Domestic Homicide Review Report into the death of:

‘Rosie’
Died February 2018

Author: Tony Blockley
AND
East Riding Community Safety Partnership (with Home Office Permission)
Report completed: June 2025

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Acronyms

DHR	…….	Domestic Homicide Review
IMR	…….	Individual Management Report
IAPT	…….	Rotherham Psychological Therapy Services - Improving Access to Psychological Therapies
RDASH	…….	Rotherham Drug and Alcohol Services
MARAC	…….	Multi Agency Risk Assessment Conference
IDVA	…….	Independent Domestic Violence Advisor
DVAP	…….	East Riding Domestic Violence and Abuse Partnership
DASH RIC	…….	Domestic Abuse Stalking and Honour Based Violence Risk Indicator Checklist

DHR overview report into the death of Rosie February 2018

Preface

The East Riding Community Safety Partnership Domestic Homicide Review Panel would like to express its profound condolences and sympathy to Rosie's[1] family.

At all times the panel has tried to view what happened through Rosie's eyes. We would like to assure them all that in undertaking this review, we are seeking to learn lessons to improve the response of organisations in cases of domestic abuse.

The independent chair and author of the review would also like to express his appreciation for the time, commitment, and valuable contributions of the review panel members and contributing report authors.

Rosie – a personal tribute on behalf of the family

Rosie was the third of three children; from an early age she had a love of animals. She kept dogs, cats, mice, chickens, ducks, horses and at one-point Rosie had 57 pets. She would take her rabbit for a walk in her pram, dress up with the dog and practice circus acts.

Rosie was a social, fun-loving, and outdoor girl. She loved to wear pretty dresses as a child even to climb trees. Rosie had a wide circle of friends. When she was 15, Rosie began an apprenticeship in hairdressing. She did amazingly well and blended in,

[1] 1 Rosie Is a pseudonym requested by her family.

because this was a hands-on course and Rosie was very creative, she could use her artistic side to good effect. Later in life Rosie worked as a professional hairdresser and taught hair dressing and managed shops. She had worked in London and all round the Country styling models hair.

Rosie was so affectionate and such a tactile person; she would stick up for the underdog and help them. Rosie was strict with her nieces but couldn't have loved them anymore. She had exceptionally good morals and was respectful to people. Rosie had a fun sense of humour and love to wind people up and play jokes, birthday cards would be full of glitter and when opened would be on the carpet for days. She had an infectious laugh, everyone loved Rosie.

Rosie had modelled in the past, slim, stunning, curvaceous, she would turn heads and she had a unique dress style, looking good in anything. But never wore jeans, she liked to wear denim skirts and dresses.

In August 2017 all the family went on a trip to Florida staying in an apartment and had an amazing time. Rosie went on all the rides with her nieces, swimming with Dolphins and scuba diving. The whole family went to shows, played golf and went out for many meals; we all shared her birthday celebrations whilst there.

Rosie, through sheer determination, successfully completed a detox programme and was positive about the future. She worked with all professionals to the best of her ability and with the constraints of her health.

She was an independent woman and would have a go at most things in the home, she was great at painting her house, with a love of bright colours creating a modern style only Rosie could carry off. Her home was a Gallery of family and friends' photos.

Rosie her mum and sister were exceptionally close and had a loving relationship as did all the family. Rosie was always special, first impressions were bright and bubbly, she made you laugh, she was loyal and genuine. She always tried to see where other people

were coming from and strive to help them. Rosie would never judge anyone; she would always say that people don't always choose to be how they are.

Rosie was tactile, she was a people's person. Rosie would give and want nothing in return. Rosie had everything to live for, and was forward planning for her future having bought a 6 month beauty package for near £300 2 days prior to her death.

1 Introduction

1.1 The key purpose of undertaking a Domestic Homicide Review (DHR) is to enable lessons to be learnt from homicides where a person dies because of domestic abuse. It should be noted that homicide does not mean an act of murder – an intentional act has taken place. A homicide may result from accidental, reckless, or negligent acts even if there is no intent to cause harm.

A DHR is intends to ensure the following, that any lessons are learnt as widely and thoroughly as possible, that professionals understand fully what happened in each homicide, and most importantly, what needs to change to reduce the risk of such tragedies happening again. Rosie's death met the criteria for conducting a DHR under Section 9 (3)(a) of the Domestic Violence, Crime, and Victims Act 2004.[2]

DHRs were established on a statutory basis under the Domestic Violence, Crime and Victims Act 2004 and were enacted in 2011.

The Act states:

(1) In this section "domestic homicide review" means 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

[2] Comment will be made regarding suicide and Domestic Homicide Reviews

(b) a member of the same household as himself,

held with a view to identifying the lessons to be learnt from the death.

***The term domestic abuse will be used throughout this review where possible, as it reflects the range of behaviour encapsulated within these definitions and avoids the inclination to view domestic abuse in terms of physical assault only.* The term domestic abuse is referenced to the cross-government definition issued under the Home Office Circular: 003/2013, that was implemented on 31st March 2013.

1.2 Domestic Violence and Abuse definition

Domestic violence and abuse is defined as any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

- Psychological
- Physical
- Sexual
- Financial
- Emotional

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

It should be noted that the legal definition for domestic abuse changed during the course of this review, The Domestic Abuse Act 2021 received Royal Assent and became law at the end of April 2021.

Domestic abuse is any single incident, course of conduct or pattern of abusive behaviour between individuals aged 16 or over who are "personally connected" to each other as a result of being, or having been, intimate partners or family members, regardless of gender or sexuality. Children who see, hear or experience the effects of the abuse and are related to either of the parties are also considered victims of domestic abuse.

Behaviour is "abusive" if it consists of any of the following: physical or sexual abuse; violent or threatening behaviour; controlling or coercive behaviour; economic abuse; or psychological, emotional or other abuse.

This includes incidences where the abusive party directs their behaviour at another person (e.g. a child).

Economic abuse means any behaviour that has a substantial adverse effect on someone's ability to acquire, use or maintain money or other property, or obtain goods or services.

1.3 **The purpose of a DHR is to:**

a) Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

b) Identify clearly what those lessons are both within and between

agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

c) Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

d) Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e) Contribute to a better understanding of the nature of domestic violence and abuse; and

f) Highlight good practice.

1.4 This DHR examines the circumstances leading up to the death of Rosie, who appeared to take her own life in February 2018.

1.5 **Decision to hold a DHR**

1.6 Rosie appears to have taken her own life in February 2018. Humberside Police carried out an investigation at the time of Rosie's death and concluded that there was no third-party involvement. As a result, a Coroners enquiry commenced. The investigation concluded at the end of the inquest on 27th June 2022. The details of the conclusion of the inquest are as follows:

Rosie was vulnerable due to a history of domestic abuse and anxiety and depression, her emotional distress caused alcohol dependence. On [redacted], Rosie was found [redacted]. The level of alcohol in her system would have impaired her cognitive function.

1.7 On 29th June 2018, a sub-group of representatives of the East Riding Community Safety Partnership met to discuss the case and determined that a DHR should be undertaken. The Home Office was duly notified.

Appendix A details how Rosie's family fed back in the review process that the right to hold a DHR should be every family's right, and that they should be given information about this process at the earliest opportunity rather than having to instigate this process themselves which was the case with Rosie's family.

2 Overview

2.1 Persons involved in this DHR

Name	Gender	Age at the time of death	Ethnicity
Rosie	Female	34	White British

Summary of the incident

2.2

2.3 This DHR Overview Report concerns Rosie, a 34-year-old woman, who died in East Yorkshire in February 2018.

2.4 Rosie had separated from her partner, Dave [3], in 2017 and fled to East Yorkshire during that summer. Rosie lived alone, with the support of her family, but did not have any supportive friends in the area and was isolated from her friends due to this abuse. The review acknowledges the huge impact fleeing has on victim's of domestic abuse, including the unsurmountable impact on mental health. Victims flee their own homes, places and areas they are familiar with, when perpetrators should be held accountable for their abuse. Removing victims from their homes makes those who flee further isolated, and this impact should be widely acknowledged by agencies.

Rosie was vulnerable due to a history of domestic abuse and anxiety, her emotional distress caused alcohol dependence. On [redacted], Rosie was found [redacted]. The level of alcohol in her system would have impaired her cognitive function.

[3] This is a pseudonym selected by the author of this report.

3 Parallel reviews

3.1 There was a coroner inquest pending and the outcome did indeed result in an article 2 inquest. This resulted later in a Prevention of Future Death Report by the Coroner to the Secretaries of State for Safeguarding and Health and Social Care. Rosie's family state it was a fight to achieve the article 2 inquest when this should have been a right.

3.2 Article 2 inquests are enhanced inquests held in cases where the State or 'its agents' have 'failed to protect the deceased against a human threat or other risk' or where there has been a death in custody. Cases where the deceased has been under the care or responsibility of social services or healthcare professionals are also often included in this category of inquest.

Article 2 of the European Convention on Human Rights provides that:

1. Everyone's right to life shall be protected by law.

The Article further provides that every person has a right:

- Not to be unlawfully killed by the state
- For the state's systems to be designed so that they protect life, including through the criminal law
- For the state to investigate suspicious deaths
- In certain circumstances to require the state to take reasonable steps to prevent the loss of life

This can be further described as meaning that member states have the following duties:

1. A negative duty to refrain from taking life

2. A positive duty to take the appropriate steps to safeguard a person's life

Following the conclusion of this report, an inquest into Rosie's death has been concluded and the findings were that:

> *Rosie was vulnerable due to a history of domestic abuse and anxiety and depression, her emotional distress caused alcohol dependence. On [redacted], Rosie was found [redacted]. The level of alcohol in her system would have impaired her cognitive function.*
>
> *The lack of an appropriate, co-ordinated approach to her issues, which was further hampered by inadequate information sharing, while not directly causative of her death, would have affected the state of her mental health and contributed to her decline.*

A Regulation 28: Report to Prevent Future Deaths, was issued by the coroner.

As was Rosie's family's experience which they shared about securing a DHR; Rosie's family also fedback during the review process that families should be supported and given awareness and advice about what article 2 inquests are, looking at where the state or 'its agents' have 'failed to protect the deceased against a human threat or other risk'.

4 Domestic Homicide Review Panel

The DHR panel was comprised of the following:

Tony Blockley	Independent Chair and Author
Alison Haynes	East Riding Partnership Substance Misuse Service Manager
Amanda Raven	Childrens Services, and Domestic Abuse and Sexual Abuse Lead at Rotherham Council
Andy Miller (Previously Stacey Grayson)	Detective Sergeant within South Yorkshire Police Protecting Vulnerable People Performance and Governance

Caroline Elvidge	National Probation Service Senior Probation Officer
Max Hough	East Riding Community Safety Partnership Crime and Disorder Manager

Charlotte Hetherington	East Riding Community Safety Partnership Officer
Denise Dobb	Lead Investigator Patient Safety and Investigation Team at Rotherham, Doncaster & South Humber NHS Foundation Trust
Robert Maginnis	Head of Patient Safety and Claims at Rotherham, Doncaster & South Humber NHS Foundation Trust
Julie McGarry	Nottinghamshire Healthcare Trust
Elisabeth Alton	Named GP for safeguarding adults for Humber and North Yorkshire ICB
Emma Heatley (Previously Aidan Clarke)	Humberside Police Chief Inspector
Joanne Gale	East Riding of Yorkshire Council (Safe Communities), Domestic Violence and Abuse Partnership Team Leader
Lyndsey McClements	Hull & East Yorkshire MIND Director of Operations
Sam Bell	Hull & East Yorkshire MIND Director of Operations
Rebecca Daniels	East Riding of Yorkshire Council (Adult Services) Safeguarding Adults Team Manager
Nicki Bloor	East Riding of Yorkshire Council (Communities Manager)

Nicola Codd	Humber Teaching NHS Foundation Trust
Simon Robinson	Humber Teaching NHS Foundation Trust Substance Misuse Addictions Lead
Shelley Goodinson	East Riding of Yorkshire Council (DA & Safeguarding Partnerships Manager)

**Where possible panel members did not have any involvement with Rosie to remain independent for the purpose of this review. If panel members were involved with Rosie, they were not to allow any personal thoughts or considerations impact on the independence of the review.

5 Independence

5.1 Author

Tony Blockley, an Independent Chair and author, was appointed by the East Riding Community Safety Partnership. He is a specialist independent consultant in the field of homicide investigation and review. With over 30 years-experience in the field of investigations and has senior management experience in all aspects of public protection, when he was head of crime in a UK police force. He retired from Derbyshire Constabulary in 2010 and having conducted numerous DHR's was considered appropriately independent.

*Further information is included at Appendix B

5.2 All panel members and Individual Management Reports (IMR) authors were, where possible, independent of any direct contact with the individuals of this DHR, nor were they the immediate line managers of anyone who had direct contact with the persons within this review. If panel members were involved with Rosie, they were not to allow any personal thoughts or considerations impact on the independence of the review.

6 Terms of Reference and Scope

6.1 The full terms of reference can be found at Appendix A, the terms of reference identified the following:

- To consider whether the incident in which Rosie died was an isolated one or whether there were any warning signs. To also consider whether more could be done to raise awareness of services available to victims of domestic abuse.

- Whether there were any barriers experienced by Rosie or her family and friends in reporting any abuse in East Riding of Yorkshire or elsewhere, including whether they knew how to report domestic abuse should they have wanted to?

- Whether there were opportunities for professionals to 'enquire' as to any domestic abuse experienced by Rosie that were missed.

- Whether there were opportunities for agency intervention in relation to domestic abuse regarding Rosie or other family members that were missed.

- The review should identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services in the area covered by the East Riding Community Safety Partnership.

- The review will also give appropriate consideration to any equality and diversity issues that appear pertinent to Rosie e.g., age, disability, (which the review report reflects on learning disabilities and differences in educational ability within this), gender reassignment, marriage and civil

partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

- How should friends, family members and other support networks and, where appropriate, the perpetrator, contribute to the review and who should be responsible for facilitating their involvement?

- How should matters concerning family and friends, the public and media be managed before, during and after the review and who should take responsibility for it.

- How will the review take account of a coroner's inquiry, and (if relevant) any criminal investigation related to the homicide, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process or compromise to the judicial process?

- Does the review panel need to obtain independent legal advice about any aspect of the proposed review?

- How should the review process take account of previous lessons learned from research and previous DHRs?

- Whether Rosie was 'in need of care' within the auspices of the Care Act 2014

- Whether there were any issues in communication, information sharing or service delivery between services.

Key lines of enquiry for the review were set by the East Riding Community Safety Partnership, and are identified as:

- To consider and analyse key practice episodes within the timeframes, including services response to friends and family, and sharing of information.

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- Should specific issues which arise prior to these timeframes be seen as significant, these should be included.

  To review professionals understanding of risk and whether risks were identified and responded to appropriately in Rosie's case.

- Consider the robustness of professionals holding each other to account.

- To review how professionals ensured that Rosie's voice was heard.

- Look at whether thresholds were understood and that professionals were working in accordance with statutory guidance and East Riding Safeguarding Adults Board (ERSAB) safeguarding procedures.

- To identify any learning there may be and formulate draft recommendations for future practise.

- To identify any areas of good practise.

- To produce an overview report that summarises concisely the relevant chronology of events including the actions of all the involved agencies, analyses and comments on the appropriateness of actions taken and makes recommendations with the aim of improving safeguarding where domestic violence is a feature.

- Identify, based on the evidence available to the review, whether any intervention and / or omission would have had a significant negative

- impact that may have affected the eventual outcome, with the purpose of improving policy and procedures in East Riding and perhaps more widely.

- Identify from both of the circumstances of this case, and the homicide review processes adopted in relation to it, whether there is learning, which should inform policies and procedures in relation to homicide reviews nationally in future and make this available to the Home Office.

  The Review will exclude consideration of how Rosie died or who was culpable - that is a matter for the Coroner and Criminal Courts respectively to determine.

** It is understood that publication dates may have to change where criminal proceedings are pending; however, these will not prevent the review from progressing.

6.2 The scope of the review commenced in 2013 through to the date of Rosie's death in 2018. This date enabled the capture of information prior to Rosie's relationship with Dave and throughout that relationship. Agencies were asked to search their records between those dates for involvement with Rosie and/or Dave. This covered the geographical areas of both South Yorkshire and East Riding of Yorkshire.

Following review of the DHR process, it is reflected by the CSP and in the addendum in appendix 1 that there are gaps in the DHR panel and contributions to IMR's in relation to the Ambulance Trust, Acute Hospital Trusts from Hull and Rotherham (although the ICB Commissioning (formerly CCG (Clinical Commissioning Group) organisation for Health was represented in East Riding), and finally the Residential Detox Woodlands in Nottingham.

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6.3 The review has been subject to a series of delays. The panel met on seven occasions, between November 2018 and February 2020. Rosie's family attended one of the meetings and was able to discuss Rosie and the family's thoughts with the panel although this was only for 30 minutes and then asked to leave for the panel to continue.

6.4 The delays in completing the review were due to several reasons. Humberside Police undertook a review of the original investigation to consider whether any further criminal investigations should take place. Family feedback during the review process that the original investigation showed unconscious bias in

terms of a lack of consideration about follow up in terms of a suspected victim suicide, and that training should encompass investigations that challenge the decision about a case being a victim suicide as opposed to a suspected victim suicide. Following their review, they decided there was nothing further for them to investigate and the original investigation was robust and effective. During this period the review was 'suspended' to ensure the review did not jeopardise any potential future criminal investigation. Other delays were due in part to the complexity of the DHR, gathering information from agencies, a number of bereavements the Chair experienced whilst conducting the review, and other commitments. Rosie's family reflected that these other commitments including substantial areas of other work by the Author significantly affected the development of the review and production of the final report.

7 Confidentiality and dissemination

7.1 The findings of this DHR report are restricted. Until the report is published it is marked: Official Sensitive Government Security Classifications April 2014. Information is available only to panel members and Community Safety Partnership until the review has been submitted and approved for publication by the Home Office Quality Assurance Panel. The East Riding Community Safety Partnership will widely disseminate the report to all linked partnership boards and forums after publication.

7.2 As recommended within the 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' to protect the identities of those involved, pseudonyms have been used where appropriate and precise dates obscured.

7.3 The Executive Summary of this report has also been anonymised where appropriate.

7.4 This has not prevented agencies acting on the findings of this Review in advance of publication.

8 Methodology

8.1 As background information, the review considered the following key documents:

- The Home Office multi-Agency Statutory Guidance for the conduct of Domestic Homicide reviews 2016
- The Home Office Domestic Homicide Review Tool Kit Guide for Overview Report Writers 2012
- Call an End to Violence Against Women and Girls – HM Government (February 2016)
- Home Office Domestic Homicide Reviews – Common themes identified and lessons learned – December 2016
- Prevalence of intimate partner violence: findings from the WHO multicountry study on women's health and domestic violence, 2006.
- 'If only we'd known': an exploratory study of seven intimate partner homicides in Engleshire - July 2007 [4]
- What is domestic violence and how common is it? In Intimate Partner Abuse and Health Professionals: New Approaches to Domestic Violence - Hegarty 2006 [5]
- Domestic abuse and suicide: exploring the links with refuge's client

[4] Regan, L., Kelly, L., Morris, A. & Dibb, R. (2007). 'If only we'd known': an exploratory study of seven intimate partner homicides in Engleshire. London: London Metropolitan University Child and Woman Abuse Studies Unit. [5] Roberts G, Hegarty K, Feder G, editors. Intimate partner abuse and health professionals: new approaches to domestic violence. Edinburgh: Churchill Livingstone; 2006. pp. 19–40.

Base and work force - Aitken and Munro (2018)[5]

- Substance abuse and domestic violence: Stories of practitioners that address the co-occurrence among battered women. - Rogers, McGee, Vann, Thompson and Williams (2003)[6]
- The human-companion bond: How humans benefit. – Friedmann and Son (2009)[7]
- Fear, guilt, and grief: Harm to pets and the emotional abuse of women. – Faver and Strand (2007)[8]
- The Abuse of Technology in Domestic Violence and Stalking. – Woodlock (2017)[9]
- Technology-facilitated domestic abuse in political economy: a new theoretical framework – Yardley (2020)[10]
- Working with Risk: Skills for contemporary social work – Kemshall, Wilkinson and Baker (2013)[11]
- Home Office (2024) *Fatal domestic abuse reviews renamed to better recognise suicide cases*. Available at:

[5] Aitken, Ruth and Munro, Vanessa (2018) Domestic abuse and suicide: exploring the links with refuge's client Base and work force. London: Refuge

[6] Rogers, B., McGee, G., Vann, A., Thompson, N., & Williams, O. J. (2003). Substance abuse and domes- tic violence: Stories of practitioners that address the co-occurrence among battered women. *Violence Against Women*, *9*, 590598.

[7] Friedmann, E., & Son, H. (2009). The human-companion bond: How humans' benefit. *Veterinary Clinics of North America: Small Animal Practice*, *39*, 293-326.

[8] Faver, C.A. and Strand, E.B., 2007. Fear, guilt, and grief: Harm to pets and the emotional abuse of women. *Journal of Emotional Abuse*, *7*(1), pp.51-70

[9] Woodlock D (2017) The Abuse of Technology in Domestic Violence and Stalking. *Violence Against Women*, 23(5): 584-602.

[10] Yardley, E., 2020. Technology-facilitated domestic abuse in political economy: a new theoretical framework. *Violence against women*.

[11] Kemshall, H., Wilkinson, B. and Baker, K., 2013. *Working with Risk: Skills for contemporary social work*. Polity. [13] Postmus, J; Hoge, G; Breckenridge, J; Sharp-Jeffs, N; Chung, D. (2018). Economic Abuse as an Invisible Form of Domestic Violence: A Multicountry Review. Trauma, Violence, & Abuse.

https://www.gov.uk/government/news/fatal-domestic-abusereviews-renamed-to-better-recognise-suicide-cases (Accessed: 20 March 2024).

- Economic Abuse as an Invisible Form of Domestic Violence: A Multicountry Review - Postmus, Hoge Breckenridge Sharp-Jeffs and Chung (2018)[13]

- Economic Abuse Experiences and Depressive Symptoms among Victims of Intimate Partner Violence. Journal of Family Violence. - Stylianou (2018)[12]
- Monckton Smith, J., 2020. Intimate partner femicide: Using Foucauldian analysis to track an eight stage progression to homicide. *Violence against women*, 26(11), pp.1267-1285.
- Johnson, M.P., 2008. *A typology of domestic violence*. Upne.
- Stark, E. and Hester, M., 2019. Coercive control: Update and review. *Violence against women*, 25(1), pp.81-104.
- Sharp-Jeffs, N. and Kelly, L., 2016. Domestic homicide review (DHR): Case analysis.
- Dangar, S., Munro, V. and Young Andrade, L., 2023. Learning legacies: An analysis of domestic homicide reviews in cases of domestic abuse suicide.
- Rowlands, J. and Dangar, S., 2023. The Challenges and Opportunities of Reviewing Domestic Abuse-Related Deaths by Suicide in England and Wales. *Journal of Family Violence*, pp.1-15.
- Newberry, M., 2017. Pets in danger: Exploring the link between domestic violence and animal abuse. *Aggression and Violent Behavior*, *34*, pp.273-281.

[12] Stylianou, A. (2018). Economic Abuse Experiences and Depressive Symptoms among Victims of Intimate Partner Violence. Journal of Family Violence.

** other documents are referenced within the relevant sections.

8.2 The review considered the purpose of IMR's. The Home office guidance in considering the purpose and the content of an IMR provides the following:

8.3 It is important that any agency or employer that is approached to provide an IMR does so to provide the review panel with a chronology of its involvement with the victim and others that may be the subject of the review. This will allow the review panel and chair to fully analyse events leading up to the homicide.

This is commented on within the key issues/lessons learned section.

8.4 It was determined that the following agencies were required to produce a full report:

- South Yorkshire Police
- Humberside Police
- Rotherham, Doncaster and South Humber NHS Foundation Trust
- Rotherham Drug and Alcohol Services
- East Riding Domestic Violence and Abuse Partnership
- East Riding Social Services
- East Riding CCG GP practice
- Hull and East Yorkshire Mind
- East Riding Partnership Addictions Service

8.5 Due to their limited involvement, it was determined that the following agencies would produce a factual summary report for the review:

8.6 • Rotherham Children and Young People's Service

- Nottinghamshire Healthcare NHS Foundation Trust

- Family concerns however state that this was not limited involvement, and that Rosie was resident there about a month, where care was neglectful and the family complained about this care to the Addictions Services.

8.7 The recommendations to address lessons learnt are listed in section 14 of this report and action plans to implement those recommendations are included in Appendix C.

8.8 Each report was scrutinised by the Panel and discussed in depth to ensure that any learning could be identified and used.

8.9 The Panel and IMR authors have been committed, within the spirit of the Equalities Act 2010, to an ethos of fairness, equality, openness, and transparency, and have ensured that the Review has been conducted in line with the terms of reference.

8.10 This report is an anthology of information and facts gathered from:

- The factual summary reports
- The Police Senior Investigating Officer
- The initial investigation and associated press articles
- DHR Panel discussions
- Information from friends and family members
- Information from the perpetrator

8.11 East Riding Community Safety Partnership is responsible for monitoring the implementation of the action plans.

Family note the lack of communication in updates on the action plan and learning as a result.

8.12 **Involvement of Family and Friends**

8.13 **Rosie's Family**

8.14 During the process of the review, Rosie's family were involved in discussions with the chair providing written comments, raising questions and issues they felt appropriate to the review. Rosie's family also attended one DHR panel meeting where they shared thoughts on the Police investigation and the review. Rosie's pen portrait was read and shared and only opportunity for brief comments were given at the panel meeting for Rosie's family they reflected. Rosie's family also reflect that their experience of the DHR panel shows no challenge by professionals or professional curiosity. They were supported and represented by an advocate from Advocacy After Fatal Domestic Abuse (AAFDA). The following section from Rosie's mother captures those thoughts and issues.

8.15 *I am a mother of three children who were the focus of my life. Mine and my family's life has changed forever and you will never comprehend the impact of losing Rosie has had on us.*

8.16 *Rosie had a right to life she had a right to feel safe, free from harm and protected by professionals. Staffing levels, resources, timeframes, experience, communication, the amount of support, should not be what contributes to an individual taking their life, after experiencing controlling, coercive, threatening, degrading and violent behaviour including sexual abuse.*

8.17 *Rosie was repeatedly targeted; she was a victim to these male perpetrators. Evidence clearly identifies abuse affects women disproportionately. We must be more proactive in identifying both men and women who are victims of abuse and how we can protect them now and in the future.*

8.18 *We need to work together, look at dual diagnosis. Many victims as a result of domestic abuse suffer from anxiety and depression, use drugs or alcohol as coping mechanisms. These victims cannot be treated by just looking at*

domestic abuse, mental health or addictions in isolation, holistic care is needed.

8.19 *More must be done for vulnerable people in our society. We need to ask the question, identify early and ensure appropriate support is in place. Time and effort needs to be put into place to ensure that victims are safe and are able to prosecute.*

8.20 *Can you even imagine a little of what these victims experience? Years of abuse, both physically and mentally, the mind games, the embarrassment, the pain. It should be standard that every victim is offered or treated for posttraumatic stress, educated to protect themselves, build their confidence and self-esteem. Better history needs to be taken from clients, tools need to be used to evidence levels of care and not judge them. Support needs to be given for those fleeing, accommodation, moving, the isolation, the financial implications, the impact was above your comprehension. It is my opinion that not only was Rosie let down, but as a family we have been. We have had to challenge all services for the right to be heard, the right to a fair hearing. Victim Support, information for families, communication, updating, would go a long way to support families.*

8.21 *No investigation was initially completed, I am not convinced that Rosie took her life. Her perpetrator had a long history of strangling Rosie, he stalked her and had no intention of letting her go. Anybody who knew Rosie would know she would never want me to find her, she would have spoken to her sister. She had planned for me to meet her new friend. Rosie would never have locked her dog up, left the back door open all left the key in the front door.*

8.22 *I strongly believe that nobody goes out to do a bad job, but we must accept failings have been made or else Rosie would be here today.*

8.23 **Questions for the review posed by Rosie's family.**

• Why did professionals not support Rosie and make it safe for her to give evidence under the victim's charter, did professionals get on board enough to help her make a prosecution to protect her in the future?

8.24 • Did Rosie have mental capacity at the time to make the decision not to prosecute? She had been severely assaulted, petrified of the perpetrator, had mild learning disabilities, suffered from anxiety.

8.25 • Did Rosie fully understand the complexity of events she had no family or supportive friends in the immediate vicinity and was isolated.

8.26 • Rosie would not report domestic abuse incidents to the police as Dave was well known to the police service. Rosie told me but it is no use reporting him as the police will back him, also he would say it was just kinky sex that got out of hand when he used to strangle her.

8.27 • Ambulance and police services reported Rosie as a vulnerable adult, yet nothing happened. These incidents caused significant post-traumatic stress for Rosie.

8.28 • A lack of understanding of the impact of domestic abuse and post-traumatic stress, nobody took the time to understand Rosie holistically.

8.29 • When domestic abuse happened in June information was freely given by Rosie to a police officer, but this information was not recorded. I was told by South Yorkshire Police, but they followed policy and procedures. A Domestic Abuse Stalking and Honour Based Violence (DASH) assessment and referral to an Independent Domestic Violence Advisor (IDVA). Are we hiding behind these policies and procedures?

8.30 • Gaslighting was never considered in Rosie's case and we as a family have to push for it to be looked at.

8.31 • Originally the decision was made that Rosie's death would not meet the DHR criteria, it was only our persistence that it was agreed to carry out a review. Why should families have to fight to request this, this is unacceptable at a time of grief.

8.32 **Sister**

8.33 The following information is a summary of the discussions with Rosie's sister, the review has not sought to clarify or add to the comments.

8.34 Rosie's sister explained that Dave would ring Rosie many times a day. Rosie was close to her sister and although they did not see each other face to face often because they lived a considerable distance apart, they kept in touch regularly by phone.

8.35 On one occasion during the summer, not long after Rosie and Dave had got together, they visited Rosie's sister. Rosie was wearing a 'strappy dress' with a neck scarf. When questioned about it, Rosie showed her sister a friction burn around her neck saying that it was due to 'kinky sex'.

8.36 Rosie later told her sister that Dave was a 'sex addict' and that he enjoyed rough sex. Rosie also told her that he would 'dress her up' before having sex. Dave also had a 'black book' of people he had slept with and would leave it out so Rosie would see it.

8.37 Rosie kept her work location quiet; however, Rosie told her sister that Dave would drop her off, but not pick her up. He would take money off Rosie and buy fresh

food for himself, but nothing for Rosie. Dave would also take money out of their joint account without Rosie knowing. She felt that Dave was financially abusing Rosie. Dave insisted that Rosie got money for them to live on.

8.38 Dave would frequently undermine Rosie saying that she should be more like her sister and dress more like her, undermining Rosie's confidence and isolating her.

8.39 Dave would also take the 'mickey' out of Rosie due to Rosie's dyslexia. This upset Rosie and the constant demeaning behaviour again undermined Rosie.

8.40 Dave would also tell Rosie that he knew the police in South Yorkshire, and they would allow him to get away with things. This behaviour meant that Rosie did not trust the police and could explain why she did not report the abuse. On one occasion close to Halloween Rosie went around to a friend's house covered in blood from an assault by Dave.

8.41 When Rosie and Dave split up, he would ring Rosie and tell her that his son missed her and wanted to see the dog. This coercive control was really hard for Rosie. When he did see her, Dave would take her to the bank to get money out.

8.42 Rosie's sister explained the story of the naked photographs on Facebook after Rosie and Dave had split up and the impact this had on Rosie, the embarrassment that it caused her.

8.43 Rosie had changed from being an outgoing person who enjoyed life, to an isolated person who was afraid of Dave. Rosie would tell her sister that she craved normality, a family, she wanted to get married and have a baby, she had even talked about baby names.

8.44 Rosie's sister knew a lot about the relationship between Rosie and Dave but said that she did not know the true extent of the abuse. She also felt that Rosie did not see herself as a victim but that the behaviour from Dave towards her was normal.

8.45 **Friends**

8.46 The following information is a summary of the discussions with Rosie's friends, the review has not sought to clarify or add to the comments.

8.47 During the conversation a friend expressed surprise that Rosie had taken her own life as she was against suicide. Even when people joked about it, Rosie would get angry and upset. She also said that Rosie would not have left her dog, that her animals were her life.

8.48 Her friends felt that Dave used Rosie as a trophy, showing her off. However, as the relationship developed, Dave became more controlling, snapping at Rosie for not doing things in the home. Dave would also phone around Rosie's friends to find out if she had been drinking.

8.49 Dave did not like Rosie's friends and would try to keep them apart, in an attempt to isolate Rosie even more.

8.50 Rosie had confided that Dave was a sex addict, that he would strangle Rosie although she did not want to do it. On one occasion Rosie was wearing a scarf due to the marks left when he had strangled her.

8.51 Dave knew where Rosie worked, he would regularly drop her off. Rosie had bought Dave the car he drove. Dave wanted the money Rosie earned and would also encourage her to drink when he wanted a drink.

8.52 When Rosie had had a drink, the following morning Dave would ask her if she knew what she had done the night before or say, 'do you know what you looked like'. Behaviours to undermine Rosie.

8.53 After the assault by Dave on Rosie, Dave was constantly harassing Rosie to drop the charges, he would tell her that she (Rosie) had made him lose his son. When they had split up, Dave threatened to commit suicide in an attempt to get Rosie back.

8.54 Rosie was not strong enough to keep Dave away, Dave was described as 'very clever' and 'manipulative'. The overriding concern was that Rosie would not have taken her own life.

8.55 **Rosie's workplace**

The following information is a summary of the discussions with staff at Rosie's workplace, the review has not sought to clarify or add to the comments.

8.56 Rosie originally started work and attended for four weeks. She then left this workplace and returned after one year. The workplace had regular visits from the police and the safeguarding team who discussed domestic violence and sexual violence and sexual health with the people who worked there.

8.57 Dave was aware about her workplace. Following Dave's friend becoming aware of the workplace, he took her over to Ireland and challenged her. There was an incident where Dave was physically abusive and isolated Rosie from her family unable to see them on a planned week following this.

8.58 When they returned, Dave quit his job and began to live on Rosie's earnings. Whilst Rosie was with Dave, she used to have to give all her money to him. She started to leave money at the workplace to save as she said she was going to leave him and needed money to escape.

8.59 Whilst at the workplace she would tell staff what Dave was like, she told them he frequently beat her and on one occasion Dave's son was downstairs playing on his x-box whilst he, Dave was beating Rosie. She recalled another incident when Dave strangled her over a car bonnet and another when Dave wrapped Rosie's head in clingfilm before poking a hole where her mouth was so she could breathe.

8.60 The staff explained that Rosie always had bruises to her body and that Dave would often threaten Rosie, using her dog to abuse her.

8.61 Staff often collected Rosie when she had caught the train to Sheffield as she was scared to get a taxi in case Dave followed her. They had previously taken Rosie home when she had split up with Dave to ensure she got home safely as Rosie was fearful of Dave. They said Rosie was terrified of Dave. On one occasion Dave came to the workplace wanting to speak with Rosie, he was told she did not want to speak to him, and she would not be coming out. It was only when Dave was threatened with the police that he left.

8.62 They were clearly upset by Rosie's death describing her as a beautiful person. At the same time, they were surprised by the circumstances of Rosie's death. They said Rosie would never have left her dog, she never left the key in the front door, and she would never have left the back door unlocked.

8.63 **Dave**

The Author engaged with the perpetrator to ascertain their views as per the statutory guidance on conducting DHRs and these are included in the Analysis section along with an analysis of these views.

9 Key events

9.1 In 2013, Rosie was in a relationship with an abusive partner and was a victim of domestic abuse. She left this relationship despite him continuing to harass her and a restraining order was granted.

9.2 In April 2013, on a visit to her GP, Rosie's notes record that she looked anxious, likely relating to this domestic abuse. This is a missed opportunity to enquire further about domestic abuse and a lack of professional curiosity.

9.3 In August of the same year, Rosie's ex-partner went to her house and began to bang on the door. He also wrote the word 'prostitute' on her kitchen window, which couldn't be removed. This was not only a criminal offence, but a breach of the restraining order. This demonstrates a lack of understanding about domestic abuse and no support was given to Rosie following this. This affected Rosie's confidence in the Police service.

From records there is nothing to suggest the ex-partner was contacted or spoken to, it is the view of the independent author that this was a missed opportunity to further support Rosie and also disrupt the perpetrator. Family also reflect that no action was taken, and Rosie was left in the house following the incident petrified – no support offered. This left Rosie feeling further that her safety as not a priority and contributed to her lack of faith in the Police overall.

9.4 In December 2013, Dave was reported as assaulting his then partner. On the attendance of South Yorkshire police, the partner would not give any details and the officers were unable to ascertain if any injuries or assault had taken place, as such the incident was concluded without any confirmation of domestic abuse. However, family reflect that access to Dave's son was then ceased due to involvement with Children's Services, which demonstrates some information sharing regarding the risk to Dave's son.

9.5 In February 2014, Rosie attended her GP as she had difficulty sleeping. She explained to her GP that this was due to the impending court case with her ex-partner. She again visited the GP a month later and was still not sleeping. Rosie was later referred to psychological therapy and prescribed antidepressants.

9.6 On a visit to her GP in July 2014, it is recorded that Rosie has 'drunk heavily' since the age of 18 years old. The records state her drinking as causing her issues at work even though she had a supportive boss in her hairdressing role. Rosie had tried to engage with services previously, but this had not helped her. She also explained that she lived alone. Rosie's family reflect here that she did live with Parents at this point and they would be aware if she drank heavily.

9.7 On a further two visits to the GP that month, her notes record that Rosie was taking amphetamines and that her friends were a 'bad influence' on her, although this was not explored any further by the GP.

9.8 During the remainder of 2014 and into 2015, Rosie attended her GP on several other occasions, complaining that she still wasn't sleeping well and agreed to engage with alcohol services. It was also noted in her GP records that Rosie was anxious to engage with the service as they did not assist her.

Rosie was also described as 'low and anxious'.

9.9 In the early part of 2015, Rosie's employment as a hairdresser ended. Rosie disclosed this to Rotherham's Psychological Therapy Services - Improving Access to Psychological Therapies (IAPT) in Sept 2015. No enquiry was made as to why Rosie's employment ended, yet Rosie also had a period of selfemployment in this time.

9.10 In June 2015, Rosie was referred into Rotherham Psychological Therapy Services but her anxiety made it difficult to engage. She was again referred into the

service during July and there was a brief period of engagement before Rosie stopped attending. This was a missed opportunity to further engage with Rosie and try to continue to supporting access into services and support.

9.11 Rosie was referred into Rotherham Drug and Alcohol Services (RDaSH) in August 2015 and undertook an initial assessment. During that assessment it identified her reliance on alcohol and the impact the alcohol had on her in terms of her psychological wellbeing and her anxiety and depression. Rosie was also referred into Rotherham Drug and Alcohol Services for Psychosocial intervention.

9.12 During another appointment with RDaSH in August, it was recorded that Rosie was tearful but did not say why, she was 'really keen' to continue reducing and keen to stop with a view to commence Antabuse – a prescribed medication to treat alcoholism. It is unclear whether there was any exploration of the reasons for her tearfulness, again another missed opportunity to explore further with Rosie and ask about domestic abuse, and undertake an assessment of her mental health.

9.13 Rosie had another appointment in August with RDaSH, but she did not attend. Rosie contacted RDaSH after that appointment date and explained she had got her dates mixed up. Rosie's family state that she struggled with her memory and the impact of being in an abusive relationship would make attendance of appointments very difficult due to the abuse from the perpetrator and the effects of this on Rosie. This was significantly due to the ongoing effects from repeat strangulation from the perpetrator. This needs to be a recommendation to ensure professionals understand the impact of non-fatal strangulation. Further discussed in section 15.72.

9.14 In September 2015, Rosie attended an appointment with Rotherham Psychological Therapy Services - IAPT. During this appointment, Rosie explained that she

used alcohol to cope with anxiety that leaves her feeling unable to leave the house at times. She explained that alcohol has always been something she's turned to but over the past few years it has become a real problem for her. Rosie explained that she had lost her job as a hairdresser due to drinking prior to work, and that she was now working with an alcohol worker at Rotherham Drug and Alcohol Services to reduce her drinking.

9.15 Rosie went on to explain that she uses alcohol as a safety behaviour to deal with her anxiety and would like some support with her anxiety once she is stable. During the appointment it was explained that it would be difficult to deal with her anxiety whilst she was still consuming the quantity of alcohol she was doing.

It is the view of the independent author that this is an example of the need for treatment of multi diagnosis and as such a missed opportunity. This is an action within the Rotherham and the East Riding CCG recommendations.

9.16 During a visit by the Drug addiction therapy team (RDaSH) in October 2015, Rosie explained that she was using alcohol and she felt that she could not leave the house without it due to her anxiety and confidence. Rosie told the worker that she was found to have dyslexia at school and therefore, was put in different classes which she did not like. As a result, she didn't always attend school and left school from the age of 15.

9.17 Later that month Rosie visited her GP and was in a 'low mood' and tearful. It is recorded that she had no thoughts of deliberate self-harm, and her family were a protective factor for her. There was no exploration of the reasons for the low mood or tearfulness, again a missed opportunity.

9.18 In November 2015, Rosie attended the GP with a 'deep laceration' to her head. The nurse at the surgery dressed the injury that Rosie blamed on being drunk. There was no further exploration of the injury or the cause. There was no

question or discussion about domestic abuse, or about any relationships she had.

The view of the independent author is that the GP should have explored the injury and as such was a missed opportunity to engage with Rosie and ask about domestic abuse. Rosie's family state here that Rosie was pushed down the stairs by the Perpetrator and tipped out of the bed when she was ill, causing her to hit her head on the radiator that hard that it damaged the radiator pipe connection. Rosie's family state the Police were also later informed about this. Again, another missed opportunity.

9.19 Later in November, Rosie attended another appointment with RDaSH, and she explained her mood was more positive, which she suggested was due to the medication she was now on. Rosie also explained that her benefits had been stopped, although she was being supported by her family and friends.

This was an opportunity to explore the situation and provide signposting where relevant, this is considered a missed opportunity.

9.20 In early December 2015, Rosie attended a further appointment with IAPT, which during an assessment she disclosed that nearly every day she felt nervous, anxious or on edge. That she couldn't stop or control worrying and that the worrying was not just one issue but about different things. The assessment also identified that nearly every day she felt down, depressed, or hopeless. The assessment tool is not clear at this point reflects Family on this review, and that no action plan was put in place to support Rosie despite sharing her feelings of depression and hopelessness. Why was this not challenged by the review panel the family expresses concerns regarding, where no pathways were followed into support for depression or suicide risk. The panel were also not questioned on their pathways and assessment tools for accessing support for Rosie for her anxiety and depression. The family therefore have requested

a recommendation asking agencies to review the pathways and assessment tools for assessing risk of suicide, anxiety and depression, and mental health.

9.21 Within the notes of the assessment, it is recorded that *'Things have got worse in Rosie's life overall unfortunately, she has had her benefits sanctioned due to missing an Rosie's appointment at the benefits office and feels she's too confused to understand how to get them reinstated, she says she has severe dyslexia and has found it difficult to understand the letters she's been sent, although friends have tried to help. Due to this, Rosie has no money coming in and her mortgage has been passed to a debt recovery company. She is finding it difficult to find enough money to eat as she's spending what little she has on food for her cat and rabbit. In terms of anxiety, Rosie finds herself to be continually anxious; she feels nervous before going out and avoids seeing people or leaving the house, even avoids phone calls, as she begins to get anxious.'*

Treatment options were discussed with Rosie, and she was informed that as she was engaged with alcohol services, IAPT could try and help her with her anxiety management, looking at psychoeducation and relaxation techniques. However, due to her ongoing alcohol use and the serious financial problems and her lack of engagement with groups, it was unlikely that step 2 CBT would have an enormous benefit but may provide her with some help. The keyworker noted he was happy to try indicated some work towards dual help of both mental health and alcohol use. The keyworker also provided Rosie details for accessing a food parcel from the Trussell Trust in Rotherham. Rosie explained that she was finding it hard to call the benefits office due to the cost and the length of time spent 'on hold', the keyworker asked her to bring the number to their next session, so that they could try to call them from the surgery. They agreed a further follow up in two weeks' time. Although supportive, additional barriers to accessing a food bank or assistance and support with this would have been highly beneficial for Rosie.

Family reflections however are concerned why no referral to the Crisis Team took place, and no consideration as to how Rosie could get to or access the Food Bank. This could also be a risk due to challenge of accepting charity by the Perpetrator. This demonstrates a clear lack of understanding of domestic abuse by professionals.

9.22 In January 2016, Rosie attended a further assessment with IAPT and on this occasion it is recorded that Rosie had '*made some positive changes to her lifestyle, such as taking up jogging. She has a new dog to focus on and has had her benefits reinstated so her financial situation isn't as dire. She has also made the decision to sell her house and move back home to her family and feels that now she's made that decision, a weight has been lifted off her shoulders and she no longer feels trapped.*

Despite this presentation, a lack of professional curiosity did not consider the risk of domestic abuse and coercive control from the perpetrator, which included getting a pet and selling the home being a decision of the perpetrator as family have shared.

Rosie was scoring sub-clinical for depression and anxiety. Rosie was advised of the referral process as she again visited her GP being referred back to the service within 2 weeks.

Following their work within this review, IAPT now have an increased focus on self-referral, which is a proactive improvement in practice compared to this period of time. IAPT recognise and identify that the ability to self-refer and to understand the requirements of therapy are an indicator of suitability and desire to engage, coupled with capacity to do so. With the patterns of additional barriers affecting Rosie being able to engage with the service as discussed above, IAPT considers that they worked proactively to try and engage her and to reduce barriers to her continuing treatment.

Family also state how no professionals checked on the financial control from the perpetrator in relation to checking if Rosie's benefits were reinstated or not or the perpetrators control in relation to selling her house.

9.23 During the latter part of January 2016 and February 2016, Rosie did not attend her appointments with RDaSH and therefore she was discharged. It is noted that as 'the patient' was aware of the discharge policy that no letter would be sent.

The invitation to access services is with an 'opt in' letter when an individual is referred to them. This is beneficial to assess their motivation and ability to engage. The nature and success of the therapeutic interventions offered is dependent on the proactive engagement of the service user.

Historically and currently a service user's capacity is reviewed and their ability to engage whilst they are working with them. As a primary care service there is an expectation that patients can understand and retain personal responsibility. Further work could be done here to address additional barriers with dyslexia, reading difficulties, and complex life circumstances affecting ease of access to services. Recommendations for agencies to address this in their referral process, for example easy read material and creative engagement should be considered by all agencies. A service user who presents with increased vulnerability would be stepped up to services able to meet their increased needs. A service user who fails to respond to the invitation to access the service would be discharged and notified accordingly.

If a service user attended via a professional referral the referrer would be similarly notified of the lack of response either via letter, email, or the shared clinical system.

Domestic Abuse Screening questions and mental health should also be undertaken by professionals.

9.24 In mid-February 2016, Rosie was again referred into Rotherham Psychological Therapy Services but she did not attend two of the scheduled appointments. Rosie was sent a letter informing her that she was discharged. The electronic patient record (EPR) indicated that should a further referral occur the "team" would reach out to Rosie's GP to discuss a plan for engagement/ attendance and not to re-register Rosie until after that discussion.

9.25 In September 2016, Rosie attended her GP and explained that her anxiety was worsening, although there was no enquiry as to why that was.

It is the view of the independent author that this was a missed opportunity to engage with Rosie to have a greater understanding of her anxiety.

9.26 The following month, October 2016, Rosie again attended the GP and again explained that her anxiety was worsening, although on this occasion she was accompanied by her 'partner.' There is no exploration of the relationship, who 'the partner' was or how long had they been together.

This was a lack of professional curiosity and should have been explored.

9.27 At the end of October 2016, Rosie was again referred into Rotherham Psychological Therapy Services, on this referral it was disclosed that she was 'currently abstinent' from substance misuse.

9.28 In November 2016, due to the time elapsed since Rosie had last been seen and that the referral had come from Rosie's GP, Rosie was accepted directly, rather than having an interim discussion with her GP as discussed in February. Rosie was consequently sent an "opt in letter" to which she responded, and she was booked in for an appointment.

9.29 In December 2016, Rosie arrived late for an appointment with IAPT, Rosie said that she was struggling with her anxiety and that she worried what people would

think about her as the police have been involved, due to her drinking. Although she hadn't drunk in three months. Rosie also said that she wanted to be able to travel on a bus on her own to the town centre, but at that time she could not go to the GP practice on her own. Due to the time available only limited information could be gathered at this time. This information collection was the start of the assessment process, which would have accumulated more detail as it progressed. No further questions were asked about why Rosie was late, or professional curiosity in relation to the impact of the control and abuse by the perpetrator.

9.30 Following a further two missed appointments, in January 2017, Rosie was discharged from the service and the information referred to in December was not collected.

9.31 In early February there was a third-party report of a domestic incident taking place. South Yorkshire Police attended the incident and found Rosie crying. She confirmed a verbal altercation had taken place with Dave although it is reported that Rosie stated that no crime or assault had taken place. South Yorkshire Police took no further action. Family reflect lack of professional curiosity from panel members regarding whether Rosie was interviewed separately by the Police here or not.

9.32 In February 2017, several days after this incident, Dave and Rosie attended the Rotherham, Doncaster and South Humber NHS Foundation Trust crisis team, where Dave was seen alone. During the meeting he disclosed that he and Rosie had been together for 2 years and that he had lost access to his son because he [Dave] had found out that Rosie had been performing intimate acts on clients for money.

He explained that he had debts of £7,000 so "was conflicted" and had "many stressors with his sons' mother over (*their*) son". He was "deemed to be at risk

of suicide" and it was noted that he had taken an overdose 10 years previously. It was also noted that he had "bought a rope 5 weeks ago with the intention of hanging himself". There is nothing recorded within agency records of any subsequent engagement with Dave concerning the purchase of the rope and intended actions. Family reflect here that it was due to the alleged domestic abuse with his son's Mother that caused ceased contact, and at the time he had no fixed address. He also bought the rope for climbing expeditions as documented in a local paper which demonstrates his manipulative behaviour and victim blaming.

9.33 In March 2017, Rosie attended her GP with a 'low mood', that she had resumed drinking and her anxiety had worsened. There was no exploration of the cause of this resumption in drinking, although it was around the time of the domestic incident.

It is the view of the independent author that this was a missed opportunity to engage with Rosie to have a greater understanding of her resumption in drinking.

9.34 In mid-May, South Yorkshire Police attended a domestic incident where it was reported that Dave and Rosie had been arguing about Rosie working. Dave had grabbed Rosie by the throat and strangled her to unconsciousness, whilst slapping her in the face 'a number' of times. The police officer in attendance noticed 'slight reddening' to Rosie's neck and a '3-inch cut/graze' to the back of her head.

This indicates a need to respond to Non-fatal Strangulation, which is now identified as a criminal offence in the Domestic Abuse Act 2021, and processes should be in place regarding how all agencies respond to this including the high risk of suicide in response to this. Recommendation to ensure this has taken place with all agencies in the review.

9.35 As a result of this incident Dave was arrested, charged and bailed to attend Sheffield Magistrates Court in June 2017. A Multi Agency Risk Assessment Conference (MARAC) referral was made for Rosie by South Yorkshire Police.

9.36 Three days after this incident, an individual / ex-partner uploaded onto the internet intimate sexual images of Rosie to cause her humiliation and embarrassment. This breached section 33 of the criminal justice and courts Act 2015. The Government created a new criminal offence to ensure that Revenge pornography is fully captured by the criminal law Rosie reported this to South Yorkshire Police, and the offence of a 'Malicious Communication was recorded. It is not clear that anything further was done to investigate the source of this, and further not followed up by the Panel Family reflects.

9.37 Some days after the assault on Rosie and the arrest of Dave, Dave attended the Rotherham, Doncaster and South Humber NHS Foundation Trust crisis team, where he said that Rosie was now his ex-partner. He also described that he had a "turbulent relationship with *(his)* partner who uses drugs and alcohol" and that he had "pushed her away recently leading to her falling over the bed and she began laughing". He went on to say that Rosie had called South Yorkshire Police and he was arrested, but that the charges had now been dropped. Dave was charged which was stated at the Inquest but it did not proceed to court. Consideration should have been given to a victimless prosecution.

9.38 During the MARAC meeting in South Yorkshire following the assault on Rosie, information was provided by Rosie to the IDVA that there had been various incidents of domestic violence whilst she had been together with Dave. These often resulted in injury to her, but she had not reported these to the police. As a result of the incidents, she had received lacerations to her head and bruising to her body and face. On one occasion she had had treatment for an injury to her head when Dave 'smashed it' on the floor.

The coercive control Rosie endured also resulted in minimisation of the rape and sexual harm she endured due to the fear of continued harm and abuse, with explanations given that included Dave having a high sex drive and was very rough whilst they were having sex. She had explained that she often pretended to be asleep on the sofa so that she did not have to be in bed with him, or fake illness, avoiding sex. He would also demand sex when they were out or at someone else's house and she found it easier to 'comply' then say no, indicating the level or rape and serious sexual harm in this relationship.

She also described that during sex he would grab her around her throat or throw her about, causing injuries such as bruising and swelling to her neck and back. Rosie told Dave that she did not want to have sex like that, but he proceeded anyway, therefore raping Rosie on many occasions and using sexual violence to continue to dominate and control Rosie.

Recommendation to ensure robust safety planning around sexual violence and IDVA support, which includes this and signposting to sexual assault referral centres.

9.39 In July 2017, Rosie attended the GP and explained that she was 'having trouble with domestic violence' that she was moving out and needed a medical certificate.

She was also leaving the relationship; this is a time of high risk for victims particularly referenced in the Homicide Timeline by Monkton-Smith 2020[13] and should have triggered further enquiries. There were no discussions, no risk assessment and no consideration of the sharing of information, albeit a

[13] Monckton Smith, J., 2020. Intimate partner femicide: Using Foucauldian analysis to track an eight stage progression to homicide. *Violence against women*, 26(11), pp.1267-1285.

MARAC had already taken place. There is nothing in the GP records that indicate Rosie had been subject of a MARAC.

Recommendation to ensure Homicide Timeline training including in both areas of this review.

The independent author considers this a missed opportunity to share information and for the GP to explore the domestic abuse and should trigger a repeat referral to MARAC. MARAC minutes should also be shared with all agencies involved not just those present at the MARAC meeting – Recommendation.

9.40 Rotherham Children and Young People's Service were involved with Dave's son due to the domestic incident; it is recorded that there was an incident of

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domestic abuse where Dave assaulted Rosie. It is also recorded that Dave provided information that Rosie was alcohol dependant, using amphetamines, working as an escort and that Dave gave counter allegations that Rosie was perpetrating domestic abuse towards him, which is a common tactic deployed by perpetrators of domestic violence and abuse to manipulate and gaslight both victims and professionals (Johnson 2008). Some of this information is correct, there was an incident of domestic abuse; however, Dave was the perpetrator and Rosie the victim. Rosie was alcohol dependent and had worked as an escort. She was not perpetrating domestic abuse towards Dave. This information was not cross referenced and as such was inaccurate. The information relating to Dave that he was a victim was also not shared. Despite Rotherham Children's Services being involved Dave was allowed to collect his son after being charged for this incident. Recommendation for Children's Services which seeks to ensure that safeguarding policy protects children at risk in domestic abuse incidents working jointly with the police.

Considering the information received within this review, the independent author considers the cross referencing and the information that Dave was a victim were both missed opportunities.
Family also reflect that Dave was taking Rosie to the workplace and living off her earnings.

Recommendation for Children's Services to increase understanding of domestic violence and abuse and of perpetrator typologies and behaviours, including counter allegations. To ensure appropriate risk assessed responses to this for both victim and perpetrator that ensures safety of both victim and child(ren).

9.41 Some days after visiting her GP, Rosie contacted South Yorkshire Police to report that she had been informed by neighbours that Dave was breaking into her house to steal her dog. When officer arrived and spoke to Rosie, she
told them that Dave had legitimate access allegedly and that it was a misunderstanding, which demonstrates coercive control from the perpetrator and fear from Rosie following this control.

This indicates further need for frontline Police forces to ensure effective understanding and responses to domestic violence and abuse, and that information sharing, DA Matters training, and risk assessment is prioritised.

9.42 In early August, Rosie attended her GP, on this occasion a new GP. Again, Rosie explained that she was 'escaping domestic violence', although there was no exploration of the issues or history. This was an opportunity to understand the background to Rosie and be fully informed. There is nothing else recorded in her notes that provide information and no mention of any referral to MARAC.

In these circumstances and given the nature of the disclosure, the independent author considers this was a missed opportunity to discuss with Rosie and refer to MARAC.

9.43 In August 2017, Dave attended IAPT, and it was noted that he was "making positive progress *(and)* making decisions about *(his)* ex-girlfriend living with a friend". Family states was not the case and this was not clarified by the panel. Rosie was living with Parents at this time, and was also in Florida for two of those weeks.

9.44 In mid-August, Rosie's MARAC case was transferred from South Yorkshire to East Riding. The original referral was provided. Within the referral were several comments relevant to the abuse she had suffered. Rosie detailed the incident leading to the MARAC referral involving the assault and strangulation. She also disclosed that Dave would harass her with phone calls and texts when he had her number. Dave had also started to ring Rosie's family. Rosie also thought he was aware of her new address in East Yorkshire,

which again proves the perpetrators gaslighting and manipulation in relation to his views contributing to this review.

9.45 Following the MARAC transfer, the East Riding Domestic Violence and Abuse Partnership (DVAP) worker tried to contact Rosie by telephone and letter. The worker also sent a text message to follow this up, which is good practice, but there was no response from Rosie. Family reflect that this was an unknown number which causes further barriers to engagement. Recommendation to review contact methods in Domestic Abuse Services following this feedback.

9.46 Towards the end of August, Rosie's mother contacted South Yorkshire Police to inform them that Rosie had moved to East Yorkshire and that Dave had been seen in Rosie's Rotherham address. There were no further investigations as 'there was no victim confirmation, no domestic had actually taken place and

Rosie's mother wanted this to be logged in case of further incidents.' At this time, Rosie's parents had the locks to the property changed.

9.47 At the end of August Rosie contacted DVAP, although the call was missed, and Rosie left a message upon return from a Family holiday. The call was returned but, on that occasion, Rosie did not answer, a further voicemail apologising for missing each other was left, although Rosie did not respond to that message.

9.48 In Early September, a MARAC action was initiated, that the DVAP worker would update Humberside police if any issues became apparent if and/or when Rosie engaged in support.

9.49 The day following Rosie's mother contacted the DVAP worker to tell them that she had been receiving calls from Dave, so had her other daughter. Rosie's mother also told the worker that there had been an incident where

Dave had pinned Rosie against a wall and taken £400 from her, which was only 3 weeks after the domestic abuse incident where was Rosie was strangled and Dave charged. It also appeared that Dave had removed all the money from the joint account he had with Rosie.

Dave caused Rosie to change her bank account to a joint one and he was taking taking money out of this account right until 22nd January 2018.

9.50 Following this report from Rosie's mother, the DVAP worker met with Rosie and completed the initial assessment and DASH risk assessment. During this assessment, Rosie informed the DVAP worker that the abuse was getting worse, and Dave was 'massively jealous' about the time she spent with friends. Dave became angry if she spent money on friends. On one occasion, getting very angry in front of a neighbour for buying the neighbours child two birthday cards and a helium filled balloon.

Rosie was also assaulted while Dave's son was in the House. Family states this was never referred to Children's services which should have taken place.

Panel members should also have challenged this.

She also said that when Dave had found out about her sex work, he encouraged her to continue, using coercive control if she said she wanted to stop, saying that his son needed something and therefore, the money. Rosie also discussed her dog and she felt that Dave would try and take the dog, just to get back at her. These are all significant information regarding the later abuse Dave perpetrated.

On strangulation, Rosie explained that Dave would strangle her to unconsciousness during sex as 'it was his thing'. On occasions she had been gagged and vomited, Dave would then put her face in the vomit to make her gag further. Within the Domestic Abuse Act 2021, non-fatal strangulation is a specific criminal offence.

Rosie felt that Dave could have killed her during the assault relating to the MARAC referral but did not because his son was in the house. She was also concerned that if Dave found her in East Yorkshire, then he would kill her. Dave used coercive control towards Rosie, threatening that he would commit suicide if she left the relationship. This indicates high risk domestic abuse and safety planning should address this.

It was also noted in the meeting that Rosie was tearful, seemed anxious and was "squeezing her upper arms".

9.51 Several days later, it was reported to the DVAP worker that Dave 'had an idea' of where Rosie was living. This was also reported to South Yorkshire Police and Humberside Police. To ensure Humberside Police had all the relevant history and information of risk, they contacted South Yorkshire Police before dispatching an officer. As a result, an officer from Humberside Police attended the home address of Rosie and met with her and her mother. There was

discussion about the security at the house and there was to be further security measures implemented, including the fitting of a security alarm.

The officer explained that there was nothing more he could do; however, he submitted a DASH risk assessment for the incident and a vulnerable adult form to East Riding Adult Services and contacted the DVAP worker. On this occasion the DVAP worker advised there was 'nothing more for the Police to do other than create an incident log.'

Within the incident log, the officer recorded a domestic incident and Rosie was identified as the victim. It was noted in the incident that Rosie had a 'drink problem' that appeared to be exacerbated by the anxiety she felt at the thought of Dave turning up at her new address and causing further problems. This evidence of stalking and harassment could have been further explored by the domestic abuse worker and Police.

9.52 In consideration of the incident, Humberside Police have reported that consideration was given to a MARAC referral, but at the point in time the incident was classed as medium risk and did not meet the MARAC threshold. There were no offences committed, which may have instigated a repeat MARAC. There was no evidence of a restraining order in place. Family reflect that the risk was initially recorded as low risk by a Junior Officer and on review was then made medium risk by a Sergeant.

However, since this incident in 2018, the guidance on a repeat MARAC was changed to include all incidents between the perpetrator and the Victim not just those that involved crimes. This means that today the incidents will have been considered for MARAC, especially considering the threats to life Rosie experienced that she discussed with her domestic abuse worker. Humberside Police now also secondary check all risk assessments and given the previous

information shared with the domestic abuse worker this would now be escalated to MARAC.

9.53 At the same time there was communication between Dave and Rosie's mother requesting the return of his property. The DVAP worker also suggested to Rosie's mother that they should consider fitting a lifeline to Rosie's home as it became apparent that Dave knew where she was living, which demonstrates positive safety planning by the domestic abuse worker.

9.54 During this same period, Rosie's mother contacted the DVAP worker and explained that "following further contact from Dave – Rosie's mental health is deteriorating". Rosie also attended a session of the Freedom Programme, although she did leave early.

> *The 'Freedom Programme' is a domestic violence programme primarily designed for women as victims of domestic violence and abuse. The programme examines the roles played by attitudes and beliefs on the actions of abusive men and the responses of victims and survivors. The aim is to help victims to make sense of and understand what has happened to them.*[16]

Following her attendance on the programme, Rosie had said she thought she was 'wasting your time', highlighting the significant control Dave still had over Rosie, but Rosie's mother explained she would encourage her to attend.
Rosie's mother also asked for Rosie's drinking to be addressed urgently.

9.55 Rosie was provided with details for the East Riding Partnership (drug service) drop – in and an email was sent to Rosie's mother providing details of local solicitors, who offered legal aid. Family state that Rosie was not entitled to Legal Aid as she owned her property which professionals should have been aware of.

Rosie's GP also gave Rosie and her Mum information on Alcohol drop in services, of which Rosie spent several days trying to get a hospital admission, and home visit for a direct appointment.

Recommendation for all professionals to understand the barriers for victims and survivors in seeking help and support including financial and economic abuse, and barriers to accessing financial support for this including legal aid.

9.56 East Riding Adult Services received the referral from Humberside Police four days after the submission, although there was no contact phone number, and a letter was sent to Rosie's home address. It is noted that Rosie had identified dyslexia that was reported in 2015, although this information does not appear to have been routinely shared amongst agencies and practitioners.

16 https://www.freedomprogramme.co.uk

9.57 Four days after the referral in September 2017, Rosie's mother contacted the DVAP worker and explained that Dave had sent Rosie a letter to her current address, stating that he had been watching the dog in her window, again a sign of stalking and harassment which was missed. This had upset Rosie and she needed urgent help. From this incident it was clear that Dave was aware of Rosie's address and his coercive behaviour was continuing and escalating.

9.58 Some days later Rosie's mother attended a Humberside Police station to report that she (mother) had been receiving texts from Dave and reported that the situation had again escalated. Rosie's mother says she explained that Rosie had recently destroyed her fourth mobile phone because Dave had obtained the number, these events had left Rosie "depressed, anxious, suicidal" clearly having an adverse effect on her behaviour. She also added that Rosie was

scared of the Police. A log was created, and a risk assessment undertaken, this led to officers being dispatched to Rosie's house.

During their investigations following Rosie's death, Humberside Police examined the phone records and identified that Dave was in contact with Rosie from around mid-October 2017 and that he had been visiting her with her prior agreement to see their dog. They went on to say, the tone and content of the sent and received text messages recovered from Rosie's phone did not support a pattern of coercive and controlling behaviour or 'gas lighting'. This demonstrates again a further need for ensuring domestic abuse training for front line Police, and how coercive control should be seen as a pattern of events rather than an isolated incident, and how perpetrators use manipulation, love bombing, and coercion to control their victims[14].

9.59 An officer from Humberside police visited Rosie at her home address and noted that she had been drinking and that she was 'openly anti-Police, accusing South Yorkshire Officers of disclosing her personal information to

Dave'. It was also recorded that Rosie was being treated for mental health problems. The officer recorded that the incident related to a small number of text messages that were not offensive or threatening and had been sent to Rosie's mothers phone relating to sorting out Rosie's finances after the separation. The officer did not feel the incident warranted a complaint, identified that no offences were committed, and that the incident did not constitute a domestic incident.

Humberside Police now record all harassment within a domestic abuse setting as stalking, they are not dealt with in isolation but as one offence. Training

[14] • Stark, E. and Hester, M., 2019. Coercive control: Update and review. *Violence against women*, 25(1), pp.81-104.

has now been provided to all supervisors in relation to stalking and stalking protection orders, to protect victims.

The family have also received a formal apology in 2024 from Humberside Police for failing to acknowledge the stalking and harassment that Rosie endured.

A lack of recognition of the levels of stalking and harassment that Rosie endured was a common theme across all agencies.

9.60 In early October, following discussions regarding a non-molestation order, Rosie decided that she did not want to take legal advice and pursue the order. Family state this was because Rosie thought she already had one at a previous address and would incur additional costs to attain another. The impact on her for this financially and mentally and emotionally due to this added pressure would have been significant, and in fact deterred her from pursuing another order, which could have further protected her.

9.61 During this time, Rosie's father attended Rosie's previous address in Rotherham to facilitate Dave recovering his clothes. Whilst there, Dave threatened to assault Rosie's father. The matter was reported to South Yorkshire Police for recording, no offences were recorded. Family state Dave had to be supervised by the Police to take his belongings off the property

while Rosie's Father locked himself in his car for fear of his abuse. Family state the panel did not challenge this information and why the Police did not do anything more. This risk of harm was not taken seriously by the Police and the level of violence that the perpetrator was threatening to Rosie's father.

9.62 Some days after this incident in October, Rosie called the 111 lines on three separate occasions, on two of the occasions she said she was suicidal and then cleared the line. As a result, an ambulance from the Yorkshire Ambulance Service was despatched. On their arrival they met Rosie and she said she lived

on her own, was feeling suicidal and was an alcoholic. Rosie went on to explain that she had recently moved due to domestic violence. Throughout the contact, Rosie was tearful. Rosie refused to go with the ambulance and as such there was little else, they could do. Should the ambulance service had a suitably trained professional in domestic and suicide, Rosie would have been able to access the support she needed at that time.

The ambulance personnel submitted a vulnerable adult form to East Riding Adult Services. Family state they should have called a family member to further support Rosie.

9.63 Rosie's mother contacted the DVAP worker and informed her of the ambulance attendance and expressed concerns over Rosie's mental health and well-being. At the same time Rosie's mother also contacted East Riding Adult Services requesting that there was an assessment for service for Rosie.
Family state nothing was done here to support Rosie.

9.64 East Riding Adult Services contacted the East Riding Partnership Addictions Service Key Worker requesting further information. The worker explained that they were working with Rosie and were awaiting a detox service at The Woodlands, Nottingham.

9.65 During this same period, Rosie visited her GP in Beverley and discussed her sleeping, she also disclosed that Dave was trying to get involved with her 'rehab'. It is recorded that she denied suicide ideation although the surgery did comment that due to her frequent change of phone it was difficult to get in touch with her. Family state that the reason Rosie often changed her phone was to lose contact with Dave but that Rosie's Mum agreed for her contact information to be used and that she and Rosie gave consent for this information to be shared for contact in relation to her daughter.

It is unclear what discussion took place about Dave and his involvement, in these circumstances and given the nature of the disclosure, the independent author considers this was a missed opportunity to discuss the circumstances with Rosie.

9.66 Towards the end of October, Rosie attended a meeting with East Riding Partnership Addictions Service, and a worker from Hull and East Yorkshire Mind attended also to introduce herself. Rosie's mother and a peer mentor were also in attendance. The session was recorded as an introductory one, although it is unclear whether there were any discussions about Rosie's history or ongoing issues with domestic abuse and Dave. Rosie's family reflect here that it was discussed here that Rosie had fled domestic abuse and this reflects a poor chronology in this report.

9.67 In early November, Rosie attended the GP, and it was recorded that she was 'looking and feeling better', there was no suicide ideation, and it was noted Rosie would be attending rehab soon. Family state that Rosie's Mum was present and Rosie would not want to say about feelings of suicide in her presence as this would upset her, she should have been asked in private.

9.68 Rosie's mother contacted the DVAP worker and explained that Rosie was still having to pay her council tax for the address in Rotherham and the worker contacted Rotherham Council, with a view to stopping this. This was because Rosie's Mum asked the worker to do this to stop the Council charging Rosie for Dave's Council Tax because there was no forwarding address for him. This is a significant lack of understanding that this is another source of financial control.

9.69 At this time, a referral was made by the East Riding Partnership Addictions Service to Nottinghamshire Healthcare NHS Foundation Trust, The

Woodlands, Highbury Hospital, with Rosie's Mum present, who then contacted Rosie to welcome her and discuss her admission.

9.70 In mid-November, Rosie was the victim of bogus tradesman, where she was pressured into having work done that was unnecessary. The police were called and the individuals responsible were arrested. It is noted by the Humberside Police that Rosie had mental health issues and appeared to feel pressured into having the work done without realising she could change her mind. When the work began Rosie, contacted Humberside Police as she didn't want it done but didn't feel she could stop him.

9.71 At the end of November, East Riding Adult Services were informed that Rosie had been admitted to The Woodlands hospital and was expected to be there for 7-10 days. It was also noted by Woodland's hospital that Rosie had been contacting Dave, due to 'loving him'.

Recognising the previous comments relating to text messages between Rosie and Dave, the independent author considers that the information should have been shared with DVAP or other agencies and as such is a missed opportunity.

Further to this, Rosie's phone was removed before admittance therefore this is a concern that Woodlands knew she was in contact and did not progress to investigate how or share this information at this time.

9.72 During the period from the end of November through to early December, Rosie was resident at The Woodlands Hospital undertaking her detox treatment.

9.73 During Rosie's stay at The Woodlands, there was some communication between The Woodlands and East Riding Partnership Addictions Service regarding possible medication treatment for Rosie, but nothing was shared about her history to provide a broader overview.

Given the ongoing circumstances, the independent author considers this is a missed opportunity.

9.74 At the point of Rosie's discharge, it was noted by The Woodlands Hospital that Rosie had received a phone call from Dave and as she was fleeing a 'domestic violent relationship' this information was passed to East Riding Partnership Addictions Service. It does not appear this information was shared more widely with DVAP by East Riding Partnership Addictions Service.

Whilst recognising the previous comments relating to text messages between Rosie and Dave, the independent author considers that the information should have been shared with DVAP and as such is a missed opportunity.

9.75 Following Rosie's discharge, East Riding Partnership Addictions Service contacted East Riding Adult services and explained that Rosie may not require Social Services support as the addictions service were supporting her, although it is unclear what that support entailed.

9.76 After discharge from The Woodlands, Rosie contacted the DVAP worker and explained that she did not feel she required support from the service anymore, stating 'that side of her life was not a problem anymore.' Family state that this statement should have been an alarm bell and triggered some professional curiosity, and requested this to be reviewed with Rosie.

9.77 At this point, East Riding Partnership Addictions Service contacted East Riding Adult Services saying that Rosie would like to access the day programme. An appointment was made, but Rosie did not attend. Rosie had two referrals into Adult Social Care. One relating to her as a vulnerable adult and the other relating to assessment of addiction needs and funding for either a Community or Residential Rehabilitation placement. Rosie had become ambivalent about the latter as an aftercare plan, and her key worker endeavoured to keep Rosie

engaged in support and keeping the referral open for this element of her treatment pathway. She subsequently chose to engage with appointments and expressed positivity about this. One appointment that Rosie attended was the day before her death.

There were huge expectations by agencies for Rosie to attend appointments included one where a neighbour helped her due to having a panic attack. Family also stated that Rosie said she wanted to jump off the Humber Bridge in one of these appointments after Dave finding her again. This was informed to Adults Services substance misuse worker the day prior and not followed up. This demonstrates a lack of following procedure in relation to actual risk of suicide which has been included as a recommendation.

9.78 Some days after the missed appointment, Rosie also cancelled an appointment with Hull and East Yorkshire Mind. Rosie attended a further appointment a week later; it is noted that there was a 'risk regarding potential development of relationship with ex-partner who has previously been physically abusive.' During the session Rosie had also received a phone call, although it is not known who was on the phone.

It is not clear what next steps were taken following the identification of the risk. Rosie had presented with no concerns but then appeared to 'become agitated' following the phone call.

There is nothing recorded about any wider communication or dissemination in relation to this incident. No risk assessment was carried out as Hull and East Yorkshire Mind did not then undertake DASH risk assessments. Given the nature of the services provided by Mind, the independent author considers this was a missed opportunity to conduct a risk assessment or share the information more widely. There was no professional curiosity here or referral to MARAC which should have taken place.

Hull and East Yorkshire Mind were aware of the history of Domestic abuse from the referral received from East Riding Partnership and acknowledge they should have asked if there was a DASH risk assessment in place. The DASH risk assessment had been initiated in early September although a further assessment should have been made to understand any changes in circumstances and therefore, changes to risk.

It is standard practice of Hull and East Yorkshire Mind to carry out a risk assessment and this would include looking at risks to self, risks from others and risks to community but not specifically a DASH risk assessment. It is accepted that there is no evidence of this having been carried out.

Rosie missed the next appointment but attended her appointment two weeks later. During this period, East Riding Partnership Addictions Service contacted East Riding Adult Service requesting a further appointment. Rosie also missed two GP appointments within this period.

9.79 At the end of January, Rosie attended another appointment with Hull and East Yorkshire Mind where she disclosed that she had met with her expartner earlier in the day to walk the dog. It was recorded that she was chatty and friendly and that she appeared on this occasion more calm.

The review acknowledges the findings of Humberside Police regarding Rosie and Dave's text messages following the investigation into her death . Despite MIND being aware of the domestic abuse, they had not conducted a thorough risk assessment and so were unaware of the extent of domestic abuse Rosie had been subjected to. Given the circumstances and the previous lack of risk assessments, the independent author considers this a missed opportunity.
Family state that the MIND worker was aware of domestic abuse, as Rosie's Mum was also present at the last meeting with them. They did not meet her needs and the response was "we will see how things go". Family state this should have been reviewed by a more senior member of staff.

9.80 Rosie later arranged to meet with her DVAP worker, at the appointment she explained that she was in contact with Dave, mainly over her dog. Rosie said she still had feelings for Dave but did not know why.

Rosie requested the direction of an outside security light altering. This light had previously been fitted at the request of Humberside Police, to provide reassurance and an element of security for Rosie, a referral for an adjustment was agreed. Rosie also said she would like to re-start the Freedom Programme.

Given the history and the events with Dave, the behaviours Dave had been displaying and the impact of coercive and controlling behaviour, the independent author considers that a professionals meeting should have been arranged, or discussions should have taken place.

9.81 On the same date, Rosie met with East Riding Social services and disclosed that she had previously had suicidal ideation. She had previously thought about 'jumping off the Humber Bridge' this was recently when she found out that Dave had identified where she lived and was coming along to 'pick the dog up'. This information was not contained in the chronology for the review but was in the unedited notes.

This is significant as only the day before according to Rosie, she had met Dave. Although this information had not been shared. It is unclear what East Riding Social Services did with the information, or what actions they took regarding the suicidal ideation. This was extremely significant as this was so close to when Rosie was suspected to take her own life only two days after. Family states again this should have been challenged by the agencies and the panel in this lack of action and lack of clarity.

9.82 Over the next few days there was further communication between East Riding Social services and East Riding Partnership Addictions Service regarding future appointments.

Rosie called her addiction worker on the evening of her death which was spoken about at the inquest. This was not documented however was on her works phone. This should have been extremely important to the investigation Rosie's family state and to the review.

The timeline was evident and Rosie fedback to the addictions worker that Dave was present at the address. The information was also not recorded by the worker or shared to protect Rosie at the time due to risk from the perpetrator.

9.83 Two days before her death Rosie contacted the DVAP worker and said that she would be attending the Freedom programme the following week.

10 Approach to analysis

10.1 The Individual Management Reviews have been considered to ascertain if each of the agencies' contacts was appropriate and whether they acted in accordance with their set procedures and guidelines. Where they have not done so, the Panel has deliberated if lessons have been identified and are being properly addressed.

Rosie' family add that Rosie's voice is not heard in this report, and there is no positive contribution from agencies. "No one understood her fear, screaming night terrors, pain, escalating anxiety and depression, acrophobia, posttraumatic stress, financial deprivation, and isolation from fleeing. Who saw the level of appointments given, and the judgemental attitudes of professionals"? The family state than an independent voice for victims should have been on the panel for example a survivor or an expert in trauma or abuse. This is something the Community Safety Partnership should take forward as a recommendation.

10.2 Author states the Review Panel is satisfied that agencies have engaged fully and openly with the Review which Rosie's family later reflect is only within the knowledge they have, and that lessons learned and recommendations to address them are appropriate. However as previously mentioned the family and CSP agree there are gaps in contributions from Ambulance Trust, Acute Hospital Trusts, from Hull and Rotherham (although the ICB Commissioning (formerly CCG (Clinical Commissioning Group) organisation for Health was represented in East Riding), and finally the Residential Detox Woodlands in Nottingham.

Family refer to how it takes a lot of courage and strength for someone to call services for many reasons, and Ambulance services are often the first port of call for the vulnerable. They can be frightened of being judged, being a nuisance, frightened of being a risk to themselves.

Family state that ambulance services need to have specialisms or pathways that understand domestic abuse and addictions linked to domestic abuse, technology for advice and signposting, improvements on staff training in relation to domestic abuse, the link between domestic abuse and suicide, and improved communication and information sharing with other agencies. Suicide is seen in isolation, not linked to domestic abuse. When communication is not clear when there is alcohol use, strangulation, and suicidal ideation; there is no professional curiosity as to this and unclear communication linked to strangulation and resulting brain deprived of oxygen which is further exacerbated when there are previous historical accounts of strangulation and domestic abuse. Family request a recommendation that the CSP engage with the Ambulance Service to review their pathways and responses for responding to and identifying victims of abuse including signposting to support, and particularly when victims are expressing suicidal thoughts.

10.3 Authors of the IMRs and Reports have followed the Review's Terms of Reference carefully and addressed the points within it that were relevant to their organisations. Family state that agencies have not been thorough and transparent in this process.

11. Equality and Diversity

11.1 Section 4 of the Equality Act 2010 defines protected characteristics as:

- Age
- Disability
- Gender Reassignment
- Marriage and Civil Partnership
- Pregnancy and Maternity
- Race
- Religion or Belief
- Sex
- Sexual orientation

11.2 Section 6 of the Act defines 'disability' as:

[1] A person [P] has a disability if —

[a] P has a physical or mental impairment, and

[b] The impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities[15]

11.3 There is nothing in agency records that indicated that any subjects of the review lacked capacity[19] in accordance with the Mental Capacity Act 2005. Professionals applied the principle of the Mental Capacity Act 2005:

'A person must be assumed to have capacity unless it is established that he lacks capacity'.

Family reflect however that nobody actually assessed Rosie's capacity.

"Evidence in reports say she was dyslexic and had mild learning

[15] Addiction/Dependency to alcohol or illegal drugs are excluded from the definition of disability.

disabilities, and self harm. Her anxiety and depression when escalating made her lack capacity. Alcohol made her lack capacity"

Rosie's Mum reflects how many organisations allowed her to counter sign and engage due to Rosie's lack of capacity. How can this be? Family request a recommendation for all agencies to review their Mental Capacity Act response in terms of how family members are able to counter sign due to victims lacking capacity but no formal assessment of capacity has taken place?

There is no link to Rosie and her voice and experience here family expresses.

11.4 **ROSIE**

When considering protected characteristics under the Equality Act 2010 the review has highlighted the following characteristics of relevance, subject to the evidence and information made available to the panel.

11.5 **Gender:**

[19] The Mental Capacity Act 2005 established the following principles;
Principle 1 [A presumption of capacity] states "you should always start from the assumption that the person has the capacity to make the decision in question".
Principle 2 [Individuals being supported to make their own decisions] "you should also be able to show that you have made every effort to encourage and support the person to make the decision themselves". Principle 3, [Unwise decisions] "you must also remember that if a person makes a decision which you consider eccentric or unwise this does not necessarily mean that the person lacks capacity to make the decision".
Principles 1 – 3 will support the process before or at the point of determined whether someone lacks capacity.
Principles 4 [Best Interest] "Anything done for or on behalf of a person who lacks mental capacity must be done in their best interest".
Principle 5 [Less Restrictive Option], "Someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the persons rights and freedoms of action, or whether there is a need to decide or act at all. Any interventions should be weighed up in particular circumstances of the case". [Mental Capacity Act Guidance, Social Care Institute for Excellence] ,

Rosie was female and it is incredibly pertinent to note the substantial body of evidence which outlines how the risk of being a victim of Domestic abuse rises if you are female. The DHR seeks to identify if, at any point, services should have considered this, using professional curiosity to explore if domestic abuse was taking place.

The number of domestic abuse crimes recorded by the police in England and Wales in the year ending March 2021 increased by 6% – from 798,607 (in the year ending March 2020) to 845,734. This continues the trend of increases seen over previous years.

Domestic homicide and domestic abuse in particular, are predominantly a crime affecting women, with women by far making up the majority of victims, and by far the vast majority of perpetrators being male. A detailed breakdown of homicides reveals substantial gender differences. Female victims tend to be killed by partners/ex-partners. For example, in 2018, the Office of National Statistics homicide report stated:

'There were large differences in the victim-suspect relationship between men and women. A third of women were killed by their partner or ex-partner (33%, 63 homicides) in the year ending March 2018. In contrast, only 1% of male victims aged 16 years or over were killed by their partner or ex-partner'. 'Among homicide victims, one in four men (25%, 115 men) were killed by friends or social acquaintances, compared with around one in fourteen women (7%, 13 women)'.[16]

11.6 **Mental Health:**

The review acknowledges some of the struggles Rosie had with her mental health. We can see from the information and evidence provided as part of the review that these struggles were exacerbated by Dave through his consistent control and abuse. Mental health is something every human has experience

of and it is broad in its scope. Although when an individual's mental state is in significant distress, for example in an abusive relationship, there can be

[16] Office for National Statistics (2021) *Domestic abuse in England and Wales overview: November 2021*. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2021 (Accessed: 26 April 2024).

symptoms. We can see this as part of this review, in such areas as use of alcohol and an increased state of anxiety and depression.

The World Health Organisation defines mental health as a state of mental well-being that enables people to cope with the stresses of life, realise their abilities, learn well and work well, and contribute to their community. It is an integral component of health and well-being that underpins our individual and collective abilities to make decisions, build relationships and shape the world we live in. Mental health is a basic human right. And it is crucial to personal, community and socio-economic development.

Mental health is more than the absence of mental disorders. It exists on a complex continuum, which is experienced differently from one person to the next, with varying degrees of difficulty and distress and potentially very different social and clinical outcomes.

Mental health conditions include mental disorders and psychosocial disabilities as well as other mental states associated with significant distress, impairment in functioning, or risk of self-harm. People with mental health conditions are more likely to experience lower levels of mental well-being, but this is not always or necessarily the case.

Throughout our lives, multiple individual, social and structural determinants may combine to protect or undermine our mental health and shift our position on the mental health continuum.

Individual psychological and biological factors such as emotional skills, substance use and genetics can make people more vulnerable to mental health problems.

Exposure to unfavourable social, economic, geopolitical and environmental circumstances – including poverty, violence, inequality and environmental

deprivation – also increases people's risk of experiencing mental health conditions.

Risks can manifest themselves at all stages of life, but those that occur during developmentally sensitive periods, especially early childhood, are particularly detrimental. For example, harsh parenting and physical punishment is known to undermine child health and bullying is a leading risk factor for mental health conditions.

Protective factors similarly occur throughout our lives and serve to strengthen resilience. They include our individual social and emotional skills and attributes as well as positive social interactions, quality education, decent work, safe neighbourhoods and community cohesion, among others.[17]

11.7 **Disability:**

The report highlights Rosie's dyslexia at various points, noting this as a vulnerability that the perpetrator took advantage of. The British Dyslexia Association states that "Dyslexia can have a substantial and long term adverse effect on normal day to day activities, and is therefore, a recognised disability under the Equality Act 2010." The report highlights that Rosie would struggle at school due to her dyslexia and this would result in non-attendance. The Equality Act 2010 states that schools and higher education institutions have a duty to make reasonable adjustments for disabled students (this includes students with learning difficulties such as dyslexia).

Family contribute stating how Rosie had no academic qualifications from school, and limited ability to read and write. No Agencies or panel members asked any screening questions to ascertain her educational levels. Yet letters

[17] World Health Organization (2022) Mental health. Available at: https://www.who.int/news-room/factsheets/detail/mental-health-strengthening-our-response (Accessed: 26 April 2024).

were sent, with an expectation of Rosie to understand these letters, and also find locations for appointments she was unfamiliar with.

11.8 **Marriage or Civil Partnerships:**

The Equality Act 2010 states "a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic.". This review considered that while Rosie and Dave were not married, Dave would 'love bomb' and discuss Marriage with Rosie, often at times when Rosie was at her most vulnerable, for example while detoxing. Rosie was not married and did not have this protective characteristic although worthy of note due to the use of proposed marriage as a tool of coercive control.

12 Addressing the terms of reference

12.1 The terms of reference have been addressed within the key lines of enquiry and analysis. There is extensive discussion relating to Rosie, the domestic abuse she was subjected to, warning signs and agencies awareness. As well as, the role and engagement of agencies, her vulnerability, and any barriers Rosie and/or her family encountered.

Further discussions centred around the opportunities for professionals to 'enquire' that were missed and interventions that could have been taken and consequently were missed.

Within agencies, there is a need for some greater awareness to ensure standardisation of knowledge and actions. Issues of communication and information sharing between agencies have been highlighted.

Throughout the review previous DHR's and their findings, together with other academic learning, have been used to identify any learning points.

12.2 • The review will also give appropriate consideration to any equality and diversity issues that appear pertinent to Rosie e.g., age, disability (including learning disabilities and differences in educational ability within this), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

All nine protected characteristics in the 2010 Equality Act were considered by the DHR panel. The protected characteristics considered relevant to this DHR, are gender, and disability in terms of mental health, alcohol use, and dyslexia,

There are specific considerations concerning Rosie's mental health, dyslexia and alcohol use that have impacted on service delivery and Rosie's support, they are discussed within the key lines of enquiry and analysis section at Section 14.

12.3 • How should matters concerning family and friends, the public and media be managed before, during and after the review and who should take responsibility for it.

Any media will be managed through the East Riding Community Safety Partnership. All agencies are aware of this and are in agreement. If there is a need for any statement a joint agreed statement between the partnership and agencies will be issued.

12.4 • How will the review take account of a coroner's inquiry, and (if relevant) any criminal investigation related to the homicide, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process or compromise to the judicial process?

Initially, a Coroner's Inquest was expected to be undertaken after the completion of this review. However, due to significant delays referenced in section 6 and Appendix A, the coroners inquest took place before the DHR was completed.

It is noteworthy to include that swift action was taken by the Community Safety Partnership to ensure that learning identified in the draft action plan was responded to as soon as possible, and all actions from recommendations initially identified were completed and done so prior to the inquest, which was shared for the inquest.

Family states that the DHR was not agreed in its final draft for submission, and that family were not listened to or satisfied with the DHR. However they had to agree the final draft in this unacceptable standard to continue with the Inquest, which they state "I felt cornered and had to agree to something I totally disagreed to. My personal wishes would have been for the complete re-write that I had asked for, but I understood the needs of my family who wanted the inquest to proceed to have some closure. The DHR had to be accepted, for the Chair/Author to refer to a sentence in the draft DHR in the inquest".

The CSP agreed to the re commissioning and was in the middle of the commissioning business process, yet stopped this at the request of the family via Solicitor due to the inquest stating they needed the DHR to proceed.

12.5 • Whether Rosie was 'in need of care' within the auspices of the Care Act 2014.

Section 42 of the Care Act 2014 places a statutory responsibility on local authorities regarding individuals who require care.

> *This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)—*
>
> *(a) has needs for care and support (whether or not the authority is meeting any of those needs),*
>
> *(b) is experiencing, or is at risk of, abuse or neglect, and*
>
> *(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.*

This is discussed further in section 15.77.

However Rosie's family reflect of relevance here that Rosie was in full receipt of Personal Independence Payments so met this criteria, yet this is not at all reflected in this report or by any agencies.

13 Key lines of enquiry

Identified Themes for Key lines of enquiry were identified as:

(For full explanation and analysis see section 14)

13.1

- Connection between domestic abuse and suicide
- Mental health and domestic abuse
- Alcohol
- Barriers to engagement
- Perpetrator's behaviours
    - Controlling behaviour – financial abuse
    - Controlling behaviour –Sexual violence
    - Victim Blaming
    - Controlling behaviour – Use of pets
    - Gaslighting

Coercive Controlling behaviour

Stalking and harassment
Counter allegations

Professionals manipulation

Post separation abuse

Revenge Pornography

Sleep deprivation and Night Terrors

Non-Fatal Strangulation

Trauma and Post Traumatic Stress experienced by Rosie

- Risk assessment
- High risk categories

  Financial and emotional exploitation

  Strangulation and Non-fatal strangulation Threats to life
- Vulnerable adult – Adult at Risk

  Anxiety and depression – expectations
- Missed opportunities
- Agency response and sharing of information

14 Areas of Supportive Practice to note

There were instances of agencies working to support Rosie and information sharing and joint working, but more could have been done.

East Riding Partnerships Addictions Service attended appointments with Rosie to support her and carried out home visits as did the DVAP worker. Family state these appointments with DVAP however were when this was asked for by Rosie's Mum as Rosie was unable to attend without support.

Woodland's hospital did share information with DVAP that Rosie had received a phone call from Dave after her discharge from the service, thereby ensuring all available information was known.

Rosie's GP showed compassion, empathy and kindness, and a nonjudgemental approach; and ensured consistency by ensuring she could see her whenever possible so that Rosie did not have to repeat her story. She did the best within the processes and systems that were in place.

15 Analysis

15.1 • Connection between domestic abuse and suicide

15.2 It is recognised that intimate partner violence is a significant risk factor for attempting and dying by suicide[18]. Suicide and domestic abuse is also a significant and increasing issue seen in domestic homicide reviews[19] [20] [21]. The Government has in fact taken this into consideration by renaming domestic homicide reviews domestic abuse related deaths due to this recognition in terms of deaths resulting from domestic abuse related suicide [22]. It is suggested that the link between suicidality and domestic abuse relates, in part, to the feelings of powerlessness, depression, loss of control, social isolation, and financial issues. [23] The correlation between accessing

[18] Reviere, S. L., Farber, E. W., Tworney, H., Okun, A., Jackson, E., & Zanville, H. (2007). Intimate partner violence and suicidality in low-income African American Women—a multimethod assessment of coping factors. Violence Against Women, 13, 1113–1129.
[19] Sharp-Jeffs, N. and Kelly, L., 2016. Domestic homicide review (DHR): Case analysis.
[20] Dangar, S., Munro, V. and Young Andrade, L., 2023. Learning legacies: An analysis of domestic homicide reviews in cases of domestic abuse suicide.
[21] Rowlands, J. and Dangar, S., 2023. The Challenges and Opportunities of Reviewing Domestic AbuseRelated Deaths by Suicide in England and Wales. *Journal of Family Violence*, pp.1-15.
[22] Home Office (2024) *Fatal domestic abuse reviews renamed to better recognise suicide cases*. Available at: https://www.gov.uk/government/news/fatal-domestic-abuse-reviews-renamed-to-better-recognisesuicide-cases (Accessed: 20 March 2024).
[23] Anderson, D.K., Saunders, D.G., Yoshihama, M., Bybee, D.I. and Sullivan, C.M., 2003. Long-term trends in depression among women separated from abusive partners. *Violence against women*, *9*(7), pp.807-838. [28]

psychological services combined with adult physical abuse increases the rates for suicidal attempts.[28]

15.3 There is a traditional reluctance from agencies to acknowledge domestic abuse suicidality as it is connected to non-bodily forms of injury.[24] Whereas the common perception is focussed on a rigid classification grounded in the category of harm or the intentions of the perpetrator in its infliction, rather than its severity from the victim's perspective[25]. However, it is also noted there has been extensive education with agencies regarding coercive control that has led to successful prosecutions.

15.4 There have been recent developments in respect of the classification and criminalisation of coercive and controlling behaviour together with understanding the outcomes in the Serious Crime Act 2015. This provides an opportunity to assist agencies to understand and correlate the actions and behaviours of the abuser and understand the impact this has had on victims, including fatal domestic abuse due to suicide. Domestic abuse related deaths where the deceased has died from suicide maintains the connection between domestic abuse and suicide for all victims and is now embedded in this change in statutory guidance for domestic homicide reviews (Home Office 2024).

15.5 Rosie was accessing psychological services in connection with her alcohol and drug abuse. On several occasions Rosie was asked about suicidal ideation, she did not suggest that she was considering any such actions, in fact she appears to have responded oppositely and that she had no intentions. However, Rosie told the ambulance service she was suicidal, and, on another occasion, she

Tidemalm, D., Långström, N., Lichtenstein, P. and Runeson, B., 2008. Risk of suicide after suicide attempt according to coexisting psychiatric disorder: Swedish cohort study with long term follow-up. *Bmj*, *337*.
[24] Aitken, Ruth and Munro, Vanessa (2018) Domestic abuse and suicide: exploring the links with refuge's client Base and work force. London: Refuge
[25] Ibid

had told East Riding Social Services that she had previously thought about 'jumping off the Humber Bridge'. Victims often minimise the extent of the abuse and develop coping mechanisms to manage the abuse. It is not uncommon for victims to use potentially harmful strategies, such as alcohol or drug use, to numb the painful reality of domestic abuse. [26]

Family also reflect how Rosie was asked about suicidal ideation when Mum was present. This would result in tears in the meetings as Rosie would say that she wouldn't do that to her Mum, and conversations would continue, However Rosie was not spoken to alone at these times and if so she may have said differently.

15.6 Rosie contacted 111 on three separate occasions in October 2017, stating that she lived on her own, she was alcoholic and was feeling suicidal. The 111 service contacted the crisis team, who stated that Rosie was not currently having any support from them; however, they had advised her in September to get in touch with the various agencies supporting her to help her with her alcohol issues. The Yorkshire Ambulance Service submitted a 'Request for Social Care Assessment' including all the information described to the East Riding Partnership Adult Social Care.

Family are deeply concerned that the Ambulance Service was not a panel member due to the many calls they had received from Rosie. Family state that some ambulance staff lacked empathy and were judgemental over alcohol use and had no comprehension of the impact of domestic abuse, thus it would have been important to hear the conversations and extrapolate learning from this review.

Family reflect that despite this, "Rosie remained polite and respectful throughout", and they are deeply proud of her for this strength in character

[26] Rogers, B., McGee, G., Vann, A., Thompson, N., & Williams, O. J. (2003). Substance abuse and domestic violence: Stories of practitioners that address the co-occurrence among battered women. *Violence Against Women*, *9*, 590-598.

despite the lack of empathy and judgement she experienced when accessing services.

15.7 There is nothing further within this review that would indicate Rosie's suicidal thoughts were considered, assessed, or addressed. The Adult referral form submitted was considered but after consultation with East Riding Partnership Addictions Service no further action was undertaken.

15.8 In January 2018, during a visit with East Riding Social Services, Rosie did tell staff that she had considered 'jumping off the Humber Bridge'. Rosie had suggested that this was directly linked to the fact that Dave had found out where she lived and was coming to 'pick the dog up'. There was no further follow up of the comment, nor was there any further assessment or exploration of the suicide ideation or the link to domestic abuse by Dave.

15.9 If partners would have considered Rosie's history and background, there was domestic abuse from both Dave and previous partners, isolation, financial issues, substance abuse, depression, and lack of control. All these aspects contributing towards the increased risk of suicide.[27]

15.10 • **Mental health and domestic abuse**

15.11 There is no doubt Rosie suffered with anxiety, it is recorded on many occasions that she felt anxious every day. The use of alcohol was a means to cope with the anxiety, although the alcohol creates greater anxiety.[28] Rosie was also not aware of the risks of alcohol use and the link to increasing anxiety. The challenge for Rosie and services was that to assist with her anxiety, the levels of alcohol needed to reduce. This spiral of behaviours was causing difficulties

[27] Ibid

[28] Kushner, M.G., Maurer, E., Menary, K. and Thuras, P., 2011. Vulnerability to the rapid ("telescoped") development of alcohol dependence in individuals with anxiety disorder. *Journal of studies on alcohol and drugs*, *72*(6), pp.1019-1027.

for Rosie and although there was substantial and ongoing support from her family, without the ability to reduce her alcohol intake the anxiety would remain.

15.12 The anxiety was severely impacting on Rosie's ability to go about her life. In 2016, Rosie explained that she was too nervous to use public transport and was unable to attend benefit assessments. The anxiety was ever present throughout 2016 and 2017, exacerbated by the loss of her job, her move, the loss of her independence and the thoughts of Dave turning up unexpectedly/uninvited to her home, all directly linked to coercive and controlling behaviour. Rosie was reported on many occasions to be anxious

daily, Family question why this was not followed up better with formal action and pathways and referrals for support.

15.13 There is recognition that domestic abuse is associated with high rates of depression, substance abuse and anxiety disorders[29]. The longer-term impact of sustained abuse creates greater mental health issues for the victims, although there does not seem to be a recognition of such within some agencies. Hull and East Yorkshire MIND as an example (as well as others) did not examine the issues of domestic abuse within their sessions. Indeed, on one session in late December 2017 Rosie provided information that her '*expartner had been round this morning. Prior to leaving Rosie received a phone call from a male asking, "where are you and how long will you be". Rosie appeared to become agitated following this phone call.'* This information was not explored, nor was it passed or communicated further, and it does not appear that they had been made aware that a MARAC had taken place. There is no evidence to suggest this was Dave, but the reaction from Rosie would suggest it was.

[29] Campbell J: Health consequences of intimate partner violence. Lancet 2002; 359:1331–1336

15.14 During a following visit in January 2018 to Hull and East Yorkshire MIND, some three weeks later, the phone call and anxiety it caused was not explored. There was no discussion relating to domestic abuse and as such is a missed opportunity. Throughout the four months Rosie was involved with Hull and East Yorkshire MIND, there was no discussion about domestic abuse or the impact it had on Rosie.

15.15 There were many other occasions when Rosie disclosed her anxiety, for example at meetings with DVAP, to her GP, IAPT and RDaSH. There was no overarching combined plan for agencies to work together to reduce Rosie's anxiety or respond collectively to reduce the risk to her from the perpetrator. Rosie explained on many occasions she used alcohol to control her anxiety and that the domestic abuse by Dave increased her anxiety. It could be argued

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that unless agencies addressed the domestic abuse this never-ending circle of behaviours would not stop.

15.16 Treatment of the holistic impact of Domestic abuse is important. Isolated treatments may have short term impact, but longer-term results require a joint holistic approach between agencies. The only time Rosie did have a coordinated approach was during the MARAC process and it could also be argued when East Riding Adult Services and East Riding Partnership Addictions Service communicated regarding Rosie's vulnerable adult referral. It is recognised that experiencing more than one type of abuse (physical, sexual, and/or emotional/psychological) increases the probability of having depressive symptoms.[30] Domestic abuse and coercive control are known to be a pattern of cumulative incidents that contain coercive control and other

[30] Stylianou, A. (2018). Economic Abuse Experiences and Depressive Symptoms among Victims of Intimate Partner Violence. Journal of Family Violence.

forms of abuse including emotional / psychological abuse, economic abuse and physical abuse (although not always)[31].

15.17 • **Alcohol**

15.18 Rosie's alcohol use became a concern during the relationship with Dave.

15.19 There does not appear to have been a link drawn between her alcohol use and domestic abuse, nor an understanding of whether the alcohol abuse created a vulnerability that was exploited by her partners, or whether it was a coping mechanism. Victimisation may elevate an individual's risk of substance misuse[32]. Although it is recognised that RDaSH asks a question about domestic abuse. Current practice and services, including the Doncaster Drug and Alcohol Service [ASPIRE], all utilise standard assessment tools. The Rotherham, Doncaster and South Humberside NHS Foundation Trust has distinct assessment tools that will prompt the opportunity to consider and discuss risks, including domestic abuse.

15.20 High levels of negative effect caused through assault can lead to individuals to engage in behaviours that reduce negative emotions[33]. The use of alcohol minimising the effects of trauma, which was apparent in Rosie's behaviours.

15.21 This correlation between alcohol and increased vulnerability is often unrecognised and rather than substance use highlighting the greater potential for exposure to abusive behaviours, can be seen to minimise the behaviours and apportion blame to the victim.

[31] Sharp-Jeffs, N. and Kelly, L., 2016. Domestic homicide review (DHR): Case analysis.
[32] Angelone, D.J., Marcantonio, T. and Melillo, J., 2018. An evaluation of adolescent and young adult (re) victimization experiences: Problematic substance use and negative consequences. *Violence against women*, *24*(5), pp.586-602.
[33] Levenson, R.W., Oyama, O.N., & Meek, P.S. (1987). Greater reinforcement from alcohol for those at risk: Parental risk, personality risk, and sex. Journal of Abnormal Psychology, 96, 242-253.

15.22 It is suggested that the use of alcohol and drugs are often used to medicate the pain involved in situations of domestic violence and trauma by women.[34] It has also been shown that women victims are more likely to use alcohol and drugs to alleviate the impact of the abuse[35] and Women in treatment for alcohol and other drugs report elevated rates of victimisation[36].

15.23 During an incident recorded by Humberside Police in September 2017, it is recorded that 'Rosie has a drink problem that appeared to be exacerbated by the anxiety she felt at the thought of Dave turning up at her new address and causing further problems.' A vulnerable adult referral was submitted, and a DASH risk assessment completed. There was a clear correlation of alcohol use and anxiety linked to domestic abuse; however, Rosie was not re-referred into MARAC. Under current policies and processes Rosie would now have been re-referred into MARAC.

15.24 Rosie had been a High-risk MARAC victim and, as such, was vulnerable to abuse, and this may have impacted on her treatment and/or psychological status. Rosie explained on numerous occasions to rDaSH and her GP's that she used alcohol for her anxiety and yet there was not exploration of the cause of the anxiety.

15.25 • **Barriers to engagement**

15.26 In December 2015 during an appointment at Rotherham IAPT (Improving Access to Psychological Therapies) service, Rosie explained that her benefits had

[34] Zilberman, M.L. and Blume, S.B., 2005. Domestic violence, alcohol and substance abuse. *Brazilian Journal of Psychiatry*, *27*, pp.s51-s55.
[35] Zilberman, M.L. and Blume, S.B., 2005. Domestic violence, alcohol and substance abuse. *Brazilian Journal of Psychiatry*, *27*, pp.s51-s55.
[36] Miller BA, Wilsnack SC, Cunradi CB. Family violence and victimization: treatment issues for women with alcohol problems. Alcohol Clin Exp Res. 2000;24(8):1287-97.

been stopped. She further explained that she had difficulty understanding communications and as she had not been attending appointments, that's why they had been stopped. Agencies should be aware of the challenge's individuals face. The use of alcohol, drugs and history of domestic abuse could have contributed to Rosie being unable to engage with services and, as such, leaving her vulnerable.

15.27 In October 2015, Rosie was visited at home by the Drug Addiction Therapy Services in Rotherham. During this visit she explained that she felt she could not leave the house without using alcohol due to her anxiety and lack of confidence. She also explained that she had been diagnosed with dyslexia at school and this had been the reason she had not attended.

15.28 The use of alcohol and her dependency to be able to leave the house whilst managing her anxiety is a barrier to any service engagement. There is an expectation that individuals will mostly attend appointments for services away from their home. However, in certain circumstances this could have a detrimental effect on their well-being and be a cause for disengaging or simply not attending.

15.29 During January 2016, Rosie explained to the Rotherham IAPT, that she did not like using public transport and that she did not like going to Sheffield. This lack of confidence and ability to openly and actively engage in services created further isolation and anxiety and depression. It should be noted that this represented a general anxiety and depression and not directed at the IAPT response as appointments with IAPT took place at the GP surgery.

15.30 Following the assault on Rosie in May 2017, Dave was charged and due to appear in court. Rosie did not attend the court and consequently the charges against Dave were withdrawn. Consideration should be given of how to support individuals in such a position as Rosie, how agencies can minimise the impact

and reduce the anxiety and depression they face to ensure justice is able to be made. The Domestic Abuse Act 2021, specifically identifies the measures available for victims in criminal proceedings for offences involving domestic abuse, and special measures to support victims in court.

Family state that the Police had enough evidence to proceed with a victimless prosecution for non-fatal strangulation, but this did not take place.

15.31 During Rosie's involvement with DVAP, they were informed that Rosie would not routinely pick-up phone calls from withheld numbers. This could be a barrier to engagement, if Rosie and other victims do not answer withheld numbers, and be a consideration for agencies communicating with victims.

Within the domestic abuse setting individuals are often offered the Freedom programme as a means of support, this was the case with Rosie. She did attend but felt it was a real challenge, being in the groups setting. This was so challenging that Rosie's Mum accompanied her and waited outside due to her anxiety. This was extremely difficult for Rosie to attend and engage whilst she was trying so hard to move forward. This may be a challenge for a lot of victims, to be able to discuss and engage with strangers, discussing their personal lives and situations. In the circumstances one – one support was more appropriate, however this did not take place due to staffing shortages within the service, staff leave, and closure of the service during Christmas Holidays.

Family request a recommendation that DVAP review support over holiday periods and that there are plans in place for when individual support workers go on leave for long periods of time.

IDVA training took place for the full DVAP Service in 2019 following Rosie's death to ensure the full service had this training amongst other domestic abuse professional training. These Domestic Abuse Practitioners became IDVA's after receiving the IDVA training.

15.32 **Perpetrator Engagement, Analysis, and Behaviours** Perpetrator Engagement:

The Author engaged with the perpetrator to ascertain their views as per the statutory guidance on conducting DHRs.

The perpetrator, known as Dave for the purpose of this report, shared his views which are summarised with resulting analysis combined below.

Dave stated he met Rosie in 2014/2015, where she was a hairdresser at the time and they met through a mutual acquaintance at a bar. Dave stated Rosie took amphetamines alongside alcohol to cope with social anxiety.

Dave's belief wasthat he got on well with Rosie's parents early on in the relationship and felt that he was able to secure Rosie's s fathers support in helping Rosie with her drinking. Family dispute this stating Dave never got on well with Rosie's family. Rosie's family reflect on these comments stating that Dave always had to be present when they visited Rosie. Rosie had to call him if they were there, and he would return. At the time he said "he would like to see us" in relation to Rosie's parents, but now the coercive control and domestic abuse is evident and this was the beginning of this picture.

Perpetrators comments contributing to the review demonstrated victim blaming by indicating that Rosie's father was doing this so that she would not jeopardise her relationship with Dave.

This victim blaming continued with comments including Rosie needing to sort her alcohol consumption out to stay in a relationship with him, including doing an eight week detox at home which resulted in her being very poorly, just so he wouldn't leave her. This demonstrates coercive controlling behaviour, a sense of entitlement and victim blaming when sharing views towards this review. Rosie's family also reflect that Dave locked Rosie in the house during this time

furthering her suffering and serious health risk from the alcohol withdrawals and detox from abstinence rather than reduction.

Dave shared how he found out Rosie was not working at a Hairdressers following this detox and was working at an establishment as a sex worker at around November / December 2016. Rosie did not voluntarily share this information with him, and Dave found money in her handbag and challenged her with this including calling her previous place of work indicating again further coercive controlling behaviour, stalking and harassment, control of finances, and further financial / economic abuse.

Dave admitted to checking Rosie's phone without her permission to see messages from others about her work detailing stalking behaviour.

Dave admitted he wanted Rosie to continue working at the establishment but demonstrated gaslighting behaviour by saying to Rosie this was because he didn't want to lose her and that he would support her work to financially support them both. Family reflect that the level of abuse and financial control was to the point where Dave bought a car, paid his son's child maintenance, personal loans and accommodation fees from this exploitation of Rosie's work and finances.

In May 2017 Dave admitted to "flipping his lid" at the home address where the police were called to an incident when she was working with a client, and he was charged with assault against Rosie. Dave denied that the incident occurred and was successful in manipulating and controlling the allegation to be dropped and the prosecution not taking place.

After this incident Dave alleged that Rosie gave the address of the new house she was moving into in East Yorkshire and alleged that she wanted to continue seeing him in secret, and that he then visited Rosie at the house in East Yorkshire

regularly. Dave stated Rosie's parents found out about the visits and he didn't hear anything from Rosie until Oct 2017 when she phoned him from a new phone.

Following increasing visits, Rosie's parents were present at the address regularly each week to deter Dave from visiting he stated.

Dave attempted to allege that Rosie's father tried to threaten cutting ties with family unless she left Dave, again indicating coercive controlling and manipulative behaviour using family relationships.

Dave also minimised his sexual and physical violence, and use of non-fatal strangulation which is referenced many times in this report by family and friends that Rosie experienced at the hands of the perpetrator. Non-fatal Strangulation is now a criminal offence and is significant high risk of serious harm and death. Dave minimised this behaviour calling it "rough sex" and that Rosie "enjoyed it", further demonstrating the sense of entitlement and gratification from causing significant physical and sexual harm to Rosie.

Dave further admitted to love bombing and gaslighting Rosie with comments about getting married when Rosie was going through an alcohol detox, and saying he would leave her because he didn't want to come between her and her family.

15.33 Dave was an abusive partner. A previous incident in 2013 had been reported by his then partner, that she had been assaulted. When officers attended, she denied the assault and would not give any further information. As such there was no further investigation.

15.34 Early in the relationship Rosie and Dave had visited Rosie's sister and whilst there Rosie had disclosed marks on her neck. Rosie had said Dave had used a bath

robe belt to strangle her as part of 'rough sex'. Dave when interviewed as part of this review admitted to strangling her as highlighted and said that Rosie had enjoyed it, minimising the sexual and physical violence he had subjected Rosie to, and the strangulation which is now a criminal offence within the Domestic Abuse Act 2021.

15.35 In early February 2017, South Yorkshire Police attended the report of a domestic incident, where they found Rosie crying. When spoken to Rosie did not disclose any crime had occurred and she was not injured. Some days later Dave attended the Rotherham, Doncaster and South Humber NHS Foundation Trust, crisis team where he claimed that Rosie had been performing sex acts on clients and that he was conflicted. This would appear to have been evidence of counter allegations by Dave attempting to identify himself as the victim and placing the blame of behaviours on Rosie, which is typical of perpetrators of abuse to deny accountability and minimise their behaviours, blaming and shaming their victims as a result.[37]

15.36 During the time when Rosie was working, it was reported to staff by Rosie that she was afraid of Dave. It was further reported that he took her money and he had given up his job whilst she earned money, he was financially exploiting Rosie and blaming her for this and her work. This had become such an issue for Rosie that she had been saving money at work to ensure Dave did not have access to it. Dave also turned up at her place of work and was warned to stay away by staff, who reported that Rosie feared him. On one occasion staff took Rosie home so she would avoid seeing Dave. This

information has come to light by the review and the information was not made available to agencies previously. Managers from the workplace were always happy to be engaged in the review family have reflected, but unfortunately were not approached.

[37] Stark, E. and Hester, M., 2019. Coercive control: Update and review. *Violence against women*, 25(1), pp.81104.

15.37 In May 2017, South Yorkshire Police attended Rosie's address and ascertained that she had been assaulted by Dave. Dave had grabbed her by the throat, strangling her to unconsciousness while slapping her in the face several times. It was seen that Rosie had 'reddening' to her neck and an injury to her head. Dave was arrested and charged with an offence, although there was no prosecution as Rosie withdrew her claim due to the fear, and consequences of retaliation from Dave.

There are many reasons why a victim may withdraw an allegation within the considerable situational constraints often influenced by an abusers' controlling behaviours.[38] The rationale employed by victims can include, that they are fearful of their personal safety, reconciliation, financial concerns, or other vulnerability. Now this would remain an offence of non-fatal strangulation under the Domestic Abuse Act 2021, and evidence based prosecutions are prioritised by the Police whereby victims do not need to engage in the prosecution.

15.38 Following the attack on Rosie, Dave reported to the Rotherham, Doncaster and South Humber NHS Foundation Trust crisis team that the cause of the argument was Rosie and her work, that she was 'bringing clients to the house'. There is no evidence that this was the case. He also suggested the cause of the incident was in part due to Rosie using drugs and alcohol and that they had a 'turbulent relationship.' There is no doubt Rosie did use alcohol and drugs; however, the only incidents are connected to Rosie as a victim and Dave the abuser. In his discussions Dave minimised his involvement, stating he had 'pushed her away' and that she had fallen over

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the bed and started laughing. From the involvement of South Yorkshire Police, this was not the case. Rosie had been strangled during an assault and there is

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[38] Hoyle, C. and Sanders, A., 2000. Police response to domestic violence. *British journal of criminology*, *40*(1), pp.14-36.

other evidence supporting other strangulation that was excused as 'rough sex'.

15.39 In 2017, Rosie reported that Dave was trying to break into her house in Rotherham to steal her dog. When she spoke to the police, she then informed them that Dave had legitimate access and there were no offences. The use of pets remains a common tactic deployed by perpetrators in order to control and dominate their victim[39]. This also disempowers the victim, preventing them leaving the relationship and controlling the victim post separation.

15.40 **Controlling behaviour – financial abuse**

15.41 Rosie had reported financial abuse on several occasions. Rosie's mother had also reported financial abuse in relation to the text message relating to 'sorting out' the finances following separation. It is recognised that financial abuse is an invisible form of abuse, it is used by perpetrators to exert control through coercive tactics.[40] Financial abuse can take many forms, such as preventing the victims with access to finance and controlling spending through the management of monies. However, it appears that Dave implemented another form of abuse, and that was exploiting Rosie for money. Family reflect how Dave would buy steaks and food for his son but would not allow Rosie to have anything. He would buy designer clothes, but Rosie would have to buy from Charity shops or what her family bought for her.

15.42 When in an intimate relationship, Rosie and Dave lived in Rosie's house. When Dave found out where she was working and that she was earning a good

[39] Newberry, M., 2017. Pets in danger: Exploring the link between domestic violence and animal abuse. Aggression and Violent Behavior, 34, pp.273-281.
[40] Postmus, J; Hoge, G; Breckenridge, J; Sharp-Jeffs, N; Chung, D. (2018). Economic Abuse as an Invisible Form of Domestic Violence: A Multicountry Review. Trauma, Violence, & Abuse.

income, he encouraged her to continue her work, driving her to the unit in a car she had purchased for him. On occasions when she wanted to stop, Dave would coercively control her to continue saying his son needed things, which she needed to provide through her work.

15.43 When Rosie spent money on friends, Dave became angry, evidenced when buying two cards and a helium filled balloon for a friend's child. Rosie had paid for the dog, but Dave was claiming it was his. On another occasion Dave had pinned Rosie against a wall and taken £400 from her, he had also withdrawn all the money from the joint account they had and taken money from her handbag.

15.44 Whilst working Rosie did not want to take her money home as she knew Dave would take it and so she kept some at work to avoid this and also to help her to flee one day. These examples are a demonstration of Rosie's' exploitation by Dave, who exploited her personal economic situation.[41] The relationship exhibits underlying pathology with an imbalance of power, leading to the exertion of coercive control by Dave over Rosie.[42]

15.45 **Controlling behaviour –Sexual Violence**

15.46 Rosie revealed on more than one occasion Dave's propensity to 'rough sex' and perpetration of rape. During the MARAC proceedings information was supplied that Dave would 'grab her around her throat or throw her about', causing injuries such as bruising and swelling to her neck and back. Rosie told Dave that she did not want to have sex like that, but he proceeded anyway, therefore raping Rosie and inflicting physical and sexual violence. Dave would also strangle Rosie to unconsciousness, or gag her until she became sick. If

[41] Ibid
[42] Coleman DH, Straus MA. Marital power, conflict, and violence in a nationally representative sample of American couples. Violence Vict. 1986 Summer;1(2):141-57.

she did vomit, he would then rub her face in it to make her gag. This is an extreme form of torture, which degrades the victim and also uses sexual violence to exert control.

15.47 Such was the behaviour that Rosie would pretend to be asleep on the sofa to avoid this sexual violence and fear of rape, and would comply to avoid further physical, sexual violence and control. Rosie did indeed state to professionals that she feared Dave would kill her, so this would no doubt contribute to this fear for her safety and life, and domination through these forms of violence. This coercive and controlling behaviour indicates the type of relationship Rosie endured.

The use of excessive force, rape and strangling Rosie to unconsciousness was clearly an indication of Dave's behaviours and use of extreme violence including sexual violence to control, degrade, and dominate Rosie.

15.48 **Victim Blaming**

15.49 There are evidenced occasions when Dave used information to divert actions away from his behaviours to create the impression that Rosie was the perpetrator and he the victim, creating counter allegations and attempting to manipulate professionals. On a visit to Rotherham, Doncaster and South Humber NHS Foundation Trust, Dave explained that he had a "turbulent relationship with *(his)* partner who uses drugs and alcohol" and that he had "pushed her away recently leading to her falling over the bed and she began laughing". This minimised the actual assault, the strangulation and injury to Rosie's head. The tactic of minimisation and apportioning responsibility towards Rosie is a clear tactic to deflect responsibility and deny accountability, and apportions blame and shame on the victim.

15.50 During a visit to Rotherham Children and Young People's Service Dave provided information that Rosie was alcohol dependant, using amphetamines, working as an escort and perpetrating domestic abuse towards him. Whilst it is acknowledged that some of this information is correct in that there was an incident of domestic abuse, the evidence records that Dave was the perpetrator and Rosie was the victim. Rosie was alcohol dependent and had worked as a sex worker. There is nothing to suggest Rosie was perpetrating domestic abuse towards Dave. Perpetrators making counter allegations is a common tactic deployed to manipulate professionals and others and continue the spiral of abuse.[43]

15.51 **Controlling behaviour –Dog**

15.52 Rosie's dog was a significant part of her life. It had remained constant throughout her troubles, and she had taken it with her when she fled the relationship. Dave used the dog to coercively control her through power and control. In August 2017 after leaving the relationship, Dave had been seen breaking into Rosie's house to steal the dog. Rosie's Dog was her physical protection and Dave used the dog to disempower and control Rosie. It was a way of preventing Rosie from leaving the relationship and continued post separation abuse.

15.53 During an appointment with DVAP, Rosie discussed her dog and she felt that Dave would try and take the dog, just to get back at her. In September 2017, Dave had sent a letter to Rosie stating that he had been watching the dog in her window, demonstrating stalking and harassing behaviour.

15.54 Understanding the relationship that Rosie had with her dog, is important in this context. People look to their pets for social support, comfort, and security.[44]

[43] 48 Stark, E. and Hester, M., 2019. Coercive control: Update and review. *Violence against women*, 25(1), pp.81104.
[44] McConnell, A. R., Brown, C. M., Shoda, T. M., Stayton, L. E., & Martin, C. E. (2011). Friends with benefits: On the positive consequences of pet ownership. *Journal of Personality and Social Psychology*, *101*, 1239-1252. [50]

Furthermore, pets have been found to positively influence their owners' physiological health by reducing stress and promoting relaxation.[50] It is recognised that animals can be a barrier to leaving an abusive relationship.[45] Rosie's dog was thus her physical protection and the abuse from Dave prevented her from leaving the relationship or continued the abuse and control post separation.

15.55 The threat of taking Rosie's dog created greater levels of anxiety and again, exhibited coercive and controlling behaviour. Control tactics in an abusive relationship can include a myriad of other behaviours such as, threats of physical violence, financial control, threats to harm or take the children, isolation, and emotional abuse. [46] Abuser's target pets as one way to intimidate, frighten, terrorise, and exert control over their partners and children.[47]

15.56 **Gaslighting**

15.57 Throughout the interview with Dave, he explained that he had been in constant contact with Rosie, often at her request. He said he often visited Rosie at her home address in East Yorkshire and had regular telephone contact with her. Rosie's family dispute that and say that Dave was harassing Rosie. Although, records from Humberside Police do suggest there was regular amicable contact with Dave and that he had been visiting her with her prior agreement to see their dog. In September 2017, when Rosie and her mother reported harassment to Humberside Police, the officers found text messages that had been sent to Rosie's mother and concerned the financial

Friedmann, E., & Son, H. (2009). The human-companion bond: How humans' benefit. *Veterinary Clinics of North America: Small Animal Practice*, *39*, 293-326.

[45] Fitzgerald, A.J., Barrett, B.J., Stevenson, R. and Cheung, C.H., 2019. Animal maltreatment in the context of intimate partner violence: a manifestation of power and control?. *Violence against women*, *25*(15), pp.18061828.

[46] McMahon, M. and McGorrery, P., 2020. Criminalising coercive control: An introduction. *Criminalising coercive control: Family violence and the criminal law*, pp.3-32.

[47] Faver, C.A. and Strand, E.B., 2007. Fear, guilt, and grief: Harm to pets and the emotional abuse of women. *Journal of Emotional Abuse*, *7*(1), pp.51-70

arrangements between Rosie and Dave, they were not offensive or threatening. This demonstrates a lack of awareness by Police regarding domestic abuse and how it is a pattern of cumulative events, rather than one off incidents, and that the abuse and control forces the victim to conform and make excuses for the perpetrator to minimise the consequences and worsening abuse from the perpetrator. This has been included as a recommendation for change regarding Police improving understanding and awareness of domestic abuse.

15.58 Several days after reporting the text messages, Rosie received a letter from Dave stating that he had been 'watching the dog in the window'. This behaviour clearly demonstrated that Dave had visited the area, that he was aware of Rosie's address and sought to create more anxiety for Rosie, further displaying stalking and harassment behaviours with clear evidence of this on this occasion. Although, there is no doubt this had been happening on regular occasions as per families concerns and Rosie's information shared with the DVAP worker.

15.59 Rosie had destroyed four mobile phones as Dave had found her number, again indicating the fear she had of his domination, violence and control. Dave had identified Rosie's address and his car was also seen near Rosie's address. Stalking and the use of the text messages creates a presence and demonstrates a broader sense of control and intimidation. This is also balanced against Humberside Police's findings of the regular contact with Dave through recovered text messages from her phone. As such, technologically facilitated domestic abuse is increasing [48] . The use of

[48] Yardey, E., 2020. Technology-facilitated domestic abuse in political economy: a new theoretical framework. *Violence against women*.

technology allows the abusers to be *omnipresent*, whereby they use technology to create a sense of constantly being present in a person's life[49]

Family further reflect that not all phones were recovered as Rosie also had pay as you go phones that Family purchased, so that Rosie could always contact them.

Humberside Police acknowledged that Rosie's alcohol issues were exacerbated by the anxiety caused at the thought of Dave turning up at her address and causing problems.

15.60 • **Risk assessment**

15.61 There have been several occasions when risk assessments have not been carried out regarding domestic abuse. These are:

There is no access to any records from Woodlands that would help indicate whether a risk assessment was or was not carried out.
MIND not undertaking a risk assessment or discussion re. any areas of her domestic abuse.
GP also did not undertake any risk assessment or signposting to agencies for her experiences or risk of domestic abuse before Rosie fled.

15.62 In 2015, Rosie attended her GP with a 'deep laceration' to her head. Rosie tried to minimise this to reduce further violence and control from the perpetrator by saying she was drunk and injured herself. The GP did not ask about

[49] Woodlock D (2017) The Abuse of Technology in Domestic Violence and Stalking. *Violence Against Women*, 23(5): 584-602.

domestic abuse and accepted Rosie's word for the injury, as such no information was revealed or obtained, and no risk assessment undertaken.

15.63 Early August 2017, Rosie reported that she was 'escaping domestic violence' to her GP, there was no assessment, and nothing appears to have been asked or passed on regarding that information.

15.64 On several attendances with MIND, risk assessments were not carried out despite disclosure of domestic abuse. In December 2017, it is noted that there was a 'risk regarding potential development of relationship with ex-partner who has previously been physically abusive' and no assessment was undertaken.

15.65 On a later appointment some 12 days later, Rosie disclosed she had met 'her Ex-boyfriend as he was going to take the dog, but she said she called his bluff and he turned up and they walked the dog.' The notes add that Rosie had said 'that he had gone and that the meeting had gone okay, and she had no concerns.'

15.66 Despite the comments by Rosie, it is incumbent on organisations to understand and assess risk with a clear focus on any risks she was exposed to.[50] Rosie had been a 'High Risk' MARAC before moving to the East Riding, involving the same individual. This was less than 12 months as Rosie died 9 months after this. The DASH record was downgraded to 'standard' by Humberside police as Dave lived in Rotherham, and although Humberside Police were unaware at the time, Rosie was in contact with Dave through text messages. Regardless of the risk assessment, target hardening was carried out at Rosie's address (at this point however Rosie was not in contact with Dave) and a vulnerable adults form was submitted seeking support for Rosie's anxiety and mental health concerns and consideration was given to this going to MARAC, but it did not

[50] Kemshall, H., Wilkinson, B. and Baker, K., 2013. *Working with Risk: Skills for contemporary social work*. Polity.

meet the threshold in this risk assessment which it should have. As previously mentioned, the physical presence of an abuser is not necessary to exert coercive and controlling behaviours This refers back to *omnipresence* through the use of technology, whereby technology is used to create the feeling that the abuser is constantly present in a person's life, and this can be clearly recognised in this case.

Family reflect how the MARAC case was archived too soon as the high risk was clearly present for Rosie but this was not acknowledged by professionals.

The inquest family note also discussed this with the reason given that Rosie fled and was not registered by the GP – despite the fact that she was.

15.67 Hull and East Yorkshire Mind were aware of the historic domestic abuse Rosie suffered, and were informed by Rosie's family about her being referred to MARAC at the first meeting with Rosie. The lack of further enquiry however demonstrated a lack of knowledge and understanding of domestic abuse. Rosie's family also reflect how no risk assessment for anxiety or depression was undertaken by any agency.

15.68 • **High risk categories**

15.69 All agencies should be aware of the high-risk categories associated with domestic abuse, two of the five categories were present within the relationship and articulated within the MARAC meeting in South Yorkshire; strangulation and separation. These behaviours are ever present and should be considered within all assessments. Professional Curiosity is now also prioritised within the risk assessment process, enabling risk assessments to be graded as high if there are concerns wider than these categories or that cause alarm and concern for significant harm or threat to life. The incident at South Yorkshire in June 2017 clearly demonstrated high risk and consequently, Rosie was discussed in the MARAC meeting. During the process of the MARAC transfer

and the assessment completed by East Riding DVAP, Rosie disclosed other history and behaviours perpetrated by Dave that identified her as high risk.

15.70 These included:

Perpetrator fearing a loss of control (jealousy)

Rosie stated the abuse was getting worse and Dave was 'massively jealous' about the time she spent with friends. Dave became angry if she spent money on friends. On one occasion getting very angry in front of a neighbour for buying the neighbours child two birthday cards and a helium filled balloon.

15.71 **Financial and emotional exploitation**

When Dave had found out about her sex work, he encouraged her to continue, exhibiting coercive behaviour if she said she wanted to stop, saying that his son needed something and therefore the money. On another occasion Dave 'pinned Rosie against the wall' and took £400 off her, and also stole money out of her handbag. Dave made Rosie change her bank account to a joint one, and then cleared the joint account of all their money. Dave used coercive control towards Rosie, threatening that he would commit suicide if she left the relationship. He also love bombed Rosie and discussed marriage when she was undergoing detox from her alcohol use.

Learning for all agencies should be prioritised how perpetrators can manipulate professionals and victims even to the extent using mental health and suicide to gaslight and coerce victims.

15.72 **Strangulation**

Dave would strangle Rosie to unconsciousness during rape and sexual violence. On occasions when she had gagged and been sick, Dave would then put her face in the vomit to make her gag further, demonstrating severe torture and degrading tactics utilised by the perpetrator.
The severity of this was so that Rosie felt she was not believed by Ambulance Services and Police. She was disorientated, confused, had marks on her neck. The risk of possible brain damage here was significant and also Rosie was left in the house following this with Dave's son.

The review recognises how there was found to be an 11% increase in cases where a suspect in suspected victim suicide following domestic abuse cases has previous non-fatally strangled a victim following the introduction of the criminal offence of Non-Fatal Strangulation in 2021. Coercive Controlling Behaviour (CCB) is also noted as a factor in just under half of suspected victim suicides following domestic abuse. Lastly, non-fatal strangulation is found to co-occur with CCB in just under a third of suspected victim suicides following domestic abuse. Recommendations in the report highlight the importance of Police forces and partner agencies recognising the prevalence of CCB in cases of non-fatal strangulation and separation, and how this is even higher in cases of suspected suicide following domestic abuse, than intimate partner homicides (IFAS 2024[57]).

This review has acknowledged the importance of ensuring the offence of Non-Fatal Strangulation is understood by all agencies and that particularly health agencies understand the role in responding to this, including Ambulance services. All agency responses including Police will also be recognised in the recommendation to ensure effective responses and understanding of this legislation.

15.73 **Threats to life**

Rosie felt that Dave could have killed her during the assault relating to the MARAC referral, but did not because his son was in the house. She was also concerned that if Dave found her in East Yorkshire, then he would kill her. Family reflect that this is due the perpetrator feeling that he hadn't given Rosie "permission" to leave. Everything had to be on his terms and Rosie feared for her life and for risks to her family.

[57] *Domestic Abuse Act 2021,* c. 17. Available at: https://www.legislation.gov.uk/ukpga/2021/17/contents (Accessed: 12 April 2024).
[57a] IFAS (2024) VKPP Year 3 report. IFAS Response. Available at: https://ifas.org.uk/vkpp-year-3-reportifas-response/. Accessed 19 09 2024)

15.74 Information was provided to South Yorkshire Police that Dave had found the street where Rosie was now living. This information was also provided to Humberside Police. The accompanying risk assessment by Humberside Police was deemed as standard due to Dave living in Rotherham despite information stating he knew where Rosie lived, and that Rosie had been subjected to highrisk behaviours in the past. Target hardening measures had been put in place.

15.75 Several days later Rosie's mother reported to DVAP that Dave had been in contact with Rosie again and this had a detrimental impact on Rosie's mental health. At the end of September 2017, Rosie's mother again informed Humberside Police that she (Rosie's Mum) had been receiving messages from Dave, but they were deemed to be a 'small number of text messages relating to financial issues concerning the separation, that were not offensive or threatening.' It was also determined by Humberside Police that the messages did not constitute a domestic incident as they concerned finances and were between Dave and Rosie's mother. Family state this was between Dave and Rosie and

these messages were so that Dave could call Rosie. These were a large number of texts in a short space of time.

15.76 High risk behaviours are not single incidents, the cumulative effect of such behaviours means they cannot be considered in isolation. The domestic abuse is ever present with the victim and whilst individual incidents occur, the culmination and patterns of behaviours are often overlooked. It is important that cases are considered holistically to ensure appropriate action and assessment is made. Here we can see the evidence of how the perpetrator has attempted to manipulate and control both professionals and the victim's family in order to continue his campaign of terror on Rosie.

15.77 • **Vulnerable adult – Adult at Risk**

15.78 Rosie was identified as a 'vulnerable adult'. This terminology has been replaced by 'Adult at Risk' in the Care Act 2014 and includes persons who are unable to protect themselves from either the risk of, or the experience of abuse or neglect. This was reported formally on two separate occasions by Humberside Police and the Yorkshire Ambulance service, and frequently by family. Whilst the East Riding Adult Services did receive the referrals and did consult with other agencies, it is unclear what direct action and/or intervention they undertook.

This should have been followed up by the agency and referrer to ensure that the seriousness was acknowledged and followed up family reflect. Professional curiosity also helps remove barriers that organisations and agencies place in the way of making the necessary steps to reduce risk and respond to referrals for vulnerable adults at risk.

15.79 The purpose of highlighting a 'vulnerable adult' in such circumstances would indicate that the individual has some vulnerability that needs support and/or addressing. It is acknowledged that Rosie was receiving support through East Riding Partnership Addictions Service, yet there does not appear to be any further activity to address Rosie's vulnerability.

Rosie also had an inability to do everyday activities of living, including caring for herself, personal hygiene, diet, shopping, getting out, medication, in addition to many more; which again adds to the picture of Rosie's vulnerability family reflect.

15.80 An element of Rosie's vulnerability stemmed from her dyslexia. In one appointment with IAPT, Rosie explained that she found it difficult to understand letters that had been sent. Whilst it is important that agencies contact and provide information to individuals there should be a rationale and consideration of the wider implications for that person. For someone suffering

dyslexia and having difficulty understanding, the abuser could be the only person able to read the letters and therefore compromising the

safety of the individual. Conversely, not sending a letter could be equally harmful because the individual may have someone they can trust who can convey the content. Had agencies had greater awareness, they may have considered different approaches to communication and /or had a better understanding of the challenges Rosie faced.

15.81 **Anxiety and depression – expectations**

15.82 Rosie's anxiety and depression was discussed within most meetings and appointments. Her anxiety and depression was ever present in her life, to the point of debilitation, which should have been recognised and better responded to. Rosie explained that the use of alcohol was one mechanism to control her anxiety, albeit treating her anxiety when she was consuming alcohol was always going to be a challenge.

Family reflect how no formal assessment of anxiety and depression was completed, which would make it unable to assess whether Rosie was escalating or improving in relation to her anxiety and depression. This needs understanding of anxiety and depression from all professionals and the impact on mental wellbeing and the high risk of suicide. This has been included as a recommendation in addition to professional understanding of the reality of living life with such debilitating anxiety and depression.

15.83 Rosie explained that she avoided people, phone calls, or leaving the house. She was unable to use public transport. Her anxiety increased with the thought that Dave knew where she lived.

15.84 Whilst agencies were aware of the anxiety, there was an expectation that Rosie would be able to attend appointments. On some occasions she was supported and home visits undertaken, East Riding Partnership Addictions Service and

DVAP are two services that did this, although family reflect that this would be at a limited amount of time due to Rosie's anxiety. All agencies should consider their policies and processes to take account of the vulnerabilities of individuals and recognise the challenges they may have.

15.85 • **Missed opportunities**

** it should be noted that the following section is an amalgam of agency relevant missed opportunities highlighted within the report, rather than highlighting and addressing every identified missed opportunity.

A missed opportunity does not indicate an opportunity to prevent Rosie being a victim of domestic abuse, it includes those opportunities to engage with Rosie to have a better understanding of the issues she was facing, whilst providing greater levels of knowledge for the relevant agency and thus, opportunities for them to respond.

15.86 There are several missed opportunities highlighted throughout the review. The GP visit in November 2015 is an example when Rosie attended with a deep laceration to her head. During a further visit Rosie explained she had low mood and she had resumed drinking, there was no exploration of the reasons. Rosie attended the GP again and explained she was escaping domestic violence and there was no enquiry at this time.

15.87 Humberside Police, having submitted a vulnerable adult form, on another occasion with a different officer no form was submitted and yet there was clear indication of Rosie's vulnerability identifying her mental health issues and being exploited by bogus traders. Rosie's family also reflect here how one Officer asked for Rosie's Mum to sign the statement as she did not have capacity, yet a vulnerable adult form was not completed. Recommendation included in the report regarding reviewing all agencies response to mental capacity assessment at the family's request.

15.88 East Riding Adult Services did not communicate the information that she had been contacting Dave at the time of her detox. This would have been useful for DVAP who were supporting Rosie at that time. The thoughts of suicide and 'jumping off the Humber Bridge' disclosed to East Riding Adult Services were not shared with anyone, neither was Rosie cutting her wrists.

15.89 Hull and East Yorkshire Mind did not share their concerns of the 'risk regarding potential development of relationship with ex-partner who has previously been physically abusive' with any other agencies, nor did they carry out any form of risk assessment. On another appointment Rosie disclosed that she had met with her ex-partner earlier in the day to walk the dog.

15.90 Whilst these missed opportunities are isolated incidents, collectively they show a need to share information widely relating to victims of abuse. MARAC is a useful service when the victim becomes high risk and providing all agencies are represented. However, given the number of victims in MARAC represents a small percentage of victim's overall, consideration should be made of how to share information more widely within the constraints of GDPR and other legislations**.**

15.91 • **Agency response and sharing of information**

15.92 In July 2017, Rosie attended the GP and explained that she was 'having trouble with domestic violence' that she was moving out and needed a medical certificate. This is a direct indication of domestic abuse. She was also leaving the relationship; this should have triggered further enquiries especially given the recognition of separation increasing risk, now reflected in the Domestic Abuse Act 2021 [51] . There were no discussions, no risk assessment, and no consideration of the sharing of information, albeit a MARAC had already taken

[51] *Domestic Abuse Act 2021,* c. 17. Available at: https://www.legislation.gov.uk/ukpga/2021/17/contents (Accessed: 12 April 2024).

place. There is nothing in the GP records that indicate Rosie had been subject of a MARAC.

15.93 **Counter Allegations and Perpetrator Manipulation** - Rotherham Children and Young People's Service were involved with Dave's son due to the domestic incident, it is recorded that there was an incident of domestic abuse where Dave assaulted Rosie. It is also recorded that Rosie was alcohol dependant, using amphetamines, working as an escort and perpetrating domestic abuse towards Dave. Some of this information is correct, but there is nothing to suggest she was perpetrating domestic abuse towards Dave, nor was she working as an escort. This information was not cross referenced and as such was inaccurate. Dave indeed was making false allegations, which is a typical perpetrator tactic deployed, and Children's Services should be more aware of perpetrator typologies in order to protect children, victims and families. Children are now victims of domestic abuse in their own right in the Domestic Abuse Act definition of domestic abuse 2021, therefore this is a significant responsibility for Children's Services to respond to.

More recognition should be given to current and historic family dynamics and experiences of abuse. Perpetrator behaviours to their own families, and where there is estranged contact and experiences of perpetrating abuse with their own families which Rosie's family state was the case with Dave. Family genealogies should be prioritised within assessments including for the perpetrator family and this is included as a recommendation to be explored.

15.94 During a visit to East Riding Adults Social Services, Rosie explained she had previously thought about 'jumping off the Humber Bridge' this was when she found out that Dave had identified where she lived and was coming along to 'pick the dog up'. This information was not contained in the chronology for the review provided as part of the DHR process but was in the unedited notes.

This detail in the records is significant and should have been included and was a missed opportunity for the agency to respond to and further protect Rosie. This was a vital opportunity to share information to protect victims and reduce risk. Recommendation to ensure that professional's share information when victims disclose thoughts of suicide. This should be shared with the identified lead professional in the multi-agency meeting. Recommendation to consider coordination, multi-agency approach and lead professionals in medium and high risk domestic abuse cases where there a multi professionals involved.

16 Recommendations

East Riding Community Safety Partnership

- To ensure domestic abuse training and education captures the impact of domestic abuse within the context of suicide and the learning from this DHR. Specifically in the following areas: ○ Impact of alcohol and the use by victims as a result of domestic abuse or a causation of domestic abuse.
    - Coercive control using animals.
    - The cumulative impact of coercive control and how all incidences should not be viewed in isolation – holistic approach is needed
    - Gaslighting, perpetrator victim blaming and the impact of the 'omnipresence' and the use of technology to continue to abuse by the perpetrator.
    - How isolation, financial issues, substance abuse, depression, and the perception of a lack of control by victims contributes to the increased risk of suicide.

- Training and understanding on PTSD following impact of domestic abuse, torture, and strangulation.
- How professionals should develop confidence to always ask the question do you feel suicidal when high risk domestic abuse is identified
- Financial and Economic Abuse and how to support victims – this must include the barriers for victims and survivors in seeking help and support included in financial and economic abuse, and barriers to accessing financial support for this including legal aid, and those who cannot access legal aid
- Impact of isolation and agrophobia linked to anxiety and risk of suicide – due to the domestic abuse
- Stalking and harassment understanding, awareness and agency response for all agencies. ○ Homicide Timeline training.
- NFS implementation and response
- Understanding of addiction and domestic abuse and how addiction and domestic abuse should considered together as a cyclical issue which impacts on each other.
- the reality of living life with debilitating anxiety and depression, alongside domestic abuse

- To ensure all agencies are aware of the complexity of coercive and controlling behaviours, being able to recognise their impact on victims.

- To review MARAC information sharing and ensure all appropriate agencies are informed of any appropriate outcomes and ensure that minutes and actions are shared with all agencies not just those attending. To review archive procedure to ensure that MARAC cases are not archived early when they may be a repeat risk of domestic

abuse. To ensure that MARAC cases are transferred out of area and that processes are in place to accept MARAC transfers from other areas.

- To undertake a thorough review on MARAC and its effectiveness including:
    - The time given for high complex cases to assess and discuss
    - Archiving of cases without re assessment and when there is interaction in a new setting
    - Training on how and who can refer in ○ Information Sharing
    - Safety Plans and action / objectives whether victim engaged or not
    - Identification of a lead professional in each case to enable true multi-agency working
    - Attendance of all professionals including Health and GPs ○ Impact of family members and others at risk due to the perpetrator
    - Action planning when victims' location becomes known by the perpetrator
- To ensure professionals awareness and understanding of the risks of technology in continued abuse, and how physical separation does not reduce MARAC threshold or risk. To ensure processes are in place which support professionals in risk assessments in the consideration of technology and abuse regardless of physical or geographical separation, especially considering the links with domestic abuse and suicidality.
- To review risk assessment processes, and training for risk assessments, ensuring all professionals and agencies are aware of the role and importance of professional curiosity and judgement; the role of technology in continuation of abuse despite separation; perpetrator victim blaming; and victim disclosure of fear of life – victims should be believed first. Family genealogies should be prioritised within

assessments including for the perpetrator, to further understand the perpetrator and the family dynamics and history of abuse.

- To consider coordination, multi-agency approach and lead professionals in medium and high risk domestic abuse cases where there a multi professionals involved.
- The CSP to engage with the Yorkshire and Humber Ambulance Service to review their pathways and responses for responding to and identifying victims of abuse including signposting to support, and particularly when victims are expressing suicidal thoughts. Consideration to be given to trained professionals in the ambulance services specialising in domestic abuse and suicide
- IMR and Chronology, and Panel member training for all those involved in DARDR's in the East Riding. This should include training on how panel members and agencies challenge their own professional practice and other agencies, to ensure that gaps are identified and improvements made.
- To explore a representative reflecting the voice of families is in attendance at DHR panel meetings, for example a survivor or an independent expert in domestic abuse or trauma.
- To ensure a person centred, supportive and compassionate engagement with families engaged in domestic abuse related death reviews in the future including letters of condolence and support through the process.
- To undertake a review on sleep deprivation and the links with domestic abuse and suicide, and for training to be provided to all professionals on this.
- CSP to ensure both local authorities have robust safety planning around sexual violence and IDVA support, which includes this and signposting to sexual assault referral centres.
- For the CSP's of both local authorities to ensure Homicide Timeline training including in both areas of this review.

- CSP to consider how to ensure awareness advice or support is provided to families regarding the DHR process and securing an Article 2, and how professionals can be more aware and understand about both of these processes
- CSP to ensure processes are in place to support victims remaining in their own homes and areas where possible and safe, and that perpetrators are held accountable including the perpetrator having to leave the area rather than the victim.
- Multi-agency understanding of the whole picture and the victim as a whole person and the impact of all the abuse on the victim in its entirety.

All agencies

- To ensure information sharing is embedded in practice to ensure all information relating to domestic abuse victims and perpetrators is appropriately shared within the East Riding wide partnerships. To ensure that relevant and wider context is shared to inform understanding of risk.
- To view domestic abuse using a holistic approach and the cumulative impact and effect of events and not as isolated incidents. To consider processes to support the sharing of information to facilitate this (within and outside of MARAC) For example, Professional's meetings when concerns are raised or made aware of.

- Greater understanding and awareness of the impact of dyslexia / mild learning disabilities within communications with victims. Agencies should address this in their referral process, for example easy read

material, educational level assessments and ability, and creative engagement should be considered by all agencies.

- Learning from non-interaction, non-attendance or responses from calls or letters. All agencies to consider professional curiosity as to why non response or attendance in cases of domestic abuse and to explore continued engagement including safe and creative ways to engage

- All Agencies to review contact methods that support engagement with victims and survivors of domestic abuse, including reviewing the use of withheld numbers or means of contact around this.

- To consider accessibility to their services that allow all service users equal access.

- The role of third party reporting for incidents of domestic abuse.

- To ensure all agencies have processes in place to respond to Non-fatal Strangulation, which is now identified as a criminal offence in the Domestic Abuse Act 2021. , and the high risk of suicide associated with this

- For all Agencies to review pathways and processes, including assessment tools for assessing risk of suicide, anxiety and depression, and mental health; and ensure that pathways are in place to respond to this. To implement an audit process to ensure the protocols are followed and that referrals for support or completed if victims are identified at risk

- All agencies to review their Mental Capacity Act response in terms of ensuring assessments of capacity takes place under the guidance in the Act and how this specifically impacts on victims of domestic abuse
- For all agencies to ensure HR policies are in place that support staff around domestic abuse, including support for managers in understanding, recognising and signposting to support for staff in their appraisals, supervision, and performance reviews.

- To ensure record keeping which promotes information sharing and awareness of risk, including documenting perpetrators name and details, incidents and injuries to the victim that would aid further information sharing and understanding of risk

- Recommendation to ensure all agencies make families aware of the Domestic Homicide Review Process and that all agencies understand what this is.
- All agencies to understand the importance of supporting the victim with prosecution, with evidence gathering and collating information and how important this is to support a victim with a prosecution which can further prevent future risk.

East Riding CCG

- To ensure all GPs are aware of the need to routinely enquire about domestic abuse and the actions necessary regarding any disclosures.
- Consider providing treatments for multi diagnosis presentations, particularly in relation to mental health, domestic abuse, and substance / alcohol misuse.
- Ensure all Health trusts including primary care have accurate recording keeping and recording when there is a risk of suicide, and that referral pathways are in place for support
- To ensure all trusts have training on domestic abuse related suicide, the risks, and how this can be prevented
- To review pathways and referrals to mental health and crisis support / teams when risk of suicide is identified

Rotherham CCG

To ensure all GPs are aware of the need to routinely enquire about

- domestic abuse and the actions necessary regarding any disclosures.
- Consider providing treatments for multi diagnosis presentations.
- Ensure all GPs share information about risk of domestic abuse including training about the role of GPS in MARAC
- Ensure all Health trusts including primary care have accurate recording keeping and recording when there is a risk of suicide, and that referral pathways are in place for support
- To ensure all trusts have training on domestic abuse related suicide, the risks, and how this can be prevented
- To review pathways and referrals to mental health and crisis support / teams when risk of suicide is identified

Humberside Police

- To ensure consistency for completion of vulnerable adult (Adult at Risk) referrals.
- To ensure effective understanding and responses to domestic violence and abuse, particularly for investigations, prosecutions, and front line police response; and that information sharing, DA Matters training, and risk assessment is prioritised.
- To improve awareness amongst the public and professionals of the Domestic Violence Disclosure Scheme (Clare's Law), and the police response in implementing applications that promote safety and reduce risk.
- To ensure understanding and implementation of children's safeguarding in cases of domestic abuse to protect any children who are at risk due to the abuse

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Rotherham Drug and Alcohol Services

To ensure communications with service users is appropriate and recognises their individual needs and requirements.

Hull and East Yorkshire Mind

- To review their policy on risk assessments and to ensure appropriate information relating to domestic abuse is recorded within expected national best practice, including the use of the DASH risk assessment.

- Greater awareness of the high-risk factors associated with domestic abuse.

- To ensure all and any information relating to clients and domestic abuse is appropriately shared where necessary to relevant agencies.

East Riding Domestic Violence and Abuse Partnership

- To ensure that all information provided by victims is considered and shared where necessary, including financial abuse.

- To ensure communications with service users is appropriate and recognises their individual needs and requirements.
- For DVAP to review support over holiday periods and that there are plans in place for when individual support workers go on leave for long periods of time

Rotherham and East Riding Children and Young People's Service

- The importance of accurate recording of information and professional curiosity.

- To increase understanding of domestic violence and abuse and of perpetrator typologies and behaviours, including counter allegations.
- To ensure appropriate risk assessed responses to this for both victim and perpetrator that ensures safety of both victim and child(ren).

Ensure safeguarding policy protects children at risk in domestic abuse incidents working jointly with the police

East Riding Adult Services

- To ensure all and any information relating to clients and domestic abuse is appropriately shared where necessary to relevant agencies.
- To ensure appropriate action is taken when "vulnerable adult" / "adult at risk" forms are submitted in relation to individuals experiencing or at risk of domestic abuse.
- Establish relevant protocols / process in ERSAB safeguarding procedures to ensure this action takes place and staff are aware and trained.

Appendix A

Domestic Homicide Review Family Engagement

Addendum

This addendum seeks to outline the engagement challenges Rosie's family experienced and the learning as a result of these experiences that we as a Community Safety Partnership, and the Author, will endeavour to uphold, following this DHR.

Challenges and Concerns from a Community Safety Partnership perspective

- This was the first DHR for the East Riding. Following the Author's commissioning process, the family were not engaged in the development of the Terms of Reference in the initial panel meeting, identifying areas to explore and questions to consider for the review. This review (both Community Safety Partnership and Author) identifies that

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future reviews will take this into consideration and ensure that Family Engagement is completed at the beginning of the initiation of a DHR and throughout the whole process.

- The Community Safety Partnership / Author also notes that a leaflet on DHR's was not given to the family although the family were written to by the Community Safety

Partnership. The Author notes that the Family was engaged with AAFDA however this did not take place until after the DHR was initiated, and was engaged with by research by family rather than being offered to the Family. Future reviews will ensure a leaflet on DHRs will be given to families at the initiation of the review. Rosie's family also reflect that no support was offered with the process despite this grieving time.

- Family engagement was sought for the final draft of the report; however, due to the inquest taking place; delays were experienced in making amendments to the final draft for it to be completed by the time the inquest was taking place. This made the final draft unacceptable to the family and the amendments they requested not completed. Family also reflect that the amendments requested by them to the Chair took place before the inquest however this was not shared with the Panel or the CSP.

  • Family considered recommissioning the review, which the Community Safety Partnership explored and agreed to; however, the final decision was made by the Family via their solicitor to continue with the original DHR to enable to process to be completed for the family's sake, and the inquest to continue without any delay from the DHR. Rosie's family state they felt blackmailed as if they did not agree to the DHR they were not able to refer to it in the inquest. The inquest proceeding was more important for the family's mental health and wellbeing and for closure rather than having an inadequate DHR. "There is a difference to agreeing, than having no choice".

  • The final report was, therefore, sent to the Home Office for their comments at the Quality Assurance Panel, and a complex exchange and return of amendments have since taken place to help the report achieve publishable standard.

- Significant delays were experienced in this process between 2022 and 2024 due to Home Office delays in the Quality Assurance Panel hearing DHR report drafts, (at 12 months sometimes), and liaison between the Community Safety Partnership and the Author to agree the final draft standard. Vacancies were also experienced in the Local Authority with appropriate Community Safety Partnership Managers and Officers.
- Both Home Office and Author agreed for the Community Safety Partnership to make alterations and amendments at the final stage, including this addendum, to enable the report to be published.
- Final draft at this stage and this addendum has been shared with the family and the comments are detailed below:

Challenges and Concerns from Rosie's Family Perspective

- Although they attended one panel meeting, Rosie's family felt that they should have been able to attend more and that their involvement in the review was not as positive and inclusive as was needed. Rosie's family felt that they needed to instigate and chase contact rather than being invited and that their views and wishes regarding the report were not taken into account or reflected fully into the report. Family should be able to fully participate in reviews and the panel meetings. They also feel that families should be updated about progress on action plans and that Community Safety Partnerships should ensure this takes place.
- "Rosie's voice is not heard in this report, I believe I was the only link between Rosie and professionals. Good practice would be to have an independent person on the panel who had direct insight into domestic abuse, this will help to get the victims voice heard and give the panel a better understanding of the impact of domestic abuse. Who would understand that fear, the pain, repeated trauma? Also, a psychologist on the panel or even just asked for their input to give understanding of the trauma, posttraumatic stress. The review does not reflect the victim".
- Rosie's family shared concerns about the time taken to complete the review and the recommendations and impact from learning on the system being lost / outdated.
- The review did not take into account engagement with the Crisis team, the Acute Hospital Trusts from Hull and Rotherham, Ambulance Service, and finally the Residential Detox Woodlands in Nottingham, which family stated Rosie received very poor treatment from and was shut down soon after she attended.
- There is no mention of A&E attendance in the report for attempted suicide and selfharm. Rosie informed she had fled domestic abuse and was alcohol dependent however there was no referral to the Crisis Team the family states, or back into MARAC. It was reported as accidental, but how can anyone cut both wrists accidentally?
- No one spoke about how brave and strong Rosie was for fleeing to an entirely new area where she did not know anyone, the streets, places, transport and leaving her own home, when in constant worry about the threat from the perpetrator. This was a massive step for Rosie and no one gave her the credit and well done that they could have for this, we are incredibly proud of her strength for bravery for doing this.
- Rosie's family expressed deep concerns with the poor quality of reporting in the IMR's and chronologies and lack of information sharing which should be a learning outcome itself. Why was this not challenged by the review panel itself? Family request a

recommendation for IMR and Chronology and Panel member training for all those involved in DARDR's in the East Riding.

- Rosie's family were concerned that nowhere in the report details about an assessment relating to her anxiety and depression, although it frequently mentions Rosie's anxiety and depression. This has been included as a recommendation at the family's request.
- No report from Acute trust regarding attendance at Accident and Emergency where Rosie had cut her wrists, and another occasion where Dave pushed her down the stairs and Rosie was unable to walk properly for 5 weeks.
- No professionals took responsibility or showed care or consideration for Rosie's general health including her dental health, no one had a thought about her holistic health and wellbeing.
- Rosie's neurodiversity and her special needs was not taken into consideration at all by anyone.
- No mention on the importance of the impact of sleep deprivation on Rosie and this was requested to be added to the report to the Author but was not included.
- The information is detailed below. Family request a review on sleep deprivation and the links with domestic abuse and suicide, and that training should be provided to all professionals on this.

SLEEP DEPRIVATION

Rosie had chronic insomnia, and sleep is essential for good mental health. No agencies fully acknowledged the level of sleep deprivation due to the impact of domestic abuse and coercive control. Rosie was honest with her GP and advised that she had been using sleep medication which she was unable to obtain since fleeing domestic abuse. Rosie's GP advised it was another addiction but this could have been better managed with a planned and supported reduction.

Rosie also advised her alcohol worker about this who agreed it was another addiction but no plan of support was given about this. Rosie's MIND worker gave a session on sleep, which included 50% from Rosie's personal experiences and 50% information from a sheet, and Rosie was not asked how she was sleeping personally.

Prior to detox, Rosie would say that she would drink until she was unconscious, as this was the only way she would get some sleep and stop her recurrent nightmares following the domestic abuse. Rosie would avoid sleep to prevent nightmares. Rosie would wake up screaming.

When Rosie was in detox, she was given night sedation and this was stopped when discharged.

Sleep deprivation made it difficult for Rosie to attend appointments. She would be exhausted, physically, mentally and emotionally, and this would compromise her decision making and memory.

Rosie would eat excessively day and night and I believe this is due to sleep deprivation and levels of hormones leptin and ghrelin. I informed all professionals of this.

The evidence is clear that the long term effects of sleep deprivation drains your mental abilities and puts your physical health at risk. Chronic sleep deprivation escalates the effects on mood and can increase anxiety and depression.

Rosie was in a repeated cycle, would worry about forthcoming events, fear for her life which would make her anxious, and this is the most common cause for sleep deprivation.

Sleep deprivation when continues can cause psychological risks inducing impulsive behaviour and suicidal thoughts.

As a family, we supported Rosie by staying with her. We would indulge her in feet and hand massages. We bought her a new bed and curtains to return from detox to help her get a better sleep pattern. Rosie and I attended several mindfulness sessions, but Rosie had difficulty concentrating due to anxiety and depression of being out of her home environment, and methods used. This included imaging climbing up a mountain, and the perpetrator climbed mountains.

Professionals need to understand better and take sleep deprivation more seriously, due to this impact on physical and mental health.

Appendix B

Domestic Homicide Review

Terms of Reference

Overarching aim

The over-arching intention of this review is to learn lessons from the homicide to change future practice that leads to increased safety for potential and actual victims. It will be conducted in an open and consultative fashion bearing in mind the need to retain confidentiality and not to apportion blame. Agencies will seek to discover what they could do differently in the future and how they can work more effectively with other partners.

Principles of the Review

1. Objective, independent & evidence-based.

2. Guided by humanity, compassion, and empathy with the victim's voice at the heart of the process.

3. Asking questions, to prevent future harm, learn lessons and not blame individuals or organisations.

4. Respecting equality and diversity.

5. Openness and transparency whilst safeguarding confidential information where possible.

Terms of reference

Following review of the guidance and factors for consideration, the following were felt to be applicable.

- To consider whether the incident in which Rosie died was an isolated one or whether there were any warning signs. To also consider whether more could be done to raise awareness of services available to victims of domestic abuse.
- Whether there were any barriers experienced by Rosie or her family and friends in reporting any abuse in East Riding or elsewhere, including whether they knew how to report domestic abuse should they have wanted to?
- Whether there were opportunities for professionals to 'enquire' as to any domestic abuse experienced by Rosie that were missed.
- Whether there were opportunities for agency intervention in relation to domestic abuse regarding Rosie, or other family members that were missed.
- The review should identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services in the area covered by the East Riding Community Safety Partnership.
- The review will also give appropriate consideration to any equality and diversity issues that appear pertinent to Rosie e.g., age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation.

Under the management of the review the panel also considered the following factors:

- How should friends, family members and other support networks and, where appropriate, the perpetrator, contribute to the review and who should be responsible for facilitating their involvement?
- How should matters concerning family and friends, the public and media be managed before, during and after the review and who should take responsibility for it.
- How will the review take account of a coroner's inquiry, and (if relevant) any criminal investigation related to the homicide, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process or compromise to the judicial process?
- Does the review panel need to obtain independent legal advice about any aspect of the proposed review?

- How should the review process take account of previous lessons learned from research and previous DHRs?
- Whether Rosie was 'in need of care' within the auspices of the Care Act 2014
- Whether there were any issues in communication, information sharing or service delivery between services.

Key lines of enquiry

The Review Panel (and by extension, IMR authors) will consider the following:

- Whether the incident in which Rosie died was an isolated one or whether there were any warning signs and whether more could be done to raise awareness of services available to victims of domestic abuse.

- Whether there were any barriers experienced by Rosie or her family and friends in reporting any abuse in East Riding or elsewhere, including whether they knew how to report domestic abuse should they have wanted to?

- Whether there were opportunities for professionals to 'enquire' as to any domestic abuse experienced by Rosie that were missed.

- Whether there were opportunities for agency intervention in relation to domestic abuse regarding Rosie, or other family members that were missed.

- The review should identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services in the area covered by the East Riding Community Safety Partnership.

- The review will also consider any equality and diversity issues that appear pertinent to Rosie e.g., age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

- How should friends, family members and other support networks and, where appropriate, the perpetrator, contribute to the review and who should be responsible for facilitating their involvement?

- How should matters concerning family and friends, the public and media be managed before, during and after the review and who should take responsibility for it.

- How will the review take account of a coroner's inquiry, and (if relevant) any criminal investigation related to the homicide, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process or compromise to the judicial process?

- Does the review panel need to obtain independent legal advice about any aspect of the proposed review?

- How should the review process take account of previous lessons learned from research and previous DHRs?

- Whether Rosie was 'in need of care' within the auspices of the Care Act 2014

- Whether there were any issues in communication, information sharing or service delivery between services.

Key lines of enquiry for the review were identified as:

- To consider and analyse key practice episodes within the timeframes, including services response to friends and family, and sharing of information.

- Should specific issues which arise prior to these timeframes be seen as significant, these should be included.

- To review professionals understanding of risk and whether risks were identified and responded to appropriately in **Rosie's** case.

- Consider the robustness of professionals holding each other to account.

- To review how professionals ensured that **Rosie's** voice was heard.

- Look at whether thresholds were understood and that professionals were working in accordance with statutory guidance and East Riding Safeguarding Adults Board (ERSAB) safeguarding procedures.

- To identify any learning there may be and formulate draft recommendations for future practise.

- To identify any areas of good practise

- To produce an overview report that summarises concisely the relevant chronology of events including the actions of all the involved agencies, analyses, and comments on the appropriateness of actions taken and makes recommendations with the aim of improving safeguarding where domestic violence is a feature.

- Identify, based on the evidence available to the review, whether any intervention and / or omission would have had a significant negative impact that may have affected the eventual outcome, with the purpose of improving policy and procedures in East Riding and perhaps more widely.

- Identify from both the circumstances of this case, and the homicide review processes adopted in relation to it, whether there is learning, which should inform policies and procedures in relation to homicide reviews nationally in future and make this available to the Home Office.

- The Review will exclude consideration of how **Rosie** died or who was culpable - that is a matter for the Coroner and Criminal Courts respectively to determine.

Family involvement and Confidentiality

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

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.

We will identify the timescale and process and ensure that the family are able to respond to this review endeavoring to avoid duplication of effort and without undue pressure. **Disclosure & Confidentiality**

- Confidentiality should be maintained by organisations whilst undertaking their IMR. However, the achievement of confidentiality and transparency must be balanced against the legal requirements surrounding disclosure.

- The independent chair, on receipt of an IMR, may wish to review an organisation's case records and internal reports personally, or meet with review participants.

- Individuals will be granted anonymity within the Overview Report and Executive Summary and will be referred to by pseudonyms.

- Where consent to share information is not forthcoming, agencies should consider whether the information can be disclosed in the public interest.

Timescales

Guidance for Domestic Homicide Reviews states they should be submitted to the Home Office within 6 months of notification. Any delays to this deadline will be communicated to the Home Office.

Media strategy

Any media enquiries during and post publication should be referred to the East Riding Community Safety Partnership who with the Chair will agree a media strategy.

Chairing & Governance

An independent chair has been appointed to lead on all aspects of the review and will report to the chair of the East Riding Community Safety Partnership.

A Panel has been convened specifically to overlook the review process. This is a mix of statutory and voluntary sector agencies and includes specialist domestic violence services.

The East Riding Community Safety Partnership will sign off the final report and submit it to the Home Office Quality Assurance process.

Additionally, representatives from the East Riding area will be invited to participate in the review process and, where appropriate, the findings from the Domestic Homicide Review will be shared with the relevant agencies and / or partnerships in that area,

Agency roles and responsibilities

- Delegate a senior officer to lead on the review on behalf of their organisation
- Senior officers will attend all Panel meetings
- Complete Individual Management Reviews within agreed timeframes
- Contribute to the Review Report

Information Sharing & Confidentiality

The principles outlined in East Riding Community Safety Partnership Information Sharing Guidance will be applied at all times. In addition to this, further reference will be made to the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews.

Appendix C

Domestic Homicide Review

Further Information about the Chair and Report Author

Tony Blockley is a highly experienced consultant within the field of homicide reviews. Throughout his extensive career he has both investigated and been responsible for homicide reviews, including domestic homicides. As Chief Superintendent and Head of Crime for a UK police force, he was chair of Multi Agency Public Protection Arrangements (MAPPA) and was responsible for the management and operation of public protection units including all forms of abuse, child, and adults.

Since completing over 30 years of policing practice he was a consultant in Northern Ireland supporting and engaging with families bereaved because of 'The Troubles'. This involved reviewing historic and significant incidents involving the death of a person in the military or by the military. This was a particularly sensitive role, politicised throughout the province. He has been involved in numerous other homicide reviews throughout the UK and abroad,

Tony chaired the independent panel responsible for the introduction of Clare's Law and the Domestic Violence Protection Notice and Orders within Derbyshire. He was also responsible for the implementation of the 1st perpetrator programme within Derbyshire and a member on the board at a Domestic Violence and Abuse charity.

Having been involved in around 60 Domestic Homicide Reviews he has a wealth of knowledge and experience managing and reporting reviews, engaging, and supporting families and presenting findings. He is a special advisor to a 3rd sector organisation that provides domestic abuse services (not in the area covered by the East Riding Community Safety Partnership)

At the time of the review, he was a Senior Lecturer in criminology at the University of Derby and now Professor (Policing) and Head of School for Criminology, Investigations and Policing at Leeds Trinity University.

Home Office

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www.homeoffice.gov.uk

Shelley Goodinson
Domestic Abuse and Safeguarding Partnerships Manager
East Riding of Yorkshire
Council County Hall
HU17 9BA

28th January 2025

Dear Shelley,

Thank you for resubmitting the report (Rosie) for East Riding Community Safety Partnership to the Home Office Quality Assurance (QA) Panel. The report was reassessed in December 2024.

The QA Panel felt that there were positive elements to the report, notably the involvement and voice given to Rosie's family. They commended the impactful and compassionate tribute – provided to the panel and included within the report – from Rosie's relatives, which provide a heartfelt and sensitive insight into Rosie as a person. There is also evidence of good practice in including the specific questions asked by Rosie's family.

The QA Panel also commented that there are times when the report makes good use of research, such as that focusing on the links between domestic abuse and suicide, and the impacts on victims of domestic abuse and suicide. The QA Panel noted that most of the issues raised in the previous feedback letter have now been addressed.

The view of the Home Office is that the DHR may now be published.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This

should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel

East Riding
COMMUNITY
SAFETY
PARTNERSHIP

East Riding of Yorkshire Community Safety Partnership

Domestic Homicide Review

Action Plan in Respect of the Death of *Rosie*

Died: December 2018

Independent Chair and Author of Report:

Independent Chair Tony Blockley

Author Tony Blockley AND East Riding Community Safety Partnership

Lead Agency	Scope of recommendation i.e. local or regional	Recommendations	Actions to take	Assigned to:	Key milestones achieved in enacting recommendation	Target Date	Completion Date and Outcome

East Riding Community Safety Partnership	Local	• To ensure domestic abuse training and education captures the impact of domestic abuse within the context of suicide and the learning from this DHR. Specifically in the following areas: ○ Impact of alcohol and the use by victims as a result of domestic abuse or a causation of domestic abuse. ○ Coercive control using animals.	DA Training and Development Officer to review the DA Training offer the ensure it captures the areas in the recommendation The SDAB DA Board to be reported on the review of this	SDAB DA Training and Development Officer		Sept 2025	

Date: *June 2025*

		○ The cumulative impact of coercive control and how all incidences should not be viewed in isolation – holistic approach is needed ○ Gaslighting, perpetrator victim blaming and the impact of the 'omnipresence' and the use of technology to continue to abuse by the perpetrator. ○ How isolation, financial issues, substance abuse, depression, and the perception of a lack of control by victims					

		contributes to the increased risk of suicide. o Training and understanding on PTSD following impact of domestic abuse, torture, and strangulation. o How professionals should develop confidence to always ask the question do you feel suicidal when high risk domestic abuse is identified o Financial and Economic Abuse and how to support victims – this must include the barriers for victims					

		and survivors in seeking help and support included in financial and economic abuse, and barriers to accessing financial support for this including legal aid, and those who cannot access legal aid o Impact of isolation and agrophobia linked to anxiety and risk of suicide – due to the domestic abuse o Stalking and harassment understanding, awareness and agency response for all agencies.					

		○ Homicide Timeline training. ○ NFS implementation and response ○ Understanding of addiction and domestic abuse and how addiction and domestic abuse should considered together as a cyclical issue which impacts on each other. ○ the reality of living life with debilitating anxiety and depression, alongside domestic abuse					

		• To ensure all agencies are aware of the complexity of coercive and controlling behaviours, being able to	DA Training and Development Officer to review the DA Training offer the ensure it captures the	SDAB DA Training and Development Officer		Sept 2025	

		recognise their impact on victims.	learning from this case including the complexity of CCB The SDAB DA Board to be reported on the review of this				

		• To review MARAC information sharing and ensure all appropriate agencies are informed of any appropriate outcomes and ensure that minutes and actions are shared with all agencies not just those attending. To review archive procedure to ensure that MARAC cases are not archived early when they may be a repeat risk of domestic abuse. To ensure that MARAC cases are transferred out of area	MARAC Coordinator to review the information sharing process, sharing of minutes and actions, archive procedure, and MARAC transfer procedure as per the recommendation To report back to the SDAB	MARAC coordinator SDAB		Sept 2025	

		and that processes are in place to accept MARAC transfers from other areas.					

		• To undertake a thorough review on MARAC and its effectiveness including: o The time given for high complex cases to assess and discuss o Archiving of cases without re assessment and when there is interaction in a new setting o Training on how and who can refer in o Information Sharing o Safety Plans and action / objectives whether victim engaged or not	SDAB to exreview full and process timeline	SDAB		April 2026	

		○ Identification of a lead professional in each case to enable true multi-agency working ○ Attendance of all professionals including Health and GPs ○ Impact of family members and others at risk due to the perpetrator ○ Action planning when victims' location becomes known by the perpetrator • To ensure professionals					

		awareness and understanding of the risks of technology in continued abuse, and how physical separation does not		DA Training and Development Officer SDAB			

		reduce MARAC threshold or risk. To ensure processes are					

		in place which support professionals in risk assessments in the consideration of technology and abuse regardless of physical or geographical separation, especially considering the links with domestic abuse and suicidality. To review risk assessment processes, and training for risk assessments, ensuring all professionals and agencies are aware of the role and importance of professional curiosity and judgement; the role of technology in continuation of abuse despite •	DA Training and Development Officer to review the inclusion of separation and technology enabled abuse in the DA Training Offer. To report back to SDAB DA Training and Development Officer in partnership with DVAP to review DASH training to ensure these factors are included and to report back to SDAB	DA Training and Development Officer SDAB DVAP		Sept 2025	

		separation; perpetrator victim blaming; and victim disclosure of fear of life – victims should be believed first. Family genealogies should be prioritised within assessments including for the perpetrator, to further understand the perpetrator and the family dynamics and history of abuse. To consider coordination, multi-agency approach and lead professionals in medium and high risk domestic abuse cases where there a multi professionals involved. The CSP to engage with the Yorkshire and Humber Ambulance Service to review their pathways and responses •	To evaluate training to ensure practitioners understanding SDAB Manager to connect with the	SDAB Manager		Sept 2025	

			Y&H Ambulance service via the NY & Humber ICB and	ICB DA Lead SDAB CSP			

		for responding to and identifying victims of abuse including signposting to support, and particularly when victims are expressing suicidal thoughts. Consideration to be given to trained professionals in the ambulance services specialising in domestic abuse and suicide IMR and Chronology, and Panel member training for all those involved in DARDR's in the East Riding. This should include training on how panel members and agencies challenge their own professional practice and other agencies, to ensure that •	collaboratively review the pathways and responses for identifying and supporting victims of DA. To report back to SDAB and CSP SDAB Manager, CSP Manager and DA Training and Development Officer to review panel member training for DARD''s in the ER and commission an effective programme that can be offered to panel members.	SDAB and CSP Manager, DA Training and Development Officer SDAB CSP CSP Manager /		By report publish date Sept 2025	

				Chair			

		• gaps are identified and improvements made. To explore a representative reflecting the voice of families is in attendance at DHR panel meetings, for example • a survivor or an independent expert in domestic abuse or trauma. To ensure a person centred, supportive and compassionate engagement with families engaged in domestic abuse related death • reviews in the future including letters of condolence and support through the process. To undertake a review on sleep deprivation and the links with domestic abuse and suicide, and for training to be provided to all professionals on this.	To report back to SDAB and CSP CSP Manager to work with CSP Chair to review the process for Family Engagement in future DARDRs – to report back to CSP SDAB Manager and DA Training and Development Officer to commence review and report back to SDAB with recommendations for training for the partnership				

		• CSP to ensure both local authorities have robust safety planning around sexual violence and IDVA support, which includes this and signposting to sexual assault referral centres. • For the CSP's of both local authorities to ensure Homicide Timeline training including in both areas of this review. • CSP to consider how to ensure awareness advice or support is provided to families regarding the DHR process and securing an Article 2, and how professionals can be more aware and understand about both of these processes	CSP Manager	CSP Manager		Sept 2026	

		• CSP to ensure processes are in place to support victims remaining in their own homes and areas where possible and safe, and that perpetrators are held accountable including the perpetrator having to leave the area rather than the victim. • Multi-agency understanding of the whole picture and the victim as a whole person and the impact of all the abuse on the victim in its entirety.					
All Agencies	Regional	To ensure information sharing is embedded in practice to ensure all information relating to domestic abuse victims and perpetrators is appropriately shared within the East Riding whole partnership. To ensure that relevant and wider context is	SDAB Manager to review multiagency arrangements for medium and high risk DA cases and report back to the SDAB with options to ensure	SDAB Manager SDAB		Sept 2026	

		risk. ed to inform understanding of	processes are in place as above recommendation, and that processes are in place to ensure wider contexts are shared in these forums that protect victims				
		• To view domestic abuse using a holistic approach and the cumulative impact and effect of events and not as isolated incidents. To consider processes to support the sharing of information to facilitate this (within and outside of MARAC) For example, Professional's meetings when concerns are raised or made aware of.	As above include with above recommendation regarding information sharing and reporting back to SDAB	As above include with above recommendation regarding information sharing and reporting back to SDAB		As above include with above recommendation regarding information sharing and reporting back to SDAB	

		• Greater understanding and awareness of the impact of dyslexia / mild learning disabilities within communications with victims. Agencies should address this in their referral process, for example easy read material, educational level assessments and ability, and creative engagement should be considered by all agencies.	DA Training and Development Officer to ensure that the awareness and understanding of LD is embedded within the DA Training Offer. SDAB to ensure all agencies review their communication methods with victims – particularly DA services, to ensure that easy read material is available, and that assessments consider education ability	DA Training and Development Officer SDAB Manager SDAB		March 2026	
		• To consider accessibility to their services that allow all service users equal access. • Learning from non-interaction, non-attendance or responses from calls or	SDAB to review all agencies accessibility of services	SDAB Manager to ensure on agenda and review in 6 months		Sept 25	

		letters. All agencies to consider professional curiosity as to why non response or attendance in cases of domestic abuse and to explore continued engagement including safe and creative ways to engage • All Agencies to review contact methods that support engagement with victims and survivors of domestic abuse, including reviewing the use of withheld numbers or means of contact around this.					

		• The role of third party reporting for incidents of domestic abuse.	SDAB Manager and DA Training and Development Officer to review and provide update to SDAB.	SDAB Manager and DA Training and Development Officer		By March 2026	

			SDAB to implement recommendations dependant on review				
		• To ensure all agencies have processes in place to respond to Non-fatal Strangulation, which is now identified as a criminal offence in the Domestic Abuse Act 2021 , and the high risk of suicide associated with this	ICB to lead on Task and Finish group to ensure responses are in place across all agencies. Report back to SDAB with outcomes from Task and Finish Group	ICB DA Lead		Sept 2025	

		• For all Agencies to review pathways and processes, including assessment tools for assessing risk of suicide, depression, anxiety and depression and mental health, and ensure that pathways are	SDAB to initiate review from all agencies – to take place in the DA Operational Sub Group. SDAB Manager to report back on	SDAB Manager DA Op sub group		March 2026	

		• in place to respond to this. To implement an audit process to ensure the protocols are followed and that referrals for support or completed if victims are identified at risk • All agencies to review their Mental Capacity Act response in terms of ensuring assessments of capacity takes place under the guidance in the Act and how this specifically impacts on victims of domestic abuse For all agencies to ensure HR policies are in place that support staff around domestic abuse, including support for managers in understanding, recognising and signposting to support for staff in their	findings and recommendations to SDAB. SDAB to ensure pathways are in place to respond to this in all agencies As per previous action to review communication methods (SDAB Manager to ensure in place and report back to SDAB) DA Training and Development Officer to ensure this is included in the DA Training offer in the ER – to report back to SDAB	SDAB Manager SDAB Manager DA Training and Development Officer SDAB Manager		Sept 2025 March 2026	

			SDAB Manager to initiate review and report back to	DA Training and Development Officer		Sept 2025	

		• appraisals, supervision, and performance reviews. To ensure record keeping which promotes information sharing and awareness of risk, including documenting perpetrators name and details, incidents and injuries to the victim that would aid • further information sharing and understanding of risk Recommendation to ensure all agencies make families aware of the Domestic Homicide Review Process and • that all agencies understand what this is. All agencies to understand the importance of supporting the victim with prosecution, with evidence gathering and	SDAB. DA Training and Development Officer to identify MCA Training offer for the partnership DA Training and development officer to ensure in place in DA Training offer and all agencies to review this in their own assessments – to report back to SDAB SDAB Manager to review across all agencies and ensure in place via the DA Sub Group – to report back to SDAB	DA Training and Development Officer SDAB SDAB Manager DA Sub SDAB		March 2026 Sept 2025	

		collating information and how important this is to support a victim with a prosecution which can further prevent future risk.	DA Training and Development Officer to ensure in place in DA Training Offer	DA Training and Development Officer			
East Riding & Rotherham CCG – now Yorkshire & Humber ICB (integrated Care Board, and South Yorkshire	Regional	To ensure all GPs are aware of the need to routinely enquire about domestic abuse and the actions necessary regarding any disclosures.	ICB DA Leads to review the use of routine enquiry in Primary Care in their respective areas and report back to the SDAB for any areas of progress / improvement required	ICB DA Leads SDAB		Sept 2025	

ICB)	Regional	Consider providing treatments for multi diagnosis presentations, particularly in relation to mental health, domestic abuse, and substance / alcohol misuse.	ICB DA leads to review the current offer / pathway and provide recommendations to the SDAB and CSP to improve this offer	ICB DA Leads SDAB CSP		Sept 2025	

		• Ensure all GPs share information about risk of domestic abuse including training about the role of GPS in MARAC • Ensure all Health trusts including primary care have accurate recording keeping and recording when there is a risk of suicide, and that referral pathways are in place for support • To ensure all trusts have training on domestic abuse related suicide, the risks, and how this can be prevented					

		• To review pathways and referrals to mental health and crisis support / teams when risk of suicide is identified					

Humberside Police	Local	• To ensure consistency for completion of vulnerable adult (Adult at Risk) referrals. • To ensure effective understanding and responses to domestic violence and abuse, particularly for investigations, prosecutions, and front line police response; and that information sharing, DA Matters training, and risk assessment is prioritised. • To improve awareness amongst the public and professionals of the Domestic Violence Disclosure Scheme (Clare's Law), and the police response in implementing applications that promote safety and reduce risk.	DA Lead in Humberside Police to audit the completion of Adult at Risk Vulnerable adult referrals and report back to the SDAB with areas for improvement DA lead to provide a report to the SDAB on the Forces response to DA Training, Front Line responses and investigations and prosecution with the CPS. To provide recommendations to Board on areas for improvement following this HP DA lead to work with the	DA Lead HP SDAB DA Lead HP SDAB		Sept 2025 March 2026	

			partnership to raise awareness	DA Lead HP			

		• To ensure understanding and implementation of children's safeguarding in cases of domestic abuse to protect any children who are at risk due to the abuse	of DVDS and to review the support to victims in response to this with relevant agencies in the partnership. Report back to the SDAB	SDAB		Sept 2025	
Rotherham Drug and Alcohol Services	Regional	• To ensure communications with service users is appropriate and recognises their individual needs and requirements.	DA lead to review the communication pathways for their service and report back to their CSP with areas for improvement	DA Lead Rotherham area CSP		Sept 2025	

Hull & East Yorkshire MIND	Local	• To review their policy on risk assessments and to ensure appropriate information relating to domestic abuse is recorded within expected national best practice, including the use of the DASH risk assessment. • Greater awareness of the high-risk factors associated with domestic abuse. • To ensure all and any information relating to clients and domestic abuse is appropriately shared where necessary to relevant agencies.	SDAB Manager and DA Training and Development Officer to work with HEY MIND Directors in implementing DA Training and DASH risk assessment training, and appropriate protocols and pathways including recording and reporting following this – to report back to SDAB on progress	SDAB Manager DA Training and Development Officer HEY MIND Directors		Sept 2025	

East Riding Domestic Violence and Abuse Partnership	Local	• To ensure that all information provided by victims is considered and shared where necessary, including financial abuse. • To ensure communications with service users is appropriate and recognises their individual needs and requirements. • For DVAP to review support over holiday periods and that there are plans in place for when individual support workers go on leave for long periods of time	DVAP Principle to audit cases to ensure that IDVA's are recording and sharing information appropriate relating to all areas of abuse and that safety planning and supportive responses are in line with good practice. To review communication pathways to ensure they meet the needs of clients within the service for all areas of diverse need To review support over holiday period and resiliency	DVAP Principle SDAB		Sept 2025	

			amongst the workforce for				

			leave and absence to ensure continued support for victims and clients. To report back on all the above to SDAB				

Rotherham and East Riding Children's Services	Regional	• The importance of accurate recording of information and professional curiosity. • To increase understanding of domestic violence and abuse and of perpetrator typologies and behaviours, including counter allegations. • To ensure appropriate risk assessed responses to this for both victim and perpetrator that ensures safety of both victim and child(ren). • Ensure safeguarding policy protects children at risk in domestic abuse incidents working jointly with the police	DA Leads in Rotherham and East Riding Childrens Services to audit cases to review information sharing, recording of cases that promote safety and reducing risk and understanding of domestic abuse by all professionals in their service working with victims and families. To review risk assessment training and responses and ensure that appropriate training is in place to facilitate the continued	DA Leads in both East Riding and Rotherham Childrens Services		Sept 2025	

			practice that promotes safety and reducing in risk				

East Riding Adult Services	Local	• To ensure all and any information relating to clients and domestic abuse is appropriately shared where necessary to relevant agencies. • To ensure appropriate action is taken when "vulnerable adult" / "adult at risk" forms are submitted in relation to individuals experiencing or at risk of domestic abuse. Establish relevant protocols / process in ERSAB • safeguarding procedures to ensure this action takes place and staff are aware and trained.	DA Lead in Adults Services to review information sharing in DA cases and ensure all professionals in Adults Services working with victims and families attend the partnership DA training offer. To review the responses to vulnerable adult at risk referral forms for adults experiencing domestic abuse and report back to the SDAB on outcomes and recommendations for improvement. To work with the ERSAB (East Riding Safeguarding Adults Board_ to ensure that their multi-agency	DA Lead Adults Services ERSAB SDAB		March 2026	

			safeguarding procedures are				

			up to date with the relevant processes and pathways for responses for domestic abuse				