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

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Domestic Homicide Review

Executive Summary

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
June 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 order that lessons can be learned.

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.

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Section One – The Review Process

1.1 Summary of Circumstances Leading to the Review

1.1.1 This summary outlines the process undertaken by the South Nottinghamshire Community Safety Partnership (the 'CSP') Domestic Homicide Review panel in reviewing the death of Chloe, who was a resident within their area prior to her death in August 2020.

1.1.2 The following pseudonyms have been used in this review for the victim, perpetrator, and others (as set out below), to protect their identity and those of their families:

- The deceased in this case will be known as Chloe. She was a white British woman who was only 33 years old at the time of her death.
- Her ex-partner will be known as George.
- Chloe was the mother of two children: a youngest child, whose father was George; and an older child, whose father was an ex-partner of Chloe.

1.1.3 Chloe died alone at a hotel in Derby. She had a history of chronic physical and mental-ill health, and at the time of her death, was under the care of local mental health services. She was separated from George at the time, but contact was maintained for care of the children. Only two days before she died, she had argued with George after he attended her home and she had told him that the relationship was over. He became angry, and he damaged items in the house. This was reported to police and was under investigation at the time of her death, as was the damage to four tyres on her car, which had happened after she had arrived at the hotel.

1.1.4 No criminal proceedings were subsequently brought in connection to her death. An inquest was held in May 2022, at the conclusion of which, HM Coroner came to a finding that Chloe had taken her own life. Her cause of death was recorded as an overdose of prescribed medication, together with evidence of cocaine use.

1.1.5 The process of review began on 21st August 2020, after the police notified the CSP of the circumstances of Chloe's death. On 1st September, the Strategic Group of the CSP met and agreed that the circumstances met the criteria for a DHR: the review was then commissioned. The Independent Chair and Author were appointed. All agencies were asked to scope their records for prior relevant contact with the deceased and preserve their records for the purposes of the review. Nine organisations confirmed relevant contact.

1.2 Contributors to the Review

1.2.1 Nine agencies contributed to the Review by way of an Individual Management Report (IMR) or a summary report. They were:

- Derbyshire Healthcare NHS Foundation Trust – IMR
- Department of Work and Pensions – IMR
- East Midlands Ambulance Service – IMR
- General Practitioner for Chloe via Derbyshire CCG (now ICB) – IMR
- Nottingham University Hospital – IMR
- Nottinghamshire County Council (Children's Social Care) – IMR

- Nottinghamshire Healthcare NHS Foundation Trust (NHCT) – Summary report
- Nottinghamshire Police – IMR
- South Yorkshire Police – Summary report

1.2.2 The independence of the IMR authors was confirmed through the review process.

1.2.3 Specialist support to the review was provided by Juno Women's Aid, who provided support and advice relating to women victims of domestic abuse.

1.2.4 The Review was assisted by Chloe's mother, stepfather, and father: all supported by AAFDA. They have helped the review understand more about Chloe and the challenges she faced.

1.3 The Review Panel Members

1.3.1 The members of the original Review Panel were:

Member	Role	
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

1.3.2 All members of the panel and IMR authors were independent of direct involvement with either Chloe or her partner. The panel met in full, four times.

1.4 Domestic Homicide Review Chair and Overview Report Author

1.4.1 The Independent Chair for this review was Gary Goose. He is a former police officer who 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 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. Thereafter, he has been self-employed as a safeguarding review Independent Chair.

1.4.2 The Independent Overview Author for this review was Christine Graham. She 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.

1.4.3 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 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.

1.4.4 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.

1.4.5 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) and refresher training, provided by AAFDA (Advocacy After Fatal Domestic Abuse). Details of ongoing professional development are available in the full overview report.

1.5 Terms of Reference

1.5.1 The full terms of reference for this review can be found at Appendix One of the overview report. This review sought to focus on the following specific areas of note:

- 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.

Section Two – Summary Chronology

2.1 This section summarises the information gathered by the Review. Full details are contained within the overview report.

2.2 Chloe was only 33 years old when she died. She had recently separated from her partner, George, who was the father of her second child. She was still in contact with him, and the father of her first child, around contact to the children. In the months that preceded her death, Chloe had moved into a new home close to her parents.

2.3 Those who knew Chloe, describe her as a loving mother who thought the world of her children and wanted the best for them.

2.4 She had a number of physical illnesses and disabilities that affected her on a day-to-day basis. These were exacerbated by, and in some cases caused by, a car accident that she had in 2007. She had struggled for years with Functional Neurological Disorder (FND). 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. The car she drove was modified to be 'hands-only' in its mechanism.

2.5 In addition to her physical conditions, Chloe had been diagnosed with Emotional Unstable Personality Disorder: a condition that causes sufferers to experience intense and fluctuating emotions that can last from a few hours to several days.

2.6 Chloe had separated from her first partner, when she met George in around July 2017. In conversation with her GP around this time, Chloe disclosed that she felt that some of her psychological issues were due to her first partner being controlling in their relationship.

2.7 The overview report in this case, details a comprehensive review of Chloe's journey through medical services – both physical and mental health – from 2018 until the time of her death. They will not be repeated here; however, there was significant agency involvement in relation to her health for this whole period. In addition, police were called to her relationship with George on several occasions. Children's Social Care also became involved as a result of concern for the impact upon the children of witnessing abuse and the impact of Chloe's illnesses upon her.

2.8 It is clear that the relationship was not a healthy one, and Chloe reported that George had left the household in the August of 2018. The couple continued to have contact because of the children. It appears at times that he also became part of the household again. This undoubtedly affected Chloe, and she disclosed a number of stressors to those caring for her.

2.9 In May 2019, Chloe was reported missing from home by her family. After an extensive police search, she was subsequently found alone in a field: she had taken a large quantity of prescription medication. She received lifesaving treatment at the scene and was taken to hospital, where thankfully she made a recovery.

2.10 It appears that the couple finally separated in August 2019.

2.11 Chloe, with the support of her family, was thereafter a single parent coping with significant physical and mental health struggles. In March 2020, after COVID-19 arrived in the UK, she moved in with her mother and stepfather.

2.12 She continued to be at risk of self-harm through overdose, and there was significant health and other service involvement with her – as she attempted to take her life of a number of occasions.

2.13 Following one of these attempts, she was admitted to an acute inpatient mental health ward – as it was considered unsafe for her to be discharged due to her attempts at suicide and her feelings of hopelessness. During her time in hospital, she disclosed previous sexual assaults and other forms of abuse by a partner. She later reported to her own GP, whilst still on the ward, that George had previously sexually assaulted. She also reported to others that he had threatened her whilst she was on the ward. These reports are subject of scrutiny and comment by this review. It was during this stay that she developed a close friendship with a fellow patient.

2.14 Chloe was discharged from hospital in June and continued to engage with services on a regular basis.

2.15 Following her overdoses, concern continued in relation to Chloe's children, and they stayed with Chloe's parents whilst she struggled with the pressures upon her. The situation with her children clearly affected her, and in early August, she was particularly distressed. She disclosed to her GP that George was pressuring her into sex again and that she 'just wanted to die'.

2.16 The mental health crisis team were involved with Chloe on a daily basis from this time onwards. She spoke about wanting to go back into hospital; however, those treating her, came to a view that this would be counterproductive. The decision not to admit her back into hospital was subject of intense scrutiny during the inquest process, and this review has not sought to revisit that aspect.

2.17 During conversations with her care workers, Chloe denied the allegations made about sexual assault by George. She spoke about the relationship between the two of them, saying that he was, at that time, supportive but that it was too late to rekindle the relationship.

2.18 On 14th August, George went to Chloe's house expecting her to be packed for a planned weekend away with her parents. She was not there and was told that she had gone to Cornwall with a friend. He became angry and caused damage at the house. Thereafter followed exchanges of calls and texts between George and Chloe, at which he accused her of going away with a new male friend.

2.19 Chloe had not gone to Cornwall but in fact had gone to a hotel in Derby. After the damage was discovered, Chloe's mother reported it, and the attendant circumstances, to the police. It is clear that contact between George and Chloe continued for most of that day. Chloe was hoping for her friend to join her at the hotel, but that did not materialise. The tyres on her car were damaged whilst she was at the hotel. This was reported to the police, with her being visited there in relation to it. She extended her planned stay at the hotel for one further night. After others had been unable to raise her, she was found dead in the hotel room. She had overdosed on a variety of tablets.

Section Three – Key issues arising from this Review and lessons identified

3.1 This review has identified a number of areas where lessons can be learned from the scrutiny of this case. These are summarised within this section.

3.2 Firstly, we have looked at whether a trail of abuse is evident in this case, and what can we learn from the way in which agencies responded to any reports of such abuse.

3.3 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, we have spent time 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.

3.4 When Chloe's diagnosis of Emotional Unstable Personality Disorder is added to her chronic physical condition, her vulnerability to an abusive man becomes even greater.

3.5 We see in this review a range of different behaviours displayed by Chloe's partner that are clear evidence of abuse. Not all abuse is immediately visible, and the way in which he preyed upon her vulnerabilities is distressing to see. We make recommendations in relation to domestic abuse awareness training for professionals, in order that they can better recognise the signs of non-physical abuse in others.

3.6 During her time in hospital, Chloe made a number of disclosures about past abuse, including serious sexual abuse, rape, and ongoing threats. Whilst these issues appear within the records of those treating her, there is no trail of appropriate onward safeguarding concerns being raised in relation to them. The safeguarding procedures, that were in place during her stay in hospital, were not effectively followed. Similarly, when Choe rang from the hospital ward and spoke to her GP, the information she provided was not acted upon. We make recommendations in relation to both areas.

3.7 We also look at the effect of domestic abuse on the Chloe's children, how it manifests itself, and what can be learned from this case.

3.8 Finally, we have looked in depth at the link between domestic abuse and suicide. We have looked at the suicide prevention work being undertaken locally and make a recommendation in relation to the commitment of agencies (locally) to this important area of work.

Section Four – Recommendations

4.1 **DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST**

4.1.1 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.

4.1.2 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.

4.1.3 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.

4.1.4 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.

4.1.5 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.

4.2 **GP PRACTICE**

4.2.1 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.

4.3 **NOTTINGHAMSHIRE HEALTHCARE FOUNDATION TRUST**

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

4.4 **ALL AGENCIES ON DHR PANEL**

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

Section Five – Conclusions

5.1 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.

5.2 Chloe suffered from severe physical and mental ill-health conditions. In the days leading up to her death, she had declined in 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.

5.3 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.

5.4 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 the full overview 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.

5.5 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.

5.6 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.

5.7 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.

5.8 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.