the company and had been promoted. When her health meant that it was difficult for her to work, regrettably, Chloe lost her job. She bounced back, doing accounts for a nail company, and then trained as a nail technician. Her family said that she was very creative and was very good at this: making a good living for herself. She was very confident and helpful with clients. She got on well with people. She left this role in August 2019 due to her poor physical health.

2.2 Chronology

Chloe's ex-partner, George is the father of Child 2 and was in a relationship with Chloe until November 2019. Her family say that a short-lived attempt at reconciliation around Christmas was unsuccessful. Chloe and the children moved to live with her parents early in lockdown before moving to a property around the corner from them.

Friend 1 is a man that she met in hospital, and it is thought that they were in a short relationship from May 2020.

2.2.1 **Background**

2.2.2 The review has been made aware that when Chloe was 16 or 17 years old, she reported to her parents that she had been touched inappropriately by a teacher. The teacher denied this, and Chloe felt that she had not been believed.

2.2.3 Chloe was known to Nottingham University Hospital (NUH) since 2008, when she first presented with right-sided neck and arm pain. She was known to suffer with significant anxiety and would often disclose physical symptoms at times of high anxiety. Chloe also had other physical issues and symptoms that were managed via various specialities, including neurosurgery, ear nose and throat, and gynaecology. Chloe was known to have a functional neurological disorder, borderline personality disorder, and suffered with panic attacks and anxiety. Chloe would often be accompanied by her mother at appointments and said that she had good support from family and friends. Chloe presented at A and E several times when experiencing neck pain and severe pain in her arms and legs.

2.2.4 **Outside the scope of the review**

2.2.5 **2014**

2.2.6 Chloe first had spinal intervention in 2014. This was due to a disc herniation, and she required surgery and physiotherapy. She was in hospital for nine days. Following surgery, Chloe continued to describe nerve pain, spasms, and reduced sensations in her legs, and she also had problems with urinary incontinence. These symptoms were problematic throughout her life, affecting her physical and mental health and, at times, preventing her from being able to care for herself and her children.

2.2.7 **2015**

2.2.8 In the summer of 2015, Chloe left her job where she had been a credit controller for eight years. Her physical health had led to her having a lot of time off work, and she was released by the company. She signed a legal compromise agreement when she left.

2.2.9 From 24th August 2015, Chloe claimed Employment and Support Allowance (ESA).

2.2.10 **2016**

2.2.11 On 4th July, the records held by DWP indicate that Chloe was now living alone.

2.2.12 In November, Chloe was referred to the Department of Psychological Medicine (DPM) by the neurologist who was treating her for functional neurological disorder, as they were concerned that she may have bipolar disorder.

2.2.13 **2017**

2.2.14 Chloe was seen by the DPM for an initial assessment in January. Whilst the doctor did not feel that Chloe met the criteria for bipolar disorder, they agreed to offer her ongoing support around functional symptoms. She then had regular appointments until July, when she was unable to attend an appointment due to ill health: it was agreed that she would contact the department again when she was well enough to attend.

2.2.15 In April, Chloe's GP received a discharge letter from Talking Mental Health Derbyshire. This was as Chloe had self-referred to them but had failed to respond to the opt in letter within the required 14 days. Chloe's family believe that she did not respond as she believed that she was not experiencing mental health issues.

2.2.16 In July, Chloe began a relationship with her partner, George. They met via a dating app.

2.2.17 In August, Chloe told a GP, during a home visit, that she attributed some of her problems to her ex-partner who had been controlling and with whom she had been in a relationship on and off since the age of 18. She said that they were no longer together but amicable over the care of their child: Child 1.

2.2.18 In September, Chloe's GP received a letter from the consultant neurologist. It stated that Chloe had benefitted from input from Psychological Medicine and that he would be liaising with her to continue therapy. He said that she had also been assessed for CBT but felt unable to attend regular appointments in person, so telephone contacts would take place.

2.2.19 Chloe then attended the DPM in October, when they began to discuss a possible diagnosis of personality disorder. A referral was made to the personality disorder team (NPDNN) in November. DPM planned to space out Chloe's appointment, with a view to discharge.

2.2.20 In December, Chloe was discussed in the NPDNN allocation meeting, but she was felt unsuitable for the service. The case was subsequently closed without any formal diagnosis.

2.2.21 Chloe's involvement with the DPM ended in December 2017.

2.2.22 **Within the scope of the review**

2.2.23 **2018**

2.2.24 Prior to January 2018, Chloe had been seen at the health centre on six occasions for support with her own health, and once by the health visitor for support with Child 1. It is recorded in her health record that she disclosed possible childhood trauma. She had said that she could not remember anything about her past and had no childhood memories that she believed could be connected to her varied physical symptoms in adulthood, which included anxiety, generalised pain, and depression.

2.2.25 In April, Chloe was admitted to a ward at NUH with pleurisy that was secondary to a lower respiratory tract infection. She was discharged two days later.

2.2.26 Three days later, East Midlands Ambulance Service (EMAS) received a request from NHS 111 to send an emergency ambulance to Chloe's address, as she stated that she had back and rib pain. On arrival, Chloe was sitting on the sofa with her partner (name not recorded). Chloe had been discharged from hospital three days earlier when she had been diagnosed with pleurisy due to a lower respiratory tract infection. Chloe was 25 weeks pregnant at this time. Her pain was worse on inspiration, and she scored her pain as being 10/10 (10 being the worst). She was taken to hospital for further assessment.

2.2.27 In July, Chloe was seen by the health visitor from the health visiting team. Routine enquiry was considered but not discussed, as father was present; however, at the 6 – 8-week review, Chloe was seen alone, and routine enquiry was undertaken. She did not disclose domestic abuse but discussed anxiety. She was offered appropriate support for this issue.

2.2.28 In August, Chloe advised the Department of Work and Pensions (DWP) that her partner had moved in and that he worked full time.

2.2.29 At 2.11 am on 26th September, Nottinghamshire Police received an abandoned phone call from Chloe at her home address. When officers attended, Chloe said that Child 1 had called the police by accident. When the officers asked to go in, they heard aggressive shouting from upstairs, and it was identified that George was creating a stressful situation. The police told him to stop shouting and calm down. Chloe was asked where the children were and completed a 'safe and well check'. Child 2 was asleep in a basket next to Child 1's bed. Child 1 was awake but told officers he was ill because he had a tummy bug (this was unrelated to the incident).

2.2.30 The officers asked George to leave and took him to a hotel where he was going to stay. ***This is an example of positive action to remove him from the situation.*** En route, he told officers

that Child 1 had nipped and hurt Child 2. He had been very unhappy with this, and it had caused an argument.

2.2.31 Officers returned to the property and spoke to Chloe about the 'nipping' incident. She said that George was making it sound worse than it was because he was drunk. Chloe's mother was also at the address and had been present when the incident had occurred. She said that Child 2 had been playing with Child 1 and had caught his face, causing him to cry. There was no sign of visible injury to Child 2. It was clear that Child 1 was not the child of George, and Chloe said that he did not like the fact that Child 1 had made his child cry. George had said to Chloe that he would harm Child 1 if it happened again. This had been the comment that had upset Chloe, although she said that he had never been aggressive, and that he was different when sober.

2.2.32 Children's Social Care first became involved with the family when a referral was made to the Multi-Agency Safeguarding Hub (MASH) by Nottinghamshire Police, following the incident. A risk assessment was completed, and Chloe was deemed to be standard risk.

2.2.33 A MASH social worker contacted Chloe by telephone, and she reported that it was she who had contacted the police, not Child 1. She stated that George had been drunk and was 'kicking off'. He had made threats to harm Child 1, as he believed that Child 1 had hurt Child 2, although Child 1 had only accidentally caught the younger sibling in the face whilst playing with them. Child 2 did not have any injuries.

2.2.34 Information sharing with other agencies took place in the MASH, and no further concerns were raised by other agencies. The MASH social worker recommended that no further action be taken because the incident appeared to be a one-off, this was a first referral, and mother appeared to have acted appropriately to protect the children. However, the MASH team manager did not agree with this recommendation and made the decision that a Child and Family Assessment (CAFA) should be progressed – as further exploration was required around the family dynamics and functioning, mother's understanding regarding domestic abuse and impact on the children, and direct work to be undertaken with Child 1.

2.2.35 In October, Chloe claimed Universal Credit due to becoming a single parent of two children.

2.2.36 A Child and Family Assessment was subsequently progressed to determine if there were any safeguarding concerns or support needs in respect of the children. Chloe was visited at home and spoken to as part of the assessment. Both Chloe and George independently reported that he did not normally drink alcohol to excess and that his behaviour in the September incident had been out of character. George advised that he worked away in the week and only visited the family at the weekend.

2.2.37 It was reported that the incident had been a one-off and there was no other information at the time contrary to this. The Healthy Families Team (HFT) and Child 1's school were contacted as part of the assessment and information sharing.

2.2.38 Following the request for information, the HFT escalated the family to 'Partnership Plus', which would mean greater involvement by the team. The team tried, unsuccessfully, to gain further information from the MASH so that they could tailor their support, but no information was provided.

2.2.39 The Child and Family assessment was completed, and the case was closed to CSC.

2.2.40 In November, EMAS received a request from NHS 111 to send an emergency ambulance to Chloe's address. Child 2 was being held when the ambulance arrived and was not showing any signs of distress. The parents reported that Child 2 had not been keeping feeds down. They described projectile vomiting and said that there was a blanching rash to his body. Child 2 was taken to hospital for further assessment.

2.2.41 **2019**

2.2.42 In February, George contacted the police to report that Chloe had his passport and would not give it back to him. He said that Chloe had said that she had destroyed it, but her mother told him that Chloe still had it. The matter was quickly resolved. When officers contacted George again, he confirmed that he had the passport and that it was undamaged. He said that Chloe was just upset because he was due to work abroad. There was no complaint, and George did not want any further action.

2.2.43 Chloe was seen by the HFT in April 2019 for Child 2's 8 – 12-month development review. At this meeting, she said that she was not in a relationship and had moved to be near her family. No other concerns were documented.

2.2.44 On 11th May, Chloe attended NUH ED with a seizure. She was discharged following review.

2.2.45 On 19th May, EMAS received an emergency call from the police. They were told that Chloe had been reported missing earlier that day, and they had found her in a field. Chloe said that she had taken an overdose of medications with the intent of killing herself, but she did not know what time she did this. She said that she had children who were in the care of a family member. A large number of medication packets and bottles were found at the scene. It was thought possible that she had taken oxycodone (5mg/5ml, 5x 250ml bottles), diazepam (2mg x14 tablets), diazepam (5mg x56 tablets), diclofenac (50mg x 35 tablets), and gabapentin (100mg x 8 tablets). Chloe denied taking any alcohol or illicit drugs. Chloe became less responsive, vomited, and was given naloxone and air management. She was taken to hospital via blue lights. Despite not having details of the children – as the crew were providing lifesaving treatment to Chloe in a field – the attending crew made a safeguarding referral that was shared with Adult and Children's Social Care, GP, and Child Health Team. ***This is an example of good practice.***

2.2.46 On 3rd June Chloe contacted DWP and said that she now had a partner living with her who was in receipt of high earnings and so the claim was cancelled.

2.2.47 George left Chloe in August 2019 and, despite their holiday later that year, they were never a couple again.

2.2.48 On 5th August Chloe made a claim to DWP for Universal Credit and said that she was housebound.

2.2.49 In October, during a consultation with her GP, Chloe alluded to the fact that her previous relationship had been abusive but that her present relationship was calm, and the relationship was good[11].

[11] It is assumed that when Chloe speaks of her previous relationship, she is referring to the father of Child 1, and when she speaks of her present relationship, she is meaning George.

2.2.50 Chloe and George split up in October 2019, but they did, it appears, continue to have contact[12].

2.2.51 Chloe attended the ED at NUH on 23rd October with increased weakness and numbness in her lower limbs, and a new issue with incontinence. She was admitted to the ward for further investigation and was discharged on 29th October.

2.2.52 In November, Chloe advised DWP that her partner had left the household on 15th November. She made a claim for Universal Credit and declared no partner. A home visit was arranged to verify her private rent. Two people were named on the tenancy agreement, but it was decided in Chloe's favour. It was an untidy tenancy as the other person named on the tenancy agreement no longer lived in the household.

2.2.53 Towards the end of November, DWP received a call from Chloe. She was very upset and said that she had no money left. She was given the telephone number for Nottinghamshire Welfare Assistance Fund, and a Budgeting Advance was paid for white goods.

2.2.54 In December, Chloe attended a routine appointment at the neurology department at NUH. She was very distressed and spoke about a decline in her health and her partner leaving her. She had two follow-up pain management appointments in December and January (2020)

2.2.55 On 11th December, Chloe contacted DWP and was advised to speak to Citizens Advice Bureau about childcare costs.

2.2.56 At some point during December, Chloe and George went on holiday together (according to Chloe's report to CSC in June 2020), as the holiday had been booked before they split up. She said that George had drunk excessively throughout the holiday.

2.2.57 **2020**

2.2.58 In March, when the COVID-19 lockdown began, Chloe and the children moved in with her parents, as she could not cope on her own.

2.2.59 Chloe was seen by her GP in May, and she expressed suicidal thoughts due to her partner 'coming and going'. She said that she was planning to cut her wrists in the bath, but she was living with her parents. Later that day, Chloe's mother called the surgery on a couple of occasions because of the uncertainty as to whether she may have overdosed. After a conversation with one of the GPs, Chloe's mother agreed to take her to the ED. The GP spoke to the Crisis Resolution and Home Treatment Team, who declined to become involved due to it being reactive to the situation: they advised contacting the mental health helpline.

2.2.60 Chloe's GP spoke to her again a week later, and Chloe said that she was previously unable to get help with Emotionally Unstable Personality Disorder (EUPD) because she was not thought to be suicidal. She said that there was now proof (due to recent episode of taking too much medication). However, she was sure that she would not see it through because of the children. Chloe said that her stepfather would take control of her medication. However, the GP has no recorded conversation with him in which it was agreed that he would collect her medication.

[12] This was reported to CSC in June 2020 by Chloe.

2.2.61 On 19th May, Chloe's stepfather called the police to report that Chloe had gone missing. She had taken her brother to Ilkeston Hospital, as he had an appointment. She was to wait outside but when her brother returned, she was not there. She had been sending text messages to her partner about the songs that she wanted at her funeral. The family said that Chloe had made several attempts on her life, which had included four overdose attempts in the past two weeks.

2.2.62 Chloe's stepfather told the police that Chloe had collected her prescription on 19th May, despite him having agreed with her GP on 18th that Chloe would not be allowed to collect her prescription. An officer spoke to the GP, who confirmed that there was no agreement that only her stepfather would be collecting her prescription; although the GP had been advised by Chloe that her stepfather was taking control of her medication.

2.2.63 Nottinghamshire Police initiated a high-risk missing person enquiry, and a risk assessment confirmed her high-risk status. A recent overdose in the Doncaster area was confirmed. Chloe was suffering from depression and was lonely since splitting up with her partner. It was confirmed that she had collected a large quantity of prescription medication that morning.

2.2.64 The incident was treated with urgency and a high-risk missing person enquiry was initiated. Significant resources were deployed. Extensive enquiries were completed, and a handover undertaken between Nottinghamshire Police and Derbyshire Constabulary, as per National Guidelines. Chloe was located in a field and her condition was described as life-threatening. Chloe had driven to Ambleside in Derbyshire, parked her car, and switched off her mobile phone (which she left in her car). She had then walked a short distance and taken a large amount of the prescribed drugs she had collected earlier.

2.2.65 Following this incident, a referral was received by the MASH on 20th May 2020 from Nottinghamshire Police. It was decided not to share the referral with Adult Social Care as there was no indication that she had needs for care and support for daily function. Therefore, a view was taken that there was no purpose or justification for sharing her information with Adult Social Care. The information was shared with Children's Social Care, as the concerns raised for Chloe were in relation to mental health/suicide attempts and there were children who would be impacted by Chloe's mental health. The referral was shared with County MASH Children's Social Care, as a Child Concern.

2.2.66 Following the incident, she was admitted to the Emergency Department (ED) at Royal Derby Hospital on 21st May – after she had taken an overdose of 5 bottles of 250ml of oxycodone, around 15mg of diazepam, 800mg of gabapentin, and 35 tablets of 50mg diclofenac (but no alcohol) on 19th May at around 2 pm. She was admitted to the high dependency ward. Chloe said that she had not pre-planned this but that she had received her prescription from the pharmacy that day, which she used to take the overdose. She said that the stressors were her relationship with her partner, financial pressures, and her physical health.

2.2.67 A MASH social worker spoke to Chloe on the telephone on 21st May, and Chloe reported that the children were in her parents' care and consented for the social worker to speak to them. It was noted by the social worker that Chloe's speech was slurred.

2.2.68 The social worker subsequently had a telephone conversation with Chloe's mother, also on 21st May, who confirmed that she had care of the children, and that both the children and Chloe had been living with them recently because Chloe had been struggling to cope since

the 'lockdown'. It was reported that Chloe and her partner had separated approximately six weeks ago, and that this had impacted on Chloe's mental health.

2.2.69 On 21st May, George contacted CSC. He enquired about plans for the children and whether he could remove Child 2 from the care of Chloe's parents. He told the social worker that Chloe's medication made her either sleep all day or made her volatile. He said that he had care of Child 2 at weekends. He did not raise any concerns regarding Chloe's parents' ability to care for the children; however, he did raise concerns regarding them not taking Chloe's mental health seriously. He reported that, on a previous occasion, when Chloe had gone missing, she had spoken to him, and she had asked him to promise to play a certain song at her funeral. He said that he had told Chloe's parents about this, and they didn't take him seriously. CSC did not discuss these concerns with Chloe's parents.

2.2.70 On 22nd May, after an assessment by the Mental Health Liaison Team, in consultation with the Crisis Resolution and Home Treatment Team, Chloe was admitted to a Ward 36 at the Radbourne Unit (an acute inpatient ward), as it was felt that it was not safe for her to be discharged due to her suicide attempt and presenting as hopeless.

2.2.71 On 24th May, it was noted that Chloe was well settled on the ward and 'has appeared to get on with her peers very well. With them she appears jovial and upbeat'.

2.2.72 On 26th May, Chloe spoke to a member of staff about her partner. She said that he had control over her. The member of staff talked to her about taking back control and finding strength to build herself back up. They looked at changing mindsets from 'can't' to 'can'. Chloe frequently said that she hated herself and so the member of staff talked to her about the positives about her. Chloe disclosed that she had taken more overdoses than she had admitted to professionals, and that she had tried to hang herself in the past. She said that she was scared to tell people because of CSC taking her children away. She said that she felt safe on the ward, and it felt like the right environment for her to get better before returning home to her children. She identified a protective factor being her new home for her and her children. She said that her parents had been supportive in looking after the children.

2.2.73 On 26th May, Chloe talked about her mental health during a ward round. She said that she had always struggled with depression but had felt happy since she had been on the ward. She said that she previously had troubled relationships, which caused stress, and that she had been 'secretly overdosing' in the past. She felt unable to control her emotions and sometimes found them 'overwhelming', and that she 'suddenly gets a feeling of wanting to be dead when feeling low in mood'. A plan was made to review her antidepressant medication.

2.2.74 Chloe's mother also reported that Chloe was struggling with physical illness due to having a spinal operation a number of years ago, which had left her with seizures and neurological issues. She said that she and her husband had been administrating Chloe's pain medication recently, as Chloe had been in pain a few weeks ago and had taken too many tablets. She said that since then, they had agreed with Chloe's GP that they would collect her medication; however, on this occasion, Chloe had collected her medication herself and had taken the overdose[13]. Following the referral, it was deemed that there was no further role for CSC, as the children were safe in the grandparents' care.

[13] Evidence heard at the inquest indicated that, whilst the GP understood that Chloe's medication was to be monitored at home by her parents, there is no record that the GP understood that Chloe could not collect her own medication.

2.2.75 On 2nd June, during the ward round, Chloe said that she had a lot of difficulty with maintaining friendships and relationships. She said that she had had two long-term relationships in the past 15 years. She said that one of her partners (father of Child 1) abused her physically and sexually. Chloe said that she was also sexually abused by people brought to her by him, and she had a child by him. She said that he had never abused their child, who had a good childhood. She said that she was no longer with him and said that she had never reported him to the police. Chloe was not specific about when this abuse had occurred.

2.2.76 Chloe said that she had been with her partner, George for three years, and she also had a child with him. She said that he had abused her psychologically. She said that she was worried about when her child went to spend time with him, as she described him as an alcoholic and was not sure that he would not hurt him. Chloe said that her 'children are major protective factors for her'. She also said that 'her children are her life'. Chloe said that 'she feels that she wants to live but sometimes has overwhelming memories of sexual abuse which is too much for her. She feels that the sertraline and diazepam has helped her in the short term'. She said that she felt that her current main issue was her flashbacks about past abuse. She also felt low and anxious often.

2.2.77 On 5th June, Chloe made an allegation against a male patient on the ward, accusing him of taking her iPad, and she said that he had threatened to 'set her on fire'. She said that in her previous relationship (with Child 1's father), she was subject to a lot of abuse and was threatened with hot oil and sugar, so it brought back memories for her. Chloe's iPad was later found in her pillowcase.

2.2.78 On 6th June, an occupational therapy bath/shower assessment was carried out, and Chloe reported no difficulties in this regard.

2.2.79 On 7th June, Chloe approached night staff and appeared distressed. She said that her partner had been texting her, threatening to 'cut her throat'. She was advised that this would be a police matter and that she should contact them via 101. Because of these alleged threats, Chloe felt scared and reported feeling very anxious. The threats were documented for day staff to be informed.

2.2.80 On 7th June at 7.05 am, South Yorkshire Police were telephoned by George. He reported that he had received a phone call from an unknown number. An unknown male said that he should leave Chloe alone, that he had been abusive to her, and that the unknown caller knew where he lived. George had then sent a text to the unknown number and had received a further text with the same message. He said that he believed that Chloe had been sectioned, although he was not sure where. He believed that the caller was also a patient at the same place; however, there was no evidence to substantiate this. George called South Yorkshire Police again at 9.25 am and said that he did not wish to pursue the criminal investigation. At 4.55 pm, an officer spoke to George in person: again, he declined to make a formal statement or pursue a criminal investigation. A DASH risk assessment was undertaken with George and was assessed as standard risk. The case was closed due to evidential difficulties, as the suspect could not be identified. Whilst a crime was confirmed, George was not able to support the police investigation further to identify the suspect.

2.2.81 On 8th June, Chloe contacted her GP from the inpatient unit and disclosed that she had experienced significant trauma at the hands of her previous partner, including rape and being forced to have sex with others. She said that 'he broke me' (referring to father of Child

1). Chloe admitted that she was addicted to oxycodone, as she wanted to blot out the bad memories. Chloe was anxious to get her medications in place for her imminent discharge. The GP advised Chloe that they would have to wait for a letter from the hospital but acknowledged that Chloe was determined to reduce her opiate use. Chloe told the GP that she trusted them and asked for video consultation when discharged. The GP planned to follow up Chloe's disclosures at that appointment.

2.2.82 On 8th June, the MASH received a referral from South Yorkshire Police reporting malicious communication between Chloe and George. George had reported that he had been receiving text messages to leave Chloe alone. A MASH social worker initially had a telephone conversation with Chloe on 9th June, and she advised that she had received abusive telephone calls from him when he was under the influence of alcohol. She claimed that he would make nasty comments and had told her to kill herself. A friend of Chloe's, Friend 1, admitted to sending a text message to George asking him to leave her alone. Friend 1 said that this had resulted in him receiving threatening messages from George.

2.2.83 A Child and Family Assessment was progressed, and the timescale was subsequently extended because the social worker initially struggled to contact Chloe. On one attempted home visit on 23rd June, Chloe's father reported that Chloe was not at the home, as she had been staying at a hotel to get some space. He said that the children were fine but that 'they were just a bit full on for Chloe'.

2.2.84 On 9th June, the ward noted improvement in Chloe's mental state and planned to continue her current medication and consider her having home leave the following week, with a view to discharge in two weeks. Chloe said that she was looking forward to discharge and said she would stay in a hotel; however, she also said that her new place, near to her parents, was ready to move into. It was noted that George had been sending her threatening texts. Chloe said that she regretted previous attempts to harm herself and had 'no plans to do so in future as she wants to be a good mother to her children'.

2.2.85 On 10th June, a case note review on the ward identified that despite Chloe's reports of an 'impulsive overdose', there were elements of prior planning. This review also noted long-term problems, including fluctuating mood, relationship difficulties, and over-sleeping. The psychological formulation also indicated that Chloe struggled with structure and routine and relied upon significant support from others, including support to look after her children.

2.2.86 On 11th June, as suggested, Chloe wrote a letter detailing her difficulties with relationships, moods, and feelings.

2.2.87 On 16th June, it was noted during the ward round that Chloe had tested positive for cocaine and alcohol. Chloe's family have said that she had requested a drugs test as she believed another patient had 'spiked' her drink.

2.2.88 She said that she didn't want to die or hurt herself anymore, and she didn't want to take any illicit drugs and asked to be tested the day before because she thought she might have been spiked. Chloe thought that she would be safe when she was discharged home. She said that she would engage with the Crisis Resolution and Home Treatment Team and with the Community Mental Health Team. She said that her children were major protective factors. Chloe thought that when she came into hospital, she was much less well than she was now.

2.2.89 The doctor explained that she did not think that Chloe should leave, as she looked more low than usual. The doctor called Chloe's mother. Chloe became very angry during the conversation and left the ward round, shouting that her parents thought she was a drug addict. After she left, Chloe's mother said that she did not think that Chloe was a drug addict. Chloe's mother offered to sort her old house for Chloe if she self-discharged. A plan was made to make a referral to safeguarding in regard to threats from George, refer her to the Community Mental Health Team, and plan to discharge on Monday. If Chloe decided to discharge herself, it would be against medical advice, but she was not suitable for section at this time. It was decided that, if her mental state improved by the next day, a period of leave might be suitable under the care of the Crisis Resolution and Home Treatment Team.

2.2.90 On 17th June, Chloe had a further medical review, as she was keen to be discharged. Chloe stated that she felt a lot better now. She said that she now understood the reason why the doctor did not discharge her the previous day, as it was felt it was too unsafe for her. Chloe spoke about how she was happy to go back home, and her mother was happy with this decision. It was decided that Chloe would be discharged later that day once her medication had been ordered and sent up to the ward for her to take home. With regards to safeguarding, it was noted that Chloe still had contact with George, who had sent her threatening messages, and the police were aware of this. It was noted that he was the father of one of Chloe's children. Safeguarding had been put in place for Chloe. Chloe was given numbers to call for support for women who have experienced abuse. Chloe was happy to call them when she feels she wants to. It was agreed that she would be followed up by the Early Discharge team and Crisis Resolution and Home Treatment Team and would have regular contact with the community psychiatric nurse. She would be followed up by the Community Mental Health Team in 4 – 6 weeks. There was no change to medication, and it was noted that she was on a high dose of diazepam. Her GP was to review sertraline (antidepressant) to see if it needed increasing, depending on Chloe's mood.

2.2.91 Chloe spoke to the staff and said that she was appreciative of the care she had received. She said that, on discharge, she planned to see an ex-patient that she had met on the ward, although this would be limited due to lockdown.

2.2.92 The family have told the review that Chloe challenged two previous letters that said that she was leaving hospital on home leave which would have entitled her to return however on the day of discharge she was told it was not home leave. The family feel that this is an important point.

2.2.93 On 19th June, Chloe had her two-day post-discharge follow-up via telephone call from the ward. Chloe said that she was alright but was unhappy that she wasn't given all her medications or a letter on discharge. She planned to call her GP. She was reminded that the Community Mental Health Team would be contacting her next week, and she was happy with that. She was discharged from the Crisis/Early Discharge Team.

2.2.94 As she had indicated, Chloe called her GP. She said that she was clearing her house and was moving in with her parents. The GP discussed with her the possibility of her family taking control of her medication to avoid compulsive overdose, but Chloe became distressed and did not want this, as they had not been supportive and did not believe that she had been forced to have sex and take cocaine by George. The practice planned to seek clarification from the hospital about the medication doses because a discharge letter had not been received, and the GP wished the family to supervise the medication. Chloe's stepfather

advised the GP that he thought that she was much better and could be trusted with her medication.

2.2.95 On 19th June, EMAS received a 999-emergency call from the police. The police reported that Chloe was the driver of a vehicle when another car had struck her passenger door. Chloe had pain in her back and her right leg. Chloe initially declined being taken to hospital due to concerns about COVID-19. On crew assessment, Chloe had pain and numbness in her groin. She said that she was unable to feel anything between her legs and bottom. Chloe advised that she had a historical spinal injury and normally self-catheterised. Chloe's pain increased, and she agreed to be taken to hospital for further assessment. She was reviewed in the ED at NUH and then discharged home.

2.2.96 On 24th June, an occupational therapist from the Erewash Community Mental Health Team was allocated as Chloe's Care Co-ordinator (CCO). She tried to make contact, via telephone, with Chloe but had been unable to reach her. She followed up with a call to Chloe's GP, who noted that Chloe had not collected her medication. The CCO was told by the GP that they had offered to deliver the medication, but that Chloe had declined.

2.2.97 Chloe called her GP on 24th June to disclose that both of her former partners (presumably the father of Child 1 and George) were physically abusive to her and that George had alcohol problems. The GP had tried to discuss the children's well-being and safety with Chloe. Chloe asked that her 'friend' be permitted to collect her medication. When she was told that this was not possible but that her parents could collect it, she ended the call abruptly. The GP tried to call her back, but the call was not answered.

2.2.98 On 25th June, Chloe telephoned the Community Mental Health Team for more information about her benefit claim – so that she would not need to have a face-to-face assessment. The CCO explained that they had not met her but gave her information from the notes, which Chloe seemed satisfied with. The CCO tried to phone Chloe to arrange an assessment appointment but was unable to contact her, and so a letter was sent advising her of an appointment on 3rd July.

2.2.99 On 26th June, Chloe advised her GP that she wanted her friend, Friend 1, to collect her medications, as her parents were not willing to do this. She said that she was staying in a hotel because her medication made her drowsy and her parents did not want her around the children. The GP was not happy with this and rang Chloe's mother to obtain an address to which the medication could be delivered (at this time, Chloe was receiving four days' worth of medication at a time). Her mother was not sure of the address but offered to collect the medication, as Chloe was moving back in with them the next day. The GP also spoke to Chloe's mother about Child 2, due to Chloe's allegations of George's alcohol use.

2.2.100 On 30th June, CSC contacted the GP surgery to enquire about Chloe's mental health and substance misuse. The GP surgery were to telephone CSC or send an email.

2.2.101 Chloe contacted DWP on 30th June to advise of a change of address.

2.2.102 On 2nd July, Chloe and the children moved into their own home, which was on the same street as her parents.

2.2.103 When Chloe was seen by the social worker on 1st July, she raised concerns regarding George drinking too much but advised that when he had Child 2 for contact at the weekend, her mother would facetime Child 2 on a regular basis to check that George was not under the

influence. She said that George had indicated that he would like the relationship to resume; however, she said that she was now in a much better place and felt like a 'new woman'. Chloe's parents played a significant role in the communication between Chloe and George about contact arrangements. During the assessment, Chloe advised that she and the children were due to leave her parent's house and move into their own property on 21st June 2020.

2.2.104 On 3rd July, at her parents' house, Chloe was introduced to her Care Co-ordinator (CCO) from the CMHT. This was 17 days after she had been discharged from hospital. She was with her children and Friend 1 (who she had met in hospital). He was introduced as her new partner. This initial meeting with Chloe was to arrange further contacts and a further assessment to guide the ongoing care plan. Chloe said that she was moving to a privately rented house.

2.2.105 The social worker spoke to George on the telephone on 8th July. He reported that he was living in Doncaster, and he raised concerns that Chloe was in a relationship with someone she had met in hospital (Friend 1), and that this male was living with Chloe and the children. George said he had no specific concerns about this man but that the relationship had been a bit quick. He reported that Chloe had told him that Friend 1 was living with her and had sent him photographs of her with Friend 1 in her new house. He said that Chloe was playing 'mind games', and he was getting mixed messages from her about whether she wanted him around more. He said that, at times, Chloe's parents had told him to stay away from Chloe but when he did, Chloe would then be upset with him.

2.2.106 The CAFA was completed on 9th July 2020, which recommended no further action by CSC. George had admitted that he had acted inappropriately, and both Chloe and George had reported that they were no longer in a relationship. No further concerns were raised by professionals working with the children.

2.2.107 On 10th July, the CCO visited Chloe at her privately rented property that she had just moved to. Friend 1 and her children were present. Chloe reported ongoing struggles to adjust following discharge from hospital and was requesting practical help with bills, benefits, and access to food. It was agreed to refer Chloe to a reablement worker to help with practical things, such as paying bills and to request a review of her medication regime by the outpatient consultant.

2.2.108 On 14th July, Chloe's father rang the GP about Chloe's prescription. It was explained to him that there had been a delay because the GP had been trying to ascertain if the consultant had made any changes to the prescription. It was not specifically documented in this record that Chloe's father was to collect the prescriptions.

2.2.109 The Care Co-ordinator received a telephone call from Chloe on 14th July. She said that she was being issued medication twice weekly and would like to have this decreased to weekly, as she did not think that she was at risk of suicide. The Care Co-ordinator said that she would inform Chloe's consultant psychiatrist of this for review.

2.2.110 On 16th July, Chloe's Care Co-ordinator referred her to a reablement worker. The CCO also contacted the safeguarding team at CSC to discuss safeguarding concerns. It was agreed that they would forward their concerns to mental health services safeguarding.

2.2.111 The Care Co-ordinator attempted to visit Chloe at home on 17th July for a pre-arranged appointment, but there was no reply. The Care Co-ordinator did see Chloe's stepfather, who

was caring for the children. He raised no concerns about Chloe but said that she had been getting up late. A copy of the assessment/treatment plan was left, along with a leaflet about SV2 counselling (they support victims of sexual violence)[14]. Chloe's stepfather was advised about the Care Co-ordinator's leave and advised how to contact the team in their absence. A date for a new appointment was also left.

2.2.112 On 20th July, EMAS received a 999-emergency call to report that Chloe had taken an overdose. Chloe said that she had taken nine boxes of her own medications, including zopiclone, diazepam, and diclofenac, with an intention to end her own life. The crew spoke to her stepfather on the telephone. He said that he and Chloe's mother were caring for her two children. He said that Chloe lived alone and had been recently discharged from a local mental health hospital. He said that, whilst an inpatient, Chloe had tested positive for cocaine use. The ambulance staff recorded that Chloe's stepfather reported that Chloe was using cocaine every weekend, whilst her children were present, and was then spending all day asleep on the sofa. The attending crew raised a detailed safeguarding referral, which included both children's names and dates of birth. The crew identified a safeguarding risk from mental health and substance misuse. This referral was shared with adult and children safeguarding teams, the child and family health team, and Chloe's GP. Chloe was taken to hospital for further assessment.

2.2.113 A referral was made to the MASH by Royal Derby Hospital on 21st July. The referral advised that Chloe attended A&E on 20th July, alleging a significant overdose: this included seven different medications and 108 tablets. Chloe reported to the hospital that she had recently had a stay at the Radbourne Unit, was under the care of a community psychiatric nurse, and she had a diagnosis of Emotionally Unstable Personality Disorder.

2.2.114 On 22nd July, contact was made with the MASH by an anonymous caller who said that they had concerns for the welfare of the children. The caller raised concerns about Chloe's mental health, her being in a new relationship, and abusing prescription and Class A drugs (cocaine). The caller advised that Chloe's parents were 'sugar coating', to social workers, Chloe's mental health, drug use, and parenting abilities.

2.2.115 A MASH social worker contacted family members to establish the current situation. They spoke to Chloe's mother, George, and Child 1's father on 22nd July; however, they were unable to contact Chloe by telephone. It was confirmed that the children were in the care of Chloe's parents. It was reported that although Chloe and the children had moved into their own property on the same street as her parents on 2nd July, her parents had continued to provide much of the care for the boys. Chloe's mother said that Chloe had struggled to get up in a morning with the boys, so they had continued to have them overnight. The fathers of both children reported that they wanted the children to remain at Chloe's parents' home – to provide them with stability – and that they currently only wanted Chloe to have supervised contact with them. George had already spoken to Chloe's mother about this. The MASH social worker agreed with Chloe's mother that until an assessment had been undertaken, it would be appropriate for Chloe to have supervised contact with the children.

2.2.116 A further Child and Family Assessment was progressed to explore the concerns raised, impact upon the children, and support needs for both the children and Chloe. Chloe was visited by an Assessment Team social worker on 27th July and was seen alone as part of the

[14] https://www.sv2.org.uk/help-support/counselling-therapy/

assessment. She confirmed that the children were still in the care of her parents and that she was having supervised contact. Chloe stated that she did want the children back in her care. Chloe said that her recent overdose was because she had come out of hospital/ Radbourne Unit and had felt overwhelmed. She did not feel that she had sufficient follow-on support regarding her mental health. Chloe had moved into the new property and had found this an additional pressure. Chloe stated that the children were not in her care when she took the overdose. She said that the overdose had been a cry for help and that she had no intention to take her life. Chloe reported that her mental health was getting better, although she did have good and bad days. She said that she did not have any drug or alcohol issues. She denied that she was in a relationship with Friend 1. Chloe reported that she had recently contacted George so that they could sort out their differences for the sake of the children. She said that he had agreed to stay over at the family home for the weekend so the children could be at home with Chloe, as she was still only having supervised contact with them.

2.2.117 During a home visit to the children at Chloe's parents' home on 27th July, Chloe's mother reported that contact between the children and their respective fathers was going well. She stated that Chloe and George were getting on well and could potentially get back together. They also reported that they felt Chloe's mental health had improved.

From this point, the dates have been removed to disguise the date of Chloe's death.

2.2.118 At the end of July, the Care Co-ordinator visited Chloe at home, with her parents present. Chloe presented as distressed and described feeling that she was not coping with the care of her children. She was worried about CSC involvement and had subsequently asked her ex-partner (Child 2's father) to stay for a few days to help care for the children. The Care Co-ordinator discussed if this was a good decision, as Chloe had previously reported that he had abused her, and he also wanted to get into a relationship with her, which she claimed she did not want. Chloe said that she felt forced into making this decision due to CSC putting restrictions on her and needing his help. She also said that she felt pushed into this by her mother, which her parents denied. They stated that they were providing a lot of support for her and the children, which prompted her to start crying, and Chloe said that she felt that she was being controlled. She said that she felt frustrated that she could not even take her children out alone, and this made her feel like a bad parent. The Care Co-ordinator reminded her that this was only a short-term measure until she could demonstrate that she was stable and able to take on responsibilities. The Care Co-ordinator agreed to talk to her social worker about the plan.

2.2.119 The Care Co-ordinator discussed with Chloe, taking back some control in her life. She said that she felt frustrated that she was still only being allowed medication to be collected twice a week, and she was advised that until she was stable and was no longer taking overdoses, this would not change. Chloe said that her last overdose had been a cry for help, and she was not intent on taking her life. Chloe said that she felt that she needed help to manage her emotions. The Emotion Regulation Pathway was discussed as an option. When asked, Chloe said that she had not attempted to contact SV2 (an organisation that supports victims of sexual violence).

2.2.120 The CCO noted that Chloe presented as constantly seeking more medication and appeared fixated on having her twice weekly prescriptions returned to weekly prescriptions.

2.2.121 Chloe's GP telephoned the Care Co-ordinator to advise that Chloe had requested more lorazepam. This was discussed with the consultant, who agreed, and her GP advised that this would be prescribed.

2.2.122 Four days later, the Care Co-ordinator followed up the referral for a reablement worker and was advised that it was likely to be a further three weeks before allocation.

2.2.123 Two days later, Chloe contacted her GP by telephone. She appeared distressed and incoherent on the telephone. She said that George wanted her back so he could pressurise her into sex with him (as before), and she just wanted to die. She said that she would hang herself or throw herself under a train, as overdoses didn't work. The GP referred Chloe to the Crisis Resolution and Home Treatment Team, as she had missed a routine CPN visit earlier that day. Chloe was distressed that further hospital admissions might influence the decisions regarding her having her children back with her: they were still residing with her parents at this point and not with her.

2.2.124 The Care Co-ordinator attempted a home visit on the same day, but Chloe did not answer the door: a note was left. This was followed up with a phone call to CSC, and the Care Co-ordinator spoke with Chloe's social worker. They discussed how Chloe was managing with her children and whether a referral had been made to adult safeguarding in regards to Chloe's previous abuse. The social worker advised that no referral had been received.

2.2.125 The social worker confirmed that a referral was made to CSC, following Chloe's overdose, as there were concerns that she was unable to look after her children. She said that Chloe was still being assessed and currently she was not allowed to have the children on her own. The Care Co-ordinator informed the social worker that Chloe had been upset about the fact that she was unable to take her children out alone, and the social worker confirmed that she would not be able to during the assessment period.

2.2.126 The Care Co-ordinator enquired of the social worker if they were aware that George was staying at the house on a few nights, which the Care Co-ordinator was concerned about – as Chloe had reported that he had previously been abusive towards her. The social worker advised that they were aware of one incident a few years ago but had no other evidence of any abuse, and Chloe had been happy to have him there. It was agreed that the Care Co-ordinator and the social worker would remain in contact, with a plan to contact the adult safeguarding team regarding Chloe's allegations of abuse. It is not clear who was to contact Adult Social Care.

2.2.127 The Child and Family Assessment was completed the next day, and it was recommended that the children should be made subject to Child in Need Plans. Although there was good support in place, concerns had been raised by mental health services that mother's engagement was sporadic, and that without this support, a further deterioration in her mental health was likely. The Child in Need Planning Meeting was arranged for 25th August.

2.2.128 Chloe's Care Co-ordinator contacted Chloe, by telephone, on the morning of the same day, following concerns being raised by her GP after she had contacted the GP the previous night in a distressed state: she stated that she wanted to end her life. The Care Co-ordinator visited Chloe at her home, and she said that she wanted to die because she was not getting better. The Care Co-ordinator reminded Chloe that she had missed their appointments, including the previous afternoon, and that this would delay her recovery. Chloe explained that she was asleep when the Care Co-ordinator had called round the previous day at 2 pm,

as she had been on the previous afternoon. The Care Co-ordinator advised Chloe that she intended to complete an assessment for the Emotional Regulation Pathway because Chloe had identified that she needed to manage and regulate her emotions.

2.2.129 Chloe disclosed that the main trigger for how she was feeling was that she was having very little contact with her children, whom she was not allowed to see unaccompanied. She said that they were with her parents most of the time, and they had not brought them round to see her. When the CCO suggested that Chloe could call round (as they were only round the corner), Chloe said that they were very controlling, and she had fallen out with them. Chloe also identified that another trigger was George, who had been staying at her house on a few occasions: as suggested by her mother so she could have access to her children. Chloe said that she did not want him there because he had mentally and sexually abused her, forcing her to have sex. The Care Co-ordinator advised Chloe that she would need to refer this to safeguarding, which Chloe reluctantly accepted. Chloe was advised that the Care Co-ordinator also needed to make a referral to safeguard her because she had alleged her previous partner (Child 1's father) had raped her. She became distressed about this. She stated that she did not want the Care Co-ordinator to do this and refused to reveal his name.

2.2.130 Chloe said that she felt that she needed to be back in hospital because she believed that she was not making progress at home. She was advised that if she went to hospital, she would still be returning home to the same situation, which seemed to be a huge trigger for her depression. Chloe said that if she could get better, she felt that she would be able to look after her children. Chloe acknowledged that at present, she could not look after herself, spent most of the time in bed, and was not caring for herself. Chloe said that she no longer had contact with Friend 1, who she met on the ward, and her family had not bothered with her. The CCO reminded Chloe that the last time Chloe had been seen, her parents were present, and the CCO thought that they seemed supportive. Chloe said that this was fake because the CCO was visiting. She said that 'they are controlling and treat me as a child'. The Care Co-ordinator suggested that they may have been acting in that way because they were concerned and that she may cause the children distress. The Care Co-ordinator suggested that it would be helpful for them to discuss with Chloe's family, a way forward, so she was able to see her children. Chloe provided her mother's number but would not give permission for them to ring her that day.

2.2.131 The CCO advised Chloe that they had been in contact with her social worker (who was still assessing her); however, the social worker had said that, if she wanted to be able to have access to her children, Chloe needed to engage with mental health services. Chloe said that she wanted her children back but did not feel able to look after them and needed more support. When the CCO said that they had been in touch with Nottinghamshire Social Services about the referral for a reablement worker and had requested urgent allocation, Chloe said that she had not heard from them.

2.2.132 Chloe said, again, that she wanted to die but would not overdose this time. She had thoughts of jumping under a train or off a bridge and did not feel safe. She had no plans to see anyone over the weekend and felt isolated. The CCO said that they would make a referral to the Crisis Resolution and Home Treatment Team to assess for hospital admission or home treatment.

2.2.133 The Care Co-ordinator planned to refer Chloe to the Crisis Resolution and Home Treatment Team and contact the safeguarding team, at social services, about the allegations of rape made by Chloe. If Chloe was not admitted to a ward, the Care Co-ordinator planned to visit

her again in a week and try to encourage a meeting with the family, chase up the referral for a support worker, and complete the assessment for the Emotional Regulation Pathway.

2.2.134 **Eleven days before Chloe's death**

2.2.135 Chloe was assessed at home by the Crisis Resolution and Home Treatment Team. Chloe summarised the concerns that she had previously expressed to her Care Co-ordinator. She was focused on going back into hospital to get better and had her bags packed to do so. Chloe said that she was struggling to cope and talked about the ongoing issues related to parenting and CSC involvement. Chloe also expressed regret about a recent sexual liaison with George but described it as consensual.

2.2.136 **Eight days before Chloe's death**

2.2.137 Chloe's assessment was discussed in the Crisis Resolution and Home Treatment clinical meeting. The team also reviewed recent contacts and the history relating to Chloe's admission in May 2020. The agreed plan was to attempt to support and maintain Chloe in her home environment. Interventions were identified to support her management of distress. No changes to prescribed medications were planned, and the team were also aware of child and adult safeguarding concerns.

2.2.138 The Crisis Resolution and Home Treatment Team then visited Chloe at home. More in-depth discussion took place with Chloe and her stepfather about her use of opiate medication, as he expressed concerns that Chloe was misusing and had developed a dependence/addiction to these. Chloe strongly disagreed with this. Her stepfather said that he was part of a church group that offers rehabilitation type placements for people with substance misuse difficulties, and he was advised that this was something to discuss with Chloe and her Care Co-ordinator. Hospital admission was discussed further, but the visiting nurses felt this would be detrimental to Chloe and that ongoing support from Crisis Resolution and Home Treatment Team would be more beneficial. Chloe reluctantly agreed to try this plan. A limited supply of medication was also discussed at this visit to try and reduce the risk of an impulsive overdose.

2.2.139 **Seven days before Chloe's death**

2.2.140 The Care Co-ordinator called Chloe after reading the Crisis Resolution and Home Treatment Team notes. In the notes, she had told them that she had consented to sex with her Ex-partner (Child 1's father), and that he had not raped her. As this was contradictory to what she told the Care Co-ordinator, the CCO wished to clarify the situation before ringing social services as planned. Chloe answered the phone and was quite angry with the Care Co-ordinator. She said that the Crisis Resolution and Home Treatment Team was now involved, but she had not been admitted to hospital because the Care Co-ordinator had told them this was not needed. The Care Co-ordinator explained that this was not the case, and that they would have made the decision after their assessment.

2.2.141 Chloe then called the Crisis Resolution and Home Treatment Team. She was highly distressed and expressed regret, as she felt her disclosure of recent abuse was being used against her. Chloe ended the call abruptly. The team attempted to call her back numerous times. Later, Chloe answered and appeared calmer but irritated by the call. She said that she did not want to talk, and again ended the call.

2.2.142 **Six days before Chloe's death**

2.2.143 The Crisis Resolution and Home Treatment Team visited Chloe at home. Chloe apologised for her temper on the previous visit and said that she felt that there was a focus on the negatives and reminded the worker that the medication was prescribed for her FND. Chloe said that she felt brighter, and a physical health questionnaire was completed. Chloe shared plans for that coming weekend and said that her partner was again staying with her to support with the children. Chloe said that she had planned to go to the seaside for a few days) with her parents and the children.

2.2.144 **Four days before Chloe's death**

2.2.145 The Crisis Resolution and Home Treatment Team made several attempts to speak to Chloe on the phone, without response. They visited her home, but there was no answer. However, the car was on the drive. A call was then made to Chloe's mother who said that Chloe was 'absolutely fine' and had been much more stable in her mental health over past two days and had been shopping with her the previous day. Chloe's mother was told about the Risk Strategy Meeting that was being arranged and that Chloe was to be allocated a new Care Co-ordinator after she said she no longer wanted to work with her current one. Chloe's mother was advised that the team would visit the next day at 1.30 pm. Chloe's mother agreed to ensure that Chloe was available at home for this. A Risk Strategy Meeting (over Microsoft Teams) was set for 2 pm on 28th August.

2.2.146 **Three days before Chloe's death**

2.2.147 The Crisis Resolution and Home Treatment Team visited Chloe at home, but Chloe had forgotten about the appointment. Chloe was washing and ironing and appeared to be preparing for time away with the children. She reported that she had struggled over the last few days, which conflicted with her mum's report. She spoke tearfully about the children referring to her as Chloe and not knowing who she was. She also spoke about the relationship with George, the conflict she felt about the support he provided, and the history of abuse. Chloe talked for a while about her previous relationship with George and how, even though he was now supportive, helped her, and she appreciated this, he had been 'mentally abusive' in the past, and she could not forget this. She said that he had apologised for this, but she also said that it may be too late to rekindle their relationship.

2.2.148 Chloe continued to express a desire to go into hospital, as they 'would make her eat', and she identified having more routine and structure there. Chloe's family recall that she had gone from 12 stone in weight to 9 stone. She spoke about the relationship she had started with Friend 1 whilst in hospital and explained that she was 'in love' with him. Chloe spoke about feeling conflicted about her relationship with opiates and her stepdad's concern about her possibly having an addiction problem.

2.2.149 The pending Risk Strategy Meeting, the change of Lead Professional at her request, and her plans for the coming weekend, were also discussed. It was noted that despite evidence to the contrary, Chloe said that she was not going away.

2.2.150 In his statement to the coroner, George said that he had arrived at her house at about 3 pm that day expecting to find Chloe packed and ready to go away on the holiday with her parents. Chloe was not there but her purse and keys were in the house. He was concerned, so he rang Chloe's mother and she said that he should go to their house, which he did. He

was told that Chloe had gone to Cornwall with Friend 1 but was invited to stay and go away with the family. He said that he was upset because she had planned to go away and had not told him. Consequently, he went to her house and cut the cable at the back of the fridge and cut up a pair of shoes he had bought for her the week before, out of frustration[15]. He then took Child 2 and went to Doncaster for the weekend. He said that he had a facetime call with Chloe, who wanted to see that Child 2 was OK. They then messaged on WhatsApp during the evening.

2.2.151 Phone records show that between 3.04 pm and 3.09 pm, George left five voicemail messages for Chloe. At 3.10 pm, he sent her a text saying: 'Answer me please'. There then followed a further 11 voicemail messages before a text at 3.53 pm, saying: 'Do you want me to go'. He then left two further voicemail messages in ten minutes.

2.2.152 At 4.05 pm, George sent a text saying: 'So you've gone to Cornwall I'm guessing with [Friend 1]. Chloe replied with two text messages that said: 'It's always negative with you' and 'I wanna fix myself'. A conversation, over text[16], then followed:

4.06 pm	George	No it's not how you do this
4.07 pm	Chloe	Can't fix anything till I fix myself
4.07 pm	George	I'm walking away now goodbye Chloe
4.20 pm	George	You've just thrown away the last bit of hope we had
4.50 pm	George	Tell me the truth
4.50 pm	George	Your with Friend 1
4.50 pm	George	I'm not stupid not a Chance your in Cornwall on yo…
4.50 pm	George	Spineless
4.52 pm	George	*Left a voicemail*
6.02 pm	George	You need to pick the phone up and speak to me I've
6.03 pm	George	You need to pick the phone up and speak to me I've
6.58 pm	George	Took [Child 2] spoke to sis and the police see you in
7.05 pm	George	*Left a voicemail*
7.06 pm	George	Where's your children gone
7.06 pm	George	Far far away

2.2.153 George then left seven more voicemail messages between 7.17 pm and 7.42 pm, when he left a text message saying: 'Speak to me now and I will leave you alone for good'.

2.2.154 Later in the day (time not known), the Crisis Resolution and Home Treatment Team received a distressed telephone call from Chloe. She said that she was at the Jury's Inn Hotel in Derby 'for a break'. She described an altercation with George, after she had made it clear that the relationship was over. She alleged that he had smashed windows, cut wires to the house, and took the TV. She said that he had then taken their child in his car (without a car seat) to his address in Doncaster.

2.2.155 These events were confirmed with Chloe's mother. It became apparent that the incident had not been reported to the police. It was agreed that Chloe's mother would report the incident, and that the Crisis Resolution and Home Treatment Team would contact CSC – as

[15] Chloe's family recall that George cut the wire to the fridge, smashed the wall socket to the fridge which tripped the house electrics, cut the wire to her hair drier, smashed mirrors, cut up clothing and took the TV.

[16] It appears as though some of the text is missing but this is the full extent of the data that the police recovered from the handset download i.e., not all data was downloaded.

they were already involved due to safeguarding concerns for the children. Contact details for George were clarified, CSC were made aware, and the case was passed to Nottinghamshire Police.

2.2.156 At 8.50 pm, Chloe's mother contacted the police to report that George had collected Child 2 from her house. She had given him the keys to Chloe's house so that he could collect clothing for Child 2. Whilst there, he had caused damage to the flex cord of a fridge/freezer and electric blanket. He had smashed a mirror and damaged items of clothing, including a pair of trainers.

2.2.157 Chloe's mother explained to the police that they were looking after the children whilst Chloe had some time away, and that George had access to the children at the weekends. However, when he took Child 2 on this occasion, he said that they would not be getting him back. Chloe's parents were concerned because George had been drinking. The police were told that CSC were involved, and that Child 2 was, at that time, staying with them. They explained that Chloe had separated from George in October, and that she was now living round the corner from them. They explained that it had been agreed with CSC that George would have Child 2 from Friday to Sunday, and that Chloe would see Child 1 and Child 2 when she was with her parents. George had asked Chloe's parents where Chloe was. However, unbeknown to any of them, and on the advice from the Crisis Resolution and Home Treatment Team, Chloe had booked herself into the Jury's Inn in Derby. They had contacted Chloe because they were concerned, as they were due to take the children away to the coast.

2.2.158 From text messages between Chloe and Friend 1, it is clear that they were planning to meet up. At 4.18 pm, Chloe told Friend 1 that they were staying at the Jury's Inn in Derby and that they were then planning to go to Cornwall. However, at 5.21 pm onwards, it appears that Friend 1 had a change of heart, and he said: 'I know that this going to go side way for me …' and 'I am done cus I new I was fucking right u been with …'. Chloe tried to change his mind, but at 6.08 pm, he sent four messages saying that he didn't want any part of anything anymore. Chloe continued to beg him to join her at the hotel, but at 6.35 pm, he said: 'Listen I don't want any of that shit and I don't want …'.

2.2.159 When Chloe's parents had gone to Chloe's address, they had found the damage. They had spoken to George, and he had admitted causing the damage. He had also said several times on the phone that he was not bringing Child 2 back and that there was no reason why he had to, as the agreement with CSC was just a verbal agreement.

2.2.160 Later the same day, Chloe contacted the police because her car tyre had been slashed whilst parked at the Jury's Inn. According to a log on police systems at 3.46 pm two days before Chloe's death, the criminal damage had been recorded on Niche, and an officer had visited Chloe at the Jury's Inn and completed a PNN with Chloe.

2.2.161 Chloe believed that George was responsible for 'slashing' her tyre, but she had no proof of this. Chloe did not believe that Child 2 was in any danger from George, as he was good with him and looked after him, but she did have concerns about George being an alcoholic.

2.2.162 The officer recorded that Chloe was clearly suffering considerably with her mental health at that time. She said that her relationship with George was never good and felt that he was responsible for her current mental state. She said that he was never nice to her and was constantly saying cruel things to her, including that when she left hospital, he said that he

was gutted that she had not gone through with the suicide. He would also call her ugly and never allow her to touch him, and he never said that he loved her.

2.2.163 The officer recorded in their notes that they were concerned that Chloe clearly needed further support with her mental health. The officer recorded that Chloe's sole concern was her children and wanting them to be OK, and that she needed advice from CSC about this. The officer felt that CSC should consider the child contact arrangements, as Chloe's stepfather said that CSC had been in touch and advised that George was okay to be caring for Child 2. Arrangements were made for George to attend the police station for a voluntary interview, and he was told that he would be entitled to a solicitor.

2.2.164 A risk assessment was conducted, and Chloe was assessed as medium risk (as there was no significant history between Chloe and George and no initial concerns over the children). However, there was concern that George had possibly located the hotel in which Chloe was staying and was suspected to have slashed her car tyres, although this was unproven at that time.

2.2.165 Chloe later contacted the Crisis Resolution and Home Treatment Team at 11:39 pm and asked if her dad should drive to Doncaster to collect her son. The Crisis Resolution and Home Treatment Team contacted Nottinghamshire Police to discuss this but was advised that they would not attend the Doncaster address and were intending to pass the case on to South Yorkshire Police. The Crisis Resolution and Home Treatment Team updated their incident details with George's address.

2.2.166 **Two days before Chloe's death**

2.2.167 At 1.33 am, Chloe messaged Friend 1 to say that she was at the Jury's Inn. Friend 1 replied to say that he would call the police to report that her house had been smashed up, would give George's name, and tell them that she was at the Jury's Inn. The text conversation that follows, suggests that Chloe wanted Friend 1 to go to the hotel but that he refused. They continued to argue on text until 1.46 am, when Friend 1 does not answer the more than 30 messages that Chloe sent up to 10.32 am. At 10.54 am, Friend 1 sent a text saying that he did not know why Chloe was calling him.

2.2.168 The Crisis Resolution and Home Treatment Team had another discussion with Nottinghamshire Police, who called to say that they would not be taking any further action and that a report would need to be initiated with South Yorkshire Police by either the Crisis Resolution and Home Treatment Team or family members. The Crisis Resolution and Home Treatment Team called Chloe's mother to inform her of this but also contacted 999 due to immediate child safeguarding concerns. The Crisis Resolution and Home Treatment Team was advised to report this via 101, but after calling 101 and waiting for 20 minutes with no response, she called 999 again. The call went through to Staffordshire Police, and they confirmed that there were problems getting through to South Yorkshire Police. They did agree to email South Yorkshire Police with details of the concern. The Crisis Resolution and Home Treatment Team called Chloe again to provide her with an update. Chloe answered and said that she was having a bath. She said that she had spoken to George and that he was abusive towards her; however, she said that Child 2 was fine. He told her that he had spoken to the Multi-Agency Safeguarding Hub team, and they had indicated that Chloe's mother had no parental rights over Child 2. Chloe said that George kept trying to call her, but she was not answering his calls.

2.2.169 At 11 am, Chloe told Friend 1 (on text) that she really needed a friend, and at 11.35 am, she asked him to come and sit with her, as the police were on their way. Friend 1 said that he could not come because he was on the way to take his son to the zoo. At 11.57 am, Chloe asked if he would come later.

2.2.170 At 1.14 pm, Friend 1 asked Chloe (on text) if the police had come, and she replied at 1.22 pm to say that they were still there. At 1.32 pm, Chloe told Friend 1 that 'they can do him for criminal damage at the house' and that they were getting CCTV to look at when her car tyres were slashed. Chloe then asked Friend 1 if he would come to see her. At 3.28 pm, she said that the police had just left.

2.2.171 Chloe then tried to call Friend 1 a number of times over the rest of the day.

2.2.172 George contacted the Emergency Duty Team at CSC because he was concerned that information was being shared with CSC that was not accurate. He reported that Chloe had accused him of smashing up the house, which he stated was untrue. He stated that Chloe's parents had given him a key to Chloe's house and that he had cut the wire to the fridge as 'he pays for it'. He also alleged that Chloe's parents had accused him of slashing their car tyres, which he again denied. He spoke about the impact of Chloe's medication, stating that she 'was taking a cocktail of prescription drugs that have been knocking her out to the point that she is like a zombie'. George made threats that he would not be returning Child 2 back to the care of Chloe's parents following his weekend contact. He was advised to seek legal advice.

2.2.173 **The day before Chloe's death**

2.2.174 George said, in his statement to the inquest, that he had last spoken to Chloe (over the phone) at approximately 1.30 am. He said that he could not play these games with Friend 1 any longer, and if she wanted to be with Friend 1, she should leave him out of it. Chloe said that she loved him and did not want to be with Friend 1. She said she wanted to be with him but needed time at the hotel to figure things out, and she told him where she was staying. He apologised for the damage he caused at her house, and she said he should also apologise to her parents.

2.2.175 Chloe spoke to George on the phone for 19 seconds at 12.02 am. He then called her at 12.23 am and 12.31 am. He then left a number of voicemail messages:

- 4 12.56 am to 12.58 am
- 4 8.25 am to 9.22 am
- 1 11.48 am
- 29 12.03 pm to 8.39 pm

2.2.176 The last call recorded from Chloe to Friend 1 was at 6.12 am.

2.2.177 The Crisis Resolution and Home Treatment Team spoke to Chloe on the telephone. This was only a brief call, as the police were with her. Later attempts were made to speak to Chloe, but her phone went to voicemail. On 17th August, the Crisis Resolution and Home Treatment Team called Chloe's mother: she was in Skegness with Chloe's stepfather and Child 1. She confirmed that Child 2 was still with George but due to return the following day. She said that she was in contact with Chloe, who was blocking George's calls, and described the incident as 'a wakeup call' and that she was 'determined to sort herself out for her children.'

Chloe's mother was asked to remind Chloe of the joint visit planned for the next day and to tell Chloe to call the office for support if she needed to. Chloe's mother was also asked to call if she had any concerns about Chloe or could not get hold of her.

2.2.178 **The day of Chloe's death**

2.2.179 George began to leave voicemail messages for Chloe at 1.08 am: these continued until 4.15 pm (with a total of 19 more voicemails).

2.2.180 The Crisis Resolution and Home Treatment Team attended Chloe's address with the Erewash Recovery Team for a planned joint visit. There was no answer at the door, and Chloe's car was not on the drive. Numerous attempts were made to contact Chloe and her mother, without success.

2.2.181 A further assessment was undertaken by the DASU (Domestic Abuse Support Unit) assessor at Nottinghamshire Police, and a medium risk level was confirmed. This information was shared with Juno Indigo Service (specialist domestic abuse service) and Nottinghamshire County DASU (Children's referral).

2.2.182 Juno Indigo Service received a medium risk referral from the police.

2.2.183 George said that in the afternoon, Chloe's stepfather came to collect Child 2 to spend the last day of the holiday with him and the family. He apologised for everything and was invited to the caravan, which he agreed. He asked Chloe's stepfather if he had heard from Chloe – he said that he had not. Initially, he was not worried because this was common behaviour. He said that he rang the hotel on the way to the caravan and was told that she had checked out.

2.2.184 The social worker spoke to Chloe's mother who said that the situation with George refusing to return Child 2 had been resolved, and that he was returning him later that day. The other issues that George raised were not discussed with her. Chloe's mother told the social worker that she would not be able to contact Chloe because her phone was turned off.

2.2.185 The social worker spoke to a Care Co-ordinator from the Home Treatment Team in Derby. They reported that due to the issue with George not returning Child 2 following contact, Chloe had made an application for a Child Arrangement Order. This information was not confirmed.

2.2.186 EMAS received a 999-emergency call to state that Chloe had been found by hotel staff after she had failed to check out on time. On arrival of the crew, Chloe was unresponsive, was not breathing, and had no pulse. CPR was already in progress by hotel staff. The crew instructed CPR to stop, as there were obvious signs of post-mortem staining and rigor mortis present. Chloe was recognised life extinct at 4:20 pm. The police were contacted, and the scene was left as found (to preserve evidence). The hotel staff reported that the door had been barricaded so they had forced entry. The crew noted a significant number of medications (opiates and benzodiazepines), which appeared to have been laid out on the table. The crew also noted half a bottle of wine, Chloe's credit card, and a prescription.

2.2.187 **The day after Chloe's death**

2.2.188 The Crisis Resolution and Home Treatment Team contacted Chloe's mother after she was unable to contact Chloe. The worker was advised by Chloe's mother that 'Chloe had taken her own life'. She said that she had expected Chloe to join her in Skegness, and that she felt Chloe had not planned to take her life: it was more likely impulsive or a reaction to something that had happened. Chloe's mother also speculated that Chloe had felt rejected by Friend 1, whom she had met on the ward and had formed a recent relationship with. Condolences were offered to Chloe's family for their loss.

2.2.189 A call was made to Chloe by Juno Indigo Service, but there was no reply.

2.2.190 On three days after Chloe's death, the Crisis Resolution and Home Treatment Team made a further call to Chloe's mother to offer condolences and any support.

2.2.191 Six weeks after Chloe's death, George was interviewed about the incidents three days before she died. He said that he had found out that Chloe was not going on holiday with him and the rest of the family. He was frustrated and went to the house and, when he had found that she was not there, had cut the cable to her fridge and cut up a pair of shoes he had brought her the previous week. Regarding the car tyres, it was reported that all four tyres had been slashed: in fact, only one had been damaged. When Chloe's stepfather had taken the car to be repaired, the mechanic had said that the damage was consistent with the car being driven when flat, as opposed to having been slashed. No further action was taken in relation to the damage at Chloe's home, as she had since deceased. However, a statement had been taken from Chloe, and George had admitted causing the damage.

Section Three – Detailed Analysis of Agency Involvement

The chronology set out in Section 2, details about the information known to agencies involved. This section summarises the totality of the information known to agencies and analyses their involvement.

3.1 **NOTTNGHAMSHIRE COUNTY COUNCIL – CHILDREN'S SOCIAL CARE (CSC)**

3.1.1 **26th September 2018**

3.1.2 Children's Social Care first became involved with the family when a referral was made to the Multi-Agency Safeguarding Hub (MASH) by Nottinghamshire Police. It was initially reported that Child 1 had contacted the police when their mother and George were arguing. Police attended the address, and George was removed from the property, as he presented as intoxicated and aggressive.

3.1.3 Information sharing with other agencies took place in the MASH, and no further concerns were raised by other agencies. The MASH social worker recommended that no further action be taken because the incident appeared to be a one-off, this was a first referral, and mother appeared to have acted appropriately to protect the children. However, the MASH team manager did not agree with this recommendation and made the decision that a Child and Family Assessment (CAFA) should be progressed – as further exploration was required around the family dynamics and functioning, mother's understanding regarding domestic abuse and impact on the children, and direct work to be undertaken with Child 1. ***This is an example of good practice.***

3.1.4 A Child and Family Assessment was subsequently progressed to determine if there were any safeguarding concerns or support needs in respect of the children. Chloe was visited at home and spoken to as part of the assessment. Both Chloe and George independently reported that he did not normally drink alcohol to excess and that his behaviour on 26th September had been out of character. Chloe fully co-operated with the assessment and told the social worker that she would not tolerate George's behaviour around the children. She was noted to have acted appropriately to protect the children.

3.1.5 It was reported that the incident had been a one-off and there was no other information at the time contrary to this. The Healthy Families Team and Child 1's school were contacted as part of the assessment and information sharing. The assessment was completed on 1st November 2018, and the case was closed to CSC.

The review notes that Chloe was spoken to alone as part of the assessment, but there is no record of the discussions about domestic abuse and her understanding of the impact of this on her and her children. There is no evidence that she was given any information about domestic abuse support services.

Recommendation

It is recommended that all staff are reminded of the importance of sharing information about domestic abuse services and recording that this has been done.

It was recorded that Chloe was very anxious about CSC involvement. This was likely to have been further impacted by the delay in the referral being progressed in the MASH. There were four weeks between the decision to progress a CAFA being taken, and the home visit being undertaken.

3.1.6 At the home visit, Chloe was anxious and visibly shaking. Her account of the incident was consistent with the initial phone call with the social worker.

3.1.7 **20th May 2020**

3.1.8 On 20th May 2020, a further referral was received by the MASH from Nottinghamshire Police. It was recorded that Chloe had been reported missing on 19th May and had taken an overdose of her prescription medication to take her life. Chloe was reported to have been taken to Derby Royal Hospital in a life-threatening condition.

3.1.9 A MASH social worker spoke to Chloe on the telephone, and Chloe stated that the children were in her parents' care. She consented for the social worker to speak to them.

The IMR author is of the view that there should have been more communication with Chloe, and an assessment should have been undertaken to check out the information provided by her mother.

Chloe was clearly not well when she was spoken to by the social worker, and her speech was described as slurring. Her voice was not heard as part of this information gathering, which led to no assessment being undertaken.

3.1.10 During the time that the referral was being reviewed by the MASH, George contacted CSC. He enquired about plans for the children and whether he could remove Child 2 from the care of Chloe's parents. He told the social worker that Chloe's medication made her either sleep all day or made her volatile. He said that he had care of Child 2 at weekends. He did not raise any concerns regarding Chloe's parents' ability to care for the children; however, he did raise concerns regarding them not taking Chloe's mental health seriously. He reported that, on a previous occasion, when Chloe had gone missing, she had spoken to him, and she had asked him to promise to play a certain song at her funeral. He said that he had told Chloe's parents about this, and they didn't take him seriously. CSC did not discuss these concerns with Chloe's parents.

Given that it was decided that Chloe's parents were safeguarding the children and acting protectively, it is concerning that the social worker did not speak to them about George's concerns.

3.1.11 The social worker subsequently had a telephone conversation with Chloe's mother, who confirmed that she had care of the children, and that both the children and Chloe had been living with them recently because Chloe had been struggling to cope since the 'lockdown'.

It was reported that Chloe and George had separated approximately 6 weeks ago, and this had impacted on Chloe's mental health.

3.1.12 Chloe's mother also reported that Chloe was struggling with physical illness due to having a spinal operation a number of years ago, which had left her with seizures and neurological issues. She said that she and her husband had been administering Chloe's pain medication recently because Chloe had been in pain a few weeks ago and had taken too many tablets. She said that since then they had agreed with Chloe's GP that they would collect her medication; however, on this occasion, Chloe had collected her medication herself and had taken the overdose. Following the referral, it was deemed that there was no further role for CSC, as the children were safe in the grandparents' care.

The review shares the IMR author's concerns that there was no CAFA undertaken. This would have allowed Chloe's voice to be heard and ensured that her parents had a good understanding of Chloe's mental health and the potential risks that these posed to the children. The review notes that this decision may have been impacted by the COVID-19 lockdown – when workers were trying to reduce the amount of work being passed to the Assessment Team, given the uncertainty about service delivery.

3.1.13 **8th June 2020**

3.1.14 On 8th June, the MASH received a referral from South Yorkshire Police reporting malicious communication between Chloe and George. Following this referral to the MASH, a second Child and Family Assessment was undertaken. Chloe was seen in person, and George was spoken to on the telephone by the social worker.

3.1.15 Chloe said that George had been making threats to her and making nasty comments, and she felt that it was linked to his alcohol misuse. She told the social worker that they had split up in October 2019 but had gone on holiday in December 2019 because it had been booked before they split up. She said that George had drunk excessively during the holiday. She said that he had stayed with the family for a week during lockdown but again had been drinking heavily. She had tried to get support for George for his drinking, as this was the reason for them splitting up. She said that George had indicated that he would like the relationship to resume; however, she was now in a much better place and felt like a 'new woman'.

3.1.16 The CAFA considered the recent concerns about the difficult relationship between Chloe and George, and the previous concerns about her mental health. It was reported that Chloe was currently doing well and accessing support from agencies. Neither Chloe nor George was seeking any further help, and there was no further role identified for CSC. The CAFA was completed on 9th July 2020, which recommended no further action by CSC.

The IMR author notes that the decision to undertake a CAFA, at this point, may have been influenced by the decision in May, and the assessment did consider Chloe's mental health. The IMR author supported the decision-making at this point.

3.1.17 **21st July 2020**

3.1.18 The CAFA progressed in response to Chloe's further overdose, and this focused on Chloe's poor mental health and the impact of this on the children. The previous concerns regarding domestic abuse were again discussed with Chloe – to gather a holistic picture of the family situation. Information gathered from Chloe, Chloe's parents, and George, portrayed a picture of Chloe suffering with both her physical and mental health. The prescribed medication that she was taking was making her tired and had been impacting on her ability to get up in the morning to care for the boys. She had moved to be near her parents so they could support her and help her take care of the boys. Chloe appeared frustrated that the move into their new home was not the fresh start that she had wanted. Chloe reported that she currently felt that she had good support for her mental health, as she had support from a community psychiatric nurse, had a supportive GP, and was due to start counselling in September. She also felt her medication 'was kicking in'. Chloe felt that she didn't need any further support from CSC.

Although Chloe consistently reported that she didn't want or need any support from CSC, this may have been impacted due to her anxiety about CSC involvement. It appears that throughout CSC involvement with Chloe, she was anxious about this involvement. She, at times, expressed concerns about whether the children would be removed from her care. It is, therefore, likely that Chloe tried to put on a positive front to social workers and may have minimised both the domestic abuse and mental health concerns. The review notes that social workers did try and alleviate Chloe's worries, but it is not unusual for parents to be anxious about CSC involvement.

Chloe's oldest child was seen alone as part of the CAFA, and he spoke in general about his family but did not raise any concerns or worries. He reported that he liked spending time with different family members, including his mother, father, and grandparents. He also spoke of having people that he could speak to if he had any concerns.

3.1.19 **22nd July 2020**

3.1.20 An anonymous call was made to the MASH. The caller raised concerns for the welfare of the children and Chloe's mental health, her being in a new relationship, and abusing prescription and Class A drugs (cocaine). The referrer said that her parents were 'sugar coating', to social workers, Chloe's mental health, drug use, and parenting abilities.

3.1.21 A Children and Family Assessment was undertaken with the social worker. The social worker spoke to Chloe's parents, George, and the father of Child 1, as well as Chloe. Both fathers stated a wish for the children to remain with Chloe's parents and for her to have supervised contact.

3.1.22 The assessment was completed on 7th August, and it was recommended that the children should be made subject to Child in Need plans. It was felt that, although there was good support in place, concerns had been raised by mental health services that mother's engagement was sporadic, and that without this support, a further deterioration in her mental health was likely. The Child in Need planning meeting was arranged for 25th August.

The review believes that CSC acted appropriately in safeguarding the children whilst supporting Chloe to continue to have contact with them.

3.1.23 **15th August 2020**

3.1.24 George contacted the Emergency Duty Team because he was concerned that information was being shared with CSC that was not accurate. He reported that Chloe had accused him of smashing up the house, which he stated was untrue. He stated that Chloe's parents had given him a key to Chloe's house and that he had cut the wire to the fridge, as 'he pays for it'. He also alleged that Chloe's parents had accused him of slashing their car tyres, which he again denied. He spoke about the impact of Chloe's medication, stating that she 'was taking a cocktail of prescription drugs that have been knocking her out to the point that she is like a zombie'. George made threats that he would not be returning Child 2, back to the care of Chloe's parents, following his weekend contact. He was advised to seek legal advice.

3.1.25 The social worker subsequently spoke to Chloe's mother on 17th August. Chloe's mother said that the situation with George refusing to return Child 2 had been resolved, and that he was returning him later that day. The other issues that George raised were not discussed with her. Chloe's mother told the social worker that she would not be able to contact Chloe because her phone was turned off.

3.1.26 On 17th August, the social worker spoke to a Care Co-ordinator from the Home Treatment Team in Derby. They reported that due to the issue with George not returning Child 2 following contact, Chloe had made an application for a Child Arrangement Order. This information was not confirmed.

3.1.27 **Child in Need Plan**

3.1.28 A further Child and Family Assessment was progressed, and Chloe was visited by an Assessment Team social worker on 27th July: she was seen alone as part of the assessment. She confirmed that the children were still in the care of her parents, and that she was having supervised contact. Chloe stated that she did want the children back in her care.

3.1.29 The Child and Family Assessment was completed on 7th August 2020, and it was recommended that the children should be made subject to Child in Need Plans. This was due to concerns that Chloe's engagement with mental health services was now sporadic, and it was felt that if she did not engage fully, then there would be a further deterioration in her mental health, which would impact on her ability to provide safe care for the children. The Child in Need Planning Meeting was arranged for 25th August.

3.1.30 CSC record that, whilst concerns were raised about domestic abuse in Chloe and George's relationship, there was not sufficient evidence to suggest that the children were suffering harm because of this. Chloe reported that George was emotionally abusive towards her at times when he had been drinking, and that this would have further impacted on her poor mental health.

CSC were satisfied that Chloe's parents provided her with support regarding the emotional abuse that she was experiencing, taking the lead at times in communicating with George, and planning for contact with the children. Once again, Chloe's oldest child was seen alone as part of the CAFA, and he spoke in general about his family but did not raise any concerns or worries. He reported that he liked spending time with different family members, including his mother, father, and grandparents. He also spoke of having people that he could speak to if he had any concerns. Had the CIN plan progressed, then more direct work would have been undertaken.

3.2 DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

3.2.1 Given the different services that Chloe was engaged with, brief details about these services are included prior to the analysis.

3.2.2 Ward 3 of the Radbourne Unit

3.2.2.1 Ward 36 is a 15-bed mixed (between male and females) acute admission ward that admits patients from across the Derbyshire area to provide inpatient care for a range of mental health difficulties. While it admits patients who are detained under the Mental Health Act, most of its patients are usually informal, and it is an open ward for these patients. It has a lead psychiatrist and a staff team that includes psychiatric nurses, nursing assistants, occupational therapists, and a pharmacist. Each patient has their own private room and washing facilities. There are a range of activities on the ward, and each patient is assigned a nurse to help offer support.

3.2.3 Erewash Community Mental Health Team (CMHT)

3.2.3.1 The Erewash Community Mental Health Team is a multidisciplinary team based in Ilkeston. They support adults over 18 within their defined geographical area. The team provides co-ordinated specialist mental health care to people with complex and/or enduring mental health needs. The multi-disciplinary team consists of mental health nurses, occupational therapists, psychiatrists, psychologists, and administrative staff.

3.2.4 Crisis Resolution and Home Treatment Team – Derbyshire South County

3.2.4.1 This is an assessment and home treatment service that aims to safely provide intensive support in the community and avert hospital admissions. It considers support networks and patient vulnerability, both in and out of hospital. The support offered includes daily contacts, which can be tailored to suit the needs of the patient and their family. Risk is reviewed at each contact, and the team offers a range of home treatment interventions, such as safety planning, engagement work, medication compliance, and brief psychological interventions.

3.2.4.2 The team works alongside the existing care team who would be expected to remain involved for the duration of the home treatment spell. If at any time home treatment is unsafe or untenable, then alternatives such as hospital admission or a Crisis House stay would be considered. The team has access to suicide prevention training, along with ongoing learning in this area.

3.2.5 Review of the care that Chloe received and adherence to Trust policies

3.2.5.1 Radbourne Unit

- In line with the Care Programme Approach (CPA), there was a discharge plan agreed with Chloe once she asked to be discharged, and this identified that she would be allocated a CCO from the Erewash Community Mental Health Team, however:

- There is no clear documentation that care plans in the Radbourne Unit were completed in collaboration with Chloe

- Whilst Chloe had an identified named nurse on the Radbourne Unit, there is no evidence of time spent co-ordinating and planning care and discharge
- There is no documented evidence of how time was spent with Chloe, and no evidence of discussion with and feedback from Chloe
- The safety plan completed on the ward did not acknowledge Chloe's experience of chronic pain, the potential risks to her children, or a detailed account of her allegations of abuse
- Whilst a physical examination was undertaken when Chloe was admitted, there was no effective care plan to support her with her FND and the management of her symptoms.

The review is satisfied that feedback has been given to the team and will be incorporated into compliance reviews in the team to ensure person-centred care.

3.2.5.2 Whilst an initial history was completed when Chloe was admitted to the ward, the assessment did not include a more detailed social or risk history.

On 11th June 2020, Chloe handed a letter (that she had written) to the staff on the ward. It detailed her relationship difficulties and mental health problems. Although this was to be scanned to her notes for the medical team, it cannot be found in the clinical records.

3.2.6 **Erewash Community Mental Health Team (CMHT)**

3.2.6.1 The CCO completed a care plan to a good standard, as required by the Care Programme Approach, and this included a crisis contingency plan.

3.2.7 **Crisis Resolution and Home Treatment Team**

3.2.7.1 The care plan prepared was brief; however, there is evidence that it was agreed and discussed with Chloe verbally, and crisis contact information was given verbally. The appropriate risk reviews were completed on each visit to Chloe.

3.2.8 **Domestic abuse**

3.2.9 There is evidence of Chloe repeatedly reporting that she had been a victim of domestic abuse whilst an inpatient.

Whilst there is evidence of low-key interventions to reframe her thinking about feeling a lack of control, there is no evidence of consideration being given to specialist domestic abuse services.

Whilst there are several separate entries that either allude to, or directly report, Chloe being a victim of domestic abuse, there is very little follow up in later conversations.

The review agrees with the IMR author that there was no linking of the number of times that Chloe spoke of domestic abuse, which is indicative of an increased level of trauma.

3.2.10 In June 2020, Chloe reported to ward staff that she was receiving threatening texts from George whilst on the ward. The expected practice in this circumstance would be to raise a safeguarding concern and to follow up to ensure that all the necessary agencies had been advised to manage the risk.

Chloe was advised to call the police on 101 to report this. This is not in line with expected practice.

3.2.11 At the point of discharge from the ward, it is documented that safeguarding was put in place, that she had been given phone numbers for domestic abuse support, and that the police knew about the threatening texts, although it is stated that the texts were 'in the past'.

It is not clear in the notes that any further safeguarding, beyond child safeguarding, was put in place or if the police were aware of the threatening texts.

3.2.12 The day prior to discharge, there is a discussion documented around using SV2 for support, which Chloe was agreeable to.

However, it is worth noting that SV2 provides services for survivors of sexual violence: they are not a specialist domestic abuse service.

There is no evidence of contact with children's safeguarding to ascertain the safety of Chloe's discharge regarding the care of her children.

The expected practice is that there should have been a safeguarding strategy review, even if discharge was against medical advice, and that there was additional support with the children from Chloe's parents.

Recommendation

It is recommended that the Assistant Director for Safeguarding Adults supports the Senior Inpatient Nursing structure to explore how to enhance supervision arrangements in relation to safeguarding. This should include time for staff to undertake case study works to better enhance their understanding and awareness, as well as the opportunity to explore concerns with ongoing caseloads.

3.2.13 **Safeguarding Adults' Policy and Procedures**

3.2.13.1 This policy was not followed by the team on the Radbourne Unit.

An incident report was not completed when Chloe made the allegations of abuse nor in regard to the relationship with a fellow male patient on the ward. It was noted that safeguarding referrals and discussions did occur for wider concerns but that the evidence or formulation of all risks should have been included.

The Serious Incident Report concluded that safeguarding actions and record keeping was not of the standard expected.

3.2.13.2 At the time that Chloe was in the Radbourne Unit, the compliance on Ward 36 with safeguarding training was:

Adult Safeguarding Level 1 and 2 = 85.71%
Adult Safeguarding Level 3 = 66.67%
Child Safeguarding Level 2 = 66.67%
Child Safeguarding Level 1 = 100%

Whilst the SIR considered that the training levels had not impacted on the issues identified, it was considered that opportunities were not taken when Chloe was an inpatient to safeguard her following her disclosures of abuse.

The review is advised that specific training around sexual safety, starting relationships in hospital, and the risks of women with historical adverse events on commencing new relationships that may lead to further risks, has been provided to the multi-disciplinary team on the ward.

3.2.14 **Safeguarding of Chloe's children in the community**

3.2.14.1 The Radbourne Unit did not contact CSC to aid their discharge planning and risk assessment during the discharge process. A Think Family approach to Chloe as a parent, and in supporting the family, could have been considered.

3.2.14.2 It is noted that the Care Co-ordinator raised safeguarding concerns as soon as they became apparent. ***This is an example of good practice.*** This was at the expense of the therapeutic relationship and resulted in another Care Co-ordinator being allocated.

The actions of the ward staff may have been impacted by COVID-19, which is discussed later in the report.

3.2.15 **Crisis Resolution and Home Treatment Team**

3.2.16 After discharge to community-based services, Chloe appeared to be more explicit about the risks to herself, and further support was sought from social care for safeguarding and practical help. Chloe was frequently seen at home, both in the company of her family and her children. Again, information was provided on services from SV2.

3.2.17 On several occasions, Chloe expressed that she felt controlled. This was not always in relation to her relationship with George but also her parents, social care, and her GP. Chloe felt that she did not have control over aspects of her life.

3.2.18 The feeling of lack of control and her fear of CSC intervention, is likely to be reflected in Chloe's reluctance to accept a referral for safeguarding due to potential risks from George. A referral for safeguarding due to risks from previous partner (Child 1's father), caused Chloe significantly more distress; however, it is not clear from the notes if there was a continued risk from this previous partner.

> This suggests a lack of understanding by staff about the nature of domestic abuse, particularly coercive and controlling behaviour, and the powerful feelings of helplessness that this can engender.

Recommendation
It is recommended that the safeguarding team and Head of Nursing hold a learning event for those involved in this incident, to allow space for reflection on actions: with a view to identifying learning needs and training gaps. Action should then be taken to meet these needs.

Recommendation
It is recommended that the Trust reviews its current domestic abuse training to ensure that it clearly covers coercion and control and provides staff with an understanding of the impact of domestic abuse.

Recommendation
It is recommended that the Trust reviews its training provision to ensure that all staff have received up-to-date training in domestic abuse, and a programme of training and refresher training is implemented, if necessary.

3.2.19 Later, Chloe felt that these disclosures were being used against her and requested a new Care Co-ordinator.

3.2.20 When Chloe felt that she needed to return to hospital and expressed suicidal ideation, an appropriate referral to the Crisis Resolution and Home Treatment Team was made. This assessment did not result in Chloe being admitted to hospital as she wished, but extra support was provided in her home, and she was provided with interventions to help her manage her distress.

The review is advised, by the IMR author, that this was an appropriate clinical decision to make in the context of someone who struggles to regulate their emotions, and it was in line with NICE guidance.

3.2.21 The Crisis Resolution and Home Treatment Team had varying levels of success in engaging Chloe. A number of face-to-face appointments failed: the most successful engagement was over the telephone, usually at Chloe's initiation.

3.2.22 The review notes that, despite the impact of COVID-19, face-to-face meetings with Chloe were prioritised. Care plans and risk assessments were completed appropriately and captured Chloe's wishes and feelings. There was frequent communication between the Care Co-ordinator, Crisis Resolution and Home Treatment Team, and social care.

The decision not to readmit Chloe to hospital was a key component of the inquest, which heard live evidence in relation to this issue. The inquest did not find that the decision was inappropriate in all the circumstances that prevailed at the time. This review will not make further comment on that point: it has been exhaustively scrutinised by the inquest process.

3.3 **EAST MIDLANDS AMBULANCE TRUST**

3.3.1 On each of the occasions that EMAS had contact with Chloe, attendance was triaged in line with national policy. It used the Advanced Medical Priority Despatch System (AMPDS) to determine the most appropriate response based on clinical need. Each time, the ambulance attended within the appropriate timeframe.

3.3.2 On two occasions, a safeguarding risk was identified, and referrals were made to the appropriate agencies.

3.3.3 During the contacts that EMAS had with Chloe, domestic abuse was not disclosed. Given that she was very unwell on a number of occasions, this is not surprising. EMAS recognises it can be difficult for victims to disclose domestic abuse. Therefore, since June 2020, all EMAS handheld devices that are taken into patient's homes have a domestic abuse sticker that states: 'Domestic Abuse is not OK, and it can happen to anyone. EMAS has a zero tolerance for Domestic Abuse, speak to me or contact the helpline on 0808 2000 247'. Unfortunately, this was only in place for one contact with Chloe, and during that time, she was very unwell (having taken an overdose).

3.3.4 The EMAS crew did not identify any indicators of domestic abuse, and, on review of all records, there is no indication that EMAS crews missed any opportunities to identify that domestic abuse was a factor for Chloe. EMAS crews, however, did recognise Chloe's vulnerability in terms of her mental health. Chloe took two previous substantial overdoses before her death, and EMAS crews raised safeguarding referrals on both occasions. Chloe was also conveyed to a place of safety (hospital), where she was able to access further care and treatment for both her physical and mental health. There is evidence of communication with Chloe's family to ensure that her children were safeguarded. ***This is good practice by the attending crew, considering the children were not on scene at the time.***

3.3.5 Domestic abuse and its associated agendas have been rolled out during safeguarding training. This is a core subject for all frontline staff during the 2020-2021 educational year. Staff have been provided with the skills to recognise domestic abuse and signpost individuals to the appropriate services.

3.3.6 A live 'learning from events' session has been co-delivered by the police and an independent author for Domestic Homicide Reviews. This session was delivered to all frontline staff and looked at two DHRs that EMAS had been involved in. Key areas for learning were identified, which included recording of all people who are present during attendances and gaining consent for domestic abuse referrals. EMAS will continue to include domestic violence and abuse updates on a yearly basis as part of safeguarding training.

There are no specific recommendations for this organisation.

3.4 **GP PRACTICE FOR CHLOE**

3.4.1 Chloe had been registered at her GP practice since September 2014: her last communication with a GP was on 6th August 2020.

3.4.2 On 10th July 2018, the health visitor saw Chloe and recorded on her notes that domestic abuse was not discussed because George was present.

> There is no evidence that the Practice staff were formally alerted to this, and it would have been the responsibility of the health visitor to take this forward in 'safeguarding', if felt appropriate to do so. At regular children's safeguarding meetings, the practice has a health visitor present, and they have actively encouraged the sharing of these domestic violence notifications with the practice: this area of communication could be improved.

3.4.3 Chloe was always seen alone by the GP; therefore, there was no barrier to her being asked about domestic abuse.

3.4.4 On 5th October, the GP practice received notification following an incident of domestic abuse to which the police were called, and at which the children were present. On 11th October, a note was added that there was no further action for CSC after a MASH was convened.

> Although GPs are usually asked to support information for MASH meetings, there is no evidence on the files that this occurred on this occasion.

3.4.5 On 8th June, Chloe contacted her GP from the inpatient unit and disclosed that she had experienced significant trauma at the hands of her previous partner, including rape and being forced to have sex with others. She said that 'he broke me' (referring to George). Chloe admitted that she was addicted to oxycodone, as she wanted to blot out the bad memories. Chloe was anxious to get her medications in place for her imminent discharge. The GP advised Chloe that they would have to wait for a letter from the hospital but acknowledged that Chloe was determined to reduce her opiate use. Chloe told the GP that she trusted them and asked for video consultation when discharged. The GP planned to follow up Chloe's disclosures at that appointment.

> The review notes that the GP did not notify the ward about Chloe's disclosure and that this would have been important for staff to know, given her vulnerable state.

This was raised with the GP, who has acknowledged that this should have been shared, at the time, with the ward. This would have allowed the ward staff to explore with Chloe if she wished to report this to the police. This has been explored by the inquest and the review is satisfied that this was an oversight by the GP in a very pressured time; therefore, no specific recommendation is made in relation to this.

The review notes that, as the GP practice had not received the earlier MASH notification, neither Chloe's records nor her children's records had not been coded as being a victim of domestic abuse.

3.4.6 When Chloe called her GP on 19th June, she said that she was clearing her house and was moving in with her parents. The GP discussed with her the possibility of her family taking control of her medication to avoid compulsive overdose, but Chloe became distressed and did not want this – as they had not been supportive and did not believe that she had been forced to have sex and take cocaine by George.

3.4.7 The practice planned to seek clarification from the hospital about the medication doses, as a discharge letter had not been received, and the GP wished the family to supervise the medication.

3.4.8 A call was arranged but owing to an RTA recovery of vehicle and loss of medications, discussions were not taken forward. Chloe did, however, say that she was moving in with her mother and stepfather. There were several follow-up telephone calls over the subsequent few weeks before Chloe was admitted to hospital again.

The review notes that the GP practice holds regular safeguarding meetings. Furthermore, having reviewed Chloe's care, it appears that there was sufficient oversight by the GP partners of Chloe and her home environment, who were all aware of the circumstances. However, the GP practice was not advised when there was a MASH meeting or when Chloe disclosed domestic abuse when she was an inpatient.

This review has also been provided with a report from Chloe's GP regarding the management of her medication. We agree with the GP's view that there is evidence that the practice takes seriously the responsibility to monitor and review patients on high-risk medications. All GPs within the Practice are fully aware of the circumstances leading to the sad death of Chloe and have used this to reflect upon ensuring that they maintain vigilance.

3.5 NOTTINGHAMSHIRE HEALTHCARE FOUNDATION TRUST

3.5.1 Department of Psychological Medicine (DPM)

3.5.2 The Department of Psychological Medicine is a 24-hour liaison psychiatry service covering the Nottingham University Hospitals. It provides assessment, consultation, and management advice in respect to patients aged 18 – 65 who present with mental health needs and associated risks. This includes patients who present with suicidal thoughts or following self-harm or suicidal acts. DPM has the capacity to offer short-term outpatient follow-up – to work holistically with patients to provide ongoing assessment, treatment (if indicated), psychological support, and signposting to other services if required.

3.5.3 Chloe was referred to the service in November 2016 and seen initially in January 2017.

3.5.4 Chloe was seen by the team on eight occasions and missed two appointments. She was seen by two different medics over this time. The focus of her appointments appears to have been the psychological component of the pain that she was experiencing, and she needed medication (diazepam) in the short term to help her to manage her anxiety.

3.5.5 During this care period, Chloe was diagnosed with Emotionally Unstable Personality Disorder (EUPD), which Chloe felt was an accurate reflection of her difficulties, and she agreed to a referral to the personality disorder team (NPDNN).

3.5.6 During her appointments, Chloe disclosed issues within her relationships. She disclosed that her relationship with Child 1's father was coercive and controlling and that there were ongoing issues with economic abuse, such as reporting her to the job centre for working. She also disclosed issues with her extended family, who expressed concerns about the level of their care for the children; however, the information recorded is limited.

When making this diagnosis, there was limited curiosity about the impact of trauma and ongoing abuse experienced by Chloe. A risk assessment should have been completed, and this would have potentially highlighted the ongoing domestic abuse that Chloe was experiencing. It would have also highlighted any risk to her child. Greater professional curiosity may have identified increased opportunities for partnership working.

3.5.7 Her involvement ended in December 2017.

During her engagement, Chloe talked several times about domestic abuse. On some occasions, she spoke about the abuse being historic; however, at other times, it was clear that it was ongoing, even if the relationship had ended.

The review agrees with the summary report author that it would have been beneficial for practitioners to use professional curiosity to a greater degree and to use the Think Family approach to consider the impact of this abuse on her children.

Recommendation
It is recommended that adult mental health services actively share information with HFT colleagues when they are working with adults who have children.

3.5.8 **Healthy Family Team (HFT)**

3.5.9 The HFT provides universal and targeted health support to all children aged 0 – 19 across the county. The support offered follows a standardised programme in line with the service delivery framework, with the option to offer increased support if specific health needs are identified. Both children received universal services from the team, as per the service guidance.

3.5.10 Child 1 was referred in November 2017, but he was not seen until March 2018, when a routine health screening check was completed in school.

As there were no safeguarding concerns raised when Child 1 was referred, he would not have been routinely seen for a transfer-in visit.

3.5.11 Chloe was offered antenatal contact prior to the birth of Child 2, but she declined this. She was seen at home on 10th July 2018 after the birth of Child 2. Routine enquiry about

domestic abuse was considered but was not asked because George was present. However, at the 6–8-week review, Chloe was seen alone, and routine enquiry was undertaken. She did not disclose any domestic abuse but discussed anxiety. She was offered appropriate support for this issue.

3.5.12 In October 2018, the HFT received a request for information by the Multi-Agency Safeguarding Hub (MASH) relating to domestic abuse. At this point, the HFT appropriately escalated the case to 'Partnership Plus' level, with a plan to obtain more information from social care; however, despite repeated requests by HFT, no further information was received. Escalation to 'Partnership Plus' meant that there would be increased involvement.

The review considers that, having sought information, the MASH could reasonably have been expected to respond to the request for more information from the HFT to assist them in supporting Chloe.

3.5.13 Chloe was last seen in April 2019 for Child 2's 8 – 12-month development check. She reported that she was not in a relationship and had moved to be near her family. No other concerns were documented.

It was not clear from the HFT records if the children had different fathers. A further exploration and recording of this would have assisted a better understanding of the risk from historic domestic abuse.

The review notes that had the disclosures made by Chloe to DPM been shared with HFT, then they could have taken a more proactive approach to exploring domestic abuse with Chloe.

3.6 **NOTTINGHAM UNIVERSITY HOSPITAL (NUH)**

3.6.1 Chloe had a significant number of outpatient appointments in relation to her functional disorder and her second pregnancy. Chloe regularly attended her appointments. For the appointment that she changed a date or time of, she rebooked and then attended. There were no concerns that she was not able to access services freely.

3.6.2 The team that supported Chloe with the functional neurological disorder were aware that she had mental health issues but had no reason to escalate any concerns around this.

3.6.3 The obstetric service recognised that her support needs and risks were increased, so she was given an open appointment so that she could have a senior review at short notice if required. ***This shows good practice in response to a recognised clinical need.***

3.6.4 Chloe had 22 ED attendances from 2011 to June 2020. Some were for medical reasons and some related to pregnancy. There were no disclosures of, or concerns about, domestic abuse/violence on any of these attendances.

3.6.5 **Routine enquiry**

3.6.6 One of the questions that is pertinent to a DHR is whether, in the hospital, domestic abuse is routinely asked about during consultations.

3.6.7 The IMR author advised the review that this has been considered on several occasions, but the concern of the hospital is that this would become a tick box exercise. The Trust has, rather, focused on delivering training to all patient-facing staff in relation to recognising and responding to domestic abuse: this is updated annually in the mandatory safeguarding training.

3.6.8 The ED teams receive additional domestic abuse training, and this is updated every two years.

3.6.9 The Trust employs a domestic abuse specialist that supports the ED and wider clinical areas. This post is funded predominantly by the Nottingham Crime and Drugs Partnership, with some funding from NUH.

3.6.10 The Trust provides assurance via their commissioners and adult safeguarding boards in relation to their referrals, and it is actively involved in Safeguarding Adults Reviews and Domestic Homicide Reviews.

3.7 **NOTTINGHAMSHIRE POLICE**

3.7.1 **19th May 2018**

3.7.2 Chloe was reported as having gone missing by her stepfather. He was concerned as she had made four overdose attempts over the previous two weeks and had a quantity of prescription medication with her.

3.7.3 Chloe was quickly initiated as a high-risk missing person, and significant resources were deployed to this incident, which was treated with utmost urgency.

3.7.4 Chloe was located in a field in the Ambleside area of Derbyshire and taken to hospital.

The review notes that this incident was treated with utmost urgency. The early involvement of a police polSA (police search advisor) was key, as the advice was that the police should utilise a trial system called Teragence. Urgent enquiries were completed that resulted in a map being produced that offered the most likely location of Chloe, based on guidelines used in these types of enquiries. This map, however, covered a vast area that could have taken days to search. The use of the trial system narrowed this down to a much smaller area, resulting in Chloe's vehicle being located, and Chloe being found nearby.

3.7.5 **14th August 2020**

3.7.6 Chloe's mother called the police, having found damage in Chloe's home following a visit by George. Later the same day, Chloe called the police because her car tyres had been slashed at the Jury's Inn, Derby (where she was staying). Chloe believed that George was responsible.

3.7.7 The officer identified that Chloe was suffering considerably with her mental health at that time.

3.7.8 Chloe spoke about George being responsible for her mental state. A risk assessment was undertaken. On the Domestic Abuse Public Protection Notice (DAPPN), Chloe was recorded as saying:

- I am frightened that George, when drunk, will say anything to me to make me feel bad.
- George regularly says that Chloe is stopping him seeing Child 2, but she isn't. George, in this instance, has taken Child 2 when he was meant to be going away with his grandparents.
- George never gives me any compliments and would try and convince me not to go visit my family. I would see my mum once a week but didn't used to see my other family members; however, this changed when I left George, and I am in contact with my family members.
- It feels like all he wants is sex and tries it on at inappropriate times, such as when I had just come out of hospital whilst getting mental health support.
- George is an alcoholic and takes cocaine. However, although he will drink around Child 2, I do not feel he would take cocaine around Child 2.

Given the circumstances, efforts could have been taken to contact other agencies, including Chloe's GP and the Crisis Resolution and Home Treatment Team, to ensure that they were aware of her current situation and the possibility of her car tyres having been damaged by George: leaving her mental state more vulnerable.

The review has been advised that Nottinghamshire Police have recently introduced a Victim Needs Assessment (VNA): this is completed at a victim's first contact with the police and is bespoke to adults and children. It is used by officers across all crime types to assess the level of vulnerability of victims and, therefore, the level of support that is needed. This can then be shared with other agencies. To assist officers in completing the VNA, there is a 'clues and curiosity' hyperlink that provides a victim's guide for frontline officers. The VNA has replaced the need for a separate OEL (vulnerability safeguarding tool), as it signposts staff to the correct support for victims of crime.

As compliance with the VNA is monitored on a quarterly basis by a Chief Inspector, the review is reassured that had this been in place, the support that may have been needed by Chloe would have been identified and acted upon.

3.8 SOUTH YORKSHIRE POLICE

3.8.1 South Yorkshire Police had no contact with Chloe, but she was named as an interested party on the report made by George on 7th June 2020.

3.8.2 The initial call handler correctly graded the incident and recorded a tag of 'domestic abuse', in line with the Force's current procedural instruction[17]. As the incident was graded for a scheduled response, a diary appointment was arranged for a time within 48 hours of the report. Again, this is in line with current procedures.

[17] Pi10.20 – Recording, Investigation and Management of Domestic Abuse.

3.8.3 The second call handler correctly advised George that officers would still need to speak with him due to the nature of the incident being domestic abuse, despite the fact that he did not want to pursue a criminal investigation. This is in line with current procedures.

3.8.4 During the diary appointment, George reiterated that he did not wish to pursue a criminal investigation or provide a formal statement. The attending officer did record an entry in his pocket notebook, which was signed by George. The diary appointment was conducted in a timely manner.

3.8.5 The attending officer completed a DASH risk assessment, and the incident was graded as Standard Risk. The attending officers' supervisor reviewed the incident and DASH risk assessment. The supervisor agreed that the risk level should be recorded as Standard. As there was no additional information held by South Yorkshire Police, this decision was based on the information provided by George. The assessment and decisions were reached in an informed and professional manner, based on the information provided by George.

3.8.6 The DASH risk assessment is system generated (using PRONTO) and completed on a handheld device by officers. The completed DASH is electronically linked to the Connect system and corresponding investigation. However, on this occasion, due to a technical issue, the DASH failed to submit onto the PRONTO system. Therefore, the attending officer completed the DASH and manually uploaded this to the Connect system. This is good practice and often adopted when there are such technical issues, as it avoids a delay in the recording of the risk assessment.

South Yorkshire Police's process is that once the attending officer completes a DASH, the Domestic Abuse Risk Assessment (DARA) Team completes a secondary risk assessment[18]. On this occasion, the details were not forwarded to the DARA Team. This meant that George was not referred to specialist domestic abuse support services (he had provided consent for this).

3.8.7 The attending officer offered safeguarding advice relating to blocking all relevant numbers and advised George to seek legal advice regarding civil injunctions: namely, child contact arrangements. This advice was appropriate and proportionate to the needs identified by George.

There are no specific recommendations for this organisation.

[18] This is a specialist team specifically responsible for completing secondary risk assessments on all reported incidents relating to domestic abuse. Their risk assessment includes a more in-depth research of police systems, with the focus being on previous incidents and patterns of perpetrator behaviour. The DARA Team is also responsible for completing any referrals to support services, i.e., all high-risk victims are referred to the multi-agency risk assessment conference and appropriate domestic abuse service; any victim assessed as standard or medium risk, are referred to domestic abuse services, if they have provided consent.

Section Four – Analysis

4.1 Understanding Chloe and the challenges that she faced

4.1.1 The inquest explored Chloe's access to medication and her mental health, and it is not appropriate for this review to pass additional comment upon this, other than in the context of the effect of domestic abuse upon her vulnerability. However, some time will be spent exploring Chloe's physical health, in so much as it played an important part in the struggles that she faced and contributed to her vulnerability. The physical issues that Chloe lived with, contributed to her vulnerability to an abusive man.

4.1.2 Chloe began experiencing right-arm weakness and numbness after a car accident in 2007.

4.1.3 In 2014, a prolapsed disc was identified, with cord compression: this was repaired with discectomy and fusion in May 2019. Chloe developed associative seizures and was diagnosed with Functional Neurological Disorder (FND)[19] in 2014. This is a brain disorder that encompasses a diverse range of neurological symptoms, including limb weakness, paralysis, seizures, walking difficulties, spasms, twitching, sensory issues, and more. The symptoms can be severe and disabling, and they are life-changing to all who experience them.

4.1.4 FND occurs when the basic wiring in the nervous system is intact, but there is a problem with how the brain/nervous system is 'functioning' and how the brain fails to send/receive signals (messages) correctly. This impacts on how the body responds to different tasks, such as movement control and attention.

4.1.5 For Chloe, this manifested as feelings of whole-body numbness and left-leg weakness, which led to difficulty walking. She usually walked with the aid of crutches and occasionally the use of a wheelchair. FND can cause non epileptic seizures and fainting spells, and these were seen in Chloe. She also reported chronic whole-body pain and hypersensitivity, for which she was diagnosed oxycodone. She also experienced chronic fatigue, frequent panic attacks, and ongoing migraines.

4.1.6 Health professionals sometimes call these disorders 'medically unexplained', psychosomatic, and somatisation (the manifestation of psychological distress by the presentation of physical symptoms), although the term 'functional' is now more often used, as it just means that the body is not functioning quite as it should.[20]

4.1.7 These previously used terms can lead to those experiencing FND to feel that they are not believed when they describe their symptoms or that they are putting them on. During the inquest, Chloe's family referred to her being seen as a hypochondriac because she had this diagnosis. The emotional impact of this on someone experiencing extreme physical symptoms as Chloe was – on occasion being confined to the wheelchair and not able to walk – is understandable.

4.1.8 Chloe had a disability car, with hands-only controls.

[19] https://www.fndaction.org.uk/what-is-functional-neurological-disorder/
[20] https://www.sth.nhs.uk/services/a-z-of-services?id=115&page=293

4.1.9 Chloe also experienced anxiety and depression. It was noted in the inquest that Chloe had struggled to persevere with anti-depressants that were prescribed, due to the side effects. Her GP made the point that, over the years, different strategies had been explored to help Chloe, including medication and psychological therapies.

4.1.10 In 2017, Chloe was diagnosed with Emotional Unstable Personality Disorder by Nottinghamshire Healthcare NHS Trust. EUPD[21] typically causes individuals to experience intense and fluctuating emotions, which can last anywhere from a few hours to several days at a time. The emotions can range from intense happiness, euphoria, and self-belief, to crushing feelings of sadness and worthlessness later in the same day. The rapid and extreme fluctuations in mood that are associated with EUPD, can often make it difficult for sufferers to maintain stable personal relationships.

4.1.11 Symptoms of EUPD include:

- Impulsivity
- Mood swings
- An overwhelming fear of abandonment
- Extreme anxiety and irritability
- Anger
- Paranoia and being suspicious of other people
- Feeling empty, hopeless, and worthless
- Suicidal thoughts
- Self-harm
- Having a pattern of unstable or shallow relationships
- Rapidly changing your opinions of other people
- Dissociation – feeling as though you have lost touch with reality.

4.1.12 DHCT noted that Chloe displayed good insight into her presentation. She acknowledged that she struggled with relationships and reported a pattern of abuse in which she described 'troubled' relationships, which caused her stress, and she said that she had struggled for years with depression. Whilst in hospital, it was noted that Chloe had a history of secretly taking overdoses, and the notes recorded that 'she suddenly gets a feeling of wanting to be dead when feeling low in mood'.

4.1.13 During a multi-disciplinary meeting in August 2020, it was noted that Chloe was becoming overly dependent and disempowered.

4.1.14 After having a caesarean section in July 2018, Chloe experienced severe pain and was prescribed several drugs, including oxycodone[22]. This is an opiate painkiller used to treat severe pain. It works by stopping pain signals travelling along the nerves to the brain. Taken as either liquid or capsules, it works within 30 – 60 minutes but will wear off after 4 to 6 hours. It is possible to become addicted to oxycodone.

4.1.15 From January to June 2019, Chloe was being prescribed oxycodone on a repeat prescription. Chloe's family are in no doubt that she became addicted to oxycodone.

[21] https://www.priorygroup.com/mental-health/personality-disorder-treatment/emotionally-unstable-personality-disorder-eupd
[22] https://www.nhs.uk/medicines/oxycodone/

4.1.16 It was noted on Chloe's GP records that she had, in the past, disclosed possible childhood trauma but said that she could not remember anything about her past and had no childhood memories. She believed that this could be connected to her physical symptoms in adulthood.

4.1.17 Chloe was taking cocaine regularly over the years. However, this was not known by her GP until the mental health unit where Chloe was being treated not long before her death, rang to advise that she had disclosed that her partner had forced her to take cocaine. Chloe said that she used medication to 'slow things down in my head and deal with emotional distress'.

4.1.18 When in the Radbourne Unit, Chloe acknowledged that the oxycodone that was prescribed for FND, was used by her for relief from emotional distress, as well as pain relief. Whilst the medication had been legitimately prescribed to manage FND, Chloe acknowledged that at times, she did not take it in the prescribed manner, but she strongly argued that this was not an addiction, and she did not wish to engage with support regarding this.

4.1.19 Knowing that Chloe was addicted to drugs, both prescribed and illicit, her family sought a place for her in treatment. Her stepfather recommended an abstinence-based rehabilitation support centre called 'The Carpenters Arms'. During one home visit with the Crisis Resolution and Home Treatment Team, Chloe asked her stepfather to join the session to discuss the referral to drug rehabilitation that he had suggested. Chloe became very distressed within the discussion. Her stepfather was advised that the community consultant psychiatrist would continue to manage her ongoing medication. Her frequent, ~~small~~ overdoses were acknowledged, and it was noted that she was on twice-weekly prescriptions, with a view to managing this risk. It was suggested that Chloe's parents should discuss the possible placement with her CCO.

4.1.20 When Chloe was visited at home by the Crisis Resolution and Home Treatment Team on 10th August, Chloe apologised for her temper on the previous visit. She said that her stepfather concentrated on the negatives and that she had weaned herself off the prescribed oxycodone. On 14th August, she said that she was not an addict and 'I'm a mum, who would be an addict and a mum?'. At this point, Chloe did not agree with, or wish to go to, drug rehabilitation.

4.2 Evidence of domestic abuse

4.2.1 A Domestic Homicide Review is charged with identifying a history of domestic abuse in the life of Chloe.

4.2.2 The first record that the review has of Chloe disclosing domestic abuse is in 2017, when she told her GP that she had been in a relationship with the father of Child 1 (on and off) from the age of 18 and that he had been controlling when they were in a relationship. However, she said that their relationship was now amicable over the care of Child 1.

4.2.3 George moved into her home in August 2018 (according to the information that she gave to DWP).

4.2.4 The relationship with George ended in November 2019 and it is clear, from the analysis below, that the abuse continued once the relationship ended.

4.2.5 **Physical abuse**

4.2.6 Chloe disclosed that the father of her first child had been physically abusive towards her.

4.2.7 On one occasion, Chloe and George went to the home of one of Chloe's friends, and George was already drunk when they arrived. He was described as loud, obnoxious, and embarrassingly rude. Throughout the evening, Chloe spoke to her friend about being scared about when they got home and what he would do to her.

4.2.8 **Verbal abuse**

4.2.9 In September 2018, the police attended the address and found a verbal argument that had arisen when George alleged that Child 1 had 'nipped' Child 2, who was a baby at this time. Chloe's mother, who had been present at the time, said that Child 2 had been playing with Child 1 when Child 1 had caught his face but that there was no visible injury. George had told her that he would harm Child 1 if this happened again, and this had upset Chloe.

4.2.10 On one occasion when Chloe spoke to the Crisis Resolution and Home Treatment Team and said that she had spoken to George and that he was abusive towards her. Chloe's father recalls that he said: 'I never signed up to living with a phlid[23]'.

4.2.11 One of Chloe's friends described George as being angry and aggressive, which was explained as being due to PTSD from his experiences in the forces.

4.2.12 **Psychological abuse**

4.2.13 Chloe disclosed that George abused her psychologically.

4.2.14 In June 2020, when she was in hospital, Chloe reported to night staff that her partner had been texting her, threatening to 'cut her throat'. The review has been provided with texts that he sent to Chloe that read: 'I'm gutted you didn't complete what you set out to do. You fucking reprobate just die you horrible bastard'. He then went on to taunt her about the children, saying: 'Guess where Child 2 is? with me. Guess who's name he does not know? Yours'.

4.2.15 When Chloe replied to say that she had goals and that George was not part of them, he replied: 'Your goals what to be an awesome mother the kids have forgotten you. Child 2 doesn't know you'. He then went to say: 'You got a fight now saggy tits. Skin hanging off you like a mouldy chicken. Literally you just lost Child 2 he isn't coming back'.

4.2.16 In this conversation, he also said: 'your a slut', and called Chloe a 'slut', a 'whore', and a 'smack head'.

4.2.17 Messages sent in the same conversation, indicate that George encouraged her to take her own life. He said: 'die u bastard' and said that he wished she had gone through with her suicide attempt, 'Gutted you didn't complete what you set out to do. You fucking reprobate just die you horrible bastard'.

4.2.18 **Sexual abuse**

[23] Referring to a disabled person.

4.2.19 Chloe disclosed to her GP that Child 1's father had raped her and forced her to have sex with others.

4.2.20 Chloe had told her friend that when they had sex, George would just 'drop himself on top of her and have sex with her'.

4.2.21 **Coercive and controlling behaviour**

4.2.22 In August 2020, Chloe was struggling to cope and agreed to George staying a few nights to help her with the children. Chloe spoke to her GP and was described as distressed and incoherent. She said that George wanted her back so that he could pressurise her to have sex with him as before. She described a few days later, how he was helping her at the present time with the children, but that she could not forget how he had been 'mentally abusive' in the past.

4.2.23 When Chloe's friend encouraged to her seek support, Chloe would minimise the abuse and said that it was because of George's PTSD.

4.2.24 On an occasion when Chloe had a seizure and lost the use of her legs, her friend accompanied her to hospital. When George arrived, he called her a cripple and said that he had not signed up for this.

4.2.25 On 14th August, George taunted Chloe with a multitude of voicemails. In these he said that her children had gone 'far far away'.

4.2.26 During these text messages, George also said: 'Speak to me now and I'll leave you alone for good'.

4.2.27 **Sense of entitlement**

4.2.28 Once George had left Chloe, Chloe's father has told the review that he continued to use her home as if he lived there. He would walk into the house unannounced. After playing with Child 2 for a few minutes, he would go upstairs and have a shower, without asking Chloe if this was OK. He would then stay upstairs and watch the TV.

4.2.29 On another occasion in January 2020, he went to the house to see his son. Whilst he was there, he had put his washing in the machine before leaving. When Chloe's father visited, Chloe had to ask him to take the washing out because it was not easy for her to get to the machine.

4.2.30 **Abuse of the children**

4.2.31 During the incident in September 2018, George said that he would hurt Child 1 if this happened again: implying that he had done so previously.

4.2.32 A previous partner of George has spoken about being concerned about his behaviour towards Child 2 when they were together. He did not, she said, show any love and would just shout at him. She said that he would get so drunk that he became unconscious, and Child 2 had to look after himself, including taking food from the fridge and putting himself to bed.

4.2.33 **Substance misuse**

4.2.34 Regarding the incident in September 2018, Chloe said that her partner had not been aggressive before and was different when sober. She told the MASH social worker that her partner had been drunk and was 'kicking off'. As part of the Child and Family Assessment, both Chloe and George said that he did not normally drink alcohol to excess.

4.2.35 In December 2019, Chloe and George had gone on holiday together (without the children), and Chloe later told CSC that he had drunk excessively throughout the holiday.

4.2.36 One of Chloe's friends described George as being drunk whenever the friend saw him.

4.2.37 Whilst in the mental health unit, Chloe disclosed that she had been taking cocaine for a number of years, and that she was being forced by George to take this.

4.2.38 **Physical and digital stalking**

4.2.39 Chloe told her friend that, after the relationship with George had ended, he continued to stalk her and threaten her. At this time, Chloe said that she dreaded going home because he was evil.

4.2.40 From 14th – 17th August, George left 98 voicemail messages for Chloe: many during the night. These must have impacted on Chloe's state of mind. These must have impacted on Chloe's state of mind. The review has seen the content of some of these messages and they can be described as nasty, threatening and abusive. These messages followed the damage caused at the Chloe's house are likely to have been an added factor in her decision to stay at the hotel.

4.2.41 Economic abuse

4.2.42 Chloe's house and belongings were damaged by George in the days before her death. When told she had gone to Cornwall with Friend 1 rather than on the holiday with her parents and children, Chloe's family have told the review that George cut the wire to the fridge, smashed the wall socket to the fridge which tripped the house electrics, cut the wire to her hair drier, smashed mirrors, cut up clothing and took the TV. As a result of these actions, if Chloe's life had not ended, she would not have been able to return to the home with her children.

4.2.43 Chloe had reported that there were ongoing issues with economic abuse with her ex-partner, such as him reporting her to the job centre for working.

Section Five – Suicide and Domestic Abuse

5.1 Prevalence

5.1.1 The number of Intimate Partner Abuse Related Suicides (IPS) are not formally counted in England and Wales. The ONS (2019) reported that on average, 30 women took their own lives each week in the UK in 2018. It has been estimated that one third of female suicides may be related to IPA[24], which would equate to nine or ten suicides per week. This number is thought to have increased in COVID-19, with 38 suspected suicides of victims of domestic abuse reported from 1st April 2020 to 31st March 2021[25]. Suicidality is more prevalent amongst women who are domestically abused than those women who are not abused[26].

5.1.2 Analysis undertaken by Kent and Medway Suicide Prevention Team[27] of the 93 nationally published DHRs, found that 26% contained suicide of either the victim or the perpetrator.

5.1.3 The most recent report from the National Confidential Inquiry into Suicide and Safety in Mental Health[28], found that between 2015 and 2019, there were 532 patients who were known to have experienced domestic violence – 9% of all patients during this time, 104 deaths per year. The average number in 2016 – 17 was 101 per year but in 2018 – 19, this had increased to 149 per year. The majority (73%) were female – an average of 76 per year.

5.1.4 Women with a history of domestic violence were more likely to be younger than other women, and be single or divorced, living alone, and unemployed. The majority (81%) had a history of self-harm, and previous alcohol (61%) and/or drug (47%) misuse was common. Nearly a third (29%) had been diagnosed with personality disorder.

5.1.5 More women with a history of domestic violence had experienced adverse life events in the previous 3 months (115, 50% v. 351, 32%) – the most common relating to family issues (21% v. 6%), serious financial problems (22% v. 11%), and loss of job, benefits, or housing (19% v. 12%).

5.2 The coroner's finding that Chloe had taken her own life

5.2.1 For a coroner to reach a conclusion of suicide, the *intent* to kill oneself needs to be proved to the relevant standard in law. There are often difficulties in determining the intent of a person who dies. In England and Wales, it has been customary to assume that most injuries and poisonings of undetermined intent, are cases where the harm was self-inflicted; however, there was insufficient evidence to prove that the deceased deliberately intended to take their life.

[24] Walby, 2004, Stark and Flitcraft, 1996 cited in ibid.
[25] Bates et al., 2021, cited in ibid.
[26] Reviere, S., Farber, E., Tworney, H., Okun, A., Jackson, E. & Zanville, H. (2017) 'Intimate Partner Violence and Suicidality in Low-Income African American Women: A Multimethod Assessment of Coping Factors.' Violence Against Women 13: 1113-1129; Pico-Alfonso, M., Garcia-Linares, I., Celda-Navarro, N., Blasco-Ros, C, Echeburua, E. & Martinez, M.(2006) 'The Impact of Physical, Psychological, and Sexual Intimate Male Partner Violence on Women's Mental Health: Depressive Symptoms, Posttraumatic Stress Disorder, State Anxiety and Suicide.' Journal of Women's Health 15(5): 599-611. Cited in Domestic abuse and suicide, Refuge and Warwick Law School, 2018.
[27] Highlighting the relationship between domestic abuse and suicide, Transforming health and social care in Kent and Medway, 2020
[28] The National Confidential Inquiry into Suicide and Safety in Mental Health, Annual Report 2022: UK patient and general population data 2009-2019, and real-time surveillance data, University of Manchester, 2022

5.2.2 In 2018, the High Court determined that coroner's courts should move to the civil standard of proof (i.e., on the balance of probabilities) when returning a verdict of suicide. This change came into effect on 26th July 2018.

5.2.3 In this case, the coroner concluded that Chloe intended to take her own life: her death was recorded as 1A oxycodone, gabapentin, and zopiclone toxicity, with evidence of cocaine use.

5.2.4 In arriving at this decision, the coroner needed to be sure that Chloe had taken the medication with the intention to take her own life. The coroner believed that this was the case. Chloe had taken more than one medication, and although she had not left a note, there were other indications as to her intent. Namely, that she had searched on her phone (on 14th August) for how to take her own life. The ironing board had also been propped up against the locked hotel room door.

5.3 From research into suicide, what can we learn about Chloe's decisions?

5.3.1 **THE INTEGRATED MOTIVATIONAL-VOLITIONAL (IMV) MODEL**[29]

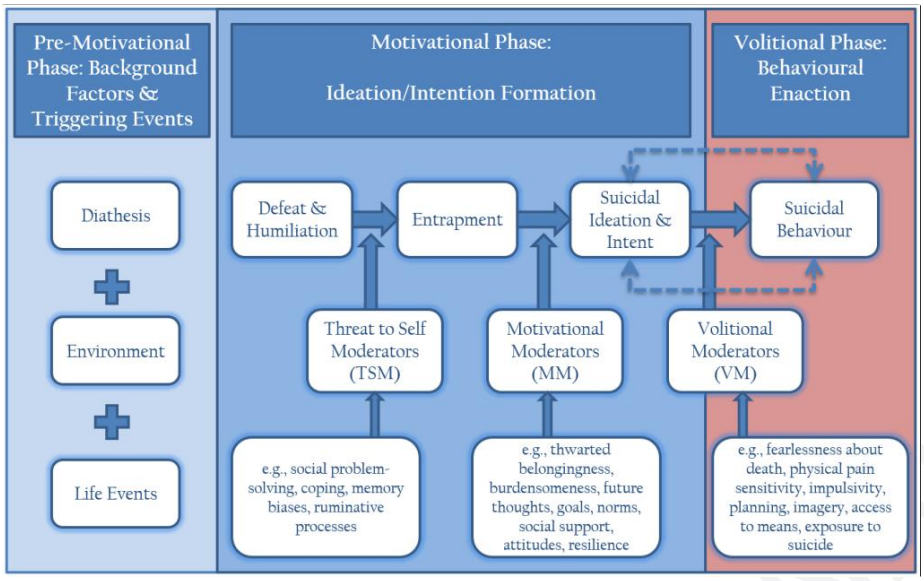
5.3.2 Suicide is complex, and the journey of suicidal ideation to suicidal behaviours is not static but fluid and can be seen as being cyclical in nature. The Integrated Motivational-Volitional (IMV) model aims to synthesise, distil, and extend our knowledge and understanding of why people die by suicide, with a particular focus on the psychology of the suicidal mind. It proposes that defeat and entrapment drive the emergence of suicidal ideation and that a group of factors (volitional moderators) govern the transition from suicidal ideation to suicidal behaviour.

5.3.3 This model includes:

5.3.4 The pre-motivational phase – background factors and triggering events

- The motivational phase – ideation and intention formation and the factors that govern the transition from suicidal ideation to suicide attempts
- The volitional phase – suicide attempts or death by suicide.

[29] The integrated motivational-volitional model of suicidal behaviour, O'Connor RC and Kirtley OJ, Royal Society Publishing, 2018



5.3.5 The IMV model of suicidal behaviour is based on seven key premises:

(1) Vulnerability factors combined with stressful life events (including early life adversity), provide the backdrop for the development of suicidal ideation
(2) The presence of pre-motivational vulnerability factors (e.g., socially prescribed perfectionism) increases the sensitivity to signals of defeat
(3) Defeat/humiliation and entrapment are the key drivers for the emergence of suicidal ideation
(4) Entrapment is the bridge between defeat and suicidal ideation
(5) Volitional-phase factors govern the transition from ideation/intent to suicidal behaviour
(6) Individuals with a suicide attempt/self-harm history will exhibit higher levels of motivational and volitional-phase variables than those without a history
(7) Distress is higher in those who engage in repeated suicidal behaviour over time, and intention is translated into behaviour with increased rapidity.

5.3.6 This model can be an effective tool to help map a story of suicide and highlight specific points or factors, of which the review should take note. The report author has used this model to explore what is known about Chloe.

5.3.7 **Pre-motivational phase: Background factors and triggering events**

5.3.8 This first phase sets the context for suicidal ideation, and Chloe experienced many vulnerability factors and stressors, some of which have been discussed in the previous sections, as well as environmental influences that should be noted when considering suicide risk:

- Long-term physical health concerns
- Social isolation
- Illicit drug use
- Unemployment
- Self-harm

- Relationship problems
- Domestic abuse
- Previous suicide attempts.

5.3.9 **Motivational phase: Emergence of suicidal ideation**

5.3.10 The centre column of the table highlights the key drivers: defeat, humiliation, and unbearable entrapment for the emergence of suicidal ideation.

5.3.11 Connor and Kirtley[30] say that entrapment can be internal or external in nature.

- Internal – concerned with being trapped by pain triggered by internal thoughts and feelings
- External – relates to the motivation to escape from events or experiences in the outside world.

5.3.12 Feelings of entrapment are likely to give rise to agitation. Whilst this phase is consistent with Williams' cry of pain hypothesis that is discussed later in the report, feelings of entrapment are distinct from hopelessness, which is a pervasive sense of pessimism for the future.

5.3.13 According to the IMV model, the presence or absence of threat to self-moderators, renders it more or less likely that defeat leads to entrapment. If we consider the potential threat to self-moderators, we can observe that Chloe was struggling to cope with her chronic and painful physical condition, as well as coercive and controlling behaviour.

5.3.14 The final part of the motivational phase is the transition from entrapment to suicidal ideation. It is suggested that the presence of motivational moderators will increase or decrease the likelihood of entrapment being translated into suicidal ideation. Whilst the motivational moderators, such as belongingness, connectedness, or attainable positive future thinking, may provide a person with reasons for living; conversely, other motivational moderators, such as feeling a burden and depleted resilience, can lead to an increase in the likelihood of entrapment.

5.3.15 From what we know of Chloe, we can see that she was frustrated that she was not able to look after her children unsupervised, and this may have led to her feeling a burden on her family. She had been subject to domestic abuse over a significant period, and towards the end of her life, even though she had tried to separate herself from George as much as she was able, this was difficult. It was suggested that she needed to keep him in her life to help with the children; however, when she did try to end the relationship, he went to her home and caused damage. Her resilience must have been at its lowest ebb.

5.3.16 **Volitional phase: Behavioural enaction**

5.3.17 This third phase considers the transition from ideation to intent. It has been identified that there are eight volitional factors from suicidal ideation to suicidal behaviour.

[30] The integrated motivational-volitional model of suicidal behaviour, O'Connor RC and Kirtley OJ, Royal Society Publishing, 2018

5.3.18 If we apply what we know about Chloe, we can begin to build a picture:

Access to means

- Chloe clearly had access to drugs, both prescribed and illicit.
- In June 2020, Chloe declined the suggestion that her family should take control of her medication.
- Later in the month, she asked for a friend to be allowed to collect her medication: this was declined.
- Chloe also spoke of hanging herself and cutting her wrists, and she would have had access to the means for both.

Planning

- In May 2020, Chloe told her GP that she was planning to cut her wrists in the bath.
- Chloe sent her Ex-partner a list of songs that she wanted at her funeral – May 2020.
- Chloe's ward record in June 2020, noted that, despite Chloe claiming she had taken an impulsive overdose, there had been elements of pre-planning.
- In July 2020, Chloe's CCO noted that she was constantly seeking more medication and was fixated on changing her prescription from twice-weekly to weekly.
- Chloe told her CCO that she had thoughts of jumping off a bridge or under a train.

Exposure to suicide or suicidal behaviour – other than reference to 'childhood trauma', we do not know if Chloe had been exposed to suicide or suicidal behaviour.

Impulsivity

- It is not straightforward to identify if Chloe's suicide attempts were impulsive. For example, in May 2020, she disappeared from the hospital where she was waiting for her brother and took an overdose. We cannot know if she planned this in advance or acted in the moment.

- Chloe was diagnosed with Emotionally Unstable Personality Disorder that may have contributed to a tendency to act impulsively.

Physical pain sensitivity/endurance

- Chloe experienced severe, chronic pain for many years and experienced little relief from her medication.
- Chloe had been subject to domestic and sexual abuse.

Fearless about death

- Chloe sent George a list of songs for her funeral in May 2020
- In August 2020, Chloe told her CCO that she wanted to die because she was not getting any better.

Mental imagery – In May 2020, Chloe told her GP that she wanted to cut her wrists in the bath, suggesting that she had imagined this. Similarly, she said that she had thoughts of jumping from a bridge or under a train.

Past suicidal behaviour

- Chloe had a history of suicide attempts – the first in the scope of this review was in May 2019
- In May 2020, Chloe's family said that she had taken four overdoses in the previous two weeks
- Whilst in the Radbourne Unit in May 2020, Chloe said that she had taken far more overdoses than she had ever disclosed to professionals.

5.3.19 Whilst we can see that Chloe has evidence of at least seven of the eight volitional factors, this should not be seen as a checklist for risk: each factor tells a story and provided an opportunity to explore her safety. If the risks are addressed, then the risk is lowered.

5.3.20 Given that Chloe had a history of suicidal ideation and suicide attempts, one important question is whether when she expressed such thoughts, these were explored with her on each occasion.

Suicide risk is not linear, it is constant and repeated. Whenever engaging in a conversation about suicide with a patient/client, it would be best practice to assess an individual, mitigate the presented risk and reassess during the next contact, or share information with a relevant service for this to be continued.

Recommendation

It is recommended that DCHT and the GP practice reassure the Community Safety Partnership that they have mechanisms in place to ensure that this approach is embedded in their services.

5.3.21 It is important to note that Chloe predominantly, as far as we know, used overdose as a method. People who use overdose have been described as ambivalent about waking up: they just want to take the pain away at that point. People who are suicidal have been described as in a tug of war – between wanting to die and wanting to live.

5.3.22 We know that for Chloe there were times when she was in more extreme emotional pain. For example, when she was experiencing domestic abuse and when she feared that she was not allowed to care for her children on her own.

5.3.23 We cannot be certain that, on each occasion, Chloe intended to end her life – she may have just wanted to take the pain away.

5.4 Cry of pain

5.4.1 Refuge[31], in their research, explain that Weaver, et al. and Williams developed understanding about suicidality through what they called a 'cry of pain' hypothesis. According to this theory, suicidal acts (completed or not) are understood as a cry of pain, rather than a cry for help, with suicide more likely where feelings of defeat and entrapment exist alongside beliefs that neither rescue nor escape is possible. It is suggested further that this constellation of feelings and beliefs can lead anyone, irrespective of psychiatric diagnosis, to consider, and even enact, suicide. A key finding, observed across several studies, is that previous suicidal behaviour, regardless of cause, is one of the most robust predictors of future suicide – with some research indicating that completed attempt often follows an uncompleted attempt within an average of one year. Therefore, to dismiss suicidality and attempts as 'merely a cry for help', risks ignoring those who are in the greatest psychological pain and more likely to take their own lives in the future.

5.5 Hope

5.5.1 Research undertaken by Refuge[32], states that: 'those trapped by domestic abuse can feel so hopeless that they believe the only way out is suicide'.

5.5.2 The power of hope has been studied by The Hope Research Centre at the University of Oklahoma. Domestic abuse victims can often only see the present – day-to-day survival – but are unable to see a future outside of the current situation. It has been argued that hopelessness can focus individuals on the short term, with little vision for the long term (Hellman 2021)[33].

5.5.3 Hope is defined as the ability to see beyond the immediate situation, and plan or visualise a future. Saleebey (2000) contends that hope is a cognitive set, essential to resilience and recovery. He said: 'Hope is about imagining the possible, the "untested feasible" as Frieire would have it. But more specifically, it is about thinking of oneself as an *agent*, able to effect some change in one's life, having *goals* that not only have the promise but also *pathways* to their accomplishment – pathways that may be short or long, full of ruts or smooth, well-lit or darkened[34]'.

5.5.4 Friere, a pioneer in the study of individuals facing oppression, points to the importance of hope to resilience. He said: 'There is no change without the dream, as there is no dream without hope'.[35]

[31] Domestic abuse and suicide, Refuge and Warwick Law School, 2018.
[32] ibid.
[33] Hellman C, The Science of Rape, St Mary's Centre SARC Annual Conference Virtual 16-17 March 2021, cited in cited in Monckton Smith et al., University of Gloucestershire, Building a temporal sequence for developing prevention strategies, risk assessment, and perpetrator interventions in domestic abuse related suicide, honour killing and intimate partner homicide, 2021
[34] The Relationship between Hope and Life Satisfaction among Survivors of Intimate Partner Violence: the Enhancing Effect of Self Efficacy, Munoz, Hellman and Brunk, Applied Research Quality of Life, 2017.
[35] The Psychology of Resilience: A Model of the Relationship of Locus of Control to Hope Among Survivors of Intimate Partner Violence, Munoz RT, Brady S and Brown V, Traumatology, 2016.

5.5.5 Research undertaken by Aitken and Munro (2018)[36] identified that 96% of victims of Interpersonal Abuse (IPA) who were identified as suicidal, suffered from feelings of hopelessness and despair, and that these feelings are a key determinant for suicidality.

5.5.6 As mentioned previously, Chloe appeared to feel powerless and to have no control over her life. She was not able to look after her children alone. She had tried to leave her abusive relationship but was being encouraged to maintain this to support her in accessing the children. She had seemingly tried to move on with her with life by entering a relationship with Friend 1, but this did not work out. It is understandable if Chloe felt that nothing would change, and she had no hope for a better future.

5.5.7 Chloe's feelings of powerlessness were recognised by the Community Teams from DCHT, and they attempted to support and empower her to manage her life. The SI report found that the care and treatment package they offered, reflected this ethos, and placed Chloe at the centre of the planning. ***This is an example of good practice.***

5.6 Local Suicide Prevention Strategy

5.6.1 The national suicide prevention strategy[37] was first published in 2012. Its key aims were to reduce the suicide rate in the general population in England and to better support those bereaved or affected by suicide.

5.6.2 To support this strategy, the NHS asked all Clinical Commissioning Groups to deliver local multi-agency suicide prevention plans.

5.6.3 Nottingham and Nottinghamshire as a Suicide Prevention Strategy 2019 – 2023[38]. The overall aim of this strategy is to *reduce the rate of suicide and self-harm in the Nottingham City and Nottinghamshire population, by proactively improving the population's mental health and wellbeing, and by responding to known risks for suicide in the population.*

5.6.4 The strategy has the following key areas for local action:

- Priority 1 – At risk groups
- Priority 2 – Use of data
- Priority 3 – Bereavement support
- Priority 4 – Staff training
- Priority 5 – Media

The review notes that this strategy recognises that suicide prevention goes hand in hand with addressing the well-recognised risk factors and at-risk groups for suicide.

5.6.5 Suicide and self-harm are often precipitated by recent adverse events across the life course. These include relationship breakdowns, conflicts, legal problems, financial concerns, interpersonal losses, and traumatic events.

[36] Aitken R and Munro V, Domestic Abuse and Suicide: Exploring the Links with Refuge's Client Base and Work Force, Refuge, 2018 cited in Monckton Smith et al, University of Gloucestershire, Building a temporal sequence for developing prevention strategies, risk assessment, and perpetrator interventions in domestic abuse related suicide, honour killing and intimate partner homicide, 2021

[37] https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england

[38] https://committee.nottinghamcity.gov.uk/documents/s94904/Enc.%202%20for%20Nottingham%20City%20and%20Nottinghamshire%20Suicide%20Prevention%20Strategy%202019-2023.pdf

5.6.6 Research has shown that, in terms of suicide prevention, it is important to note that the experience of sexual or domestic violence in adulthood is associated with the onset and persistence of depression, anxiety and eating disorders, substance misuse, psychotic disorders, and suicide attempts[39].

5.6.7 The governance structures have been strengthened and the Nottinghamshire and Nottingham City Suicide Prevention Strategic Steering Group now reports to the Health and Wellbeing Boards (for both Nottingham City and Nottinghamshire) and the Nottingham and Nottinghamshire Integrated Care System (ICS), Mental Health and Social Care Partnership Board. Membership of this Group includes strategic representatives from local authorities, clinical commissioning groups, health providers, Office of the Police and Crime Commissioner, universities, community, and voluntary sector.

5.6.8 The Steering Group has established the Nottinghamshire and Nottingham City Suicide Prevention Stakeholder Network. This provides a forum to engage, work with, and support stakeholders to implement the Nottingham and Nottinghamshire Suicide Prevention action plans and to deliver the required outcomes.

5.6.9 The review is advised that more than 60 organisations have signed up to this network. It is noted that there are organisations represented on the DHR panel that have not signed up to the network.

Recommendation

It is recommended that all agencies represented on the DHR panel, commit to the Suicide Prevention Stakeholder Network.

5.6.10 A guide has been produced for frontline workers and has been shared with all services in the city, as well as a poster for staff in primary care services. A suicide prevention and self-harm awareness and prevention pack is also being produced for primary care and pharmacies.

5.6.11 With funding from the NHSE Suicide Prevention Transformation Programme, the area will be using its three-year funding for:

5.6.12 **Communication** – campaigns will raise awareness in the public about suicide. Through extensive consultation with partners, stakeholders, and people with lived experience, new suicide prevention branding and communications materials have been developed and widely disseminated, including to services working with people experiencing domestic abuse. The new branding and communications will be used for both population level and targeted communications campaigns over the coming year. Communications direct people to an updated suicide awareness webpage to support access to the right help at the right time.

5.6.13 **Training** – A training needs assessment has been completed, and a training provider has been appointed, following a procurement exercise. The programme of training is being finalised and will be rolled out before the end of 2022. Services supporting people experiencing domestic abuse, and the community and voluntary sector, are included as target groups for training. Options for bespoke training for Nottinghamshire Police and East Midlands Ambulance Service, as 'first responders', are being explored.

[39] Hawton K, Van Heeringen K. The International Handbook of Suicide and Attempted Suicide. The International Handbook of Suicide and Attempted Suicide. 2008 cited in Ibid

5.6.14 **Real Time Surveillance System** – This area of work, being led by Nottinghamshire Police, will strengthen this system and will be exploring domestic abuse as a factor in suicide. The Terms of Reference have been revised and now include an objective to 'review learning from any Domestic Homicide Reviews shared by local Domestic Abuse Commissioning Leads where a suicide death is suspected or confirmed to identify any recommendations for action within the suicide prevention partnership'.

5.6.15 **DOMESTIC ABUSE AND SUICIDE**

5.6.16 Learning from Domestic Homicide Reviews in the area will be reviewed by the Real Time Surveillance Group and will report to the Steering Group.

5.6.17 Work is underway, with the Domestic Abuse Commissioner (led by the county council and across the Nottingham and Nottinghamshire footprint), to understand the issues for those experiencing domestic abuse and suicidal ideation. There is an intention to explore the feasibility of commissioning suicide prevention work in the domestic abuse services locally. This will be in addition to the worker from Nottinghamshire Healthcare Trust (mental health service), who already works within the domestic abuse service.

Section Six – Other Issues Considered

6.1 The effect of domestic abuse on children

6.1.1 As has been demonstrated throughout this report, the children were present when abuse occurred in this relationship.

6.1.2 One in seven children and young people under the age of 18, live with domestic abuse at some point during their childhood[40].

6.1.3 It is important to stress that research clearly demonstrates that children are not merely observers of domestic abuse but are victims in their own right. Research undertaken by the Children's Commissioner[41], highlighted that children were living with high levels of tension and unpredictability at home, and how situations could explode at any time. They also spoke about an evolving sense of shame as they began to understand that the chaos and neglect that they took for granted was not the same for all children. The children said that having to find ways to cope meant that they grew up too quickly. The research found that children often became experts at hiding what was happening at home.

6.1.4 Research undertaken by CAADA[42], found that children exposed to domestic abuse suffer a range of adverse physical and mental health, social, wellbeing, and behavioural effects[43].

6.1.5 It is important that we remember, in the words of Dr Emma Katz[44], that a coercive controller's actions are directly harming the child's world, their experience of life, and what they can and cannot do each day. They must not be seen by agencies as invisible or on the margins of the abusive relationship. Children in these families frequently suffer from limited opportunities to choose, to feel free, and to develop a sense of independence and competence (Katz, 2015[45]).

6.1.6 The impacts on the family will include fear, confusion, self-doubt/self-blame, low self-esteem, trauma, PTSD, depression, anxiety, illness, deprivation, and the feeling of 'always walking on eggshells'[46].

6.1.7 The Domestic Abuse Act 2021 has laid down in law that children must be seen as victims of domestic abuse, not just observers of it. The impact of the abuse within this family is evident throughout this report.

6.1.8 It is important to note that children who break free and achieve safety can begin to recover.

6.1.9 The review has considered if Chloe's children were given a voice by Children's Social Care. There were three Child and Family Assessments (CAFA) undertaken during the time in the scope of this review. On the first occasion, the IMR author acknowledged that limited direct

[40] Radford et al. (2011) cited in Nowhere to Turn for Children and Young People, Women's Aid, 2020
[41] "Are they shouting because of me?" Voices of children living in households with domestic abuse, parental substance misuse and mental health issues, Children's Commissioner, July 2018
[42] In plain sight: The evidence from children exposed to domestic abuse, CAADA Research Report, February 2014
[43] ibid.
[44] Coercive Control in Children's and Mothers' Lives, Katz, Dr Emma, Oxford University Press, 2022
[45] Katz, E. 2015. Beyond the Physical Incident Model: How Children Living with Domestic Violence are Harmed by and Resist Regimes of Coercive Control, Child Abuse Review, Early View
[46] Sharp-Jeff et al., 2018 and Crossman et al., 2016 Cited in ibid.

work was undertaken with Chloe's oldest child. He did not raise any concerns or issues, albeit he was not asked directly about the domestic abuse.

6.1.10 When the next two CAFAs were undertaken, the oldest child was seen alone by a social worker on both occasions. He spoke in general terms about his family but did not raise any concerns or worries and reported that he had enjoyed spending time with different family members. He said that he knew who he could speak to if he had any worries.

The review is advised that the level of work undertaken with the oldest child was as would have been expected when undertaking a CAFA, and that more work would have been done with him had a Child in Need plan been progressed.

6.1.11 Chloe's family have told the review that she felt let down by services after being discharged from hospital. She vocalised her unhappiness a lot to her family about this and was concerned that she was at risk of losing her children due to her mental health and therefore felt that she needed to have George to stay in order to keep her children.

6.2 The impact of COVID-19

6.2.1 When the country went into lockdown in March 2020, the way in which services were delivered changed with immediate effect. The impact that this may have had on Chloe's care and support is detailed in this section.

6.2.2 **IMPACT ON CHLOE**

6.2.3 Chloe expressed that she felt that she had no control of her life. It is possible that the national lockdown contributed to this, but Chloe did not specifically mention this.

6.2.4 Chloe's GP felt that it is not possible to say if the pandemic played a significant part in Chloe's deterioration, as this was already significantly established with her functional syndrome long before the pandemic.

6.2.5 **DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST**

6.2.6 The impact of COVID-19 on inpatient acute services led to a change in the way that wards were configured. Inpatients were admitted to one identified ward that provided assessment of needs and the appropriate testing and isolation regime required to manage COVID-19 safely in an inpatient environment.

6.2.7 The staffing of the ward was impacted by COVID-19, with varying levels of sickness, and staff from other teams redeployed into unfamiliar environments. The ward leadership was going through a transitional phase at the time of Chloe's admission: there were changes in the ward manager postholder, and the clinical lead role was newly developed and newly appointed too.

6.2.8 The SI review found that there was a potential impact on the ward team at the time, due to COVID-19 and the emergency measures in place, which resulted in staff redeployments and alternative ways of working. It is possible that these factors impacted on the team's effectiveness for a period.

6.2.9 COVID-19 impacted on the services in the community, as staff were redeployed to support critical services and were also impacted by varying degrees of sickness. Both CMHT and Crisis Resolution and Home Treatment Team needed to prioritise face-to-face visits to support risk management. In this case, both teams were offering Chloe face-to-face visits on a regular basis, indicating that they viewed her needs to be requiring a higher level of support.

6.2.10 **GP PRACTICE FOR CHLOE**

6.2.11 The GP practice has regular safeguarding meetings. These continued throughout the COVID-19 period, albeit with reduced frequency.

6.2.12 The COVID-19 lockdown led to restricted face-to-face consultations, but Chloe and her family were regularly contacted by telephone.

6.2.13 **SOUTH YORKSHIRE POLICE**

6.2.14 During COVID-19, response times were still maintained and monitored. South Yorkshire Police continued to respond to incidents as normal, but in the spirit of 'social distancing and safe policing methods.'

6.2.15 In line with current procedures at the time of reporting, George was asked a number of questions relating to COVID-19. Based on the answers provided, he was seen in person by the attending officer, and the service delivery was not impacted on due to COVID-19 restrictions.

Section Seven – Lessons Identified

7.1 **DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST**

7.1.1 Safeguarding procedures were not enacted when Chloe disclosed abuse and threatening texts from George whilst she was an inpatient.

7.1.2 There was a lack of meaningful intervention when Chloe started a relationship with a fellow inpatient on the ward.

7.1.3 There is a lack of awareness, both on the acute ward and in the community, of specialist domestic abuse services available and the need to support people to access them.

7.2 **EAST MIDLANDS AMBULANCE SERVICE**

7.2.1 This review has identified the continued need for crews to ensure that they document the names of other people present in the home and consider any risk they may pose. EMAS had already recognised this as an area for improvement (2020-2021): this is included in all face-to-face training, e-learning, work book, and 'learning from events' sessions. An article has also been sent out, via internal communications (ENEWs), in 2021, to remind crews about the importance of recording names of all people on scene.

7.3 **CHLOE'S GP**

7.3.1 The review believes that there is a learning point for the GP, in that they did not follow up on the allegation of Chloe being raped (that she made to them in the phone call) and did not share this information with any other agency. Any such disclosure should always be followed up.

Section Eight – Recommendations

8.1 **DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST**

8.1.1 That the Assistant Director for Safeguarding Adults supports the Senior Inpatient Nursing structure to explore how to enhance supervision arrangements in relation to safeguarding. This should include time for staff to undertake case study works to better enhance their understanding and awareness, as well as the opportunity to explore concerns with ongoing caseloads.

8.1.2 That the safeguarding team and Head of Nursing hold a learning event for those involved in this incident, to allow space for reflection on actions: with a view to identifying learning needs and training gaps. Action should then be taken to meet these needs.

8.1.3 That the Trust reviews its current domestic abuse training to ensure that it clearly covers coercion and control and provides staff with an understanding of the impact of domestic abuse.

8.1.4 That the Trust reviews its training provision to ensure that all staff have received up-to-date training in domestic abuse, and a programme of training and refresher training is implemented, if necessary.

8.1.5 That the Trust reassures the Community Safety Partnership that they have mechanisms in place to ensure that the best practice approach to assessing suicide risk is embedded in their services.

8.2 **GP PRACTICE**

8.2.1 That the GP practice reassures the Community Safety Partnership that they have mechanisms in place to ensure that the best practice approach to assessing suicide risk is embedded in their services.

8.3 **NOTTINGHAMSHIRE COUNTY COUNCIL – CHILDREN'S SOCIAL CARE**

8.3.1 That all staff are reminded of the importance of sharing information about domestic abuse services and recording that this has been done.

8.4 **NOTTINGHAMSHIRE HEALTHCARE FOUNDATION TRUST**

8.4.1 That adult mental health services actively share information with HFT colleagues when they are working with adults who have children.

8.5 **ALL AGENCIES ON DHR PANEL**

8.5.1 That all agencies represented on the DHR panel, commit to the Suicide Prevention Stakeholder Network.

Section Nine – Conclusions

9.1 This has been a desperately sad review to undertake. Chloe's death has left two children without their mother. The rest of her family loved her dearly and have been left with a void in their lives.

9.2 Chloe suffered from severe physical and mental ill-health conditions. In the days leading up to her death, she had declined in her mental health and was asking to go back into a hospital for treatment. The clinicians supporting her, made the decision that this was not the right course of action for her on this occasion. That decision has been the subject of intense scrutiny through a subsequent inquest. The inquest found no fault in the decision taken, and it is not for this review to consider that element further. The inquest concluded that Chloe had taken her own life.

9.3 It is the purpose of this review, however, to look at any trail of domestic abuse, the response by agencies, any barriers that existed in support being offered or undertaken, and the impact of that upon Chloe.

9.4 It is clear to this review that Chloe had been subject to abuse by her partner. That abuse took a variety of forms that are detailed within this report. The abuse was ongoing at the time of Chloe's death. In fact, only two days before her death, her partner had caused damage at her home after an argument between them, and he was under police investigation at the time.

9.5 After the incident at home, Chloe took herself away to a hotel in Derby. She described it (to workers from the mental health team who contacted her) as needing a 'break'. This review has been told that this was something that she had done before, and in all the circumstances, it seemed not to be an unreasonable thing for her to want to do: her health had declined again, and she had been subjected to more abuse by her partner. Her mother and stepfather had arranged for them all to go away to the coast for a weekend, and it seems that this would have been too much for her too.

9.6 During a recent stay in hospital, Chloe had also grown close to another man that she had met whilst in there, and she had commented to others about her feelings for him. It is apparent that once she had gone to the hotel to 'escape life', she wanted him to join her there for support.

9.7 After initially booking in for only one night, once there, she booked for an additional night. Whilst there, she had the tyres on her car damaged, which she believed to have been ongoing abuse by her partner. She was visited by the police in relation to the damage. The man to whom she had grown close did not join her, and it appears to this review that a combination of all that life had thrown at her, became too much to bear: she consequently took her own life. It seems perfectly reasonable to conclude that the abuse she suffered from her partner was one of a number of contributing factors.

9.8 We have identified several lessons that can be learned from this case, and we believe the resulting recommendations will make the future safer for others.

Appendix One – Terms of Reference

Terms of Reference for the Domestic Homicide Review into the death of Chloe

1.1 Introduction

1.1.1 This Domestic Homicide Review (DHR) is commissioned by the South Nottinghamshire Community Safety Partnership in response to the death of Chloe, which occurred in the summer of 2020.

1.1.2 The review is commissioned in accordance with Section 9, The Domestic Violence, Crime and Victims Act 2004.

1.1.3 The Chair of the partnership has appointed Gary Goose MBE and Christine Graham to undertake the role of Independent Chair and Overview Author, respectively, for the purposes of this review. Neither Christine Graham nor Gary Goose is employed by, nor otherwise directly associated with, any of the statutory or voluntary agencies involved in the review.

1.2 Purpose of the Review

The purpose of the review is to:

1.2.1 Establish the facts that led to the incident in the summer of 2020, and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard Chloe.

1.2.2 Identify what those lessons are, how they will be acted upon, and what is expected to change as a result.

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

1.2.4 Additionally, establish whether agencies have appropriate policies and procedures to respond to domestic abuse, and to recommend any changes as a result of the review process.

1.2.5 Contribute to a better understanding of the nature of domestic violence and abuse.

1.3 The Review Process

1.3.1 The review will follow the Statutory Guidance for Domestic Homicide Reviews, under the Domestic Violence, Crime and Victims Act 2004 (revised 2016).

1.3.2 This review will be cognisant of, and consult with, HM Coroner as the inquest into Chloe's death proceeds.

1.3.3 The review will liaise with other parallel processes that are ongoing or imminent, in relation to this incident, in order that there is appropriate sharing of learning.

1.3.4 Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable: that is a matter for coroners and criminal courts.

1.4 Scope of the Review

The review will:

1.4.1 Draw up a chronology of the involvement of all agencies involved in the life of Chloe, to determine where further information is necessary. Where this is the case, Individual Management Reviews will be required by relevant agencies, defined in Section 9 of The Act.

1.4.2 Produce IMRs for a time period commencing from 1st December 2018 to the date of the homicide[47].

1.4.3 Invite responses from any other relevant agencies, groups, or individuals identified through the process of the review.

1.4.4 To consider any additional pressures placed upon relationships by the creation of a blended family.

1.4.5 To consider the impact of the COVID-19 lockdown on the relationship and Chloe's mental health.

1.4.6 Consider the death in light of national/local suicide prevention strategies, their implementation, and practice.

1.4.7 Seek the involvement of family, employers, neighbours, and friends to provide a robust analysis of the events and understand Chloe's life.

1.4.8 Produce a report that summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken, and makes any required recommendations regarding safeguarding of individuals where domestic abuse is a feature.

1.4.9 Aim to produce the report within the timescales suggested by the Statutory Guidance, subject to:

- guidance from the police as to any sub-judice issues;
- sensitivity in relation to the concerns of the family, particularly in relation to parallel enquiries, the inquest process, and any other emerging issues.

1.5 Family Involvement

1.5.1 The review will seek to involve the family in the review process, taking account of who the family may wish to have involved as lead members, and to identify other people they think relevant to the review process.

1.5.2 We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support, and any existing arrangements that are in place to do this.

[47] This date has been selected as it is just before the birth of her first child.

1.5.3 We will work with the coroner to ensure that the family are able to respond effectively to the various parallel enquiries and reviews, thereby avoiding duplication of effort and minimising their levels of anxiety and stress.

1.6 Legal Advice and Costs

1.6.1 Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. The costs of their legal advice and involvement of their legal teams are at their discretion.

1.6.2 Should the Independent Chair, Chair of the CSP, or the Review Panel require legal advice, then South Nottinghamshire Community Safety Partnership will be the first point of contact.

1.7 Media and Communication

1.7.1 The management of all media and communication matters will be through the Review Panel, escalating to the CSP Chair, as necessary.

Gary Goose and Christine Graham
Independent Chair and Overview Author

Appendix Two – Ongoing Professional Development of Chair and Report Author

2.1 Christine has attended:

- AAFDA Information and Networking Event (November 2019)
- Webinar by Dr Jane Monckton-Smith on the Homicide Timeline (June 2020)
- Ensuring the Family Remains Integral to Your Reviews - Review Consulting (June 2020)
- Domestic Abuse: Mental health, Trauma and Selfcare, Standing Together (July 2020)
- Hidden Homicides, Dr Jane Monckton-Smith, AAFDA (November 2020)
- Suicide and domestic abuse, Buckinghamshire DHR Learning Event (December 2020)
- Attended Hearing Hidden Voices: Older victims of domestic abuse, University of Edinburgh (February 2021)
- Domestic Abuse Related Suicide and Best Practice in Suicide DHRs, AAFDA (April 2021)
- Post-separation Abuse, Lundy Bancroft, SUTDA (April 2021)
- Ensuring family and friends are integral to DHRs, AAFDA (May 2021)
- Learning the Lessons: Non-Homicide Domestic Abuse Related Deaths, Standing Together (June 2021)
- Suspicious Deaths and Stalking, Professor Jane Monckton-Smith, Alice Ruggles Trust Lecture (April 2021)
- Reviewing domestic abuse related suicides and unexplained deaths, AAFDA (May 2021)
- Young people and stalking: Reflections and Focus, Dr Rachel Wheatley, Alice Ruggles Trust Lecture (May 2021)
- Giving children a voice in DHRs – AAFDA (November 2021)
- Cross Cultural Training Webinar – Incels and Online Hate – HOPE Training (November 2021)
- Male victims of domestic abuse, Buckinghamshire DHR Learning Event (January 2022)
- Older victims of domestic abuse, Dr Hannah Bows, DHR Network (February 2022)
- Enhancing the cancer workforce response to domestic abuse – Standing Together and Macmillan (April 2022)
- Understanding Trauma – Delivered by Nikki Dhillon Keane (September 2022).

2.2 Christine has completed the Homicide Timeline Online Training (Five Modules), led by Professor Jane Monckton-Smith of University of Gloucester.

2.3 Gary and Christine have:

- Attended training on the statutory guidance update (May 2016)
- Undertaken Home Office approved training (April/May 2017)
- Attended Conference on Coercion and Control (Bristol, June 2018)
- Attended AAFDA Learning Event (Bradford, September 2018)
- Attended AAFDA Annual Conference (March 2017, 2018 and 2019)
- Attended Mental Health and Domestic Homicides: A Qualitative Analysis, Standing Together (May 2021)
- Attended AAFDA DHR Chair Refresher Training (August 2021)
- Commissioned bespoke training on DHRs and Suicide, Harmless (March 2022)
- Attended Strangulation and Suffocation: Introduction to the new offence for England and Wales, Training Institute of Strangulation Prevention (July 2022).