



Domestic Abuse Related Death Review

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

Review into the death of Catherine
in September 2020

Preface

The Safer Sunderland Partnership and the Review Panel wish at the outset to express their deepest sympathy to Catherine's family and friends. This review has been undertaken in order that lessons can be learned.

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

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

Poem written by Catherine's sister

SEE ME

A 999 call, there's a body on the beach,
Please listen to my story, I have so much to teach.
Are there any identifiers, do we know who she was?
My name is Catherine and I have so many scars.
Policies and protocol, reports to complete,
You're not listening or seeing me coz my life's obsolete.
We'll have to tell the family, is it your turn or mine?
I was abused and belittled, broken in spirit, body and mind.
Have we got all we need here, witness statements and things?
I'm sorry for my suicide and the trouble it brings.
Telling the family is not easy at all,
We have listened and if missed anything just give us a call.
You've not listened to anything; you don't know my life.
You've got what you need though, next of kin and the like.
You've got someone to identify the body on the beach,
But you've missed the desperation in my family's speech.
They are begging you to help me, to know who I am,
I'm a mother, daughter, sister and friend but I'm also the wife of a cruel, monstrous man.
I fought for my life, fought with all that I had,
But I was coerced and controlled and abused so bad.
I was left feeling worthless and scared and sad,
The abuse left me thinking that I was going mad.
Should we question capacity, could that give us a lead?
Please don't insult me. Question abuse, that's what I need.
You see, if you ask the right questions and understand who I was,
I'm no longer a body, crime number or report, I die as a victim and that's who I was.

Domestic Abuse Related Review into the death of Catherine

This summary presents the findings of a Domestic Abuse Related Death Review undertaken by the Sunderland Partnership into the death of **Catherine** (pseudonym).

Catherine died in September 2020. The review aimed to identify lessons learned from the circumstances surrounding her death and the responses of any agency involved with her in the time leading up to her death. It highlights the importance of understanding all forms of domestic abuse, particularly its coercive and controlling nature, and the impact it can have on victims' mental health and overall well-being.

Background and Context

Catherine was a 40-year-old woman who had been in a relationship with her husband, **David (pseudonym)**, for around ten years. The couple had two children and were undergoing divorce proceedings at the time of her death. Catherine had struggled with mental health issues, including an eating disorder and alcohol misuse, these issues were exacerbated by what she described as her experiences of domestic abuse.

Relationship Dynamics

The review details examples of reported controlling behaviour exhibited by David throughout their relationship. This included emotional abuse, financial control, and isolation from family and friends. Catherine's friends and family noted a significant change in her demeanour during the relationship, describing her as becoming anxious and withdrawn, particularly after the birth of their children. She specifically described:

- **Coercive Control:** She said David's controlling behaviour began early in their relationship and intensified over time, with Catherine feeling increasingly trapped.
- **Emotional Abuse:** Catherine reported that David would often belittle her, telling her she was unattractive and a bad mother, which severely impacted her self-esteem. She said that the children were used by David as a 'weapon' against her and he threatened to financially ruin her.

Agency Involvement

The review examined the involvement of various agencies, including health services and social care, in Catherine's life. It highlights several missed opportunities for intervention that could have potentially altered the course of events leading to her death.

Health Services

Catherine accessed multiple health services for her mental health and eating disorder, but the documentation of her disclosures about domestic abuse from some partner agencies was often

inadequate. While her GP did inquire about domestic abuse, the responses from professionals were not always followed up with appropriate actions, such as a DASH risk assessment.

Children's Social Services

Catherine's interactions with Children's social services were complicated by her ongoing custody battle with David. Social Services were aware of the abuse she disclosed to them. The review notes that the emotional stress from this situation negatively impacted her mental health, leading to increased alcohol use and feelings of despair.

The Impact of Domestic Abuse

The review emphasised the direct correlation between the domestic abuse she said she suffered and her mental health deterioration. Catherine's feelings of hopelessness intensified after the Family Court made an interim order to place her children with David. This decision significantly impacted her mental state and contributed to her death.

Suicide and Mental Health

The review discusses the Integrated Motivational-Volitional model, which outlines the progression from suicidal ideation to action. Catherine's experiences of humiliation, entrapment, and the lack of perceived support from agencies led her to a state of despair.

- **Pre-motivational Phase:** Catherine faced numerous stressors, including her divorce, financial instability, and ongoing domestic abuse.
- **Motivational Phase:** The court's decision regarding her children was a significant trigger that led to her feelings of defeat and hopelessness.

Lessons Learned and Recommendations

The review concludes with a series of recommendations aimed at improving responses to domestic abuse cases. It suggests the implementation of routine training for health professionals on domestic abuse and the establishment of better communication between agencies involved in safeguarding.

Key Recommendations developed in Action Plan

- **Routine Enquiry Training:** Roll out training across all GP practices to ensure consistent inquiry about domestic abuse.
- **DASH Risk Assessment:** Ensure that DASH assessments are completed whenever domestic abuse is disclosed, with appropriate referrals made to MARAC when necessary.

The tragic case of Catherine serves as a reminder of the critical need for effective communication and collaboration among agencies to safeguard vulnerable individuals and prevent future tragedies.